Service Quality of Equal Access to Health Care:

A case of Universal Health Coverage Policy in Thailand

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Abstract

Attempts to provide universal health care for all in Thailand can be traced back to 1975 when Prime Minister Kukrit Promoj initiated the Health Welfare for the Low Income Program and later was extended in 1992 by Prime Minister Chuan Leekpai to under the age of 15, the elderly, and the disabled. However, the most remarkable, successful, and internationally recognized one of all in the health care reform in Thailand would be the universal health security policy or widely known in Thailand as "the 30-Baht for All Treatment Program." After a long hard fought journey of Saguan Nitayarumphong, the leading authority in the struggle to push the policy into practice along with the support from the powerful politicians, Thaksin Shinawatra from Thai Rak Thai Party, civil society, and the international organization like World Health Organization (WHO), the National Health Security Act was eventually passed in 2002. It is for the first time in Thailand that the policy has been initiated from the bottom and led by an expert in the field; the medical doctors in this case, who were working collaboratively with the politicians, and civil society. This research explored health care reform process or the struggling path to success of this policy and to see the quality of services under this scheme. The research questions are how the policy was developed by getting all parties to involve and if the quality of services would be acceptable at the minimum costs as it is said. Theoretically, Top-down and Bottom-up policy approaches, New Public Management (NPM), and civil participation movement were used to analyze the findings. Mixed methods of quantitative and qualitative approaches in collecting data were employed in this research. Questionnaires were used to individually interview the patients at Banphaeo Hospital (Public Organization), the best practice hospital for the 30-Baht program. Also, in-depth interviews were conducted with doctors who have been practicing and affected by this policy, the board member of the National Health Security Board, and the director of Banphaeo Hospital (Public Organization).

Key Words: Universal Health Coverage, Health Care, 30 Baht Scheme, Universal Coverage in Thailand, Service Quality, Equal access

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Introduction

Thailand has one of the most complex health care systems in Asia. Prior to reform, there were about six different health benefits schemes, targeting different groups of people with different benefit packages. The first one is the low income and public welfare schemes for free of charge at designated public facilities. The second one is for those working for the government, called Civil Servant Medical Benefit Scheme (CSMBS). It provides health care benefits to both the government officers, their parents, and their dependents. The third one is the Social Security Scheme (SSS) for those working in the private sector with no copayment. It is a compulsary health insurance with limited choice of health care to a contractual public or private hospital. The fourth one is the Workmen's Compensation Scheme (WCS). It is also a compulsary insurance scheme related to work with copayments when the total charge is higher than the set ceiling. Last, but not least, is the voluntary Health Card (HC) scheme, provided by the Ministry of Public Health (MPOH) for the access to only MOPH facilities with referral networks and no copayment.

The health benefits and financing characteristics of each scheme vary and cover different groups of every Thai citizens as shown in the table below:-

Table 1: Benefit package and financing characteristics of the health benefit schemes

Scheme characteristics	Low income and public welfare	CSMBS	SSS	WCS	Health Card	Private insurance
Benefit package						
Ambulance services	Only designated public hospitals	Public only	Public and private	Public and private	Public (MOPH)	Public and private
Inpatient services	Public only	Public and private	Public and private	Public and private	Public (MOPH)	Public and private
Choice of provider	Referral line	Free	Contrafcrual basis	Free	Referral line	Free
Cash benefitws	No	No	Yes	Yes	No	Usually no
Inclusive conditions	All	All	Non-work related illness, injuries, except 15 conditions	Work-related illness and injuries	All	As stated in the contracts
Maternity benefit	Yes	Yes	Yes	No	Yes	Varies
Annual physical checkup	No	Yes	no	No	Possible	Varies
Promotion & prevention	Very limited	Yes	Health education and immunisation	No	Possible	Varies
Services not covered	Private bed, specia nurse, eye glasses	Spediaql nurse	Private bed, special nurse	No	Private bed	Varies
Financing						
Source of fund	General tax	General tax	Tripartite contributions, 1.5% of payroll	Employer, 0.2-2% of payroll with experience rating	Household purchase 500 baht plus tax subsidy 500 baht	Premium
Financing body	MOPH	Ministry of finance3	Ministry of Labour	Ministry of Labour	MOPH	Competitive companies
Payment mechanism	Global budget	Fee-for-service reimburse	Prospective capitation	Fee-for-service reimburse	Limited fee-for-service	Fee-for-service reimburse
Copayment	No	Yes, for IP at private hospital	Maternity and emergency services	Yes, if exceed the ceiling of 30,000 baht	No	Almost none

Source: Pannarunothat and Tangcharoensathien, 1993; Supachutikul, 1996; and Tangcharoensathien and Supachutikul, 1997 cited in Nitayarumphong and Mills, 2005, p. 265.

The National Health Service Reform had been officially initiated since 2001 under the "30 Baht Health Care Project." It was first implemented as a pilot project in 6 province in April 2001, namely Patumthani, Samutsakorn, Nakornsawan, Yasothorn, Payao, and Yala. About 1.39 millions of citizens (37.37% of populations in 6 provinces) were covered in this scheme. Two months later, it was expanded to cover 15 more provinces, accounted for 4.9 million or 35% of population in these provinces. Later, in October of 2001, the project had also been implemented in all other provinces in Thailand and 13 areas of Bangkok because Bangkok Administration was more complicated and so required better preparation of project management. It was not very long that the 30 Baht project had fully covered every areas of Thailand in April, 2002. So, it was a gradual and continuous process of policy implementation.

After the National Health Security Bill was passed in 2002, the government initiated the reform as promise during political election campaign. The National Health Security Office (NHSO) was setup to manage the Universal Health Care Coverage in Thailand as stipulated in the 2002 National Health Security Act. Two governing Boards, namely The National Health Security Board and the Health Service Standard and Quality Control Board, were also appointed to set the national health care policy and to monitor and control the quality of services up to the international standard accordingly.

As a result of the reform, at present the health care system in Thailand had been cut down to three major schemes, including Civil Servant Medical Benefit Scheme (CSMBS), Social Security Scheme (SSS), and the National Health Security Scheme (NHSS). The 30 Baht project had been transformed to be NHSS. Each scheme targets different groups of Thai populations with different benefit packages. The one in focus of this study is the last one since it covers about 47 million 75% of population, while 8%, 15.8% are in the CSMBS and SSS respectively.

Financing Universal Health Care

In general, there are two different approaches to finance universal health care in most developed and developing countries around the world: 1) the compulsory or social insurance, widely known as Bismarck Model and 2) the taxation method, known as the Beveridge Model (Nitayarumphong and Mills, 2005)

The Bismarck Model is considered as an insurance based system, such as a social insurance system, depending on the ability to pay and accessibility to services at time of needs independent from the government. Initiated in Germany with tight regulation framework for the contributions to health funds, it is applied to countries like Japan, Korea, and Taiwan because it creates less political conflict and a more centralized means of fund management. Furthermore, it gives more choices to the people.

The Beveridge Model is funded by tax or government revenue. The United Kingdom and Canada are the good example of countries using this model. No other countries in Asia and Latin America have applied this model to cover health care at full range.

Learning from reform experiences in different countries in Asia and Latin America, there is no "one best way" or "one size fits all." It all depends on the economic, political and social status of each individual country.

Another aspect of financial management to be considered is to decide whether to have a single fund or multiple funds of the money collected from the people. Various countries in Asia have adopted the multiple funds approach to health care such as Japan, Korea, and Chile; while Taiwan use the single way to manage funds. The only issue arises from multiple funds is the inefficiency of administrative cost. A single taxed-based health system would be easier to manage and Korea has been trying to merge or combine different funds into a single fund system.

In Thailand, the money used to support the National Universal Health Care Coverage comes mostly from the government. Based on the pilot implementation of capitation contract model in Banpaeo Hospital in January 2001 and Social Health Insurance early on in April 1991, the research concluded that the capitation contract model would be more suitable for the increase of health care costs in the future in designing Universal Coverage Scheme. The general tax financed would be the best possible way for fund management in comparison to the fee for service reimbursement model of the CSMBS. Considering the upscale of UC scheme in the future, the copayment was contemplated to be politically and technically infeasible (Tangcharoensathien and others, n.d.). Section 38 of the 2002 Act has set up a "National Health Security Fund" (NHSF) under the National Health Security Office (NHSO) with main authorities in providing and supporting health care costs and public health services to service units. There are at least 8 different sources of funding to ensure that all citizens can get access to cheap and quality health care services at reasonable and affordable price as follows:-

1. Government annual allocation
2. Local government administration
3. Fees from services as specified by the Act
4. Fine collected by the Act
5. Donations to the National Health Service Fund
6. Interests from the savings and asset of the Fund
7. Other income or asset derived from related activities of the Fund
8. Other sources as allowed by the law, e.g. Dental Fund, Subdistrict Administrative Organization Fund, Medicine Fund, Kidney Fund, etc.

Literature Review

In this research project, three leading authorities in Public Policy, New Public Management (NPM) concepts and service quality include John W. Kingdon's policy windows, the market and economic concepts from NPM and customers' satisfactions on service quality.

Public policy is a dynamic and logical process of sequencing activities depicting the relationships among actors involved in each phase. In general, the policy process model is composed of six interrelated stages: - agenda setting, policy formulation, policy legitimation, policyimplementation, policy and program evaluation, and policy change. For the purpose of this study, the process is set to four main phases of agenda setting, policy formulation, and policy implementation, and policy evaluation.

In the agenda setting, the first and crucial point in initiating legitimate policy, Kingdon (1995, 2010) discusses the important of having three interacting different streams or

activities to create the opportunities to be considered in the policy decision-making process. These three streams are the problem, policy, and political streams. The problem will not be recognized by the politicians unless there is information available, the persons affected, and how they are affected. It can be the official reports from the government agencies, the studies, academic research reports and some other valuable information regarding the problem and the possible solution to this problem.

The policy stream should be related to the problem addressed about the possible policies alternatives for all parties participating in the policy decision-making process, such as legislators, executive agencies, interest groups, academics, and policy analysts. The problem will be picked up by these stakeholders and circled around in speeches, public talks/meetings, newsletters, media, etc. With enough of information and supporting resources for possible policies alternatives, the problem will keep the public's eyes on the watch.

Last, but not least, is the political stream. It is defined as the political climate or the mood of the people concerning the problem. This can be seen in the polls, the surveys, the political campaign during the election, the results of the election, and the interests of civil society and the interest groups affected by the problem.

The problem will be pushed and moved forward to become the agenda and for the approval when all three streams come across at the same time. By then, the window of opportunity for the problem is open to convert it to policy issue for later consideration.

As the policy has been approved and legitimized through the legal process, the policy will be implemented. In this implementation stage, NPM's idea[2] of market-based management is employed to analyze the Universal Health Coverage of Thailand. In particular, among other things, the Principal-Agent theory has specifically been applied to manage healthcare and health services. Drawing from a variety of perspectives, NPM, though difficult to define (Lodge and Gill, 2011), focuses on variety of things such as results, decentralization, contracting out, privatization, performance management, disaggregation, customer satisfaction, entrepreneurial spirit, etc. In all, the new face of pubic service has becoming more like business, calculating cost-benefits, charging for services that never been collected, and so on. The government agencies are given a distinctive role of a principal or an agent to provide check and balance on the performance. One agency cannot perform both roles like before. The principal is playing the role of the "producer" or the "provider", responsible for giving the best public goods and services to the people; while the agent, representing the people will be in charge as a "purchaser" or "buyer", providing check on the quality of goods and services delivered by the principal (Hood, 1991, Pollitt, 2003). And with the public choice perspective, individuals are assumed to have rationality to choose and make the right choices that would maximize their interests and welfare.

[2] Unlike the traditional theories of Public Administration, the rival NPM have been derived from different set of theories and approaches. To name a few, public choice theory, managerialism, principal-agent theory, neo-Austrian economics, property-rights theory, and transaction-costs economics. For more details, please see GernodGruening. 2001. "Origin and theoretical basis of New Public Management," ***International Public ManagementJournal***. Volume 4: 1–25.

As for the quality of services, the five dimensions adapted from RATER criteria of SERVQUAL Model and the equality measure of the schemehave been applied in this research to evaluate customers' satisfaction on the services received from the hospital. The criteria are an acronym of five dimensions, including Reliability, Assurance, Tangible, Empathy, and Responsiveness (Parasuraman et.al, 1988; Zeithaml et.al, 1990,Bhuyan et.al, 2010).[3]

Methodology

A mixed method of quantitative and qualitative was used in this research inquiry. Qualitative data was collected from an in-depth interview and a focus group of hospital administrators, doctors, Quality Control board member, administrative staff, private doctors, representative from voluntary groups, and patient. About 254 surveys were individually gathered from the elderly who came for treatments at the Banphaeo Hospital, Prommitr Branch in Bangkok with the permission from the respondents and the Hospital's Director.

Research Findings

Agenda Setting

Applying the three streams of Kingdon, we found that the problem stream was initially brought into the light with the efforts made by Sanguan Nitayarumpong and his inspired young medical team in rural area. Sanguan played an important role to conceptualize Universal Health Care Coverage for Thai people to ensure that they can access standardized and cheap health care service nationwide. He led a long and struggled journey of perseverance and dedication to gain information and experiences from grassroots during his medical practices in small 30 inpatient care/hospital beds Srisarai Hospital in Srisaket Province in Northeastern part of Thailand. Though he was born and raised in the city of Bangkok, he gained wisdom and political ideology while he was attending the medical school in Mahidol University and very active in student activities calling for justice, equality between the haves and the have-nots, and against corruptions in government. It was no surprise that he also took part in student uprising in both incidents on October 14, 1971 and October 6, 1976 (Nitayarumphong, 1998). The idea of equal access to all was gradually developed through various exchanges in researches, meetings,and focus group discussions among all interested parties in Thailand and abroad. It was able to gain wide support from the international organizations, financially and academically, like World Health Organization (WHO), Non-Government Organizations (NGO) from Germany among others, etc. A number of publications, books, and reports were written and distributed to share idea of universal health coverage reform to solve the long enduring problem of malnutrition, insufficient and below standard of health care services in the rural and remote areas, and so on. Civil society has been involved in the process from the very beginnings. It is for the first time that the problem has been initiated from the bottom-up rather than the top-down that directly responded to the needs of the poor people.

[3] It was later developed to ten dimensions, composing of tangibles, reliability, responsiveness, competence, courtesy, credibility, security, access, communication, and understanding the customer. For the purpose of this inquiry, the RATER dimensions would be comprehensive enough to cover all ten elements.

In the policy stream, the idea of healthcare reform was well perceived among key actors in the policy process. The problem of healthcare system in the rural poor and the possible solutions have been circulated to all doctors in the fields and in the administrative posts, the politicians, volunteer groups and civil society, civil services in the Ministry of Health, and international scholars. It was given an approval and widespread support to push it forward to the legislation.In 1992, the Health Systems Research Institute (HSRI) was set up as an Autonomous Public Organization (APO) to better manage knowledge about health systems in order to provide information about health services to the people so that health systems would be better developed and improved. Series of international meetings and seminars for exchange of research findings and ideas were organized over the past 10 years. The one-on-one interview with doctors and health officers revealed that they support the policy because it was a good policy. It was necessary for the government and its duty to help guarantee the health of the people in the country. It is quite clear that the academic community has been working continuously and relentlessly to circulate and generate the idea of reform.

The political stream refers to the mood of the public in perceiving the problem of health care system in Thailand. The attempt to get the reform idea to become the political agenda at the national level was not very successful at the beginning, until the year 2001. Sanguan wrote a book on "Health Care Reform in Thailand," covering 5 basic ideas:-

1. Centralized health care expenses for betterand efficient management of budgets and funds for equal distribution to every person in need of resources in the country
2. To strengthen primary care in the village and community in all areas
3. To provide holistic and sustainable health care services from primary care to professional care not only to "cure the disease" but also to take care of "people"
4. To develop and strengthen health care personnel capability and rewards ready for the new health care reform
5. Promote social awareness for the reform and push for the legalization of the universal health care concept (Nitayarumphong, 1998.)

During the general election in 2001, Sanguan worked in the Ministry of Public Health which had given him chance to meet with an active doctor, Surapongse Suebvonglee, who turned to politician in the renowned Thai Rak Thai Party, led by Thaksin Shinawatana. Thaksin saw this idea as an opportunity to get more votes from the grassroots in rural areas. "The 30 Baht Health Care Project" was then captured as number one political campaign for Thai Rak Thai Party, which brought him the win in the general election. Never in the history of Thai Politics that any political parties could win overwhelming votes and more than half of the total number of seats in the House of Representatives, had the reform idea placed Thai Rak Thai Party on the plateau.

After the election, the social movement from various groups had continued to move the idea into law. A number of NGOs and voluntary oganizations organized forums to let people participate in this massive change. About 60,000 names were collected to propose the bill into the parliament. The National Health Security Bill was finally passed in 2002. It was widely and highly recognized as one of the people's bill to be passed during that time.

The three streams of problem, policy, and politics in the case of health care reform in Thailand converged at the right time and the same moment after a long struggling journey since 1980. It required at least three powerful driving forces of the academic and medical

professions who know the problem and have knowledge and solutions for the cure, civil society or pubic pressure that were affected by the policy, and political support that could move the issue into reality.

The Implementation of the policy

The National Health Security Act was passed at the same time of the Administrative Reform in the bureaucratic system in 2002. At that time, the country was facing the economic crisis and needed financial assistants from International Monetary Fund (IMF), which had pressed demands on restructuring and cleaning up the government with heavy dose of New Public Management measures, tools, and techniques to counteract against widespread corruptions among politicians and bureaucrats. To make the government more efficient and responsive to the people, the market principles of management, contracting out, performance management, downsizing, early retirement program, Good Governance, and etc. were heavily employed to the entire bureaucracy. In the structural design of Universal Health Coverage policy in Thailand, the National Health Security Office (NHSO) was setup to manage the Universal Health Care Coverage in Thailand as stipulated in the 2002 National Health Security Act. Two governing Boards, namely The National Health Security Board and the Health Service Standard and Quality Control Board, were also appointed to set the national health care policy and to monitor and control the quality of services up to the international standard accordingly. The Ministry of Public Health is now the major producer in health care business selling health care services to the NHSO who is acting as an "agent" on the part of the Thai people. The Ministry of Public Health will be the "principal" or sole producer in the public sector, managing and providing care and services located around the country.

The data from Health Insurance Information Service Center reveals that the number of people registering for the UC rights has increased every year from approximately 47 million, accounted for 70.14 % of population in 2011 to almost 49 million or 73.13% in 2015. It is going to be increased in the future and expected that all Thai citizens will be covered by either UC rights or other health security rights (EIS-NHSO, Health Insurance Information Service Center, 2015, online).

At present, there are about 11,342 Primary Care Units (PCU) in 13 regional offices around the country. About 1,000 units are located in Chiangmai in the North (1,264 units), Nakhornratchasimain the Northeast (1,064 units), and Ratchaburi in the central (1,006 units). On the average, each PCU is capable of providing approximately 3,500 to 4,000 people, except for Bangkok that has the capacity to handle up to 14,415 people even though it has the least numbers of PCUs, only 269 units in total. It is true that not all PCUs are equipped with the same number of doctors, nurses and personnel, medical equipments, and facilities. Most PCUs in remote areas are still not well developed to the standard of service units. However, it is the first point for the people to visit the doctor before they are referred to the second tier units and finally to the one in the city depending on the necessity and severity of the case.

Financially, the UC policy aims to help all Thai citizens to have the right to standard and cheap health care services. As stated earlier, the scheme is fully funded by the government from the tax money. Since the number of registered population for UC scheme will be increased every year and as a consequence the cost of health care using tax-based compulsory finance will rise respectively. The annual report from NHSO shows the annual

budget allocation from year 2002 to 2014 that the money allocated for UC scheme has increased from 56,091 million baht (approximately 1,605 USD at 1 USD = 35 THB) in 2003 to 154,258 million baht (approximately 4,407 USD at 1 USD = 35 THB), about three times when it was first started. However, this money is only accounted for 1.1% or 1.2% of the Annual National Gross Domestic Products (DGP), and only about 6% of the National Budget allocated each year.

Unlike other developed countries, Thailand decided to use capitation contract model to finance the scheme because everyone would be able to have equal access to public health care services regardless of their wealth at affordable costs. The amount of health coverage per person per year has increased more than 100% from year 2002 to 2014, from 1202.40 Baht to 2895.09 Baht, due to the expansion of the coverage and the benefits package to include minor care to chronic diseases.The fund allocation to each PCU is calculated based on the number of population in each area where the PCU is located. The more the number of population, the more the money is allocated.

The data from the interview also reveals that most Thai people have the habits in going straight to see doctors in the city, especially in Bangkok, because of their trusts and beliefs in the health care facilities and medical personnel. As a result, large and well known hospitals like Siriraj Hospital, Ramathibodi Hospital, to name a few, are overcrowded with patients waiting in line every day. Most are willing to come quite early in the morning, 4 or 5 o'clock before the office hours, just to see doctors for simple cold or headache. In addition, specialized doctors are handful with outpatients who do not need special medical attentions.

Quality of Services

This paper evaluate the results of the UC policy by asking the elderly who are receiving medical care at one of finest hospital running the UC policy in Bangkok. Banphaeo Hospital at Prommitr Branch is particularly providing treatment for the elderly. It has a dialysis center to patients with End StageRenal Disease, Chronic kidney disease, or Acute kidneyinjurywith regular Hemodialysis (HD) treatmentand other diseases for the elders. From a total number of 254 questionnaires distributed to this particular group of patients, the respondents were asked to answer questions regarding their satisfactions on the services received from the hospital on five dimensions adapted from PZB's RATER model and the equality dimension as the main purpose of the scheme. A Likert scale from 1-5, the least satisfied to the most satisfied, was employed in this study, asking the patients to assess the quality of service.The results were calculated and presented in terms of frequency, percentage, and mean. The statistical analysis of One-Way ANOVA was applied to test the differences of means among different factors at significant level of 0.05 (sig.= 0.05).

Demographic Background

The findings show demographic background of the respondents that 54.30% of them are male and 45.30 are female patients. Mostly 29.10% of them are between 66-70 years of age, 28.00% are 60-65 years old, and 23.60% are 71-75 years old. About 57.50% are still married and 29.90% are either divorce or separated. In terms of education background, most of them, about 32.30%, received primary education and only 29.50% received college degree. As for occupation, it was no surprise that most of them, about 32.20% are unemployed. However, there are about 20.90% employed and 17.30% of them are self-employed or

business owners. Regarding their monthly income, mostly 25.20% earn about 5,000-10,000 baht per month. About 22.40% earn their income below 2,000 baht a month. And another 20.50% earn 10,000-20,000 baht a month

As for the kind of treatments, it is found that the number one treatment, 100% of respondents, is Urinary tract infections or Nephropathy Disease. The second most received treatment, 87.00%, is eye related treatments; such aspterygium, cataract, and glaucoma.

Table 2: Services used by the respondents (N= 254)

Items	Frequency	Percentage
1. length of service usage/time		
o 0 - 1 hrs	27	10.60
o 1 – 2hrs	69	27.20
o 2 - 4 hrs	64	25.20
o 4 - 6 hrs	66	26.00
o More than 6 hrs	25	9.80
o N/A	3	1.20
2.personal cost (transportation, food, boarding, fees /visit (Baht)		
o Less than 100	7	2.80
o 100-200	89	35.00
o 200-500	102	40.20
o 500-1,000	41	16.00
o 1,000-2,000	7	2.80
o 2,000-5,000	2	0.80
o More than 5,000	2	0.80
o N/A	4	1.60
3. frequencies of visit		
o Once a month	128	50.40
o Every two months	102	40.20
o Every Three months	17	6.60
o Every six months	2	0.80
o Once a year	1	0.40
o More than a year/visit	1	0.40
o N/A	3	1.20

Table 2 shows that mostly 27.20% would spend one to two hours per visit at the hospital, 26.00% would take 4-6 hours per visit, and 25.20% spend 2-4 hours per visit. Every time they come to see doctors, most of them, 40.20% spend only 200-500 baht or less (35.00%) for transportation, food, boarding, or medical fees. Lastly, about 50.40% of them come to pay visit once a month and some 40.20% come every two months.

Opinion on Service Quality

When asked about their opinion on the quality of services in seven areas received at Banphaeo Hospital, the results (Table 3) show that they were highly satisfied with services at provided at the hospital in all seven dimensions investigated, except for minor details in the areas of facilities. All mean score are equal or more than 4.20, which means they are highly

satisfied. This can be easily explained that the hospital buildings are small, old, and not spacious. It would be a little difficult to find a parking space, as complained by the patients.

Table 3: Opinion of Respondents on Service Quality (N=254)

Service quality	Mean	S.D.	Opinion
1. Equal treatment	**4.63**	**0.58**	Highly Satisfied
1) First come, first serve service	4.63	0.54	Highly Satisfied
2) Equal treatment to all patients	4.63	0.60	Highly Satisfied
3) Treat all patients and honor and respect	4.61	0.61	Highly Satisfied
4) Personal acquainted not the main factor of special treatment	4.64	0.55	Highly Satisfied
2.On-time services (Reliablity)	**4.34**	**0.75**	Highly Satisfied
1) Operate during the official Office hours as announced	4.56	0.60	Highly Satisfied
2) Staff in services on-time	4.34	0.74	Highly Satisfied
3) Timely services	4.11	0.95	Very satisfied
4) Prompt services	4.36	0.72	Highly Satisfied
3. Sufficient services (Tangibles)	**4.24**	**0.79**	Highly Satisfied
1) Sufficient number of nurses and staff	4.51	0.68	Highly Satisfied
2) Sufficient medical equipments and appliances	4.43	0.71	Highly Satisfied
3) Sufficient drugs and pharmacy	4.51	0.61	Highly Satisfied
4) Convenient facilities	3.93	0.89	Very satisfied
5) Building design and facilities suits for providing care to elderly	3.83	0.90	Very satisfied
4. Continuous care services (Reliabilty)	**4.63**	**0.57**	Highly Satisfied
1) Open for services 7 days/week	4.56	0.63	Highly Satisfied
2) Standard services	4.67	0.54	Highly Satisfied
3) Continuous services	4.67	0.55	Highly Satisfied
5. Service improvements(Assurance)	**4.24**	**0.77**	Highly Satisfied
1) Improvement in health condition after treatments	4.48	0.70	Highly Satisfied
2) Better and faster services	4.29	0.86	Highly Satisfied
3) Remarkable improvement in staff development	4.38	0.68	Highly Satisfied
4) Better architectural design, equipments, and facilities	3.80	0.84	Very Satisfied
6. Safety (Tangibles/Security)	**4.35**	**0.64**	Highly Satisfied
1) Awareness of patients safety	4.57	0.59	Highly Satisfied
2) Safe environments and facilities	3.83	0.82	Very Satisfied
3) Well equipped with safety tools and other medical instruments in time of emergency needs	4.47	0.58	Highly Satisfied
4) Readiness of medical supplies	4.51	0.56	Highly Satisfied
7. Customers Care (medical personnel) (Empathy)	**4.50**	**0.71**	Highly Satisfied
1) Friendly doctors, nurses and staff	4.55	0.69	Highly Satisfied
2) Service mind	4.51	0.70	Highly Satisfied
3) Modest and polite	4.50	0.72	Highly Satisfied
4) Caring, listen, and responsive to the patients' demands	4.45	0.74	Highly Satisfied

As for the analytical analysis of the customer's satisfaction to the quality of services, we found the various factors that are statistically tested significant at the 0.05 level. The results show that there are significant differences between the groups as a wholeindifferent ages[F(4, 222) = 3.950, p = 0.004], occupation[F(6, 218) = 2.387, p = 0.030], the number of hours spent at the hospital[F(4, 223) = 15.084, p = 0.000], the frequency of their visit[F(2, 223) = 6.197, p = 0.000],and the cost/visit [F(4, 222) = 6.177, p = 0.000]. The details are as follows:

Table 4: Multiple Comparisons Using LSD Test by Age

(I) group_age	(J) group_age	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
60-65	66-70	.07402	.07824	.345	-.0802	.2282
	71-75	.15155	.08146	.064	-.0090	.3121
	76-80	.15383	.09544	.108	-.0343	.3419
	81 +	.49362*	.13006	.000	.2373	.7499
66-70	60-65	-.07402	.07824	.345	-.2282	.0802
	71-75	.07753	.08175	.344	-.0836	.2386
	76-80	.07981	.09569	.405	-.1088	.2684
	81 +	.41960*	.13025	.001	.1629	.6763
71-75	60-65	-.15155	.08146	.064	-.3121	.0090
	66-70	-.07753	.08175	.344	-.2386	.0836
	76-80	.00228	.09834	.981	-.1915	.1961
	81 +	.34207*	.13221	.010	.0815	.6026
76-80	60-65	-.15383	.09544	.108	-.3419	.0343
	66-70	-.07981	.09569	.405	-.2684	.1088
	71-75	-.00228	.09834	.981	-.1961	.1915
	81 +	.33979*	.14126	.017	.0614	.6182
81+	60-65	-.49362*	.13006	.000	-.7499	-.2373
	66-70	-.41960*	.13025	.001	-.6763	-.1629
	71-75	-.34207*	.13221	.010	-.6026	-.0815
	76-80	-.33979*	.14126	.017	-.6182	-.0614

*. The mean difference is significant at the 0.05 level.

In age, Multiple Comparisons using the LSD test in Table 4 shows that there is a significant difference in service quality satisfaction between the group at the age 60-65 and the age above 81 ($p = 0.000$), the age 66-70 and the age above 81($p = 0.001$), age 71-75 and

the age above 81 ($p = 0.010$), and age76-80 and the age above 81 ($p = 0.017$). This implies that the elder patients who are 81 years and above have different opinion about services quality from other groups.

Table 5: Multiple Comparisonsusing LSD test by Occupations

(I) group_occupation	(J) group_occupation	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Government	Business owner &Agriculturist	-.09381	.26562	.724	-.6173	.4297
	Employee	-.19098	.28927	.510	-.7611	.3791
	Pensioner	.00752	.27811	.978	-.5406	.5557
	Housewife	-.09228	.26781	.731	-.6201	.4355
	Contractors	-.35504	.26384	.180	-.8750	.1650
	Unemployed	-.19041	.26192	.468	-.7066	.3258
Business owner & Agriculturist	Government	.09381	.26562	.724	-.4297	.6173
	Employee	-.09718	.15080	.520	-.3944	.2000
	Pensioner	.10132	.12811	.430	-.1512	.3538
	Housewife	.00153	.10386	.988	-.2032	.2062
	Contractors	-.26124*	.09316	.005	-.4448	-.0776
	Unemployed	-.09660	.08757	.271	-.2692	.0760
Employee	Government	.19098	.28927	.510	-.3791	.7611
	Business owner & Agriculturist	.09718	.15080	.520	-.2000	.3944
	Pensioner	.19850	.17185	.249	-.1402	.5372
	Housewife	.09870	.15462	.524	-.2060	.4034
	Contractors	-.16406	.14764	.268	-.4550	.1269
	Unemployed	.00057	.14418	.997	-.2836	.2847
Pensioner	Government	-.00752	.27811	.978	-.5557	.5406
	Business owner & Agriculturist	-.10132	.12811	.430	-.3538	.1512
	Employee	-.19850	.17185	.249	-.5372	.1402
	Housewife	-.09980	.13259	.452	-.3611	.1615
	Contractors	-.36256*	.12438	.004	-.6077	-.1174
	Unemployed	-.19792	.12025	.101	-.4349	.0391
Housewife	Government	.09228	.26781	.731	-.4355	.6201
	Business owner & Agriculturist	-.00153	.10386	.988	-.2062	.2032

	Employee	-.09870	.15462	.524	-.4034	.2060
	Pensioner	.09980	.13259	.452	-.1615	.3611
	Contractors	-.26276*	.09922	.009	-.4583	-.0672
	Unemployed	-.09813	.09400	.298	-.2834	.0871
Contractors	government	.35504	.26384	.180	-.1650	.8750
	Business owner & Agriculturist	.26124*	.09316	.005	.0776	.4448
	Employee	.16406	.14764	.268	-.1269	.4550
	Pensioner	.36256*	.12438	.004	.1174	.6077
	Housewife	.26276*	.09922	.009	.0672	.4583
	Unemployed	.16463*	.08201	.046	.0030	.3263
Unemployed	Government	.19041	.26192	.468	-.3258	.7066
	Business owner & Agriculturist	.09660	.08757	.271	-.0760	.2692
	Employee	-.00057	.14418	.997	-.2847	.2836
	Pensioner	.19792	.12025	.101	-.0391	.4349
	Housewife	.09813	.09400	.298	-.0871	.2834
	Contractors	-.16463*	.08201	.046	-.3263	-.0030
*The mean difference is significant at the 0.05 level.						

From Table 5, the Multiple Comparisonsusing the LSD test revealed there is a significant difference in service quality satisfaction between the group who are business owners and contractors ($p = 0.005$),between pensioners and contractors ($p = 0.004$), between contractors and housewife ($p = 0.009$),as well as between unemployed and contractors (p = 0.046). Those working for the Government, employee, and Business owner & Agriculturist do not appear to significantly have different opinion about the service quality provided by Banphaeo Hospital.

Table 6: Multiple Comparisons Using LSD Test by time spent per visit

					95% Confidence Interval	
(I) time	(J) time	Mean Difference (I-J)	Std. Error	Sig.	Lower Bound	Upper Bound
0-1 hr	1-2hr	-.01347	.10329	.896	-.2170	.1901
	2-4 hr	.25733*	.10566	.016	.0491	.4655
	4-6 hr	.23032*	.10386	.028	.0257	.4350
	6 hr+	.69325*	.12251	.000	.4518	.9347
1-2 hr	0-1hr	.01347	.10329	.896	-.1901	.2170
	2-4 hr	.27080*	.07388	.000	.1252	.4164
	4-6 hr	.24379*	.07127	.001	.1033	.3842

	6 hr+	.70673*	.09645	.000	.5167	.8968
2-4 ชม	0-1hr	-.25733*	.10566	.016	-.4655	-.0491
	1-2 hr	-.27080*	.07388	.000	-.4164	-.1252
	4-6 hr	-.02701	.07467	.718	-.1742	.1201
	6 hr+	.43593*	.09899	.000	.2408	.6310
4-6 ชม	0-1hr	-.23032*	.10386	.028	-.4350	-.0257
	1-2 hr	-.24379*	.07127	.001	-.3842	-.1033
	2-4 hr	.02701	.07467	.718	-.1201	.1742
	6 hr+	.46293*	.09706	.000	.2717	.6542
6 ชมขึ้นไป	0-1hr	-.69325*	.12251	.000	-.9347	-.4518
	1-2 hr	-.70673*	.09645	.000	-.8968	-.5167
	2-4 hr	-.43593*	.09899	.000	-.6310	-.2408
	4-6 hr	-.46293*	.09706	.000	-.6542	-.2717

*The mean difference is significant at the 0.05 level.

From Table 6, the Multiple Comparisons using the LSD test revealed there is a significant difference in service quality satisfaction between those who spend less than an hour and those spend more than two hours at the hospital. Also, there is a significant difference in service quality satisfaction between those who spend 1-2 hrs and those who spend more than two hours for the services at the hospital. There is also a significant difference in service quality satisfaction between those who spend 2-4 hrs and those who spend up to two hours and those who spend more than six hours at the hospital. Lastly, there is a significant difference in service quality satisfaction between those who spend more than 6 hours and every other group.

Table 7: Multiple Comparisons Using LSD Test by Cost

(I)Cost	(J) Cost/Baht**	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Less than 100	100-200	.23509	.17010	.168	-.1001	.5703
	200-500	.38227*	.16962	.025	.0480	.7165
	500-1000	.60625*	.17962	.001	.2523	.9602
	1000 +	.55986*	.23133	.016	.1040	1.0157
100-200	Less than 100	-.23509	.17010	.168	-.5703	.1001
	200-500	.14718*	.06474	.024	.0196	.2748
	500-1000	.37116*	.08767	.000	.1984	.5439
	1000 +	.32477	.17010	.058	-.0104	.6600
200-500	Less than 100	-.38227*	.16962	.025	-.7165	-.0480
	100-200	-.14718*	.06474	.024	-.2748	-.0196

	500-1000	.22398*	.08673	.010	.0531	.3949
	1000 +	.17759	.16962	.296	-.1567	.5119
500-1000	Less than 100	-.60625*	.17962	.001	-.9602	-.2523
	100-200	-.37116*	.08767	.000	-.5439	-.1984
	200-500	-.22398*	.08673	.010	-.3949	-.0531
	1000 +	-.04639	.17962	.796	-.4004	.3076
1000 +	Less than 100	-.55986*	.23133	.016	-1.0157	-.1040
	100-200	-.32477	.17010	.058	-.6600	.0104
	200-500	-.17759	.16962	.296	-.5119	.1567
	500-1000	.04639	.17962	.796	-.3076	.4004

*The mean difference is significant at the 0.05 level.
**100 THB =2.85 USD, 1 USD = 35.00 THB)

From Table 7, the Multiple Comparisons using the LSD test revealed there is a significant difference in service quality satisfaction between those who spend less than 100 baht and every group who spend more than 200 baht on food, transportation, and extra medical cost. There is also a significant difference in service quality satisfaction between those who spend less than 100-200 baht and those groups who spend 200-500 baht and 500-1,000 baht per visit. Also, there is also a significant difference in service quality satisfaction between those who spend 200-500 baht/visit and those who spend 500-1,000 baht/visit. Lastly, there is also a significant difference in service quality satisfaction between those who spend more than 1,000 baht and those who spend less than 100 baht per visit. It is obviously clear that there is statistically significant difference among different groups who spend different amount of money for food, transportation, and extra medical cost when they come to see doctor for treatment. The quality of services would mean different things to these groups of people.

Table 8: Multiple Comparisons Using the LSD Test by Frequency of Visit

(I) frequency of visit	(J) frequency of visit	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Once a month	Every two months	.18540*	.06028	.002	.0666	.3042
	Every Three months	.44412*	.12761	.001	.1926	.6956
	Every six months	-.15533	.31128	.618	-.7688	.4581
Every two months	Once a month	-.18540*	.06028	.002	-.3042	-.0666
	Every Three months	.25872*	.12908	.046	.0044	.5131
	Every six months	-.34073	.31188	.276	-.9553	.2739
Every Three months	Once a month	-.44412*	.12761	.001	-.6956	-.1926
	Every two months	-.25872*	.12908	.046	-.5131	-.0044
	Every six months	-.59945	.33154	.072	-1.2528	.0539

Every six months	Once a month	.15533	.31128	.618	-.4581	.7688
	Every two months	.34073	.31188	.276	-.2739	.9553
	Every Three months	.59945	.33154	.072	-.0539	1.2528

*The mean difference is significant at the 0.05 level.

From Table 8, the Multiple Comparisons using the LSD test revealed there is a significant difference in service quality satisfaction between those whocome once a month and those who come every two months or three months. There is also a significant difference in service quality satisfaction between those whocome every two months and those who come every three months. There is no significant difference in service quality satisfaction between those who come every six months and other groups. It can be implied that the elder patients who come quite often every months, every two months, and every three months would have statistically significant different opinion on the service quality in all dimensions provided at the hospital selected for the study.

The respondents from the questionnaire gave very good comments on the services, the competent of the medical personnel and staff, and the empathy from nurses and doctors. They all have full confident in their treatments. The only negative comment received from the questionnaire is the number of parking space. They suggested that the UC benefits should be expanded to cover other serious diseases and expansion of the new branch of this hospital.

Conclusion

The attempt to have everyone able to equally get access to standardized health care benefits has been a long struggling path in Thailand. It required a team of medical experts who strive to find the best reform model for the rural poor, working collaboratively from inside and outside of Thailand to gain academic, financial, and moral support for the solution. The success story of UC policy in Thailand is partly due to the involvement of the people or civil society from the start. At present, the people voluntary groups have been active in providing information and check on the quality of services they receive at the Primary Care Units. Every year, they would come to an annual meeting organized by NHSO to give them feedback and propose new measures for better management of the UC funds. The last group that plays an important role to place the UC idea to the public eyes was the Thai Rak Thai party. With the pressure from the civil society, the National Health Security Act was passed in 2002.

The law came at the time when NPM perspectives were introduced to Thai bureaucracy during the Administrative Reform as compellingly suggested by International Monetary Fund (IMF). The tasks of producing and buying were made clear in health care services. At least two new actors were created to act as agents of the people in purchasing health services and providing check on the quality of services: NHSO and the quality control committee. The power of budget spending has been transferred from the Ministryof Public Health to NHSO under this 2002 Act, while the Ministry was left with the responsibility to manage and provide good and standardized quality services to the people.

The investigations from the interview, focus group discussion, and questionnaire revealed remarkable and satisfied results. The Secretary-General of United Nations

Conference on Trade and Development (UNCTAD)and UN Resident Coordinator all praised highly of UC policy in Thailand as the best example of health care policy by providing cheap health care services to the poor in a democratic way. It is to note that the hospital selected for the study is one of the best practice hospitals that has been doing very well. Unlike other hospitals in the UC scheme, they are now experiencing short in their budget based on capitation per head of people in the PCU because most people who come for services are from other jurisdictions. The specialized doctors spend more time giving care to outpatients for general treatments. With more patients coming to third tier hospitals instead of PCU first, the well equipped hospitals are now overcrowded, leading to the downturn of quality of care in the end.

At present, problem of health care management has submerged to the national level. The conflict between the Ministry of Public Health and the NHSO in handling the UC fund is publicly exposed in media recently (Wangkiat, The Bangkok Post, 3 July, 2015). The NHSO is blaming the Ministry for not maintaining the health care services up to the specified standards at the PCUs around the country, making it hard for people to trust and have confident in the medical treatments, leading to the collateral damage to the third tier hospitals in the city. On the other hand, the Ministry is also questioning the way the NHSO spend the taxpayers' money. There are serious allegations over inefficient and mismanagement of fund and corruption in the purchasing process, causing unequal healthcare access and financial problems at the public hospitals. The allegations were later proofed due to poor accounting at State hospital. However, to help alleviate the conflict between these two agencies, Prime Minister General Prayut Chan-o-cha transferred permanent secretary for public health Narong Sahametapat to the Prime Minister's Office so that the ongoing conflict can be resolved quickly(Prasert, The Nation,17 March, 2015).

It is believed that the UC policy is a good policy to be promoted and supported by the government. It is not another populist policy created by the politicians who looked for votes in return to win the election and the seats in the Parliament. If it is managed efficiently by all participating parties with integrity, Thai people as a whole would benefit the most.

To conclude, the UC policy is Thailand has been successful over the years. Though it has been continuously developed and fine-tunes to serve all Thai people, it is now experiencing a bump. Much can be improved in the services and management of budget to make it even more transparent, accountable, and efficient. Lessons can be learned along the path from the past to the future. It is hope by the people that the conflict would not be turned into political football game because the ones who get hurts the most are the 48 million Thai people who depend on this policy.

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