CHAPTER I

INTRODUCTION

1. Background

Many countries in the world are undergoing health sector reform in response to rapidly escalating health care cost at unsustainable rates. Financing health care and health services has received particular attention internationally in recent years, mainly, due to subsequent economic crises in many countries, particularly those in the developing world (Goodman and Waddington, 1993). Thus Governments are trying to meet the needs of rapidly changing populations and health needs. In theory, health care reforms are intended to decentralize health care systems, reduce bureaucracy, and increase cost-effectiveness and efficiency. Such reforms in the long run ensure equity, accessibility, and financial sustainability.

Reforms are also necessary to counteract people's attitudes towards their own health and wellbeing. People, in turn, value their own health through self-care and understand the huge cost involved in rendering the services.

2. Thai Situation: The Health Care Reform

Due to demographic shifts, globalization, technology evolution, political reforms, socio-economic transformations etc., Thailand had seen many reforms passing by and shaping the health care system ever since the evolution of modern medicine in the early 19^{th} century.

Health sector has rapidly developed well along with the advancement of economic development in Thailand. Health sector achieved many laurels and glories for its utmost services for the past decades in bringing improvement in the health of the general population. But all those gains in the past had made people more ambitious, accelerating the demands for more health in parallel with the increasing of non-communicable diseases. Over and above, there still remained a gap in health coverage among the general population. Therefore, among others, the health care reform in

Thailand was necessitated by higher cost of health expenditure, inefficiency, unbalanced economic development, and political and social reforms.

3. Health Status and Health Crisis

Thailand has good health services rendered through extensive networks of health infrastructure. There are health facilities in all over 76 provinces leading down to the tambon (sub-district) level. Major health threatening communicable diseases is under control and reduced in prevalence. Life expectancy at birth for males and females has increased from 60 and 66 years in 1980 to 70 and 75 years respectively in 2000. Infant and maternal mortality has decreased drastically.

Table 1 Health Indicators of Thailand (2000)

Sl.No.	Health Indicators	
1	Infant mortality rate (per 1000 live births)	21.5
2	Low birth weight rate (less than 2500 gm)	8.9%
3	Maternal mortality ratio (per 100,000 live births)	23.9
4	Life expectancy at birth	
	Male:	69.9
	Female:	74.9

Source: Plan 9th Ministry of Public Health, 2002.

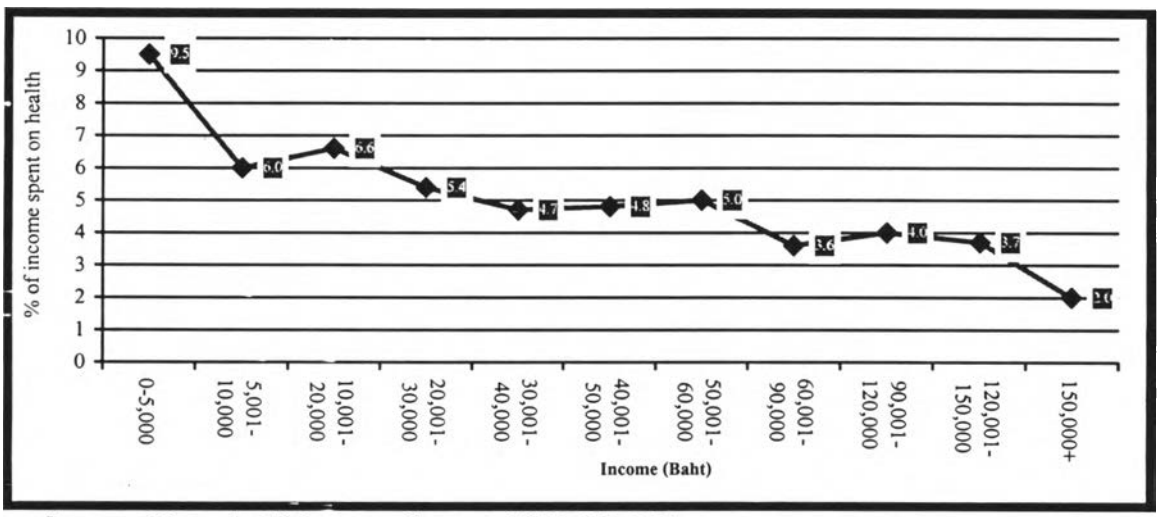
However, the cases were rising high of people dying with preventable diseases like heart disease, HIV/AIDS, drug addition, cancer, accidents etc. Ultimately, it boiled down to incurring high expenditure on these health problems, which the Government had to borne the cost. Thus, the reform was inevitable and necessary. Thailand felt the urgent need to change the system from ill-health oriented to the good-health-oriented.

The Thailand's health care system reform was on the national agenda for along time, though active developments took place only in as recent as 2000. The new constitution on (1997) invoked in the restructuring process in the health care system to provide greater coverage, equity, efficiency and sustainability.

4. Health Care Expenditure

Overall health status of Thai people has improved tremendously over the last decades with increased life expectancy, reduced infant and maternal mortality rates and other vaccine-preventable diseases (MoPH, 2001). But all of these came with a price. There was an 11 fold increase in the health expenditure from 1980 to 1998, from Baht 25

Figure 1 Household Income Spending on Health (1992).



Source: Household Income Survey 1992, MoPH.

billion to over Baht 283 billion. The per capita health expense had arisen almost 9 fold from Baht 545 to Baht 4663 during the same period. The share of GDP on health increased from 3.82% in 1980 to 6.21% in 1998 (Health Insurance System in Thailand, 2001). It could also be seen from the table 2 that expenditure through public source is increasing from 49% in 1994 to 61% in 1998.

Table 2 Total health expenditure (current price)

	1994	1996	1998
Total health expenditure, Baht	128,305	171,471	179,689
Baht. Per capita	2,186	2,858	2,924
USD per capita	87	114	71
% GDP	3.56	3.72	3.84
Public source	49%	53%	61%
Private source	51%	47%	39%

Source: Tangcharoensathien et al 1999, Pongpanich et al 2000.

However, there is variation in health expenditure at the individual levels among the different income groups. The lower and middle-income people spend higher share of their income than the people in the higher-income group. A person in 0-5000B income bracket spends almost 15% of his/her income, while only 2% for a person's income in the 150,000B group.

5. Health Insurance

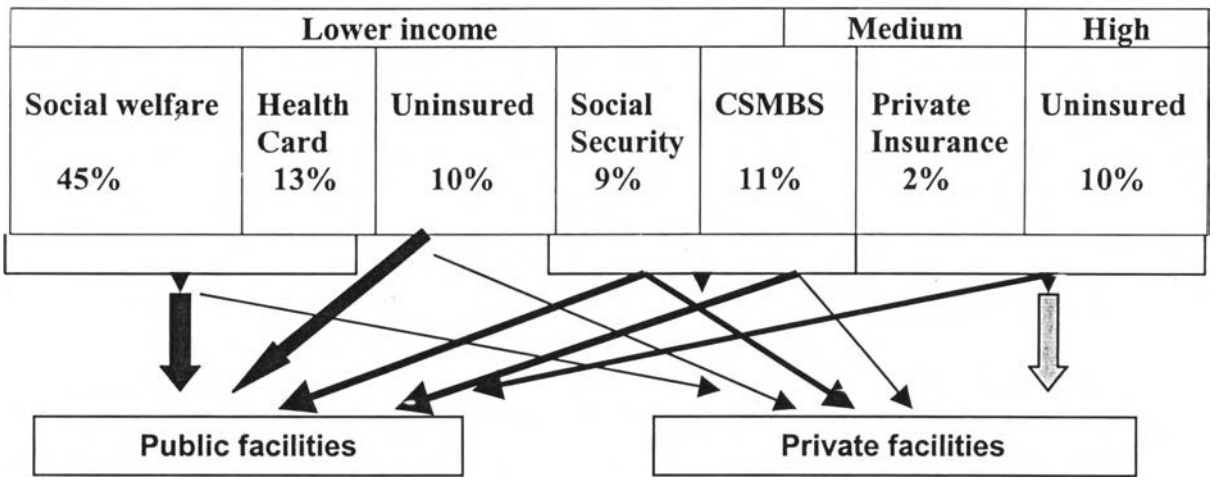
According to the Health Insurance System in Thailand (2001), there are four categoroes of health insurance schemes - i) Medical Welfare Scheme, ii) Civil Servant Benefit Scheme, iii) Compulsory Social Insurance, and iv) Voluntary schemes

But health insurance schemes are characterized by fragmentation, duplication and inadequate coverage (HSRI, 2001). There was inequitable per capita tax subsidy, and the gap in the benefit package. The Civil Servant Benefit Scheme had a problem with the cost escalation, while the social security patients had to face a cost quality trade-off. The poor are protected by Medical Welfare Scheme, whereas the marginally poor are not entitled to free health care cards but are partially or totally exempted from large inpatient bills in public hospitals. The voluntary health card scheme has a limited capacity for coverage extension due to its voluntary nature and financial non-viability.

6. Health Care Provisions

Thailand had already undergone health sector reforms since 1945 when policy of charging for drugs and some medical services was still being followed. A low-income card free medical scheme was introduced to increase accessibility by expansion of medical care coverage to low income group, also in support of primary health care concept. Since then many changes followed like introduction of medical welfare scheme, social security health insurance, civil servant medical-benefit scheme, voluntary schemes etc. to cover the wider range of population with health services.

Figure 2 Pattern of Health Service Utilization with different Health Insurance



Source: Health Systems Research Institute, MoPH, Thailand

Different social groups have different channels of accessing health care. Since the Social Security Act came into effect in 1990, by now more than 50% of low-income population are insured under social welfare and social security schemes (Ministry of Labour and Social Welfare, 2002). Yet at least 10% of population in the lower social strata remains uninsured. All government servants are covered under the Civil Servant Medical Benefit Scheme, while high-income people usually use private health insurance. Few self-employed or small firm employees are rendered health care through Health Card Scheme. It was found out that low-income rural people and urban poor use public facilities, whereas higher income rural and urban dwellers tend to use more private facilities.

7. Health Coverage

Despite many innovative schemes such as social security, student health insurance, compensation fund, insurance for road traffic accidents etc., nearly 20% of the Thai population today remains uninsured (MoPH, 2001). There exists a large difference in health status among the various population groups. Inequities of health status and resource allocation are increasing in urban and rural areas and notably in Bangkok/Regional and Bangkok/Northeast (MoPH, 2001). And along with the problem of inequities, inefficient health service system and poor quality care services are compounding factors affecting the overall health coverage. Of course, this problem is also intensified by insufficient health insurance schemes that left more

than 20 million people to take care of their own health without any support from Government. In wake of acknowledging the large number of people without any health insurance, Thai Government has taken a step further by formulating a universal health coverage policy to ensure equity of access, efficient health care system, people's choice of heath services and quality care. This policy will serve to promote and fulfil the constitution declaration (1997) on an equal right to quality health care for all Thai people. Actually, Thailand is following suit after Britain, Australia, Canada etc., which have launched policies of universal health care coverage.

8. The 30-Baht Scheme

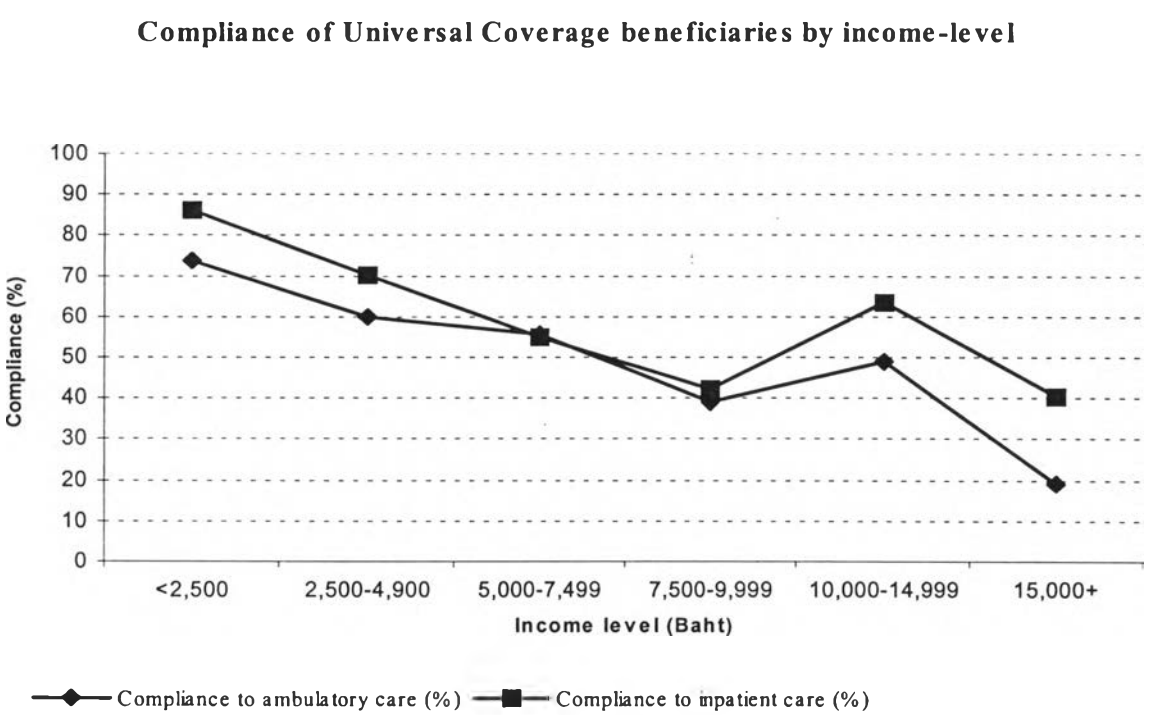
To support the policy of universal coverage for health care, the 30 Baht scheme is being implemented all over the country since last year (2001). The Thaksin Shinawatra government committed to raise the coverage of health care under the slogan "30 Baht to cure every disease". Basically, this scheme is targeting the sections of populations that are not covered under any insurance schemes. Outpatient and inpatient services are provided with the fixed amount copayment, 30 Baht per visit. Thai Government needs at least around 80 to 100 billion Baht to support this scheme (Sakunphanit, 2001). Besides, social security schemes has been extended for the employees of non-business employers and employees of street vendors to achieve greater coverage (MoPH, 2002).

The 30-baht scheme is financed through the general tax revenue with budget per capita 1,202 Baht (28.6US$). Beneficiaries are the population not covered by the Civil Servant Medical Benefit Scheme and the Social Security Scheme Benefit. The benefit package includes personal curative, preventive and promotive services. Traditional and alternative medicines have been approved to include within this package. A patient has to co-pay the amount of 30 Baht per visit. Health care providers are the public and private health care providers. Primary care provider is the main contractor, fund-holder and gatekeeper. The provider payment is done through capitation (inclusive and exclusive). At present, 45 million people are covered under this scheme. The National Health Insurance Act is enacted by the Parliament in October 2002, reinforcing the process of universal coverage policy.

9. Utilization and Satisfaction

With the new system of financing, people now have more access to health care and services. Anyone can have care from primary to tertiary levels of treatments in any public and few private hospitals with copayment of only 30 Baht. At this time, some evaluations are going on for the universal coverage and satisfaction with the 30-baht services. And the scheme is already known have covered the entire country. In keeping with the present success on coverage, it is expected that people now use more services than before. People could now even use higher levels of care, as it has become affordable for them to avail such services. However, it is difficult to know

Figure 3 Compliance of Universal Coverage



Source: Pannarunothai et. al., 2002.

people's attitude towards and the levels of satisfaction among the consumers with the 30-baht scheme. For instance, the recently conducted compliance survey for the Universal Coverage showed (figure 3) that all the 30-baht service consumers did not have the same level of compliance rate, which varied with income level.

Thus, it is with such thoughts and background picture, the study has been planned to explore and examine any change in utilization and satisfaction levels in effect of introducing new method to finance the health care.

Table 3 Utilization of medical services in six provinces (2000)

Provinces	Time OPD/person	Inpatient Person	Day per patients
Samutsakorn	2.90	0.11	4.2
pathumthani	2.22	0.05	5.3
Nakhonsawan	4.34	0.11	5.1
Phayao	3.29	0.11	4.5
Yasothaui	3.83	0.14	3.5
Yala	2.73	0.11	5.4
Average 6 provinces	**3.46**	**0.11**	**4.6**

Source: Phenkhoe et al., Office of Statistics, 2001.

10. Rationale of the Study

The Universal Coverage Policy is being implemented all over the country. Public as well as some private health facilities are the health care providers. The benefit package has all the curative, preventive and promotive services. Since such a scheme is new to the providers and consumers, rapid change with a short time for preparation might have brought some resistance from people. Inadequate budget prepared for the Universal Coverage can lead to low or unacceptable quality of care. This may, in turn, affect the use of the scheme and the way the services are provided at health facility level. The financing mechanism, providers orientation towards consumers, attitude of the consumers towards the scheme will result in change in satisfaction with and utilization of the health care services. The assessment of the attitude of consumers, utilization of the scheme and satisfaction with health care services under this scheme can measure few of the dimensions of success and failure of the implementation of the 30-baht scheme at the facility levels.

11. Purpose of the Study:

The purpose of this study is to examine the utilization of the Gold Card and satisfaction with hospital services among the 30-Baht scheme patients who visit OPD, Chulalongkorn Memorial Hospital.

12. Conceptual Framework

The conceptual framework of the study describes and considers the attitude towards the 30-Baht Scheme and satisfaction with services as one of the ways to find out to what extent health care services are utilized through this scheme.

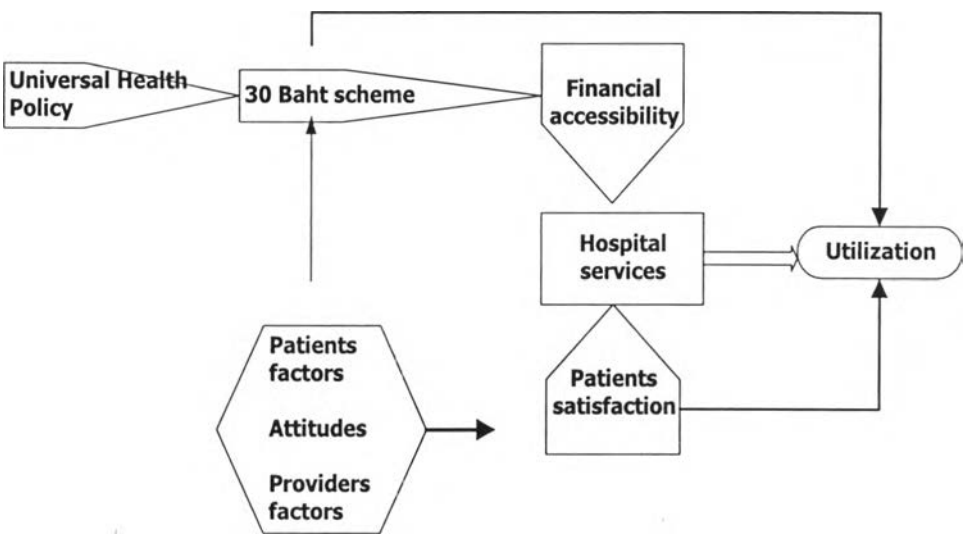
Universal health coverage policy was formulated in response to a relatively large number of people still remaining uninsured against their health. This policy also tries to materialize the constitutional statement that says "right to health for every Thai" (section 52 of constitution, 1997). The Thai Government devised a new mechanism of financing health care called - 30 Baht scheme. This mode of health provision will enhance accessibility, equity and choice of health providers and quality care, especially for uninsured people.

Under normal circumstances, there would be an increase in utilization of health services if they were made easily available and affordable. In order to promote policy on universal health coverage, people who were not insured previously were provided with 'gold card' or 'universal health card' under the 30 Baht scheme. General populace registered for the 30-Baht Scheme have the access to all kinds of medical services, except for cosmetic treatments, organ transplantation, and other non-essential treatments. Usually, the secondary and tertiary cares are more expensive than primary care. Possibility is seen that utilization of health services by people is now more than before. The 30-Bhat Scheme registered people have unconditional access to public as well as private health facilities just with the copayment of 30 Baht. Hence, the study focuses on the consumer's satisfaction with hospital care services in relation with the increase use of the new scheme.

The new method of financing health care along with attitude and demographic characteristics of providers and consumers may bring in a change in levels of satisfaction with the 30-Baht services at hospital. The 30 Baht scheme treatment might also have some impact on the behaviors of care providers. The patient's satisfaction lies in how well the health care providers serve them. Therefore, patient satisfaction is one of the indicators of how the providers served and accordingly to what extent patients used the services.

Four long-term benefits are expected to be the outcome of this innovative scheme: Equity, Efficiency, Choice of Health Care, Good Health for All Preventive and Promotive Health (MoPH, 2001).

Figure 4 Research Conceptual Framework



13. Research questions

1. What is the utilization rate of hospital services for the Registered 30-Baht Scheme patients at Chulalongkorn Hospital?
2. What are the reasons for choosing the Chulalongkorn Hospital by the Self-referred 30-Baht Scheme patients?
3. What is general attitude of patients towards the 30-baht scheme?
4. What is the difference in attitude among the 30-baht patients who do and do not use the gold card to receive health care services at hospital?
5. What is the difference in satisfaction level in hospital services between the registered and self-referred 30 Baht patients who come for health care at Chulalongkorn hospital?

14. Objectives:

1. To describe the demographic characteristics of the 30-baht patients.
2. To examine the utilization rate of hospital services among the Registered 30-Baht Scheme patients at OPD, Chulalongkorn Hospital.
3. To explain why the Self-referred 30-Baht Scheme patients choose Chulalongkorn Hospital to receive care.
4. To describe the general attitudes of patients towards the 30-Baht Scheme.
5. To examine the difference in attitudes among the 30-baht patients who use and do not use the 30-Baht Scheme.
6. To compare the difference in satisfaction level in hospital services among the Registered and Self-referred 30-Baht patients who come for health care services at Chulalongkorn Hospital.

Table 3 Variables and Definitions

Variables		Operational Definition
Independent	Satisfaction	Proportion of fulfillment of expectation for the services provided at hospital in terms of convenience, time interval, quality care and providers characteristics in respect to the new insurance scheme.
	Patient factor	Demographic and socio-economic features of patients that influence satisfaction with and utilization rate of health services.
	Provider factor	Any qualities or values in hospital provisions that affect the use of facilities by the patients, and through which they derive certain levels of satisfaction.
	Attitude	An opinion or strong feeling (likes and dislikes) towards any aspects of the 30-Baht Scheme.
Dependent	Utilization	Act of coming in contact with or accessing the health care services at Hospital OPD through certain financing means. It is dependent on the satisfaction factor.