INTENTION OF PRIVATE HOSPITALS TO BECOME CONTRACTORS IN THE PREPAID SOCIAL SECURITY SCHEME IN THAILAND: WHY AND WHY NOT?

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Abstract. The objective of the study was to examine whether private hospitals wanted be main contractors (MCs) under the social security scheme. Data were obtained from a cross-sectional survey of 94 private hospitals in Bangkok and its vicinity area conducted between August 1995 and May 1996 using in-person interview and hospital survey forms. The overall response rate was 88.3 %. The results showed that some 46 hospitals (55 %) expressed their intention to become MCs. However, nearly 40 % of MCs in 1995 indicated that they really did not want to join the scheme while several non-MC hospitals said that they wanted to participate. The most prevalent justifications for the intention of the hospitals to become MCs, or not, were operational and marketing-related in nature. While the scheme was considered a profitable market opportunity by many, it affected hospital positioning. Participation in the scheme might also complicate health services delivery. Whether private hospitals wanted, or did not want, to become MCs was associated with ownership status ($p = 0.001$) and leading competitive strategies of the hospitals ($p = 0.041$).

INTRODUCTION

The health care sector of Thailand has been changing rapidly and significantly. Although the public sector has been a major health care provider in this country, the recent growth of private hospitals significantly increases the role of the private sector in providing care for the Thai population. Nevertheless, only a few groups of the population, such as the upper and middle classes, can afford the private hospital services since a majority of Thais still pay for their health care in the private sector out-of-pocket on the charge basis (Nittayaramphong and Tangcharoensathien, 1994; Supachutikul, 1995). Since a Social Security Scheme (SSS) was established in September 1990, financial access to the private health care sector has been widened. The compulsory scheme offers medical benefits for employees in the private business sector, who previously may not have been able to afford private providers. Despite the coverage of less than ten percent of the country's population, the number of the beneficiaries has been growing from 2,925,000 in 1991 to 5,180,000 in 1995.

Main contractors (MCs) are hospitals that contract directly with the Social Security Office (SSO), taking immediate responsibility for providing medical care to the SSS beneficiaries registered with them. MCs can be public or private hospitals. Private hospitals can choose to become MCs, but they must satisfy the standards set by the SSO (Social Security Office, 1994). They are paid prospectively by the Office on a capitation basis. From 1991 to 1994, they received an advanced payment of 700 baht per person per year. (US$1 ≈ 40 baht). In 1995, the capitation rate was increased to 800 baht. Recently in early 1998, the amount has been raised to 1,000 baht for the first 50,000 registered beneficiaries, and 900 baht beyond the 50,000 threshold.

Conceptually, the scheme should positively affect private hospital business as it expands the size of population that can afford private hospitals and brings additional steady flow of revenue and new opportunities for other related services, such as child delivery and care for work-related injuries. It may also stimulate the business to improve their quality and efficiency (Chaiwongkait, 1992). However, given the capitation payment, contracted hospitals consequently become at risk for admissions, lengths of stay, and resources used to serve this

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market - a situation that rarely exists in the traditional fee-for-service market (Bodenheimer and Grumbach, 1994). MCs have to bear almost all the financial risk associated with health care provided to their defined groups of beneficiaries despite predetermined additional payments for certain specialized services and materials, such as hemodialysis and chemotherapy. Some services are not covered, such as organ transplantation (Social Security Office, 1995). Sriratanaban *et al* (1998) found that private hospitals in Bangkok and vicinity provinces perceived both positive as well as negative overall impacts of the SSS on the private hospital industry although positive impacts predominated. Empirically, another study of Sriratanaban (1998a) demonstrated that private MCs were relatively more profitable than non-MC hospitals during 1994-1995, and some environmental, organizational and managerial factors could predict private hospital participation in the scheme.

Nationwide, the number of MCs and their network subcontractors, particularly private ones, have been growing since 1991. The number of private MCs increased from 18 in 1991 to 72 in 1996 (Social Security Office, 1997). Although the government and the SSO encourage participation of private hospitals to maximize access to care for the beneficiaries, several eligible private hospitals have not done so. In Bangkok and provinces, only 41 out of 172 providers with beds (24 %) were MCs in 1995 (Medical Registration Division, 1995; Social Security Office, 1996). Therefore, we examined the questions of whether private MCs really wanted to become health care providers under the scheme-*ie* whether they entered the scheme because they had no choice-and whether non-MC hospitals wanted to join the SSS but they could not do so for some reasons. We also assessed whether their intention was related to organizational characteristics and personal characteristics of hospital executives.

MATERIALS AND METHODS

A *cross-sectional interview survey* was conducted from August 1996 to May 1997. The sample comprised all 94 private hospitals in Bangkok, the capital city, and five vicinity provinces that meet the following criteria: 1) Being legally registered with Ministry of Public Health, and named as a hospital; 2) Having more than 25 registered beds in 1994; 3) Being owned by companies or foundations; 4) Having been in operation for at least the two full years of 1994 and 1995, and remaining open during the survey; 5) Providing modern medical services with multi-specialties; and 6) Acting as an independent unit. The study area included over 47% of all private hospitals larger than 26 beds nationwide (Medical Registration Division, 1995) and had around 66% of the total number of registered SSS beneficiaries in 1995 (Social Security Office, 1995).

One of the following hospital executives, or an equivalent, was interviewed in each hospital: Chief Executive Officer, Hospital Director, or Deputy Hospital Administrator, or persons designated by these individuals as the equivalent. A pre-tested semi-structured questionnaire was used for the interview. It included the question whether an interview are really wanted his or her hospital to be a main contractor (MC) under the Social Security Scheme, irrespective of the hospital's current status-whether the hospital was an MC. The executive also had to give brief explanation of why the hospital intended or did not intend to be MC.

Self-assessment method was used to assess hospital strategies (Snow and Hambrick, 1980). Given descriptions of Porter's competitive strategies (Porter, 1980), hospital executives were asked to characterize their hospitals' leading strategies. *Differentiation* hospitals tried to make themselves unique in the mind of customers. *Cost leadership* hospitals minimized their costs of providing service, while hospitals with *focus* strategies emphasized serving only specific target groups. Moreover, the executives were asked to classify how proactively their hospitals had strategically behaved for the past five years based on Miles and Snow's typology of strategies. (Miles and Snow, 1978) In brief, they include: 1) *Defender*– maintaining stability, control and efficiency and engaging in little search for additional opportunities for growth; 2) *Reactor*– having inconsistent and unstable pattern in adjusting to its environment; 3) *Analyzer*– combining control and flexibility and pursuing new opportunities after thorough analysis; 4) *Prospector*– seeking to be flexible, actively pursuing new products and market opportunities. The self-assessment approach was considered to be fairly reliable and valid. The details of the tests of their reliability and validity were discussed and presented elsewhere (Sriratanaban, 1998b).

Table 1

General characteristics of responded private hospitals in the study

Characteristics of hospitals	No. of hospitals (%)
Geographic location:	
Inner Bangkok	44 (53.0)
Border Bangkok	15 (18.1)
Vicinity areas	24 (28.9)
Ownership status:	
Not-for-profit	9 (10.8)
For-profit, not listed in Stock Exchange of Thailand	64 (77.1)
For-profit, listed in Stock Exchange of Thailand	10 (10.6)
Registered number of beds:	
less than 100 beds	21 (25.3)
100 - 199 beds	32 (38.6)
200 beds or more	30 (36.1)
Main contractors under the Social Security Scheme:	36 (43.4)
Characteristics of interviewed hospital executives:	
Gender:	
Male	70 (84.4)
Female	13 (15.7)
Age:	
< 45 years old	31 (37.4)
45 - 60 years old	33 (39.8)
> 60 years old	19 (22.9)
Administrative position:	
Hospital director or CEO	53 (63.9)
Others, such as deputy directors	30 (36.1)
Years in current position:	
0 - 2	25 (30.1)
3 - 5	37 (44.6)
6 +	21 (25.3)
Medical training	60 (72.3)
Degree in management:	
None	67 (80.7)
Bachelor	9 (10.8)
Master	5 (6.0)
Others	2 (2.4)
Management experience before present position:	
None	34 (40.9)
Private hospital	17 (20.5)
Public hospital	23 (27.7)
Others	9 (10.8)
Holding > 1% of share of the hospital	41 (49.4)
Total number of responded hospitals	83 (100.0)

A hospital was treated as a unit of analysis. There were four executives, each of which managed two hospitals. The information from them was applied to all applicable hospitals they were managing.

Table 2

Numbers of the private hospitals by their intention to participate as main contractors and their participation status in the Social Security Scheme.

	No. of hospitals by participation status in 1995 (%)		Total
	Main contractors	Non-main contractors	
Want to participate as a main contractor	22 (61.1)	24 (51.1)	46 (55.4)
Do not want to participate as a main contractor	14 (38.9)	23 (48.9)	37 (44.6)
Total	36 (100.0)	47 (100.0)	83 (100.0)

x^2 (1df) = 0.833; p= 0.361

Overall, the response rate was 88.3 % (83 out of 94 hospitals). Non-respondents were not different from respondents in terms of geographic location (Fisher's exact test: p = 1.000), ownership status (p = 0.592) and system membership (p = 0.126). The response rates of non-MC and MC hospitals were 87.0 % and 90.0 %, respectively (p = 0.754). However, small hospitals (26-99 beds) were slightly less likely to participate in the study than medium-size (100-199 beds) and large (200 beds up) hospitals (75% *vs* 89% and 100% respectively; p = 0.009). Despite the difference, the response rate among small hospitals was still satisfactorily high. However, there were four executives, each of whom managed two hospitals. Each of them was interviewed only once. Since a hospital was treated as a unit of analysis, the information obtained from the interviews with them were duplicated for those hospitals they managed. Table 1 presents general characteristics of the 83 private hospitals and their interviewed executives participated in the study.

Statistical analysis

Using STATA 5.0 for Windows, chi-squared tests and Fisher's exact tests were primarily applied to explore relationships between the management's intention and personal factors, as well as hospital characteristics.

RESULTS

Among the 83 respondent hospitals, Table 2 reveals that 46 hospitals (55.4 %) expressed their intention to be main contractors (MCs). Among MCs in 1995, only 22 hospitals (61.1 %) indicated their true intention to become MCs. On the other hand, more than half of the non-MC hospitals said that they wanted to participate in the social security scheme (SSS) as MCs. The current participation status of the private hospitals in the scheme was not related significantly to their intention to become MCs (p = 0.361).

Table 3 provides explanations of some private hospitals, both MC and non-MC hospitals, on why they wanted to be MCs. The most prevalent justifications were operational and marketing-related in nature. Some hospitals also explicitly indicated profit potential of the scheme. It should be noted that certain operational and marketing-related motives to participate in the scheme were obviously predominating among non-MCs.

In contrast, Table 4 presents reasons given by some hospitals explaining why they did not want to

Table 3

Explanations why the private hospitals wanted to participate in the Social Security Scheme (SSS) as main contractors (MCs).

Explanations	No. of hospitals	
	MC	Non-MC
Hospital benefits		
• Financial		
1. The hospital can benefit from providing services under the SSS in terms of profit.	3	2
2. The SSS increases hospital's cash flow and income.	1	1
3. The hospital receives higher compensation in lump sum than being a subcontractor.	-	1
• Operational and marketing-related		
1. Most of patients are SSS beneficiaries / in the similar market / the SSS helps maintain patient base / the current market fills with SSS beneficiaries.	3	3
2. The SSS market is expanding now and in the near future / the trend of hospital business is to involve health insurance more and more; the SSS is a good opportunity for learning the trend and its problems.	3	3
3. It is a good opportunity for business, particularly in factory area.	1	4
4. Participation attracts new SSS patients and patients of other related fund, company employees, accidental insurance patients.	1	1
5. The hospital wants to be an industrial hospital.	1	-
6. It is good for the hospital in the "3-star" level.	-	1
7. It promotes public image, but the obstacle is compensation.	-	1
• Other		
1. The SSS helps support the expanding hospital.	-	1
2. The SSS brings more work to the hospital.	-	1
General benefits		
1. It is good for SSS patients; good for people in general.	2	-
2. The hospital wants to service all classes of patients, and treat everyone equally.	-	2
Other comments		
1. It depends on governmental policy; the SSS has good standards but the hospital will quit if they are unclear, and wait for a better system.	2	3
2. It enables the hospital to help society, the poor and the government.	-	3
3. The hospital would like to participate if the reimbursement and guidelines are good.	-	1
4. The SSS administration currently is thrifty.	-	1
No specific comment	2	2

be MCs. Again, operational and marketing-related excuses dominated. A few MC hospitals indicated that they would rather quit if they could survive in their traditional fee-for-service market alone. Some hospitals saw that becoming MCs was not profitable as they would have to take substantial financial risk owing to the capitation payment method. Their income would be fixed while their costs were increasing. Moreover, social security patients paid no co-payment when they used hospital services,

Table 4

Explanations of why the private hospitals did not want to participate in the Social Security Scheme (SSS) as main contractors (MCs).

Explanations	No. of hospitals	
	MC	Non-MC
Hospital benefits		
• Financial		
1. The hospital risks a financial loss if SSS beneficiaries choose and use the hospital; hospital services for the SSS perse are not profitable.	3	1
2. The hospital has high operating cost; the cost is increasing; the hospital cannot reduce the cost.	1	3
3. The SSS compensation is limited / the capitation rate is too low for the hospital to break even.	1	1
• Operational and marketing-related		
4. The SSS requires different positioning, incompatible with current positioning of the hospital; it is a different target group.	2	6
5. Participation would create problems in service management and double standards of treatment for patients.	2	1
6. The SSS complicates services and creates many unfavorable impacts on patient care.	2	1
7. Being an MC limits a potential to upgrade the hospital to first-class; the ultimate goal of the hospital is a first-class one.	2	-
8. The hospital needs to change its system	-	1
• Other		
9. The SSS looks problematic as seen in the case of current MCs; the hospital does not meet requirements to participate, or is not ready for Social Security Scheme.	2	4
10. The hospital may withdraw when it is well established; being an MC is good for the beginning; the hospital needs to review the scheme whether it can stand on its own target market.	3	-
11. The hospital has limited number of specialties; doctors are mainly specialists, not general physicians.	-	2
12. The hospital has full capacity and limits.	-	2
General complaints		
1. Providing services under the SSS is tiring; SSS patients are demanding and have incorrect understanding of the scheme, leading to abuse due to no co-payment.	4	-
2. The scheme can do more harm than good; it may have negative impact more than positive impacts, leading to malpractice	-	2
No specific comment	1	3

leading to abuse and unnecessary use of health services.

Table 5 indicates that whether private hospitals wanted, or did not want, to become MCs was associated with ownership status ($p = 0.001$) and leading competitive strategies of the hospitals ($p = 0.041$). All not-for-profit hospitals stated that they wanted to join the scheme but only one of them was an MC in 1995. At the same time, differentiation hospitals were much less likely to express their intention to become MCs. Nevertheless, the intention was not significantly related to the other hospital characteristics. In addition, it was not associated personal characteristics of hospital executives, including gender [chi-squared test (1df): $p = 0.901$], age (Fisher's exact test: $p = 0.538$), physician status [chi-squared test (1df): $p = 0.175$], business education (Fisher's exact test: $p = 0.222$), current position (Fisher's exact test: $p = 0.257$) and previous management experience (Fisher's exact test: $p = 0.541$).

Further analysis using logistic regressions indicated that, based on the likelihood ratio tests, the model with both ownership status (whether a hospital was listed in the stock market) and competitive strategy variables was not significantly different from the univariate models with only either one of the variables ($p > 0.05$).

Table 5

Relationship between organizational factors and the intention of the private hospitals to become main contractors (MCs).

		Do not want to be MC	Want to be MC	Total (%)	Significance
Geographic location	Inner Bangkok	22 (50.0)	22 (50.0)	44 (100.0)	
	Border Bangkok	7 (46.7)	8(53.3)	15 (100.0)	Fisher's exact:
	Vicinities	8 (33.3)	16 (66.7)	24 (100.0)	$p = 0.412$
Ownership status	Not-for-profit	0 (0.0)	9 (100.0)	9 (100.0)	
	For-profit, not listed SET	29 (45.3)	35 (54.7)	64 (100.0)	Fisher's exact
	For-profit, listed SET	8 (80.0)	2 (20.0)	10 (100.0)	$p = 0.001$
System membership	Independent	20 (41.7)	28 (58.3)	48 (100.0)	
	System with no MC	4 (33.3)	8 (66.7)	12 (100.0)	Fisher's exact:
	System with MCs	13 (56.5)	10 (43.5)	23 (100.0)	$p = 0.386$
Hospital size	26-99 beds	6 (28.6)	15 (71.4)	21 (100.0)	x^2 (2 df) =
	100 - 199 beds	16 (50.0)	16 (50.0)	32 (100.0)	2.916
	200 + beds	15 (50.0)	15 (50.0)	30 (100.0)	$p = 0.233$
Having physicians in top management	No	2 (33.3)	4 (66.7)	6 (100.0)	Fisher's exact:
	Yes	35 (45.5)	42 (54.5)	77 (100.0)	$p = 0.688$
Leading competitive strategy	No leading strategy	2 (25.0)	6 (75.0)	8 (100.0)	
	Focus	10 35.7)	18 (64.3)	28 (100.0)	
	Differentiation	16 (69.6)	7 (30.4)	23 (100.0)	Fisher's exact:
	Cost leadership	9 (37.5)	15 (62.5)	24 (100.0)	$p = 0.041$
Strategic proactiveness	Defender	11 (45.8)	13 (54.2)	24 (100.0)	
	Reactor	4 (22.2)	14 (77.8)	18 (100.0)	
	Analyzer	9 (50.0)	9 (50.0)	18 (100.0)	Fisher's exact:
	Prospector	13 (56.5)	10 (43.5)	23 (100.0)	$p = 0.159$
	Total	37 (44.6)	46 (55.4)	83 (100.0)	

DISCUSSION

The study from the provider perspective yields valuable feedback information about the social security scheme. The results we observed indicate that a majority of private hospitals in Bangkok and vicinity wanted, rather than did not want, to be main contractors (MCs) in the scheme. Surprisingly, the intention was not associated with the participation status as an MC. The evidence also suggests that the MC status seems to yield several benefits to the hospitals. However, a number of the hospitals mentioned many operational, marketing-related and financial drawbacks from participation in the SSS as health care providers, explaining why they did not intend to join the scheme.

It is suggestive that the interest among private hospitals in joining the SSS might result from their attempts to maintain and expand market bases, as well as from the profit potential of the scheme. The latter notion is supported by the study of Sriratanaban (1998a) previously mentioned and the study of Kamol-ratanakul *et al* (1993), which conducted a survey of SSS beneficiaries in Samut Prakan, one of Bangkok's vicinity provinces. They found that, in the early years of the SSS, service utilization rates-outpatient and inpatient-among MCs were much lower than expected.

Despite their intention, certain hospitals could not join the scheme. The evidence suggests that the barriers to entry may include being unqualified to the standards set by the Social Security Office and the perceptions of uncertainty in the scheme-related policies. In addition, the intention to join the SSS was at least determined by ownership status-a proxy for hospital missions-and competitive strategies. They probably were the most important barriers to entry, as indicated by non-MC hospitals. According to Shortell *et al* (1991), these factors define the strategic comfort zone of the hospitals-the area in which organization members both desire and feel able to adapt. Incompatibility of strategies and services might jeopardize quality of care and organizational performance in terms of double standard of services and high operating costs. Adverse effects on patient outcomes might occur due to attempts to control cost.

On the other hand, the relatively large number of MC hospitals (as of 1995) indicated that they did not really want to become MCs. The finding suggests that some hospitals might participate in the SSS since they had no choice. The major concern seems to be that, at that time, the scheme tended to be too economical for some when it came to the hospital payment issue. There is no patient co-payment at the point-of-service. The community-rated capitation rate might not justify the financial risk some hospitals had to bear and, thus, did not encourage participation of quality hospitals. According to the Secretary General of the SSO, the Office has already given extra compensations to MC hospitals with high utilization rates ranked in percentiles. Nonetheless, it could be foreseen that some private hospitals would leave the scheme when the environments become munificent enough, and when they could expand their patient base in the fee-for-service market despite the observed recent expansion of the private MC network of the SSS. In either case, SSS beneficiaries would lose their access to care. Quality of care would be jeopardized due to diminishing competition.

Nevertheless, some limitations of the study should be taken into consideration when applying the findings. First, although the study embodied a fairly large group of private hospitals and MCs in Thailand, generalizability of the findings to represent the whole country was limited due to the definition of the sampling frame to Bangkok and its vicinity provinces. Second, the validity of the findings relied somewhat on the assumption that the answers of the interviewed executives represented the management bodies of the hospitals. It was possible that other management team members might have different opinions. Third, it was also possible that certain negative findings of relationships between the intention to become MCs and some hospitals as well as executive characteristics were the results of insensitivity of the measures we used, or inadequate statistical power. However, to increase the sample size and to include hospitals from the whole country might jeopardize the internal validity of the study due to uncontrolled variations of hospital environments. The incremental external validity was considered not justified. Finally, there are interesting observations that need further investigations: for example, how the MCs arrange services for SSS beneficiaries, whether there are any differences in patient services between MC hospitals which showed their intention to be MCs and those which did not, and whether the differences affect patient outcomes.

In conclusion, there are differences in intention to participate as health care providers in the social

security scheme among private hospitals, irrespective of their current participation status. The Social Security Office should be aware of the intention to participate of the private hospitals, as well as their underlying motives, in order to plan and adjust its policies and payment schemes as appropriate. The Office might provide technical assistance to reduce some barriers to entry. Benefits of the scheme beneficiaries-in terms of choices, quality of care and access-will then be effectively managed and efficiently maximized.

ACKNOWLEDGEMENTS

This study used the data collected simultaneously by the survey conducted for the study of "Predictors and Financial Outcome of participation in a Social Insurance Program among Private Hospitals in Bangkok and Vicinity" by Jiruth Sriratanaban, Ong-arj Viputsiri and Mayuree Chiravisit, funded by Rachadapisek-sompoj research fund of the Faculty of Medicine, Chulalongkorn University, Bangkok, Thailand. All contributors to the data collection process of the study, both public agencies and private hospitals, were also gratefully acknowledged here.

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