Participatory and responsive governance in universal health coverage: an analysis of legislative provisions in Thailand

Aniqa Islam Marshall 1,1, Kanang Kantamaturapoj,2 Kamonwan Kiewnin,1 Somtanuek Chotchoungchatchai,1 Walaiporn Patcharanarumol,1,3 Viroj Tangcharoensathien1

ABSTRACT
Participatory and responsive governance in universal health coverage (UHC) systems synergistically ensure the needs of citizens are protected and met. In Thailand, UHC constitutes of three public insurance schemes: Civil Servant Medical Benefit Scheme, Social Health Insurance and Universal Coverage Scheme. Each scheme is governed through individual laws. This study aimed to identify, analyse and compare the legislative provisions related to participatory and responsive governance within the three public health insurance schemes and draw lessons that can be useful for other low-income and middle-income countries in their legislative process for UHC. The legislative provisions in each policy document were analysed using a conceptual framework derived from key literature. The results found that overall the UHC legislative provisions promote citizen representation and involvement in UHC governance, implementation and management, support citizens’ ability to voice concerns and improve UHC, protect citizens’ access to information as well as ensure access to and provision of quality care. Participatory governance is legislated in 33 sections, of which 23 are in the Universal Coverage Scheme, 4 in the Social Health Insurance and none in the Civil Servant Medical Benefit Scheme. Responsive governance is legislated in 24 sections, of which 18 are in the Universal Coverage Scheme, 2 in the Social Health Insurance and 4 in the Civil Servant Medical Benefit Scheme. Therefore, while several legislative provisions on both participatory and responsive governance exist in the Thai UHC, not all schemes equally bolster citizen participation and government responsiveness. In addition, as legislations are merely enabling factors, adequate implementation capacity and commitment to the legislative provisions are equally important.

BACKGROUND
Responsive governance is one of the key goals for a health system,12 which requires public participation and engagement in decision-making to improve public services and patient satisfaction, increases utilisation and compliance to treatment, and overall contributing to better health outcomes and well-being of the population.34 According to the Declaration of Alma-Ata, ‘people have the right and duty to participate individually and collectively in the planning and implementation of their healthcare’.5 Participatory governance mechanisms facilitate citizen participation in public policy processes to increase citizen empowerment,
promote deliberative democracy and ultimately bolster government responsiveness, accountability and transparency, leading to the provision of adaptive, resilient and people-centred public services. Several countries have implemented governance reforms in the health sector to increase citizen involvement in strategic decisions on health services and policies, and strengthen health governance, especially health system responsiveness to population needs. Outcome of these reforms have included increased government spending on health, pro-poor fund allocation, expansion of health infrastructure, and improved quality and efficiency of health services catering to citizens’ needs.

Legal frameworks are key entry points and enabling factors which support participatory and responsive governance. In Thailand, the National Health Act 2007 ensures citizen involvement in health decision-making, through participation in the annual National Health Assembly alongside multistakeholders including government agencies, policymakers and academia. Deliberations and resolutions at the assembly are adopted in consensus and have resulted in the adoption of some legislations such as the Prevention and Solution of the Adolescent Pregnancy Problem Act 2559 BE (2016) and Cabinet resolutions with legal and enforcement power such as the total ban of chrysotile asbestos. Legislative provisions on participatory governance embedded in the 1997 Constitution Article 170, and the 2017 Constitution Article 133 promote citizen participation in the ‘initiative process’ (a form of direct democracy where citizens can propose legislation) through submission of draft Acts for consideration by legislative bodies. These provisions enabled Thai citizens integral role in driving universal health coverage (UHC), including proposing a citizen-led draft bill on UHC endorsed by 50,000 electors, and active participation in the policy formulation process leading to the enactment of the National Health Security Act (NHSA) and ultimately the implementation of UHC in 2002. Through the adoption of the NHSA, the Universal Coverage Scheme (UCS) was introduced, providing health coverage to those insured by the previous Medical Welfare Scheme for low-income households and socially disadvantaged groups, and the publicly subsidised Voluntary Health Insurance for the informal sector, and additionally extended coverage to 30% of the population not previously insured. Together with the Civil Servant Medical Benefit Scheme (CSMBS) and Social Health Insurance (SHI), UCS resulted in the full health coverage of the Thai population (see Table 1 for a summary of the three schemes).

There are studies on Thai health system reform, UHC benefit package, impact of UHC on health status, equity, and financial risk protection; however studies on the legislative provisions and role of participatory and responsive governance in the UHC are still lacking. This study aims to identify, analyse and compare the legislative provisions related to participatory and responsive governance within the three public health insurance schemes (UCS, CSMBS and SHI) constituting UHC in Thailand. Drawing lessons from Thailand can be useful for low-income and middle-income countries in their legislative process for UHC.

### METHODS

#### Conceptual framework

To guide data collection and analysis, authors developed a conceptual framework derived from available literature. Authors purposively searched on PubMed, and grey literature was obtained through searches of WHO and other relevant UN databases, using search terms including “participation theories, health responsiveness, responsive governance, participatory governance”. A total of 340 articles were obtained and screened by authors. Authors selected 13 articles based on relevance to the themes of legislations on citizen participation and responsive governance in health systems through internal discussion, and thematically categorised the information to develop the conceptual framework.

### Table 1 Universal health coverage schemes in Thailand

<table>
<thead>
<tr>
<th>Medical Welfare Scheme</th>
<th>Civil Servant Medical Benefit Scheme (CSMBS)</th>
<th>Social Health Insurance (SHI)</th>
<th>Voluntary Health Insurance Scheme</th>
<th>Universal Coverage Scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy legal framework</td>
<td>Government policy</td>
<td>Royal Decree on Medical Benefits of Civil Servant</td>
<td>Social Security Act</td>
<td>Government policy</td>
</tr>
<tr>
<td>Population</td>
<td>Poor, elderly, children &lt;12 years and other underprivileged groups</td>
<td>Civil servants and their dependents</td>
<td>Private sector employees</td>
<td>Non-poor informal sector</td>
</tr>
<tr>
<td>Population coverage (%)</td>
<td>Not applicable</td>
<td>6 million (9)</td>
<td>11 million (16)</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

Not applicable 6 million (9) 11 million (16) Not applicable 51 million (75)
Data collection

The three public health insurance schemes constituting UHC in Thailand are each established and governed through individual laws. CSMB was enacted under the Royal Decree on Medical Benefits of Civil Servant (RD-MSCS) 1980, which was amended by the RD-MSCS 2010. SHI was enacted under the Social Security Act (SSA) 1990, amended by the SSA 2010, and UCS enacted under National Health Security Act (NHSA) 2002. Each of the three policy documents in the original Thai text was obtained from the Thai Royal Gazette through the Office of the Council of State.

Data analysis

Using a directed qualitative content analysis based on the conceptual framework in figure 1, each legal document was individually reviewed, and legislative provisions relevant to the conceptual framework were categorised then translated and interpreted in English. Taking the analysis of each individual document, the information was analysed side by side to explore the commonalities and differences across elements based on the conceptual framework.

RESULTS

Conceptual framework

Responsive governance aims to meet and adapt to the changing health needs of citizens, and promote and improve access and quality of health services. According to the ‘WHO Framework for Measuring Responsiveness’, responsiveness to citizens aims to protect citizens’ dignity, autonomy and confidentiality, ensure prompt attention and quality of services, and enable access to social support networks and choice of provider or facility. Additionally, responsiveness ensures dissemination and access to public information. Participatory governance aims to increase citizen participation in public policy processes. Involvement of citizens in the decision-making of public services can lead to governance solutions tailored to the needs of the community, ensuring more adaptive and responsive services catering to public demands. Public involvement can be viewed as a right and duty of citizens to increase democratic decision-making, and right to information and enhance accountability and responsiveness; as a result improve governance of public services and make government’s decisions more transparent and equitable. Participatory governance increases government responsiveness as it reduces the conflicts between the agent (the government) and principals (the citizens who elect the government) through proper incentive structure for the agent, bidirectional information flows, and minimise the discretion power of the agent when citizens are included in the decision-making. Reciprocally, studies have found that effective government responsiveness to citizens encourages greater participation and promotes outcomes of participatory governance.

Figure 1 Conceptual framework—synergistic and reinforcing between participatory and responsive governance. UHC, universal health coverage.
Participatory governance

Citizen representation and involvement in UHC governance, implementation and management

In the UCS, 10 provisions (NHSA Sections 13, 17, 18, 19, 21, 41, 42, 47, 48, 50) ensure citizen representation and involvement. The 30-member governing body of UCS, the National Health Security Board (NHSB), must consist of five citizens. Citizens are selected among themselves from the nine civil society organisation (CSO) constituencies registered with the Ministry of Interior whose works are related to (1) children and adolescents; (2) women, (3) elderly, (4) disabled and mentally ill patients, (5) patients with HIV and chronic disease, (6) labour, (7) slum, (8) agriculture and (9) minorities. Each board member is allocated one vote, with decisions made based on majority: providing citizens with 17% (5 out of 30) of the board’s voting power. The board directs and oversees the performance of the management and the operation of the scheme. This gives citizens the power to influence decisions on the standards and scope of health services, appointment of the secretary general to effectively implement the scheme, regulations and approval of administrative policies, financial plans, annual budget ceiling and other relevant governance matters. The board also ensures transparency and accountability of the scheme’s governance to citizens, with the duty to ensure the scheme is suitable and responds to the needs of different populations across the country, by supporting and coordinating with local government organisations. Citizens are also represented in the scheme’s Standard and Quality Control Board (QSBB). Similar to the NHSB, the 35-member QSBB must consist of five citizen representatives (14%), selected from the same nine CSO constituencies. Through this board, citizens via their CSO members, can indirectly influence decisions on the quality of care, make decisions on complaints, audit quality of care and decide on payments for no-fault financial assistance to patients experiencing adverse events from medical treatment to directly meet the needs of citizens.

In the SHI scheme, Section 8 of the 2015 amendment, as well as Sections 9 and 13, are relevant to citizen representation and involvement. The 21-member Social Security Committee must consist of seven members representing employers and seven members representing employees; while the remaining seven are ex-officios from the government. Citizen representatives in the committee are appointed by the Ministry of Interior based on the results of an election fully participated by employees, men and women, as well as disabled and disadvantaged populations. Each committee member has one vote with decisions made based on majority, giving employees 33% (7 out of 21) of the voting power. Through representation in the committee, employees have the ability to influence the decisions on regulations, policy, implementation, finances, budgetary decisions and expenses of the scheme.

Citizens’ ability to voice concerns and improve UHC

There are five provisions relevant to citizens’ ability to voice concerns in the NHSA (Sections 18, 26, 50, 57–60) and one provision (Section 85) in the SSA.

The NHSB and QSBB in UCS have the duty to facilitate citizens in lodging complaints and citizens are entitled to file against health facilities that do not comply with standards set for its members. This includes inadequacy of the facility in responding to citizen needs and adverse events from medical treatment. The National Health Security Office (NHSO), responsible for managing the scheme, is directly mandated to handle citizens’ complaints and take action. Similarly, for SHI, beneficiaries are entitled to voice concerns by filing complaints if dissatisfied with decisions on the scheme.

NHSA also mandates UCS’s boards to improve the quality and standard of health services based on the needs of citizens through gathering opinions from citizens, by holding annual public hearings with both service providers and citizen beneficiaries.

Responsive governance

Enable access to information

The Act governing UCS encourages citizens access to information on the scheme’s governance. Sections 26 and 43 of the Act mandate public disclosure of the annual performance, budget execution and annual budget utilisation. The NHSO is required to produce and publicly disseminate annual reports on the performance and operational obstacles, as well as publish financial documents reported by the boards related to revenue and use of the National Health Security Fund in the Royal Gazette, which is publicly available. These provisions demonstrate transparency and responsiveness to members in ensuring access to information to further empower citizens with knowledge to better actively participate in the scheme’s governance and ensuring its transparency.

Both UCS and SHI schemes ensure access to information on health services and facilities to increase responsiveness to citizens’ needs on health facility options and autonomy in making decisions on their facility or treatment of choice, as mandated in NHSA Sections 26, 44, 45 and 50, and SSA Section 59.
In UCS, the QSB must develop an information dissemination system to ensure access to relevant information on health services, and NHSO must publicise information regarding health service facilities to ensure citizens can make informed decisions. Health facilities are also required to provide accurate information on the diagnosis, treatment and alternative options to safeguard citizen autonomy in making decisions on their health and treatment choice.

In SHI, the information on the location and name of health facilities, which members can avail services, must be publicly available through publication in the government gazette.

Enable access to care
Ensuring access to care is mandated in the NHSA Sections 6–8, 26, 38 and 44, SSA Section 59 and RD-MSCS Sections 8, 13, 16 and 17.

In UCS, the ‘National Health Security Fund’ aims to pay for health services and allocates resources to strengthen health facilities in geographical areas with inadequate health facilities. The fund allows for improvements of supply side capacity that facilitate access to healthcare in disadvantaged areas.

For UCS members, the NHSO is required to register all members with a provider network of their choice, including on-site registration at the first use of services, for those who have not registered and immediately entitling them to health services; which indicates responsiveness to citizens’ need for prompt attention to care for those not yet registered but in need of healthcare. The Act also facilitates re-registration to different facilities to enable changes in residence or temporary migration such as for seeking jobs outside their domicile district, ensuring continued rights to health services. For accident and emergency cases, members are also covered at any nearest health provider, further supporting responsiveness to citizens’ prompt attention to access to care.

Similarly, SHI members are also entitled to their choice in health facility and changing of health facility of choice.

In contrast, civil servants under CSMBS require no registration to a health facility, but are entitled to their choice of any government hospital. Civil servants also have the ability to choose private facilities for accidents and emergencies or when government hospitals are unable to provide adequate care and therefore must transfer patients to a private facility. Additionally, healthcare costs for civil servants working or studying in foreign countries are also reimbursable by the scheme, ensuring prompt attention to health services based on the needs of members.

Ensure quality of care
Legislative provisions in the NHSA (Sections 5, 18, 26, 41, 42, 45, 50 and 57–60) and SSA (Section 63), and the RD-MSCS (Section 13) ensure provisions of care are responsive to citizens’ need for standard quality of care.

UCS members are ensured the right to quality health as the QSB and NHSO are mandated to set standards and ensure health services adhere to standards to meet citizen needs. Facilities are required to ensure prompt attention to services, protect and respect members’ dignity, grant access to social needs and maintain confidentiality. The boards are mandated to investigate any complaints made by members on facilities that are unable to meet citizen’s needs. If facilities are found to be compliant, the boards may issue warnings to respect members’ rights and benefits or take disciplinary actions, such as de-listing these health facilities from the UCS systems or legal actions against the facilities. The NHSB is also mandated to earmark not more than 1% of the National Health Security Fund for an initial ‘no-fault’ financial assistance to patients experiencing adverse events from medical interventions. Members who have been damaged by health services can be compensated, to minimise the pain and suffering resulting from the loss of life, disability or morbidity. Similarly, SHI members are also entitled to no-fault compensation for adverse events from medical services to protect members’ needs to quality and standard health services.

For CSMBS, as choice of healthcare facilities are at the discretion of civil servants, where members are free to use any public facilities, including tertiary and specialist hospitals, members are able to seek facilities they deem to have the best quality care. In cases where a public health facility is unable to provide certain services, beneficiaries are also entitled to services at private health facilities and be reimbursable by the scheme.

Table 2 summarises legal provisions related to participatory and responsive governance across three insurance schemes.

Variations across schemes
Participatory governance is implemented in the form of citizen representation in the management of the schemes as well as ability to voice concerns to improve the schemes for both UCS and SHI. In contrast, the legal provisions in the RD-MSCS do not propose a governing body or member representation in the governing body for the management of the CSMBS or empower citizen voice.

All four policies consist of responsive governance provisions. All schemes are governed by provisions on citizens’ access to care. In UCS and SHI, the access is granted through ensuring registration to health facility of choice and ability of re-registration when needed, while civil servants are granted access to any public facility of choice and private facilities in specific circumstances. Choice in health facility also serves to ensure civil servants access quality care, while quality and standard of care is explicitly mandated for health facilities under UCS with the board able to take action for incompliance. Additionally, UCS and SHI members are entitled to no-fault compensation and ensure citizens’ access to information. However, there are no such
provisions in the RD-MSCS for civil servants; members are not ensured access to health information and must take their own legal action in case of adverse events.

**DISCUSSION**

Legislative provisions on participatory and responsive governance play an important role in ensuring citizen participation and government responsiveness to citizens in Thailand’s UHC. As Thai UHC is implemented through three public insurance schemes, the extent to which beneficiaries can actively participate in the scheme’s management and obligations of the schemes in responding to its members’ needs highly vary. The NHSA consists of the most sections related to participatory and responsive governance; with 23 sections on participatory and 18 on responsive governance, while five sections (Sections 18, 26, 47, 50 and 59) overlap between the two themes. Box 1 summarises key lessons on participatory and responsive governance for the UCS in Thailand. The SSA consists of the second greatest number of legal provisions on participatory governance with four sections on participatory and two provisions on responsive governance. The RD-MSCS consists of no sections related to participatory governance, and four related to responsive governance. Online supplemental file 1 (available from website) summarises each legislative provision and its interlinks with citizen participation and government responsiveness.

The variations in the insurance scheme are directly related to the involvement and participation of citizens in the initiation and development process of the legislations. Further, the scope of this study covers the analysis of legislative provisions, which are merely enabling factors for responsive and participatory governance. The implementation capacities of each scheme and their commitment are vital in ensuring citizen participation and government’s responsiveness to citizens’ needs.

**Contributions of citizens in UHC legislative process**

The majority of participatory and responsive governance provisions in the Thai UHC are found in the NHSA. This is a direct result of the active engagement of citizens...
in the Act’s legislative process. The contents of the Act originate from CSOs’ proposed draft bill, submitted to the legislative body with endorsement from over 50,000 eligible voters. At the first reading in the House of Representatives, the draft bill was accepted in principle, and five civic group representatives were appointed as members of the parliamentary committee to review and amend the contents in the draft bill article by article in its second reading. Civic group representatives played an active role in the second reading to negotiate the bill’s contents, where the draft bill was finalised and endorsed at the third reading of the House of Representatives.

In contrast, there was neither active engagement by CSOs in legislating the 1990 SSA and its amendment in 2010, nor engagement of civil servants when the RD-MSCS was adopted in 1980.

**Citizen participation in UHC governance**

Study on citizen participation in the Thai UCS found that citizens have actively participated in governance decision-making through representation in the UCS boards, and ensured actions on local problems were taken including policy decisions and management responses to rectify the gaps and increase effectiveness and responsiveness of the scheme. The SHI also has citizen representatives in the governing board, the Quality Board and other subcommittees of the boards of the Universal Coverage Scheme ensures responsiveness of the scheme to citizens’ needs. Voice and concerns raised at the annual public hearing have received policy and management responses for performance improvement.

Responsive governance is demonstrated by public disclosure of the annual performance report which is made publicly available; enabling access to care through registration of members to a preferred healthcare facility network and re-registration as needed in particular temporary changes of address; and ensuring provision of quality care and initial financial support for adverse events.

The implementation capacity and sustained commitment by National Health Security Office is a key factor in the successful translation of these legislative provisions into reality.

Although only the NHSA mandates facilitation of complaint lodging, two other schemes have implemented complaint-handling systems. UCS operates the 24/7 call centre ‘1330’ and supports local CSO complaint centres, as well as the Ministry of Public Health established UCS units at hospitals which support patients in navigating services and resolve conflicts between providers and patients. In 2018, the ‘1330’ call centre received 5248 complaints regarding health facilities, of which 76.01% were addressed within 25 days. The Social Security Office similarly implemented a 24/7 hotline ‘1506’ in 2016, as well as live chat services on the website in order to allow SHI members to ask questions and lodge complaints. Comptroller General’s Department, which manages the civil servant’s scheme, also operates a call centre; however, it is not exclusive for CSMBS but for all consultations related to the function of the department.

The UCS has also implemented provisions on public hearings to gather opinions from citizens by hosting annual hearings for both service providers and UCS members at the provincial, regional and national levels. A study found that the public hearings have been successful in influencing policy decision-making and resulted in the development and expansion of the scheme’s benefit package, including establishment of the Rehabilitation Fund in 2004, authorisation of re-registration with new provider networks up to four times a year in 2012, and termination of restrictions which limit the number of gestations per woman entitled to maternity services in 2015.

**UHC responsiveness to citizens**

Through responsive governance, insurance agencies ensure (a) citizens’ access to information in a transparent manner, (b) access to health services and (c) access to quality of care. Ensuring access to information, the NHSO publishes annual performance and financial reports, publicly available on the NHSO website detailing National Health Security System performance, management of services, expenses and quality control, as well as complaints and satisfaction of health services. The audited financial reports are also submitted to the Cabinet, the Parliament and the Senate for accountability, as the UCS is fully financed by general tax through annual budget allocation. The Social Security Office also publishes an annual report, publicly available on its website, though they are not required to report to the executive and legislative bodies. In contrast, despite being publicly financed, the RD-MSCS does not require the Comptroller General’s Department to produce publicly available annual reports on CSMBS performance.

Access to health services is guaranteed for all schemes. Civil servants have access to any of the 11,959 public health providers across the country. UCS members are able to

---

**Box 1  Key lessons on participatory and responsive governance for Universal Coverage Scheme in Thailand**

- The forward-looking legislative provisions in the National Health Security Act, as a result of citizen participation in the legislative process, are key enabling factors for participatory and responsive governance.
- Citizen participation through civil society organisation representatives in the governing board, the Quality Board and other subcommittees of the boards of the Universal Coverage Scheme ensures responsiveness of the scheme to citizens’ needs. Voice and concerns raised at the annual public hearing have received policy and management responses for performance improvement.
- Responsive governance is demonstrated by public disclosure of the annual performance report which is made publicly available; enabling access to care through registration of members to a preferred healthcare facility network and re-registration as needed in particular temporary changes of address; and ensuring provision of quality care and initial financial support for adverse events.
- The implementation capacity and sustained commitment by National Health Security Office is a key factor in the successful translation of these legislative provisions into reality.
register with one of the approximately 12,000 public and private health service units registered with the NHSO across the country, with the ability to change registration of their health provider up to four times annually at facilities or via mobile application. SHI members can register to one of the 163 public and 79 private main contracting health units available, and are able to change their health provider once annually between 1 January and 31 March at the local Social Security Office, via their website or mobile application. Change of provider during the year is also possible for members who have moved to a new workplace or relocated.

In order to safeguard quality of health services, all public and private hospitals in Thailand need to meet national standardised assessments set by the Health Care Accreditation Institute (HAI) (public organisation). In addition, the NHSO conducts annual service unit inspections to assess all facilities based on nationally set standards and guidelines developed in collaboration with the Ministry of Public Health and relevant stakeholders; in 2019 over 90% of all units passed inspections. The office also conducts unannounced health facility visits, for those suspected to be non-compliant based on complaints and random checks with citizens. The Social Security Office similarly conducts assessments of facilities; annually for private facilities and every 2–3 years for public facilities. In addition, health facilities covering SHI members must also be accredited through the Joint Commission International or Thailand HAI. The Comptroller General’s Department does not conduct assessments, but instead uses the outcomes assessed by NHSO inspections and accreditation status by the HAI for hospitals providing services to civil servants.

A few strengths of this paper are identified. This paper demonstrates how participatory governance increases government responsiveness and reciprocally effective government responsiveness to citizens encourages greater participation and promotes outcomes of participatory governance; both of which have advanced towards a high-performing UCS. Further, the paper highlights the implementation capacity which is equally important as the legislative provisions. However, the design of this study does not allow in-depth understanding of the policy dynamics and conflicts between CSO representatives and ex-officio members in the governing board and QSB, as well as conflicts resolution in advancing the UCS performance.

**CONCLUSION**

Comprehensive legislative provisions which cover two synergistic virtues, namely support of citizen participation and enabling government responsiveness, are critical to ensure citizens’ needs and concerns are taken into account when implementing UHC. Responsive governance provides policy spaces for citizen participation, and in turn citizen participation results in responsive governance. Legislative provisions should be accompanied with adequate implementation capacity and sustained commitment.

Citizens and civil society engagement in legislative process of NHSA through the ‘initiative process’ marks the legislation in history. There was no such engagement for the legislative process of the SSA and its amendments or RD-MSCS.

In the quests for UHC, low-income and middle-income countries can draw lessons on how citizens contribute to the legislative process in ensuring provisions related to participatory and responsive governance are in the law. The implementation of these provisions by Thailand’s UHC has proven that legislative provisions are as equally important as the implementation capacity. Further, we found the framework generated from this study is simple, practical and could be applied elsewhere.

**Contributors** VT, AIM, KK and WP jointly designed the study. VT, AIM, KK and SC conducted the analysis. AIM wrote up the first draft of this article. VT, AIM and KK finalised the article. All agreed with the final version for submission.

**Funding** The authors gratefully acknowledge the funding support from WHO Southeast Asia Regional Office through the management of WHO-Thailand and the funding support through the International Health Policy Program (IHPP) from the Thailand Science Research and Innovation (TSRI), under the Senior Research Scholar on Health Policy and System Research (contract no. RTA6280007).

**Competing interests** None declared.

**Patient consent for publication** Not required.

**Ethics approval** Ethics approval was granted by the Institute for the Development of Human Research Protection, Thailand. The ethics approval number is COA No. IHRP2019095 (dated 28 October 2019).

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Data availability statement** All data relevant to the study are included in the article or uploaded as supplemental information. All data used in this paper are publicly available or included in the article.

**Supplemental material** This content has been supplied by the author(s). It has not been vetted by BMJ Publishing Group Limited (BMJ) and may not have been peer-reviewed. Any opinions or recommendations discussed are solely those of the author(s) and are not endorsed by BMJ. BMJ disclaims all liability and responsibility arising from any reliance placed on the content. Where the content includes any translated material, BMJ does not warrant the accuracy and reliability of the translations (including but not limited to local regulations, clinical guidelines, terminology, drug names and drug dosages), and is not responsible for any error and/or omissions arising from translation and adaptation or otherwise.

**Open access** This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/.

**ORCID iD** Aniqa Islam Marshall http://orcid.org/0000-0001-6575-731X

**REFERENCES**

## Web Annex 1 Legislative provisions on participatory and responsive governance

<table>
<thead>
<tr>
<th>Policy Document</th>
<th>Legislative Provision</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Health Security Act</td>
<td><strong>Section 5</strong> Right to a standard and efficient health service.</td>
<td>Participatory governance: N/A&lt;br&gt;Responsiveness governance: Citizens have the right to <strong>quality of basic amenities</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Section 6</strong> Registration for a choice of service unit, with regard given to the convenience and need of the person.</td>
<td>Participatory governance: N/A&lt;br&gt;Responsiveness governance: Citizens have the right of <strong>Choice of health facility</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Section 7</strong> Right to health at the service unit of their own choosing within the available network. Right to access any service facility, taking into consideration the convenience and necessity of the person in the case of justifiable cause, accident or emergency illness.</td>
<td>Participatory governance: N/A&lt;br&gt;Responsiveness governance: Citizens have the right of <strong>Choice of health facility</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Section 8</strong> A person not registered may access any service unit for the first service. In such case, the service unit providing service to the person shall arrange for the registration of a service unit of person’s choice</td>
<td>Participatory governance: N/A&lt;br&gt;Responsiveness governance: Facilities ensure <strong>prompt attention</strong> to citizens by allowing them access to any service for the first time if they had never been registered to any facility prior. Additionally citizens then have the right of <strong>Choice of health facility</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Section 13</strong> &quot;National Health Security Board” must consist of five representatives of the non-profit, non-governmental organizations elected and drawn from nominated representatives of the following fields: (A) children or youth; (B) women; (C) elderly; (D) disabled persons or mental health patients; (E) HIV infected persons or patients with other chronic diseases; (F) laborers; (G) populous communities; (H) farmers; and (I) ethnic minorities.</td>
<td>Participatory governance: N/A&lt;br&gt;Responsiveness governance: Citizens represented in the National Health Security Board empowers citizens to influence board decisions. Citizens have a voice and vote in ensuring their needs are met for: standard of health service facilities and services; governance and regulations of UCS; transparency and accountability of UCS performance and finances; increase general citizen participation through annual meetings.</td>
</tr>
<tr>
<td></td>
<td><strong>Section 17</strong> NHSB decisions must be made by majority of votes. Each member shall have one vote.</td>
<td>Participatory governance: N/A&lt;br&gt;Responsiveness governance: N/A</td>
</tr>
<tr>
<td>Section 18</td>
<td>The NHSB's power and duties. Including quality and standard of health service, effective implementation of the national health security scheme; implementation and management of the Fund, procedures and conditions for payment of preliminary aid, support and coordinate with local government organizations for the implementation and management of the health security system at the local level according to need of the population in the area, support community organization councils, non-governmental organizations, and the not-for-profit private sector to operate and manage the Fund at the local level according to their readiness, appropriateness and need by promoting the participatory processes in the establishment of the national health security for the population in such area as provided in Section 47; produce an annual report on performance and obstacles encountered in the operation of the Board, hold an annual meeting for the Board to receive general opinions from service providers and beneficiaries.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td></td>
<td>selecting audit sub-committee to ensure financial transparency and accountability.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The National Health Security Board must ensure quality of basic amenities, ensure the management of UCS according to the management of the health security system at the local level according to readiness, appropriateness and need of citizens and local population.</td>
<td></td>
</tr>
<tr>
<td>Section 19</td>
<td>The NHSB power and duties to oversee and ensure NHSO function.</td>
<td></td>
</tr>
<tr>
<td>Section 21</td>
<td>The NHSB must appoint an audit sub-committee to review the financial management and the operation of the NHSO to ensure effectiveness, efficiency, transparency and accountability.</td>
<td></td>
</tr>
<tr>
<td>Section 26</td>
<td>NHSO power and duties. Including recording beneficiaries, service units, and networks of service units, managing the Fund, arrange for people to have regular service units and to change regular service units, and publicize information concerning service units; ensure that the health service complies with the standard and to facilitate the lodging of complaints; produce an annual report on performance and obstacles</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Citizens have the ability to lodge complaints on the standards and quality of health services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Citizens have the right know options for service units and their choice of Provider Doctor/Nurse/Care Provider or Facility as well as have the Autonomy to be told information concerning service facilities and have the option to change their choice when wanted. The National Health Security Office is required to ensure the standard of quality of services</td>
<td></td>
</tr>
</tbody>
</table>
encountered in the operation of the NHSB and QSB for dissemination to the public.

| Section 38 | "National Health Security Fund" will support and promote the provision of health service to enable wide and efficient access to health service. Fund used for the development of health service in the areas where service units are inadequate or where service units are not properly decentralized. | N/A | The National Health Security Fund ensures prompt attention of citizens needs in terms of ensuring health facilities are geographically accessible through funding provision to develop facilities in areas inadequately prepared. |
| Section 41 | The NHS must allocate one percent of the budget to service units for financial assistance in the case where a beneficiary is damaged by the medical treatment provided by a service unit. | N/A | The National Health Security Board safeguards citizens dignity to adequate treatment and quality of care by financially assisting citizens that have been damaged by any treatment provided, as per the rules of the board which consists of citizens. |
| Section 42 | If a beneficiary is damaged by the medical treatment provided by a service unit, NHSO must take recourse with the wrongdoer following its payment of preliminary aid to the beneficiary. | N/A | Citizens are given the right to access information on the budget and expenses of the National Health Security Fund, which increases transparency and empowers citizens with knowledge to better actively participate and voice their concerns on UCS. |
| Section 43 | NHSB must submit the balance sheet and report on income and expenditures of the Fund to the Council of Ministers, Prime Minister, House of Representatives and the Senate and arrange for its publication in the Government Gazette. | N/A | Citizens have the right know options for service units and their choice of Provider Doctor/Nurse/Care Provider or Facility. Access to information regarding health facilities to make informed decisions. |
| Section 44 | NHSO must arrange for the registration of service units and networks of service units and publicize information to the public to enable the people to register for regular service units of their choice. | N/A | |

as per the Board which consists of citizens. Citizens are given the right to access information on the performance and problems related of the governance of UCS, which increases transparency and empowers citizen with knowledge to better actively participate and voice their concerns on UCS.
<table>
<thead>
<tr>
<th>Section 45</th>
<th>A service unit must provide health service of quality and standard in a manner of equality that respects personal rights, human dignity and religious beliefs; provide accurate health service information to individuals in respect to diagnosis, procedures, alternatives, and result of treatment including possible side-effects, to enable informed decision whether to utilize its service or to be referred; provide relatives with sufficient information, strictly maintain confidentiality of the beneficiaries, establish a system of health service data in order to facilitate the inspection of quality and service.</th>
<th>N/A</th>
<th>Health service units must ensure quality of basic amenities as per the rules of the board which consists of citizens, protect and respect citizens dignity when accessing services, keep citizens informed on their health information to allow their autonomy in making health care decisions, provide for citizens social needs through keeping their relatives informed, maintain citizens confidentiality.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 47</td>
<td>Ensure health needs for people in the local area are met by promoting the participatory process, and support and coordinate with local government organizations to implement and manage the national health security system at the local level.</td>
<td>Citizen participation in managing UCS is promoted through allowing local organizations and populations to implement UCS in the locality.</td>
<td>UCS is managed and implemented according to local citizens needs.</td>
</tr>
<tr>
<td>Section 48</td>
<td>“Quality and Standard Control Board” must consist of five representatives of non-profit, non-governmental organizations, elected among themselves, from a group of representatives, each of whom has been elected from the following fields: (A) children or youth; (B) women; (C) elderly; (D) disabled persons or mental health patients; (E) HIV infected persons or patients with other chronic diseases; (F) laborers; (G) populous communities; (H) farmers; and (I) ethnic minorities.</td>
<td>Citizens represented in Quality and Standard Control Board empowers citizens to influence board decisions on quality and regulation of services, rules for ensuring citizens ability to file complaints if their rights are violated or damaged by health services and improve services based on citizen needs.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Section 50
QSB power and duties, including ensuring, controlling and promoting quality and standard control of service units, prescribing conditions for filing complaints by the persons whose rights are violated by the service; procedures for considering complaints; providing assistance to the persons whose rights are violated by the service; appointing a complaint unit where a complainant can conveniently submit complaints free from the complainee’s interference; report results of the inspection and the control of quality and standard of service units and networks of service units for improvement of the quality and standard, enhance public participation in the inspection and the control of service units and networks of service units; provide financial assistance to the beneficiaries who are damaged by the medical treatment, support an information dissemination system for use by the public in its decision making related to health service.

### Quality of services must meet citizens needs through following decisions by the board that consists of citizens. Citizens dignity to adequate treatment and quality of care is safeguarded by being compensated if citizens that have been damaged by any treatment provided, as per the needs of citizens through following decisions by the board that consists of citizens. Additionally, citizens are given the right to access information on health services which increases transparency and empowers citizens knowledge to actively participate and voice their concerns as well as autonomy in making informed decisions.

### Section 57
If inspection by NSHO reveals that a service unit fails to comply with the health service standard as required, QSB will be notified and appoint an Investigation Committee to investigate the matter.

### N/A
Quality and Standard Control Board which consists of citizens can punish facilities that do not comply with citizens needs for dignity, confidentiality, autonomy, quality of services and prompt attention to services.

### Section 58
If investigation indicates that a service unit fails to comply with standards: QSB may issue a warning to comply with the standard; issue an order for such service unit to pay an administrative fine; notify relevant agencies to investigate and decide against the health professional who may be responsible for the commission of the wrongful act or proceed with other disciplinary procedures.

### N/A

---

BMJ Publishing Group Limited (BMJ) disclaims all liability and responsibility arising from any reliance Supplemental material placed on this supplemental material which has been supplied by the author(s). BMJ Global Health 6 2021; BMJ Global Health, et al. Marshall AI
### Section 59
Beneficiary, who has not been facilitated by a service unit in a reasonable manner or according to his or her right to public health service is entitled to file a request with NHSO to conduct an investigation. If the investigation indicates wrongdoing QSB must take action: issue a letter of warning to the service unit to treat the complainant appropriately and properly in accordance with his or her rights and benefits, facilitate or observe the right of the complainant; issue a letter ordering the service unit to refund the surplus fee or the inapplicable fee to the complainant.

Citizens are able to file complaints for investigation of health facilities that do not meet citizen needs.

### Section 60
If wrongful act is committed by a service unit QSB may revoke the registration of such service unit; notify the governing Minister to undertake the disciplinary procedures, notify relevant agencies for the purpose of investigating the health professional who is responsible for the commission of the wrongful act or proceeding with other disciplinary procedures.

<p>| Social Security Act | Section 7 | “Social Security Committee” must consist of five representatives of employers and five representatives of employees appointed by the Minister, as members. <strong>SSA 2015 Amendment Section 7:</strong> “Social Security Committee” must consist of seven representatives of employers and seven representatives of insured persons appointed by the Minister as members. The representatives of employers and the representatives of insured persons under paragraph one shall be selected from an election, taking into account actual participation by the employers and insured persons, male and female proportions and effective participation by disabled and disadvantaged persons. | Citizens represented in the Social Security Committee empowers citizens to influence committee decisions on regulations and finances of SHI | N/A |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 9.</td>
<td>The Committee has the powers and duties including submit opinions on policy and implementation of social security, issuance of Royal Decrees, Ministerial Regulations and other regulations, issue regulations in regard to receipts, payment and safekeeping of the Fund, and productive investment of the Fund; to review balance sheet and statement of the receipts and expenditures of the Fund and annual report on the performance of the Office, provide consultations and advices to other Committee or the Office.</td>
</tr>
<tr>
<td>Section 13.</td>
<td>The resolution of the committee meetings shall be made by a majority of votes. Each member shall have one vote.</td>
</tr>
<tr>
<td>Section 59.</td>
<td>The Secretary-General shall publish in the Government Gazette the area of coverage and the names of hospitals at which an insured person is entitled to receive medical services. An insured person shall receive medical services at the hospital or places in such locality, except if no hospitals exist in the locality or if the insured person has justifiable reason that he or she is unable to receive medical services at the hospital or places prescribed.</td>
</tr>
<tr>
<td>Section 63.</td>
<td>Benefits for non-occupational injury or sickness includes medical examination expense; (2) medical treatment expense; (3) lodging, meals and treatment expenses in hospital; (4) medicine and medical supplied expenses; (5) cost of ambulance or transportation for patient; (6) other necessary expenses.</td>
</tr>
<tr>
<td>Section 85.</td>
<td>The employer, the insured person or other person who is dissatisfied with the order of the Secretary-General or of the competent official under this Act except the order under section 50, shall be entitled to lodge an appeal in writing to the Appeal Committee within thirty days from the date of receiving such order.</td>
</tr>
<tr>
<td>Section 8</td>
<td>Government officers and dependents have the right to receive health services and treatment in: (1) Government hospitals; (2) Private hospitals under the regulation of the Ministry of Finance for in-patient services; (3) Private hospitals for possible for emergency cases; (4) Private hospitals in cases where government hospital transfers the patient to the private hospital.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Section 13</td>
<td>In cases where a medical facility does not provide access to necessary equipment, diagnostic and treatment tools needed, the beneficiaries can access other facilities, given consent by the health provider, and be reimbursed according to criteria, method, and rate defined by Ministry of Finance.</td>
</tr>
<tr>
<td>Section 16</td>
<td>Government officers performing duties in other countries can reimburse their healthcare costs for themselves and their dependents as indicated by the regulation of Ministry of Finance.</td>
</tr>
<tr>
<td>Section 17</td>
<td>Government officers, training or on temporary official duties in foreign countries have the rights to receive medical care according to the criteria and rate indicated by Ministry of Finance.</td>
</tr>
</tbody>
</table>