การประเมินนโยบาย “เพื่อคนจน”: ตัวแบบการติดตามโครงการหลักประกันสุขภาพทั่วหน้า ในประเทศไทย

นาย เบนจามิน แอนดรู ฮารคินส์

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาศิลปศาสตรมหาบัณฑิต
สาขาวิชาการพัฒนาระหว่างประเทศ
คณะรัฐศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย
ปีการศึกษา 2552

ลิขสิทธิ์ของจุฬาลงกรณ์มหาวิทยาลัย

RE-EVALUATING “PRO-POOR”: A MODEL FOR MONITORING OF THE UNIVERSAL COVERAGE SCHEME IN THAILAND

Mr. Ben Harkins

A Thesis Submitted in Partial Fulfillment of the Requirements
for the Degree of Master of Arts Program in International Development Studies
Faculty of Political Science
Chulalongkorn University
Academic year 2009
Copyright of Chulalongkorn University

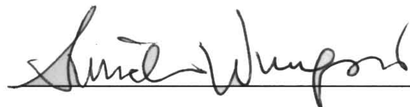
Thesis title:	RE-EVALUATING "PRO-POOR": A MODEL FOR MONITORING OF THE UNIVERSAL COVERAGE SCHEME IN THAILAND
By:	Mr. Ben Harkins
Field of Study:	International Development Studies
Thesis advisor:	Associate Professor Jiruth Sriratanaban, MD., Ph.D.

Accepted by the Faculty of Political Science, Chulalongkorn University in Partial Fulfillment of the Requirements for the Master's Degree.

______________________ Dean of the Faculty of Political Science

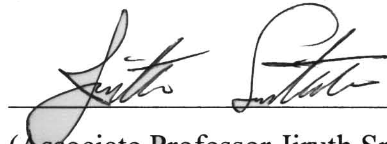
(Professor Charas Suwanmala, Ph.D.)

THESIS COMMITTEE



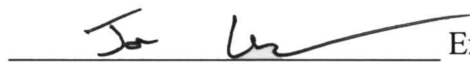
______________________ Chairperson

(Associate Professor Surichai Wun'Gaeo)



______________________ Thesis Advisor

(Associate Professor Jiruth Sriratanaban, MD., Ph.D.)



______________________ External Examiner

(Ajarn Jon Ungpakorn)

เบนจามิน แอนดรู ฮารคินส์: การประเมินนโยบาย "เพื่อคนจน": ตัวแบบการติดตามโครงการหลักประกันสุขภาพทั่วหน้าในประเทศไทย (Re-Evaluating "Pro-Poor": A Model for Monitoring of the Universal Coverage Scheme in Thailand) อ. ที่ปรึกษาวิทยานิพนธ์หลัก: รศ. ดร. นพ. จิรุตม์ ศรีรัตนบัลล์, 173 หน้า.

ประเทศไทยมีอัตรา ผลิตภัณฑ์มวลรวมในประเทศต่อหัว (GDP) ประมาณ $6,600 (PPP) แม้ว่าในช่วงระยะเวลาที่มีการออกใช้นโยบายระบบประกันสุขภาพถ้วนหน้า (บัตรทอง) ประเทศไทยได้เผชิญกับภาวะปัญหาสืบเนื่องมาจากวิกฤตเศรษฐกิจในเอเชีย แต่หากยังคงสามารถดำเนินการตามแผนระบบประกันสุขภาพถ้วนหน้าสำหรับประชากรไทยได้ตั้งแต่ปี พ.ศ. 2544 เป็นต้นมา

อย่างไรก็ตามภายใต้ระบบการประกันสุขภาพถ้วนหน้าปัจจุบันนี้ถือเป็นการประกอบกันระหว่างตัวประกันสุขภาพทั้ง 3 ของรัฐที่มีความไม่เท่าเทียมกันในเรื่องของสิทธิประโยชน์ ปัญหาความไม่เท่าเทียมกันในเรื่องสาธารณสุขภายในประเทศไทยที่เคยเป็นมานี้นำไปสู่ความพยายามในเรื่องการจัดระบบการประกันสุขภาพถ้วนหน้า และติดตามประเมินผลโครงการเรื่องคุณภาพของการรักษาเพื่อคนยากไร้ เพื่อจะมั่นใจได้ว่าคนไทยทุกคนจะได้รับการบริการสาธารณสุขอย่างทั่วถึง

วัตถุประสงค์เบื้องต้นของวิทยานิพนธ์ฉบับนี้เพื่อสร้างรูปแบบแนวคิดสำหรับการติดตามผลการดำเนินงานภายใต้ระบบการประกันสุขภาพถ้วนหน้าโดยยึดและวิเคราะห์ข้อมูลจากแบบสอบถาม สัมภาษณ์ สังเกตผู้มีส่วนได้ส่วนเสียจากโครงการนี้โดยตรง ตรวจสอบตัวเลขฐานข้อมูลระบบสาธารณสุข และศึกษากรอบทฤษฎีรูปแบบโดยอ้างอิงแนวคิดด้านการพัฒนาและสังคมศาสตร์มากกว่าการมุ่งเน้นการวิเคราะห์ในเชิงปริมาณทางเศรษฐศาสตร์

ผลจากการศึกษาข้อมูลระบบประกันสุขภาพถ้วนหน้าแสดงให้เห็นว่าตัวชี้วัดถึงประสิทธิผลของโปรแกรมเพื่อคนจนนั้นควรจะใช้ตัววัดที่มากไปกว่าการใช้เพียงแค่ตัววัดเชิงปริมาณทางเศรษฐศาสตร์ ถึงแม้ว่าผลจากการศึกษาจะบ่งชัดว่าผู้มีส่วนได้เสียในโปรแกรมนี้ได้ให้ความสำคัญต่อเรื่องภาระค่าใช้จ่าย แต่พวกเขาก็ยังตระหนักถึงการทำงานที่หนักเกินกำลังของเจ้าหน้าที่ในโครงการ รวมทั้งการบริการที่ไม่ได้รับทุนสนับสนุนเพียงพอ ตลอดจนปัญหาเกี่ยวกับคุณภาพของการดูแลผู้ป่วย ในขณะที่การประเมินทางเศรษฐศาสตร์ของโครงการที่มุ่งเน้นถึงความสำเร็จของการถ่ายโอนภาระทางการเงินออกจากผู้ยากไร้ แต่ความจริงที่ว่าภาระอันหนักหน่วงกลับตกไปสู่โรงพยาบาลรัฐและเจ้าหน้าที่สาธารณะสุขของรัฐนั้นกลับไม่ค่อยได้รับการกล่าวถึง นอกจากนี้ยังไม่มีตัวชี้วัดทางเศรษฐศาสตร์ที่เหมาะสมสำหรับการประเมินคุณค่าของการได้รับการบริการและการดูแลที่ดีเมื่อผู้ป่วยมาเข้ารับการรักษา ผลจากการวิจัยพบว่าควรมีตัวช่วยคำนวณการชี้วัดที่มากขึ้นในรูปแบบแนวคิดสำหรับการติดตามผล เพื่อนำไปสู่การประเมินผลที่ได้มาตรฐานและมีคุณภาพเพื่อจะได้ช่วยบ่งชี้และแก้ไขปัญหาของโครงการได้อย่างเหมาะสมต่อไป

สาขาวิชา การพัฒนาระหว่างประเทศ ลายมือชื่อนิสิต

ปีการศึกษา 2552 ลายมือชื่อที่ปรึกษาวิทยานิพนธ์หลัก

5181010024: MAJOR: INTERNATIONAL DEVELOPMENT STUDIES
KEYWORDS: UNIVERSAL COVERAGE SCHEME IN THAILAND/ PRO-POOR/ PROGRAM MONITORING/ HEALTH EQUITY

BEN HARKINS: RE-EVALUATING PRO-POOR: A MODEL FOR MONITORING OF THE UNIVERSAL COVERAGE SCHEME IN THAILAND. THESIS ADVISOR: ASSOC. PROF. JIRUTH SRIRATANABAN, MD., PH.D., 173 pp.

The Nation of Thailand, which had a GDP per capita of approximately $6,600 (PPP) at the time and was still struggling to recover from the crippling effects of the Asian Financial Crisis, was able to implement a universal coverage program for its citizens with a fairly comprehensive benefits package in 2001.

However, the current system for universal health coverage in Thailand is a patchwork of 3 separate and unequal public health insurance schemes. Given the inequity in the Thai health system that preceded the Universal Coverage Scheme, monitoring of the program for pro-poor qualities is a critical aspect of ensuring that the Scheme meets its goal of providing universal access to high-quality healthcare for all.

The primary objective of this research was to construct a conceptual model for pro-poor monitoring of the Universal Coverage Scheme based upon survey of frontline stakeholders, key informant interview, participant observation, review of health system data, and a theoretical framework based on development and sociological concepts rather than the more heavily emphasized quantitative health economic analytics.

The results of the research appear to show that pro-poor monitoring indicators should be expanded beyond quantitative economic measures. Although the research did indicate that UC Scheme stakeholders are concerned about economic impacts and characteristics, it also revealed their strong concerns with heavy staff workloads, underfunding of services, and quality of care provided. While the health economic evaluations of the Scheme have accentuated the successful shift of the financial burden of care from the poor, they have been less revealing about the fact that much of that burden has fallen on public health facilities and their staff. In addition, there are no econometric indicators appropriate for determining the value of receiving high quality care when medically necessary. The results appear to indicate that additional metrics should be included in the monitoring model to help address these issues.

Field of Study: International Development Studies
Academic year: 2009

Student's signature: ____________

Advisor's signature: ____________

ACKNOWLEDGEMENTS

This thesis was made possible due to the contributions and support of many wonderful people. While it is impossible to thank all of them by name in this acknowledgment, I would like to point out a few people who took a special interest in helping me to complete my studies and research.

First, I would like to thank the MAIDS Program staff, faculty, and students for providing me with the opportunity and support to come to Thailand and study International Development. I have learned a great deal from my time with all of you.

I would also like to thank my thesis advisor, Dr. Jiruth Sriratanaban, for his always helpful advice, insightful criticism and absolute patience throughout the process of conducting this research.

I must also thank my research co-conspirator, Khun Lookkaew Nartrapee, whose dedication to the research and sincere interest in helping the poor people of Thailand made the field research possible.

I would also like to say thank you to the staff at the Saraburi Provincial Health Office and particularly Khun Prasong, Dr. Waraphon, and Dr. Pijitra who were incredibly generous with their time in supporting this research.

It is also important that I thank the staff at the Rockefeller Foundation Asia Office, and particularly Khun Pen Suwannarat and Khun Treenuch Wongsuebkhao, for helping me to conduct the research on the health system in Thailand that led to my initial interest in the UC Scheme.

Finally, I have to thank the friends and family who gave nothing but unwavering support to me when I told them I was pursuing my dream of studying and working in international development overseas. I would like to especially thank Bill and Susan Harkins, Perrin Harkins, Mina Harkins, Fred and Marian Gluck, Ann Gluck, Doris Bonstein, Joan and Steve Handel, Sue Mandell, Kanchanee Chuenwong, Ruby Wilde, Denise Kenski, Chad Sabo, Harry Britt, Frank Mitchell and Emily Diamonon, without whom none of this would have been possible.

CONTENTS

Page

ABSTRACT (THAI)....................iv

ABSTRACT (ENGLISH)....................v

ACKNOWLEDGEMENTS....................vi

CONTENTS....................ix

LIST OF TABLES....................ix

LIST OF FIGURES....................xii

ABBREVIATIONS....................xiii

CHAPTER I INTRODUCTION....................1

1.1 Statement of Problem....................3

1.2 Research Objectives....................4

1.3 Research Questions....................5

1.4 Hypothesis....................6

1.5 Research Methods....................7

1.6 Research Model....................11

1.7 Scope of Research....................11

1.8 Significance of Research....................12

CHAPTER II LITERATURE REVIEW....................14

2.1 National Monitoring and Evaluation Systems....................15

2.2 Consumer Satisfaction....................15

2.3 Access and Utilization....................16

2.4 Quality of Care....................21

2.5 Health Financing and Expenditures....................23

2.6 Equity in Health Service Outcomes....................27

2.7 Health System....................28

2.8 Civil Society Organizations and Independent Researchers....................30

CHAPTER III QUALITATIVE RESULTS....................32

3.1 Saraburi Provincial Profile....................32

3.2 Hospital Profiles....................36

CHAPTER IV QUANTITATIVE RESULTS....................54

4.1 Demographics....................54

4.2 Individual Health....................58

4.3 Challenges and Accomplishments....................60

4.4 Quality....................61

4.5 Equity 63
4.6 Targeted and Appropriate 64
4.7 Barriers to Care 70
4.8 Participation, Empowerment, Accountability, and Community Development 76
4.9 Economics 80
4.10 Right to Healthcare 82
4.11 Medical Staff 84
4.12 Importance Scale 87
CHAPTER V ANALYSIS AND SYNTHESIS 89
5.1 Analysis of Qualitative Research 89
5.2 Analysis of Quantitative Research 93
5.3 Synthesis of Indicators 129
CHAPTER VI CONCLUSION AND RECOMMENDATION 138
APPENDICES 149
BIOGRAPHY 173

LIST OF TABLES

Tables **Page**

3.1: Top 5 causes of death in Saraburi Province and nationally: 35
3.2: Coverage by insurance scheme in Saraburi Province and nationally 35
4.1: Research subjects by hospital 54
4.2: Beneficiary demographics 55
4.3: Beneficiary age and monthly household income 56
4.4: Professional demographics 57
4.5: Length of enrollment in the UC Scheme 58
4.6: Generally treated by the same doctor or nurse under the UC Scheme 58
4.7: Rating of overall health 58
4.8: Health has improved as a result of using the UC Scheme 59
4.9: The UC Scheme provides effective services for your medical problems 59
4.10: Biggest challenge for providing UC Scheme services to the poor 60
4.11: Biggest accomplishment of the UC Scheme for the poor 60
4.12: Rating of quality of medicines provided under the UC Scheme 61
4.13: Rating of quality of medical facilities under the UC Scheme 61
4.14: Rating of quality of medical professionals under the UC Scheme 62
4.15: Rating of overall quality of services under the UC Scheme 62
4.16: The services provided under the UC Scheme are the same quality as those provided under the CSMBS 63
4.17: Would switch to the UC Scheme (Professionals)/CSMBS (Beneficiaries) if possible 63
4.18: The poorer users of the UC Scheme receive the same medical care as those with more money 64
4.19: The UC Scheme does as good a job of providing the services needed by women as by men (Professional responses) 64
4.20: The UC Scheme does as good a job of providing the services needed by women as by men (Gender disaggregated beneficiary responses) 65
4.21: The UC Scheme does as good a job of providing the services needed by the elderly as by adults (Professional responses) 65
4.22: The UC Scheme does as good a job of providing the services needed by the elderly as by adults (Age delimited beneficiary responses) 65
4.23: The UC scheme does as good a job of providing the services needed by the disabled as by the non-disabled (Professional responses) 66

4.24: The UC scheme does as good a job of providing the services needed by the disabled as by the non-disabled (Disability status divided beneficiary responses) 66
4.25: The UC Scheme does as good a job of providing the services needed by the poor as by the rich (Professional responses) 66
4.26: The UC Scheme does as good a job of providing the services needed by the poor as by the rich (Income delimited beneficiary responses) 67
4.27: The UC Scheme does as good a job of providing the services needed by rural inhabitants as by urban inhabitants (Professional responses) 67
4.28: The UC Scheme does as good a job of providing the services needed by rural inhabitants as by urban inhabitants (Residence divided beneficiary responses) 68
4.29: The UC Scheme addresses the major health concerns in the community 68
4.30: The waiting time under the UC Scheme is an obstacle to seeking care 70
4.31: Able to access healthcare at the location most convenient under the UC Scheme (Residence divided beneficiary responses) 70
4.32: The amount of time to access services under the UC Scheme including transportation, waiting time, and treatment (Residence divided beneficiary responses) 71
4.33: Willing to pay more out of pocket if it means not waiting as long for services (Income delimited beneficiary responses) 71
4.34: Biggest obstacle for using UC Scheme services 72
4.35: The UC Scheme still excludes or is not welcoming to some groups in the community 72
4.36: The UC Scheme is easy to use for patients with less education 72
4.37: The information given to you about the UC Scheme is easy to understand (Education divided beneficiary responses) 73
4.38: The referral process to see a specialist should be changed 73
4.39: Aware of how to change registration for the UC Scheme if relocating 74
4.40: Changing your registration to a new facility for the UC Scheme was an easy process 74
4.41: Frequency that ability to pay for services is still an obstacle for patients to receive medical care 74
4.42: The doctors in the UC Scheme explain your condition and treatment options clearly and involve you in decision making 76
4.43: The resource allocations of the UC Scheme effectively address the health needs of the poor 76
4.44: Beneficiaries should have more voice in how the services of the UC Scheme are provided in their community 77
4.45: The UC Scheme has helped the poor people of the community to have more control over their own lives 77

4.46: The UC Scheme is too bureaucratic and should be more accountable to the needs of patients and medical professionals 78

4.47: The UC Scheme has given you more control over your own health 78

4.48: The UC Scheme has improved the healthcare options available to the poor 79

4.49: The UC Scheme does a good job of protecting the poor from out of pocket payments for healthcare 80

4.50: The UC Scheme has lowered the amount that you pay out of pocket for healthcare 80

4.51: The UC Scheme does a good job of protecting the poor from high expenses created by a serious illness.. 80

4.52: The UC Scheme has made you safer from high expenses created by a serious illness 80

4.53: The economy of the community has improved as a result of the UC Scheme ... 81

4.54: The UC Scheme has benefitted the poor in the community more than the rich . 81

4.55: Patients are generally aware that they are guaranteed the right to healthcare in Thailand 82

4.56: You are aware that you are guaranteed the right to healthcare in Thailand 82

4.57: Had an experience where your rights were not respected when accessing services under the UC Scheme 83

4.58: Treated with dignity and respect when using the services of the UC Scheme ... 83

4.59: Poorer patients are treated with an equal amount of dignity and respect as those with more money when using the UC Scheme 83

4.60: Have medical concerns with the services provided under the UC Scheme (Occupation divided responses)... 84

4.61: The staff at your facility is overworked as a result of providing services for the UC Scheme 85

4.62: Have made a formal complaint about the heavy workload under UC................ 85

4.63: The medical staff has adequate time to treat their patients even with the heavy workload under UC... 85

4.64: Have considered switching to work fulltime in a private hospital or clinic (Occupation divided responses)... 86

4.65: Importance of the issue for the UC Scheme (Professional responses) 87

4.66: Importance of the issue for the UC Scheme (Beneficiary responses) 88

LIST OF FIGURES

Figure **Page**

1.1 Map of field research sites 8

1.2 Research model 11

3.1 Saraburi City 32

3.2 Map of Saraburi Province in Thailand 33

3.3 Ms. Raweewan Sirisomboon, Head of Provincial Health Insurance 34

3.4 Mrs. Pongsuda Wongraveekul, Head Nurse for Primary Care at Saraburi Hospital 37

3.5 Saraburi Hospital lobby 39

3.6 Dr. Somchart Sutjaritrungsee, Hospital Director at Don Phut Hospital 40

3.7 Don Phut Hospital emergency room 43

3.8 Dr. Prasitchai Marrajit, Hospital Director at Kaeng Khoi Hospital 44

3.9 Pharmacy at Kaeng Khoi Hospital 46

3.10 Nong Khae Hospital nursing station 48

3.11 Doctor at Sao Hai Hospital 51

3.12 Patient at Wihan Daeng Hospital 53

5.1 Model of Analysis 89

ABBREVIATIONS

ABAC: Assumption University

ADL: Activity of daily living

ARV: Antiretroviral medication

CF: Case fatality

CI: Concentration index

CKD: Chronic kidney disease

CSDH: Commission on Social Determinants of Health

CSMBS: Civil Servant Medical Benefit Scheme

CSO: Civil society organization

GDP: Gross domestic product

HRH: Human resources for health

IHPP: International Health Policy Program

KI: Kakwani index

MIS: Management information system

MOPH: Ministry of Public Health

MWS: Medical Welfare Scheme

NHSO: National Health Security Office

OECD: Organization for Economic Co-operation and Development

PCU: Primary care unit

PPP: Purchasing power parity

RRT: Renal replacement therapy

RTG: Royal Thai Government

SMR: Standardized mortality ratios

SSS: Social Security Scheme

TNSO: National Statistical Office of Thailand

UC: Universal coverage

UNDP: United Nations Development Programme

UNIFEM: United Nations Development Fund for Women

WHO: World Health Organization

CHAPTER I

INTRODUCTION

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

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

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

Research that was published during the period showed that the poor were more likely to have to pay for their own medical services than the rich, that the costs that the poor paid out of pocket for healthcare were a higher proportion of their total income, that the utilization of healthcare services by the poor was being significantly adversely affected by lack of health insurance coverage, and that 28% of the poorest

households, who easily met the eligibility requirements for the Medical Welfare Scheme (MWS), were in fact not enrolled in the program. (Tangcharoensathien & Jongudomsuk, 2004: 4-5)

The MWS was the insurance program intended to cover those defined as underprivileged by the Ministry of Public Health (MOPH). It was formulated to serve the poor, the elderly, children under 12, and the disabled. However, during the final round of enrollment for the MWS between 1998-2000, the effective coverage rate for eligible citizens was only 17% and 65% of those who were enrolled in the program did not meet the eligibility criteria. (Pannarunothai, 2001: 62-67)

This thesis is based upon research conducted on the Universal Coverage Scheme (UC Scheme) in Thailand, which was the policy designed by the RTG to address these problems. While the United States continues to be the only developed nation not to ensure health coverage to its citizens while at the same time spending over 40% more per capita on healthcare than any country with a universal coverage system, the economic threshold for achieving universal coverage has dropped to include lower-middle income countries such as Thailand. (Battista & McCabe, 1999, June 14; Hughes & Leethongdee, 2007: 999). According to the last census data in 2007, the United States was still unable to provide health insurance to over 45 million Americans representing over 15% of the population. (U.S. Census Bureau, 2008: 19) Meanwhile, the Nation of Thailand, which had a GDP per capita of approximately $6,600 (PPP) (CIA, 2002) at the time and was still struggling to recover from the crippling effects of the Asian Financial Crisis, was able to implement a universal coverage program for its citizens with a fairly comprehensive benefits package in 2001.

However, the current system for universal health coverage in Thailand remains a patchwork of 3 separate and unequal public health insurance schemes, the Social Security Scheme (SSS), the Civil Servant Medical Benefit Scheme (CSMBS) and the UC Scheme. Despite the fact that the UC Scheme has been framed as variously an entitlement program for all or a welfare program to serve the needs of the

poor depending upon the economic and political climate at the time, (V. NaRanong & NaRanong, 2006: 3-4) in practical terms it is the public healthcare program used by the poorest Thai citizens.

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

1.1 Statement of Problem

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

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

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

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

2. There are influences on capability deprivation-and thus on real poverty-*other* than lowness of income (Income is not the only instrument in generating capabilities).
3. The instrumental relation between low-income and low capability is *variable* between different communities and even between different families and different individuals (The impact of income on capabilities is contingent and conditional)" (1999: 87-88)

Applying this broader definition of poverty, public health policies designed to provide pro-poor healthcare need to do more than simply equip the poor for work. Instead, they should empower the poor to be fully participatory members of society with hope for a long life expectancy and freedom from the fear of preventable and treatable diseases. With this in mind, this thesis will examine whether pro-poor monitoring of the UC Scheme should be expanded beyond quantitative economic measurements to address poverty and the needs of the poor with a broader, more flexible, and fully inclusive approach. Through bringing a theoretically dissimilar critical perspective from the more commonly utilized health economics approach and adding to the level of participant deliberation used to determine the monitoring criteria for the UC Scheme, this research will help to identify new evaluatory criteria and address the largely vertical orientation of the management of the UC scheme.

1.2 Research Objectives

1. To formulate a conceptual model for monitoring of the UC scheme for pro-poor characteristics
2. Determine whether there are important pro-poor aspects of the UC scheme that have been neglected in the current monitoring and evaluation literature
3. Determine what the frontline stakeholder priorities are for pro-poor monitoring of the Scheme
4. Increase the level of frontline stakeholder feedback used to determine monitoring indicators

1.3 Research Questions

1. What are the critical indicators for monitoring the UC scheme as a pro-poor program outside of quantitative economic measurements?

    A. Which segments of the poor are being helped most by the UC Scheme? Which are being neglected?
    B. Does the UC Scheme target and prioritize the poor based on investment in prevention and treatment of health conditions that disproportionally affect them and that they have indicated are primary health concerns?
    C. Provide services that are designed for the specific population groups that are heavily represented among the poor including women, senior citizens, the less educated, single parents, disabled, rural inhabitants, migrant and agricultural workers?
    D. Provide services that address non-financial barriers to care such as social, linguistic or educational?
    E. Involve the poor in management, service provision, and priority setting for the UC Scheme?
    F. Have effective mechanisms in place to ensure program accountability to the poor and to public health workers?
    G. Empower the poor to a greater level of self-determination and capability in their lives?
    H. Ensure that the right to healthcare that is guaranteed to the poor under the UC Policy is being respected by service providers?

2. What are the critical monitoring indicators from the perspective of the UC Scheme professional staff and beneficiaries?

    A. Do economic indicators such as measurements of out of pocket payments, catastrophic health expenditures, poverty headcounts, equity of health financing, and reduction of economic inequality reflect the

concerns of the poor and the professional staff about the services provided by the UC Scheme?

1.4 Hypothesis

The overall hypothesis for the research is that there are additional pro-poor characteristics of the UC Scheme that should be monitored beyond quantitative economic measures. The theoretical framework of the metrics to be tested, based upon the literature review on the UC Scheme, include specific targeting of diverse segments of the poor and their health concerns, addressing barriers to care, providing opportunities and encouraging empowerment, participation in management, priority setting, and quality assurance, facilitating community development, a higher level of transparency and accountability, increased equity of services with other health insurance schemes and ensuring that the right to healthcare is respected by institutions.

It is anticipated that the professional staff will express significant concerns about resource limitations and the workloads necessary to provide the UC Scheme's services and that these input restrictions have a negative impact on providing services to the poor. The studies by Jongudomsuk (2008), Tangcharoensathien and Jongudomsuk (2004), Sakunphanit (2008), and the Bureau of Policy and Strategy (Bureau of Policy and Strategy) (2008a) all provide data showing that these remain major obstacles for the UC Scheme's service providers. As a result, the research is anticipated to demonstrate the need for increased participation for service providers in management of the UC Scheme services and responsiveness to their needs for providing care to the poor. However, it also anticipated that the professional staff will likely express a high level of pride and satisfaction with the services they provide to the poor under the UC Scheme.

For the beneficiaries of the UC Scheme, it is anticipated that the research will reveal continuing problems with the quality, usability, responsiveness, and equity of services provided. The quantitative and qualitative research studies conducted by Suraratdecha et al (2005), NaRanong and NaRanong (2006), Nitayarumphong (2005)

and Limwattananon et al (2007) point to these issues as major concerns for those utilizing the services of the UC Scheme. However, it is also anticipated that the beneficiaries of the UC Scheme with express great appreciation of the reduced financial barriers and guarantee of health care provided.

The review of health system data and relevant literature will likely point towards the importance of macro-level concerns of monitoring the UC Schemes services in relation to those provided by the other public health insurance schemes as well as internal divisions (Such as urban vs. rural) to ensure equity of services. The study by Camfield indicates that there remain significant levels of inequality between the three insurance schemes. (2009)

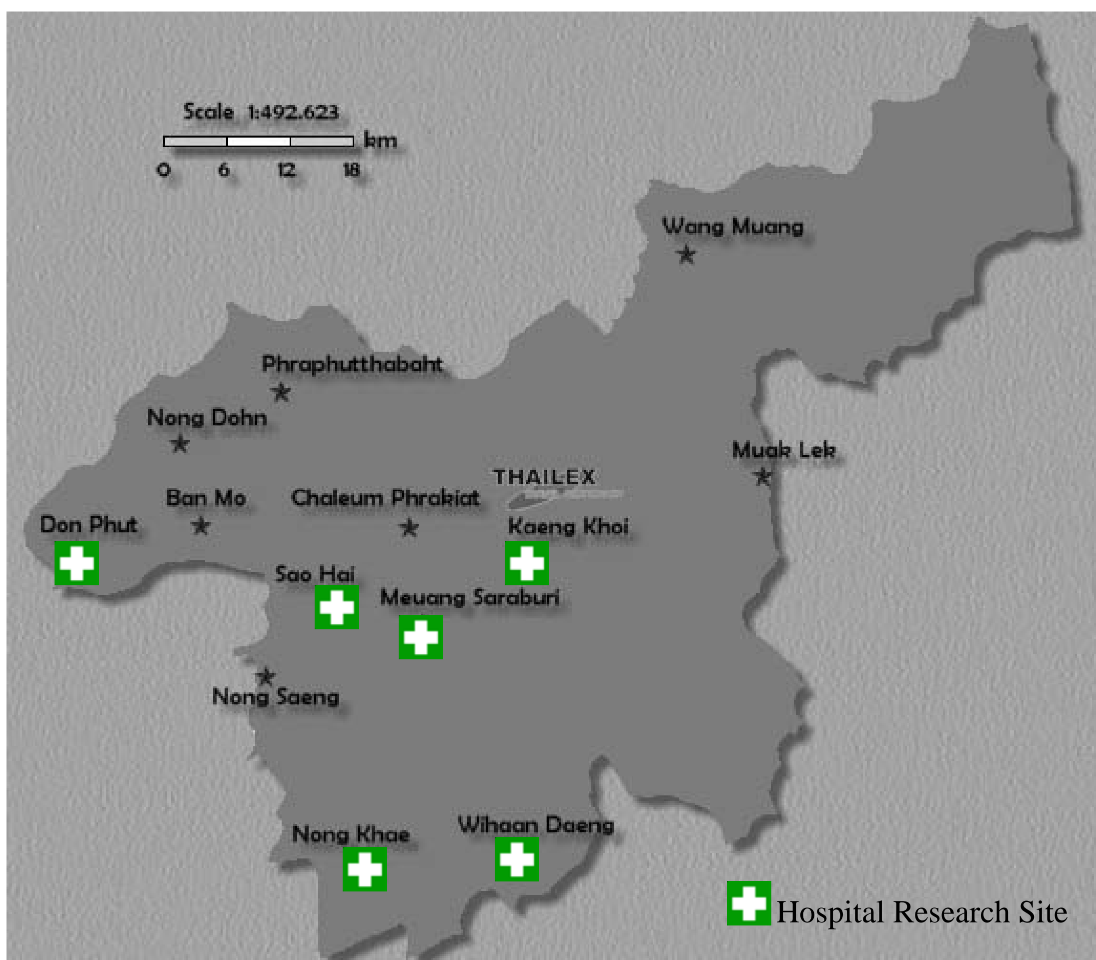
1.5 Research Methods

Two main research methods were used to gather the data for this thesis:

1. Primary research through survey, key informant interview and participant observation
2. Secondary research through review of literature published about the UC Scheme, theory relevant to pro-poor monitoring, and health system data

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

Figure 1.1: Map of field research sites



Notes: (THAILEX, 2009)

Survey subjects in each hospital were medical professionals who directly provide the services of the UC Scheme and UC Scheme beneficiaries who meet the sample qualification criteria for poverty and/or vulnerability. A total of 56 beneficiaries and 26 professionals were surveyed. An effort was made to survey roughly even numbers of research subjects at each hospital location. The sample population was not intended to be accurately representative of the entire beneficiary or staff populations for the UC Scheme and therefore only very limited conclusions should be extrapolated from the study demographics to the overall demographics of UC Scheme staff and beneficiaries or even UC Scheme staff and beneficiaries in Saraburi Province.

The sampling technique was a criteria-based random selection approach, meaning that subjects were chosen at random and then qualified or disqualified based on meeting the criteria for poverty and/or vulnerability of the study. The choice of this style of sampling was made based on a need to create and test a different understanding of the concept of pro-poor healthcare rather than to generate a convincingly representative sample of opinions. The goal of using this technique was to broaden the scope and range of available data to illustrate the many different lived realities for UC beneficiaries and medical professionals and to generate a deeper understanding of their individual situations that can used to inform decisions in the broader programmatic context. Rather than representativeness, the two functions of the demographic section of the survey were to ensure qualification of the research subject as meeting the studies criteria for poverty and vulnerability and to identify meaningful subgroup comparisons between variables through cross tabulation of data.

The sample qualification criteria for UC Scheme beneficiaries were that they meet at least 2 of the following characteristics of poverty/vulnerability: Less than a secondary education, below the age of 16 or above the age of 60, native language other than Thai, household income below 10,000 baht per month, unemployed, migrated for work, working in the agricultural sector, single parent or no parent household, 4 children or more, legally disabled, living in a rural area or female. The criterion for UC professional staff inclusion was that they spend at least 20% of their work hours on UC Scheme related duties.

Surveys of beneficiaries were administered by a Thai speaking research assistant under the supervision of the researcher. The majority of the surveys of professional staff were also conducted in Thai with a small minority conducted in English where language abilities allowed.

The survey addressed the research questions of the thesis, arranged thematically by broad theoretical areas. The survey questions were a combination of Likert type scales, multiple response sets, follow up and open-ended questions, and an importance scale table. The questions were intended to quantify stakeholder concerns

but remain open-ended enough to allow for research subjects to voice their personal convictions about the UC Scheme. Questions that addressed economic measurements were used as a control variable to test the key variable of the research which is that there are alternative non-economic indicators that are essential for pro-poor monitoring.

Qualitative research through key informant interviews of management level staff at each research site was conducted in order to gain a higher level perspective on the accomplishments and problems related to the UC Scheme at each facility. General observation and photography of hospital operations was also utilized to provide additional qualitative data.

The data was analyzed for frequency, emphasis (Critical cases), intensity (Information-rich cases) and subgroup comparison to reveal the pattern of stakeholder concerns for monitoring of the scheme. This allowed for a broad range of professional and beneficiary opinions to be incorporated in the conceptual model for monitoring and provided a solid empirical grounding for the synthesis of indicators.

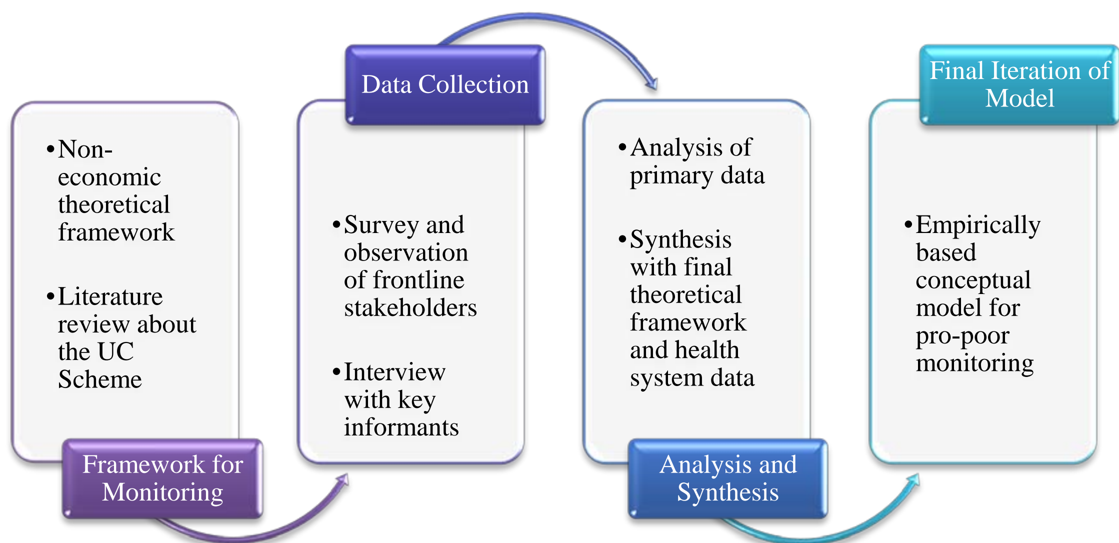
The secondary research was used to provide additional quantitative and qualitative data to mitigate the small scale of the data gathered during primary research. This allowed synthesis between grassroots stakeholder opinion about critical pro-poor monitoring concerns with a broad variety of experts on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

The review of literature published about the UC Scheme aided in identifying potential monitoring concerns prior to conducting the primary research. The review of theory relevant to pro-poor monitoring was used to bookend the research, providing the initial framework of the model as well as justifying the final iteration. The review of health system data was used to situate the study results in the larger health system setting.

Publications by the MOPH, the National Statistical Office of Thailand (TNSO), and *Thailand Public Health 2008-2009* were used as the sources of health system data. All of the literature utilized was gathered at the Chulalongkorn University library facilities and through the internet.

1.6 Research Model

Figure 1.2: Research model



1.7 Scope of Research

It is important to note that the model for pro-poor monitoring generated is not intended to determine attribution of program impacts for the UC Scheme but rather what indicators should be used for monitoring the Scheme as a pro-poor program. Several elements in the research results, analysis, and monitoring model for this thesis are related to conditions that preceded the UC Scheme's implementation. Therefore, the research should not be interpreted as an attempt at impact evaluation for the UC Scheme.

The emphasis of the research was on non-economic analysis of the UC Scheme, instead utilizing concepts about pro-poor monitoring from a development theory/sociology perspective. However, it does not cover all of the theoretical frameworks within those disciplines that could be utilized for pro-poor monitoring.

The knowledge gained from the literature review combined with a certain amount of personal judgment was used determine which frameworks appeared to be the most applicable and original for forming the basis of the model.

The field research was based at hospital locations that offered a broad range in demographic variety of beneficiaries and professional staff for interview and observation. However, while the research demonstrated the concerns of multiple critical stakeholder groups within the UC Scheme, there are obvious limitations in the amount that the results can be generalized due to the small scale and timeframe of the study. The primary research is intended to be a small cross-section of grassroots opinion from frontline stakeholders rather than a truly representative accounting.

The model itself does not cover all aspects of the UC scheme which is far too broad a program in aspect to address fully within the scope of this research. Instead, the model addresses a range of different characteristics of the Scheme not as an attempt at a fully comprehensive model for monitoring but rather as an argument for a diversity of measurements. Furthermore, the model is more conceptual than practical as the functional details of how to apply monitoring metrics are best left to those working within the UC Scheme.

Finally, only a limited amount of health system data relevant to the UC Scheme was found during the research. Data from the MOPH, the TNSO and *Thailand Public Health 2008-2009* were gathered and reviewed, however searches for publications and direct requests for data from the National Health Security Office (NHSO) were unsuccessful.

1.8 Significance of Research

The choice of indicators for monitoring of program performance plays a critical role in shaping the services, management and planning of institutions. The hope is that this research will contribute towards improving the pro-poor quality of the UC Scheme by offering a different perspective on what the critical indicators for monitoring should include. Optimistically, the conceptual model for monitoring of the

UC Scheme that has been generated could lead to more effective and responsive service provision to the poor under the UC Scheme.

Realistically, the impacts of this research are dependent upon whether the conclusions reached are original and compelling enough to influence the NHSO, the MOPH, or the RTG in policy making, financing, and providing the services of the UC Scheme. While it seems an unlikely outcome due to the size of the bureaucracy involved, the number and diversity of stakeholders, and the high levels of research capability within the institutions themselves, it is hoped that the work of this thesis will at least provide some arguments worth considering.

Finally, at the very least, this thesis will contribute a different perspective to the body of monitoring and evaluation research that has thus far been conducted on the UC Scheme and will help in determining the importance of broadening the monitoring criteria for the UC Scheme.

CHAPTER II

LITERATURE REVIEW

This literature review will examine and evaluate the monitoring and evaluation research on the UC Scheme over its 8 year history. My preliminary assumption is that while there has been a great deal of literature published on the UC Scheme's impacts on the poor, much of the work appears to place a heavy emphasis on the economic characteristics and effects of the program. The goal of this review will be to determine if there is a gap in the literature on monitoring and evaluation of the UC Scheme for pro-poor qualities.

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

This essay will also utilize the concept of "Monitoring", best defined by the International Fund for Agricultural Development as "The regular collection and analysis of information to assist timely decision-making, ensure accountability, and provide the basis for evaluation and learning. It is a continuing function that uses methodical collection of data to provide management and main stakeholders of an ongoing project or program with early indications of progress and achievement of objectives." (Guijt & Woodhill, 2002: A7) It should be noted that while the primary interest of this review is the monitoring of the UC Scheme for pro-poor qualities, much of program monitoring and MIS systems are internal mechanisms for decision support with at best goal-oriented descriptive accounts rather than actual research studies to disseminate their data and conclusions. Therefore, this review will cover published research on both monitoring and evaluation of the UC Scheme.

2.1 National Monitoring and Evaluation Systems

The Bureau of Policy and Strategy states that the monitoring and evaluation system for the MOPH has been established based upon the RTG's public sector management policy. The policy requires the use of a results-based management system whereby goals, targets, and strategies are to be set up in response to the needs of the people. This resulted in the formation of a results-based budgeting system in Fiscal Year 2003 which disciplines the Ministry to revise its programs based upon key performance indicators for health development. To ensure that monitoring and evaluation is carried out systematically, the agencies responsible for conducting these activities were merged into the Bureau of Inspection and Evaluation within the MOPH's Office of the Inspector General. (2005: 309)

A study of health information systems in Thailand for monitoring of health equity by Tangcharoensathien describes the National Health Accounts, begun in 1994, as a vital resource for data tracking of healthcare activities. He also cites the importance of two national household surveys conducted by the TNSO, the Socio-Economic Survey and the Health and Welfare Survey, for facilitating the monitoring and evaluation of equity in financing of healthcare. A partnership to improve the policy relevance and effectiveness for equity monitoring of the two data sources has been established between the TNSO and the MOPH. Other data for monitoring and evaluation activities are provided by disease surveillance and registry systems, administrative data and routine reports on health service activities, and surveys conducted by health research institutes and MOPH departments. (2007: 222-245)

2.2 Consumer Satisfaction

While the bureaucratic structure of monitoring and evaluation is an important aspect of the subject, one of the critical measures of the Scheme from a more participatory perspective is the level of consumer satisfaction with the UC Scheme. The findings of a field survey conducted by Chamchan and Mizuno in a rural area of Khonkaen Province in the Northeast of Thailand during March of 2005 are particularly relevant for this review as the average income per capita for those

surveyed was approximately 26,000 baht annually, reflecting a high density of low-income households in the village. Of those surveyed, 87% stated that they felt the quality of care had improved with the UC Scheme, 97.5% stated that the cost of healthcare had decreased with the UC Scheme, 83.1% prefer the services of the UC Scheme to their previous coverage, 41.5% agreed that the concepts behind the Scheme are good, and on a scale of 1 to 10 the mean score of respondents for overall satisfaction was 8.46. In addition, the survey found that every area of satisfaction queried (Including co-payment, waiting time, doctor, equipment, nurses and other staff, and transportation costs) was rated at least in the mid-range category of tolerable with the highest score for co-payment and the lowest for transportation costs. The researchers conclude that the UC Scheme has generally had a positive effect on consumer satisfaction with public healthcare services. (2006: 253-266)

While surveys have revealed that the UC Scheme does enjoy broad support from both rich and poor households (Pannarunothai, et al., 2002: 84-88), there is a fair amount of variety in findings by studies researching consumer satisfaction with the UC Scheme. A survey conducted by the MOPH in 2002 found that 83.8% were satisfied overall with the Scheme. (Bureau of Policy and Strategy, 2005: 348) Results published by the Bureau of Policy and Strategy from independent polls conducted by Assumption University (ABAC) found that the overall satisfaction level of consumers with the UC Scheme was 92.9% in 2003, 92.9% in 2004, and 95.7% in 2005. (2008a: 38) Meanwhile, a survey conducted by the NHSO and ABAC on the satisfaction level of UC Scheme members in 13 provinces in 2003 found that on a scale of 1 to 10 (10 being most satisfied) 66.8% rated their overall satisfaction level between 8-10, 29.9% between 5-7, and 3.3% rated it less than 5. This averages out to an 8.01 rating, equivalent to an 80% finding. (Tangcharoensathien & Jongudomsuk, 2004: 73)

2.3 Access and Utilization

There are a lot of competing ideas and agendas related to the increased access and utilization rates that have occurred as a result of the Scheme. While some view the increased use of health facilities as reflecting the desired improvements in equity

of the Scheme, others feel that the reduction or elimination of user fees has created a "Moral hazard" whereby citizens may not only may be over-utilizing services but even perhaps not taking proper care of themselves due to the safety net provided by the Scheme.

In a study of the ways in which the UC Scheme benefits the poor, Jongudomsuk notes that between 2002 and 2007, the utilization rates for outpatient care increased by 4.2% annually, while the rates for inpatient service utilization increased by 2.2% annually. It was found that the utilization of services at district hospitals increased substantially after the initial implementation of the UC Scheme in 2001 but then had a slight decline in 2004. The utilization rates at district health centers had not changed significantly as a result of the Scheme. The study concludes that based upon utilization rates, the poor benefited more than the rich from improved access to healthcare under the UC Scheme. (2008: 4) In a research paper by NaRanong on monitoring and evaluation of the first phase of the Scheme, hospital data showed that during the first six months of full implementation, the number of outpatient visits had increased substantially from the previous year while the number of inpatient admittals was relatively unchanged. (2002: 2) In the next monitoring and evaluation study conducted by NaRanong et al 3 years later, it was found that overall, utilization rates for outpatient services in the UC Scheme were actually lower than the utilization rates in the SSS and the CSMBS. For inpatient utilization, UC members had an admission rate higher than those in the SSS but still much lower than the rates for CSMBS members. Members of the UC Scheme did have the highest level of referral rates but the author concludes that this is probably due to the regulation that they first access care at their registered provider. (2005: 1-2)

A study by Suraratdecha et al provides some interesting qualitative data on health seeking behavior of UC members in the rural provinces of Tak, Sakol Nakorn, and Narathiwat soon after implementation in early 2002. The research found that UC Scheme consumers were still more likely to report that they sometimes do not seek treatment or self-treat their illness even though they would pay only 30 baht or nothing at their registered health facility. Self-medicating through drug purchase was

reported as the most popular form of self-treatment choice, with costs often being significantly higher than 30 baht. The authors of the study speculate that this may because of difficulties in accessing care or perceptions that the quality of care is poor or inadequate. The study found that choices about health seeking behavior were also affected by socioeconomic factors outside of insurance coverage such as level of education and income. Some low income respondents reported that they did not want to sacrifice their daily income to seek treatment at the health facility. Educational background altered health seeking behavior for some respondents in that less educated respondents reported not being aware of the importance of professional care for certain illnesses. It was also reported that long waiting times and an unpleasant environment were obstacles to seeking care under the UC Scheme as well as confusion about what services were covered under the benefits package due to non-standardized practices at some providers. Confidence in the quality of care provided by the Scheme was also found to be a major determinant in utilization patterns. (2005: 274-283) Nitayarumphong provides supporting evidence for these statements by showing that during the implementation phase of the Scheme, the utilization rate was quite low at .58 visits per capita annually for outpatient care and .03 admissions per capita annually for inpatient care. He concludes that this demonstrates that many Scheme beneficiaries were still utilizing services outside of their registered health facilities which he believes is either because the beneficiaries didn't understand their benefits under the program or were hesitant due to concerns about the quality of care provided by the Scheme. (2005: 204-205)

As mentioned already, many public health facilities are concerned about over-utilization of services under the UC Scheme. In their article about the UC Scheme's impacts on the poor, NaRanong and NaRanong state that a large number of providers claim that they have been flooded with patients as a result of the Scheme's introduction. Some observed that health seeking behavior had been altered so that many were accessing services sooner and often for less serious health issues that they could have treated on their own. Some even extend the logic farther as mentioned, and believe that many citizens are taking less care of themselves or taking greater risks

because of the insurance provided by the UC Scheme. The results of NaRanong and NaRanong's qualitative research refutes many of these opinions. While some of those interviewed stated that certain hospitals do seem more crowded, most stated that they did not feel their own health seeking behavior had changed. Those in urban areas indicated that for minor illnesses they still buy their own medicines at drugstores to save time while in rural areas with no access to drugstores, many would attain medicines from health centers. Only when they felt that the illness was serious based upon a self-assessment did they report going to a hospital or clinic to see a doctor. In cases of emergency, most stated that they would go to a hospital immediately however. Of these cases, the poorer respondents reported that they would go to their designated hospital under the Scheme whereas more affluent respondents stated that they would go to a larger provincial hospital or private hospital, particularly if they were concerned that staffing might be short at the public hospital at that time. (2006: 5-6) According to Pannarunothai et al, compliance rates with requirements for utilization of services have been much lower with the UC Scheme than with the other two public insurance schemes for both inpatient and outpatient services. Their findings agree with the qualitative research above that compliance was higher among low-income households than with higher income households under the scheme. (2002: 50-53)

NaRanong and NaRanong's research also found that nearly all respondents stated that they stayed away from hospitals as much as possible and were greatly surprised by the idea that anyone would seek unnecessary care just because they were covered by the UC Scheme. The only change noted by some was that they would more often use a public hospital rather than a private one if they were unconcerned about waiting time. Some UC Scheme members living in a poorer area of Bangkok said that due to bad experiences they had with a participating private hospital, they preferred to buy medicine at the local drugstore unless they thought their illness was serious. It was reported by these respondents that the doctors at the hospital did not take their symptoms seriously and simply gave them paracetamol tablets and sent them home. There were other stories as well of significant illnesses going untreated or

not being taken seriously by doctors at private hospitals under the UC Scheme, with one case even resulting in death. The study concludes that in fact health seeking behavior among the poor has not changed very much as a result of the UC Scheme. The research showed that their behaviors have probably changed less than those of more affluent groups due to the limited alternatives for treatment that existed both before and after implementation. The poor are most likely still assigned to the same facilities they utilized under previous insurance schemes and transportation costs to other facilities are a significant barrier, particularly in rural areas. This means that their confidence in the quality of services they will receive at district health centers or hospitals is often somewhat beside the point as they have little other choice for essential care. (2006: 3-9)

Another qualitative research study by Camfield supports many of NaRanong and NaRanong's findings. Most respondents interviewed expressed that health was not an inherently interesting topic in their lives, suggesting that an indicator of good health for some may be that the subject goes largely unnoticed. The implication is that the ideal health seeking strategy for many of the poor is one that is fast and efficient even if more costly. As a lack of free time has been found to often accompany a lack of financial resources, the study suggests that it is likely that poor people will continue utilizing private pharmacies and health facilities regardless of a subsidized alternative. The study concludes that while it is clear that the UC Scheme has significantly increased insurance coverage, it has not been proven that the patterns of utilization, household expenditure, and consumer satisfaction have changed demonstrably. The study notes for example that there were wide discrepancies between the availability and quality of health services provided at the study sites as well as a lack of confidence in primary care for UC Scheme beneficiaries. This leads the researcher to the conclusion that the change to emphasize primary care under the UC Scheme may have been premature due to lack of capacities. (2009: 260-261) However, findings in the 2006 Thai Health Report edited by Kanchanachitra challenge the above conclusions about utilization rates and health seeking behavior under the UC scheme. The study examined the number of inpatient and outpatient

visits by benefit scheme and year, revealing that both outpatient and inpatient utilization rates have increased significantly at all types of service providers with the exception of provincial hospitals under the UC Scheme. The report reaches the conclusion that "New policies to encourage the use of local-level facilities and to improve the referrals system clearly reduced the number of visits to provincial hospitals," and that "Universal health insurance has increased Thai people's access to health services. The poor benefit more than the rich because the poor do not pay the capital costs of their care, and because the government provides more funding to primary facilities and district hospitals." (2006: 22-23)

2.4 Quality of Care

Whereas consumer satisfaction with the UC Scheme is perhaps the best measure of quality from the demand side, it is also valuable to evaluate the UC Scheme from the perspective of another key stakeholder group, health professionals. Tangcharoensathien and Jongudomsuk provide a study of opinions on quality of services provided to different Scheme members during 2003-2004. The findings revealed that the majority of providers rated the quality of services as "good" or "very good" across all Schemes. In terms of relative quality, the services provided to UC beneficiaries were ranked the lowest, the quality of services provided to SSS members were ranked second, and the services provided to CSMBS members were considered to be the highest quality. (2004: 56-58)

Creating and maintaining a standard for quality of care provided by the UC Scheme is a long term issue documented by the Bureau of Policy and Strategy. They state that while it would be unethical for a physician to deny services based upon concerns about ability to pay, the capitation model does not necessarily cover the entire cost of services provided. If medical expenses become large and the patient is unable to pay, there is incentive created for the doctor to limit services provided based upon cost rather than medical opinion. The document concludes that it is important for the sustainability of the UC Scheme that both the financial viability of hospitals and the quality of service be protected. (2008a: 39) Hughes and Leethongdee agree

that underfunding, as well as a lack of political will during the last years of the Thai Rak Thai administration, prevented the UC Scheme from fully achieving its original more radically egalitarian objective of a single standard of care. Budget cuts led to generalized problems with service quality as well as double standards in services provided both inter and intra-institutionally at hospitals. These problems have had a detrimental effect on public confidence in the UC Scheme's services. The study states that although the issues of unequal access certainly preceded the UC Scheme, expectations created by the ambitious plans for the UC Scheme have proven difficult to match.(2007: 1006) The study by Camfield also criticizes the inequity in service quality between the UC Scheme and other public health insurance programs. She states that "Thailand is a country almost as well known for its inequality as for its remarkable economic growth, and these inequalities affect both exposure to risk and access to health facilities. Currently the UC Scheme is in danger of entrenching these inequalities rather than reducing them, partly due to people's perceptions of the quality of its services. However, the international attention it has received suggests its future is relatively secure, and with a substantial increase in per capita funding (at least equivalent to that given to the CSMBS, which is likely to contain people with fewer health problems), it could begin to make a difference not only to people's physical and material health, but also to their wellbeing." (2009: 261)

In response to the growing criticism, there have been recent efforts to improve the quality of services at public hospitals under the UC Scheme. A recent research study conducted by the International Health Policy Program (IHPP) states that the NHSO, who holds purchasing responsibilities for the UC Scheme, has been promoting participation in the hospital quality improvement program as a condition of providing services covered by the UC Scheme. As a result, hospital accreditation is now perceived as a mandatory process by hospitals where as before there was very limited effort made to meet the required criteria. As of 2004, only 86 hospitals in Thailand had met the accreditation requirements set by the Institute of Hospital Quality Improvement and Accreditation (Representing 6.6% of total hospitals). (2009: 23) A study by Pongpirul et al found that the major criteria cited by hospitals in

Thailand as obstacles in meeting the requirements are “adequacy of staff” and “Information utilization and integration”. (2006: 346)

2.5 Health Financing and Expenditures

Thanks to the long term efforts at building capacity in health economic research in Thailand, there is a very large amount of research available on the issues of household health expenditure, catastrophic health spending, and equity of healthcare financing. While this review defines the concept of pro-poor in broader than economic terms, the importance of economic analysis for determining pro-poor quality is self-evident.

Limwattanonon et al developed a research study in collaboration with the Equity in Asia-Pacific Health Systems Project to analyze 5 different data sets of household survey data from before the UC Scheme (2000-2001) as well as after (2002-2004) to analyze patterns and trends of benefit incidence under the UC Scheme. It was found that the benefit incidence analysis (Which measured the amount of public subsidy against income level of service utilizers for the UC Scheme) demonstrated that the funding of the UC Scheme is progressive, favoring the poor. The pro-poor subsidy was largest at the district health system level which includes sub-district health centers and district hospitals. The subsidy was also found to be larger for outpatient care versus inpatient care. Utilizing the Kakwani Index (KI), the research was able to determine that public subsidy at all levels of health care has helped to reduce inequality between households. (2005: 4-16) The study by Kanchanachitra supports the statement that subsidies at district hospitals favor the poor. By calculating the percentage of expenditures on different income quintiles at 3 types of health service providers, the study shows that district hospitals have the highest percentage of expenditure on poor patients, with about 60% of expenditure on the bottom two income quintiles for both inpatient and outpatient services. The provincial hospitals (et al) have a balanced expenditure between all 5 income quintiles on both inpatient and outpatient services. The private sector service providers have the highest percentage of expenditure on wealthy patients, with about 60% of their

total expenditure going to the top two income quintiles. (2006: 23) It was shown in a separately published research paper that the source of financing for the Scheme was also pro-poor, demonstrated by calculating that the Concentration Index (CI) of general tax revenue in 2002 was .6996, which indicates that the rich were contributing a larger proportion than the poor (Jongudomsuk, 2008: 5)

Out of pocket payments are a critical issue for creating equitable health systems and are a major problem in Asia where healthcare is largely paid for by individuals. In developing countries that lack risk-pooling mechanisms to finance healthcare, low-income households are at an especially high risk of being driven into poverty by out of pocket costs. Limwattanonon et al conducted a study comparing the rate of catastrophic health payments (More than 10% of total household expenditure) before and after establishment of universal coverage. The overall rate of catastrophic health expenditures was found to have decreased from 5.4% before the UC Scheme to 2.8% afterwards. However, catastrophic health expenditures were still found to be regressive against poor households even after implementation of the UC Scheme demonstrated by the CI calculation results. The researchers attribute the reduction in the overall rate of catastrophic expenditure to the comprehensive benefit package of the UC Scheme which includes many high-cost services. (2005: 4-16) Kanchanachitra and the researchers at the Institute for Population and Social research have also published interested findings about health expenditure after implementation of the UC Scheme. The study addresses the percentage of “high expenditure” on health care by income groupings of households (High expenditure is used synonymously with the term catastrophic expenditure). The report shows that there have been dramatic improvements in lowering high household expenditures for all income quintiles, and that the poor now have the lowest percentage of high expenditure of all income groups at approximately 2%. (2006: 23) A study by Somkotra and Lagrada to examine the effect of the UC Scheme on catastrophic health payments and medical impoverishment during the transitional period of program implementation reaches similar conclusions to Limwattanonon et al and Kanchanachitra. By analyzing household survey data pre and post UC Scheme, it was found that the proportion of

out of pocket payments for health as a percent of total household expenditures declined after the UC Scheme. It was also learned that the incidence and intensity of catastrophic payments had been reduced during the transition and that the lower income quintiles now have lower incidence rates than higher income quintiles. By quantifying the extent to which out of pocket payments push households into poverty, the study determined that the Scheme has been effective at preventing impoverishment since both the poverty headcount and poverty gap declined after implementation. The study concludes that there is evidence to demonstrate that the UC Scheme has been a valuable intervention strategy for increasing social protection from financial catastrophe and impoverishment caused by out of pocket payments for healthcare. (2008: 2027-2034) However, Pannarunothai et al point out that the UC Scheme was found to be inferior to the SSS in protecting low-income households from the burdens of health expenditure. They suggest that to make the UC Scheme more effective, additional improvements in supply-side quality and benefits coverage are critical to encourage Scheme compliance.(2002: 89-99)

Limwattanonon et al conducted a follow-up study in 2007 to estimate the incidence and describe the profile of catastrophic health payments and medical impoverishment in Thailand before and after implementation of the UC Scheme. Again utilizing secondary analysis of socio-economic data gathered from household surveys, incidence of catastrophic payments caused by inpatient care was found to have dropped from 31% before the UC Scheme to approximately 15% afterwards. Incidence of catastrophic payments from outpatient services declined from 12% before the UC Scheme to approximately 8% afterwards. Breaking down the data into sectors of health service providers, the highest incidence of catastrophic payments for outpatient services was at private hospitals and declined from 36% before the UC Scheme to 28% after. The rates of catastrophic payments for inpatient services were again highest at private hospitals and at similar levels. The study also measured the increase in poverty headcounts caused by out of pocket payments for health services. It was found that the rate fell from 4.4% of households before the UC Scheme to 1.8% of households after implementation. The median amount of money paid out of pocket

by households in the impoverished group increased from 583 baht before the UC Scheme to 667–833 baht afterwards. Dividing the data into provider sectors for impoverishment caused by inpatient care after the start of the UC Scheme, out of pocket payments by households to private hospitals had a median amount of 3167–3333 baht, provincial hospitals 250–1500 baht, and district hospitals 114-125 baht. The report shows that the use of inpatient services at private hospitals, using services not covered by the UC benefit package, or bypassing designated UC providers to access services puts patients at higher risk for catastrophic expenditure and medical impoverishment from out of pocket payments. “Although UC has reduced catastrophic expenditure and impoverishment, some households still face these events. Supply-side intervention is required to improve quality of care and gain the confidence of users. This in turn will minimize use of the outside contractor network by the poor, and help to ensure proper and prompt referral to tertiary care hospitals when clinically indicated.” (2007: 600-604)

Limwattanonon et al conclude that there have been 3 particularly significant policy interventions made in the health system by successive governments to supplement the pro-poor orientation of the system. The first is the extension of health coverage to the informal sector which includes a large proportion of the poor in Thailand, the second is the creation and expansion of a comprehensive health delivery system that covers all areas of the country including often underserved rural areas where the majority of the poor population reside, and the third was the institution of a 3 year mandatory service period in rural areas for medical, nursing, pharmacy, and dental school graduates which has helped to address the unequal distribution of human resources for health (HRH) between rural and urban areas which had disfavored the poor. (2005: 4-16) Kanchanachitra et al provide supporting evidence for the conclusion that the extension of coverage to the informal sector under the UC scheme disproportionately benefits the poor. By examining the income demographic distribution among the 3 public health insurance Schemes, it was found that the poor make up the majority of beneficiaries registered under the UC Scheme whereas the

SSS and the CSMBS both have over 50% of their memberships comprised by the wealthiest quintile of the Thai population. (2006: 23)

While the research does provide some useful statistics on the effect of the UC Scheme on health expenditure related risk factors for poverty, what is still somewhat lacking is insightful critical analysis based on the data. If accessible, convenient, comprehensive and high quality health services are available at no cost, it seems unlikely that consumers would willingly risk poverty by going outside of the network. So then, what are the critical factors that cause consumers to go outside the network and risk impoverishment? The assumption appears to be that quality of care is the problem but none of the studies were designed to effectively address this question.

2.6 Equity in Health Service Outcomes

In a study published in 2008, the Bureau of Policy and Strategy examined the case fatality (CF) and standardized mortality ratios (SMR) of inpatients to analyze the equity in health outcomes between the 3 public health insurance schemes. The concept of CF is that it measures the ratio of deaths within a designated population of people with a particular condition, over a certain period of time. In this case, it is being used to cover all types of illness. Analysis of data to generate age-adjusted CF rates under each of the 3 insurance Schemes showed that UC Scheme inpatients had the highest CF rate at 2.09%, followed by CSMBS in-patients at 1.77%, and SSS in-patients at 1.39%. An analysis of SMR between the 3 Schemes revealed similar results. The concept of SMR is based on comparing the figure for expected deaths in the larger population from which the study sample has been taken to that of the study sample. A ratio of 1.0 means the number of observed deaths equals that of expected deaths. If the ratio is higher than 1.0, then a higher number of deaths than expected has occurred. It was found that the SMR for UC inpatients was 1.04, whereas the ratio for the CSMBS and the SSS were lower at .96 and .64 respectively. The study concludes that the findings probably reflect the different illness characteristics of inpatients, their health seeking behaviors and variances in quality of health facilities. (Bureau of Policy and Strategy, 2008b: 344)

2.7 Health System

The major health system reforms that accompanied the implementation of the UC Scheme have had a dramatic impact on the services, infrastructure, human resources, and finances of the health system. According to Tangcharoensathien and Jongudomsuk, there have been significant improvements to services and infrastructure at the primary care level. The establishment of primary care units (PCUs) at the district level has meant an upgrade for many health centers, which are now able to provide better quality services closer to home for many beneficiaries. The improvements have included additional qualified staff, a larger stock of drugs, better medical equipment, and longer service hours. (2004: 56)

Tangcharoensathien and Jongudomsuk show that the schemes effect on public health personnel has been less favorable however. The improvements described above as well as the registration policies of the UC Scheme led to a shift in service use patterns from outpatient care in larger hospitals to greater use of care services in health centers and district hospitals. This led to a shortage of HRH to provide care particularly in district hospitals and in the Northeast region. While the increase in demand for services particularly by those who were previously uninsured can be seen as a positive effect of the UC Scheme, it has also meant a significant increase in the workloads of public health staff. A survey found that more than 70% of the public health workforce stated that their workload had increased after the UC Scheme was implemented. Partly as a result, in 2002 there was a 100% increase in the number of doctors resigning from their positions at MOPH facilities. An expansion of private sector facilities offering an alternative of both higher wages and a lighter workload certainly exacerbated the situations. This caused many PCUs to be staffed inappropriately, sometimes with overqualified specialists filling in from larger hospitals and sometimes with nurses who were not trained to perform the services required. (2004: 56-58)

There were also significant negative financial impacts of the UC Scheme on many providers due to the low capitation rate and budget allocation problems.

Tangcharoensathien and Jongudomsuk document that the UC Scheme was criticized by many for being an underfunded program, especially for inpatient services. The sudden change in the allocation model from a largely historically based supply-side estimate to a uniform capitation based determination caused many budgeting problems. The radical shift of resources from larger hospitals caused 60% of provincial hospitals to have financial problems in 2002. However, when the salaries were removed from the capitation rate in 2003, there was a sharp increase in the number of small district hospitals reporting budgetary concerns in the Northeast (from 3% to 27%). (2004: 53-55)

The UC Scheme financing problems also began to spill over on to the other insurance Schemes as hospitals tried to make up for lost revenue by charging higher fees under the largely unregulated fee-for-service reimbursement system of the CSMBS. The expenditure rate for the program increased by an average of 10% annually between 1999 and 2003, even with a decrease of 1.6% annually in the number of CSMBS beneficiaries. To a lesser degree, the SSS and the immigrant labor insurance program were also exploited to make up for revenue shortfalls. (2004: 55) The budgetary woes during the early stages of the scheme were not felt as acutely at the global level however. Despite the increase in coverage and utilization rates, it was found by NaRanong that the UC Scheme had not had a disastrous effect on the MOPH budget during the first year of full operation. In 2002, the UC Scheme increased the ministry's regular operating budget by approximately 10 billion baht or 16%, while at the same time providing insurance coverage to an additional 25 million citizens. (2002: 2) Perhaps this is a result of having delegated the financial hardships of the UC scheme to hospitals as shown in the above research study.

Four years into the UC Scheme's development, the Bureau of Policy and Strategy stated in a policy document that the UC Scheme was in need of policy amendment if it was to achieve its goals and satisfy the needs of both Scheme beneficiaries and service providers. One of the main concerns discussed was the sustainability of the program and particularly the capability of healthcare facilities to continue to provide services under the UC Scheme. (2008a: 38-39)

2.8 Civil Society Organizations and Independent Researchers

Some of the most important humanitarian reforms of the UC Scheme have been the result of monitoring and evaluation research and advocacy efforts from independent researchers and civil society organizations (CSOs) in Thailand. It was found based upon research work conducted by Prakongsai that the decision to exclude renal replacement therapies (RRTs) from the UC Scheme benefits coverage had devastating impacts on Chronic Kidney Disease (CKD) patients. Financial barriers to accessing hemodialysis treatements and to obtaining costly RRT medications were shown to be a major contributing factor to premature death from the disease. The catastrophic expenses of the disease led to various coping strategies for poor patients which had severe financial impacts not only for themselves but also for other family members who attempted to help with the costs. One low-income CKD patient said: “I am so sorry to inconvenience my children so much. I am so sorry that my children’s finances are all gone. I am so troubled, especially when I think of my daughter in Bangkok and my family here. All of my children are helping and giving all that they can but there is no one in the family who can help a lot.” (2008: 249, 260) Supported by the work of this researcher, as well as others at IHPP, the decision was made to include RRTs as a pilot program under the UC Scheme in 2006-2007, which was expanded to nationwide coverage in 2008 by utilizing financing from the National Health Security Fund. (Jongudomsuk, 2008: 2)

According to Ford et al, Antiretroviral medications (ARVs) were initially excluded from the UC benefits package because of the high cost of treatments. However, health activists and CSOs pointed out that the new constitution prohibited discrimination based upon having been diagnosed with a specific disease. A breakthrough came in 2001 when a Thai pharmaceutical company was able to manufacture a generic ARV combination that reduced the price of treatment from $9600 to $570 per year. CSOs immediately petitioned the government for a policy change which lead to the MOPH decision that ARVs would be added to the UC Scheme benefits package. However, it was not until 2006, after an additional 4 years

of lobbying, that ARVs finally became available under the UC Scheme. (2009: 260-261)

Conclusion

Given the high quantity and quality of research already conducted on the UC Scheme, is there a need for additional research to be conducted on pro-poor monitoring of the Scheme? There appears to still be a gap in the literature to be filled based on a bias in the published materials overly favoring the use of economic metrics for the evaluation of the UC Scheme. Without question, economic analysis is a vital component of assessing the UC Scheme and its impacts on the poor. However, when evaluating a health program that includes both insurance coverage and service provision, there are other aspects to be investigated beyond economic characteristics and impacts. To do so narrows the concept of poverty and who is poor to financial criterion, a formulation that is somewhat outmoded in contemporary development theory. Modern definitions of poverty generally include such concepts as limited access and capability, increased vulnerability, disempowerment and lack of participation, and analysis of cross-cutting issues of gender, ethnicity, social class and place in addition to an income based characterization. This review introduced a broader definition of pro-poor to show that the intention was to go beyond economic analysis and look at pro-poor monitoring as incorporating other theoretical frameworks from the social sciences that relate to poverty.

In order to address this gap in the literature about the UC Scheme, the theoretical framework of this research will include specific targeting of diverse segments of the poor and their health concerns, addressing barriers to care, providing opportunities and encouraging empowerment, participation in management, priority setting, and quality assurance, facilitating community development, a higher level of transparency and accountability, equity of services provided between health insurance schemes and ensuring that the right to healthcare is respected by institutions.

CHAPTER III

QUALITATIVE RESULTS

3.1 Saraburi Provincial Profile

Figure 3.1: Saraburi City

Saraburi Province (สระบุรี) is located in the central region of Thailand, approximately 108 kilometers north of Bangkok. The Province occupies 3,576 square kilometers on the eastern side of the Chao Phraya River valley. It is believed that the City of Saraburi was established in 1549 during the reign of King Maha Chakkraphat in the Kingdom of Ayutthaya. Historically, the Province was often used as a site for rallying of the population for war and still has a large military presence. (Saraburi Province, 2009; Tourism Authority of Thailand, 2009)

The Province of Saraburi is divided into 13 districts (Transliterated: Amphoe) (Tourism Authority of Thailand, 2009), which are further delimited into 111 communities (Transliterated: Tambon) and 965 villages (Transliterated: Muban).

(Saraburi Province, 2009; Tourism Authority of Thailand, 2009)

Figure 3.2: Map of Saraburi Province in Thailand

The economy of Saraburi is closely linked to the urban center of Bangkok. The primary industries include manufacturing of marble, cement, and other products, wholesale and retail trade, mining and quarrying and agricultural production in the form of dairy and rice farms. (The National Statistical Office, 2006)

It is believed that the origin of the name of the province comes from its location near the swamp of Bueng Nong Ngong. The name Saraburi is a combination of the word “Sa” which means swamp and the word “Buri” which means town. (Saraburi Province, 2009)

Provincial Health Office

Date: July 9, 2009

Key informants interviewed:

Ms. Raweewan Sirisomboon, RN, Head of Provincial Health Insurance

Mr. Prasong, Sub-Head of Provincial Health Insurance

Figure 3.3: Ms. Raweewan Sirisomboon, Head of Provincial Health Insurance

General Information

- The total population of Saraburi Province is 664,705, the majority of whom reside in urban areas.
- Average annual income per person: 160,697 Baht (2005)
- Over 60 population: 64,244 (About 10% of the population)
- Disabled population: 6,035

Health Information

- Most common outpatient illness: Upper respiratory infection
- Non-communicable diseases are becoming a more significant portion of the burden of disease in Saraburi Province.

Table 3.1: Top 5 causes of death in Saraburi Province and nationally:

	Saraburi[1]	**Thailand**[2]
1	Cancer: 481	Septicaemia: 22,706
2	Pneumonia: 239	Cancer: 13,273
3	Heart disease: 218	Stroke: 12,921
4	Stroke: 195	Pneumonia: 12,286
5	Traffic accident: 122	Heart disease: 12,163

Notes: [1]Data for year 2008

[2]Data for year 2006 (Alpha Research, 2009: 123)

Health Facility Information

- Saraburi Province has 12 public hospitals, 1 military hospital and 3 private hospitals.
- Saraburi Hospital is the provincial hospital and is the training hospital for the province as well as the only tertiary care facility.
- Praputhabat Hospital is the general hospital for the Province and receives referrals for secondary care from smaller district hospitals in Saraburi.

Health Insurance Information

- Population registered for UC Scheme in Saraburi: 426,322

Table 3.2: Coverage by insurance scheme in Saraburi Province and nationally

	Saraburi	**Thailand**[2]
UC:	65.26%	76.6%
SSS:	20.85%	12.7%
CSMBS:	7.25%	9.5%
None:	1.55%	
UC[1]	4.50%	

Notes: [1]Registered in other province

[2](The National Statistical Office, 2008c: 78)

Health Financing Information

- Promotion and prevention:___________________27,935,837 Baht
- Salaries:_________________________________848,109,736 Baht
- Special projects (Targeting specific diseases):______969,200 Baht
- Current capitation rate for UC Scheme:_____________2,202 Baht
- Average base salary for an MD in Saraburi:_________50,000 Baht

Public Health Concerns

- Low MD salaries are making it difficult to keep public hospitals staffed appropriately
- Heavy workload for all staff at public hospitals due to funding limitations and high patient demand for services
- Estimate that 20% of workers in Saraburi are foreign migrant workers that have come for factory or agricultural work. Diarrhea and malaria are significant health concerns among this population. Of the foreign population, 4,000 are registered for the SSS although many more access services that largely go un-reimbursed by the government.

3.2 Hospital Profiles

Saraburi Hospital

Date: July 9, 2009
Key informants:
Dr. Chutidy Tabongkaraksa, Deputy Medical Director
Mrs. Pongsuda Wongraveekul, RN, Head Nurse for Primary Care

Figure 3.4: Mrs. Pongsuda Wongraveekul, Head Nurse for Primary Care at Saraburi Hospital

Hospital and Patient Population Information

- Large urban provincial hospital built in 1954
- Primary, secondary, and tertiary care hospital with 680 beds. Equal amounts of primary and tertiary care are provided at the hospital
- Patients are mostly urban inhabitants and more affluent than at district hospitals
- Provide outpatient care to approximately 652,000 and inpatient care to approximately 45,000 annually
- 84 doctors on staff

UC Scheme at Saraburi Hospital

- 114,023 UC Scheme registrants

- Estimate that approximately 50% of the patients treated at the hospital are covered by the UC Scheme
- UC has been a financial burden for the hospital as the revenue generated by the capitation funding rate falls far short of covering the cost of services provided. Conversely, both the SSS and CSMBS have been profitable insurance coverage schemes for the hospital.

Hospital Financials

- 800 million baht budget for this fiscal year
- Hospital income is anticipated to increase by approximately 15% increase over last year. Income has been slightly above expenditure for the last few years.
- The hospital has 160 million baht in debt from construction costs
- Labor costs are the line item most over budget in this fiscal year. They have a shortage of both staffing and beds at the hospital.
- Overall, the hospital is losing money on primary and secondary care but making money on tertiary care because they can be reimbursed for more expensive procedures such as cancer treatments by the government.

Observations:

As we enter Saraburi Hospital there are people waiting in every part of the entryway and lobby. The lobby itself is literally bursting with people and even the stairs outside the hospital are filled with people waiting whom we are informed are awaiting screenings for flu. Despite the overcrowding however, a very organized and efficient queuing system is set up which appears to keep patients calm and everyone waits their turn very patiently. It is particularly notable that there are many elderly patients who have been triaged into wheeled hospital beds or wheelchairs to await their turn in the lobby together with the rest of the crowd.

There are clearly not enough hospital rooms available during our visit as some patients receive treatment in wheeled hospital beds while waiting in the lobby itself. We are told that the reason it is so crowded in the morning and early afternoon at the

hospital is because that is the time when patients are able to see a doctor. The afternoon is indeed much quieter, which we are informed is only a time for picking up medicines.

After the first day of interviewing, it is clear that a great deal of tact is necessary in order to get honest answers rather than just polite talk about the UC Scheme from patients and staff. Some of the most direct answers we received for the day are from the Deputy Medical Director, who is quite forthcoming about the fact that the hospital is only breaking even financially because they can rely on tertiary care as an additional income stream.

Figure 3.5: Saraburi Hospital lobby

Don Phut Hospital

Date: July 10, 2009

Key Informant:

Dr. Somchart Sutjaritrungsee, Hospital Director

Figure 3.6: Dr. Somchart Sutjaritrungsee, Hospital Director at Don Phut Hospital

Hospital and Patient Population Information

- Small rural district hospital built in the early 1990's
- The hospital provides primary and secondary care and has a 15 bed inpatient ward. Services include an expanded program on immunization, antenatal clinic, asthma clinic, diabetes clinic and a traditional Thai massage clinic.
- The hospital served 15,785 outpatients and 566 inpatients last year
- Hospital staff include 2 doctors, 1 pharmacist, 2 dentists, 25 nurses, 4 nursing aides, and 35 others
- The district population is 7500 with 30% over the age of 60. Approximately 95% of the district population works in agriculture.
- There are 6 health centers in the district which provide services to 4 Tambons.

This is necessary because during the rainy season there is great deal of flooding which makes it difficult to get to the hospital. A boat is literally needed at certain times.

Health Situation in the District

- The 5 most commonly treated diseases at the hospital are diabetes, hypertension, upper respiratory infection, gastrointestinal disorders, and musculoskeletal problems (Mostly muscle strain related to agricultural work or arthritis).
- Infectious diseases that are common in the district include dengue hemorrhagic fever and infectious diarrhea

UC Scheme at Don Phut Hospital

- 7000 UC Scheme registrants
- Estimate that approximately 90% of the patients treated at the hospital are covered by the UC Scheme
- This year, the hospital will receive 8.2 million baht in revenue from UC which constitutes about 85% of the hospitals annual income. Additional revenues of 600,000 baht and 500,000 baht are generated by the SSS and the CSMBS.

Hospital Financials

- Total annual budget for the hospital is 10 million baht. Estimate of income is between 8-10 million baht.
- The budget for the hospital had been fairly balanced over the last several years however this year they expect to be 1.5 million baht in debt by October. A large part of the budget shortfall has been because of overtime costs and increases to the extra income provision for doctors, dentists, and pharmacists in an effort to retain staff.
- The hospital has created a number of expenditure saving practices including a rational drug use policy (Including the use of traditional Thai massage in place

of medication for certain conditions), increased education about controlling chronic disease, encouraging use of health centers, and even limiting utility use.

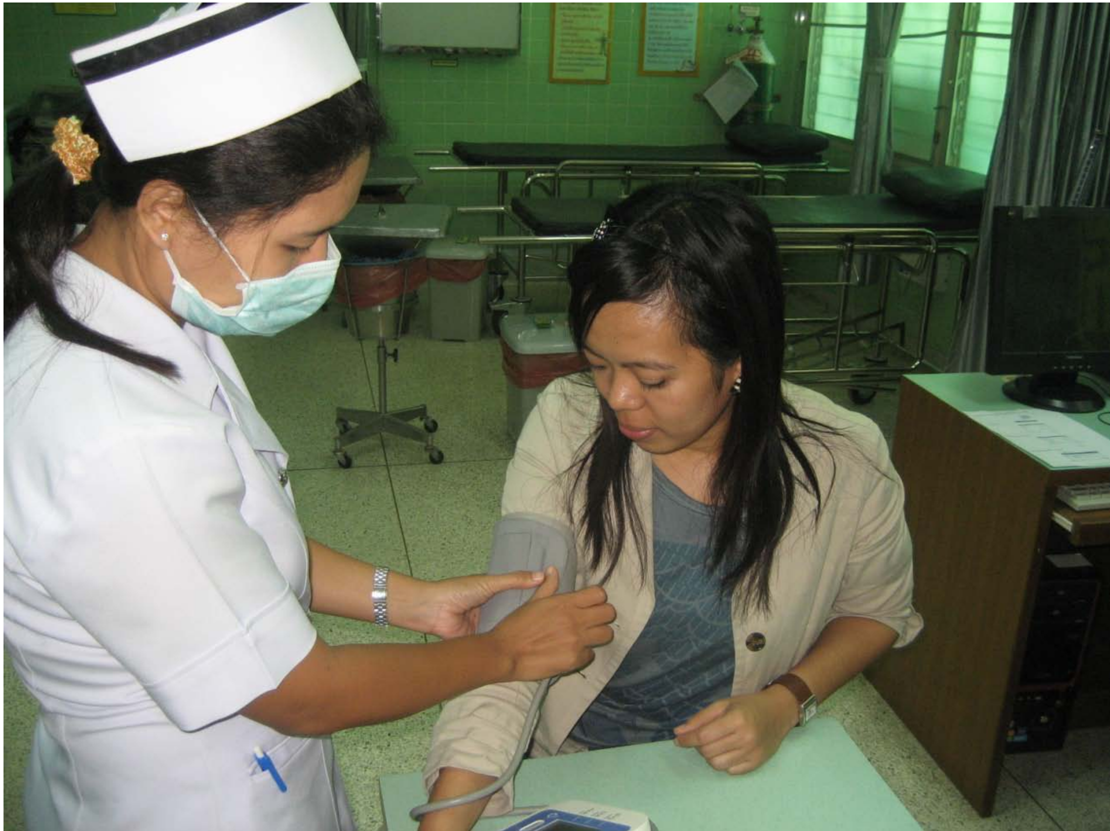
- The hospital has also developed some initiatives for increasing revenue such as a yearly checkup program for civil servants, Thai massage services, encouraging registration for UC, and promoting the use of private rooms.

Observations:

The hospital is fairly busy in the morning when it is possible to see a doctor at the hospital although nothing like the scene at Saraburi Hospital. The doctors often go out to do home visits in the afternoon at which time the hospital really empties out with only a few patients waiting to receive medications. It should be noted that one of the two doctors is also the hospital director and not very happy about it as he would prefer to simply practice medicine but literally was given no choice in the matter. There is an operational policy under the UC Scheme which states that a doctor must be available 24 hours per day at the hospital if needed which is a very difficult requirement for the hospital to meet with only 2 doctors on staff.

It is clear that the waiting time for services is a lot shorter at Don Phut due to the small population served and the utilization of Tambon health centers in the district. However, for the second day in a row during the research, we are told that a major problem with the UC Scheme is that patients use services when they are not really necessary and do not practice proper self-treatment at home before rushing off to the hospital for free care under UC. It was reported that recently many patients have begun coming to the hospital with a cough thinking that they have swine flu due to the heavy media coverage.

Figure 3.7: Don Phut Hospital emergency room



Kaeng Khoi Hospital

Date: July 13, 2009

Key Informants:

Dr. Prasitchai Marrajit, Hospital Director

Ms. Yuvarirat Sililuesai, RN, Head Nurse for Inpatient Care

Hospital and Patient Population Information

- Small/medium rural district hospital built in 1992
- The hospital provides primary and secondary care and has a 60 bed inpatient ward
- 16,000 total patients are treated annually
- Total population of 140,000 in the district who are mostly employed in agricultural and factory work. The district has a fairly mixed income level.

- 19 health centers have been established to provide services in the community
- Hospital staff includes 7 doctors, 5 dentists, 5 pharmacists, and 60 nurses

Figure 3.8: Dr. Prasitchai Marrajit, Hospital Director at Kaeng Khoi Hospital

Health Situation in the District

- The 5 most common health problems treated at the hospital are diabetes, traffic accidents, upper respiratory infection, TB, and work related injuries.
- Both key informants expressed concerns about UC beneficiaries not practicing proper prevention or self-care at home and overusing their benefits because there is no fee for using the hospital. The hospital director would like to have a co-payment re-established for the UC Scheme to help address the situation. He would also like to see more funding for health promotion and disease prevention education to help reduce the problem of over-use of services as well as the high rate of work related injuries and traffic accidents in the district. The head nurse stated that patients with chronic diseases such as

diabetes and hypertension don't make an effort to control their illnesses properly because they don't have to pay to go to the hospital for treatment when their conditions worsen. She also believes that HIV has been on the rise in recent years and estimates that they have about 2 positive HIV diagnoses per month. She feels the increase is particularly significant among young people due to unsafe sex practices and says that she has witnessed children as young as 12 years old diagnosed HIV positive.

- Counseling and ARV is provided to HIV positive patients at the hospital and is fully covered by the UC Scheme. The hospital has a strong privacy policy to protect the HIV status of patients as people diagnosed with HIV often face ostracism from their families and discrimination in employment.

UC Scheme at Kaeng Khoi Hospital

- 50,000 UC Scheme registrants
- Estimate that approximately 90% of patients treated at the hospital are covered by the UC Scheme
- Annual revenue from the UC Scheme is 30 million baht at the hospital

Hospital Financials

- 50-60 million baht annual budget
- The hospital has been breaking even financially for the last several years.

Challenges of Providing Care at the Hospital

- Both key informants stated that staffing shortages are an issue at the hospital. The Head Nurse stated that she currently has 14 staff in the inpatient ward and that a more appropriate staffing level would be 18. The average work week for a nurse in the in-patient ward is 48 hours long, including 8 hours of overtime. It is common for nurses who work at Kaeng Khoi to also work a night shift at a private hospital to earn additional money. The Head Nurse expressed concern that there will be a critical shortage of nurses for the coming

generation as many students are choosing not to study nursing due to the heavy workload and low salary.

- Even though treatment is free, there are still problems for poor people who are not able to get to the hospital or health centers due to transportation expenses.

Observations:

The hospital was very crowded in the morning when we arrived but tapered off in the early afternoon. It is obvious that a full-fledged flu panic has broken out this week and many are here to be screened for flu and are wearing masks. Despite the crowds and the fears about a flu epidemic everything seems very calm and efficiently managed in the waiting areas and as usual everyone is very patient.

Figure 3.9: Pharmacy at Kaeng Khoi Hospital

Nearly all of the beneficiaries at the hospital seemed please with the care provided there under UC. The medical staff was clearly very busy and we did hear

some complaints about short staffing and heavy workloads but clearly the morale was high and most were friendly and smiling. Staff turnover does not appear to be as big a concern at this hospital.

Nong Khae Hospital

Date: July 14, 2009
Key Informant:
Mr. Yodchai Charuves, Hospital Administrator, Pharmacist

Hospital and Patient Population Information

- Medium urban district hospital built in the 1960's
- The hospital provides primary and secondary care and has a 90 bed inpatient ward
- 4310 Inpatients and 82,494 outpatients are treated per year
- The occupation of patients at the hospital is a fairly even split between agricultural and factory workers with the majority being low-income.
- The hospital staff includes 4 doctors, 60 nurses, 5 pharmacists, and 4 dentists.

UC Scheme at Nong Khae Hospital

- 38,000 UC Scheme registrants
- Approximately 47% of patients treated at the hospital are covered by the UC Scheme
- Annual revenue from the UC Scheme is 22 million baht

Hospital Financials

- The hospital has made a profit for the last 3 years which is mostly attributable to services used by members of the CSMBS at the hospital

Challenges of Providing Care at the Hospital

- The informant expressed concerns about patients not taking proper care of themselves because they can use services for free under the UC Scheme.

Observations:

The outpatient ward was quite crowded in the morning as with all of the hospitals we have visited so far. They had set up a small triage area where 4 nurses screened patients for illness (Particularly flu) before they saw a doctor. The flu panic seems to be growing worse as virtually no one enters the hospital without a mask on. We are offered masks or hand sanitizer again and again during our visit although effective interviewing with a mask on proves to be nearly impossible.

Figure 3.10: Nong Khae Hospital nursing station

The small number of doctors at the hospital seems to be a real problem and none were available even for a short interview. It was clear that, for a medium size

urban hospital with 90 beds, 4 doctors is really not sufficient to meet the hospital's service needs. No information was available as to why there are so few doctors on staff at this hospital but it seemed that the strategy for addressing the situation was for nurses to play a larger role in providing primary care.

Sao Hai Hospital

Date: July 15, 2009
Key Informants:
Ms. Sakares Tanjareon, Head of Administration
Mr. Jakpong Chomrana, Head of Health Insurance
Ms. Pensri Tiemsuk, Nurse and Health Insurance Officer, RN

Hospital and Patient Population Information

- Small/medium rural district hospital built in 1993
- The hospital provides primary and secondary care and has a 30 bed inpatient ward
- 2100 inpatients and 100,000 outpatients are treated annually
- The occupation of patients at the hospital is a mix of agricultural and factory workers. Most patients are low-income.
- The hospital staff includes 3 doctors, 30 nurses, 2 pharmacists, and 2 dentists

UC Scheme at Sao Hai Hospital

- 17,000 UC Scheme registrants
- Approximately 60% of patients treated at the hospital are covered by the UC Scheme
- Annual revenue from the UC Scheme is only about 8 million baht at the hospital**.** Income from the SSS and the CSMBS has not been enough to cover the services provided by the hospital under the UC Scheme so the funding gap has been filled through private fundraising, particularly at local temples.

Hospital Financials

- 62 million baht annual budget
- The hospital has been running in deficit for several years and now has accumulated approximately 10 million baht in debt. We were informed that this is the largest deficit of any district hospital in Saraburi.

Challenges of Providing Care at the Hospital

- The hospital has a shortage of both doctors and nurses to provide care and have turned to private fundraising so that they can pay additional salary to retain staff and hire temporary staff as needed. They have also built a massage and spa on the campus of the hospital which helps to raise additional revenue.
- One informant expressed that he has concerns about patients not taking proper care of themselves because they can use the hospital's services for free.

Observations:

The hospital facilities at Sao Hai feature some notable luxuries that were not present at other hospitals visited and the capacity of the hospital also appears quite adequate. While it was busy in the morning as always, there appeared to be no overcrowding and the staff and facilities did not appear to be under significant strain despite the now widespread fear about H1N1 that has driven many patients to visit their district hospital. According to the staff most of the additional capacity and extra services provided at this hospital, which include a fully-equipped gym facility, spa and massage services, acupuncture, new physical therapy equipment, and an additional inpatient ward, were paid for through private fundraising in the community.

One other observation is that the doctors at Sao Hai all seem to be extremely young and just out of medical school. This phenomenon was also observed at other hospitals in Saraburi Province as well and is largely due to the 3 years of mandatory service required of new medical school graduates. During a lunchtime conversation

with 2 of the doctors in the medical staff, both expressed a desire to leave the hospital and find work at facilities in Bangkok.

Figure 3.11: Doctor at Sao Hai Hospital

Wihan Daeng Hospital

Key Informant:
Dr. Thaweesak Teangthai, Hospital Director
Date: July 17, 2009

Hospital and Patient Population Information

- Small rural district hospital built in 1973
- The hospital provides primary and secondary care and has a 30 bed inpatient ward (The hospital director described the inpatient occupancy rate as 110%, meaning that they often actually have more patients than beds)
- 200 outpatients treated per day

- The occupational mix of patients at the hospital is dominated by agricultural workers. The majority of patients are low-income.
- The hospital staff includes 3 doctors, 30 nurses, 1 pharmacist, and 3 dentists.

UC Scheme at Wihan Daeng Hospital

- 20,000 UC Scheme registrants
- Approximately 80% of the patients treated at the hospital are covered by the UC Scheme
- The hospital receives 18 million baht in income from the UC Scheme which is not enough to cover the cost of services provided to UC beneficiaries. Private fundraising, the SSS and the CSMBS are being used to balance the budget.

Hospital Financials

- 30 million baht annual budget
- The hospital has been breaking even financially for the last several years.

Challenges of Providing Care at the Hospital

- There is a staffing shortage for both doctors and nurses at the hospital. The shortage of doctors at the hospital has been particularly acute and has had a detrimental effect on the efficiency of the hospital. A big part of the problem has been loss of doctors to private hospitals due to the higher salaries and lighter workloads.
- The limited budget provided for UC services has had a significantly negative effect on the quality of drugs being dispensed to UC patients at the hospital.
- The informant stated that overuse of services by UC patients who are not taking proper care of themselves has been a problem but that overall the UC Scheme has really helped the poor people of the district.

Observations:

The hospital has an average size group waiting to see a doctor when we arrive

in the morning but no real overcrowding compared to some of the other hospitals. However, the hospital director must also serve as one of the primary clinicians at the hospital which seems to be typical at the smaller hospitals that we have visited.

Figure 3.12: Patient at Wihan Daeng Hospital

Wihan Daeng has a specialized HIV unit that hosts a well organized HIV+ peer support group that we get a chance to meet with. The group members prove to be some of the most ardent supporters of the UC Scheme that we have met during the entire research as many had no access to ARVs prior to their inclusion in the Scheme's benefit package. They tell us that the support group's budget is paid for mainly through private fundraising. Members of the group make and sell small scented gifts to the hospital for 20 baht which the hospital then sells for 25 baht using the proceeds to fund additional services for the HIV unit. I buy one and am given my own health insurance program, a blessing to ensure my good health.

CHAPTER IV

QUANTITATIVE RESULTS

The results in this chapter will be presented by the thematic areas of the research questions in the same order as the surveys were conducted. After introducing the demographic data about the research subjects, the next 10 sections are divided into: Individual health; accomplishments and challenges; quality; equity; targeted and appropriate; barriers to care; participation, accountability, empowerment, and community development; economics; right to healthcare; and medical staff. The chapter will conclude with the results from the importance scale survey. The results from the general qualitative research questions that were asked at the end of each survey are presented in the analysis chapter.

All research results are divided by professional and beneficiary responses as indicated for each question. Results for questions with an open-ended response format are given in the analysis section. Questions for which the research subjects were allowed to choose or state more than one answer are labeled "Multiple response".

4.1 Demographics

Table 4.1: Research subjects by hospital

	Subject type		Total
	Professional	Beneficiary	
Don Phut Hospital	3	12	15
Kaeng Khoi Hospital	3	7	10
Nong Khae Hospital	4	7	11
Sao Hai Hospital	6	8	14
Saraburi Hospital	6	15	21
Wihan Daeng Hospital	4	7	11
Total	26	56	82

Table 4.2: Beneficiary demographics

	Gender	Frequency	Percent	Cumulative Percent
Valid	Female	35	62.5	62.5
	Male	21	37.5	100.0
	Total	56	100.0	
	Habitation	Frequency	Percent	Cumulative Percent
	Rural Inhabitant	45	80.4	80.4
	Urban Inhabitant	11	19.6	100.0
	Total	56	100.0	
	Education Level	Frequency	Percent	Cumulative Percent
	No Formal Education	3	5.4	5.4
	Primary School	34	60.7	66.1
	Secondary School	11	19.6	85.7
	Post-Secondary School	8	14.3	100.0
	Total	56	100.0	
	Employment Status	Frequency	Percent	Cumulative Percent
	Unemployed	22	39.3	39.3
	Employed	34	60.7	100.0
	Total	56	100.0	
	Economic Sector	Frequency	Percent	Cumulative Percent
	Non-agricultural occupation	44	78.6	78.6
	Agricultural occupation	12	21.4	100.0
	Total	56	100.0	
	Internal Migratory Status	Frequency	Percent	Cumulative Percent
	Non-migrant worker	38	67.9	67.9
	Migrant worker	18	32.1	100.0
	Total	56	100.0	

Number of Children in Household	Frequency	Percent	Cumulative Percent
0	17	30.4	30.4
1-3	32	57.1	87.5
4-6	7	12.5	100.0
Total	56	100.0	
Number of Parents in Household	**Frequency**	**Percent**	**Cumulative Percent**
No parents	2	3.6	3.6
1 Parent	6	10.7	14.3
2 Parents	32	57.1	71.4
No children	16	28.6	100.0
Total	56	100.0	
Disability Status	**Frequency**	**Percent**	**Cumulative Percent**
Not disabled	46	82.1	82.1
Disabled	10	17.9	100.0
Total	56	100.0	

Table 4.3: Beneficiary age and monthly household income

		Age	Monthly Income
N	Valid	56	54
	Missing	0	2
Mean		47	10,685
Median		47	10,000
Mode		47	10,000
Std. Deviation		18.87	5,745.63
Minimum		1	3,000
Maximum		82	30,000
Percentiles	20	31	5,000
	40	45	9,000
	60	53	10,000
	80	65	15,000

Table 4.4: Professional demographics

	Occupation	Frequency	Percent	Cumulative Percent
Valid	Administration	8	30.8	30.8
	Dentist	1	3.8	34.6
	Doctor	3	11.5	46.2
	Nurse	13	50.0	96.2
	Pharmacist	1	3.8	100.0
	Total	26	100.0	
	Length of Service at Facility	Frequency	Percent	Cumulative Percent
	1 year or less	1	3.8	3.8
	2-5 years	6	23.1	26.9
	6-9 years	4	15.4	42.3
	Over 10 years	15	57.7	100.0
	Total	26	100.0	
	Work Hours Related to UC Scheme	Frequency	Percent	Cumulative Percent
	20%-50%	3	11.5	11.5
	50%-80%	8	30.8	42.3
	Over 80%	15	57.7	100.0
	Total	26	100.0	

The demographic results show that a total of 26 professional staff and 56 beneficiaries were interviewed. The gender of the research subjects was disproportionately female at 63% of respondents. Over 80% of the population interviewed were rural inhabitants. 66% of those interviewed had completed a primary school level of education or less. 39% were unemployed, 21% were agricultural workers, and 32% had migrated within Thailand for work. More than 72% of those interviewed had a household income of 10,000 baht per month or less. 29% of respondents were 60 years of age or over and 18% of all respondents reported being legally disabled.

The demographic results for the professional staff show that 50% of those

interviewed were nurses. 58% of the professional staff reported that they spent over 80% of their time on UC Scheme related duties and had been working at their current hospital facility for over 10 years.

4.2 Individual Health (Beneficiaries only)

Table 4.5: Length of enrollment in the UC Scheme

		Frequency	Percent	Cumulative Percent
Valid	Less than 1 year	6	10.7	10.7
	1-3 Years	6	10.7	21.4
	3-5 Years	4	7.1	28.6
	Over 5 Years	40	71.4	100.0
	Total	56	100.0	

Table 4.6: Generally treated by the same doctor or nurse under the UC Scheme

		Frequency	Percent	Cumulative Percent
Valid	Strongly disagree	2	3.6	3.6
	Disagree	21	37.5	41.1
	No opinion	10	17.9	58.9
	Agree	19	33.9	92.9
	Strongly agree	4	7.1	100.0
	Total	56	100.0	

Table 4.7: Rating of overall health

		Frequency	Percent	Cumulative Percent
Valid	Poor	6	10.7	10.7
	Average	24	42.9	53.6
	Good	18	32.1	85.7
	Very good	8	14.3	100.0
	Total	56	100.0	

Table 4.8: Health has improved as a result of using the UC Scheme

		Frequency	Percent	Cumulative Percent
Valid	Disagree	2	3.6	3.6
	No opinion	6	10.7	14.3
	Agree	34	60.7	75.0
	Strongly agree	14	25.0	100.0
	Total	56	100.0	

Table 4.9: The UC Scheme provides effective services for your medical problems

		Frequency	Percent	Cumulative Percent
Valid	Agree	35	62.5	62.5
	Strongly agree	21	37.5	100.0
	Total	56	100.0	

The survey results for individual health of beneficiaries showed that 71% of respondents stated that they had used the UC Scheme for over 5 years. There was an even distribution of responses between agreement and disagreement when respondents were asked if they were generally seen by the same doctors and nurses when they use the UC Scheme (41% and 41% respectively). When asked about their personal health, 46% of respondents reported good or better health and 11% reported poor health. 86% of respondents agreed that their health had improved from using the UC Scheme. A full 100% of respondents agreed that the UC Scheme provides effective services for their medical problems.

4.3 Challenges and Accomplishments (Professionals only)

Table 4.10: Biggest challenge for providing UC Scheme services to the poor (Multiple response question)

	Responses	
	N	Percent
Restrictive benefits package	8	13.3%
Challenge is low quality medicines or equipment	3	5.0%
Insufficient staffing	9	15.0%
Too much bureaucracy	3	5.0%
Ineffective budget allocations	12	20.0%
Insufficient budget	14	23.3%
Difficult patient population	8	13.3%
Other	3	5.0%
Total	60	100.0%

Table 4.11: Biggest accomplishment of the UC Scheme for the poor (Multiple response question)

	Responses	
	N	Percent
Guarantee of medical care	12	25.5%
Lower health expenses	8	17.0%
Better health	7	14.9%
Improved access to care	16	34.0%
Better quality of care	3	6.4%
Other	1	2.1%
Total	47	100.0%

The survey results for challenges and accomplishments showed that 43% of respondents selected the financial concerns of insufficient budget and ineffective budget allocations as the biggest challenges for the UC Scheme services. The challenges that scored lowest were low quality of medicines and equipment and too much bureaucracy. The results for the biggest accomplishment of the UC Scheme for

the poor revealed that access to care was the most commonly selected choice with 34% of responses, followed by guarantee of medical care at 26% of the total.

4.4 Quality

Table 4.12: Rating of quality of medicines provided under the UC Scheme

		Subject type		Total
		Professional	Beneficiary	
Poor	Count	1	2	3
	% within Subject type	3.8%	3.6%	3.7%
Average	Count	11	7	18
	% within Subject type	42.3%	12.5%	22.0%
Good	Count	13	35	48
	% within Subject type	50.0%	62.5%	58.5%
Very good	Count	1	12	13
	% within Subject type	3.8%	21.4%	15.9%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

Table 4.13: Rating of quality of medical facilities under the UC Scheme

		Subject type		Total
		Professional	Beneficiary	
Poor	Count	1	2	3
	% within Subject type	3.8%	3.6%	3.7%
Average	Count	10	13	23
	% within Subject type	38.5%	23.2%	28.0%
Good	Count	14	30	44
	% within Subject type	53.8%	53.6%	53.7%
Very good	Count	1	11	12
	% within Subject type	3.8%	19.6%	14.6%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

Table 4.14: Rating of quality of medical professionals under the UC Scheme

		Subject type		Total
		Professional	Beneficiary	
Average	Count	5	8	13
	% within Subject type	19.2%	14.3%	15.9%
Good	Count	19	33	52
	% within Subject type	73.1%	58.9%	63.4%
Very good	Count	2	15	17
	% within Subject type	7.7%	26.8%	20.7%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

Table 4.15: Rating of overall quality of services under the UC Scheme

		Subject type		Total
		Professional	Beneficiary	
Poor	Count	2	0	2
	% within Subject type	7.7%	.0%	2.4%
Average	Count	8	6	14
	% within Subject type	30.8%	10.7%	17.1%
Good	Count	14	26	40
	% within Subject type	53.8%	46.4%	48.8%
Very good	Count	2	24	26
	% within Subject type	7.7%	42.9%	31.7%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

The survey results for quality revealed that the quality of medicines for the UC Scheme was rated good or better by 54% of professionals and 83% of beneficiaries. The quality of medical facilities was rated good or better by 58% of professionals and 74% of beneficiaries. The quality of medical professionals was rated good or better by 81% of professionals and 86% of beneficiaries. Overall quality for the UC Scheme was rated to be good or better by 62% of professionals and 89% of beneficiaries.

4.5 Equity

Table 4.16: The services provided under the UC Scheme are the same quality as those provided under the CSMBS

		Subject type		Total
		Professional	Beneficiary	
Strongly disagree	Count	2	1	3
	% within Subject type	7.7%	1.8%	3.7%
Disagree	Count	10	13	23
	% within Subject type	38.5%	23.2%	28.0%
No opinion	Count	0	18	18
	% within Subject type	.0%	32.1%	22.0%
Agree	Count	11	18	29
	% within Subject type	42.3%	32.1%	35.4%
Strongly agree	Count	3	6	9
	% within Subject type	11.5%	10.7%	11.0%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

Table 4.17: Would switch to the UC Scheme (Professionals)/CSMBS (Beneficiaries) if possible

		Subject type		Total
		Professional	Beneficiary	
No	Count	23	35	58
	% within Subject type	88.5%	62.5%	70.7%
Yes	Count	3	21	24
	% within Subject type	11.5%	37.5%	29.3%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

Table 4.18: The poorer users of the UC Scheme receive the same medical care as those with more money

		Subject type		Total
		Professional	Beneficiary	
No	Count	5	5	10
	% within Subject type	19.2%	8.9%	12.2%
Yes	Count	21	51	72
	% within Subject type	80.8%	91.1%	87.8%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

The survey results for equity showed a fairly even distribution of responses about the equity of quality for the UC scheme and CSMBS, with a slightly higher number of both professionals and beneficiaries responding in agreement that that they felt the schemes were equal in quality (54% and 43% respectively). When asked if they would switch to the other scheme if they had the opportunity, 38% of beneficiaries and 12% of professionals stated they would like to switch. When asked about the equity of medical care provided under the UC Scheme between the rich and the poor, the majority of both professionals and beneficiaries stated that the care provided was equal (81% and 91% respectively).

4.6 Targeted and Appropriate

Table 4.19: The UC Scheme does as good a job of providing the services needed by women as by men (Professional responses)

		Frequency	Percent	Cumulative Percent
Valid	Disagree	1	3.8	3.8
	Agree	10	38.5	42.3
	Strongly agree	15	57.7	100.0
	Total	26	100.0	

Table 4.20: The UC Scheme does as good a job of providing the services needed by women as by men (Gender disaggregated beneficiary responses)

		Gender		Total
		Female	Male	
No Opinion	Count	6	6	12
	% within Gender	17.1%	28.6%	21.4%
Agree	Count	24	9	33
	% within Gender	68.6%	42.9%	58.9%
Strongly agree	Count	5	6	11
	% within Gender	14.3%	28.6%	19.6%
Total	Count	35	21	56
	% within Gender	100.0%	100.0%	100.0%

Table 4.21: The UC Scheme does as good a job of providing the services needed by the elderly as by adults (Professional responses)

		Frequency	Percent	Cumulative Percent
Valid	Disagree	1	3.8	3.8
	Agree	14	53.8	57.7
	Strongly agree	11	42.3	100.0
	Total	26	100.0	

Table 4.22: The UC Scheme does as good a job of providing the services needed by the elderly as by adults (Age delimited beneficiary responses)

		Age		Total
		Under 60 Years	Over 60 Years	
No Opinion	Count	3	0	3
	% within Age	7.5%	.0%	5.4%
Agree	Count	24	7	31
	% within Age	60.0%	43.8%	55.4%
Strongly agree	Count	13	9	22
	% within Age	32.5%	56.3%	39.3%
Total	Count	40	16	56
	% within Age	100.0%	100.0%	100.0%

Table 4.23: The UC scheme does as good a job of providing the services needed by the disabled as by the non-disabled (Professional responses)

		Frequency	Percent	Cumulative Percent
Valid	Disagree	1	3.8	3.8
	Agree	12	46.2	50.0
	Strongly agree	13	50.0	100.0
	Total	26	100.0	

Table 4.24: The UC scheme does as good a job of providing the services needed by the disabled as by the non-disabled (Disability status divided beneficiary responses)

		Legally Disabled		Total
		Non-Disabled	Disabled	
Disagree	Count	1	0	1
	% within Legally Disabled	2.2%	.0%	1.8%
No Opinion	Count	11	2	13
	% within Legally Disabled	23.9%	20.0%	23.2%
Agree	Count	25	4	29
	% within Legally Disabled	54.3%	40.0%	51.8%
Strongly agree	Count	9	4	13
	% within Legally Disabled	19.6%	40.0%	23.2%
Total	Count	46	10	56
	% within Legally Disabled	100.0%	100.0%	100.0%

Table 4.25: The UC Scheme does as good a job of providing the services needed by the poor as by the rich (Professional responses)

		Frequency	Percent	Cumulative Percent
Valid	Strongly disagree	1	3.8	3.8
	Disagree	2	7.7	11.5
	Agree	14	53.8	65.4
	Strongly agree	9	34.6	100.0
	Total	26	100.0	

Table 4.26: The UC Scheme does as good a job of providing the services needed by the poor as by the rich (Income delimited beneficiary responses)

		Household Income		Total
		Low Income	Non-Low Income	
Agree	Count	20	6	26
	% within Household Income	51.3%	40.0%	48.1%
Strongly agree	Count	19	9	28
	% within Household Income	48.7%	60.0%	51.9%
Total	Count	39	15	54
	% within Household Income	100.0%	100.0%	100.0%

Table 4.27: The UC Scheme does as good a job of providing the services needed by rural inhabitants as by urban inhabitants (Professional responses)

		Frequency	Percent	Cumulative Percent
Valid	Strongly disagree	1	3.8	3.8
	Disagree	2	7.7	11.5
	No opinion	1	3.8	15.4
	Agree	15	57.7	73.1
	Strongly agree	7	26.9	100.0
	Total	26	100.0	

Table 4.28: The UC Scheme does as good a job of providing the services needed by rural inhabitants as by urban inhabitants (Residence divided beneficiary responses)

		Residence		Total
		Rural Inhabitant	Urban Inhabitant	
Strongly disagree	Count	1	0	1
	% within Residence	2.2%	.0%	1.8%
Disagree	Count	5	0	5
	% within Residence	11.1%	.0%	8.9%
No Opinion	Count	5	0	5
	% within Residence	11.1%	.0%	8.9%
Agree	Count	28	8	36
	% within Residence	62.2%	72.7%	64.3%
Strongly agree	Count	6	3	9
	% within Residence	13.3%	27.3%	16.1%
Total	Count	45	11	56
	% within Residence	100.0%	100.0%	100.0%

Table 4.29: The UC Scheme addresses the major health concerns in the community

		Subject type		Total
		Professional	Beneficiary	
Strongly disagree	Count	0	1	1
	% within Subject type	.0%	1.8%	1.2%
Disagree	Count	2	0	2
	% within Subject type	7.7%	.0%	2.4%
No opinion	Count	1	7	8
	% within Subject type	3.8%	12.5%	9.8%
Agree	Count	18	37	55
	% within Subject type	69.2%	66.1%	67.1%
Strongly agree	Count	5	11	16
	% within Subject type	19.2%	19.6%	19.5%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

The survey results for targeted and appropriate services revealed that when asked whether the UC Scheme does as good a job of providing the services needed by women as for men, 96% of professionals and 79% of beneficiaries agreed that it does. When the beneficiary responses were disaggregated by gender, 83% of women and 72% of men agreed that UC does as good a job for women. 96% of professionals and 85% of beneficiaries agreed that the UC Scheme does as good a job of providing care to the elderly as it does for younger adults. When the beneficiary results were delimited into age groups, 93% of those under 60 agreed and a complete 100% of those 60 or over agreed that the services for the elderly are as good. 96% of professionals and 75% of beneficiaries agreed that the UC Scheme does as good a job of providing services to the disabled as to the non-disabled. When the beneficiary responses were divided into legal disability status, 74% of the non-disabled and 80% of the disabled agreed that the services for the disabled are as good.

When asked whether the UC Scheme does as good a job of providing the services needed by the poor as by the rich, 96% of professionals and a complete 100% of beneficiaries agreed that it does. When the responses were divided into low income (below 10,000 baht per month household income) and non-low income categories, 49% of low income and 60% of non-low income respondents strongly agreed that the services are as good for the poor as for the rich. When asked whether the UC Scheme does as good a job providing the services needed by rural inhabitants as by urban inhabitants, 85% of professionals and 80% of beneficiaries agreed. When the beneficiary results were divided by residence type, 86% of rural inhabitants and a full 100% of urban inhabitants agreed that the services are as good. In response to the question of whether the UC Scheme offers services that address the major health concerns in the community, 88% of professionals and 86% agreed that it does.

4.7 Barriers to Care

Table 4.30: The waiting time under the UC Scheme is an obstacle to seeking care

		Subject type		Total
		Professional	Beneficiary	
Strongly disagree	Count	1	3	4
	% within Subject type	3.8%	5.4%	4.9%
Disagree	Count	7	32	39
	% within Subject type	26.9%	57.1%	47.6%
No opinion	Count	3	1	4
	% within Subject type	11.5%	1.8%	4.9%
Agree	Count	8	14	22
	% within Subject type	30.8%	25.0%	26.8%
Strongly agree	Count	7	6	13
	% within Subject type	26.9%	10.7%	15.9%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

Table 4.31: Able to access healthcare at the location most convenient under the UC Scheme (Residence divided beneficiary responses)

		Residence		Total
		Rural Inhabitant	Urban Inhabitant	
No	Count	4	0	4
	% within Residence	8.9%	.0%	7.1%
Yes	Count	41	11	52
	% within Residence	91.1%	100.0%	92.9%
Total	Count	45	11	56
	% within Residence	100.0%	100.0%	100.0%

Table 4.32: The amount of time to access services under the UC Scheme including transportation, waiting time, and treatment (Residence divided beneficiary responses)

		Residence		Total
		Rural Inhabitant	Urban Inhabitant	
Less than 1 hour	Count	5	0	5
	% within Residence	11.1%	.0%	8.9%
1-3 hours	Count	33	6	39
	% within Residence	73.3%	54.5%	69.6%
4-6 hours	Count	6	4	10
	% within Residence	13.3%	36.4%	17.9%
7-10 hours	Count	1	1	2
	% within Residence	2.2%	9.1%	3.6%
Total	Count	45	11	56
	% within Residence	100.0%	100.0%	100.0%

Table 4.33: Willing to pay more out of pocket if it means not waiting as long for services (Income delimited beneficiary responses)

		Income over 10K		Total
		No	Yes	
Strongly disagree	Count	13	3	16
	% within Income over 10K	31.7%	20.0%	28.6%
Disagree	Count	21	8	29
	% within Income over 10K	51.2%	53.3%	51.8%
No Opinion	Count	1	1	2
	% within Income over 10K	2.4%	6.7%	3.6%
Agree	Count	2	2	4
	% within Income over 10K	4.9%	13.3%	7.1%
Strongly agree	Count	4	1	5
	% within Income over 10K	9.8%	6.7%	8.9%
Total	Count	41	15	56
	% within Income over 10K	100.0%	100.0%	100.0%

Table 4.34: Biggest obstacle for using UC Scheme services (Beneficiaries only) (Multiple response question)

	Responses	
	N	Percent
Cannot be away from work	15	26.3%
Transportation	12	21.1%
Time away from family	17	29.8%
Expense	1	1.8%
Unpleasant treatment at facility	5	8.8%
Poor quality services	2	3.5%
Other	5	8.8%
Total	57	100.0%

Table 4.35: The UC Scheme still excludes or is not welcoming to some groups in the community

		Subject type		Total
		Professional	Beneficiary	
No	Count	23	52	75
	% within Subject type	88.5%	92.9%	91.5%
Yes	Count	3	4	7
	% within Subject type	11.5%	7.1%	8.5%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

Table 4.36: The UC Scheme is easy to use for patients with less education (Professionals only)

		Frequency	Percent	Cumulative Percent
Valid	No	3	11.5	11.5
	Yes	23	88.5	100.0
	Total	26	100.0	

Table 4.37: The information given to you about the UC Scheme is easy to understand (Education divided beneficiary responses)

		Education Completed				Total
		No formal education	Primary school	Secondary school	Post-secondary school	
No	Count	1	6	2	0	9
	% within Education Completed	33.3%	17.6%	18.2%	.0%	16.1%
Yes	Count	2	28	9	8	47
	% within Education Completed	66.7%	82.4%	81.8%	100.0%	83.9%
Total	Count	3	34	11	8	56
	% within Education Completed	100.0%	100.0%	100.0%	100.0%	100.0%

Table 4.38: The referral process to see a specialist should be changed

		Subject type		Total
		Professional	Beneficiary	
Easier	Count	11	8	19
	% within Subject type	42.3%	15.1%	24.1%
Remain the same	Count	14	45	59
	% within Subject type	53.8%	84.9%	74.7%
More difficult	Count	1	0	1
	% within Subject type	3.8%	.0%	1.3%
Total	Count	26	53	79
	% within Subject type	100.0%	100.0%	100.0%

Table 4.39: Aware of how to change registration for the UC Scheme if relocating (Beneficiaries only)

Migrant Status Divided Responses		Relocated within Thailand for Work: Non-migrant worker	Relocated within Thailand for Work: Migrant worker	Total
No response	Count	1	0	1
	% within Relocated for Work	2.6%	.0%	1.8%
No	Count	15	7	22
	% within Relocated for Work	39.5%	38.9%	39.3%
Yes	Count	22	11	33
	% within Relocated for Work	57.9%	61.1%	58.9%
Total	Count	38	18	56
	% within Relocated for Work	100.0%	100.0%	100.0%

Table 4.40: Changing your registration to a new facility for the UC Scheme was an easy process (Beneficiaries only)

		Frequency	Percent	Cumulative Percent
Valid	No	2	3.6	3.6
	Yes	5	8.9	12.5
	Never had to	48	85.7	98.2
	No response	1	1.8	100.0
	Total	56	100.0	

Table 4.41: Frequency that ability to pay for services is still an obstacle for patients to receive medical care (Professionals only)

		Frequency	Percent	Cumulative Percent
Valid	Never	4	15.4	15.4
	Rarely	10	38.5	53.8
	Occasionally	6	23.1	76.9
	Frequently	6	23.1	100.0
	Total	26	100.0	

The survey results for barriers to care showed that when asked whether the waiting time to receive services was a major obstacle to seeking healthcare, 58% of professionals and 36% of beneficiaries agreed that it is. When beneficiaries were asked whether they are able to access healthcare at a convenient location, 91% of rural inhabitants and a full 100% of urban inhabitants said that they were able to. When beneficiaries were asked how long it takes them to access services including transportation time, waiting time, and treatment, the most frequent response for both urban and rural inhabitants was 1-3 hours. 36% of urban inhabitants and 13% of rural inhabitants reported that it takes them 4-6 hours to access services and 0% of urban inhabitants and 11% of rural inhabitants reported that it takes them less than an hour to access services. When beneficiaries were asked if they would be willing to pay more out of pocket if it meant not waiting as long to receive services, 80% of the total responses stated that they disagreed with the solution and the results were not significantly different between income groups.

When beneficiaries were asked what the biggest obstacle for them to use UC Scheme services is, 30% chose time away from their family, 26% chose cannot be away from work, and 21% chose transportation. When subjects were asked whether the UC Scheme excludes or is not welcoming to any groups in the community, 12% of professionals and 7% of beneficiaries responded yes. When professionals were asked if they think that UC services are easy to use for patients with a low educational level, 89% responded yes. When beneficiaries were asked if they found the information given to them about the UC Scheme easy to understand, 84% responded yes. When the results were divided by educational level, there was a decline in understanding from 100% of those with a post-secondary education, to 67% of those with no formal education.

When asked about whether the referral process to see a specialist should be easier, more difficult, or remain the same, the majority of both professionals and beneficiaries felt that it should remain the same (54% and 85% respectively). However, a full 43% of professionals and only 15% of beneficiaries thought that referrals should be easier. When beneficiaries were asked if they were aware of how

to change their registration for the UC Scheme if they were to move, 59% responded that they were. There was no distinct difference in responses between those who had already migrated for work and those who had not. When beneficiaries were asked if they found the process easy, 4% replied no, 9% replied yes, and the vast majority replied that they had never had to re-register. When professionals were asked how often ability to pay for services is still an obstacle for patients to access services, there was a fairly even distribution of responses with "Rarely" the most common at 39%.

4.8 Participation, Empowerment, Accountability, and Community Development

Table 4.42: The doctors in the UC Scheme explain your condition and treatment options clearly and involve you in decision making (Beneficiaries only)

		Frequency	Percent	Cumulative Percent
Valid	Strongly disagree	2	3.6	3.6
	Disagree	7	12.5	16.1
	No Opinion	9	16.1	32.1
	Agree	28	50.0	82.1
	Strongly agree	10	17.9	100.0
	Total	56	100.0	

Table 4.43: The resource allocations of the UC Scheme effectively address the health needs of the poor (Professionals only)

		Frequency	Percent	Cumulative Percent
Valid	Strongly disagree	1	3.8	3.8
	Disagree	13	50.0	53.8
	No opinion	2	7.7	61.5
	Agree	8	30.8	92.3
	Strongly agree	2	7.7	100.0
	Total	26	100.0	

Table 4.44: Beneficiaries should have more voice in how the services of the UC Scheme are provided in their community

		Subject type		Total
		Professional	Beneficiary	
Strongly disagree	Count	0	6	6
	% within Subject type	.0%	10.7%	7.3%
Disagree	Count	1	8	9
	% within Subject type	3.8%	14.3%	11.0%
No opinion	Count	4	19	23
	% within Subject type	15.4%	33.9%	28.0%
Agree	Count	14	20	34
	% within Subject type	53.8%	35.7%	41.5%
Strongly agree	Count	7	3	10
	% within Subject type	26.9%	5.4%	12.2%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

Table 4.45: The UC Scheme has helped the poor people of the community to have more control over their own lives

		Subject type		Total
		Professional	Beneficiary	
Disagree	Count	4	0	4
	% within Subject type	15.4%	.0%	4.9%
No opinion	Count	2	3	5
	% within Subject type	7.7%	5.4%	6.1%
Agree	Count	17	33	50
	% within Subject type	65.4%	58.9%	61.0%
Strongly agree	Count	3	20	23
	% within Subject type	11.5%	35.7%	28.0%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

Table 4.46: The UC Scheme is too bureaucratic and should be more accountable to the needs of patients and medical professionals

		Subject type		Total
		Professional	Beneficiary	
Strongly disagree	Count	2	3	5
	% within Subject type	7.7%	5.4%	6.1%
Disagree	Count	11	30	41
	% within Subject type	42.3%	53.6%	50.0%
No opinion	Count	2	8	10
	% within Subject type	7.7%	14.3%	12.2%
Agree	Count	9	11	20
	% within Subject type	34.6%	19.6%	24.4%
Strongly agree	Count	2	4	6
	% within Subject type	7.7%	7.1%	7.3%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

Have made a formal complaint about services received under the UC Scheme (Beneficiaries only)

Responses: 100% responded “No”

Table 4.47: The UC Scheme has given you more control over your own health (Beneficiaries only)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	1	1.8	1.8	1.8
	No Opinion	3	5.4	5.4	7.1
	Agree	29	51.8	51.8	58.9
	Strongly agree	23	41.1	41.1	100.0
	Total	56	100.0	100.0	

Table 4.48: The UC Scheme has improved the healthcare options available to the poor (Professionals only)

		Frequency	Percent	Cumulative Percent
Valid	Disagree	2	7.7	7.7
	Agree	15	57.7	65.4
	Strongly agree	9	34.6	100.0
	Total	26	100.0	

The survey results for participation, empowerment, accountability and community development revealed that when asked whether they thought beneficiaries should have more voice in how the UC Scheme services are provided in their community, 81% of professionals and only 41% of beneficiaries agreed. When asked whether the UC Scheme has helped the poor people of the community to have more control over their own lives, 77% of professionals and 95% of beneficiaries agreed that it has. When beneficiaries were asked whether their doctor explains their condition and treatment options clearly and involves them in decision making, 68% agreed that they do.

When professionals were asked if they felt that the resource allocations of the UC Scheme effectively address the health needs of the poor, 54% of respondent disagreed with the statement. When asked whether the UC Scheme is too bureaucratic and not accountable enough to patients and medical professionals, the majority of both professionals and beneficiaries disagreed with the statement (50% and 59% respectively). When beneficiaries were asked if they had ever made a formal complaint about services received under the UC Scheme, 100% responded that they had not. When beneficiaries were asked if the UC Scheme had given them more control over their own health, 93% responded in agreement. When professionals were asked if the UC Scheme has improved the healthcare options available to the poor, 92% agreed that it had.

4.9 Economics

Table 4.49: The UC Scheme does a good job of protecting the poor from out of pocket payments for healthcare (Professionals only)

		Frequency	Percent	Cumulative Percent
Valid	Disagree	1	3.8	3.8
	Agree	13	50.0	53.8
	Strongly agree	12	46.2	100.0
	Total	26	100.0	

Table 4.50: The UC Scheme has lowered the amount that you pay out of pocket for healthcare (Beneficiaries only)

		Frequency	Percent	Cumulative Percent
Valid	No Opinion	1	1.8	1.8
	Agree	10	17.9	19.6
	Strongly agree	45	80.4	100.0
	Total	56	100.0	

Table 4.51: The UC Scheme does a good job of protecting the poor from high expenses created by a serious illness (Professionals only)

		Frequency	Percent	Cumulative Percent
Valid	Strongly disagree	1	3.8	3.8
	Agree	14	53.8	57.7
	Strongly agree	11	42.3	100.0
	Total	26	100.0	

Table 4.52: The UC Scheme has made you safer from high expenses created by a serious illness (Beneficiaries only)

		Frequency	Percent	Cumulative Percent
Valid	Disagree	3	5.4	5.4
	No Opinion	1	1.8	7.1
	Agree	16	28.6	35.7
	Strongly agree	36	64.3	100.0
	Total	56	100.0	

Table 4.53: The economy of the community has improved as a result of the UC Scheme

		Subject type		Total
		Professional	Beneficiary	
Strongly disagree	Count	2	0	2
	% within Subject type	7.7%	.0%	2.4%
Disagree	Count	3	1	4
	% within Subject type	11.5%	1.8%	4.9%
No opinion	Count	7	4	11
	% within Subject type	26.9%	7.1%	13.4%
Agree	Count	11	32	43
	% within Subject type	42.3%	57.1%	52.4%
Strongly agree	Count	3	19	22
	% within Subject type	11.5%	33.9%	26.8%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

Table 4.54: The UC Scheme has benefitted the poor in the community more than the rich

		Subject type		Total
		Professional	Beneficiary	
Disagree	Count	4	8	12
	% within Subject type	15.4%	14.3%	14.6%
No opinion	Count	0	2	2
	% within Subject type	.0%	3.6%	2.4%
Agree	Count	15	16	31
	% within Subject type	57.7%	28.6%	37.8%
Strongly agree	Count	7	30	37
	% within Subject type	26.9%	53.6%	45.1%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

The survey results for economics revealed that when professionals were asked whether the UC Scheme does a good job of protecting the poor from out of pocket payments for healthcare, 96% agreed that it does. When beneficiaries were asked the same question about themselves, 98% agreed with the statement. When professionals were asked whether the UC Scheme does a good job of protecting the poor from the risk of high expenses created by a serious illness, 96% of professionals agreed that it does. When beneficiaries were asked the same question about themselves, 93% agreed.

When research subjects were asked if they feel that the economy of the community has improved as a result of the UC Scheme, 54% of professionals and 91% of beneficiaries agreed that it has. When asked whether the UC Scheme has benefitted the poor in the community more than the rich, 85% of professionals and 82% of beneficiaries agreed that it has.

4.10 Right to Healthcare

Table 4.55: Patients are generally aware that they are guaranteed the right to healthcare in Thailand (Professionals only)

		Frequency	Percent	Cumulative Percent
Valid	No	5	19.2	19.2
	Yes	21	80.8	100.0
	Total	26	100.0	

Table 4.56: You are aware that you are guaranteed the right to healthcare in Thailand (Beneficiaries only)

		Frequency	Percent	Cumulative Percent
Valid	No	2	3.6	3.6
	Yes	54	96.4	100.0
	Total	56	100.0	

Table 4.57: Had an experience where your rights were not respected when accessing services under the UC Scheme (Beneficiaries only)

		Frequency	Percent	Cumulative Percent
Valid	No	49	87.5	87.5
	Yes	7	12.5	100.0
	Total	56	100.0	

Table 4.58: Treated with dignity and respect when using the services of the UC Scheme (Beneficiaries only)

		Frequency	Percent	Cumulative Percent
Valid	Strongly disagree	1	1.8	1.8
	Agree	37	66.1	67.9
	Strongly agree	18	32.1	100.0
	Total	56	100.0	

Table 4.59: Poorer patients are treated with an equal amount of dignity and respect as those with more money when using the UC Scheme

		Subject type		Total
		Professional	Beneficiary	
Strongly disagree	Count	1	1	2
	% within Subject type	3.8%	1.8%	2.4%
Disagree	Count	2	0	2
	% within Subject type	7.7%	.0%	2.4%
Agree	Count	15	37	52
	% within Subject type	57.7%	66.1%	63.4%
Strongly agree	Count	8	18	26
	% within Subject type	30.8%	32.1%	31.7%
Total	Count	26	56	82
	% within Subject type	100.0%	100.0%	100.0%

The survey results for right to healthcare show that when professionals were asked if patients are generally aware that they are guaranteed the right to healthcare in Thailand, 81% responded yes. When beneficiaries were asked the question of themselves, 96% stated that they were aware of their right. When beneficiaries were asked if they have ever had an experience where they felt that their rights were not respected when using the UC Scheme, 13% responded that they had.

When beneficiaries were asked if they feel that they are treated with dignity and respect when using the UC Scheme, 98% of respondents agreed that they are. When asked if they feel that poorer patients are treated with an equal amount of dignity and respect as those with more money when the using the UC Scheme, 89% of professionals and 98% of beneficiaries agreed.

4.11 **Medical Staff** (Professionals only)

Table 4.60: Have medical concerns with the services provided under the UC Scheme (Occupation divided responses)

		Occupation					Total
		Administration	Dentist	Doctor	Nurse	Pharmacist	
No	Count	6	0	0	8	0	14
	% within Occupation	75.0%	.0%	.0%	61.5%	.0%	53.8%
Yes	Count	2	1	3	5	1	12
	% within Occupation	25.0%	100.0%	100.0%	38.5%	100.0%	46.2%
Total	Count	8	1	3	13	1	26
	% within Occupation	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 4.61: The staff at your facility is overworked as a result of providing services for the UC Scheme

		Frequency	Percent	Cumulative Percent
Valid	Strongly disagree	1	3.8	3.8
	Disagree	4	15.4	19.2
	No opinion	3	11.5	30.8
	Agree	12	46.2	76.9
	Strongly agree	6	23.1	100.0
	Total	26	100.0	

Table 4.62: Have made a formal complaint about the heavy workload under UC

		Frequency	Percent	Cumulative Percent
Valid	No	22	84.6	84.6
	Yes	4	15.4	100.0
	Total	26	100.0	

Table 4.63: The medical staff has adequate time to treat their patients even with the heavy workload under UC

		Frequency	Percent	Cumulative Percent
Valid	Disagree	6	23.1	23.1
	Agree	18	69.2	92.3
	Strongly agree	2	7.7	100.0
	Total	26	100.0	

Table 4.64: Have considered switching to work fulltime in a private hospital or clinic (Occupation divided responses)

Occupation Divided Responses		Occupation					Total
		Administration	Dentist	Doctor	Nurse	Pharmacist	
No	Count	7	0	1	10	1	19
	% within Occupation	87.5%	.0%	33.3%	76.9%	100.0%	73.1%
Yes	Count	1	1	2	3	0	7
	% within Occupation	12.5%	100.0%	66.7%	23.1%	.0%	26.9%
Total	Count	8	1	3	13	1	26
	% within Occupation	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The survey results for medical staff concerns showed that when asked if they felt that the staff at their facility is overworked as a result of providing services for the UC Scheme, 69% of professionals agreed. When asked if they had ever made a formal complaint about the heavy workload, 15% of professionals stated that they had. When asked if they felt that the medical staff has adequate time to treat their patients even with the heavy workload, 77% of professionals agreed.

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

When asked if they had ever considered switching to work fulltime in a private hospital or clinic, 27% stated that they had considered it. The totals were much higher for dentists and doctors who were asked this question, with the majority of both replying that they had considered switching.

4.12 Importance Scale

Table 4.65: Importance of the issue for the UC Scheme. (Scale of 1-5, 1-Least important to 5-Most important) (Professional responses)

Professional Responses	N	Minimum	Maximum	Mean	Std. Deviation
More funding for services?	26	4	5	4.7	.43
Ensuring the right to healthcare for all citizens?	26	3	5	4.5	.64
Patients are treated the same regardless of income?	26	1	5	4.4	.94
Services that provide patients with greater control over their own health?	26	2	5	4.2	.87
Easily accessible location for services?	26	2	5	4.2	.77
Services that help to strengthen the community?	26	3	5	4.2	.81
All stakeholders having a voice in managing UC Scheme services?	26	1	5	4.1	1.04
Highly trained medical staff?	26	2	5	4.0	.93
Services designed for the health needs of the poor and vulnerable?	26	1	5	4.0	.89
High quality medical facilities?	26	2	5	4.0	.93
Reduced cost for expensive treatments?	26	1	5	3.7	1.17
Cost paid out of pocket for services?	26	1	5	3.7	1.17
High quality medicines	26	1	5	3.7	1.03
Equity of service quality with other public insurance schemes?	26	1	5	3.7	1.25
Reduction in economic inequality in the community?	26	1	5	3.5	1.20
Ability to choose medical facility for accessing services?	26	1	5	3.3	1.25
Reduced waiting time for services?	26	1	5	3.1	1.29

Table 4.66: Importance of the issue for the UC Scheme. (Scale of 1-5, 1-Least important to 5-Most important) (Beneficiary responses)

Beneficiary Responses	N	Minimum	Maximum	Mean	Std. Deviation
Services designed for the health needs of the poor and vulnerable?	56	4	5	4.8	.37
High quality medical facilities?	56	2	5	4.8	.51
High quality medicines?	56	3	5	4.8	.58
Easily accessible location for UC scheme services?	56	3	5	4.7	.47
Ensuring the right to healthcare for all citizens?	56	3	5	4.6	.54
Highly trained medical staff?	56	2	5	4.6	.61
Patients are treated the same regardless of income?	56	2	5	4.6	.67
More funding for services?	56	2	5	4.3	.86
Reduced cost for expensive treatments?	56	2	5	4.3	.94
Cost paid out of pocket for services?	56	1	5	4.3	.99
Reduced waiting time for services?	56	1	5	4.2	.96
Equity of service quality with other public insurance schemes?	56	1	5	4.2	1.01
Reduction in economic inequality in the community?	56	2	5	4.2	.76
Services that help to strengthen the community?	56	3	5	4.1	.74
Services that provide patients with greater control over their own health?	56	2	5	4.1	.77
All stakeholders having a voice in managing UC Scheme services?	56	2	5	3.9	.85
Ability to choose medical facility for accessing services?	56	1	5	3.6	.97

The survey results for the importance scale showed that the 3 issues ranked highest for professionals were more funding for services, ensuring the right to healthcare for all citizens, and that patients are treated the same regardless of income.

The 3 issues ranked highest for beneficiaries were services designed for the health needs of the poor and vulnerable, high quality medical facilities, and high quality medicines.

CHAPTER V

ANALYSIS AND SYNTHESIS

In this chapter, the results of the qualitative and quantitative research are analyzed to form the empirical basis of the model for monitoring:

Figure 5.1: Model of Analysis

The analysis of qualitative data from key informant interview and participant observation is ordered by field research site. The analysis of quantiative data from the medical professional and beneficiary survey is ordered by the thematic areas of the research questions. This chapter concludes with the synthesis of monitoring indicators produced by the analysis.

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

5.1 Analysis of Qualitative Research

Saraburi Provincial Health Office

The UC Scheme appears to have had a number of both positive and negative impacts on Saraburi Province, many of which are consistent with the successes and challenges associated with the program on a national level. Without question, the UC Scheme has expanded access to care in Saraburi. Almost all poor residents of the province are now able to access services at their district hospital without fear of incurring significant out of pocket costs. In addition, the overall insurance coverage rate of 98% is above the national average of 96% (The National Statistical Office,

2008c: 78) and represents near universal coverage. However, this increased access has had a number of detrimental effects on healthcare provision in the province. The health system infrastructure in Saraburi shows the strains of providing services to the 426,322 registered members of the UC Scheme in the Province. Underfunding of hospitals has led to heavy workloads on public health staff and an inability to pay doctor salaries competitive with those available at private sector facilities. In addition, the epidemiological transition in Saraburi (As well as in Thailand as a whole (UNESCAP, 2009: 59)) to a higher burden of non-communicable diseases has forced hospitals to shoulder the cost of providing expensive treatments for chronic illnesses. The overall shortage of funding caused by an annual capitation rate of only 2,202 baht per person for the UC Scheme, combined with a high demand for services has led to problems with the quality of inputs and outcomes of UC services.

Saraburi Hospital

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

The other strategy that was mentioned for avoiding financial hardship at the hospital, subsidizing UC Services with profits from providing care to SSS and CSMBS patients, seems to be a much more common approach for covering the budgetary shortfalls caused by universal coverage. However, this creates a system of disincentive for hospitals to provide UC Scheme services or at least encourages providing them in the cheapest manner possible. It is difficult to ensure equity of care between insurance schemes when hospitals are receiving a guaranteed reimbursement for services provided to SSS and CSMBS members under a fee for service model and a set and often insufficient level of remuneration for services to UC members under capitation.

Don Phut Hospital

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

Again, a key informant mentioned that a major problem with the UC Scheme is that patients use services when they are not really necessary and are taking less care of themselves. This is one of the frequent claims made against the UC Scheme by many working in public health although it is difficult to quantify in practice. While increased utilization appears to be a definite result of the UC Scheme, determining whether or not that increase is due to negligence on the part of patients in relation to their own health, and further whether or not patients are using services unnecessarily are both much more of a gray area.

Kaeng Khoi Hospital

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

Scheme would most likely reduce the amount of patients seeking care but would also disproportionately hurt the poor, for whom even a small co-payment can be a significant obstacle.

Nong Khae Hospital

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

Sao Hai Hospital

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

Wihan Daeng Hospital

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

5.2 Analysis of Quantitative Research

Demographics

Contemporary understandings of poverty recognize that there is more than just a single homogenous demographic group that can be defined as “The poor”. Instead there are many causes and manifestations of poverty in any population group which has led to increased specificity in classification of poor populations such as “The vulnerable poor”, “The working poor” and “The extreme poor”, etc. According to the World Bank, “The terms “poor” and “vulnerable” are often used interchangeably even though these groups may not be the same. Vulnerability is defined as the ex ante probability of the household to be poor in the next period, given assets and likely exposure to risks. A household can be vulnerable but not poor because their predicted poverty rate in the future is quite high if they are exposed to a high probability of shocks (e.g. exposure to natural disasters). On the other hand, a household can experience a momentary downturn but not be vulnerable to future poverty. This is the case of the openly unemployed or ex-civil servants for whom, given their education and asset levels, their current poverty status may be quite transitory. And, a household can be part of what is commonly referred to as a “vulnerable group” but not be poor

per se, for example the rich disabled and better-off female headed households." (Domelen, 2007: 12)

In any community, people create their own categories of who is poor based upon local conceptualizations and causes of poverty. Therefore it is important to broaden monitoring measurements to make pro-poor evaluations beyond income based headcounts and include other assessment techniques that are based upon the local context and multiple elements of and proxies for poverty and vulnerability.

The gender of the research subjects surveyed was disproportionately female at 63% of respondents. As has been noted by other researchers, "A great deal of research on health depends on the good will, participation and time of women, although the choice of women as respondents is not always dictated by an overwhelming desire to explore women's needs and experiences as such." (Earle & Letherby, 2008: 101) In this case, the disproportionately is reflective of the poor and vulnerable populations in many of the developing countries of the world, a phenomenon often referred to as the "Feminization of poverty". (Moghadam, 2005: 2) In its annual Human Development Report, the UNDP stated that "70% of the world's poor are women". (UNDP, 1995: 4) This demographic tendency has also been documented in the developing countries of Asia. According to UNIFEM's *Progress of the World's Women 2008/2009*, national level data collected in the countries of East Asia and the Pacific reveal that women are more likely than men to live in poverty and are at a higher risk for hunger due to the discrimination they face in education, ownership of assets and healthcare. (UNIFEM, 2009: 20) Perhaps reflecting this fact, the UC Scheme enrolled population of the Central Region is also disproportionately female with 5,109,061 women and 4,738,312 men. (The National Statistical Office, 2008b: Table 1) Gender is a critical cross-cutting issue for all of the causes and manifestations of poverty and vulnerability in developing countries and disaggregated statistics must be included in any monitoring system for pro-poor healthcare.

Over 80% of the population interviewed were rural inhabitants, which is a key demographic group targeted by the UC Scheme as well as generally recognized even

in many developed countries as a group who face a high degree of socio-economic and health inequality. (Andrain, 1998: 223-226)

There have been large amounts of epidemiological research conducted that strongly and consistently demonstrate the importance of education, income, and occupation as social determinants of health. (Berkman & Kawachi, 2000: 22) Their importance as indicators of poverty and vulnerability are self-evident. In this study, 66% of those interviewed had completed a primary school level of education or less. In addition, 39% were unemployed, 21% were agricultural workers, and 32% had migrated within Thailand for work. The study respondents were also overwhelmingly low-income, with more than 72% of those interviewed having a household income of 10,000 baht per month or less (In 2007, the average household income for the Central Region of Thailand was 18,932 baht per month). (The National Statistical Office, 2008a: Table 34)

While age is often a neglected variable in sociological analysis, it can be just as meaningful as gender and ethnicity in establishing identity and social status and can be both a source of self-esteem as well as discrimination. Clearly many of the aspects of capability, often measured for the elderly as ADLs (Activities of daily living), are heavily affected by the aging process. In relationship to health and health systems, the association between age and a variety of chronic and disabling illnesses is well established and is seen as a major and emerging problem for service capacity and cost containment both in Thailand and globally.(Gabe, Bury, & Elston, 2004: 18-22) In this study, 29% of respondents were 60 years of age or over.

“Disabled people are so severely excluded from all areas of society that there is not even comparable or reliable data on incidence, distribution and trends of disability, let alone the extent of disabled people’s poverty. Despite this lack of comparable data there is plenty of anecdotal and more substantiated evidence to show that disabled people make up a large proportion of the world’s poorest.” “Recent World Bank studies contend that ‘half a billion disabled people are undisputedly amongst the poorest of the poor’ and are estimated to comprise ‘15% to 20% of the

poorest in developing countries'." (Yeo, 2001: 5-9) The demographic results for the study show that18% of all respondents reported being legally disabled.

50% of the professional respondents interviewed were nurses which reflects the heavy reliance on nurses for primary care in Thailand. The key informant interviews at the 6 field research hospitals revealed an average nurse to doctor ratio of approximately 10:1. For OECD Countries, the average ratio is 2.9:1. (OECD, 2007: 58) There is no international consensus about the optimum ratio to balance service quality with cost-effectiveness however.

Of those surveyed, 58% reported that they spent over 80% of their time on UC Scheme related duties and had been working at their current hospital for over 10 years. This shows a well-informed population of professionals in the study group to offer their opinions about the UC Scheme.

Individual Health

The results reveal a number of interesting facts about the individual health of UC Scheme beneficiaries. 71% of respondents stated that they had used the UC Scheme for over 5 years which demonstrates the importance of the program for those enrolled.

There was a fairly even distribution of responses between agreement and disagreement when respondents were asked if they were generally seen by the same doctors and nurses when they use the UC Scheme. It should be noted that it is not a generalized policy of the Scheme to assign an individual doctor to each patient however.

When asked about their personal health, 46% of respondents reported good or better health and 11% reported poor health. A more meaningful result was attained when respondents were asked about improvement in their health based upon using the UC Scheme. 86% of respondents agreed that their health had improved from using the UC Scheme, an impressive achievement which would seem to be highly attributable

to increased access to services. 100% of respondents agreed that the UC Scheme provides effective services for their medical problems, which reflects either a remarkable endorsement or an improper phrasing of the question.

The responses for what respondents would do for healthcare if the UC Scheme did not exist yielded some very interesting comments. While it may be somewhat of an outlier among the responses, the following comment was particularly arresting: “Use public hospital but would have to pay out of pocket which she cannot afford. Her daughter would likely have to sell their farmland which has belonged to the family for many generations. Even then they might not be able to afford her treatments.” This was the response of an elderly woman with type 2 diabetes which had already caused her to lose vision in one eye due to diabetic retinopathy. While the response was more dramatic than most, I think it reflects a common reality for many of the rural poor in Thailand which is that the family members of the chronically ill would suffer just as much financially as the patients themselves in the absence of a subsidized healthcare system. The opportunities and capabilities for the elderly woman’s daughter, who works in Bangkok, to escape from poverty and vulnerability are just as contingent on the UC Scheme as for the elderly woman herself.

To generalize about the frequency and character of responses, it appears that most would continue to use public hospitals in the absence of the UC Scheme which I suspect is largely due to familiarity and ease of access. It was not clear if the majority would still be able to afford this service if forced to pay the actual cost of care. Several respondents stated that they had been unable to access healthcare prior to UC due to the expense. However, the majority seemed to feel that they would still be able to afford to use the public hospital regardless. A fair number also reported that they would use private clinics which likely shows that they currently use public facilities out of financial need or ease of access rather than out of a concern for quality of care.

*Length of enrollment in UC Scheme * Working in Agriculture Crosstab*

All 100% of subjects surveyed who were employed in agriculture responded that they had used the UC Scheme for at least 3 years. This result demonstrates the

importance of the UC Scheme to many employed in the agricultural sector who make up a large proportion of the rural poor in Thailand.

*Length of enrollment in UC Scheme * Legally Disabled Crosstab*

The subgroup comparison showed that 90% of disabled research subjects had been enrolled in the UC Scheme for over 5 years. This reveals the importance of the UC Scheme to another critical demographic group within the poor and vulnerable population as the disabled often have both more medical needs and fewer options for healthcare than the general population.

*Length of enrollment in UC Scheme * Gender Crosstab*

The crosstab results showed that 86% of women had used the UC Scheme for over 3 years compared to 67% of men. This is likely due to the higher concentration of women employed in the informal sector, including work in unrecognized or "invisible" jobs that often go largely undocumented in official statistics. This includes not simply unpaid housework and caregiving but also frequently home-based remunerative work as well as work as street vendors and in agriculture.

While the relationship is not as simple as working in the informal sector and being poor or working in the formal sector and not being poor, there are important connections that can be made. Women are over-represented in the informal sector, which is the primary source of employment for women in most developing countries, and there is a higher rate of poverty among those working in the informal sector than in the formal sector. In addition, informal employment often lacks many of the crucial social protections of formal employment such as regular work, worker benefits, and of course, health insurance.(Chen, 2001: 71-82)

*Rating of overall health * Residence Crosstab*

Urban residents in Saraburi reported good or better health in 64% of responses compared with 42% of rural residents. However, when a comparison was made about whether their health had improved as a result of using the UC Scheme, the results did

favor rural inhabitants with 89% agreeing that their health had improved compared with 73% of urban inhabitants. This may indicate that while health status is still affected by place of residence in Thailand, the playing field is beginning to be leveled slightly.

Challenges and Accomplishments

The survey results for challenges and accomplishments of the UC Scheme display a snapshot of staff priorities for the program. 43% of respondents selected the financial concerns of insufficient budget and ineffective budget allocations as the biggest challenges for the UC Scheme services. The challenges that scored lowest were low quality of medicines and equipment and too much bureaucracy. Common threads running throughout the research for the professional staff were concerns that the UC Scheme is underfunded and that the money is not being allocated properly to address basic service concerns such as appropriate staffing levels.

The results for the biggest accomplishment of the UC Scheme for the poor showed that access to care was the most commonly selected choice with 34% of responses. This was followed by guarantee of medical care at 26% of the total. One perspective on these results is that the most frequent responses can be viewed as what the medical staff believes that the UC Scheme does best. Therefore, the other side of the analysis demonstrates what they believe that the UC Scheme does worst, which has been to improve quality of care at only 6% of the total. These are unsurprising results but expressive of the common understanding of what the UC Scheme has accomplished. Significantly improved access to care has been achieved under the UC Scheme but quality of care is still an issue that needs to be addressed.

Quality

According to the American Medical Association, “Quality is the degree to which care services influence the probability of optimal patient outcomes.” (Al-Assaf, 2001: 16) However, it is critical that measures of quality should be customer-oriented even when measuring medical outcomes. A major part of achieving quality in

healthcare is the result of meeting the needs and expectations of the patient. (Al-Assaf, 2001: 1)

The measures for quality used in this study were all input-based with the exception of overall quality which was left to the subjective interpretation of the respondent. The results for the queried aspects of quality in the study were more diverse, and therefore more meaningful, for professional responses. In all 4 categories of quality, beneficiaries rated the UC Scheme higher than professionals, even in the quality category of the professionals themselves. The quality of medicines for the UC Scheme was rated good or better by 54% of professionals and 83% of beneficiaries. The quality of medical facilities was rated good or better by 58% of professionals and 74% of beneficiaries. The quality of medical professionals was rated good or better by 81% of professionals and 86% of beneficiaries. Overall quality for the UC Scheme was rated to be good or better by 62% of professionals and 89% of beneficiaries.

While the stricter ratings by professionals are not all that surprising based upon their higher level of knowledge about modern healthcare standards, it must be said that overall the results for UC Scheme quality came out far better than expected. Even in the category of quality of medicines, a notorious issue for the UC Scheme, only 4% of both professionals and beneficiaries rated the medicines to be of poor quality.

The results of the open-ended question about how to improve the quality of the UC Scheme yielded mostly staffing related suggestions from the professional responses. Improving capabilities and increasing the quantity of staff seemed to be the highest priority for many. A critical case response received for this concern was “Increased capability at the primary care level to limit the need for secondary and tertiary care.” An increase in education about health promotion and disease prevention to prevent overuse of facilities was the second most common response for suggested improvements. The beneficiary responses to the question were quite varied with little duplication of suggestions. Several responses did mention quality of medicines as a necessary improvement. One of the most thought provoking comments was related to

speed of service: “Service should be faster. The system is too slow and they often have to wait a long time. They sometimes just have to use private clinics even though they have to pay because daughter has limited time to take her mom to the hospital.” This comment raises the concern that although the UC Scheme may be free and accessible to all, if the time demanded for accessing services becomes too long, patients may give up on public health facilities and utilize private sector services despite the cost.

*Rating of overall quality of services under the UC Scheme * Occupation Crosstab*

The division between doctors’ and nurses’ interpretation of overall quality appeared very distinct with 100% of doctors rating the quality as average or worse and 85% of nurses rating quality as good or better. This demonstrates the importance of getting the opinion of different occupational subgroups about the quality of the UC Scheme which may vary considerably due to differences in experience.

*Rating of quality of medical facilities under the UC Scheme * Hospital Crosstab (Beneficiaries)*

The highest score for quality of facility was received by Saraburi Hospital with 93% rating the hospital good or better. It appears that although the UC Scheme was meant to strengthen local district hospitals, provincial hospitals are still recognized as much higher quality facilities by many beneficiaries.

*How would you rate the quality of medical facilities provided under the UC Scheme? * Residence? Crosstab*

The crosstab results revealed that there is a significant division between urban and rural inhabitant ratings, with 91% of urban residents rating their facilities good or better and 69% of rural residents rating their facilities good or better. This implies that the quality divide in facilities for urban and rural residents likely still exists.

*Rating of quality of medical professionals under the UC Scheme * Education Crosstab*

The comparison of subgroups shows that those with a lower level of education tended to give a higher rating for the quality of medical professionals. 100% of those with no education or primary school only rated UC Scheme medical professionals good or better whereas only 50% of those with a post-secondary education did so. A similar relationship was also found for those with an income below 10K baht per month, who gave a significantly higher rating to UC medical professionals than those an income over 10K (93% and 67% respectively). This could be due to a more limited range of experience with medical professionals or just simple gratitude for effective services provided to those with fewer options for healthcare.

*Rating of overall quality of services under the UC Scheme * Legally Disabled Crosstab*

Legally disabled respondents gave a significantly higher overall rating of quality than the non-disabled with 70% rating services as very good quality compared with only 37% of the non-disabled survey population. Disabled patients do appear to receive special attention at hospitals based on the care that was witnessed during observation and statements made by research subjects in the survey results.

Equity

According to the WHO Commission on Social Determinants of Health (CSDH), "Access to and utilization of health care is vital to good and equitable health. The health-care system is itself a social determinant of health, influenced by and influencing the effect of other social determinants. Gender, education, occupation, income, ethnicity, and place of residence are all closely linked to people's access to, experiences of, and benefits from healthcare." (2008: 8) As examined during the literature review, comparative analysis of the income distribution between the CSMBS and the UC Scheme reveal significant differences. While the poor are the majority of beneficiaries registered under the UC Scheme, over half of the enrollment for the CSMBS is comprised of the wealthiest quintile of the population. (Kanchanachitra, 2006: 23) Therefore, establishing and maintaining equality of benefits between coverage schemes must be a priority for health equity in Thailand.

The results for equity related questions revealed a wide variety of opinions about the comparison between the 2 coverage schemes. A fairly even distribution of responses was received about the equity of the schemes, with a slightly higher number of both professionals and beneficiaries responding in agreement that that they felt the schemes were equal in quality (54% and 43% respectively). For those who disagreed about the equity of the 2 schemes, the responses of professionals about how to make them equal included comments about including private rooms, higher quality of medicines and choice of hospitals for UC Scheme members. The beneficiary responses addressed similar concerns including choice of hospitals, private rooms, and improved quality of medicines as well as faster service for the UC Scheme. There were some responses from both professionals and beneficiaries that they actually felt the UC Scheme was superior due to the lack of advance payment required.

When asked if they would switch to the other scheme if they had the opportunity, 38% of beneficiaries and 12% of professionals stated they would like to switch, meaning that the majority for both subject types preferred not to switch. When asked why they would want to switch schemes, professionals mentioned lack of advance payment, and medical equipment being covered by the UC Scheme as reasons. The top three reasons for beneficiaries wanting to switch were better benefits, better service and care, and wanting to be able to use any hospital. One response that was somewhat of an outlier but not that unlikely given the amount of money brought in to hospitals by the CSMBS was simply "Feels that civil servants get treated better."

When asked about the equity of medical care provided under the UC Scheme between the rich and the poor, the overwhelming majority of both professionals and beneficiaries stated that the care provided was equal (81% and 91% respectively). For the small number of those who responded that the care provided is not equal, professionals stated that the rich still have more options, receive better treatment and that sometimes the poor are not confident about using UC Scheme services. By far the most information-rich case for beneficiaries was "If you are willing to pay, you can receive lab test results faster. You can pay 500 baht under the table to the lab tech and get your results in 2 hours instead of 2-3 days." It should be pointed out that this

response was uncorroborated by any other data gathered during the research. Another beneficiary respondent stated that “Quality of medicine is worse for the poor”.

*The services under the UC Scheme are the same quality as under the CSMBS * Percentage of work hours spent on UC Scheme Crosstab*

Based upon the comparison of subgroups, it appears that those who spend more of their time working on the UC Scheme are more likely to believe that the 2 schemes are of the same quality with 60% of those who spend 80% or more of their time on the UC Scheme agreeing and 0% of those who spend 20-50% of their time on UC agreeing. However, those who spent 80% of their time on UC were only 7% more inclined to want to switch schemes themselves which calls into question the authenticity of the responses to the previous question somewhat.

*The services under the UC Scheme are the same quality as under the CSMBS * Residence Crosstab*

The crosstab results showed that rural inhabitants were more likely to disagree that the schemes are equal than urban inhabitants (29% and 9% respectively). This is an interesting finding since there are also far fewer CSMBS enrollments in rural areas. Whether this is based upon speculation or actually witnessing better quality care is unclear.

*Would switch to the CSMBS if possible * Working in Agriculture Crosstab*

A 58% majority of those working in agriculture responded that they would like to switch schemes compared with a 32% minority of those working in non-agricultural occupations. Why most agricultural workers want to switch could be the result of an association between the CSMBS and higher social status for agricultural workers that is not as strong for industrial workers.

*Would switch to the CSMBS if possible * Number of Children Crosstab*

The subgroup comparison yielded an interesting result as 65% of households with 0 children responded that they would like to switch and the percentage decreased steadily as the quantity of children in the household increased. All 100% of those households with 4-6 children responded that they would not want to switch schemes. This is perhaps an issue for further study as to why beneficiaries with children believe that the UC Scheme is better for them.

*The poorer users of the UC Scheme receive the same medical care as those with more money * Working in Agriculture Crosstab*

The subgroup comparison yielded discouraging results for the UC Scheme as those working in agricultural frequently are lower income households and were significantly more likely to believe that those with a lower income do not receive the same quality of care. (25% compared to 4%).

Targeted and Appropriate

Making a gender-informed analysis of pro-poor healthcare means considering the broader context of social and economic relations between men and women in society, and probing what the impact of those inequalities of power and economic resources have on the health of both women and men. (Gabe, et al., 2004: 8-13)

More women than men rely on the UC Scheme for healthcare partly due to higher levels of employment in the informal sector as well as unrecognized and unremunerated work as caregivers and homemakers. The UC Scheme needs to provide services that actively engage with the specific needs of women rather than just presume that providing services to all will be inclusive of women's health needs.

When asked whether the UC Scheme does as good a job of providing the services needed by women as for men, 96% of professionals and 79% of beneficiaries agreed that it does. When the beneficiary responses were disaggregated by gender, 83% of women and 72% of men agreed that UC does as good a job for women. Certainly a positive result although the question is quite broadly evaluative and does

not highlight the specific health concerns of women. For those who disagreed and were asked how to improve UC services for women, the only response was from a professional who suggested increased promotion of pap smear testing.

While popular support in society tends to express a very serious commitment towards taking care of the health of ill children, whatever the cost, similar commitment to funding services for the elderly can at times be lacking or full of qualified sentiment. There is little doubt that arguments of the supposedly high cost of providing hospital services to the elderly and such issues as "blocked beds" due to providing care to them are entangled with a degree of age-discrimination. (Gabe, et al., 2004: 20-21) It is important to acknowledge this tendency both in the healthcare establishment and in society as a whole in order to provide non-discriminatory care to the elderly.

The survey results showed that 96% of professionals and 85% of beneficiaries agreed that the UC Scheme does as good a job of providing care to the elderly as it does for younger adults. When the beneficiary results were delimited into age groups, 93% of those under 60 agreed and a complete 100% of those 60 or over agreed that the services for the elderly are as good. It should be pointed out that culturally, the elderly are highly respected in Thailand, and this was reflected in the care witnessed at hospitals during the research.

In recent years, many disability activists have attempted to challenge the medicalization of disability as an epidemiological consequence and argue that the concept of disability is essentially the result of social oppression and discrimination. While accepting the physical reality of impairment caused by illness or trauma, the inability to actively participate in the social or economic life of society is the function of barriers established by that society, both physical and social. Medicalizing the concept only justifies and reinforces those barriers. (Gabe, et al., 2004: 79-81)

In their survey responses, 96% of professionals and 75% of beneficiaries agreed that the UC Scheme does as good a job of providing services to the disabled as to the non-disabled. When the beneficiary responses were divided into legal disability

status, 74% of the non-disabled and 80% of the disabled agreed that the services for the disabled are as good. It was repeatedly mentioned by both beneficiaries and professionals that disabled patients are allowed to skip the queue to see a doctor and that special staff are assigned to look after their needs.

"Within countries, the differences in life chances are dramatic and are seen worldwide. The poorest of the poor have high levels of illness and premature mortality. But poor health is not confined to those worst off. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health." (Commission on Social Determinants of Health, 2008: Exec Summary) The connection between poverty and poor health has been well established by the health research community. The health of different groups within society is closely linked to their social and economic status. This was an explicit concern supporting the UC Scheme policy formation.

When asked whether the UC Scheme does as good a job of providing the services needed by the poor as by the rich, 96% of professionals and a complete 100% of beneficiaries agreed that it does. When the responses were divided into low income (below 10,000 baht per month household income) and non-low income categories, 49% of low income and 60% of non-low income respondents strongly agreed that the services are as good for the poor as for the rich.

"Policies and investment patterns reflecting the urban-led growth paradigm have seen rural communities worldwide, including Indigenous Peoples, suffer from progressive underinvestment in infrastructure and amenities, with disproportionate levels of poverty and poor living conditions." (Commission on Social Determinants of Health, 2008: 60) Rural areas throughout the world, and in Thailand specifically, are often where poverty is most concentrated. As of 2004, 86% of the poor in Thailand were residing in rural areas. (Office of the National Economic and Social Development Board, 2006: 3)

When asked whether the UC Scheme does as good a job providing the services needed by rural inhabitants as by urban inhabitants, 85% of professionals and

80% of beneficiaries agreed. When the beneficiary results were divided by residence type, 86% of rural inhabitants and a full 100% of urban inhabitants agreed that the services are as good. While these figures are slightly lower than for the other targeted and appropriate questions, the differences are not very significant. When asked an open-ended question about how the UC Scheme can provide better services to rural inhabitants, the only professional response offered no solutions but admitted that "There are still differences in access to healthcare for rural people." The beneficiary responses emphasized that rural hospitals are not as good quality as urban hospitals and that the UC Scheme relies heavily on referral to the provincial hospital for specialized care which is generally not available at rural hospitals.

Despite policies intended to decentralize control of the UC Scheme, most of the decision making about management of the program still occurs at the national level and this includes decisions about additional investment for targeting of specific illnesses. However, in response to the question of whether the UC Scheme offers services that address the major health concerns in the community, 88% of professionals and 86% agreed that it does. When asked an open-ended question about what health concerns still need to be addressed in the community, one professional response was particularly compelling: "The UC agenda is set at the national level and not at the local level. It is possible to write to the NHSO for additional funding to target a specific disease in the community but this is a difficult process." The only beneficiary response repeated the often stated opinion that "The quality of medicines is not good enough. They often prescribe paracetamol or other cheap medicines that are less effective."

*The UC Scheme does as good a job of providing services needed by rural inhabitants as by urban inhabitants * Hospital Crosstab*

The results of the crosstab were actually not all that different by hospital, although it is interesting to see where the divisions lie. Two rural hospitals, Kaeng Khoi and Wihan Daeng, both had fairly significantly lower levels of agreement with the question than the survey average (57% for both compared with an 80% survey

average). Whether this was in response to the services provided at the hospitals or simply a stronger rural community spirit in those districts is unclear.

*The UC Scheme services address the major health concerns in your community * Residence Crosstab*

The subgroup comparison shows that rural residents were actually significantly more likely to agree that the UC Scheme addresses the health concerns in their community than urban residents (91% and 64% respectively). Perhaps this is due to the lack of total coverage for traffic accidents under the UC Scheme which are likely more prevalent in urban areas.

Barriers to Care

"Barriers to health care are obstacles within our health care system that prevent vulnerable patient populations from getting needed health care, or that cause them to get inferior health care compared to advantaged patient populations." (American Medical Students Association, n.d.).

While providing access to healthcare for the entire population is a huge accomplishment for Thailand, it must be acknowledged that just theoretically providing care to all is not the same as operationalizing a program that meets their practical needs. The poor and vulnerable in Thailand often face additional obstacles when accessing care that must be addressed in establishing an efficient and effective system for universal healthcare.

Even though the UC Scheme is intended to provide inclusive rather than exclusive services, targeted program design is still needed to facilitate access and overcome obstacles to care that are frequent among the poor such as social, linguistic or educational. This ensures that benefits accrue to poorer people rather than the most problem-free populations to provide services to. If services are provided that do not address these types of barriers there is a significant risk of exacerbating differentiation between rich and poor during service provision.

When asked whether the waiting time to receive services was a major obstacle to seeking healthcare, 58% of professional and 36% of beneficiaries agreed that it is. It was an interesting finding that the majority of beneficiaries were willing to accept the queue times whereas the majority of professionals agreed that it is a barrier. At least partly, I believe this can be attributed to the culture of Thailand, which places a high value on accepting situations which are beyond your ability to control. Keeping a "Cool heart" is considered a highly desirable personality trait. Another explanation for this result may be due to the fact that many beneficiaries feel such gratitude to the UC Scheme for providing free healthcare that a waiting time for services is a completely acceptable tradeoff.

When beneficiaries were asked whether they are able to access healthcare at a convenient location, 91% of rural inhabitants and a full 100% of urban inhabitants said that they were able to. This is a very good result for the UC Scheme, and implies that the decades of investment that have gone into the rural health infrastructure in Thailand have been effective at increasing physical access to healthcare.

When beneficiaries were asked how long it takes them to access services including transportation time, waiting time, and treatment, the most frequent response for both urban and rural inhabitants was 1-3 hours. Surprisingly, the results strongly favored rural inhabitants overall which appears to be due to long waiting times at busy urban hospitals. 36% of urban inhabitants and 13% of rural inhabitants reported that it takes them 4-6 hours to access services. 0% of urban inhabitants and 11% of rural inhabitants reported that it takes them less than an hour to access services, all of which was due to a very short waiting time at the smallest rural hospital visited, Don Phut.

When beneficiaries were asked if they would be willing to pay more out of pocket if it meant not waiting as long to receive services, 80% of the total responses stated that they disagreed with the solution and the results were not significantly different between income groups. Clearly, waiting is less of a barrier to the vast majority than is paying out of pocket.

When beneficiaries were asked what the biggest obstacle for them to use UC Scheme services is, there were 3 responses that came out as clearly the most critical obstacles. 30% chose time away from their family, 26% chose cannot be away from work, and 21% chose transportation. While transportation and time away from work were fairly predictable responses, it was slightly surprising that that the number one response was actually time away from family. Searching for a cultural explanation, the heavy importance placed on family in Thailand is well-known, and particularly for women, time away is likely a major difficulty.

When subjects were asked whether the UC Scheme excludes or is not welcoming to any groups in the community, 12% of professionals and 7% of beneficiaries responded yes. When asked to identify the groups, the professional responses highlighted that the homeless and other Thai citizens with no ID cards are excluded. One beneficiary also stated that “Older poor people who have difficulty getting to medical facilities” are excluded.

The problem of the homeless and those with no ID cards being excluded from the UC Scheme was an issue that came up several times during the interviews and surveys. Presumably, the homeless are excluded because they have no ID to prove that they are Thai citizens. Excluding these groups certainly puts the Thai Government in a difficult ethical position however. While it is understandable that the government wants to limit the program to Thai Nationals with ID cards as proof of citizenship, it must be pointed out that the existence of Thai citizens with no ID cards is partly an administrative failure of the government itself. The situation would seem to call for a more tactful and generous response by the government than outright exclusion. In practical terms, we were informed that these groups are rarely denied services and often become charity cases for the hospitals or social service organizations.

When professionals were asked if they think that UC services are easy to use for patients with a low educational level, 89% responded yes. When asked why they were not easy to use for those who responded negatively, the only professional

response was that “Sometimes the very poor and less educated patients are not confident and comfortable when accessing healthcare”. When beneficiaries were asked if they found the information given to them about the UC Scheme easy to understand, 84% responded yes. When the results were divided by educational level, there was a very steady decline in understanding from 100% of those with a post-secondary education, to 67% of those with no formal education. For those who responded that they found the information confusing, the reasons stated were a lack of information or conflicting information given by staff. One respondent observed that “Many are not fully informed about UC, especially the elderly”.

When asked about whether the referral process to see a specialist should be easier, more difficult, or remain the same, the majority of both professionals and beneficiaries felt that it should remain the same (54% and 85% respectively). However, a full 43% of professionals and only 15% of beneficiaries thought that referrals should be easier. This suggests that the burdens of the process fall more on the medical staff than on the beneficiaries themselves.

The Thai population has a high level of internal migration, particularly among younger workers who often relocate to urban areas for employment opportunities. This includes a large number of the rural poor. The UC Scheme should provide help in facilitating access to services for beneficiaries who move away from their registered PCU to ensure that the program is empowering to the poor rather than an obstacle to seeking a better life.

When beneficiaries were asked if they were aware of how to change their registrations for the UC Scheme if they were to move, 59% responded yes. There was no distinct difference in responses between those who had already migrated for work and those who had not. When beneficiaries were asked if they found the process easy, 4% replied no, 9% replied yes, and the vast majority replied that they had never had to re-register. It is likely that the amount of those who know the actual process for changing their registration may actually be lower than self-reported which is a concern for urban areas like Bangkok that receive a lot of internal migrants.

When professionals were asked how often ability to pay for services is still an obstacle for patients to access services, there was a fairly even distribution of responses with “Rarely” the most common at 39%. When asked which conditions or treatments are most often the cause of inability to pay, using the Scheme’s services improperly was the most commonly stated reason. Car accidents, cancer, HIV, and diabetes were all medical causes mentioned, as well as food, medications, and transportation. Transportation costs were a recurrently mentioned problem for poor patients at rural hospitals during the research, an issue which is monitored on the health system level by the TNSO in their annual health and wellness survey but not necessarily specifically for the UC Scheme or for poor and vulnerable demographic groups.

*Amount of time to access services under the UC Scheme including transportation time, waiting time, and treatment * Hospital Crosstab*

The subgroup comparison results showed significant variation between hospitals. It was interesting to note that the longest average waiting time for accessing services was at the largest urban hospital in the study at 4-6 hours and that the shortest time was at the smallest rural hospital at 1-3 hours. This may show that the redistribution of resources from larger urban hospitals to smaller rural hospitals under the UC Scheme is not always beneficial to the poor.

*Biggest obstacle is cannot be away from work * Income over 10K Crosstab*

Surprisingly, the crosstab results show that those with a household income of over 10k per month were more likely to say that they could not be away from work whereas the assumption would be that those with a lower income would not be able to afford the time off. Possibly unemployment for those who reported a lower income accounts for some of this result.

*Biggest obstacle is time away from family * Gender Crosstab*

This was the most frequently cited obstacle for using the services of the UC Scheme, however the subgroup comparison does not show as significant a divide along gender lines as was anticipated (37% and 19% respectively). Interestingly, income over 10K also proved to have a significant effect on choosing this obstacle, with those making over 10K more likely to state that time away from family was a problem. It is possible that this was a sentimental rather than functionalist response however. Unsurprisingly, both larger number of children and fewer number of parents in the household proved to significantly increase the chances of choosing time away from family as an obstacle.

*Biggest obstacle is unpleasant treatment at facility * Hospital Crosstab*

While it would not be ethical to name the hospital given the unreliability of the test due to small sample size, 80% of all of the respondents who chose unpleasant treatment as the biggest obstacle were from a single hospital location. Given that benefiaries have no option to use a different facility, the responsibility falls upon individual hospitals to be vigilant about maintaining a high standard of customer service.

*Changing your registration to a new facility for the UC Scheme was an easy process * Residence Crosstab*

While the crosstab results did not reveal a particularly meaningful difference between urban and rural residents for finding the re-registration process easy, the more notable result was that it was overwhelmingly urban residents who had experienced the process at all at 86% of the total. This may be attributable to the very large number of Thai citizens who relocate from rural to urban areas for work.

Participation, Empowerment, Accountability, and Community Development

"Community participation in health has traditionally been defined according to one of two distinct perspectives. Firstly, it can be a utilitarian effort on the part of donors or governments to use community resources (Land, labor, money) to offset the

cost of providing services. On the other hand, participation can be viewed as an empowerment tool through which local communities take responsibility for diagnosing and working to solve their own health and development problems. This can be described as the empowerment approach, or people-centered development." (Morgan, 2001: 221-222) This second approach is essentially the concept of participation, empowerment, and community development that what was addressed during the research. According to the WHO, some of the benefits of social empowerment strategies in community health can include "Increasing citizens' access to information and resources, raising the visibility of previously ignored health issues, developing the consciousness, self-identity, and cohesion that underlie social action, and involving population groups in priority-setting for planning." (Commission on Social Determinants of Health, 2008: 96-97)

When asked whether they thought beneficiaries should have more voice in how the UC Scheme services are provided in their community, 81% of professionals and only 41% of beneficiaries agreed. This was an interesting divide in responses which shows that while community participation always sounds like it will be a great benefit to the community as a whole, getting individual members to participate is often a significant challenge. When those who agreed that beneficiaries should have more voice were asked an open-ended question about what community interests they think are currently being ignored, some of the professional responses included more doctors, more mental health professionals, choice of hospitals, waiting time and that beneficiaries should have been more involved from the beginning of policy formation." Beneficiary responses mentioned choice of hospitals as well but most answers focused on what the normative approach for participation should be including: "All people should have a chance to give their opinions. As a community, we should brainstorm our ideas and the health officer should listen and help to translate the ideas into practical terms." "Feels that the poor are the majority in Thailand and that it is very important for them to be able to express their opinions and ideas."

Health is one of the most basic and essential services provided in any community. The UC Scheme provides an opportunity to create a culture of mutual aid within local communities, where community members can participate in decision making that benefits the community as a whole and emphasizes the needs of the most vulnerable members. When asked whether the UC Scheme has helped the poor people of the community to have more control over their own lives, 77% of professionals and 95% of beneficiaries agreed that it has. When asked an open-ended question about how the poor have more control over their lives, the professional responses were very focused on the poor being able to access healthcare at no cost. Another professional stated that “Health promotion and disease prevention education has helped to empower the community.” Beneficiary responses were more varied but no less focused on essential questions: “Before UC many poor people had difficulty getting healthcare” and “I feel safer because I can access emergency treatment at any time for no cost.”

When beneficiaries were asked whether their doctor explains their condition and treatment options clearly and involves them in decision making, 68% agreed that they do. A positive result overall, although perhaps one that needs to be unpacked to show exactly what level of explanation and involvement is actually occurring between doctors and beneficiaries in the UC Scheme given the shortness of time available for examinations.

“At its most general, accountability is about individuals who are responsible for a set of activities and for explaining or answering for their actions. Accountability therefore entails procedures and processes by which one party provides a justification and is held responsible for its actions by another party that has an interest in the actions.” (Emanuel & Emanuel, 1996: 2) Accountability in the context of healthcare is critical for establishing the legitimacy of the management, service provision, and financing of the UC Scheme. Mechanisms need to be put in place to ensure that the UC Scheme remains accountable to the needs of the frontline stakeholders in the UC Scheme. This means not only participation in management of the scheme as mentioned previously but practical and effective means for addressing grievances

such as poor service quality or unfair workload burdens placed upon the human resources of service providers. The funding decisions and management of the UC Scheme should be a fully transparent process to ensure beneficiary and service provider confidence in the program.

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

When asked whether the UC Scheme is too bureaucratic and not accountable enough to patients and medical professionals, the majority of both professionals and beneficiaries disagreed with the statement (50% and 59% respectively). This was a somewhat surprising result for professionals given the strong sentiment expressed about mismanagement of resource allocations but it is possible that many respondents had a negative reaction to the characterization of the UC Scheme as bureaucratic.

When beneficiaries were asked if they had ever made a formal complaint about services received under the UC Scheme, 100% responded that they had not. However, according to the professional staff, a large volume of more informal complaints are made by UC beneficiaries. The results bring up concerns about what the procedure for making an official complaint is and if beneficiaries are made aware of the how to do so.

When beneficiaries were asked if the UC Scheme had given them more control over their own health, 93% responded in agreement. When asked an open-ended question about in what way it has given them more control, the responses focused on the positive impacts of the health promotion and disease prevention programs and the ability to access healthcare when needed without being concerned about the cost. Several beneficiaries mentioned that they were better able to control

diabetes as a result of more frequent medical care. One beneficiary even stated that "The hospital determined that he had cirrhosis of the liver and convinced him that he had to take better care of himself by giving up drinking." This is certainly a good example of encouraging empowerment over personal health.

When professionals were asked if the UC Scheme has improved the healthcare options available to the poor, 92% agreed that it had. When asked an open-ended question about how the UC Scheme had improved the healthcare options of the poor, there was a very strong focus in responses on the increased access and affordability of healthcare under the UC Scheme. One response specified that "Cancer care is available which was previously unaffordable to the poor." As has been demonstrated already, access and affordability are clearly the two major successes of the UC Scheme.

*The doctors under UC explain your condition and treatment options clearly and involve you in decision making * Hospital Crosstab*

The subgroup comparison revealed significant differences between the levels of patient involvement at the hospitals visited. Perhaps unsurprisingly, the two hospitals with the lowest ratio of doctors to outpatients served were the hospitals where patients felt less involved in decision making with 43% and 25% agreement compared with a survey average of 68%. This is an important aspect of service quality that is heavily affected by the short staffing at many hospitals under the UC Scheme.

*Beneficiaries should have more voice in how the services of the UC Scheme are provided in their community * Hospital Crosstab*

Based on the crosstab results, there are distinct differences in how much patients want to participate in decision making about the UC Scheme by hospital. Patients at one hospital were in 83% agreement with the need for increased participation whereas patients at another hospital were in 100% disagreement. It appears that some hospitals are doing a better job of encouraging beneficiary involvement than others.

*The doctors under UC explain your condition and treatment options clearly and involve you in decision making * Gender Crosstab*

The results of the subgroup comparison showed that women actually felt more involved in decision making with their doctor than men (77% and 52% respectively). This is a very encouraging result as historically women have often been largely shut out of involvement in decisions about their own health.

Economics

"Health economics is defined as the branch of economics which deals with the provision of healthcare services, their delivery, and their use, with special attention to quantifying the demands and measuring outcomes for such services, the social, financial, and opportunity costs of such services, and of their delivery, and the benefits obtained. More emphasis is given to the costs and benefits of healthcare to a population than to the individual."(Academy Health, 2003: 4) While employing the theories and tools of health economic research to determine pro-poor quality for the UC Scheme is not the objective of this research study, the importance of health economic concepts for evaluating the UC Scheme is self-evident and should be included as a part of the monitoring package.

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

When professionals were asked whether the UC Scheme does a good job of protecting the poor from the risk of high expenses created by a serious illness, 96% of professionals agreed that it does. When beneficiaries were asked the same question about themselves, 93% agreed. Again, this result concurs with the conclusions of the

economic analysis that has been completed on reduction of catastrophic health expenditures under the UC Scheme.

When research subjects were asked if they feel that the economy of the community has improved as a result of the UC Scheme, 54% of professionals and 91% of beneficiaries agreed that it has. It is difficult to account for the different response between professionals and beneficiaries on this question, although one would assume that professionals answered from a broader community-wide perspective and that beneficiaries gave more consideration to the economic status of themselves and those close to them when formulating their responses. Attribution of economic development as a result of the UC Scheme is quite difficult to prove convincingly although it is an important impact related to health status improvements in the community.

When asked whether the UC Scheme has benefitted the poor in the community more than the rich, 85% of professionals and 82% of beneficiaries agreed that it had. The percentage of beneficiaries who strongly agreed with statement was nearly twice the amount of professionals. When asked to explain how the UC Scheme has or has not benefitted the poor in the community more than the rich, the most frequent professional response was that there has been equal benefit to all under the UC Scheme. However, many professionals also made comments similar to the following: "The rich could afford healthcare before but now the poor can as well." The two most frequent beneficiary responses were "Equal benefit to all" and "The poor have more access to healthcare." A response that is likely representative of the situation for many of the poor was: "Before UC she often had to buy medicine and treat herself because she could not afford to go to the hospital." A reduction in un-medically supervised self-treatment, at least for more severe illness, is definitely a positive health system impact of the UC Scheme.

Right to Healthcare

"(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, medical

care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.” ("Universal Declaration of Human Rights," 1948: Article 25) While the universal declaration of human rights established the right to healthcare over 60 years ago, the actual effect of the declaration on healthcare provision in many parts of the world, even in industrialized nations such as the United States, has often been somewhat limited.

The right to healthcare in Thailand was first established legislatively in the constitution of 1997, which declared that citizens of Thailand had the “Right to receive health care in an equal, universal, and equitable manner.” (Bureau of Policy and Strategy, 2008b: 23) However, it was not until the enactment of the National Health Security Act on November 18, 2002 that a practical policy, both establishing the universal right and providing the mechanism for guaranteed healthcare, was put into place. (Bureau of Policy and Strategy, 2008b: 403)

The UC Scheme was established with the understanding that it would ensure the right of all Thai citizens to healthcare and health security. However, research has shown that the poor sometimes face discrimination in accessing services, particularly at private facilities that provide services under the UC Scheme. Regular monitoring of discrimination at healthcare institutions under the Scheme is an important part of guaranteeing this right.

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

When beneficiaries were asked if they have ever had an experience where they felt that their rights were not respected when using the UC Scheme, 13% responded that they had. When asked to describe these experiences, the majority of responses

were related to staff acting impolitely. A more troubling response was provided by one beneficiary who stated that she "Was told that she could not get the medicines she needed for diabetes because they are not covered by UC." While the details of the situation are not available, it is true that some imported medications are not covered by the UC Scheme. Generic national brands from the essential drug list are used as a substitute in most cases.

When beneficiaries were asked if they feel that they are treated with dignity and respect when using the UC Scheme, 98% of respondents agreed that they are. Rephrasing the question to include professionals and depersonalize the response for beneficiaries, when asked if they feel that poorer patients are treated with an equal amount of dignity and respect as those with more money when the using the UC Scheme, 89% of professionals and 98% of beneficiaries agreed that they are. Apparently, despite several complaints of impolite behavior by beneficiaries in different sections of the research, the overall feeling is a high level of contentment with the treatment received. Given the generosity and kindness witnessed throughout the field research between staff and patients, this was not a surprising result.

*Patients are generally aware that they are guaranteed the right to healthcare in Thailand * Hospital Crosstab*

The comparison of subgroups showed that the patients at 2 of the hospitals in the survey were apparently less informed about their right to healthcare (86% compared with 100% at all other hospitals in the survey). Although the sample size limits drawing any broad conclusions, this may indicate the need for greater outreach activities in some districts.

Medical Staff

"Rapid economic growth and a government investment policy started in the late 1980s to support private hospital investment with a free flow of low-interest foreign loans resulted in a rapid growth of the private health sector in the past decade (1988–1997). This situation created a second period of brain drain, but this time it was

internal brain drain from the rural district and provincial hospitals to the rapidly growing urban private hospitals.” (Wibulpolprasert & Pengpaibon, 2003: 5) In fact, a regular pattern of internal human resource shifting has developed within the health system of Thailand. During economic downturns, flight to the relative stability of the public sector has occurred whereas during growth, migration towards higher paying and lighter workload jobs in the private sector has taken place.

When asked if they felt that the staff at their facility is overworked as a result of providing services for the UC Scheme, 69% of professionals agreed. Not an unexpected result but nevertheless an alarmingly high total. When asked if they had ever made a formal complaint about the heavy workload, 15% of professionals stated that they had. When asked an open-ended question about what the result of the complaint was, all responses were that nothing had changed or that there was no response. A professional who sounded like he was speaking from experience stated: “No response. The ministry seems to be more interested in patient concerns than staff concerns.”

When asked if they felt that the medical staff has adequate time to treat their patients even with the heavy workload, 77% of professionals agreed. Apparently, the staff feels that the heavy workload does not impact the quality of care provided severely, although there were some stories about lack of thorough examination or insufficient diagnostic testing revealed during the course of the research.

When asked if they have any medical concerns with the services provided under the UC Scheme, the majority of professionals answered no at 54% of the total. However, when divided by occupation, it is clear that it was overwhelmingly administrators and nurses who had no concerns about the medical care provided. In fact, 100% of the doctors, dentists, and pharmacists interviewed expressed that they had medical concerns about the UC Scheme. When asked an open-ended question about what their medical concerns were, most responses were related to the heavy workload or insufficient funding for the UC Scheme. One response stated that “Car accidents are not covered by UC which causes problems.” Another respondent

brought up the moral hazard argument that the UC Scheme "encourages people to be less responsible for their own health." It remains unclear if this frequently stated perception of increased recklessness has basis in reality or has become an urban legend among the public health staff in Thailand.

When asked if they had ever considered switching to work fulltime in a private hospital or clinic, 27% stated that they had considered it. The totals were dramatically higher for dentists and doctors who were asked this question, with the majority of both replying that they had considered switching, however far fewer dentists and doctors were available for survey which may skew the statistics. When asked an open-ended question about why they chose not to switch, notable responses included "Don't want to only treat rich patients" and "Realizes that if he switches to a private hospital, the other doctors at the hospital will have an added burden." The most heartwarming response to the question was definitely: "Does not want to leave the HIV positive patients that she works with."

*Have medical concerns with the services provided under the UC Scheme * Percentage of work hours spent on the UC Scheme Crosstab*

The subgroup comparison showed that those who spent more time working on the UC Scheme had a higher chance of reporting that they had medical concerns with the services provided. 67% of those who spent more than 80% of their time on the UC Scheme reported medical concerns, whereas only 18% of those who spent less of their time on the UC Scheme reported concerns. This obviously raises some worries about the medical soundness of care under the UC Scheme as those who have more practical experience with the program are less confident in the medical care being provided.

Importance Scale

"It is important to acknowledge limitations to professional knowledge as well as to respond to inequalities in health; through citizens' juries, user consultation panels, focus groups, questionnaire surveys and opinion surveys, local knowledge can

be used to effect such a response."(Jordan, Dowswell, Harrison, Lilford, & Mort, 1998: 1668)

There are some obvious limitations in the data generated by asking respondents to rank each of the above issues for the UC Scheme from 1-5. No background information was provided to respondents about the issues and there was no opportunity for community deliberation to shape the larger response. However, the results still reveal an interesting set of priorities for staff and beneficiaries of the UC Scheme.

The 3 issues ranked highest for professionals were:

1. More funding for services
2. Ensuring the right to healthcare for all citizens
3. Patients are treated the same regardless of income

The 3 issues ranked highest for beneficiaries were:

1. Services designed for the health needs of the poor and vulnerable
2. High quality medical facilities
3. High quality medicines

For professionals, the top priority is more funding for services and that message was repeated throughout the research. The staff at public hospitals in Saraburi Province overwhelmingly expressed that the UC Scheme is underfunded and critically needs additional financing to provide the necessary services. It is notable that although the capitation rate for the UC Scheme has been raised significantly since the beginning of the UC Scheme, the rate still fell short of completely funding services provided under the UC Scheme at every hospital visited during the research. This may be reflective of reduced financial commitment to public health by the RTG in recent years. The overall MOPH budget has declined from 6.8% of the total budget of the RTG in 2000, to 3.9% in 2008. Within the MOPH budget, the NHSO budget has also declined as a percentage of the total budget, from 2.3% in 2004, to 1.2% in 2008. (Alpha Research, 2009: 328, 337) The other 2 professional priorities are more normative in nature and show that the motivation for many of the professionals

working in public health is a strong concern for the citizens of Thailand and particularly the needs of the poor.

For beneficiaries, the top priority was services designed for the needs of the poor and vulnerable which was a surprisingly intangible issue to be the number one concern but shows that a real a passion for public health has been instilled in the community. The other two choices were more expected as both the quality of medical facilities and medicines are well established as prime concerns with the services of the UC Scheme. It is also notable that there was no correspondence between the top 3 priorities of professionals and beneficiaries.

*Importance of the cost paid out of pocket for services under the UC Scheme * Residence Crosstab*

The crosstab results revealed that 90% of rural inhabitants felt that out of pocket payments were more important or very important compared to only 54% of urban inhabitants. One explanation for this may be that rural residents have fewer other options for accessing healthcare and are concerned about the cost since they cannot go elsewhere. Adding a control variable of income over/below 10K did not change the results significantly.

General Concerns

When professionals were asked what the most common complaints they hear from poor patients are about the UC Scheme, the most common response was by far waiting time, followed by low quality medicines and services, and impolite staff. None of these are surprising responses although it is interesting that the staff report so many complaints about the waiting time when very few complained about it in this survey and most seemed very accepting of the fact that a queue is unavoidable. It seems likely that the waiting time is not as acceptable in practice as was expressed in the survey results. Another frequent response was typified by “Patients have problems understanding their rights.” An indication that perhaps the high level rhetoric of the

policy sometimes causes problems when patients are told that there are actually significant limitations to what is covered by the UC Scheme.

When asked what the critical things that could be done to improve the UC Scheme for the poor are, the most frequent professional responses were “Allow patients to use any hospital”, “Better quality medicines”, “Increased budget”, and “More education about health promotion and disease prevention”. Interestingly, ability to choose medical facility was the issue that scored dead last on the scale of importance for beneficiaries, so it is not clear how much of a priority this issue is for the poor themselves. Some of the most information-rich responses to this question were: “Sometimes more invasive treatments are used because more expensive procedures are not covered by UC. For example, because root canals are not covered, tooth extractions are performed instead.” “Doctors sometimes do not approve CT scans for UC patients even when it seems to be medically indicated in order to save money.” “District hospitals should provide transportation to each village because many patients still can't afford transportation costs.” A critical case response for the question that summed up many of the answers was “If the government wants to continue UC, they need to focus on reducing staff workload and financial incentives for both hospitals and medical staff.”

When beneficiaries were asked the same question, the most frequent responses were “Additional medical staff”, followed by “Better quality medicines”. A compelling response was given by one woman who answered that she “Has to pay 300 baht each way to go to the hospital which is very far away. There is a health center near her house but they don't carry the medicine she needs. She wishes there was more cooperation between the health center and the hospital so that she would not have to travel so far.” Another answer that seemed to express the concerns of many was “More comprehensive services at the district hospital so that referral to the provincial hospital is not necessary.” It was apparent during the research that many of the district hospitals essentially function as outpatient clinics and rely on the provincial and general hospital for more sophisticated care provision.

When professionals were asked if they have any personal stories that they would like to share about providing care to the poor under the UC Scheme, two stories that were shared effectively illustrate some of the successes and failures of the program: “A 3 year old boy had a detached retina and had to have his eye removed which meant his parents had to be out of work to care for him. His parents had to pay 2000 baht per month for medicine even with UC and did not have enough money to live on.” “She treated the father of a family of 5 who had leprosy as well as one of his daughters who also had leprosy. She treated them for 2 years at no cost under UC.”

When beneficiaries were asked if they have any positive experiences or stories about using the UC Scheme to share, some of the most compelling included: “Had a mental disorder which required a lot of treatment and imported medicines. UC paid for all of the treatments and medicines and is why he is alive today.” “Has HIV and before UC, she was not receiving any treatment because she is very poor. However, after UC was started she got proper treatment and has learned how to care for herself. She is healthy enough now to volunteer for the HIV support group and at the hospital.” “Has HIV and was dying until a doctor persuaded her to come to the hospital by using UC. Now she receives regular treatment and her health is better.” “He has cirrhosis of the liver and was referred several times for more specialized care. The cost of the treatment was actually around 70,000 baht but he only had to pay 51 baht. He feels UC saved his life.” “Her daugher had an abortion and needed emergency care afterwards. The hospital treated her and saved her life for only 30 baht.” Perhaps the critical case response was “Very helpful to the poor in her village.”

When beneficiaries were asked if they have any negative experiences or stories about using the UC Scheme to share, one response repeated what has become a bit of a folk story about the UC Scheme: “His friend came to the hospital with a headache but the doctor did not check him thoroughly and just gave him paracetamol and sent him home. Later he died and it was believed that the doctor had not taken the case seriously enough.” Several responses emphasized problems with the quality of care at district hospitals: “His nephew was bitten by a snake and the young and inexperienced doctor at the community hospital was not sure about how to treat him.

A referral was made to the provincial hospital which saved him but there was a long delay." "During one illness he came to the hospital many times but the doctor was not proficient enough to diagnose him. After nearly a month of improper treatment he asked for a referral to the provincial hospital where his illness was immediately determined and treated properly." "He went to the public hospital twice and his health did not improve. Then he used a private hospital and his illness improved. He feels this is a result of lower quality medicines at the public hospital."

When asked for any additional comments about the UC Scheme, perhaps a definitive response from one professional was "UC is a good program but certain parts need improvement such as quality of medicines." For beneficiaries, the following additional comment seemed to sum up much of what was expressed about the program during the research: "Feels that care provided under UC is based upon need rather than how much money a patient has."

5.3 Synthesis of Indicators

Demographic Indicators

While target demographic indicators perhaps do not make sense given the multivariate definition of poverty and vulnerability used in this research, the importance of measuring impacts on groups considered main constituencies or at risk for poverty is a clear imperative for pro-poor monitoring. Particular groups that face discrimination or disadvantage in society including but not limited to women, the elderly, rural inhabitants, the less educated, the unemployed, migrant workers, agricultural workers, single parent families, and the disabled should be monitored for program inclusion and impact.

Individual Health Indicators

The subgroup analysis of survey results showed the importance of the program to many of the poor and vulnerable demographic groups who use the UC Scheme. Monitoring of length of service use by different demographic groups would aid in

identifying which groups are most dependent on UC services so that services can be better targeted.

While health status is still affected by place of residence in Thailand, the subgroup analysis of survey results seemed to demonstrate that the playing field is beginning to level slightly. Medically-based and self-described metrics for quality of health among poor and vulnerable demographic groups will help in monitoring this and other social determinants of health.

Aggregated cause of death data collected during key informant interview at the Saraburi Provincial Health Office and survey results about improvement in health related to using the UC Scheme demonstrate the importance of monitoring of the impact of services on disease management and health outcomes on specific poor and vulnerable demographic groups.

Quality Indicators

The survey results revealed a broad base of patient and medical staff concern with the level of quality of many of the aspects of the UC Scheme. Patient and medical staff based metrics for quality of inputs, outputs, and outcomes of the UC Scheme would help in maintaining quality assurance for the program.

The review of literature about the hospital accreditation process for the UC Scheme shows that an attempt is being made to make accreditation mandatory for hospitals providing UC Scheme services. The survey results show that there is a fairly wide variation in patient perception of quality, particularly at district hospitals, therefore it would be beneficial to include significant mechanisms for customer evaluation of the quality of services at each hospital as part of the accreditation process.

Subgroup comparison within the survey results showed much different perceptions of quality between the different occupational groups that provide UC Scheme services. Focus group meetings by medical profession in each province to

determine what the criteria, priorities and needs are for providing high quality services, with funding supplied to support determinations, would assist in ensuring that each group is capable of meeting its own service standards.

The key informant interview with the Provincial Health Office showed that a good deal of statistical monitoring of public hospitals in the province is being conducted. However, much of the monitoring is not performance based and the survey results seem to indicate that there are significant differences in quality between district hospitals. Increased monitoring by provincial health insurance offices with ancillary funding provided to support successes in raising quality standards would help in ensuring a single standard of care.

Equity Indicators

The literature review, survey results, and health system data appear to indicate that while the UC Scheme has increased equity of services between public health insurance schemes, significant inequalities still exist. Monitoring for the equity of service quality, patient satisfaction, utilization, health status and outcomes between public health insurance schemes would help in addressing this concern.

While the survey results for internal equity of the UC Scheme for the rich and the poor was positive overall, subgroup analysis appeared to indicate that there are still disadvantages for some groups and particularly in poor rural communities. Monitoring of equity within the UC Scheme based on service quality, patient satisfaction, utilization, health status and outcomes to identify disadvantage among poor and vulnerable demographic groups would help in assessing the inequity.

Targeted and Appropriate Indicators

The survey results showed that many of the demographic groups for poverty and vulnerability feel that they are receiving targeted and appropriate services under the UC Scheme. However, there were also indications that rural inhabitants still sometimes have difficulty accessing the services they need. Metrics for type of health

services and medical treatments utilized by poor and vulnerable demographic groups would help in guiding investment to address their healthcare needs.

Barriers to Care Indicators

The survey results revealed significant differences in access time for services at UC Scheme facilities as well as the fact that time away from family and work are both significant obstacles to seeking care. Monitoring of access time for services by tambon, district, and province, as well as nationally would help in goal setting and limiting variation based upon place. The metrics should address both travel time and waiting time for accessing services.

The key informant interviews and survey results demonstrated that the poor still face significant costs outside of payment for services when using the UC Scheme. Food, transportation, and time away from work are all significant expenses which the poor must bear when using UC Scheme services. Metrics for the real cost of accessing UC services, measured by tambon, district, province, and nationally would help to determine how much of a financial obstacle still exists.

The key informant interviews and survey results showed that while a considerable amount of outreach has been conducted to ensure inclusion of poor and vulnerable groups, there may still be some members within these groups that are not enrolled in the UC Scheme. Monitoring of the comprehensiveness of UC enrollment coverage among poor and vulnerable groups as well as the number of patients who are excluded from enrollment in the UC Scheme by cause would help to guarantee universal coverage.

The survey results showed that although it is not a frequent occurence, there are still circumstances where patients are forced to pay out of pocket for medical services at public hospitals and have difficulty affording the cost. Monitoring of the number of uncovered service episodes by patient demographics and type of treatment would aid in determining the cause of these events.

The survey results showed that time away from family was the most frequently cited obstacle for using the UC Scheme and subgroup comparison revealed that single parent families and those with more children were more likely to say that it was an obstacle. Monitoring of the suitability of childcare at every public health facility would help in addressing this barrier to care.

The subgroup comparison of survey results showed that there were significant differences in the level of understanding and knowledge of UC Scheme procedures. Monitoring of accommodation provided to beneficiaries for registering and accessing services of the UC Scheme as well as dissemination of knowledge about UC Scheme procedures would help in ensuring that all beneficiaries are able to use the UC Scheme regardless of educational attainment.

The key informant interview at the Provincial Health Office indicated that many beneficiaries are registered for the UC Scheme far away from where they actually reside. Monitoring of the number of beneficiaries who do not live near their registered PCU and are unable to access services without an out of pocket payment would help to determine the scale of the problem.

Participation, Empowerment, Accountability, and Community Development Indicators

While the subgroup comparison of survey results showed a positive result for women in understanding and involvement with medical treatment decisions, further monitoring among all poor and vulnerable demographic groups to ensure similar results would be beneficial.

Subgroup comparison of survey results seem to indicate that there are differences in the commitment to community outreach for encouraging participation in the UC Scheme between district hospitals. Monitoring of community outreach efforts among poor and vulnerable demographic groups by district would help to ensure that equal efforts at outreach are conducted.

The survey results and particularly the scale of importance table demonstrate the valuable perspective to be gained from beneficiary participation in the management of the UC Scheme. Monitoring of poor and vulnerable beneficiary participation in priority setting, service provision, and outreach for the UC Scheme would support an increased voice from these groups.

The key informant interviews, literature review, and health system data show the need for monitoring of hospital management staff participation in provincial and national level financial decision making for the UC Scheme to ensure the continued sustainability of the program.

The literature review, key informant interview and survey results all seem to indicate that monitoring of upper level management accountability and transparency is an important concern for stakeholder groups. Regular reporting, auditing, and forums for community feedback on policy decisions would help in guaranteeing stakeholder confidence in the UC Scheme.

The survey results show that beneficiaries are not filing official grievances when they have complaints about the UC Scheme despite making informal complaints to staff members. Monitoring that open display of information about the complaint process is maintained and that staff are ready and willing to document complaints would help in formalizing the process.

Economic Indicators

As this model is intended to determine the need for non-economic metrics for pro-poor monitoring, no metrics are included in this section. This is not meant as a dismissal of their importance but rather an acknowledgment that the health economic evaluations of the UC Scheme have already been very thorough and effective. The research results did demonstrate the importance of their inclusion for pro-poor monitoring and it is unavoidable that a certain amount of economic evaluation is incorporated into many of the indicators in this model regardless. However, the

research results also appear to show that there are important concerns for the poor that cannot be addressed with these types of metrics.

Right to Healthcare Indicators

While the survey results showed that awareness of the right to healthcare under the UC policy is widespread, it is self-evident that those interviewed would be aware as they were already actively utilizing their rights. The importance of monitoring of policy awareness among poor and vulnerable demographic groups who may not yet know about their rights is still indicated based on health system data which shows less than full enrollment coverage.

The survey results and literature review show that a fair number of beneficiaries feel that they have had experiences where their right to healthcare was not respected. Monitoring of the number and type of reported rights violations and their resolutions by the NHSO would help in defining what a rights violation is and determining the scale of the problem.

Medical Staff Indicators

The survey results show that some beneficiaries and medical staff reported concerns with the thoroughness of medical examinations and the judiciousness of diagnostic testing ordered for UC patients. Monitoring of the number and type of malpractice events and analysis of the data to identify demographic patterns would help in addressing these concerns.

The literature review, key informant interview, survey results, and health system data show that increased utilization of public health facilities under the UC Scheme is having a detrimental effect on public health staff as well as possibly on the quality of care provided. Monitoring of the work stress of medical staff at public hospitals and establishing standards for service utilization to medical staff ratio and progress towards reaching those standards would aid in limiting the impacts of increased utilization.

The literature review, survey results, and health system data seem to show that resignation from public health facilities is a concern for providing effective services under the UC Scheme. Monitoring based upon exit interviews to evaluate the most frequent reasons for resigning from public health positions by occupation would help in generating evidence to determine the cause of the problem.

The literature review, key informant interviews, and survey results show that many public health staff are convinced that the UC Scheme encourages reckless behavior and or lack of responsibility for personal health. Metrics to monitor the "Moral hazard" hypothesis of the UC Scheme would provide data to help in determining if any level of attribution is possible.

The survey results show that many public health staff members believe that increased investment in health promotion and disease prevention programs would greatly benefit poor and vulnerable groups. Increased monitoring of the health impacts of these programs to determine whether they should change subject focus, program targeting or be increased in scale would be beneficial.

The survey results showed that a significant number of professional staff members had medical concerns with the services that are provided by the UC Scheme benefits package. Establishing a reporting system for medical professionals to document when more invasive, riskier, or less effective treatments are dictated by the coverage limitations of the UC Scheme would be useful in order to gather evidence for inclusion of additional treatment options.

Other Indicators

The survey results demonstrated that some beneficiaries may not be able to access services as effectively as possible due to a lack of coordination of care between health centers and their corresponding district hospitals. Monitoring of the effectiveness of the coordination of care between health facilities would be useful, particularly for patients who have difficulty physically accessing their district hospital.

The literature review and survey results revealed that many beneficiaries believe that the quality of medicines provided under the UC Scheme are not good because of stories of patients with serious illnesses being given paracetamol and sent home. Metrics to monitor the “Paracetamol myth” to see how often and under what circumstances the drug is actually prescribed under the UC Scheme would help in increasing the level of beneficiary confidence in the quality of medicines provided.

All of the primary research conducted demonstrated the immense personal concern of public health staff for the wellbeing of the people of the communities they serve. An award system for outstanding humanitarianism by staff members would help in providing well deserved recognition for outstanding service as well as role models for other staff.

CHAPTER VI

CONCLUSION AND RECOMMENDATION

The UC Scheme in Thailand has enjoyed both a very high level of national support from the Thai population and a large amount of international attention for its innovation and achievements. There is good reason for much of this support and praise as anyone with practical involvement with the UC Scheme can attest. The expansion of coverage accomplished has improved access to healthcare for millions of poor Thai citizens and freed them from the fear of not being able to afford essential medical care. The majority of those interviewed during this research responded with praise and civic pride when asked about the UC Scheme.

So why conduct research to refine the monitoring system for this program? Why waste time on refining the metrics for a program that, unlike so many other well-intentioned attempts at improving the everyday lives of poor people in developing countries, actually has succeeded in making a significant material, psychic, and social difference for its beneficiaries? While the principles and beliefs that went into formulating the objectives of the policy are beyond question, the realities of its translation into an implemented program appear to sometimes fall short of the ideals. It must be admitted that universal coverage has been achieved partly at the expense of public hospitals, public health staff, and quality of care.

The central research questions for this thesis were to determine what frontline stakeholders believe are the critical indicators for pro-poor monitoring of the UC Scheme and whether there are pro-poor characteristics of the UC Scheme that should be monitored beyond quantitative economic measures. While the research results did indicate the importance of economic monitoring to address some key stakeholder concerns, they also revealed other critical stakeholder concerns for monitoring to address such as heavy staff workloads, underfunding of services, and quality of care provided. This research seems to expose that there is a certain danger in relying too heavily upon economic metrics for monitoring of the UC Scheme because they place a heavy emphasis on the already known achievements of the program and do not reveal many of the continuing problems. Significantly, while the health economic

measures of the UC Scheme have accentuated the successful shift of the financial burden of care from the poor, they have been less revealing about the fact that much of that burden has fallen on public health facilities and their staff. In addition, there are no econometric indicators appropriate for determining the value of receiving high quality care when medically necessary. The recommended indicators in the monitoring model are formulated to help in highlighting these types of concerns.

This conclusion is not intended to be a broad based indictment of the UC Scheme but rather a precipitate of stakeholder opinions in one province of Thailand about how the operations and services of the UC Scheme can be improved to better serve the needs of the poor and vulnerable. Admittedly, it is easy to write a laundry list of additional characteristics to monitor when you don't have to be concerned about resource limitations and the compromises that they demand. The goal for universal coverage is not that every rural tambon in Thailand has access to the quality of health services offered at Bumrungrad International Hospital. However, having achieved universal access to care should not be confounded with having achieved universal equity of care, and both ideals were declared as primary objectives of the Universal Coverage Policy.

Rather than proposing programmatic changes or future funding priorities, this research set out to learn what people who use and work for the UC Scheme in Saraburi Province think is good and bad about the program and construct a conceptual model to monitor those characteristics. All too often, programs fail to reach their potential for benefitting their target populations because of the disconnect between those who know what is and is not working and those who actually have the decision making authority to do something about it. This research is a small scale attempt to help voice some of the primary concerns of those personally engaged with the UC Scheme. They are voiced in the form of monitoring criteria to suggest that while the UC Scheme seems to be doing a very good job at meeting the healthcare needs of the poor in some respects, universal coverage is not a completed project. The results of this research appear to show that the UC Scheme could be improved to better meet the

needs of the poor and vulnerable through monitoring of additional indicators. Further study of stakeholder concerns on a broader scale would be beneficial.

Recommendation of Indicators for Pro-Poor Monitoring

Individual Health Indicators

- Monitoring of length of service use by poor and vulnerable demographic groups
- Medically-based and self-described metrics for quality of health among poor and vulnerable demographic groups
- Monitoring of the impact of services on disease management and health outcomes among poor and vulnerable demographic groups.

Quality Indicators

- Patient based metrics for quality of inputs, outputs, and outcomes of the UC Scheme
- Medical staff based metrics for quality of inputs, outputs, and outcomes of the UC Scheme
- Hospital accreditation process for the UC Scheme should include significant mechanisms for customer evaluation of the quality of services
- Focus group meetings by medical profession in each province to determine what their criteria, priorities and needs are for providing high quality services, with funding supplied to support determinations
- Increase the scope of performance monitoring of hospitals by provincial health insurance offices with ancillary funding provided to support successes in raising quality standards

Equity Indicators

- Monitoring for the equity of service quality, patient satisfaction, utilization, health status and outcomes between public health insurance schemes.

- Monitoring of equity within the UC Scheme based on service quality, patient satisfaction, utilization, health status and outcomes to identify disadvantage among poor and vulnerable demographic groups

Targeted and Appropriate Indicators

- Metrics for type of health services and medical treatments utilized by poor and vulnerable demographic groups to guide investment. The rural population should be a critical emphasis of the statistical measures.

Barriers to Care Indicators

- Monitoring of access time for services by tambon, district, and province, as well as nationally. These should be further broken down into measurements of travel time and waiting time to access services.
- Metrics for the real cost of accessing UC services, measured by tambon, district, province, and nationally. Food, transportation, and time away from work are all significant costs that the poor must bear when using UC services.
- Monitoring of the comprehensiveness of UC enrollment coverage among poor and vulnerable groups
- Monitoring of the number of patients who are not able to enroll in the UC Scheme by reason for exclusion
- Monitoring of the number of uncovered service episodes by patient demographics and type of treatment
- Monitoring of the suitability of childcare at every public health facility
- Monitoring of accommodation provided to beneficiaries for registering and accessing services of the UC Scheme
- Monitoring of the dissemination of knowledge about UC Scheme policies and procedures
- Monitoring of the number of beneficiaries who do not actually live near their registered PCU and are unable to access services

Participation, Empowerment, Accountability, and Community Development Indicators

- Monitoring of patient understanding of their medical conditions and involvement in treatment decisions among poor and vulnerable demographic groups
- Monitoring of hospital community outreach efforts among poor and vulnerable demographic groups
- Monitoring of poor and vulnerable beneficiary participation in management, priority setting, service provision, and outreach for the UC Scheme
- Monitoring of upper level management accountability and transparency through regular reporting, auditing, and forums for community feedback on policy decisions
- Monitoring of hospital management staff participation in provincial and national level financial decision making for the UC Scheme to ensure the continued sustainability of the program.
- Monitoring that open display of information about the complaint process is maintained and that staff are ready and willing to document complaints

Right to Healthcare Indicators

- Monitoring of policy awareness among poor and vulnerable demographic groups
- Monitoring of the number and type of reported rights violations and their resolutions

Medical Staff Indicators

- Monitoring of the work stress of medical staff at public hospitals
- Establish standards for service utilization to medical staff ratio and monitor progress towards reaching those standards
- Monitoring of the number and type of malpractice events and analysis of the data to identify demographic patterns

- Monitoring based upon exit interviews to evaluate the most frequent reasons for resigning from public health positions by occupation.
- Metrics to monitor the “Moral hazard” hypothesis of the UC Scheme to provide data to help in determining if any level of attribution is possible.
- Metrics for the health impacts of health promotion and disease promotion programs on poor and vulnerable demographic groups to determine if they should change subject focus, targeting or scale.
- A reporting system should be established for medical professionals to document when more invasive, riskier, or less effective treatments are dictated by the coverage limitations of the UC Scheme in order to gather evidence for inclusion of additional treatment options

Other Indicators

- Monitoring of the effectiveness of the coordination of care between health centers and their corresponding district hospitals
- Metrics to monitor the “Paracetamol myth” to see how often and under what circumstances the drug is actually prescribed under the UC Scheme.
- An award system to nominate and recognize outstanding humanitarianism by staff members

References

Academy Health (2003). *Health Economics Core Library Project*. Washington DC: National Library of Medicine.

Al-Assaf, A. F. (Ed.). (2001). *Health Care Quality: An International Perspective*. New Delhi: WHO SEARO.

Alpha Research (2009). *Thailand Public Health 2008-2009*. Nonthaburi: Alpha research.

American Medical Students Association (n.d.). Breaking Barriers Retrieved August 6, 2009, from http://www.amsa.org/programs/barriers/barriers.html.

Andrain, C. (1998). *Public Health Policies and Social Inequality*. London: Macmillan Press LTD.

Battista, J. R., & McCabe, J. (1999, June 14). *The Case For Single Payer, Universal Health Care For The United States.* Paper presented at the Association of State Green Parties, Moodus, Connecticut.

Berkman, L., & Kawachi, I. (Eds.). (2000). *Social Epidemiology*. New York: Oxford University Press.

Bureau of Policy and Strategy (2005). *Thailand Health Profile 2001-2004*. Nonthaburi: Ministry of Public Health.

Bureau of Policy and Strategy (2008a). *Health Policy in Thailand 2007*. Nonthaburi: Ministry of Public Health.

Bureau of Policy and Strategy (2008b). *Thailand Health Profile 2005-2007.* Nonthaburi: Ministry of Public Health.

Camfield, L. (2009). Universal Coverage but Unequal Access? In V. Møller & D. Huschka (Eds.), *Quality of Life and the Millennium Challenge: Advances in Quality-of-life Studies, Theory and Research* (pp. 239-263). New York: Springer.

Chamchan, C., & Mizuno, K. (2006). Assessment of People's Views of Thailand's Universal Coverage (UC): A Field Survey in Thangkwang Subdistrict, Khonkaen. *Southeast Asian Studies, 44*(2), 250-266.

Chen, M. A. (2001). Women in the Informal Sector: A Global Picture, The Global Movement. *The SAIS Review, 21*(1), 71-82.

CIA (2002). *The World Fact Book*. Retrieved April 13, 2009. Available from http://www.faqs.org/docs/factbook/geos/th.html#Intro.

Commission on Social Determinants of Health (2008). *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*. Geneva: World Health Organization.

Domelen, J. V. (2007). *Reaching the Poor and Vulnerable: Targeting Strategies for Social Funds and Other Community-Driven Programs*. Washington DC: The World Bank.

Earle, S., & Letherby, G. (Eds.). (2008). *The Sociology of Healthcare*. New York: Palgrave Macmillan.

Emanuel, E. J., & Emanuel, L. L. (1996). What Is Accountability in Health Care? *Annals of Internal Medicine, 124*(2), 229-239.

Ford, N., Wilson, D., Cawthorne, P., Kumphitak, A., Kasi-Sedapan, S., Kaetkaew, S., et al. (2009). Challenge and co-operation: civil society activism for access to HIV treatment in Thailand. *Tropical Medicine & International Health, 14*(3), 258-266.

Gabe, J., Bury, M., & Elston, M. A. (2004). *Key Concepts in Medical Sociology*. Thousand Oaks: Sage Publications.

Guijt, I., & Woodhill, J. (2002). *Managing for Impact in Rural Development: A Guide for Project M&E*. Rome: IFAD, Office of Evaluation and Studies.

Hiroshi Nishiura, Sujan Barua, Saranath Lawpoolsri, Chatporn Kittitrakul, Martinus Martin Leman, Masri Sembiring Maha, et al. (2004). Health Inequalities in Thailand: Geographic Distribution of Medical Supplies in the Provinces. *Southeast Asian Journal of Tropical Medicine and Public Health, 35*(3), 737.

Hughes, D., & Leethongdee, S. (2007). Universal Coverage In The Land Of Smiles: Lessons From Thailand's 30 Baht Health Reforms. *Health Affairs, 26*(4), 999-1008.

International Health Policy Program (2009). The Role of the Private Health Sector in Developing Countries. Unpublished research paper. Rockefeller Foundation.

Jongudomsuk, P. (2008). *How do the poor benefit from the Universal Healthcare Coverage Scheme? Thai experience*. Retrieved February 24, 2009. Available from http://www.hsri.or.th/en/download/detail.php?id=18&key=puben.

Jordan, J., Dowswell, T., Harrison, S., Lilford, R. J., & Mort, M. (1998). Health needs assessment: Whose priorities? Listening to users and the public. *BMJ, 316*(7145), 1668-1670.

Kakwani, N., & Pernia, E. M. (2000). What is Pro-poor Growth? *Asian Development Review, 18*(1), 1-16.

Kanchanachitra, C. (Ed.). (2006). *Thai health 2006*. Nakhon Pathom: Institute for Population and Social Research, Mahidol University.

Limwattananon, S., Tangcharoensathien, V., & Prakongsai, P. (2007). Catastrophic and poverty impacts of health payments: results from national household surveys in Thailand. *Bulletin of the World Health Organization, 85*(8), 600-606.

Limwattanonon, S., Tangcharoensathien, V., & Prakongsai, P. (2005). Equity in financing healthcare: impact of universal access to healthcare in Thailand. EQUITAP Project: Working Paper 16. International Health Policy Program.

Moghadam, V. (2005) The "Feminization of Poverty" and Women's Human Rights. Paris: UNESCO.

Morgan, L. M. (2001). Community participation in health: perpetual allure, persistent challenge. *Health Policy Plan., 16*(3), 221-230.

NaRanong, V. (2002). *The Monitoring and Evaluation of Universal Health Coverage in Thailand, First Phase 2001/02*. Nonthaburi: Health Systems Research Institute.

NaRanong, V., & NaRanong, A. (2006). Universal Health Care Coverage: Impacts of the 30-Baht Health-Care Scheme on the Poor in Thailand. *TDRI Quarterly Review, 21*(3), 3-9.

NaRanong, V., NaRanong, O., & Tiarmworakul, S. (2005). *Monitoring and Evaluating Universal Health Care Coverage in Thailand, 2002-2003*. Nonthaburi: Health Systems Research Institute.

Nitayarumphong, S. (2005). Achieving Universal Coverage of Health Care in Thailand through the 30 Bahts Scheme *Social Health Insurance: Selected Case Studies from Asia and the Pacific* (pp. 191-209). New Delhi: SEARO, WHO.

OECD (2007). *Health at a Glance 2007: OECD Indicators*. Paris: OECD.

Office of the National Economic and Social Development Board (2006). *Poverty in Thailand*. Retrieved August 6, 2009. Available from http://poverty.nesdb.go.th/poverty_new/doc/NESDB/wanchat_25490930065254.pdf.

Pannarunothai, S. (2001). *Medical welfare scheme: financing and targeting the poor*. Nonthaburi: Health Systems Research Institute.

Pannarunothai, S., Patmasiriwat, D., Kongsawatt, S., Srithamrongsawat, S., Suttayakom, W., & Rodsawaeng, P. (2002). *Sustainable Universal Health Coverage: Household Met Need*. Phitsanulok: Centre for Health Equity Monitoring, Naresuan University.

Pongpirul, K., Sriratanaban, J., Asavaroengchai, S., Thammatach-Aree, J., & Laoitthi, P. (2006). Comparison of Healthcare Professionals' and Surveyors' Opinions on Problems and Obstacles in Implementing Quality Management System in Thailand: A National Survey. *International Journal for Quality in Health Care, 18*(5), 346-351.

Prakongsai, P. (2008). *The Impact of the Universal Coverage Policy on Equity of the Thai Healthcare System.* PhD Thesis, London School of Hygiene and Tropical Medicine, London.

Sakunphanit, T. (2008). *Universal Health Care Coverage through Pluralistic Approaches: Experience from Thailand*. Bangkok: ILO Sub-Regional Office for East Asia.

Saraburi Province (2009). Retrieved July 10, 2009, from http://en.wikipedia.org/wiki/Saraburi_Province.

Sen, A. (1999). *Development as Freedom*. New York: Anchor Books.

Somkotra, T., & Lagrada, L. (2008). Payments for health care and its effect on catastrophe and impoverishment: Experience from the transition to Universal Coverage in Thailand. *Social Science & Medicine, 67*(12), 2027-2035.

Suraratdecha, C., Saithanu, S., & Tangcharoensathien, V. (2005). Is universal coverage a solution for disparities in health care? Findings from three low-income provinces of Thailand. *Health Policy, 73*(3), 272-284.

Tangcharoensathien, V., & Jongudomsuk, P. (Eds.). (2004). *From Policy to Implementation: Historical Events During 2001-2004 of Universal Coverage in Thailand*. Bangkok: National Health Security Office.

Tangcharoensathien, V., Limwattananon, S., & Prakongsai, P. (2007). Improving health-related information systems to monitor equity in health: lessons from Thailand. In D. McIntyre & M. Gavin (Eds.), *The Economics of health equity* (pp. 222-246). New York: Cambridge University Press.

THAILEX (2009). Saraburi Provincial Map. Retrieved July 10, 2009, from http://www.thailex.info/THAILEX/THAILEXENG/LEXICON/Copy%20of%20Saraburi.htm.

The National Statistical Office (2006). *Gross Provinicial Product at Current Market Prices by Industrial Origin: 2001 - 2005*. Retrieved July 28, 2009. Available from http://saraburi.nso.go.th/saraburi/excels/O-src-09/2549/000/saraburi_O-src-09_2549_000_40000100.xls.

The National Statistical Office (2008a). *The Core Economic Indicators of Thailand 2008*. Retrieved August 5, 2009. Available from http://web.nso.go.th/indicator/eco_ied08.pdf.

The National Statistical Office (2008b). *The Health and Wellness Survey 2007*. Retrieved August 5, 2009. Available from http://web.nso.go.th/en/survey/hw/hw.htm.

The National Statistical Office (2008c). *Key Statistics of Thailand 2008*. Bangkok: The National Statistical Office.

The World Bank (2005). *World Development Report 2006: Equity and Development*. Washington DC: The World Bank and Oxford University Press.

Tourism Authority of Thailand (2009). Destination Guide: Saraburi. Retrieved July 29, 2009, from http://www.tourismthailand.org/destination-guide/saraburi-19-4667-1.html.

Towse, A., Mills, A., & Tangcharoensathien, V. (2004). Learning from Thailand's health reforms. *BMJ, 328*(7431), 103-105.

U.S. Census Bureau (2008). *U.S. Census Bureau, Current Population Reports: Income, Poverty, and Health Insurance Coverage in the United States 2007*. Washington DC: U.S. Census Bureau.

UNDP (1995). *Human Development Report 1995*. New York: UNDP.

UNESCAP (2009). *Statistical Yearbook for Asia and the Pacific 2008*. Bangkok: United Nations.

UNIFEM (2009). *Progess of the World's Women 2008/2009 Executive Summary*. Bangkok: UNIFEM.

Universal Declaration of Human Rights (1948).

Wibulpolprasert, S., & Pengpaibon, P. (2003). Integrated Strategies to Tackle the Inequitable Distribution of Doctors in Thailand: Four Decades of Experience. *Human Resources for Health, 1*(1), 12.

Yeo, R. (2001). *Chronic Poverty and Disability*. Somerset: Chronic Poverty Research Centre.

APPENDICES

APPENDIX A

BENEFICIARY SURVEY

Beneficiary Survey **Research Site:**

Demographic Information

Residence?

○ Urban ○ Rural

Age?______

Gender?

○ Male ○ Female

Education completed?

○ No formal education ○ Primary school ○ Secondary school ○ Post-secondary School

Native language?

○ Thai ○ Other

Household income per month?__________

Currently employed?

○ Yes ○ No

Working in agriculture?

○ Yes ○ No

Relocated within Thailand for work?

○ Yes
○ No

Number of children in household?

○ None
○ 1-3
○ 4-6
○ 7 or more

Number of parents in household?

○ None
○ 1
○ 2

Legally disabled?

○ Yes
○ No

Individual Health

How long have you been using the services of the UC Scheme?

○ Less than 1 year
○ 1-3 years
○ 3-5 years
○ Over 5 years

When you use health care services, are you generally served by the same doctor or nurse every time?

○ Strongly agree
○ Agree
○ No opinion
○ Disagree
○ Strongly Disagree

Overall, how would you rate your own health?

○ Very good
○ Good
○ Average
○ Poor
○ Very Poor

Do you feel that your health has improved as result of using the services of the UC Scheme?

○ Strongly agree
○ Agree
○ No opinion
○ Disagree
○ Strongly Disagree

Do you feel that the UC Scheme provides effective services for your medical problems?

○ Strongly agree ○ Agree ○ No opinion ○ Disagree ○ Strongly Disagree

If you disagree, what improvements would you like to see?

If the UC Scheme did not exist, what would you do for health care? Could you still afford to go to the hospital?

Quality

How would you rate the quality of medicines provided under the UC Scheme?

○ Very good ○ Good ○ Average ○ Poor ○ Very Poor

How would you rate the quality of medical facilities provided under the UC Scheme?

○ Very good ○ Good ○ Average ○ Poor ○ Very Poor

How would you rate the quality of medical professionals providing services under the UC Scheme?

○ Very good ○ Good ○ Average ○ Poor ○ Very Poor

Overall, how would you rate the quality of services provided under the UC Scheme?

○ Very good ○ Good ○ Average ○ Poor ○ Very Poor

What would you like to see improved to increase the quality of the services provided under the UC Scheme?

Equity

Do you think that the services provided under the UC Scheme are of the same quality as those provided under the civil servant medical benefit scheme?

○ Strongly agree ○ Agree ○ No opinion ○ Disagree ○ Strongly Disagree

If you disagree, what do you think needs to be done to improve the quality of the UC Scheme to make them equal?

____

____

Would you switch schemes if you had the opportunity be enrolled in the civil servant medical benefit scheme?

○ Yes ○ No

If you would switch, please state why?

____

____

Do you feel that poorer users of the UC Scheme receive the same medical care as those with more money?

○ Yes ○ No

If not, please give examples of how the poor receive worse medical care than the rich?

____

____

Targeted and Appropriate

Do you feel that the UC Scheme does as good a job of providing the services needed by women as by men?

○ Strongly agree ○ Agree ○ No opinion ○ Disagree ○ Strongly Disagree

If you disagree, please state what should be improved to provide better services to women?

Do you feel that the UC Scheme does as good a job of providing the services needed by the elderly as by adults?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you disagree, please state what should be improved to provide better services to the elderly?

Do you feel that the UC Scheme does as good a job of providing the services needed by the disabled as by the able bodied?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you disagree, please state what should be improved to provide better services to the disabled?

Do you feel that the UC Scheme does as good a job of providing the services needed by the poor as by the rich?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you disagree, please state what should be improved to provide better services to the poor?

Do you feel the UC Scheme does as good a job of providing the services needed by rural inhabitants as by urban inhabitants?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you disagree, please state what should be improved to provide better services to rural inhabitants?

Do you feel that the UC Scheme offers services that address the major health concerns in your community?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If not, what do you think the major health concerns that need to be addressed are in your community?

Barriers to Care

Do you think that waiting time to receive services under the UC Scheme is a major obstacle to seeking healthcare?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

Are you able to access healthcare at the location most convenient for you when using the UC Scheme?

○	○
Yes	No

Including transportation, waiting time, and treatment, how long does it usually take you to access services under the UC Scheme?

○	○	○	○	○
Less than 1 hour	1-3 hours	4-6 hours	7-10 hours	Over 10 hours

Would you be willing to pay more out of pocket for healthcare if it meant not waiting as long to receive services?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

Which of the following is the biggest obstacle for you to using the services of the UC Scheme? (You many select more than one answer)

○	○	○	○	○	○	○
Cannot be away from work	Transportation	Time away from family	Expense	Unpleasant treatment at facility	Poor quality services	Other

Other?

Do you feel that the UC Scheme still excludes or is not welcoming to any demographic groups in your community?

○	○
Yes	No

If yes, which groups do you feel are excluded or unwelcomed?

Do you find the information given to you about the UC Scheme easy to understand?

○	○
Yes	No

If not, why was the information confusing?

Do you feel that it should be easier, more difficult, or that the process should remain the same to get a referral to see a specialist?

○	○	○
More difficult	Remain the same	Easier

Are you aware of how to change your registration for the UC Scheme if you were to move to a different location?

○	○
Yes	No

If you have had to change your registration to a new medical facility for the UC Scheme, did you find it was an easy process?

○ Yes ○ No ○ Never had to

If you found it difficult, please explain why?

____

____

Participation, Accountability, Empowerment, and Community Development

When you see a doctor under the UC Scheme, do they explain to you what your condition and treatment options are clearly and involve you in decision making?

○ Strongly agree ○ Agree ○ No opinion ○ Disagree ○ Strongly Disagree

Would you like to have more voice in how the services of the UC Scheme are managed and delivered for your community?

○ Strongly agree ○ Agree ○ No opinion ○ Disagree ○ Strongly Disagree

If you agree, are there specific issues where you feel the interests of the community are being disregarded?

____

____

Do you think that the UC Scheme has helped the people of your community to have more control over their own lives?

○ Strongly agree ○ Agree ○ No opinion ○ Disagree ○ Strongly Disagree

If you agree, please state in what way the poor have more control over their own lives?

____

____

Do you feel that the UC Scheme is too bureaucratic and should be more accountable to the needs of frontline stakeholders such as patients and medical professionals?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

Have you ever made a formal complaint about services received under the UC Scheme?

○	○
Yes	No

If yes, what was the outcome of the complaint?

Do you feel that the UC Scheme has given you more control over your own health?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you agree, please give examples of how you have more control over your own health?

Economics

Do you feel that the UC Scheme has lowered the amount that you pay out of pocket for health care?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

Do you feel safer from the risk of high expenses created by a serious illness because of the UC Scheme?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

Do you feel that the economy of the community has improved as a result of the UC Scheme?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

Do you feel that the UC Scheme has benefitted the poor in your community more than the rich?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you agree or disagree, please explain how?

Right to Health Care

Are you aware that you are guaranteed the right to health care in Thailand?

○	○
Yes	No

When you use the services provided by the UC Scheme, do you feel that you are treated with dignity and respect?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

Have you ever had an experience where you felt that your rights were not respected when accessing services under the UC Scheme?

○	○
Yes	No

If yes, please describe the experience when you felt that your rights were not respected?

Do you feel that poorer patients are treated with an equal amount of dignity and respect as those with more money when using the UC Scheme?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you disagree, please give examples of how the poor are not treated the same as those with more money?

IMPORTANCE SCALE SURVEY

For each question below, circle the number to the right
that best fits your opinion on the importance of the issue.

Question	Scale of Importance				
	Least important	Less important	Average importance	More important	Most important
More funding for services?	1	2	3	4	5
Services that help to strengthen the community?	1	2	3	4	5
All stakeholders having a voice in managing UC Scheme services?	1	2	3	4	5
Highly trained medical staff?	1	2	3	4	5
Services that provide patients with greater control over their own health?	1	2	3	4	5
Easily accessible location for services?	1	2	3	4	5
High quality medical facilities?	1	2	3	4	5
Equity of service quality with other public insurance schemes?	1	2	3	4	5
Patients are treated the same regardless of income?	1	2	3	4	5
Ability to choose medical facility for accessing services?	1	2	3	4	5
High quality medicines?	1	2	3	4	5
Cost paid out of pocket for services?	1	2	3	4	5
Reduced cost for expensive treatments?	1	2	3	4	5
Reduction in economic inequality in the community?	1	2	3	4	5
Ensuring the right to healthcare for all citizens?	1	2	3	4	5
Reduced waiting time for services?	1	2	3	4	5
Services designed for the health needs of the poor and vulnerable?	1	2	3	4	5

General Questions

Do you have any negative experiences or stories to share about the UC Scheme?

Do you have any positive experiences or stories to share about the UC Scheme?

What do you think are the critical things that should be improved about the UC Scheme?

Do you have any additional comments about the UC Scheme that you would like to share?

Notes

APPENDIX B

MEDICAL PROFESSIONAL SURVEY

Medical Professional Survey **Research Site:**

Personal Information

Occupation?

○	○	○	○	○	○
Nurse	Tech	Medical Assistant	Doctor	Administration	Other

How many years have you worked at this health care facility?

○	○	○	○
Less than1 year	2-5 years	6-9 years	Over 10 years

What percentage of your work is directly related to providing services or administration for the UC Scheme?

○	○	○	○
Less than 20%	20%-50%	50%-80%	Over 80%

Challenges and Accomplishments

What do you feel is the biggest challenge in providing services under the UC Scheme to the poor? (You may select more than one answer)

○	○	○	○	○	○	○
Restrictive benefits package	Low quality medicines or equipment	Insufficient staffing	Too much bureaucracy	Ineffective budget allocations	Insufficient budget	Difficult patient population

Other?

____

____

What do you think is the biggest accomplishment of the UC Scheme for the poor? (You may select more than one answer)

○	○	○	○	○
Guarantee of medical care	Lower health expenses	Better health	Improved access to care	Better quality of care

Other?

Quality

How would you rate the quality of medicines provided under the UC Scheme?

○	○	○	○	○
Very good	Good	Average	Poor	Very Poor

How would you rate the quality of medical facilities provided under the UC Scheme?

○	○	○	○	○
Very good	Good	Average	Poor	Very Poor

How would you rate the quality of medical professionals providing services under the UC Scheme?

○	○	○	○	○
Very good	Good	Average	Poor	Very Poor

Overall, how would you rate the quality of services provided under the UC Scheme?

○	○	○	○	○
Very good	Good	Average	Poor	Very Poor

What would you like to see improved to increase the quality of the services provided under the UC Scheme?

Equity

Do you think that the services provided under the UC Scheme are of the same quality as those provided under the civil servant medical benefit scheme?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you disagree, what do you think needs to be done to improve the quality of the UC Scheme to make them equal?

Would you switch schemes if you had the opportunity be enrolled in the UC Scheme?

○	○
Yes	No

If you would switch, please state why?

Do you feel that poorer users of the UC Scheme recieve the same medical care as those with more money?

○	○
Yes	No

If not, please give examples of how the poor receive worse medical care than the rich?

Targeted and Appropriate

Do you feel that the UC Scheme does as good a job of providing the services needed by women as by men?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you disagree, please state what should be improved to provide better services to women?

Do you feel that the UC Scheme does as good a job of providing the services needed by the elderly as by adults?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you disagree, please state what should be improved to provide better services to the elderly?

Do you feel that the UC Scheme does as good a job of providing the services needed by the disabled as by the able bodied?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you disagree, please state what should be improved to provide better services to the disabled?

Do you feel that the UC Scheme does as good a job of providing the services needed by the poor as by the rich?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you disagree, please state what should be improved to provide better services to the poor?

Do you feel the UC Scheme does as good a job of providing the services needed by rural inhabitants as by urban inhabitants?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you disagree, please state what should be improved to provide better services to rural inhabitants?

Do you feel that the UC Scheme offers services that address the major health concerns in the community?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If not, what do you think the major health concerns that need to be addressed are in the community?

Barriers to Care

Do you think that waiting time to receive services under the UC Scheme is a major obstacle to seeking healthcare?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

Do you feel that the UC Scheme still excludes or is not welcoming to any demographic groups in the community?

○	○
Yes	No

If yes, which groups do you feel are excluded or unwelcomed?

Do you think that the UC Scheme services are easy to access for patients with less education?

○	○
Yes	No

If not, what makes them more difficult to use for patients with less education?

Do you think that the UC Scheme services are easy to access for patients who are not native Thai speakers?

○ Yes ○ No

If not, how frequently does this problem occur?

Do you feel that it should be easier, more difficult, or that the process should remain the same for patients to get a referral to see a specialist?

○ More difficult ○ Remain the same ○ Easier

How often is ability to pay for services still an obstacle for patients to receive medical care?

○ Frequently ○ Occasionally ○ Rarely ○ Never

What are the most common medical conditions or treatments that cause patients to be unable to pay for services?

Participation, Empowerment, and Community Development

Do you feel that the resource allocations of the UC Scheme effectively address the actual health needs of the poor?

○ Strongly agree ○ Agree ○ No opinion ○ Disagree ○ Strongly Disagree

If you disagree, what should the UC Scheme invest more resources in to help the poor more effectively?

Do you think that beneficiaries should have more voice in how the services of the UC Scheme are provided in their community?

○ Strongly agree ○ Agree ○ No opinion ○ Disagree ○ Strongly Disagree

If you agree, are there specific issues where you feel the interests of the community are being disregarded?

Do you think that the UC Scheme has helped the poor people of the community to have more control over their own lives?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you agree, please state in what way the poor have more control over own their lives?

Do you feel that the UC Scheme is too bureaucratic and should be more accountable to the needs of frontline stakeholders such as patients and medical professionals?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

Do you feel that the UC Scheme has improved the health care options available to the poor?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you agree, please give examples of how healthcare options have improved for the poor?

Economic

Do you feel that the UC Scheme does a good job of protecting the poor from out of pocket payments for health care?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

Do you feel that the UC Scheme does a good job of protecting the poor from the risk of high expenses created by a serious illness?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

Do you feel that the economy of the community has improved as a result of the UC Scheme?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

Do you feel that the UC Scheme has benefitted the poor in the community more than the rich?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

If you agree or disagree, please explain how

Right to Health Care

Are patients generally aware that they are guaranteed the right to health care in Thailand?

○	○
Yes	No

Do you feel that poorer patients are treated with an equal amount of dignity and respect as those with more money when using the UC Scheme?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

Medical Staff

Do you have any medical concerns with the services provided under the UC Scheme?

○	○
Yes	No

If yes, what are your medical concerns about the services provided under the UC Scheme?

Do you feel that the staff at your facility is overworked as a result of providing services for the UC Scheme?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

Have you ever made a formal complaint about the heavy workload?

○	○
Yes	No

If yes, what was the outcome of the complaint?

____

____

Do you feel that the medical staff has adequate time to treat their patients even with the heavy workload?

○	○	○	○	○
Strongly agree	Agree	No opinion	Disagree	Strongly Disagree

Have you ever considered switching to work fulltime in a private hospital or clinic?

○	○
Yes	No

If yes, what has kept you from making the switch to a private hospital or clinic?

____

____

IMPORTANCE SCALE SURVEY

For each question below, circle the number to the right
that best fits your opinion on the importance of the issue.

Question	Scale of Importance				
	Least important	**Less important**	**Average importance**	**More important**	**Most important**
More funding for services?	1	2	3	4	5
Services that help to strengthen the community?	1	2	3	4	5
All stakeholders having a voice in managing UC Scheme services?	1	2	3	4	5
Highly trained medical staff?	1	2	3	4	5
Services that provide patients with greater control over their own health?	1	2	3	4	5
Easily accessible location for services?	1	2	3	4	5
High quality medical facilities?	1	2	3	4	5
Equity of service quality with other public insurance schemes?	1	2	3	4	5
Patients are treated the same regardless of income?	1	2	3	4	5
Ability to choose medical facility for accessing services?	1	2	3	4	5
High quality medicines?	1	2	3	4	5
Cost paid out of pocket for services?	1	2	3	4	5
Reduced cost for expensive treatments?	1	2	3	4	5
Reduction in economic inequality in the community?	1	2	3	4	5
Ensuring the right to healthcare for all citizens?	1	2	3	4	5
Reduced waiting time for services?	1	2	3	4	5
Services designed for the health needs of the poor and vulnerable?	1	2	3	4	5

General Questions

What are the most common complaints that you hear from poor patients about the UC Scheme?

What do you think are the critical things that could be improved about the UC Scheme to better serve the poor?

Are there any personal stories that you would like to share about providing care to the poor under the UC Scheme?

Do you have any additional comments about the UC Scheme that you would like to share?

Notes

BIOGRAPHY

Ben Harkins was raised in Freeport, Maine, a small seaside New England town two hours north of Boston. He is the son of loving parents Bill and Susan Harkins, and the younger brother of notorious foodie Perrin Harkins. When he graduated from Soule School Elementary, he was given the Thomas Jefferson award, perhaps an early acknowledgment of his lifelong dislike of tyranny. He grew up enjoying the natural world of Maine and dying his hair unnatural colors.

Ben moved to San Francisco, California to attend New College of California for his undergraduate studies. His coursework in cultural studies and the arts exposed him to people and ideas that left a lasting belief in the potential of humanity for good as well as the joys of pollo asada super burritos. After completing his studies he began his professional career working at a non-profit community center, where he learned to his delight that it was possible to make a living from helping others.

Moving back to his adopted home city of San Francisco, Ben continued his work in non-profit social service at Meals on Wheels of San Francisco, an organization that provides nutrition and case management services to homebound senior citizens in order to prevent their premature institutionalization. Ben spent 6 years working at the agency, where he was promoted to Director of Home Delivered Meals and was responsible for managing a delivery network that provided meals and social services to 1400 senior citizens every day.

Following a lovely visit to Thailand on a holiday, Ben decided to pursue his long-held dream of working overseas in humanitarian aid by studying in the MAIDS Program at Chulalongkorn University. His experiences in Thailand have been both challenging and wonderful and he is hopeful that his studies will lead to a meaningful future career in international development work.