From the Constitution to the Hospital: Universal Health Care in Thailand

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From the Constitution to the Hospital: Universal Health Care in Thailand

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Introduction:

In 2001, Thailand embarked on one of the world’s newest experiments in universal health care. Led by Prime Minister Thaksin Shinawatra’s Thai Rak Thai (“Thais love Thais”) party, the country set out to ensure that all 64 million Thai citizens had access to health care. The plan, known as the “30 Baht cure all” plan, is simultaneously modeled after universal health care systems in other countries’ and specifically designed to address the historical, economic, and political realities of Thailand. [1]

In order to understand the system in Thailand and to place it in a theoretical framework and international context, there are three sections to this thesis. The first section explores a theoretical framework for universal health care systems by seeking to define health care systems and universal health care systems; explore the challenges they face, the goals they set; the structures they set up to meet those goals; and issues raised in measuring outcomes. The second section examines the international context by exploring issues raised in five countries that have implemented very different types of universal health care—Cuba, the UK, Taiwan, Chile, and Thailand. The third and final part of this thesis evaluates qualitative data collected from health care providers in 6 provinces of central Thailand in the summer of 2005 regarding their experiences with and attitudes toward the new universal health care system. With background on different models of health systems, universal health systems, and four international examples of universal health care, the study seeks to elicit Thai health care providers’ thoughts on the positive and negative points of their particular model. Ultimately, lessons derived from these health care providers in Thailand are intended to be useful for international policy-makers and to Thai policy makers in choosing the way forward,
Section I: Conceptual Framework for Universal Health Care Systems

Defining Health Systems:

Aptly put by Curtis and Taket, "National health care systems are difficult to describe because of their scale and complexity." [2] Many different fields have attempted to define "health system" without consensus. The definitions can be quite broadly focused and include everything related to "health," or focus rather narrowly on "biomedicine" and/or western health care. [2] In fact, some people choose to describe "health systems," [3-8] while others choose to describe "health sectors" [2]. From an integrative social sciences approach claiming to incorporate geography, sociology, anthropology, epidemiology, and other social sciences, Curtis and Taket describe the health sector as:

...the sector within a society whose main concern is with health care. The sector comprises all the different kinds of activity undertaken with the purpose of protecting or promoting health, and providing care, treatment, cure, or support to those in ill health [2]

In a book that is a collaboration between a sociologist, an anthropologist, and an economist, the interdisciplinary definition again focuses on the resources involved in the provision of health care itself:

A health care system may be defined as the combination of health care institutions, supporting human resources, financing mechanisms, information systems, organizational structures that link institutions and resources, and management structures that collectively culminate in the delivery of health services to patients. [5]

Field goes slightly further, adding "commitments" in his definition of a health care system as:
That aggregate of commitments and resources (human, cultural, political, and material) any society devotes to, or sets aside for, or invests into the "health" concern as distinguished from other concerns such as general education, defense, industrial production, communications, capital construction, and so on. [8]

Lee goes even further into the abstract, incorporating "ideas" into his definition:

The health care system of a society can be broadly defined as a set of ideas, practices, and organizations which have been developed to deal with the problems of health and illness in a society. [4]

Whether it includes activities, resources, commitments, and/or ideas, the notion of a "health system" is clearly a difficult one to delimit. It is also interesting to note in the definitions, whether health care systems are conceived of as addressing "problems" [4], "concerns" [8], or simply as systems with a goal of providing an output—health care [2, 5-7]. Like many, Matcha tends to the latter, avoiding describing problems or concerns (and also avoiding enumerating the components that make up all systems) by describing a health system as:

...any combination of those components identified by a society that facilitates the provision of health and health care for its members [7]

Rather than trying to determine whether or not commitments, ideas, or specific types of management or institutions are incorporated into a "health care system" this paper will adopt Matcha’s definition when referring to a "health care system." It will, however, focus on the set of policies, insurance and finance schemes, and other mechanisms of providing western medical care to populations.

Challenges Faced by Health Care Systems:

Regardless of how countries structure their health care system, each of them face particular challenges. The reality of limited resources, which exists in all contexts, means that they cannot allocate resources to everything that "deserves"
resources. Meanwhile, health care has become increasingly expensive and has taken up a larger portion of the budgets of most nations. According to Blank and Burau:

While Countries vary significantly as to the percentage of their gross domestic product (GDP) that they devote to health care, in virtually all cases it has increased significantly over the last three decades. This means that health care costs are increasing at rates exceeding that of economic growth, a pattern that most countries will not be able to sustain. [10]

The following Table, reproduced from Blank and Burau, demonstrates the rising health care costs in a set of so-called “developed” countries:

<table>
<thead>
<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Australia</td>
<td>5.7</td>
<td>7</td>
<td>7.9</td>
<td>8.2</td>
<td>8.6</td>
<td>2.9</td>
</tr>
<tr>
<td>France</td>
<td>5.7</td>
<td>7.4</td>
<td>8.6</td>
<td>9.1</td>
<td>9.4</td>
<td>3.7</td>
</tr>
<tr>
<td>Germany</td>
<td>6.3</td>
<td>8.8</td>
<td>8.7</td>
<td>9.7</td>
<td>10.3</td>
<td>4</td>
</tr>
<tr>
<td>Italy</td>
<td>5.1</td>
<td>7</td>
<td>8.1</td>
<td>8.4</td>
<td>8.2</td>
<td>3.1</td>
</tr>
<tr>
<td>Japan</td>
<td>4.6</td>
<td>6.5</td>
<td>6.1</td>
<td>6.3</td>
<td>7.4</td>
<td>2.8</td>
</tr>
<tr>
<td>Netherlands</td>
<td>7.2</td>
<td>8</td>
<td>8.5</td>
<td>8.9</td>
<td>8.7</td>
<td>1.5</td>
</tr>
<tr>
<td>New Zealand</td>
<td>5.2</td>
<td>6</td>
<td>7</td>
<td>7.6</td>
<td>8.1</td>
<td>2.9</td>
</tr>
<tr>
<td>Singapore</td>
<td>n/a</td>
<td>n/a</td>
<td>2.8</td>
<td>3.2</td>
<td>2.9</td>
<td>0.1</td>
</tr>
<tr>
<td>Sweden</td>
<td>6.9</td>
<td>9.1</td>
<td>8.5</td>
<td>8.5</td>
<td>7.9</td>
<td>1</td>
</tr>
<tr>
<td>UK</td>
<td>4.5</td>
<td>5.6</td>
<td>6</td>
<td>6.9</td>
<td>6.8</td>
<td>2.3</td>
</tr>
<tr>
<td>USA</td>
<td>6.9</td>
<td>8.7</td>
<td>11.9</td>
<td>13</td>
<td>12.9</td>
<td>6</td>
</tr>
</tbody>
</table>

Source: Blank and Burau [10]

This increase in health care costs is often caused by country-specific challenges (see below), and also causes challenges that may be country-specific. Later sections will describe specific challenges in five countries. However, in countries considered “developed” or who have made considerable health progress in recent decades, certain causes of the rising health care costs have become generally recognized: ageing of the population, rapid advances in medical technology, increasing public demand for health care. [10] A further problem in both “developed” and “developing” countries is epidemiologic change. [2] Examples of this are the rise in
AIDS in Sub-Saharan Africa, South and Southeast Asia, and Russia as well as increasing diabetes prevalence in the United States.

**Goals of Health Care Systems:**

With all of these challenges in mind, what are the goals of most health care systems? The World Health Report 2000 identifies three main goals: 1) better health (primary goal), 2) fairness in financial contribution, and 3) “responsiveness to people’s expectations in regard to non-health matters.” In this set of goals, better health is primary, and “desiderata such as accessibility are really a means to an end; they are instrumental rather than final goals.” [11] Blank and Burau take a different tack when they identify what they consider the three main goals: 1) equity/access, 2) cost containment/efficiency, and 3) quality. That is, a system should strive to provide equity to all citizens in access to health services, provide it in a cost efficient manner that maximizes health benefits, and maintain high quality of the services throughout. [10] In this conception, equity/fairness (albeit in provision not finance) are primary goals.

A slightly different perspective is taken by policy analysts who explore what Oliver has called “inconsistent triads.” The notion is that any two of three goals may be met, but not all three. For example, Oliver describes a triad of “comprehensive care,” “high quality care,” and “care on the basis of need rather than the ability to pay.” According to his assessment, any two of these can be met, but never all three. [12] Rodrigo Salinas in the Chilean Ministry of Health simplifies the triad slightly to “high quality,” “comprehensive,” and “free.” [13] The goal of the health system, in this view, is to balance the three parts of the triad, in a way that chooses to either compromise slightly on each of the three goals, or that gives one up entirely.
Other potential goals of a health care system include “satisfaction” and “choice.” Focusing on satisfaction for a moment, one may surmise that good health is not the only outcome health systems may produce (discussed further in section on outcomes). It also is one of the reasons health systems are so politicized. Beyond the fact that health care facilities are “great concentrations of economic resources” and thus “the subject of political struggle”[14], they also become politicized when satisfaction is low. For example, in countries with long waiting lists for elective surgeries, shortening the waiting lists may take resources away from more essential medical care (primary care, preventive care, emergency care, etc.). However, if it increases public satisfaction (or gets a political party elected), it may be a worthwhile trade-off for the society (or political party). [12]

In addition to seeking satisfaction, health systems may set themselves up in a way to provide patients more or less choice in where and from whom they access health care. Blank explains that “the level of choice reflects the way health services are organized, but also more explicit decisions about the appropriate level of patient choice.”[10] Many argue that increased patient choice causes competition between health care providers on the basis of quality and cost which may ultimately benefit patients [12, 15, 16]. Others argue that competition may actually be detrimental to the functioning of health care systems. [2, 12] The basic debate is whether and when the free market provides more benefit to more people versus where regulation must step in to increase efficiency. Without taking up this debate in the abstract (outside of country specific contexts), it is clear that much of this argument is based in different economic ideologies.

Both sides in the argument, however, have come to accept that health care markets are different than normal business markets and have certain “market failures”
which keep them from functioning as efficiently as possible. This necessitates some level of planning and regulation, and introduces a further goal of the health system: to control market failures. In a seminal 1963 paper, Kenneth Arrow described the reasons for market failures in health care. Some of the reasons he elaborates are that health care demand is unpredictable, that physicians don’t act the way businessmen would in that they “avoid the stigmata of profit maximizing,” and that patients have significant uncertainty as to the quality of the product they are receiving. [17] More recently, Blank and Burau explain further by enumerating 3 conditions under which free markets best serve consumers: 1) “all decisions must be the consumers’,” 2) “consumers must know the values and costs of what they are purchasing,” and 3) consumers “must pay the full cost and receive the full value of the goods they choose to buy.” They point out that “not one of these conditions is present in the market for health care services.” [10] All of these conditions keep a perfectly free market from being the most efficient way for the health care market to function, and necessitate government intervention at the “health care system” level.

The discussion as to how much intervention and how much of the free market health care should face becomes even more complicated when the notion of rights is introduced. Many people and many societies consider health care to be a basic human right. The question that naturally follows this assertion is “who is responsible for making sure that right is met?” In their argument against universal health care, Goodman et al. assert that:

*What the right to health care means almost everywhere is nothing more than the opportunity to get services for free (or at very little cost) as the government decided to make those services available. But government is under no particular obligation to provide any particular service. [16]*
As will become clear in the discussion of the five countries taken up by this paper, there are in fact countries where government is under obligation to provide particular services. Furthermore, this assertion fails to distinguish between negative and positive rights. Negative rights (do rights attribut) protect people from harm by others and are generally agreed upon in health care. Positive rights (dorits creance) entitle people to certain goods and services, and are a much more challenging discussion in the health care arena. Blank and Burau apply negative and positive rights to the health care arena explaining that:

"[negative rights] relate to the freedom to be left alone to use one's resources as one sees fit... Health care as a negative right would allow patients with adequate personal resources to maximize their use of health care... In contrast positive rights impose obligations on others (society?) to provide those goods and services necessary for each individual to exercise his/her rights..." [10]

In Goodman’s conception of the right to health care, health care is mainly a negative right. However, many countries have envisioned, legislated, and (debatably) enacted positive rights to health care. Thailand, the focus of this thesis, is one such example, with explicit positive rights language regarding health care in the constitution. [19] As Thailand and the other example countries will demonstrate, however, universal health care systems can guarantee access to health services with or without describing it as a positive right.

When the health care as a human right discussion is conducted, Oliver’s “inconsistent triads” [12] must be kept in mind. As a system guarantees more services, the practical consequence is often lower quality or longer waits. The specific consequences of a health care system depend largely on the way a system is organized.
Types of Health Care Systems:

Curtis and Taket warn that “Because health systems are complex, any attempt to describe a national health system involves a large degree of abstraction and simplification.” [2] Matcha points out that “agreement regarding an international classification system and location of countries does not exist.” [7] However, because of the potential usefulness of having schema for understanding national health care systems, numerous ones have been developed.

Curtis and Taket, in fact, begin by separating health care systems into two large ideological categories, based on the market control versus freedom debate discussed above, which they dub “collectivist” and “anti-collectivist” health care systems. In collectivist systems, “access to health services is not seen as part of the reward system in the society, but more of a natural right for all citizens.” Meanwhile anti-collectivist systems emphasize that “free markets should be allowed to govern the distribution of health services because this is the most efficient and effective way to meet the demand for health services…” [2]

Light schematizes systems based on who is at the center of control. In his schema, there are four main models:

1. **Mutual Aid Model**: Originating 400 years ago to provide support and money to sick workers, this system is funded and controlled by workers, and administered largely by non-physician health providers.

2. **State Model**: Controlled by the government, this model is described as being subject to abuse by democratic governments as a means of cost control and by autocratic governments for indoctrination.

3. **Professional Model**: Physicians control this system, providing medical care only to those who can afford it, a source of inequity.
4. **Corporate Model**: In this model, the government is not explicitly in control, but acts as an intermediary between all parties. [3]

Mark Field organizes his schema largely based on the level of organization and government control within the system. His spectrum of five types of system ranges from “anomic,” where physicians act as solo-practitioners paid directly by patients, on one end to “socialized,” where the government owns and controls all facilities, material resources, and human resources, at the other end. His five schemas are:

1. **Anomic**: physicians as solo-practitioners paid directly by patients
2. **Pluralistic**: Physicians are located in groups with both private and public ownership of facilities.
3. **Insurance/Social Security**: Health care is guaranteed rather than being a private good. Still mixed public-private ownership of facilities.
4. **National Health Insurance**: Health Care is guaranteed and government is the primary owner of health facilities.
5. **Socialized**: Health care is guaranteed, the government owns all resources, and employs all physicians.[20]

Matcha organizes the system along a similar spectrum, however with a heavier emphasis on funding of the system. His schema includes 4 models:

1. **Entrepreneurial**: Emphasis is on a strong private marketplace.
2. **Bismarck Model**: Named after the first German Chancellor (end of 19th century), this system is based on a partnership between government and employers to financially insure a system’s citizens with provision of health care services, which are largely private.
3. **Beveridge Model**: Named after a consultant to the British government, this model is specifically financed by tax revenues and provides centrally financed (i.e. government-financed) health care. Provision of health care is largely public with physicians employed by the state.

4. **State Controlled Model**: Described only as the “communist” model, this model is rapidly changing in the former socialist Eastern Bloc states. [7] Robert Blank and Viola Burau describe a very similar schema as the above, but focus on the source of insurance in the system. They include 1) private insurance, 2) social insurance/Bismarck, and 3) National Health Service/Beveridge.

Like all of the systems described thus far, this system includes some element of a spectrum from free market driven to rigidly controlled. In fact Blank and Burau explain that all of the systems in their schema are along a spectrum in which neither extreme actually exists. They represent it visually as follows:

<table>
<thead>
<tr>
<th>Private Insurance</th>
<th>Social Insurance</th>
<th>National Health Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free Market</td>
<td></td>
<td>Government Monopoly</td>
</tr>
</tbody>
</table>

All of these systems, in fact, can be placed on various spectrums: free market→government intervention; private finance→public finance; individual control→government control; individual responsibility→collective responsibility; etc. The reason for the lack of agreement on an international schema for categorizing health care systems is largely that health care systems are multi-dimensional falling at a set of different points in different spectrums.

**Types of Universal Health Care Systems:**

Universal health care systems, although a sub-section of health care systems generally, are not terribly different, in that they are also multi-dimensional and hard
to schematize. They are also quite specific to national contexts and must be understood as such (see country descriptions). Generally, however, there are some important distinctions between models of universal health care.

*Bismarck Versus Beveridge Model*

A major first category on which to distinguish is the employment arrangement of physicians. In the Beveridge model, for example, the state employs most physicians, whereas in the Bismarck Model the private sector is the main employer of physicians. [10] There are also many mixed models, where individual physicians can have both public and private employment or where there is a significant portion of physicians who practice entirely in the public and entirely in the private sector (see country descriptions).

*Universal Versus Uniform Systems:*

Another crucial distinction is between *universal* and *uniform* health care systems. “Universal” health care implies that everyone has access to some kind of health care. “Uniform” health care, on the other hand, indicates that everyone has access to the same kind of health care (at least in theory). Universal health care systems can exist with quite divergent levels of explicit access for the different participants. For example, in a number of systems, government employees or military personnel receive different health care benefits than the rest of society. Another example is a system which allows participants with sufficient resources to opt out of the universal scheme and purchase private coverage instead.

The key issue brought up by universal but not uniform systems is how well they do at meeting the health care system goal of equity. If equity is one of the
explicit goals of a system, and it explicitly provides different health care to different members of society, there is an inconsistency. Sometimes this inconsistency is taken on for political, social, or economic reasons that include a trade-off for benefits towards other goals of the system.

If a system does choose uniformity, however, one major benefit is a concept known as solidarity. Based in collective and redistributive actions, solidarity comes from the fact that everyone is eligible for a uniform system, and everyone is required to participate. According to Maarse and Paulus, there are two kinds of solidarity in health systems: risk solidarity and income solidarity. Risk solidarity “means that everyone should have access to health insurance, independent of their risk profile,” that is independent of age, sex, socioeconomic status, health status, etc. Income solidarity means that policy holders must pay for their health insurance based on their ability to pay. [21] Another conception of solidarity is that when everyone participates in a system together, they somehow feel a common goal. Irrespective of economic or ideological viewpoint, one can see that the net effect in systems with income and risk solidarity is a redistribution of resources from people who can afford to provide them to people who need them for health care.

While practically difficult to achieve, solidarity helps dramatically in avoiding many of the pitfalls of non-universal, or universal but non-uniform health care systems. A phenomenon known in economics as “adverse risk selection,” “adverse selection,” or “risk selection” occurs when people have the choice whether or not to purchase insurance, or the ability to opt out all together from a national system. To understand adverse selection, an illustration is useful. Imagine a country with a million people, 800,000 of whom are completely healthy. If all one million citizens are offered the same health insurance and are all given the option to keep their tax
money instead, who is most likely to keep their tax money? The healthy people would be more likely to keep the money, of course. This leaves an insurance system/health care system with the 20% of sicker, more expensive patients. In other words, the people with greater health risks are selected to be in the system, and those with lesser health risks do not participate in the system. If, instead, all one million citizens are forced to contribute equitably to the system, beyond financial solidarity, there is also what is described as “risk-pooling” amongst the high and low risks. While essentially this is subsidization of the sick by the healthy, it also allows people over a time-course to be subsidizers at certain points of their lives and the subsidized at others.

Another benefit of solidarity is present in the concept of “voice.” Wealthier and more active people tend to have more clout in the political and social arena, and are more able to make their voices heard. In non-universal systems or universal but non-uniform systems where wealthy and active people may opt out of the system altogether (choosing private health care insurance or no insurance) their voice is not present from within the system. If there are elements of a system that need to be improved, only those who are left can use their “voice.” If those left are the sick and the poor, their voice is more than proportionally diminished. If, however, a system is uniform and all members of the society must participate, the voice of the healthy, the sick, the rich, and the poor are all present in the demands for improvements.

*Primary Care Focus Versus Non-Primary Care Focus*

Another important distinction among universal health care systems is whether or not they focus on primary care. The World Health Organization defined primary care in 1978 as:
Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. [22]

Curtis and Taket explain that primary health care is provided in settings which are generally outside of the hospital and “must be provided in close proximity to the places where people live.” [2] Systems set up with a primary focus on primary care, then, tend to de-emphasize hospitals as the access-point for health care. Meanwhile, they seek to prevent health problems from occurring or from progressing to the point where they require secondary or tertiary care.

On the other hand there are systems which are secondary and tertiary care-based. Secondary care is difficult to define and distinguish from tertiary care, but Roemer defines secondary care as “specialized ambulatory medical service, commonplace hospital care, care by non-medical specialists, and general long-term care.” [6] Tertiary care, as defined by Matcha, is “those medical services which are extremely complex, require extensive technological intervention, and, as a result, are costly.” [7] While systems that are secondary and tertiary care-based do not necessarily treat common conditions with complex and expensive care, they do use the centers where complex, expensive care is provided as the access points to primary care. In other words, primary-care-based universal health systems tend to be community-based, prevention focused, and administered by physicians and non-physicians, while non-primary-care-based systems tend to be hospital-based and largely administered by hospital doctors.
Financing Issues

Another way of distinguishing between universal health care systems is based on financing. Both the form of taxation and the methods of government payment for health care services are of interest. In the Bismarck Model, for example, employment-based taxes are the source of funding, whereas in the Beveridge model, general taxes finance the system. Meanwhile, payment can be made to doctors, to groups of doctors, or to hospital systems in very different ways, which provide different incentives to the health care providers.

The first part of financing to notice is the level and form of taxation upon the general population. Taxes can be described as progressive or regressive based on the portion of peoples’ income taxed. Progressive taxes tend to favor the poor, while regressive taxes tend to favor the rich. A progressive tax is a tax where the more one earns, the higher a portion of their income they pay in taxes. The classic example of a progressive tax is income taxes, with higher tax brackets for higher incomes. A regressive tax is a tax where the more one earns, the lower the portion of their income they pay in taxes. A classic example of regressive tax is sales tax. Sales tax is regressive because those with higher incomes tend to spend a smaller portion of their income. Therefore, a universal health care system funded by an income tax with increasing income brackets would be progressive, while a system funded by a sales tax would be regressive. In this sense, the Bismarck Model is less regressive than the Beveridge Model. Financing in the Bismarckian systems tends to be a standard percentage of income which is neither progressive nor regressive. In Beveridge systems, general taxes tend to be regressive.

The second distinction within financing is how the government uses those tax funds to pay health care providers for the services they provide. There are a huge
number of possible payment schemes, many of which are quite complex. However, there are some general categories of interest. An older version of the way governments paid health care providers is on a fee-for-service (FFS) basis. In this model of payment, the government pays health care providers set fees for each good or service rendered. So a blood test, an X-ray, a prescription, a periodic health check-up, or a heart surgery would each have a set payment rate for the health care provider. When it comes to heart surgeries, this payment arrangement would probably have little effect on the frequency of the procedure. However, when it comes to more routine procedures or products, such as lab tests or basic medications, there would be some inducement to provide more. The more X-rays a health care provider performed, the more money they would make in FFS-reimbursed systems. To deal with this inefficient inducement, many systems have shifted away from FFS reimbursement to what is known as capitation. Capitation provides a set amount of money per person per year for all health services. Any costs above and beyond the capitated payment are born to a certain degree by the health care provider, and any money left over is rewarded to a certain degree to the health care provider (often to offset more expensive patients, but sometimes kept as income). The incentive in this system is for the health care provider to provide services and keep their patients healthy in the most cost-effective manner. There may also be some perverse incentives to withhold treatment that would otherwise be provided.

The other issue in finance is whether or not the patient faces any portion of the cost of their care. If all services are completely free to patients at the point of access, economists worry about what is called “moral hazard.” Kenneth Arrow introduced the idea to the health care realm in his 1963 paper explaining that “widespread medical insurance increases the demand for medical care.” [17] As Blank describes
it, moral hazard consists of "over-consumption because neither the patient nor the physician has an incentive to economize when an amorphous third party is paying the bill."[10] Basically, moral hazard explains the phenomenon of patients requesting and doctors assenting to health care that would not be requested if either party faced more of the cost of that care. On the patient side (the one usually emphasized now that payment has largely shifted to some sort of capitation), there is concern that patients will access far more care than they need, imposing a huge bill on the government and thus society. Some universal health care systems attempt to manage this with copayments or coinsurance. With copayments, the patients pay a set amount for each service or good they receive from health care providers. In coinsurance, the patient pays a set percentage of the cost.

This potential for a huge bill brings up another issue often used to distinguish between health care systems generally—the percent of Gross Domestic Product (GDP) spent on health care per capita. Figure 1 shows the percent GDP per capita that the nations evaluated in this paper (minus Taiwan plus a few others) spent on health care in 1997.

**Figure 1:**

<table>
<thead>
<tr>
<th>Country</th>
<th>Percent GDP spent on Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>0.0</td>
</tr>
<tr>
<td>Canada</td>
<td>6.1</td>
</tr>
<tr>
<td>Chile</td>
<td>8.3</td>
</tr>
<tr>
<td>Cuba</td>
<td>10.0</td>
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<tr>
<td>Thailand</td>
<td>12.0</td>
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<tr>
<td>United States of America</td>
<td>14.7</td>
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<tr>
<td>Afghanistan</td>
<td>16.0</td>
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One of the major concerns as this percentage increases is that other sectors of the economy will face "crowding." That is, as more of the resources of a country are devoted to health care, other industries and services of the society will receive fewer resources. Meanwhile, contrary to what one might think, there is little relationship between the percent GDP per capita spent on health and satisfaction with the system [10] or health outcomes. [23]

Outcomes

According to Blank and Burau, "given the universality of healthcare as a problem, one must question whether what governments do about it... makes a difference." [10] As was made apparent in the section on the goals of a system, there are many potential goals of government, which can be used to assess how well a system is doing. For example, the mean life expectancy of a country may increase dramatically, but if there are large disparities in life expectancy between different groups within society the goal of equity is not being met well. Such a disparity can often be due to one or more intermediate factors such as the poor distribution of resources generally. It can also be due to the poor distribution of health resources (usually sparse in rural areas) and limited physical (as opposed to financial) access, poor targeting of health resources to those in need, long wait-times and low satisfaction with and confidence in the quality of the system. [10]

Meanwhile, these are almost all difficult things to measure. Both measuring and making conclusions based on outcomes of health systems are very contentious topics. The literature is largely dominated by debates of if and when certain measures are useful. Buck et al. assert that in order to be useful, "an adequate conceptual
framework to measure the benefits of healthcare must deal with the following problems:

- No population health outcome measure can be a perfect indicator of population health status due to contextual factors.
- Health outcomes are influenced by many factors other than healthcare.
- Healthcare contributes to welfare other than improvements in health status.
- Many of the links between healthcare and changes in health status are poorly understood.
- Many of the influences of healthcare on health status operate over a long period of time. [24]

The third point raises one of the primary problems in measuring the outcomes of a health system, and one implicit in the judgments made above by the various sets of goals for health systems. If healthcare contributes to welfare other than improvements in health status, are those secondary or primary goals of the system? If they are primary, then they certainly should be measured and used in assessing a health system’s achievement. However, if they are secondary, the focus should be primarily on health outcomes. Even if the focus is primarily on health outcomes, though, the second and fourth points make it very difficult to causally relate changes in a health system to health outcomes, or even to compare different health systems. Finally, the health outcomes of a change in a health system may not appear for years or even decades. When this is the case, measuring the health outcomes of a new health care system will completely miss the impact the system is having (positive or negative). For this reason, many people disregard health outcomes as measures of health system performance. [25]
Despite all the challenges in measuring outcomes of health systems (health and otherwise), there have been innumerable attempts to do so. The most comprehensive recent one was the World Health Report 2000. It presents basic health indicators (life expectancy, child mortality, etc.), and ranks all 191 member states of the World Health Organization on summary performance measures including the level and distribution of health, the level and distribution of health system responsiveness, fairness in financial contribution, overall goal attainment, performance on level of health, and overall health system performance. [11] While these data are potentially useful, they have been criticized as biased against universal health care policies "on very superficial grounds"[25] and potentially dangerous if used to guide policy. [26] Specifically, the measure of healthy life expectancy, the Disability Adjusted Life Expectancy (DALE), has been criticized as subject to problems of reliability and ethical problems in policy application [26], the indicator of health distribution has been shown not to correlate with measures of social inequalities in health, [27] and the Fairness of Financial Contribution index has been described as unable to discriminate between regressive and progressive health financing systems based on the fact that it depends on both horizontal and vertical equity, rendering it useless for policy decisions. [28] Horizontal equity, or equitable contributions to a health care system from people with equal incomes, is certainly something to strive for in most systems. However, vertical equity, or equal contributions to a health care system across incomes may or may not be. Vertical equity can certainly increase the regressive nature of a system. [25] With questions like these looming, cautious analysis of the various outcomes measures in the WHR 2000 are called for, though it remains the only method that has been used to evaluate financing in all nations. [29]
In summary, both health outcomes and measures of health system performance should be taken with a grain of salt when assessing health systems performance, and health outcome measures should certainly not be assumed to be causally related to any changes in a system. With that in mind, the following sections will include some outcomes measures while discussing five examples of universal health care systems.

**Section II: International Context for Universal Health Care Systems**

**Introduction:**

There are a number of works which explore health systems around the world in a theoretical context. There are also works which explore systems of the "developing world" or of the "developed world." However, a large-scale academic evaluation of universal health care systems around the world has not yet been written in English. While there are too many countries to cover in a master's thesis, the following section will attempt to give an introduction to five distinct models of universal health care systems from five countries: Cuba, the United Kingdom, Taiwan, Chile, and Thailand.

Anytime one evaluates a health care system, it is essential to present the basics of the historical, political, and economic contexts. [30] Within these contexts, the particulars of a health system can be understood by describing the goals, methods and outcomes. The following sections will attempt to very briefly describe these six elements (not in any particular order) for each country.
Cuba:

Cuba is perhaps the most straightforward and unusual model of universal health care in today’s world. It is neither Bismarckian nor Beveridge, and is closest to what Field calls “socialized” [8] and what Blank and Burau call the “state-controlled model.” [10] All doctors are employees of the state, all facilities are owned by the state, and everyone is entitled to health care in a geographically evenly distributed, primary-care based universal and uniform health care system.

This system came into existence after the 1959 socialist revolution led by Fidel and Raul Castro, Camillo Cienfuegos, and Che Guevara that removed the Batista dictatorship. According to De Vos, prior to the revolution in the 1950’s, “Cuba’s health system was built on the same three pillars that characterize most other Latin American health systems up to this day.” These three pillars are a social security health system for formal sector employees, a private health system for the rich, and an “under-financed public health care system for indigents.” [31] All three of these systems were concentrated in urban areas, mainly in Havana, and most people in rural areas had never seen a doctor. [32] According to Fidel Castro’s 1953 defense of himself before a Batista Magistrate (before leaving the country and returning to take power):

Public hospitals, which are always full, accept only patients recommended by some powerful politician who, in turn, demands the electoral votes of the unfortunate one and his family so that Cuba may continue forever in the same or worse condition. [33]

As far as the social security insurance, around 20% of the population had health insurance through their employer and that same insurance fund accounted for 45% of the hospital beds in Cuba. [31] That disproportionate representation further hints at the weakness of the public system. Meanwhile, the wealthy received the best health
care money could buy in their system. These disparities, along with corruption of many public sectors including law enforcement, were among the many factors that led to the armed revolution. [34]

From the revolution forward the cornerstone of all policies was the “belief that access to health services is a human right for every citizen.” [32] From the Revolution to the present day, De Vos describes four major phases of the health care system: 1) Post-Revolutionary (1959-1970), 2) Consolidation (1970s), 3) Development (1980s), and 4) Adjustment (1990s). [31]

Immediately after the revolution, the health care system was dramatically changed with the nationalization of pharmaceuticals and private clinics. The price of drugs declined sharply. Meanwhile half of Cuba’s 6,000 doctors left the country, [35] including most of the faculty members at the only school of medicine. [31] It took until 1970 for the number to return to 6,000. In 1965, after a bitter debate between the old guard and new guard of doctors, private practice was renounced and banned. During the same period there was a redistribution of health care resources that included a “social and rural medical service” which sent doctors to rural areas starting in January of 1960. [35] The most significant change for health however, was in the political structure. A socialist government guaranteed employment, food, and housing to all citizens. [31]

Despite the challenge of limited health infrastructure, by 1972 Cuba had preventable diseases mainly under control and had shifted it’s focus to dealing with the diseases of “developed countries.” [36] The “Consolidation” phase of the 1970s was dominated largely by central planning and decentralization of administration. In 1976, Cuba’s 14 provinces and 169 municipalities were divided into health zones each serviced by one polyclinic. Meanwhile, a plan to increase the number of
physicians manifested in the proliferation of medical schools in strategically placed areas of Cuba, including rural areas, where doctors could be recruited who would want to stay and practice in their own communities.

The "Development" phase of the 1980's was characterized by an expansion of the role of general practitioners (GPs). There were further divisions of the health zones, which had approximately 30,000 people each, into neighborhood zones of 500-800, each serviced by one GP. [31]

The "Adjustment" phase of the 1990's brought not only the health sector, but all sectors of Cuba special challenges as the Soviet and Eastern European Blocs fell in the late 1980's. Those countries had been responsible for 80% of Cuban imports, 63% of its food, and 98% of its oil. [32] The economic crisis and the accompanying tightening of the US blockade (under the Toricelli and Helms-Burton Acts) caused Cuba's Gross National Product to drop 34% between 1989 and 1993. Absence of foreign currency decreased the availability of foreign drugs and health resources. Health status declined rapidly with a dramatic resurgence of tuberculosis, as well as death from heart disease and diabetes (see Figure 2). [37]

**Figure 2**

*Diabetes Deaths in Cuba*

![](image)

**Source of data:** Cuban Department of Statistics [37]
Meanwhile, Cuba's early investment in human resources started to pay off as the number of family doctors coming out of the many regionalized medical schools increased dramatically. While in 1989 there were only 6,000 family doctor's offices, by the year 2000 there were 14,965. [31] Throughout the country, they lived (and continue to live) alone in identical white houses with a water tank on top, a bottom floor for their clinic, and the top floor for living quarters (this is obviously different in more urban settings). [34] The number of nurses also surged. [31] As Cuba's economy gradually started to improve in the latter half of the 1990's, health status began to improve again. For example, cases of tuberculosis and measles as well as death from heart disease and diabetes all declined from their spike in the early and mid 1990's (see Figure 4). [37]

This basic background of the development of the system should be supplemented with the notions that in Cuban politics the health of the populace is seen as symbolic of the health of the body politic, and that health care workers are one of Cuba's primary resources in international diplomacy. Sending physicians to many Latin American and African nations, Cuba has attempted to increase international goodwill and spread its political message in promotion of socialism. [35] The health system has not only had the goals of fulfilling the human right to health care and improving the health of people within its borders, but also of doing the same outside its borders.

Soberats lists some of the accomplishments of the Cuban health care system since the revolution:

→ all Cubans have access to full and free health services
→ the number of doctors increased from 1 per 1,000 to 1 per 396
→ the number of dentists has increased 30 times from 200 to 6500
the number of nurses increased 22 times from 2,500 to 53,595

... 

the infant mortality rate fell from 60 deaths per 1,000 live births to 11.1 in 1989

the rate of mortality due to infectious disease decreased from 62.7 to 9.3 per 100,000 inhabitants and its percentage in general mortality went down from 11.6 percent to 1.4 percent [32]

The health outcomes really are quite impressive given that GDP per capita was only $3694 in 2005 and only 7.3% of that is spent on health. Health indicators like child mortality rates of 7 per 1000 for boys and 8 per 1000 for girls and life expectancy at birth of 75 for men and 80 for women are comparable with much wealthier nations. [38] The World Health Report 2000 ranks Cuba in the top 25 for Fairness in Financial Contribution among the 191 member states. [11]

In summary, Cuba’s heavily state controlled universal and uniform health system has the goals of “fulfilling the basic human right to health care,” improving health, and demonstrating inside and outside of Cuba that the “body politic” of socialism is successful. While it is difficult to assess the latter, the first two have been addressed by dramatically increasing human resources and distributing them in an even geographic/demographic pattern to ensure primary medical care for all citizens. While economic challenges have diminished resource availability, health outcomes remain above par for the level of income in the country.

The United Kingdom:

Similar to Cuba’s universal health care system, the UK is command-and-control focused. As some history will explain, it is the original Beveridge system. Its
core objectives are to be universal, based on need, comprehensive, and free at the point of use. [12] The system is uniform (though allowing private health care), doctors have been both salaried by and contracted with the government, and it has had varying levels of focus on primary care. It has been through a number of reforms since its inception in 1948, which will be used to illustrate some of the central debates in universal health care markets.

Prior to World War II, health care availability in England was rather spotty. In 1911 parliament passed a limited national health insurance act for workers (following the Bismarck Model already in existence in Germany). In addition to that, there were “provident societies, doctors’ ‘clubs,’ and fraternal organizations” [39] that offered private health insurance. The majority of the population, however, received their care through private payments, charity, or public hospitals. Public hospitals were better funded than the private ones, and access to specialists was limited to the urban areas to which they gravitated. [39]

As Oliver notes, “Politics has always been a more important factor than economics in driving the development of the NHS.” [12] Throughout the 1920’s and 1930’s, a debate raged between two proposals to expand the health care system. The first one, based on the principle of individuals having the right to health care, was to expand the 1911 act to all citizens in a Bismarckian system. The other proposal, based on the principle that society has an obligation to provide health care services, was to expand and universalize the public health system. [39] The debate was largely between physicians and politicians. It raged on, with no progress being made until World War II came, with the German Luftwaffe, in which 2 million homes were damaged or destroyed and more than 100,000 people were killed. Some believe it took this kind of disastrous emergency situation for the factions in the health care
debate to put aside their differences. [40] During the war, an Emergency Medical Service took central control of all medical services in the nation and “created a coordinated hospital service, national and regional services for laboratory work and blood transfusions, and national services for surgery, neurology, psychiatry, and rehabilitation.” [39]

In 1941, Sir William Beveridge, a well-known radio personality, educator, and civil servant was appointed to plan the reconstruction after the war. His report, “Social Insurance and Allied Services” called for a tax-based national health service, which was not insurance based, as in the Bismarck Model, but also actually provided health care as a public good. Thus, the Beveridge Model was born. It took a heavy-handed Aneurin Bevan, appointed as minister of health in 1944, to actualize this plan because of the resurgence of the debate of the 1920’s and 1930’s. GPs fought to maintain their independent contractor status, and were granted it. This created a system where financing was split between hospital care and primary care. [39]

As recently as the 1980’s this split system and the means in which financing was provided to hospitals provided perverse incentives for quality and cost-efficiency. While the NHS budget as a whole is determined by the British Treasury based on historical outlays and estimates of inflation, the Public Hospitals were given their budget by Regional Health Authorities (RHAs). Prior to 1982 there were 14 regional health authorities that received a capitated budget for the health of their entire population and contracted with hospitals and GPs. [41] The RHAs had little incentive to contract with the most efficient hospitals, as efficiency would reduce their future budget. Hospitals, in turn, had no incentive to be efficient, and in fact found that they received more money when they performed poorly. [15, 41] After 1982, the 14 RHAs were split into 192 District Health Authorities (DHAs) in an
attempt to improve efficiency by cutting back bureaucracy. [12] However, Family Practitioner Committees controlled the budget for primary care (recall the GPs fighting for their independence), so the DHAs had no ability to ensure integrated care. An American Economist, Alain Enthoven, explains that any system where there is a public monopoly, excess demand, and providers do not get paid more for serving more people is unlikely to be efficient.[15]

Concerned about these inefficiencies and the resultant increase in cost and decrease in quality of care, the conservative government of Margaret Thatcher, advised by American economists, introduced reforms in 1989 (enacted mainly in 1991) designed to introduce "internal markets." [12, 39, 41, 42] In this system, there was an attempt to separate "purchasers" and "providers" of health care services in order to replace Soviet-(or Cuban)-style command and control with American-style competition. The separation was intended to increase competition among providers for contracts being offered by purchasers. The purchasers were the District Health Authorities and GPs with large patient populations, who were given the option of becoming "fundholders." These GP fundholders were given a capitated amount of money to purchase secondary services for their patients. They were allowed to keep any surplus, as long as it was spent to the benefit of their patients. In effect the GP fundholders and DHAs were functioning like American HMOs. However, the competition stopped there. Patients could not choose their "purchaser" except by moving to a different district. [42] Further, physicians long used to acting, and being perceived to act, as having no economic interests in care, were resistant to following economic incentives. In LeGrand's version of Hume's terminology, they were used to functioning as admirable "knights," not "knaves" who seize all profit-bearing opportunities. She concludes that other models that try to introduce "internal
markets” should keep in mind both the knavely and knightly motivations of health care providers. [42]

That is exactly what Tony Blair’s Labour party did after it took power in 1997, while continuing market-based reforms. They gradually removed all purchasing responsibility from the DHAs (leaving them only an oversight role), and consolidated it in the hands of providers. They did this by universalizing fundholding, requiring all GPs to join one of 481 Primary Care Groups (PCGs), subsequently made into 303 Primary Care Trusts (PCTs). PCTs became fully operational in 2004 and receive capitated budgets for approximately 170,000 people. [12] The group nature of the PCTs encourages collegial collaboration, while the capitation encourages competition among providers on efficiency and quality.

Meanwhile quality, wait time, and disparities became increasing political problems with the NHS. The National Institute for Clinical Excellence (NICE) was ostensibly established to eliminate geographical inequities, however they function mainly to determine if new and existing clinical interventions are cost-effective and if they should be offered in the NHS. [12] Since one of the major goals of the system is that it be universal based on need, anything other than need causing differential access to care is counter to that goal. Studies have shown that while health care utilization on the whole is concentrated towards lower income groups, [43] inpatient care and GP visits show a pro-poor bias, and specialist visits show a pro-rich bias. [44] Arguing the opposite, Oliver asserts that the majority of studies show that “the better off use more health services—particularly specialist elective services and preventive services—more often than the worse off.” [12] He explains this difference by a combination of physical access, ability to take time off work, and ability to use “voice” effectively. These conflicting assessments warrant further studies.
While disparities between income groups must be addressed in a system whose core objectives are diametrically opposed to the existence of such disparities, quality must also be ensured if the service is to truly be "comprehensive." For example, GP consultation times, referrals, and prescribing have been shown to vary tremendously. [45] Beyond the introduction of NICE, the Blair government has tried to improve quality by implementing a payment mechanism known in the US as Diagnostic Related Group (DRGs) and in the UK as Healthcare Resource Group (HRG). The basic idea is that by eliminating competition for patients on the basis of price, it will force providers to compete based on quality. [12]

Like quality of care and disparities, waiting times have also been a problem and became a "political imperative." The Blair government has consistently increased the percent of GDP spent on the NHS budget. It has increased from 7% in 1995 under the conservative government to 8% in 2003, and incremental jumps tended to occur in general election years. [46] Likely as a result, waiting time has been reduced. However, many believe the increasing funding of the NHS was strictly due to the political concern of lowering wait times rather than efficiency calculations of how to best spend government money. [12] To explain the consequences of this spending, Oliver introduces another of his "inconsistent triads" (the previous one being "comprehensive care," "high quality care," and "care on the basis of need rather than ability to pay"). This new triad is between a system that is "comprehensive," "cheap in terms of percentage GDP spent on it," and "quick." He goes on to explain that while you can make the system quicker, you will compromise one or both of the other factors of this triad. Since speed was not one of the original goals of the system, it must be balanced, he argues, against the core objectives of the system. [12]

Meanwhile, as Enthoven pointed out in 1996, at the height of the wait-lists,
dissatisfaction with the system was 41%, the highest in Europe. [15] The Blair government has faced a difficult task, indeed.

In a system that has focused on the individual right to receive free, comprehensive care based on need rather than ability to pay, and driven by political imperatives, the outcomes have been mediocre by some measures and tremendous by others. Disability Adjusted Life Expectancy (caveat above), has been quite static since the 1980s. [12] At the same time, the UK is ranked in the top 11 by the WHO for Financial Fairness in Contribution. Interestingly, they are also ranked 14 in the level of health attainment and 2 in the distribution of health attainment. [11] Regardless of the accuracy of these measures, non-health outcomes—those that are difficult to measure—may also be significant.

**Taiwan:**

Taiwan, a much more recent entrée to the ranks of countries to provide universal health care, learned significantly from the lessons in the UK and faced an overlapping, though distinct, set of pressures. The structure is very much like the Bismarck Model (or in Field’s scheme “social security” and in Light’s scheme “corporatist”), with the government both insuring and mandating health insurance for all citizens under a National Health Insurance (NHI). Care is provided by both public and private hospitals which contract with the government. The three goals identified by the NHI planning task force were: “(1) to provide equal access to adequate health care for all citizens in order to improve the health of the people; (2) to control the health care costs at a reasonable (or socially affordable) level, and (3) to promote the efficient use of health care resources.” [47]
The emphasis on efficiency and costs derives mainly from the history of dramatic increases in health costs before the NHI was implemented. The system that the new NHI replaced was a complex patchwork of ten insurance schemes, with 3 major ones (Labor Insurance-39.7%/1950, Government Employees Insurance-8.48%/1958, Farmer’s Insurance-8.21%/1985 [48]), that covered 59 percent of Taiwan’s 21.4 million people. This left 41% (8.62 million) uninsured, most of whom were children under 14 and people over 65 years of age. [49] All three major insurance systems covered outpatient, inpatient, and pharmaceutical care. The enrollees paid a registration fee and then all care was provided free of charge. Providers were reimbursed based on retroactive FFS payments. With these financing arrangements, “prior to NHI, neither physicians nor patients had incentives to be cost conscious.” [48] This is largely what led to the dramatic rise in health care spending from 1980-1994. In this time period, per capita health spending increased by an average of 15.7% annually, as compared to per capita GNP which increased by 12.1% annually. While the per capita GNP growth was a very prosperous trend that brought per capita GNP to US$13,000 by the late 1990s [29], the health spending growth was clearly unsustainable. The beginnings of this unsustainable pattern, identified by Blank and Burau as one of the major reasons for international reform, [10] was recognized by the commissions on social welfare (1984) and NHI planning (1986). They went on to design the NHI with mechanisms for cost control.

While these commissions acted to respond to economic concerns, they were established in the first place largely due to political pressures. In the late 1970’s there was increasingly aggressive criticism from individuals and groups in opposition to the ruling Kuomintang (KMT) party. These pressures continued even after the announcement in 1986 by Premier Kuo-Hwa Yu of the objective of “health insurance
for all by the year 2000." [47] In fact, the criticisms sped the process of implementation for the NHI system. Following the formation of the first opposition party, the Democratic Progressive Party, in 1986 and their fierce attacks on the slowness to implement national health insurance, Premier Yu moved the target date up five years to 1995. [47] The law was submitted to the executive Yuan (parliament) by president Lee Teng-Hui in 1993 [49] and heavy lobbying of the KMT legislators ensued. The particular target date, and the pressure put on KMT legislators to pass the law in July 1994, is thought to have been influenced by the coming election of legislators in late 1995. [47] Beginning full implementation in early 1995 allowed for a fading of the chaos expected immediately after implementation so that it would be stable by election time.

There was in fact chaos on implementation, but this quickly faded along with public dissatisfaction. [49] After the March 1st, 1995 inauguration, the system enrolled an astounding 92% of the population by the end of 1995, and 96% by the end of 1996. The remainder is thought to include people living overseas or in very remote areas, and wealthy, self-employed individuals. [29] There are three main ways to enroll—as an employee, as a family member of an employee, or as a community member—with three separate premium rates. The premium for the employed is 4.25% of payroll split between the employee, the employer, and the government (with different shares for different categories of employment). [48] Preventive services are mainly free, regular office visits have a $5 copay, outpatient hospital visits have an $8 copay, and inpatient services have a 10% coinsurance rate. There is a cap of yearly payment for any individual at 10% of average national per capita income [29], which was implemented in response to a RAND study, to protect low-income families from adverse health effects of not seeking care. [47]
While these financing mechanisms are designed to make health care affordable for all, there are also mechanisms in place to meet the other two goals of the system: cost containment and efficiency. As described by Chiang, there are three major strategies for macro-efficiency and four major strategies for micro-efficiency within the Taiwanese system. Chiang explains that "(1) a single-payer system; (2) a uniform fee schedule; and (3) a global budget" are designed to increase macro efficiency. [47] A single-payer system with the government as the only payer is designed to give both the incentive and the monopsony power needed to control costs of the whole system. The uniform fee schedule was a stop-gap measure to keep costs down (as opposed to reimbursing different providers at different and sometimes inflated fees) until global budgets could be implemented in 2002. Finally, global budgets can determine *a priori* what the budget will be, thus controlling overall cost.

As far as micro-efficiency, Chiang describes the strategies the NHI introduced as "(1) patient cost sharing; (2) contract-based supply arrangements; (3) a prospective payment system; and (4) profile analysis." [47] Cost sharing is designed to be a demand-side cost control measure, reducing moral hazard. Contract-based supply arrangements allow the private hospitals to stay in practice and encourage efficiency in the public hospitals based on competition. Prospective payment systems are supply-side cost control measures that prevent induced demand (e.g. the running of unnecessary tests). Profile analysis allows the Bureau of National Health Insurance (BNHI) to profile physicians and hospitals to monitor and ensure quality does not decline. [47] An additional supply-side cost measure is to implement volume-standards, reducing the payment physicians receive for excess patients they see in one day. They receive NTS$220/visit for the first 50 office visits in one day, NTS$180 for
visits 51-70, and NT$120 for all visits beyond 70 per day. This is both a mechanism of preventing the “3 minute visit” and of keeping costs under control. [29, 48, 49]

All of these cost measures, have indeed managed to keep costs under control. The presence of volume-standards for physicians reduces induced demand, and prospective payments to hospitals reduced average length of inpatient stay. [29] Based on an analysis of the “residuals” for health spending after known factors are controlled for, Lu and Hsiao conclude that the NHI as a whole has reduced the rate of rise of health costs (see Figure 3).

**Figure 3:**

![Graph showing average residual over years (1992-2000).]

**Source:** Lu and Hsiao [29]

As the figure shows, despite a dramatic rise in 1995 as the program was implemented, the rate of rise in costs as a whole stayed low from then on. [29]

At the same time as costs were controlled, the system had other successes. The utilization pattern of previously uninsured patients quickly rose to match that of previously insured patients, [47] indicating some level of equity in access. Average patient out-of-pocket spending as a percent of health costs dropped from 48% in 1993 to 30% in 2003. [29] While Taiwan is not recognized by the World Health
Organization, and therefore is not reported on in the WHR 2000, Lu and Hsiao used the WHO methods to calculate the Financial Fairness in Contribution. They did so for the years 1994 and 1998 with a gross result of 0.881 and 0.992, respectively. This 1998 index compares favorably to nations such as Canada (0.974), Germany (0.978), and Japan (0.977). [29] Meanwhile patients maintain the right to choose their providers, while physicians maintain the right to choose their model of practice.

Despite the successes, there are still challenges the system faces. Drug prices and prescriptions remain the primary ones. Hospitals are allowed to mark-up drug prices significantly from the price they pay the drug companies. This is known in Taiwanese vernacular as the "drug price black hole." [49] Not only do hospitals stand to make money from selling the same drugs they did before the NHI, but they are given the perverse incentive to sell more drugs than they otherwise would. Lu and Hsiao report that in a 2002 report commissioned by the Taiwanese department of health, the following prescription pattern was seen for upper respiratory infections (for which drugs are usually not necessary): half of the doctors in Taiwan prescribe four to five drugs, ten percent prescribe eight or more drugs, and only fourteen out of 103,024 outpatient visits resulted in no drugs prescribed. [29] As a result of this over prescription, negative health and economic outcomes have transpired. Because of over prescription of antibiotics, resistance to *Streptococcus pneumoniae* in Taiwan is the highest in the world. Meanwhile, drug prices were responsible for 22 percent of national health spending in 2000 and 23.8 percent in 2001. With public outrage growing, maximum drug prices have been successively cut in 2000, 2001, and 2002. [29]

In addition to drug prices, inefficient global budget application has contributed to rising health care costs. Global budgets have been placed on hospitals
as a whole rather than on individual hospitals. That is, all the hospitals in Taiwan have a common budget that the group of them has access to. This is a zero-sum game and does not provide any individual hospital an incentive to control costs (in fact, some would argue it does the opposite). Placing global budgets on individual hospitals or small groups of hospitals would allow better cost-control incentive. [49] Better cost controls on drugs and hospital budgets would both contribute significantly to keeping the rate of health spending down, and thus prevent the necessity of premium increases for Taiwanese citizens. In 2002 premiums paid by individuals insured had to be raised from 4.25 to 4.55% to prevent imminent bankruptcy of the NHI. [49]

In addition to cost concerns, many are also still concerned about poor distribution and physical access to care. [50] The government has improved access in remote areas by filling posts with professionals who received scholarships for training. However, the disparities in access continue.

In summary, in a Bismarckian system that focused on equal access, cost control, and efficiency, all of these have been achieved to a limited extent, while to a great extent choice was also preserved. Much remains to improve equality in access (by redistributing health resources), cost-control (via drug prices), and efficiency (via global budgets).

Chile:

Chile’s universal health care system is slightly older than Taiwan’s NHI at 54 (formed 1952). Thus, like the UK, it has been through a number of reforms. However, recently the system has been more Bismarckian than the UK in that many providers have been largely in the private sector. The system is currently two-tiered
with two separate insurance schemes (previously three [51]), which are funded through payroll taxes and general taxes. The tiered nature makes it universal but not uniform. Workers in the formal sector pay 7% of their income and have the choice of having that applied to the public system, or opting out and applying the 7% of their income towards private insurance (ISAPRES). [52] The private insurers then provide or contract for the provision of health care to these individuals at separate private facilities. Everyone who does not buy private insurance receives their care from the public health care system (FONASA). The explicit goals of the system have been largely to address epidemiologic factors and improve health outcomes, with military regimes favoring free market-based approaches and left-winged governments favoring more state intervention. [53]

Before 1952, there had been a number of significant health care laws, mainly focusing on disease prevention and control. In 1918, the first Sanitary Law was passed followed by the Social Security Law of 1924 which provided health coverage for workers and their families (Bismarckian). In 1938, the Law of Preventive Medicine allowed for the screening of all blue and white collar workers for syphilis, tuberculosis, and cancer. Contrary to the way the debate has proceeded elsewhere, liberals in Chile tended to oppose limitations on individual freedom espoused by the developments of these health care programs. On the other side “interventionists” argued they were essential for the good of the population. In fact, it was a progressive military coup in 1924 which allowed the Bismarckian law to be enacted against the will of organized labor, who saw it as a state appropriation of their money. [53]

The non-uniform Bismarckian structure caused a number of disparities to arise. In 1939, a young physician, co-founder of the Chilean Socialist party, and
minister of health, Salvador Allende, presented data to the senate demonstrating
 glaring inequities between poor families and workers’ families covered by social
 security. The infant mortality rates were almost ten times as high among poor
 families not covered by the Bismarckian social security. [53]

In addition to the disparities present, the background to the 1952
implementation of the NHS has many similarities to the conditions in the UK. While
in the UK, the system was based largely on the emergency response to the Luftwaffe,
in Chile it was based largely on response to another disaster—an earthquake. In 1941
legislators from the Popular Front (a group that included the democratic radicals,
communists, and socialists) proposed a unified health system based on the model of
the unified emergency services in response to the 1939 earthquake. Also similar to
the UK, doctors were heavily opposed to the idea and had to be placated with
generous salaries, gaining the law the moniker “The Millionaire Doctors’ Law.” A
debate raged for a number of years between the legislators who proposed the law,
pointing to limited gains of the past 20 years of modest intervention, and liberal-
conservatives who opposed deeper government intervention in any matter.
Consensus was finally reached to unite the hospitals which had previously been
organized as private charity hospitals, social security facilities, or state-run sanitary
organizations. However, implementation was delayed until after the economic
instability of World War II had passed. During the delay, white collar workers
decided to establish their own separate health system (SERMENA), which meant the
system was tiered from the beginning. [53]

During the first thirty years of the national health system, the focus was on
maternal and child health and preventive primary medicine. [54] The system at this
point was actually somewhat Bismarckian in that it was funded partly by payroll tax
and somewhat like the Beveridge model in that it was funded partly by general tax revenues and the provision of care was mainly public. Economic expansion during the 1960's allowed continued expansion of the system. When Salvador Allende became the socialist president of Chile in 1970, he nationalized many industries, but left the health care system largely alone. Some of his legislators proposed making private medical practice illegal, which did not pass and only stoked the furor of the anti-communists. [53]

Shortly thereafter, the military government of General Agosto Pinochet took power via a military coup on September 11, 1973. That government also left the health care system largely alone for a number of years. It focused on returning other industries to free market forces until 1979 when it started reorganizing the health system. Their major reform was based on a precedent set in 1968. At that time, white collar workers who used SERMANA had been allowed to take their social security contributions out of the public system (FONASA) and contribute them to SERMANA instead. Pinochet's technocrat legislators (known as "the Chicago Boys" because of their loyalty to the economist Milton Freedman at the University of Chicago) seized on this precedent, creating a private health insurance market. They created the market by allowing social insurance tax to be taken out of the public system and transferred to private insurance companies (ISAPRES—Instituciones de Salud Provisional).[53] This was the beginning of the end of income solidarity in the Chilean universal health care system.

Despite a re-democratization of Chile in 1990, most of the health policies of Pinochet's regime, including the ISAPRES, remained in place. The national health budget grew by 50% over 4 years, funded in large part by wealthy democracies eager to support Chile's return to democracy. [53] However, quality in the public system
continued to decline, and abuses proliferated in the ISAPRES system. ISAPRES were allowed to create as many specialized insurance plans as they wanted. In fact, there were 9000 different ISAPRES insurance options in 1995—mainly catering to the wealthy. [51] Some plans were basic and many others were not. Plans existed for young men to go on fully covered vacations to improve health and “meet young women.” [55] With such diverse plans, the ISAPRES were able to strategically select healthy and wealthy patients [52, 54, 56], and exclude the elderly, poor, and high-risk patients. [52] Elderly and high-risk patients did not participate because of stop-loss provisions for the insurer that allow them to stop paying for expensive care beyond a certain sum. Poor people did not participate because care in FONASA was free and they would have to pay extra for most ISAPRES plans.[52] This adverse selection left sicker, poorer, and older people in FONASA.

These problems have persisted despite health reforms that have been underway in earnest since 2000. [57] In 2002 a set of reforms known as Plan Auge was passed. It included implementation of law 19.966 which establishes a basic benefits package that guarantees care for 56 diseases. [13, 58, 59] This benefits package was designed based on technical assessment of epidemiologic trends and cost effective ways of addressing them. In fact the 56 diseases were computed by those in the ministry of health to represent 75% of disease burden and 50% of discharges from hospitals.[54] Law 19.966 article 1 states:

*The general regimen of guarantees in health, the furthering of the general regimen of guarantees, is an instrument of sanitary regulation that forms an integral part of the regimen of health services referred to by article 4 of Law 18.469...*[59]
This focus on "instruments of sanitary regulation" is emblematic of Chile's continued ideological focus not on human rights but on a top-down approach to improving population health.

This approach has been successful when assessed based on average health outcomes, but deeper inspection reveals immense and persistent health disparities. In fact David Villena, president of El Colegio Medico, the national doctors' association, describes "intolerable inequities in indicators of access, opportunity, quality, financial coverage, and health outcomes between the richest and poorest sectors of the population." [60] The following figures are reproduced from David Villena's presentation and show the correlation between infant mortality and poverty as well as cardiovascular disease and poverty across provinces in Chile.

**Figure 4:**

![Graph showing correlation between infant mortality and poverty in different provinces in Chile. Source: MINSAL/CASEN](source: Villena [60])
Figure 5:
Mortality Associated with Cardiovascular Disease in persons aged 45-64 and poverty (2002)

[Graph showing mortality rates and poverty levels]

Fuente: MINSAL

Source: Villena [60]

Antonio Infante speaks of the positive indicators in maternal and child health, which are overlaid with tremendous inequities in global performance. To illustrate this, he points to the fact that in the World Health report 2000, Chile ranks well in overall goals, but poorly on goals relating to fairness. He points to the Financial Fairness in Contribution index on which Chile ranks 168 out of 191 and the distribution of health system responsiveness on which Chile ranks 103 out of 191. [57] While this is true, examination of the WHR 2000 also shows that Chile ranks first out of all 191 nations on distribution of health goals achieved. [11] So while there are disparities in health between the rich and the poor, the much greater ones are in financing and responsiveness of the health system—largely due to the lack of solidarity created by the multi-tiered system.

In summary, in a tiered system that mixes elements of the Bismarck and Beveridge models and emphasizes improving health outcomes above all else, there
has been significant success on overall health, with persistent inequities driven by the multi-tiered nature of the system.

Studying these outcomes in Chile is especially relevant as Chile has been described as the “punta de lanza” or head of the spear in Latin American health systems, with other countries following Chile’s lead. [61] Understanding the consequences of the multi-tiered system in Chile is also relevant for the newest universal health system in the world, which also happens to be multi-tiered: Thailand’s.

**Thailand:**

In 2001, spurred on by social movements and compelled by researchers, a Thai political party known as the Thai Rak Thai (Thais Love Thais) party added a universal health care plan to its platform. [62, 63] The plan, known as the “30 Baht Scheme” (after the copayment people pay for doctor’s visits) or the “Gold Card Scheme” (after the gold card participants are issued), took effect in October 2001 and was fully implemented in April 2002. [64] The new national system is three-tiered in the public realm (private insurance being a fourth tier), with the Gold Card Scheme (GC) overlaid on two older public health insurance schemes. The Gold Card scheme is capitated for outpatient care with payment for hospitalization being made on prospective diagnosis related groups (DRG). [62, 64] Provision of care is conducted mainly in public facilities, but private facilities may also contract with the government to provide GC care in urban areas where they are present. The goals of the system are “to provide access to health care according to health need for the [previously] uninsured” [64] and to actualize a human rights focus elaborated in the 1997 constitution and 2002 National Health Security Act. [1, 65] A secondary goal
of reducing catastrophic health spending was added after the revelation that almost 5% of the population had spent 25% or more of household income on health in 1996.

Thailand began earnestly addressing issues of poverty and maldistribution of resources in 1972 when the Third National Economic Development Plan went into effect. At the same time a law was passed to ensure some level of free medical care. However, many continued to be entirely unprotected from financial loss or lock-out of medical care. In 1975, The Social Welfare Scheme (SWS) for health care was started. Its intent was to waive health care user fees for poor people, but it failed to reach its target population and provided no real insurance. [64] Later, two true insurance plans were adopted for civil servants and formal sector employees. The former, the Civil Servants Medical Benefits Scheme (CSMBS), was funded from general taxes and providers are reimbursed on a fee-for service basis. [62] The latter, the Social Security Insurance Scheme (SSI), was funded by tripartite contributions from employees, employers and the government (1.5% of income each), and providers were reimbursed on a capitated basis. [66] Finally, a third true insurance scheme was introduced in 1983 but not subsidized by the government until 1993. This scheme, the Health Card Scheme (HCS) was a means-tested voluntary insurance scheme with cheap buy-in and basic benefits package. The idea was to help hospitals recover some of the cost of the free care they were already providing while helping formalize insurance on the road to a universal coverage plan. [67] To summarize the various plans in existence prior to the universal coverage, CSMBS covered civil servants, SSI covered formal sector employees, HCS covered the near poor who bought-in, and SWS waived user fees for the poor.

Despite this complex meshwork of divergent health plans, in 2001 30% of the Thai population was still uninsured. [62] These uninsured individuals tended to be
low income, with 86% in the lowest income bracket (less than 8000 Baht or $200/month), and less educated, with most having only primary school education.

[68] This situation had been worsened by the economic crisis in 1997 that caused over a million people to enter poverty, 54% of them became “ultra-poor.” As a result, health spending decreased 24% among the poor, and self-medication largely replaced institutional care. [69]

In addition to the problem of those not covered by existing health insurance schemes, were the problems experienced within those schemes. The Health Card Scheme suffered from adverse selection. That is, because it was voluntary, it tended to be pursued by those who were sick or at high-risk. This trend was not helped by the fact that national advertisements promoted the card based on benefits to individuals rather than solidarity. The system eventually was no longer viable, despite a 50% government subsidy, [68] because hospitals bore so much of the cost and were losing so much money taking care of older, sicker patients. [67] Costs were also rising dramatically in the Civil Servants Scheme (CSMBS). Because of the FFS reimbursement mechanism, and the attendant lack of incentive for providers to limit care to the most efficient types, the average yearly cost for a member of CSMBS was 4000 Baht ($160) as opposed to 400 Baht ($16) in the Social Welfare (low income) scheme. The tenfold difference was also partially caused by the failure of copayments for drugs in CSMBS. Though a copayment had been introduced in the late 1990s, there was a provision in the law for the waiving of the copayment if a committee of three doctors felt it was medically necessary. In effect, waiving the fee became the rule, preventing cost control when it came to drugs. [62]

The failure of the HCS to be sustainable and the CSMB to contain costs brought important lessons to the process of designing the universal health coverage.
Researchers at the Health Systems Research Institute (HSRI), a research group associated with, but “at arm’s length from,” the Ministry of Public Health, took serious note of the failure of both voluntary enrollment and FFS reimbursement schemes. Therefore, in designing the 30 Baht Scheme they sought to make it an entitlement, mandatory, and capitated. Also, fueled by the revelation of high catastrophic health spending, they decided to use catastrophic spending as one of their outcome measures. This catastrophic spending problem was fueled by the fact that poor people who did not buy into HCS had to pay out-of-pocket for most or all of their care. [62]

To effectively communicate these complex messages about the need for change in simple, reasonable language, researchers at HSRI aligned themselves with the media and NGOs. As a result, they received both the endorsement of one of the two competing political parties in the 2001 election campaign (the Thai Rak Thai party, but not the Democratic party) and widespread public buy-in. Unlike in the UK and Chile, where doctors put up widespread resistance, Thai doctors and the Thai Medical Association were convinced by the arguments for capitation. The plan also included general tax funding because of the problems that would have existed with collection and enforcement of income taxes in an economy with a huge informal sector. The plan became one of three populist measures adopted by the Thai Rak Thai party into their platform (the other two being a moratorium on debt for poor farmers and a “village fund” to generate income). According to Tangcharoensathien et al, “In this case of universal coverage, political commitment was the fuel, evidence was the compass and the social movement was the catalyst for reform.” [62]

When the Thai Rak Thai party won the election, and their candidate Thaksin Shinawatra became prime minister, they immediately moved to implement the 30
Baht plan. The plan replaced both the low income (Social Welfare) scheme and the voluntary health card scheme. The 30 Baht scheme, then, covers individuals formerly under these schemes, the 30% of the population that was uninsured, and anyone else who is not covered by CSMBS or SSI. CSMBS and SSI remain in existence, forming the other two tiers in the three-tiered public system. See figure 6 for a schematic of the Thai health care system reproduced from Tangcharoensathien et al.

Figure 6:

The 30 Baht scheme covers ambulatory care, inpatient care, prevention and promotion, accident and emergency care (with the last two paid on a fee schedule above and beyond capitation rate). [68] Not covered were cosmetic care, obstetric delivery beyond two pregnancies, drug addiction treatment, hemodialysis, organ transplant, infertility, and some high cost interventions such as anti-retroviral therapy.
(ART). [64] ART was later added due to political pressure. There is a program to waive the 30 Baht copayment for poor people. [64] The 30 Baht Scheme was introduced into all parts of Thailand except for a few regions of Bangkok in October of 2001 and was fully implemented in all 76 provinces by April 2002. [64]

In 2002 the policy was brought to the level of legislation by the National Health Security Act. Section 14 of the act states “a person shall have an equal right to receive from the state an adequate public health service that is essential to his/her health and survival.” This makes clear that the system is viewed as a right of the citizens, following the language of the 1997 constitution. Phoolcharoen explains of the constitution:

*The new constitution has paved the way for the re-orientation of health and its relation to the general public. It stipulated that health is a human right, which must be protected by the state. This is the first time an egalitarian view towards health has been expressed in Thai political philosophy. More specifically, health entitlement has been introduced for a wide range of the disadvantaged members of the population...*[1]

While the entitlement is now in place, there are significant limitations in the system. Staff are overburdened and are facing rising medical malpractice suits. [70] Enforcement of quality of care is challenging with only a small number of hospitals seeking quality-based accreditation. [66] The budget is likely set too low. [63] As in the UK, Thailand has split the provider and purchaser. While the MOPH used to be both provider and purchaser, now it is only the provider of care. A new entity, called the National Health Insurance Office (NHIO) is now the purchaser. However, as of 2002, neither organization had the institutional capacity to make such contracts efficiently. [68] For patients, choice of provider is ideal. However, it is only possible in urban areas, because rural areas (where 70% of the population lives) tend to have only the Ministry of Public Health (MOPH) providers. In effect, this gives MOPH a
geographical monopoly, which may raise concerns for efficiency in the future. [68] There is limited further data on geographic distribution of health resources in Thailand. One statistical compilation indicates that while less than 10% of the population lives in Bangkok, 6046 or 34.5% of the physicians were located there in 2002. Meanwhile, the Northeastern region with just under 35% of the population, had only 2972 or 17% of physicians in the country in 2002. [76] Further, a small ethnographic study in 1994 found low utilization of village health volunteers—liaisons between people in rural areas and their regional health care providers. [77] There is also a problem for both rural and urban patients in the residence-based nature of registration for the 30 Baht system. If a family or an individual moves, there is an onerous process of re-registration, during which time they have no coverage for the facilities in their new place of residence. [64] Further barriers to care include the tradition of bypassing primary care to go directly to tertiary care centers, [71] the inability to select providers, [72], and low confidence in the health system. [71] There is also an ideological opposition to providing care to the rich based on utilitarian principles. [63]

These last points raise interesting issues about the conception of the system. While Thailand's previous health infrastructure consisted largely of curative care in tertiary centers, the thrust of the 30 Baht system is to use primary and preventive care to keep people healthier. [73] If Thai society does not conceive of the system that way, there is need for bridging the perception gap between the framers and society. Also, while the system was intended to provide a human right, many do not believe the rich should use this right if they don't need to. Thailand had before the universal coverage law and continues to have a quite developed private health care industry. In fact, this industry accounts for 30% of all health spending in Thailand. [74] This
fourth tier of the system not only prevents solidarity, it draws doctors out of the public system, offering them significantly higher wages.

Another significant issue raised by the multi-tiered nature of the system is equity. Chile has a multi-tiered system, but does not explicitly speak in egalitarian human rights language about health care. Thai society somehow has to reconcile the fact that health care was described as a human right in their constitution under egalitarian philosophies, but they have four different tiers of health care. If one follows the money it is hard to understand how care could be equal in the different tiers. In 2002, capitation rates (which are now in all systems) for the three public schemes were as follows: CSMBS $120/person/year, SSI $45/person/year, 30 Baht system $35/person/year. [74] One way to measure the implications of this would be to assess patient satisfaction in the three schemes. Suraratdecha et al. describe the need to explore this issue. [64] Another way to measure equity in the system generally is to examine the amount different groups of people are spending on health. The Fairness in Financial Contribution Index from the WHR 2000 is one such measure, but the 30 Baht system did not yet exist in 2000. However, studies have found that in some low-income provinces there are still a significant number of people with no coverage at all, people who are disproportionately poor. [64] Further, one small 2002 survey measured the percent of income people in the lowest income quintiles were spending on health based on which health care tier they were in (CSMBS, SSI, or 30 Baht). They found that those in the lowest income quintile who were in the 30 Baht system were spending 7.5% of their income on health as opposed to those in SSI who spent 1.6%, and those in CSMBS who spent 0.1%. [75] On the national level, the percent of people facing catastrophic health spending has steadily declined from 4.9% in 1996 to 3.0% in 2002. [62] However, this decline began
before implementation of the 30 Baht system, and therefore cannot be attributed to it. It does, however, place Thailand among the countries in Southeast Asia who have managed to keep catastrophic costs on the low end. [78]

Though reduction of individual or national spending on health was not an explicit goal of the system, it is informative to evaluate it in the Thai context. The decline in catastrophic spending, both total health expenditure as a percent of GDP and the percent of that spending that was private declined (see Table 2). While percent of GDP spent on health declined from 3.5% in 1999 to 3.3% in 2003, the percent of that spending that was from private expenditures declined from 45.2% in 1999 to 38.4% in 2003, while the percent of health spending by the government increased from 54.8% to 61.6% in those same years. This increased government spending also translated to an increase in health expenditures as a percent of the government budget (from 11.4% in 1998 to 13.6% in 2003). In addition to increased government spending, there was a shift in the allocation of private health expenditures from out-of-pocket expenditures to payments for pre-paid private insurance plans. This percentage shift likely results not from increased proportional spending on private plans, but rather the decrease in private out-of-pocket spending.
<table>
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<td>10.5</td>
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<td>10.3</td>
<td>11.8</td>
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<tr>
<td>Out-Of-Pocket Expenditure (% of Private Expenditure on Health)</td>
<td>78.2</td>
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<td>76.8</td>
<td>75.7</td>
<td>76.3</td>
<td>74.8</td>
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<tr>
<td>Private Prepaid Plans (% of Private Expenditure on Health)</td>
<td>11.6</td>
<td>12.6</td>
<td>12.8</td>
<td>13.6</td>
<td>13.4</td>
<td>14.6</td>
</tr>
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Source: World Health Organization Statistical Information System

Though none of these trends can necessarily be attributed directly to the 30 Baht scheme, there has been a decrease in private spending and a proportional increase in government spending on health since the 30 Baht Scheme was implemented. Total national health spending, however, has actually decreased slightly from 3.5% of GDP in 1999 to 3.3% in 2003, a period of slow overall GDP growth, following the Asian economic crisis of 1997.

As this spending decreased, some have expressed concern about quality of care. However, quality improvements were not a primary goal of the system. In fact, what quality assurance mechanisms are currently in place in Thailand were in place before the 30 Baht system was implemented. The main mechanism, begun in 1996, is Hospital Accreditation (HA). This system requires accredited hospitals to apply Total Quality Management (TQM) principles, to assess their own performance regularly, and to demonstrate that they are acting in a manner consistent with quality assurance and customer-focused continuous quality improvement (CQI). The system is based largely on the Canadian Council on Health Services Accreditation (CCHSA) model.
Both before and after the implementation of the 30 Baht system, this system has had low uptake by hospitals, with only 6.6% of hospitals or (84 hospitals) being accredited by October 2004. [79] This low uptake begs the question: how has quality of care changed (or not changed) since the implementation of the 30 Baht system? More investigation is necessary here, though one study explores physician attitudes towards the quality improvement mechanisms. It finds that they believe “adequacy of staff” is the major obstacle to implementing quality improvement mechanisms. [79]

In summary, in a four-tiered, non-uniform universal health care system based on egalitarian human rights principles, there have been significant gains in coverage and decreases in private expenditures on health, but persistent disparities between tiers and between income groups and unclear effects on quality of care mechanisms or outcomes. There is a perceived need for improving choice of provider, monitoring of quality, balancing inequities, and convincing the population to refocus on primary care. There is also a perceived need to further study the consequences of setting the budget too low, [63] conceptions of the system by different stake-holders, [63] issues of universality in services across tiers, [64] and portability of insurance when people move. [64]

**Summary of Country Analysis:**

Table 3, on the following page, is designed to integrate the design of the above systems and what this might help predict about their outcomes. For example, those systems with a political hurry in implementation (Taiwan and Thailand) both had challenges in the logistics and costs of implementation. Meanwhile, those with copayments were better able to control overall costs of the Health care system (potentially by reducing moral hazard), and those with income-solidarity and non-
tiered systems (Cuba, the UK, and Taiwan) were better able to avoid disparities in access an outcomes. The more portable the insurance, the more choice of provider was maintained, and the more centralized and mandatory the quality control measures, the better quality was maintained.

These observations would lead one to believe that over time in Thailand, the transitional "growing pains" of the new system will have faded; that costs will be reasonably controlled; that there will be persistent challenges in equity of access; that choice in provider will be limited; and that quality will be difficult to ensure. See table 3 for further summary.

The above observations form the basis of the research hypotheses below. The following section of this paper will evaluate conceptions of, opinions about, and

<table>
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<td>Provision?</td>
<td>No</td>
<td>Yes</td>
<td>All Patients</td>
<td>No in Government System, Yes in Private</td>
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<tr>
<td>Insurance</td>
<td>Non-Portable</td>
<td>Portable</td>
<td>Portable</td>
<td>Portable</td>
</tr>
<tr>
<td>Portability?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No, Two-Tiered</td>
</tr>
<tr>
<td>Income</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Equality?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Quality</td>
<td>Top-Down</td>
<td>CHG To Force</td>
<td>Profile Analysis</td>
<td>Top-Down In Public, Independent Private Environment</td>
</tr>
<tr>
<td>Measures</td>
<td>Competition on Quality</td>
<td>on Quality</td>
<td>on Quality</td>
<td>on Quality</td>
</tr>
<tr>
<td>Geographic Distribution</td>
<td>Even</td>
<td>Unclear</td>
<td>Poor</td>
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<th>Outcomes</th>
<th>Good Health</th>
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<tbody>
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<td>General</td>
<td>Right met, Highly by WHO on Financial Fairness, Health Attainment, and Distribution of Health Attainment</td>
</tr>
<tr>
<td>Indicators</td>
<td>Improved Average Health Outcomes with Improved Access to Care, Reduction in Catastrophic Health Spending, Between Income Groups, Between Poor Financial Income Groups, Limited Choice of Provider</td>
</tr>
</tbody>
</table>

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attitudes towards the system held by health care providers in Thailand.

**Section III: Qualitative Study in Thailand**

**Statement of problem**

In 2005, when this study was conducted, there was no literature addressing Thai health care providers’ opinions of and attitudes towards the new universal health care system (since then one study has been published on their attitudes about quality measures in the system [79]). As they are the primary people who make this system work, amplifying their voice is an essential part of any process that seeks to continually improve the system. With the potential challenges discussed above, the input of health care staff may become especially useful in the further tailoring of the system to address ongoing issues. Specifically, as Phoolcharoen (2002) noted, there are some differences between the health infrastructure, as it existed before the 30 Baht system was implemented, and the goals it is supposed to meet now. [73] In such a situation, it becomes essential to know how those within the infrastructure are conceiving of and dealing with the changes.

Now that former Prime Minister Thaksin Shinawatra and his Thai Rak Thai party have been overthrown in a military coup, this information is especially relevant to the reform process. The caretaker military government has promised to keep the universal health care system in place, but to “make modifications as necessary.” While the data gathered here was done so in the summer of 2005, before the coup took place, it is still relevant to current policy decisions. It is the hope of this researcher that the government will consider the input of health care providers in that process.

**Research Objectives:**

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The objective of this study is to evaluate the experience of Thai health care providers with the new universal health care system—their opinions of, attitudes toward, and conceptions of the system. The study seeks to address, in part, the need for assessing stakeholder conceptions of the goals and outcomes of the new system. The 30 Baht system was a campaign promise of the “Thai Rak Thai” government who framed health care as a human right and the goal of the system to have “30 baht cure all.”

Going beneath the political messages, the question asked here is: What do Thai health care providers see as the goals and outcomes of the universal health care system? Subordinate questions to this primary one include:

→ Do they consider health care to be a human right?

→ Do they think the new Thai health care system is truly universal?

→ Do they think the new 30 Baht system affected the utilization of preventive services?

→ Do they think it changed the patient population?

→ How has it practically affected staff?

→ What do they think needs to improve within the system?

Previous models (e.g. the UK and Chile) have shown that when health care staff are not on board for changes in the health care system, it creates both political impediments to public buy-in and challenges in implementation. Therefore, knowing whether Thai health care staff buy-in to the system and share the goals elaborated by the government is important to predicting the system’s progress and outcomes. Assessing their perception of whether the health care system is truly universal may provide insight both into their buy-in and into ways to improve the extreme ends of inequities expected within the system based on its multi-tiered, residence-based design (see above predictions). Evaluating health care staff insights into local
changes in utilization of preventive services may provide insight into both how well
the health infrastructure is adapting to the new demands of the system discussed
above; insight into ways in which the expected inequities may be balanced by an
increase in equity in access to care; and insight into trends that may affect the
financial viability of the system (i.e. are cost control measures working?). Assessing
their perceptions of changes in the patient population is one means of assessing
improvements in equity to access that the system is striving for. Asking about the
impact on staff is intended to elicit both staff satisfaction and evaluate the attitude of
staff towards the government, with an eye to potential for future collaboration and
buy-in to the system. Finally, asking for staff ideas regarding improvements needed
within the system is an attempt to capture on-the-ground knowledge and wisdom
about the true functioning of the system for those who shape its policy future.

Generally, the intent is to amplify the voice of Thai health care providers and
provide valuable information for policy-makers. While Thai health care providers
had little say in the development and implementation of the new universal health care
system in Thailand, their opinion of it holds valuable information for policy-makers,
and may determin the system’s fate.

Research Hypotheses:

The following were the hypotheses going into this research:

1. Thai health care staff will consider health care a human right, but may have
   practical concerns about what that means in the hospital, as
   infrastructure was not sufficiently expanded before the system was
   implemented.

2. They will think the new system is not truly universal and will cite
geographic mal-distribution of health infrastructure and barriers to care faced by the poor.

3. They will cite inequities between the tiers (as exists between tiers in Chile).

4. They will cite increases in preventive services utilization based on a large influx of new patients, but may again describe how there are not enough staff to deal with this increase.

5. They will describe seeing more poor patients and others who did not come before. The example of Taiwan, where the new system dramatically increased utilization by the previously uninsured, is one that is expected to be replicated here.

6. They will express being overworked and expected to care for more patients than they can handle.

7. They will want the government to expand the number of health care staff in the system (as Cuba did in order to meet similar human rights-based goals in their system)

Sample Design:

This study used purposive sampling of 8 hospitals in 6 provinces of the central region of Thailand. Hospitals were selected in consultation with Thai medical school professors and policy researchers to provide a diversity of settings: large and small hospitals; urban and rural areas; industrial, commercial, and residential neighborhoods; wealthier and poorer areas; areas with lower and higher doctor to patient ratios; etc. For purposes of confidentiality the exact locations of interviews cannot be divulged. Demographic analyses of the sample provinces are presented below. Interviews were scheduled with the administrative assistants to the directors
of the hospitals. The hospitals were asked to invite staff members from various professions: doctors, nurses, pharmacists, dentists, public health officers, health education specialists, and administrators.

Below is de-identified information on the provinces sampled in this survey. They are in no particular order in each chart, so as to avoid the potential of identifying individual provinces based on their collective statistics. As is evidenced by the following charts (Figures 7-15), the mean of the sample provinces showed that they were generally wealthier (based on Gross Provincial Product—GPP, Figure 7); had more doctors (Figure 10), dentists (Figure 12) and hospital beds per capita (Figure 14); had fewer nurses (Figure 11) and pharmacists (Figure 13) per capita; had higher birth and death rates (Figures 8 and 9); and had a similar mix of public and private hospital beds (Figure 15). While this information tells us about the provinces from which the sample hospitals were selected, the individual hospitals in the sample are not necessarily representative of their respective provinces. Therefore, this data on sample provinces is intended merely to give a general idea of the areas sampled, not to assert the level (or absence) of representative-ness of the sample hospitals with respect to Thailand as a whole.
Figure 10:

Residents per Doctor in Sample Provinces (2001)

Figure 11:

Residents per Professional Nurse in Sample Provinces (2001)

Figure 12:

Residents per Dentist in Sample Provinces (2001)
Procedures for Interviews:

Interviews were conducted by two research assistants affiliated with the World Health Organization (WHO) Collaborating Center for Health Economics at Chulalongkorn University in Bangkok. This WHO collaborating center is under the direction of Siripen Supakankunti, Ph.D. The research assistants were trained in qualitative research methods, informed consent, and the specific procedures of this study. Interviews were conducted in Thai or English, depending on the preference of the subject, using an interview guide written in English and translated into Thai. Two interviews were conducted in English and thirty-eight interviews were conducted in Thai. One Thai interview was unable to be transcribed due to recorder malfunction. For the Thai interviews, one research assistant conducted the interview while the other transcribed and translated synopsis answers for the researcher, in order to tailor upcoming questions. After completion of the interviews, the research assistants transcribed the audio records in Thai and translated to English. Forty interviews were conducted with at least three and as many as fifteen members of each of the professions listed above. The interview guide is attached as an appendix.

Procedures for analysis

The interview transcripts were entered into NVivo 7 analytical software and coded using a grounded theory approach. Both etic and emic frames were used. That is, codes were derived both from the theoretical framework of the researcher and from emergent themes expressed by subjects. Domains of codes were determined by the researcher before the interview. The diversity of responses to open-ended questions, all of which could not be anticipated, dictated that codes within the domain were determined after the interviews. For example, one domain is "equity among
systems.” Codes within that domain that emerged from the interviews include “care is the same,” “lack of equity elsewhere, but equity at this hospital,” “tiers are not equal,” and “medicines are better in CSMB and SSI than in the 30 Baht system.” The twelve domains contained 127 codes.

The twelve domains are:

1. Goals of the system
2. Whether goals achieved
3. Thoughts on human rights
4. Left out of the system
5. Professional opinions of the system
6. Preventive service utilization—overall and per person
7. Patient population changes
8. Equity between tiers
9. Staff satisfaction—general and personal
10. Most important things for people to know—Thais and foreigners
11. Change needed—for staff and for patients
12. Other emergent themes

Each transcript/subject was then assigned “attributes” based on profession, gender, history of working in the private health care facilities, status as an administrator, and multiple demographic and health care measures of the province in which the subject practiced. Matrix coding queries were run in NVivo 7 to determine if there were trends among the subjects with respect to attributes being associated with certain codes. For example, were nurses more likely to say that there was inequity between the systems? Were administrators more likely to have positive assessments of staff satisfaction? Were women more likely to describe the goal of the system as
caring for the poor? Matrices including every combination of “attributes” and codes were examined for significant trends.

Results:

This analysis will cover each of the domains above, sequentially. However, it should first be noted why this paper is including so many quotes, the voices of the staff rather than simple numerical tallies. The words of professionals from two different health care fields give voice to the need for these voices:

_Thailand at the moment has one disadvantage; civil servants cannot “speak”. If anything is different from the goal the politicians want, they just “slash”, or move us, making us afraid to speak what they should know. If the politicians just listen, we have showed all along that we never object to this project. But we mean we have to open up and discuss to what extent it can be done, what the obstacles are, and what suggestions we might have, to ‘share’. For example, this is our capacity, and you should listen to us. We have a certain amount of money; you listen to us._

_X: What I really want the central body to change is the structure. They should invite responsible staff, not higher-level such as heads of provincial public health offices but operative staff such as directors of hospitals, to discuss problems and implications that they have faced._

_Q: Basically, you want them to hear from people who are doing the job, not from those who wrote the policy._

_X: Yeah._

The following are the words of people on the front lines of universal health care in Thailand.

**Domain 1: Goals of the system**

The subjects interviewed in this study had widely divergent views of the goal of the new universal health care system. Many expressed multiple goals of the system. However, no consensus existed as to any of the individual goals expressed. No single shared goal was expressed by over half of the subjects. The most common
perceived goal of the system was to increase access to health care (n=15), followed by improving equity (n=12) and promoting preventive services (n=12), followed by creating an entitlement (n=8). Other perceived goals expressed included to target the poor (n=6), cost containment (n=5), and to increase the health status of the population (n=4). Doctors were most likely to cite the goal of increasing access to care; nurses were most likely to cite the goals of equity and promoting preventive services; dentists were most likely to cite the goal of promoting prevention; public health professionals were most likely to cite the goal of increasing access; those with administrative duties were most likely to cite the goals of equity and increasing access to health services; and those without administrative duties were most likely to cite the goals of promoting preventive services and granting an entitlement to people. Women were significantly more likely than men to cite the goal of promoting preventive services (though this may be explained by the fact that most nurses were women, and nurses tended to cite this goal). Figure 16 summarizes the sub-groups of subjects and the goals of the system they were most likely to cite.

**Figure 16: Goals most expressed by various professionals**

<table>
<thead>
<tr>
<th></th>
<th>Doctors</th>
<th>Nurses</th>
<th>Dentists</th>
<th>PH Professionals</th>
<th>Administrators</th>
<th>Non-Administrators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entitlement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Equity</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Increase Access</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Promote Preventive</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Not only were there divergent ideas between individuals as to what the goal of the system is, individuals themselves seemed to have multiple and/or shifting goals of
the system. For example, a nurse answered the standard question “what do you think
the goal of the 30 Baht system is?” with the following:

The goal is to provide equal rights to everybody, no matter
rich or poor. Especially at this time, we focus on the poor.
We want them to receive the same standard of services without
paying too much money.

In response to the same question, a dentist responded simply that the goal is to
“encourage prevention.” While the possibility of nervousness (the question was
towards the beginning of the interview) and a desire to please the interviewers (based
on knowledge of the study topic) are possible explanations for the divergence in these
answers, it is clear that there are significant differences present. However, are these
differences simply what came to peoples’ minds first, or would they actually dispute
each others’ conceptions of the goal?

In answering this question, it is useful to look at the end of the interviews
where the subjects were asked if the system is a success at achieving its goals so far.
The dental officer says:

If you ask me whether the system is successful ... (laughs)
... For one thing, we have to rely on people, to take care of
themselves. But it’s not easy a task to change people’s
behaviors. It takes a lot of time. Importance ... some of
them do not see any importance in that. So, for some groups,
the program is not effective.

Consistent with her first answer about the goal of the system, she is clearly
expressing a rather narrow view of the goal of the system as preventing people from
becoming sick. The nurse, on the other hand, explains: “I think it is rather successful
because there hasn’t been any problem about the budget or any institutes resisting the
30 baht system.” Here she expresses that the system is successful, but successful at
achieving goals other than those she elaborated in her first response. This indicates
that unlike the dental officer, she has a shifting notion of the goals of the system
(either many simultaneous goals, or an unclear picture as to exactly what the goal is). This was a very common trend among the transcripts. While some individuals had very fixed notions of the goal(s) of the system, and assessed it’s success based on these goals, others did not seem to be entirely sure what the specific goals of the system are and how to assess them. It should also be noted that seven subjects at various points in the interview expressed that this project was “political,” or a “tool of the government to gain popularity.” As such, it was implemented rapidly. One doctor explains:

*In Thailand, maybe political power interfered with proper planning. In fact the system has been altered many times. And no sooner than it was created, it was launched. It involves politics. When the new government was set, The system was started immediately. If anyone wants to copy it, the system should be planned for the long-run and should have a pilot study first...*

One possible explanation for the divergent thoughts among health care staff as to the goal of the system they were implementing may be that: the political hurry did not allow time for the government to disseminate a strong message. A second, non-mutually exclusive explanation is that the message the government did disseminate was tailored to patients and not health care staff.

**Domain 2: Whether goals were achieved**

When asked, later on in the interview, whether the 30 Baht system was a success at achieving its goals, the predominance of subjects said that it was, at least in part. The most common code in this domain was that the goal of increasing access was achieved. Meanwhile, significant problems were also cited—the most common of which were budget problems and trouble promoting preventive care.
To begin with the most common code in this domain, many of the subjects explained that the 30 Baht system had increased people's access to health care. For example, one pharmacist explained:

*If we say that the goal is to give a chance to everyone to access health care, fulfilling the right to ones who don't have any right in health insurance—civil servant benefits, social security, and others—we achieved that.*

Likewise, a dentist related how the insurance situation has changed to improve access:

*I think it is successful since it can help people obtain more services. They feel free to come to us and tell us what seems to be the problem, and what kind of service they need from us.*

A nurse explains that the increased access is largely among the poor:

*What I can see clearly is that patients who couldn't previously reach the services can now reach them. For example, the poor can access, more easily and more obviously. People who have never gone to the hospital, never had blood/blood pressure tested all their lives until 50, come to us for such services.*

Finally, a doctor gives an example of these services now being accessed:

*As I said earlier, underprivileged people who never had a chance to access health care services can now come to us. They have an opportunity to go to a big hospital. For instance, patients with cataracts would not be able to afford treatment if there was no 30 Baht scheme.*

Meanwhile, there was a significant minority of subjects who explained why the goal of increased access had not been met. They cited continued lack of access on the part of the poor, especially immigrants who are registered for care in another part of the country and therefore cannot receive any care in the place where they live.

As far as the other major goals explored in domain 1, not a single subject mentioned the goal of creating an entitlement or whether the goal of equity is being reached. The majority who spoke of the goal of promoting preventive services explained that it had not been reached yet. They described a situation where there are
massive increases in patients coming in for curative care, but no increase in preventive care. On the contrary, there were some who explained that they had dramatically increased preventive services in the community. They enthusiastically described going to the homes of their patients and the benefit these services have provided. One even characterized the reaching of the goal as “more than 100%.”

Mentioned just as frequently as the difficulty some hospitals had in increasing preventive services, budgetary issues seemed to be a big problem in reaching goals. While both prevention problems and budgetary issues raised concern among staff members that the system may not be sustainable, budgetary issues were spoken about in more depth and with more colorful language. It also was used to qualify answers about the system’s ability to reach multiple goals. For example, when asked if the 30 Baht system is achieving its goals many subjects qualified their responses with budget worries, like these two doctors:

Really tough question. Actually, for some people there are good advantages of the 30 Baht system, like some people getting very expensive surgeries. But in general it looks like it will bankrupt the whole health care system of the country.

In which way? If you mean in the aspect of the government, it’s a success. However, regarding the sustainability, I’m not sure. It’s a great idea, though. I’m just worried about sustainability, regarding the budget.

One public health professional explained in his qualifications that the budgeting was different from other government ministries, in that the services and salaries come out of the same budget:

There is only one problem: budgeting. Every type of budgets such as compensation of employees has to be tied with the budget from the scheme. In fact, it’s not right. In principles of service providers, it’s not right. Other ministries don’t have to do so. They got their own budget: policemen, soldiers, and teachers, for instance. They don’t have to take a fraction of the sum for students to support
the teachers. Then why do we have to take some part of the budget for population to pay for the staff? Personally, it’s not right.

Other concerns raised in the context of qualifying the success of the system based on the budget include: that the other insurance schemes are supporting the 30 Baht system; that small hospitals are being forced out of business; that there’s not enough money for preventive and curative medicine; and that the low budget makes it hard to recruit staff.

**Domain 3: Thoughts on human rights**

When asked if they agreed with the UN Declaration of Human Rights that health care is a human right, every single subject agreed. While the right in Thailand is based on the constitution and not the UN Declaration of Human Rights, this question was also intended to elicit responses about the Thai constitution. And it did to a limited extent. One subject said she agreed with the UN Declaration of Human Rights *because* the right to health care was also in the Thai constitution. Others spoke of the fact that they would be “guilty” if they did not follow article 52 of the constitution. Still others explained that if Thaksin’s government had not met the right to universal health care the next government would have had to because of the constitution (ironic given the constitution was dissolved by the next, provisional government).

On what turned out to be a more contentious issue within the subjects sampled, one doctor explained that:

*The 30 Baht system follows the same principle as that declared by the constitution that a person shall have the right to health care services. This is the rationale why the 30 Baht system is not only for the poor. As it is the basic right, everybody should have the right to receive health care services when they are not well.*
In other parts of the interview, many people expressed the opposite feeling—that the rich should not have access to the 30 Baht system and were, in fact, abusing it. At the very least, most people who addressed this issue thought that the rich should have to have a co-pay for the services they received. What does this insistence on the wealthy people either not using the system or supporting the system more illustrate about the subjects’ view of the Thai version of universal health care? It shows that they do not frame the issue in terms of solidarity. The majority of the individuals in this sample conceive of the 30 baht system not as a way of universalizing the right to health care, but rather as a way of extending access to the poor.

The distinctly Thai way of thinking about health care as a human right is also ironically evidenced within the universal agreement with the western, UN document. While there was universal agreement with the basic principle of health care as a human right, many subjects qualified their answer. These qualifications spoke mainly to the traditional Thai philosophy of patronship and how rather than demanding that something be provided, the emphasis should be on the beneficence of its provider. These qualifications give interesting insight into why a western entitlement-based universal health care system has faced challenges when imported to Thailand:

_I agree, totally agree. However, I have to remind you that it is the western concept which focuses on “calling for”. On the other hand, the concept of the east is about “giving”. The point is, when there is an abrupt change towards the western concept within our society...like nowadays, people of our generation will say that we have to pay respect to our teachers. In contrast, children will disagree. They will say that it is teachers’ duty to teach. It’s a completely different story. People these days care only about their rights. If you are parents, then you have... parents’ duty. This is wrong. It is the western concept that encourages people to call for the thing they want. But if everyone keeps demanding... what if doctors came out and demanded that we would not work more than 40 hours per week? What will happen? The problem will never be over._
A dentist qualified his limits on the human right to health care on different grounds—those of creating perverse incentives:

I agree to some level—when people get sick they shall get health care, but there must be limits. If it is a very severe disease, you have to take responsibility for that part too. Otherwise, the patients will be too comfortable to use it, anytime, to any extent, and they don’t take care of their own health. This is more than caretakers can tolerate. We have to take care of ourselves. If we let other people pay for us all the time, it will turn out that we are negligent in our health because we think we won’t have to pay for anything.

This individual was not alone in expressing concern over perverse incentives. Many subjects spoke of this issue at one point or another in the interview. One doctor discussed it in terms of an analogy of the 30 Baht system as a helmet, or rather not a helmet:

People have to take care of their health. The 30 Baht system is not a helmet. People can’t drive carelessly just because they wear a helmet. The helmet helps nothing but holding your brains together so that it won’t spread all over the street.

This is a colorful example of how, in addition to being concerned about the western concept of moral hazard (discussed in Domain 6), subjects of this study worried about perverse incentives of rights-based health care. They were worried that if people knew they can get curative care, they would ignore both preventive care and personal care for their own health. One doctor framed the issue in terms of the errors in the 30 Baht slogan itself:

Actually the information about “30 Baht cures all” is wrong, wrong since the act was issued together with the slogan. It should be “30 Baht promotes health” instead. I agree with the new slogan that “30 Baht keeps Thais distant from illness” because as a result of the last slogan it turned out to be passive...

Thai health care staff, then, agree that health care is a human right, but have a distinctive way of thinking about it that favors targeting the poor, de-emphasizing
entitlement, and focusing on individuals’ rights and responsibilities with respect to health care.

**Domain 4: Left out of the system**

When asked who is still left out of this system, the most common response was immigrants. By this term, most subjects meant immigrants within Thailand, but a few also explicitly included immigrants from outside of Thailand. This was the top response from men, women, administrators, non-administrators, all professions, and all provinces sampled. Subjects mentioned the following other groups of people left out of the system: the disabled, the elderly, ethnic minorities, the ultra-poor, and those with registration problems. There was a significant overlap between people who mentioned immigrants and those who mentioned registration problems, as moving is one of the primary ways people come up against registration problems. One doctor explained how this issue was relevant in urban areas:

*In urban areas, these people are those who usually move from one place to another. Also, there are people who don’t have household registration and hence their names don’t appear on the 30 baht program’s list. Moreover, there are those who have withdrawn their rights from the Social Security, but they can’t get the gold card immediately because of delays within the registration system. Such cases occur a lot in urban vicinity since people usually move into and out of the area. As a result, the percent of uninsured people is quite high...*

Meanwhile, a nurse explains other ways people may have registration problems:

*Those without birth registration, no birth certificate or having lost one or those whose parents were missing, and have been raised in a temple or relatives’. They don’t care about birth registration, because they feel that it is inconvenient.*

However, these individuals are not eligible for, and therefore left out of the 30 baht system.
It should also be noted that a significant minority of subjects (n=6) stated that no one is left out of the 30 Baht system, and that it has, in fact, achieved universal coverage.

In summary, while a significant minority stated that the 30 Baht system was truly universal, the majority of respondents felt that some groups were still left out, the largest of them being immigrants and people who have trouble with registrations for a variety of reasons.

Domain 5: Professional Opinion of the System

When asked for their professional opinion of the system, the most common response was that the system was good in theory, but not in practice. Brought up by nearly half of the doctors and many of the administrators, responses in this category included concerns that have been discussed above including insufficient budgeting, inducement of perverse incentives, the abruptness with which the system was implemented, and problems with registration and coverage of immigrants. These concerns were raised across professional, sex, and demographic categories. The only significant trend is that subjects in provinces with higher incomes were significantly more likely to raise the issue or perverse incentives described in the domain above. There was no significant difference between provinces, between men and women, administrators and non-administrators, or demographic characteristics of the provinces.

One doctor raised many of the concerns raised by the sample group in his response:

Well, it has to be divided into 2 aspects. The first one is the topic about concept, which is the health insurance itself; and the other is the implementation of the project. Staff who have been working within the range of the 30 baht program are all concerned and agree with it. This is because it's about social security of the society. People's
health condition should not be mixed up with their economic status. And now... about the implementation...
The implementation is usually involved with politics. Hence, there comes the popularist element. It in turn affected the cost and the budget spending, which is not enough. Moreover, the implementation has also resulted in... it reformed the structure as well. It reformed the budget allocation, but it didn't prepare people to understand the system. Therefore, problems occurred. There are hospitals which gain, and others which lose. In contrast, people always gain. I mean, there are concerns about people's rights, but people's responsibility have never been mentioned.

As mentioned, registration was an additional concern, as expressed by this nurse:

*I think it's a good idea in general. But in practice, you will face lots of problems because people in Thailand move all the time.*

Others qualified their concern over the practicality of the system, stating that the initial problems were starting to resolve. This nurse explains:

*After the 30 baht system was launched, at first it didn't focus on practical matters. But recently there is more supervision, so things became clearer and more possible to practice.*

In addition to the very common concern that the 30 Baht system was good in theory but not in practice, many people expressed their positive opinions of the system. For example, a public health professional and two nurses from three different hospitals in three different provinces each explained how the “active strategy” of going into the field had allowed them to become closer to their patients and understand their home context:

*In the past, there was no active work done in communities; sometimes it was difficult for people to reach us... but in fact, it is because since the 30 baht was implemented, the staff have had more chances to do field work. So we can see more of their life, their communities – how they live and stuff. And sometimes we can establish relationships with them, so they feel good about us.*

*With PCU’s [primary care units] like this one, we gain*
more access to communities

When we were in the hospital in the past, we could involve with a patient's relatives only at the hospital. Now it has changed; we go and see them at their houses, in communities. The relationship between us is, therefore, stronger than before. They feel free to come to us for consultation... but I don't go very often, only on Wednesday and Friday. One patient of mine is not able to walk. She once came to me and told me that she wanted me to visit her at home. The patient was very glad when I paid her a visit.

To summarize the opinions expressed by subjects when directly asked their opinion of the 30 Baht system, most felt that the system was great in theory, but a number of them worried about practical matters. Others extolled the virtues of expanding care to more people and of being freed to work with patients in their home/community setting.

**Domain 6: Preventive service utilization**

While questions about utilization rates of individual services proved ineffectual, Thai health care staff had a lot to say about general changes in utilization of preventive services. The overwhelming majority of them spoke of the dramatically increased numbers of patients, though many qualified this by saying that it was a global increase in patients for all services. Similar to answers in the previous domain, many subjects also qualified their answers by saying that much of the preventive work was done in the community, not the hospital. There were no significant deviations from this trend by sex, profession, administrative responsibility, or province.

A nurse explains that in order to manage the increasing patient load, staff have used their own free time outside of working hours:

*I say it is the active work. We have to open doors to people. They might not see any importance in prevention. In doing prevention, staff must find time, extra time from working hours, because it is time when people stay home,
Thai people. For example, I am doing screenings diabetics and hypertensions for people aged 45 up. They don't come in, so we have to go out, providing services on Sundays. Although they have to pay 30 baht, they don't come in. If we go out—like this—they are willing to pay, a lot, because it is convenient.

Contrary to her perception that the service utilization pattern was based on convenience rather than cost, other subjects related that patients were in fact coming in more now that care was cheap. For example, one nurse says:

Patients holding gold cards or free cards come to us all the time. Some go to public health center at their ease, every month like “addicted” to the staff. Sometimes we have to ask “Oh! You don’t have anywhere else to go?” teasing them. Some groups got “addicted” to doctors after the 30 Baht was implemented. Little things happen and they come in.

A pharmacist relates the perception that patients not only come in because care is cheap, but also because medicines themselves are cheap:

They want to see a doctor in order to receive medicines. Therefore they come in more often. Some people say they have a little problem, but when the doctor diagnoses them they are not really ill. We only give them a bottle of balm, and they are still happy about it.

In fact, a number of staff members related that patients are careless with their medicines because they know they can come in and get more. One doctor said “they get medicine, go home, and forget it in the bus; the next day they come again, and we have to give them more medicine.” Another doctor says:

Sometimes they [patients] don't know what their rights are, so they ask more than their rights. Or they overuse them. In general, this health insurance is for necessity. But now some use it more than what is needed, cheat a bit. Or is it because they don’t have to pay. They see no prices, but these medicines... perhaps they give them to cats, or give them away, or just throw them away. From my experience there are lots of these cases.
Contrary to the above subjects who focused on concepts relating to moral hazard, an equal number of staff explained that individuals had not changed their utilization patterns based on cost. When asked if individuals had more visits per person after the implementation of the 30 Baht system, the most common answer was affirmative. However, a significant minority (n=8) explained that the utilization patterns of individual patients were dictated either by the disease they were being followed for or structural issues, such as the frequency with which prescriptions could be refilled. A doctor explains:

> And for chronic patients, they come in more often too, but because of the other reason – under the 30 baht program the hospital will not prescribe medicines for 3 months’ time, so [we] make an appointment for everyone. This makes the number of visits increase. Actually, the figure should drop, but because of this [procedure] it rises.

A final qualification commonly made about the increase in preventive services was that it was not truly a result of the 30 Baht system. A number of people mentioned that the “Healthy Thailand” program, a distinct entity from the 30 Baht system, was responsible. For example one doctor says:

> When the 30 baht system was implemented, did we start to do more preventive services? Yes, but not much, not really much. We started to do this more seriously when we did the campaign ‘Healthy Thailand’. Have you heard of this? ‘Healthy Thailand’ : 2004 was the first year they start implementing Healthy Thailand. In 2005, they added another: exercise, food, non illness, emotion, and environmental health. The sixth Or is immorality (such as gambling, drug abuse).

In summary, the majority of subjects felt that there was a dramatic increase in the number of patients using preventive services and the number of preventive visits per person, with some qualifications and divergences in opinions as to the cause. There was an emphasis that this probably occurred due to the “active strategy” rather than more patients coming in to the hospital. Subjects disagreed on how financial
incentives, convenience factors, and provider instructions played a role in utilization. In addition to these qualifications, it is not even entirely clear to all of the subjects how much of the change in preventive service utilization is due to the 30 baht system versus the "Healthy Thailand" program.

**Domain 7: Patient population changes**

In addition to changes in utilization of preventive services, subjects were asked to describe any changes in the demographics of the patient population they were treating. The most common answer was that there was no change in the demographics of the patients that subjects were treating, followed closely by the response that there were more poor patients since the 30 Baht system. Doctors were most likely to cite more poor people, nurses and public health professionals were most likely to cite no change, and dentists and pharmacists cited more poor people and no change equally. In one province there was a large majority of subjects citing no change, while in the rest, more poor people or more middle class people were predominantly cited. Women were most likely to cite more poor people and men were most likely to cite no change independent of the province they came from. Finally, the majority (10 of 11) of subjects who cited more poor people came from regions with large private sectors (as measured by the proportion of hospital beds in the private sector).

There are many possible explanations for this latter trend. It may be that in sample provinces with larger private sectors, those with money fled the public system after the 30 Baht system was implemented and there was efflux of wealthier patients. It could also be that provinces with larger private sectors had significant influx of poor patients who had managed to purchase private insurance before the 30 Baht system. However, neither of these explanations was cited by any subject.
In addition to the majority opinion that there was no change in the population, and the slightly less common opinion that there were more poor people, other responses cited more middle class people, more elderly people, and more children. A particularly poignant picture of the latter was painted by a doctor describing antenatal care (ANC) in her neighborhood:

*there is a change in the group of patients. Before, patients coming for ANC were mainly aged 20-30 years, but now that we have the 30 baht, they are younger, the patients. They turned out to be children aged 13-17 who come for ANC. The group of patients, that's what definitely changed. Previously, these kids didn't come for ANC, being patients with 'no ANC', they showed up when they were about to deliver. After the 30 baht, there is more of this group of patients - a lot more - the pregnant teenagers. Or it might be due to social change. I don't know. It turns out though that this group is the 'main group' of 30-baht ANC in this neighborhood.*

In summary, most subjects felt that there was no change in the type of patient accessing medical services after the 30 Bah system was implemented, though a significant minority felt that there were more poor patients, and smaller groups of subjects thought that there were more middle class people, elderly people, and children as patients after the 30 Baht system.

**Domain 8: Equity between systems**

Telescoping out from the 30 Baht system, subjects were asked to compare the type and quality of care patients receive in the 30 Baht system versus the other two public insurance schemes—civil servants (CSMB) and social security (SSI). A majority of subjects felt that the care was exactly the same, many citing an absence of "discrimination." Others explained various ways in which the type or quality of services was different including the following (in descending order of the number of subjects that cited them):

- The system is truly multi-tiered
→ Drugs are better for patients in the CSMB and SSI
→ 30 Baht is better at promotion and prevention (P&P)
→ CSMB and SSI better at curative services
→ Basics are equal, but there are more luxuries in CSMB and SSI
→ There is inequity at other hospitals, not this one

An example of the first and most common response (a nurse):

No. The civil servants seem to be at the best level and the second one is social security and the worst one is the 30 Baht. In general for the whole country. If you ask me for [my] Hospital, I will say that the [systems] are about the same.

A dentist gave a similar response, ranking the three systems A, B, and C in the same order as above (and in the order in which they are reimbursed by the government). In general subjects who described inequities described the system as “almost equal,” and then proceeded to acknowledge what small differences still remained. The example of drugs is useful. Some subjects specifically explained that the drugs were the same across systems, even though patients incorrectly think they are different. Others explained that though there are differences among the drugs, the “necessary ones” are the same:

For instance, all analgesics have a similar action, yet people...Like a car, no matter what it is, Toyota or Benz, it can run alright. But, rich people are still...It's the passion...human's nature. People usually prefer the Benz because they think it's better. Likewise, under the system of our country, people always perceive a better medicine as being easier to consume; for example, the dose of this medicine is only a tablet a time while that medicine's is 4 tablets a time, but with a price 4 times higher. Something like that. People always keep saying, "I have the right". ... If you Ask me whether there are any differences, I'll say that there are some differences like those I've just mentioned. For instance, every patient in pain will receive analgesics. The effectiveness or the result is the same; patients will be recovered. In other words, if we eat some food, no matter what it is, Pad Thai or shark fin, we will be full.
With the analogies in his response, this doctor addresses the fact that there are differences between the systems, but in his reckoning they all provide the essentials.

Despite these differences, many subjects were quick to point out that they do not discriminate between patients and that treatment decisions are made first and foremost based on professional standards:

> Suppose I want to prescribe some medicines to insured patients. I probably won't be able to do so because there is no such medicine here. So I would tell them to try other medicines first, and if the treatment doesn't work, I would suggest them to go to other hospitals. Insured patients have more choices – they can go to both other public hospitals and private ones. But this is not the case for the 30 baht patients or social security users. After all, we never give under-treatment; we do it according to the professional standard.

This sentiment was a very common one among both the subjects who felt there was a difference between the systems and, especially, those who felt there was no difference between the type and quality of services between systems. A dentist for example explains:

> It's not different because we have a single standard, frankly speaking, we have a single standard. I mean our work... when we select dental supplies to be used in our department, it must be a consensus among the dentists [across all systems], that the quality is acceptable...

Likewise a doctor explains:

> In this profession, we don't discriminate among patients, No matter whether they have privileges or common Patients. We do it based on privileges.

He goes on to explain the case of ANC specifically and how the services are the same for people across systems.

Some subjects went even further to describe the 30 Baht system as better. The case of ANC comes up as one nurse describes the fact that she feels 30 Baht patients
actually receive better care because the staff are more familiar with the patients they treat.

In summary most subjects felt that there was no difference in the type or quality of services between public insurance systems in Thailand. On the other hand, some cited the superiority of the 30 Baht system at preventive care and/or the CSMB and SSI systems’ better drugs. Regardless of whether they felt their was equity in care, most of the subjects were quick to point out that health care providers made their decisions based first and foremost on professional standards. This issue comes up again in the following domain.

**Domain 9: Staff satisfaction**

Practicing in a system with the limitations described above—increasing number of patients, limited resources, etc.—undoubtedly adds some level of stress to anyone’s job. Interestingly the majority of subjects stated that in general staff satisfaction was low because of increasing workloads, but stated that they themselves were satisfied with their job. This is true across all professions, provinces, and demographic data. The subjects describe negative effects of this workload on both patient care and staff morale. For example this doctor relates:

*My staff are tired. They are worn out. We try to recruit more people to make them work more happily. If you don’t work happily, how could you provide good services satisfactorily? It will come back, as a cycle on and on.*

Another explains one of the ways this cycle has played out “we try to find incentives for them to stay with us; otherwise they will leave for private hospitals.” This issue of staff efflux to private hospitals is a significant one. Many subjects mentioned both the fact that because staff are tired they switch to the private system, and that the reason
staff were so tired is because other staff have left for the private system. It is a positive feedback loop. One dentist explains:

And now for the workers like physician, nurse, or dentist, or any worker, they have to work so hard because so many patients… much higher than before. They must work so hard. And you know that about the salary for physicians or dentists when you compare with the private you find so much difference. They work so hard and they have no incentive for the work, so many physician/dentist they might retire to go to the private sector after the 30 Baht system was started.

Another dentist explains:

I want to increase the number of doctors. Now, there are few of them in civil service. They all have moved to private sector. Suppose we are patients, if we have to wait for doctors for a whole day, and there are lots of patients, then we want more doctors, more health professionals. Sometimes I pity the patients; there are 2 doctors for 40 patients – they have to wait so long that they get really bored.

In addition to making clear how integrated dental and medical professionals are at Thai hospitals, this pair of quotes also shows the implications for patients of the cycle causing doctors to leave for the private system. In fact one of the dentists relates that he wouldn’t even let his own grandmother use the 30 Baht system because he didn’t want her to have to wait in the lines. Subjects also related that patients like her, who have means of going to private health care facilities, are doing so. One doctor explains:

So there is a situation that people with money, who can afford private services, ‘flee’ because there are already many people at public hospitals. If they can afford it, they don’t want to wait here, so there are some who go to private hospitals. But then they have to pay a lot of money – they already have the 30 baht cards. We all know that when they distribute the cards, they are not only for poor people, but also rich ones who don’t have any other rights, unable to claim the money, or with no Social Security. These people receive the 30 baht rights too. So there is this phenomenon – for “little” examinations, they go to
private hospitals, but when it is serious, for example when having to get operations and spend a lot of money... they use 30 baht services.

This phenomenon is also addressed by a nurse who refers to it as "the rich take advantage of the poor." In effect, the subjects explain that the 30 Baht system has created a flow of previously uninsured patients into the public health care system for all care, a new usage of the public health care system by the wealthy for expensive care, and the "fleeing" of public health care staff to the private system to escape these influxes of patients. This process is represented in figure 17.

Figure 17:

Another ways in which the influx of patients affects the staff is in their sense of professional pride (as discussed above). When a huge number of patients come in expecting to be cared for and there is a simultaneous decrease in staff, there is a mismatch in patient expectations and reality. One nurse explains:

*People have to understand the staff as well, not just only claim for their rights; doctors feel the staff are dishonored. They say that doctors are not servants. There should be a way to encourage doctors that they*
are still honored. Nowadays sometimes it's like patients come in just to claim for their legal rights and it's the doctors' duty to serve them. The staff should be honored as they do the job because they really want to help people, not because they are ordered to do so.

This nurse's quote makes clear the complex relationship between the patients' right to health care and the staff's need for respect.

In summary, there are many ways in which the 30 Baht system has affected staff satisfaction. Most subjects thought staff members generally were overworked but reported being satisfied themselves. They also reported a complex flow of patients and providers between the public and private systems represented in figure 17. Finally, they expressed the concern that increased number of patients and decreased numbers of staff in the public health care system has increased patient wait times and decreased quality of services provided.

**Domain 10: Most important things for people to know**

When asked what the most important things Thai people and foreign people should know about the 30 Baht system, subjects largely wanted Thai people to understand what is and isn't covered by the 30 Baht system and foreigners to simply know that universal health care exists in Thailand. The other major issue subjects wanted the Thai people to know about was how important prevention is to the success of the 30 Baht system. Other themes/codes about what Thai people should know include (in descending order of passages coded):

→ There are financial limits on the system

→ One does not need to go to tertiary care centers for every health issue

Other themes/codes about what foreigners should know include (in descending order of passages coded):

→ There needs to be financial sustainability in a health care system
→ The goal of a health care system should be clear

→ We (many countries) should work together to make better systems

→ There should be more planning for health care systems

→ good management is essential in a health care system

→ Job security is essential in a health care system

The major themes, however, were mentioned far more commonly across groups than the minor ones (twenty-five subjects mentioned that Thai people should know what is really covered by the 30 Baht system, and 15 mentioned that Thai people should understand the importance of prevention, whereas 4 mentioned the tertiary center issue). There were no significant deviations from this trend by sex, profession, administrative responsibility, or province.

There were a number of ways of framing the issue of understanding the limitations of the system. One doctor puts it this way: “Thai people should know that it is not '30 Baht cures all.’” However, others focused on the need for patients to understand their “rights.” A nurse explains, “People should know their own rights. Many people don’t know they are covered by the 30 Baht system.” This discussion had significant overlap with that of human rights where people discussed both the entitlements and the limitations they wanted patients to know about. A public health professional explains:

*For people, I want them to know their rights: what items are included in the 30 Baht system, what are the limits, where and how to use the card. They have to know to what extent does the 30 Baht support them.*

When it comes to what foreigners should know, there were more and less optimistic ways of looking at the same basic idea that foreigners should simply know that universal health care exists in Thailand. One doctor explained:

*Thailand has created health insurance for every Thai. If you are ill you can receive standardized health care.*
Everybody, no matter how rich they are, should have the same opportunity to access the same standard of medical treatment.

On the other hand, another doctor had the following to say about what foreigners should know:

*Well, they should know that the project was intended to create “universal coverage,” and to provide preventive and “promotive” services. But about the outcome, we’ll see...*

As far as worries about sustainability that subjects wanted to share with foreigners, a nurse had the following to say:

*The 30 Baht system is wonderful, but I’m afraid the government may not be able to provide financial support for this system in the long run. The 30 Baht system is fairly good in the respect of morality, but may not be enough money. The reason for this is that we keep our services’ standard high, so the cost is definitely almost always far more than 30 Baht.*

In summary, most subjects wanted Thai people to know about the rights and limitations of the 30 Baht system as well as the importance of prevention. They also wanted foreigners to know that “universal coverage” exists in Thailand, though they differed on their opinions of the success or sustainability of that coverage.

**Domain 11: What needs to change**

When asked what needs to change for the system to be successful for patients and for staff, the largest number of subjects mentioned that budgets (n=10) and salaries (n=9) should be increased for the system to be successful for staff and that for patients’ sake, there should be more of a focus on prevention.

There were a diversity of opinions on what should change for staff’s sake. Administrators and those who had never worked in the private sector were more likely to mention the budget than non-administrators and those who had ever worked in the private sector. Doctors and dentists were most likely to mention higher salaries,
whereas nurses were more likely to mention the need to clear up confusion among patients in order to improve the work environment, and public health professionals were most likely to mention the budget. Subjects in most provinces were most likely to mention both the budget and higher salaries; however in one province the most commonly mentioned change needed was a change in management. Men were most likely to mention the need for higher salaries, whereas women mentioned budget increases, the need for more staff, and the need to change management with equal frequency.

There was less diversity in opinions of what needed to change for patients’ sake. Most agreed that a focus on prevention was of the utmost importance. However, there were a few exceptions. Public health professionals were more likely to mention the fact that coverage should be expanded. In one province the budget was stressed as most important to the success of the system for patients while in another province subjects were more likely to mention fixing the registration problems with the system. Both men and women, and administrators and non-administrators, however, were most likely to mention the dominant answer: a focus on prevention was the single most important factor in making the 30 Baht system a success for patients.

With respect to the concerns for staff, below are some examples of the dominant concern of budget issues (from two doctors).

_ I say money, money, money. I think most hospitals suffer loss because of not enough money._

_ I think there should be an adjustment in budget allocation to the hospitals under the scheme. I don't think all hospitals in the country should be under a single financial management system. We have to figure out appropriate methods for each hospital like the way we cure different diseases differently. Moreover, the budget should be increased both for the medication and the payments for staff. The government_
should provide more money for this. When there are incentives in work, people will be more willing to do their jobs, and I believe the work, eventually, will be better.

These have some overlap with the issue of better pay for staff, an issue addressed more specifically by many subjects. This issue is part of the picture addressed with staff satisfaction in domain 9 and figure 17 with respect to doctor’s becoming unsatisfied and leaving the public health care system. Part of the draw out of the system, described by subjects here, is that they are paid more in the private system.

With respect to what needs to change for the system to be successful for patients, there were a number of poignant comments made about focusing on prevention as a way of making the system better. One nurse explained that focusing on prevention would decrease the number of patients in the waiting room which would make both staff and patients happier. She described how staff could come to work with a smile again, rather that having the attitude “Oh, here they come again!”

A pharmacist explains:

We have to stress more on active services, or preventions. However, our hospital has many limitations. What can be done is probably to set up centers to take care of such services. Now it seems like most people come here for curative services.

And a nurse shows the benefit of what such a switch would be:

...we should go to the communities and detect people who at risk of diseases. We have to go in and find out what their problems are and what help they need in terms of public health. And if we can do more prevention, the ‘confrontation’ [curing] will be less. We will “build” more and “fix” less.

Less commonly mentioned issues that subjects thought need to change for the 30 Baht system to be successful for patients include the following (in descending order of passages coded):

→ Coverage should be expanded
→ The Budget should be improved
→ Registration problems should be fixed
→ Patients should be assured about the quality of services
→ More staff should be hired
→ All services should be free
→ Quality of services should be improved
→ Hospitals should be open on the weekends
→ The private sector should be incorporated into the system
→ Wait time should be reduced
→ Staff should have more input into management

In summary, there was a significant diversity of suggestions made by subjects as to how the 30 baht system could be improved for both staff and patients. The most common answers as to how the system could improve for staff were that the budget and staff compensation should be increased. The most common answer as to how the system could be improved for patients was that prevention should be emphasized more.

Domain 12: Other issues

These issues were already addressed in the context of the domains in which they were raised.

Summary of Results and Discussion:

While the passages included above are designed to demonstrate the wide diversity of opinions among the subjects, some majority opinions and significant minority opinions emerged. In assessing them, the initial hypotheses will first be revisited and then additional findings enumerated. Certain lessons can be drawn from
these findings that may have relevance for both the new government of Thailand and policymakers elsewhere.

_Hypothesis 1: Thai health care staff will consider health care a human right, but may have practical concerns about what that means in the hospital, as infrastructure was not sufficiently expanded before the system was implemented._

In fact subjects unanimously agreed that health care is a human right, but framed it in a unique way—in terms of targeting the poor (with limited rights for the wealthy) with a de-emphasis on entitlement relative to the rights _and_ responsibilities of patients. In other words, using the Thai notion of “patronage” some subjects emphasized that while health care is a human right, it should be thought of in terms of the beneficence of the provider rather than the demands of the receiver. With respect to the emphasis on targeting the poor and limiting the rights of the rich, some adjustment in policy may be called for if this truly is the goal of providing health care as a human right. The new constitution may provide further guidance on this issue.

With respect to the expectation that a chief concern would be the absence of a program to expand health infrastructure (i.e. staff numbers), an unexpected response was found. Rather than focus on the fact that there was not an expansion of health care staff to meet the rise in patients, many subjects focused on the fact that salaries were too low to keep the staff already present in the public health care system. Instead, they are leaving for the respite they need in the easier lifestyle and better pay of the private health care system. While most subjects demonstrated perseverance by stating that they themselves were satisfied with their job, it was telling that they thought most of their colleagues were not. The solutions to the problem they were
describing could be many-fold and depend largely on the political structure. If Thailand were a command and control society like Cuba, they could simply increase health care staff training in a top-down fashion, or outlaw the private health care industry. Each of these approaches could be politically difficult in Thailand. Therefore, most subjects recommend an expansion of salaries. Clearly this is in their own self-interest and would not be tremendously good for keeping the costs of the health care system under control. However, it is a bit of wisdom from the front lines explaining why there may be, in fact, a decrease in health care staffing when the opposite is needed to sustain the system. It also provides a model for international health policy makers of what can happen in a side-by-side public/private system when patient load is dramatically increased in the public system without changing staffing levels or salaries.

_Hypothesis 2. They will think the new system is not truly universal and will cite geographic mal-distribution of health infrastructure and barriers to care faced by the poor._

In fact, while a significant minority of subjects felt that the system was truly universal, a majority felt that immigrants and others were still left out due to registration problems. If the Thai government would like the system to be completely universal, they must make some attempt to include these groups beyond what has already happened. This also provides an example for international health policy makers of the benefits and drawbacks of residence-based registration.

The providers did not cite geographic issues of health infrastructure distribution. However, this may be due to the sample design, which focused in areas
where health infrastructure was more developed (see province analysis in sample
design).

Hypothesis 3: They will cite inequities between the tiers (as exists between tiers
in Chile).

Contrary to the hypothesis, most subjects felt the care was the same across
systems. Much of their explanation stemmed form a sense of professionalism that
demands they treat all patients equally. There was a significant minority that felt that
drugs and curative services were better in the other two government systems, while
preventive services were better in the 30 Baht system. This illustrates how, at best,
this multi-tiered system has created a “separate but equal” level of care between tiers.
At worst, it has perpetuated inequities in health care and access to health care. It also
further emphasizes LeGrand’s notion that both the “knightly” and “knavely”
motivations of health care staff must be addressed. [42] While the “knightly”
motivations may help equalize the inherent inequities in providing different capitation
levels for different people, multi-tiered systems like Chile’s and Thailand’s still
inherently have some level of inequity.

Hypothesis 4. They will cite increases in preventive services utilization based
on a large influx of new patients, but may again describe how there are
not enough staff to deal with this increase.

On the whole, subjects believed the goal of increasing preventive services had
not been reached despite the large new influx of patients. It was also not clear to them
what portion of the gains in preventive services were due to the 30 Baht system versus
the “Healthy Thailand” program. This illustrates how changing goals alone, without
dramatically restructuring infrastructure to match the goals can lead to less than complete achievement of a re-emphasis on preventive services. However, quantitative research methods, as are being carried out by the Thai HSRI, will much better assess actual changes in utilization. See discussion of hypothesis 1 for health infrastructure issues.

*Hypothesis 5. They will describe seeing more poor patients and others who did not come before. The example of Taiwan, where the new system dramatically increased utilization by the previously uninsured, is one that is expected to be replicated here.*

Subjects did not give a consistent answer on the demographics of new patients. They described either no change in the number of poor people, or a slight increase. This again, could be further explored using quantitative research methods. However, anecdotal evidence was present in this study that people who could not previously access health care were able to do so under the 30 Baht system.

*Hypothesis 6. They will express being overworked and expected to care for more patients than they can handle.*

Again, see the discussion of hypothesis 1. Thai health care staff did, in fact, express feeling overworked and having to care for too many patients. However, they also expressed great resilience and sympathy for the patients who are also affected. They explained that with the high patient loads for provider came attendant long wait-times for patients. This wait-time increase adds to the example for international health policy-makers of what can happen in side-by-side public/private health systems that have a sudden increase in patient load.
Hypothesis 7. They will want the government to expand the number of health care staff in the system (as Cuba did in order to meet similar human rights-based goals in their system)

Actually, as described in the discussion of hypothesis 1, the subjects focused on making salaries commensurate with the level of work. Some mentioned that having more staff in the hospitals and primary care units would help, but this was not the majority response. This provides Thai policy makers with an interesting choice of means to maintain staffing levels in the public health care system. To stop the trend of staff exodus, they can either increase the staffing levels, thus decreasing everyone's workload, or increase salaries.

Additional Findings and Recommendations:

First and foremost, Thai health care staff would like their input to be taken more seriously in policy decisions. If it is not, the Thai government risks losing their buy-in to the system and a further exodus of public health care staff to the benefits of the private health care system. Part of avoiding the pitfalls demonstrated in Chile and the UK where staff were not aligned with the government goals for many years, could be to provide the health care staff with a clearer picture of the goals of the system. It is not necessary that all Thai health care staff be in lock-step with the government with respect to the goals of the system. However, as the system existed at the time of this study, the government had presented a purely political message about the system ("30 Baht cures all") and the staff had no clear agreement among themselves as to what the goals were. The combination of not sharing at least general principles about the goals of the system with their colleagues or the government and a sense that the
government does not listen to the input of health care staff is a potentially dangerous one. An attempt by the government to unify staff around common goals (or at least principles) within the new system, drawing on their "knightly" motivations, could help avoid the problems faced in Chile and the UK when health care staff start to oppose government plans for the health care system.

Another major concern of subjects that seems to merit mention is that of the budget. While subjects acknowledged progress towards the various goals they enumerated, some also expressed concern that budgeting problems would compromise all of the gains and "bankrupt the whole health care system of the country." While the numbers illustrate that health care spending per capita had not increased from 1999 until 2003, [80] the number of people receiving traditional western medical care certainly did. The question, then, is if it is sustainable for a national health care system to dramatically expand the number of people it covers without increasing health spending per capita (that is, without dramatic cost control measures to reduce previous waste in the system, as were implemented in Taiwan). This study does not seek to answer that question, but rather raise it as a concern of the subjects.

A final lesson of this study comes from the observation that the implementation of this system was subject to a political hurry and that transition to implementation was a difficult one for many of the subjects. Many subjects said that other new systems trying to accomplish universal coverage should move more slowly and use "pilot studies." While the Thai system did in fact use certain hospitals as pilot projects, some of which were included in the sample of this survey, the implementation was quite rapid after the Thai Rak Thai government took power. Subjects cited initial turbulence in the flow of patients through their clinics and
hospitals, and the financial difficulties small hospitals faced in the transition. International health policy makers have a large literature to draw on discussing “incrementalism” versus “big bang” approaches to health reform. This study, however, provides some front line feedback from selected Thai health care providers that the “big bang” approach provided significant bumps in their clinical practice.

Summary of International Lessons:

→ In side-by-side public/private health care systems, when patient loads are dramatically increased in the public system with a commensurate increase in health care staffing and infrastructure, staff may become overworked and flee the public system while patients may experience long wait-times.

→ Residence-based registration for national health systems has the drawback of not capturing immigrants, the homeless, and other groups without residence or proof of residence.

→ While “knightly” motivations of health care staff may help compensate for differing levels of financing for different tiers within a national health care system, inequities are still inherent in multi-tiered systems.

→ With health care staff that are overworked due to increased patient loads, there may be multiple options for improving staff satisfaction: increasing staffing levels or increasing staff salary.

→ One way to keep staff buy-in to a health care system may be to have a clearly communicated set of goals of principles within the system.
Limitations

The limitations of this study are numerous. It is in no way intended to be generalize-able to all of Thailand, or even to the central region whose provinces made up the sample. A comparison of the provinces in the study to national averages across demographic and health-related measures is presented in the sample design generally, it indicates that the provinces in the study were somewhat wealthier, had more health care staff per capita, and a larger private sector than the national average.

The hospitals, while in these areas, were not necessarily representative of their respective provinces. Within the provinces in the study, the selection of hospitals was purposive, not random (though response rate was 100%). The selection of staff within those hospitals was also not random. Rather it was conducted by administrative staff at the hospital in processes outside of the view of the researchers. There seemed to be a bias towards staff members in positions of power—a number of the subjects were directors of hospitals, PCUs, nurses units, dental clinics etc.

Other biases include those within subjects. Recall bias is an issue as subjects were asked to compare the present situation to a situation many years in the past. Also, subjects were aware that the subject of the study was “the 30 Baht system and preventive care.” This could have biased answers towards emphasizing preventive care more than it otherwise would have. Also, it was not clear that some subjects understood the confidential nature of the interview. One subject even said “whoever hears this record, please don’t be angry with me.” Therefore, some answers may have been overly positive with the perception that superiors or government officials may hear the transcripts and act against the subjects accordingly.

Further limitations include the extended process through which transcripts were transcribed and translated. Language issues made some of the transcripts
somewhat messy (e.g. British spellings versus American), with some grammatical imperfections. This limited the decipherability of certain passages.

Future research

Many future studies would help the general understanding of the universal health care system in Thailand. Studies could be designed to assess staff perspective of how the Civil Servants’ (CSMB) and Social Security (SSI) systems have changed since the implementation of the 30 Baht system, as well as how the 30 Baht system has changed since the coup (as this study was conducted before the coup).

There is room for further qualitative studies on the 30 Baht system—both among health care providers and patients. Asking patients to describe their experiences with the 30 Baht system is one obvious example. Another is to explore similar issues to this study with health care providers in the more rural Northern and Southern regions of Thailand. Qualitative studies could also help evaluate ways in which the 30 Baht system and the Thai health care system have evolved since the coup.

In addition to further qualitative studies, many quantitative studies could answer questions that this study could not. For example, large, survey-based studies could assess general support for the 30 Baht system among staff and/or patients, staff satisfaction, patient satisfaction, and self-reported trends in utilization. Hospital-based studies comparing patient records before and after the 30 Baht system (or within the 30 Baht system before and after the coup) could evaluate trends in management of specific diseases within the system. Other studies evaluating the ways in which utilization trends have progressed since the 30 Baht system are being conducted by the Thai Government (though they are only available in Thai language documents).
One that would be especially useful is to examine if the rates of utilization among previously uninsured and poorer Thai citizens has approached that of the previously insured as it did in Taiwan.

Patient perspectives of all of these changes would also add immensely to the voices policy-makers should hear when considering future directions.
Appendix:

Interview Guide:

* Introduction:
  Informed Consent Explanation
  Confidentiality Explanation

* Research Questions:

  **Personal Information**
  1. How long have you been working in public health care facilities?
  2. What is your position?
  3. What other positions have you had in public health care facilities? For how long?
  4. Have you ever worked in private health care facilities? If so, what position(s)? For how long?
  5. Do you currently work in private health care facilities? If so, in what position(s)?

  **General Professional Observations**
  1. What do you think is the goal of the 30 Baht system?
  2. What is your professional opinion of the 30 baht system?
  3. Has the 30 Baht system affected the hospital environment? If so, how?

  **Service Utilization Questions**
  1. What do preventive service visits consist of now?
  2. Has the 30 Baht system affected the way patients access preventive services?
  3. Have you noticed a change in how many people come in for preventive service visits?
  4. Have you noticed a change in how many people come in for pre-natal visits?
  5. What about well-baby visits?
  6. Pap Smears?
  7. Diabetes or hypertension screening?
  8. Vaccinations?
  9. Do you think individuals have more visits per person since the 30 Baht system was implemented?
  10. Have you noticed a change in content, process, and/or time of preventive services (pre-natal visit, well baby visit, pap smear, diabetes or hypertension screening other) since the 30 Baht system was implemented? If so, how?

  **Patient and Professional Experiences**
  1. Have you noticed a change in the patient population since the 30 Baht system was implemented? (for example more or less poor people, more or less women) If so, how?
  2. Have you noticed any change in patient satisfaction since the 30 Baht system was implemented?
  3. Have you noticed any change in staff satisfaction since the 30 Baht system was implemented?
4. Do you feel more or less content with your job since the 30 Baht system was implemented?
5. Do you feel more or less content with the medical care you are helping patients get since the 30 Baht system was implemented?
6. In what other ways is your job different since the 30 Baht system was implemented?
7. Do you feel more or less likely to encourage a patient to receive preventive services since the 30 Baht system was implemented?

Societal Issues
1. Do people receive the same type and quality of care in the Social Security, Civil Servants, and 30 Baht health care plans?
2. From your experience, is there anyone who is left out by the 30 Baht system? If so, who?
3. Do you feel that the 30 Baht system is a success at achieving its goals? The UN Declaration of Human Rights says that health care is a human right. Do you agree?
4. If so, do you think that the 30 Baht system is achieving this goal?

Open ended summary questions:
1. From your professional perspective, what are the most important things you think people in Thailand should know about the 30 Baht system?
2. From your professional perspective, what are the most important things you think people in other countries should know about the 30 Baht System (if any)?
3. From your professional perspective, is there anything that needs to change to make the 30 Baht system more successful for patients? If so, what and how?
4. From your professional perspective, is there anything that needs to change to make the 30 Baht system more successful for public health care facility staff? If so, what and how?

• Thank Subject:
• Review confidentiality
• Review contact information in case of questions
Works Cited


73. Poolcharoen, W., "*Health System Reform and the Role of the Health System Research Institute*". Health System Research Institute, 2002, July.


