

**A STUDY ON MEDICAL CARE IMPEDIMENTS IN
UNIVERSAL COVERAGE HEALTH INSURANCE:
A CASE STUDY OF MAHARAJ NAKORN RATCHASIMA
HOSPITAL, NAKORN RATCHASIMA PROVINCE**

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SAENGARON THIRHARAUNGRAT

**A THESIS SUBMITTED IN PARTIAL FULFILLMENT
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Thesis

Entitled

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was submitted to the Faculty of Graduate Studies, Mahidol University
for the degree of Master of Arts (Cultural Studies)

on
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Saengaroon Thirharaungrat

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ABSTRACT

This study investigated knowledge of the treatment rights, opinions of service provision, and problems in the Universal Coverage Health Insurance Scheme project. This study was cross-sectional descriptive research using questionnaires. Four hundred samples were randomly selected from out-patients. Who had a Universal Coverage Card, from 10 wards of Maharaj Nakorn Ratchasima Hospital, during October 2005. The data were analyzed by descriptive statistics, which were percentage, mean, standard deviation, t-test and one-way ANOVA.

The results were as follows: firstly, the samples' knowledge of treatment rights in the Universal Coverage Health Insurance Scheme was low, personal factors associated with this knowledge were marital status, educational level and income. Secondly, 57.8% of samples' opinion on quality of service was moderate, 42.0% was good and 0.3% should be developed. Finally, less than 20% of the selected samples had problems which were lack of correct treatment knowledge, long waiting times at the registration unit, and lack of satisfaction with the staff service, such as impolite, unfriendly, or unenthusiastic service.

It is suggested that public relations on the benefit of this project should be developed. At the same time, the administrators and related staff must find causes of the problems and implement solutions as soon as possible.

KEY WORDS: PROBLEM, IMPEDIMENT TO PROVIDING SERVICE IN
UNIVERSAL COVERAGE HEALTH INSURANCE SCHEME/
KNOWLEDGE LEVEL OF THE SAMPLE/ NAKORN
RATCHASIMA PROVINCE

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บทคัดย่อ

การวิจัยครั้งนี้มีวัตถุประสงค์เพื่อศึกษาระดับความรู้ของผู้รับบริการเกี่ยวกับสิทธิด้านการรักษาพยาบาลตามโครงการหลักประกันสุขภาพถ้วนหน้า ความคิดเห็นของผู้รับบริการเกี่ยวกับบริการที่ได้รับ รวมทั้งปัญหาอุปสรรคจากการรับบริการตามโครงการหลักประกันสุขภาพถ้วนหน้า การวิจัยครั้งนี้เป็นการวิจัยเชิงพรรณนาแบบภาคตัดขวาง (Cross-Sectional Descriptive) กับกลุ่มตัวอย่างจำนวน 400 คน ที่มารับบริการที่แผนกตรวจโรคผู้ป่วยจาก 10 แผนกของโรงพยาบาลมหาราชนครราชสีมา จังหวัดนครราชสีมา โดยใช้สิทธิบัตรประกันสุขภาพถ้วนหน้า ระหว่างวันที่ 1-31 ตุลาคม 2547 เครื่องมือที่ใช้ในการเก็บรวบรวมข้อมูลคือ แบบสอบถาม และวิเคราะห์ข้อมูลโดยใช้สถิติเชิงพรรณนา ได้แก่ ค่าร้อยละ ค่าเฉลี่ย ส่วนเบี่ยงเบนมาตรฐาน t-test และ One-way ANOVA ประมวลผลโดยเครื่องคอมพิวเตอร์โปรแกรมสำเร็จรูปสำหรับการวิจัยทางสังคมศาสตร์ ผลการวิจัย พบว่า (1) กลุ่มตัวอย่างมีความรู้เกี่ยวกับสิทธิด้านการรักษาพยาบาลตามโครงการหลักประกันสุขภาพถ้วนหน้าอยู่ในระดับน้อย ปัจจัยส่วนบุคคลที่มีความสัมพันธ์กับความรู้เกี่ยวกับสิทธิด้านการรักษาพยาบาล ได้แก่ สถานภาพสมรส ระดับการศึกษา และรายได้ (2) ความคิดเห็นของผู้รับบริการเกี่ยวกับคุณภาพของบริการที่ได้รับอยู่ในระดับปานกลาง ร้อยละ 57.8 รองลงมาไม่มีความคิดเห็นว่าคุณภาพของบริการที่ได้รับอยู่ในระดับดี ร้อยละ 42.0 ส่วนที่เหลืออีก ร้อยละ 0.3 มีความคิดเห็นว่าโรงพยาบาลควรต้องมีการปรับปรุงคุณภาพของการให้บริการ และ (3) ปัญหาอุปสรรคในการมารับบริการ มีผู้มารับบริการไม่ถึงร้อยละ 20 ที่พบปัญหา ซึ่งปัญหาที่พบเรียงลำดับจากมากไปน้อย 3 อันดับแรก ได้แก่ 1) ประชาชนที่มารับบริการขาดความรู้ความเข้าใจเกี่ยวกับสิทธิด้านการรักษาพยาบาล ตามโครงการหลักประกันสุขภาพถ้วนหน้า 2) ปัญหาเกี่ยวกับบริการที่ได้รับจากห้องบัตรที่ต้องรอนานเกินไป เจ้าหน้าที่พูดจาไม่ชัดเจนหรือพูดจาไม่สุภาพ และ 3) ปัญหาเกี่ยวกับบริการที่ได้รับจากพยาบาลผู้ให้บริการที่พยาบาลบางคนพูดจาไม่สุภาพ ไม่เป็นมิตรกับผู้ป่วย พยาบาลขาดความกระตือรือร้น งานวิจัยได้เสนอแนะว่า ควรจัดให้มีการเผยแพร่ประชาสัมพันธ์ทำให้ความรู้ความเข้าใจเกี่ยวกับสิทธิผู้ป่วยตามโครงการหลักประกันสุขภาพถ้วนหน้าให้มากยิ่งขึ้น นอกจากนี้ผู้บริหารรวมทั้งผู้ที่เกี่ยวข้องจะต้องศึกษาสาเหตุที่แท้จริงเกี่ยวกับคุณภาพของบริการ เพื่อหาแนวทางในการแก้ไขต่อไป

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CONTENTS

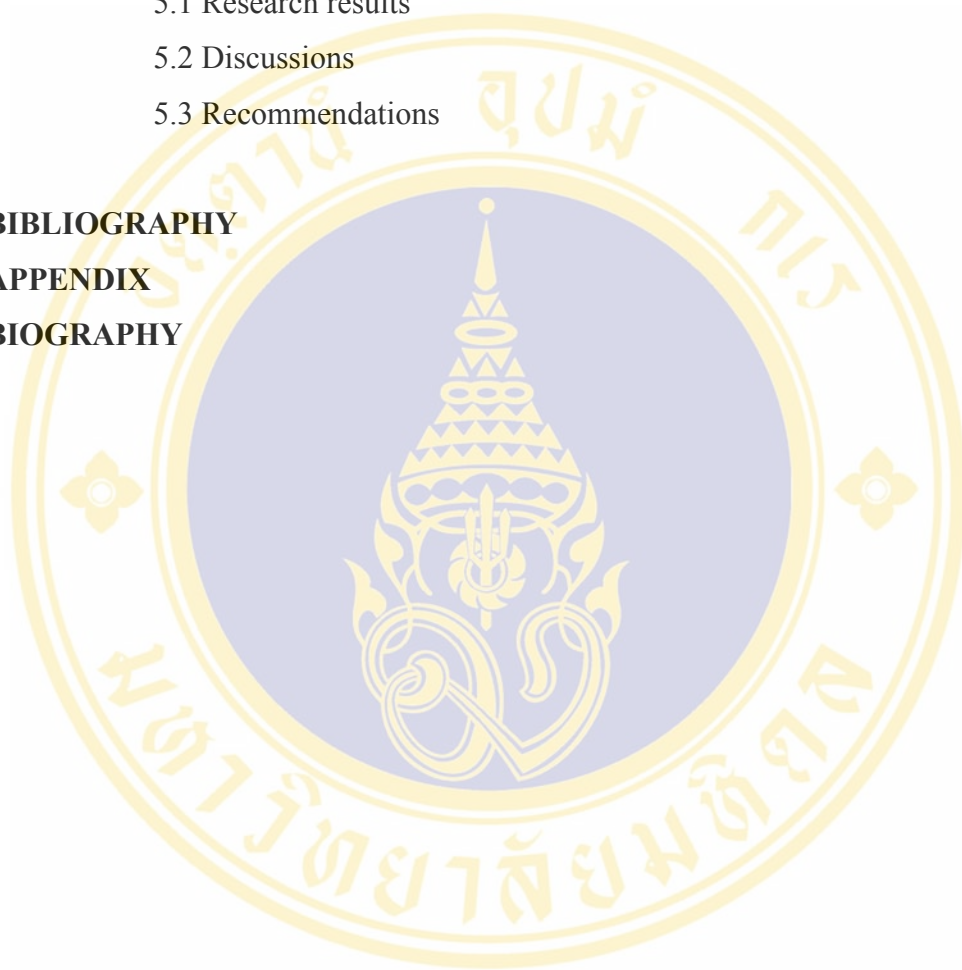
	Page
ACKNOWLEDGEMENTS	iii
ABSTRACT (ENGLISH)	iv
ABSTRACT (THAI)	v
LIST OF TABLES	ix
LIST OF FIGURE	xi
CHAPTER	
1 INTRODUCTION	
1.1 Rationale and background	1
1.2 Objective of the research	2
1.3 Research questions	2
1.4 Expected benefit of the research	2
1.5 Scope of the research	2
1.6 Research assumption	3
1.7 Definitions of term	3
1.8 Studied area	4
2 LITERATURE REVIEW	
Part 1: General data on health insurance	
1. Concept on health insurance	5
2. Concept on universal coverage health insurance	8
3. Development of health insurance in Thailand and other countries (Project of 30 baht covered all disease)	9
4. Universal coverage health insurance scheme (30 baht full health overage)	13
5. Universal coverage health insurance of Maharaj Nakorn Ratchasima Hospital	15

CONTENTS (Cont.)

		Page
	Part 2: Review literature	
	1. Individual factors affecting on universal coverage health insurance scheme	18
	2. Health center's factors	20
	3. Problems and obstacle of health insurance project	21
3	RESEARCH METHODOLOGY	
	3.1 Population and sample	25
	3.2 Research instruments	27
	3.3 The quality of the instruments	29
	3.4 Data collection	29
	3.5 Data analysis	29
4	RESULTS	
	4.1 Socio-economic and demographic characteristics	31
	4.2 The knowledge level of patients on the right under universal coverage health insurance scheme	33
	4.3 The association between demographic factor and the knowledge level of the sample on their right under the universal coverage health insurance scheme	38
	4.4 The attitude level of patient on quality of health care service under the universal coverage health insurance scheme	42
	4.5 Problem of the use of the 30 bath health scheme card and recommendation	48
	4.6 Recommendation for improving the services of the universal coverage health insurance scheme	51

CONTENTS (Cont.)

	Page
5 RESULTS, DISSCUSSION AND RECOMMENDATIONS	
5.1 Research results	53
5.2 Discussions	56
5.3 Recommendations	58
BIBLIOGRAPHY	59
APPENDIX	70
BIOGRAPHY	94



LIST OF TABLES

Tables		Page
1	Comparison the advantage and disadvantage of liberal and social welfare health service systems	6
2	The number of sample in each section	26
3	Percentage distribution of respondent by socio-economic and demographic characteristics	32
4	Percentage distribution of respondents by the knowledge level on the right under universal coverage health insurance scheme	34
5	Percentage distribution of respondents by the knowledge on the right under the universal coverage health insurance scheme	35
6	Association between sex and the knowledge level on the right under the universal coverage health insurance scheme	38
7	Association between age group and the knowledge level on the right under the universal coverage health insurance scheme	39
8	Association between marital status and the knowledge level on the right under the universal coverage health insurance scheme	40
9	Association between education and the knowledge level on the right under the universal coverage health insurance scheme	40
10	Association between occupation and the knowledge level on the right under the universal coverage health insurance scheme	41
11	Association between income and the knowledge level on the right under the universal coverage health insurance scheme	42
12	Percentage distribution of respondents by the attitude level on the rights under the universal coverage health insurance scheme	43
13	The mean score of the attitude of respondents on the quality of health care service under the universal coverage health insurance scheme	44

LIST OF TABLES (Cont.)

Tables		Page
14	Percentage distribution of respondents by the attitude level of health service system under the universal coverage health insurance scheme	46
15	The mean score of the attitude of respondents on the quality of health service system under the universal coverage health insurance scheme	47
16	Percentage distribution of respondents by the attitude level on the quality of the universal coverage health insurance scheme	48
17	Percentage distribution of respondent by problem under the universal coverage health insurance scheme	49

LIST OF FIGURES

Figures		Page
1	The organizational structure of universal coverage health insurance section in Maharaj Nakorn Ratchasima Hospital	17
2	Conceptual framework	24



CHAPTER 1

INTRODUCTION

1.1 Rationale and background

Illness is a suffering and a part of life. Patients will have more suffering if they are unable to access treatment. It is found that nowadays some Thai people could not access health service when getting ill. It is because physicians could not come on time to save patients' life, in emergency the hospitals reject to give primary care if patients have no money or any guaranties to afford the service.

Thai health care system emphasized on treatment rather than prevention which caused a lot of money. And we still have many people died from protective diseases. In 2002, Thailand health expense was 300,000 millions baht. One of the third was responsible by the government and the less by the people. (Kasemsiri Nanthawatesanti, 2002: 1) Moreover, the expenses were rising 10 % every year.

Inequity to access health service was also an important problem of Thai health system; about 30% of Thai people have not any health insurance (Sudarat Keyuraphan, 2001). So when they had seriously ill, it would affect family income.

So it is necessary that the government should arrange health insurance for all Thai people. In 2001 the government had arranged the Universal Coverage Health Insurance Scheme (30 baht full health coverage)for all Thai people. This project had continued for four years, but many people still doubt on it quality.

As the mentioned reasons, the author inspired to study problems and obstacles regarding on the Universal Coverage Health Insurance Scheme by selecting Maharaj Nakorn Ratchasima Hospital, Nakorn Ratchasima province as a studied area since Nakorn Ratchasima is the biggest city of the Northeast with 2.6 million population.

1.2 Objectives of the research

1. To study patients' knowledge on the treatment right in universal coverage health insurance scheme.
2. To study patients' opinion on universal coverage health insurance scheme service.
3. To study problems and obstacles of universal coverage health insurance scheme service.

1.3 Research questions

1. The patients have knowledge on the treatment right in universal coverage health insurance scheme or not.
2. What was the patients' opinion on the treatment right in universal coverage health insurance scheme?
3. What are the problems and obstacles of the patients who use universal coverage health insurance scheme at Maharaj Nakorn Ratchasima Hospital, Nakorn Ratchasima province?

1.4 Expected benefit of the research

The results of this study would be benefit for the administrators and related staffs of Nakhon Ratchasima Hospital for development better service of universal coverage health insurance scheme.

1.5 Scope of the research

1. The research's contents scoped on 3 issues as following:
 - 1.1 Knowledge on treatment right under universal coverage health insurance scheme.
 - 1.2 Opinion on service under universal coverage health insurance scheme.

1.3 Problems and obstacles of universal coverage health insurance scheme.

2. The samples were out-patients who had coverage health insurance card, using services from ten sections of Maharaj Nakorn Ratchasima Hospital which were Medicine, Pediatric, Surgery, Orthopedic (Bone and Joint), Optical, Dental, Nasal, Gynecology, Obstetrics and Psychology.

1.6 Research assumption

1. “Gold card” would be used sometimes in this research equivalent to An Universal Coverage Health Insurance card.

2. The samples were out-patients who passed 3 steps of service, registration unit to screen their right, diagnosis unit and drug supply unit.

3. This study selected only the out-patients who paid 30 baht for each service because the author thought that free of charge might affect opinion on problems and obstacles of treatment.

1.7 Definitions of term

1. Out-patients. A person who had a right of UC card at Maharaj Nakorn Ratchasima Hospital, used hospital service at any departments but was not admitted as in-patients. Accident and emergency patient was excluded.

2. Types of disease. It was divided into 2 types as follow:

2.1 Chronic disease. The diseases occur more than 3 months. Some diseases might be included in chronic disease although it was not over 90 days. The disability might be appeared after the patients were cured. So they had to be rehabbed until they were invulnerable such as Sinusitis, Asthma, Leprosy, Neurosis and Cancer etc.

2.2 General diseases. Disease that occurred with many symptoms in a short period, might be severe or not such as cold, head age, diarrhea, Appendicitis, Measles, Chickenpox and Conjunctivitis etc.

3. Using service across area. The patients didn't use a UC card at the main or sub contractors identified in UC card.

1.8 Studied area

The study was focused patients of Outpatient Department, Maharaj Nakhorn Ratchasima Hospital, Nakhorn Ratchasima Province which had 10 sections such as Medicine, Pediatric, Surgery, Orthopedic (Bone and Joint), Optical, Dental, Nasal, Gynecology, Obstetrics and Psychology.



CHAPTER 2

LITERATURE REVIEW

This research aimed to study problems and obstacles of using universal coverage health insurance scheme service of out-patient department, Maharaj Nakhorn Ratchasima Hospital, Nakhorn Ratchasima Province. The author had summarized related document and research and divided them into 2 parts as following:

Part 1: General data on health insurance

1. Concept on health security and health insurance
2. Concept on universal coverage health insurance (Project of 30 baht covered all diseases)
3. Development of health insurance in Thailand and other countries
4. Universal coverage health insurance scheme (30 baht full health coverage)
5. Universal coverage health insurance project of Maharaj Nakhorn Ratchasima Hospital

Part 2: Review literature

Part 1: General data on health insurance

1. Concept on health insurance

Principals and concepts on health insurance are different in each country but all originated from 2 concepts, liberalism and social welfare.

1.1 Concept on liberalism

This concept regards that all people have freedom of choices to decide to do everything including health service. If people can access proper information on services and reasonable cost, they are able to decide to use that service. This concept

believes that marketing mechanism will encourage health places to have competition. The government has not to involve. The government should help only invulnerable people such as low income and old people. This concept was used in developed countries such as United State of America and South Africa. (Sanguen Nittayaramphong, 2000: 22)

1.2 Concept on social welfare

This concept regarded that all people must have health service which was special and more sophisticate for people to have enough information to determine or to understand. If we let marketing mechanism to run freely, people who could afford will get unnecessary service or pay a lot of expense. Thus, the government should interfere to make sure that all people could access in necessary services although they couldn't afford. This concept was used in the countries having liberal economic system such as England, Sweden, and Canada etc. (Sanguen Nittayalamphong, 2000: 23). The comparison of both health service systems under concept of liberalism and social welfare was in table 1.

Table 1 Comparison the advantage and disadvantage of liberal and social welfare health service systems.

Concept	Advantage	Disadvantage
Liberalism	<ul style="list-style-type: none"> - To have competition between health centers so that the customers will receive better service. - People have a right to get service's information and to proclaim when received unsatisfied service. 	<ul style="list-style-type: none"> - Country health expense is very high - Poor people that the government can not afford will be ignore. - To have bad relationship between physicians and patients. A lot of sue will be happened. - To have over use of technology.

Table 1 Comparison the advantage and disadvantage of liberal and social welfare health service systems. (cont.)

Concept	Advantage	Disadvantage
Social welfare	- All people can access necessary health service.	- No competition between health centers so physicians and nurses have no enthusiasm to give a better service. - People don't have enough opportunity to know service information they get and to choose health centers they prefer.

To have health insurance system, the government should consider these issues as follow:

1.2.1 Freedom of people. All people must have health insurance but they should have chance to select various health insurance services by themselves while poor people must be a special group to be take care.

1.2.2 Equity among various groups. All groups should have equal chance to access the same quality of health services. All health insurance services that have different quality should be revised. The health insurance premium should be managed under the principal of economic equity for both heath providers and customers which are government, private sectors and individual.

1.2.3 Efficiency of health insurance system management. The system should have efficiency in economic and administration. Regarding to economic aspect, it should be the lowest expense, good quality and can cover all the country health targets. For administrative view, it should avoid huge and complicated bureaucracy.

1.2.4 Possibility of health insurance system. The possibility both in economic and administrative policy should be considered. And this system must not be the burden of the government, civil, health providers and customers.

2. Concept on universal coverage health insurance (Project of 30 baht covered all diseases)

Universal Coverage means the right of all people to access health care service with standard and equity regardless of the expenditure of treatment.

The objectives and reasons to have universal coverage health insurance are summarized as follow:

2.1 Reasons and necessity to have universal coverage health insurance.

2.1.1 The constitution of the kingdom of Thailand B.E. 2540, Act No. 52 formulated that a person has right to receive a standard health service according to the law.

2.1.2 Most people got trouble when becoming ill because they could not afford for the treatment. About 30 percent of Thai people have to pay for all treatment by themselves. And about 60 % of Thai families got trouble when they had severe sickness. Some people had debt from treatment.

2.1.3 About 20 million Thai people have not any insurances while about 23 million have social welfare which no guarantee for the standard and quality.

2.1.4 Only 20 % of Thai people have health insurance which have more standard and quality than others.

2.1.5 People lack information and knowledge to select service. Moreover, they don't have any power to bargain for the best service.

2.1.6 Universal coverage health insurance can decrease the expenses that all people have once to pay. Thus, this health insurance would be one way to solve poverty problem.

2.2 The objectives of universal coverage health insurance.

2.2.1 Equity: The equity in paying health expense and accessing standard health service.

2.2.2 Efficiency: The efficiency in distributing and using resources with good quality management and primary care network service which can reduce health cost.

2.2.3 Service choice: People should have right to select various health service centers, not only the governmental services but also the private ones.

2.2.4 Personal health care: Universal coverage health insurance system aims to build health for all. It is not covered only expenses but also emphasized personal health care, health promotion and prevention.

2.3 Principal of universal coverage health insurance (National Health System Reform Office, 2001)

2.3.1 Per capita expense: The per capita expense system will be equity for all people according to Thai Institution. The poor, vulnerable, remote area people will have more equity.

2.3.2 To combine health promotion, prevention, and care activities in one package into family level are both active and passive health management.

2.3.3 To emphasized on primary health service, near house-near mind as the first health service and establish network between secondary and tertiary governmental and private hospitals. This network system can take responsibility for amount of people.

3. Development of health insurance in Thailand and other countries

3.1 Health insurance in other countries

According to the history of the health insurance in many countries, it found that industrial workers, in industrial countries, were the first group receiving health insurance because of changing mode of production from agriculture to industry. The workers had to live in crowded and bad environment that effected health system. Whenever they got ill, they could access health service. So they tried to gather to help

themselves and developed to be a labour union. (Saowakon Rattanawijitsin, 2001: 116 - 117)

The model of health insurance are in developed countries as follow:

Canada: Health insurance in Canada had been developed from There hospital insurance. In 1956, the government built an Act about Hospital insurance and diagnostic service (HIDS) for all people having service from the hospital. In 1966, the universal coverage health was changed to National Medical Care Act. This system covered all primary care and health service in hospitals and run by was non governmental organization.

England: All British people had health insurance. Whenever getting sick, they didn't pay anything because the government paid for them. In 1948, there was National Health Service Act and National Health Service, a health organization, that took responsibility for health insurance.

Australia: According to Australian Institute and National Health Act, Australia had established National Health Insurance System namely Medicare Program. All Australian and foreigners having contact with Australian government were in the program which concluded primary care with co-payment by patients.

Germany: Social insurance was established in Germany since 1881 in the time of Bismarck. He wanted all employees to have social insurance and pension. In 1883, the government had a first Social Insurance Act to help employees in medical care and give compensation in case that they couldn't work. In 1884, an Act for disability and aging people was established.

All countries mentioned above were developed and western countries. The oriental countries that succeed in health insurance were 4 countries such as Japan, Taiwan, South Korea and Singapore. These countries developed their health insurance as follow.

Japan: Heath insurance act in Japan was passed in 1992, using German model. And in 1938, Ministry of Public Health and Social Welfare had been established for take care people health after the second world war. According to Japan Institute, the government had to take responsibility in social and health. Japan had many kinds of health insurance running by both government and private. The employees used co-payment system.

Taiwan: Worker's health insurance system was taken place in Taiwan after government officers' health insurance. However, this insurance didn't cover all people. So the government had declared health insurance for all by the Year 2000 policy. To fulfill the objective, the government established National Health Insurance which covers 3 sections such as health care service both acute and chronic diseases, diagnosis and treatment, rehabilitation, psychic illness, dental, health prevention and promotion and home health care. Nowadays, about 96 percent of people were under national health insurance system.

South Korea: National health insurance system was established in South Korea since 1977. In this year, about 500 employees were forced to have health insurance. In 1983, the government had passed working health insurance law. However, health insurance benefit in South Korea was lower than Japan because of the low payment.

Singapore: The government declared public health as the fifth important issues. Singapore had not health insurance fund but had Medical Saving Fund.

3.2 Health insurance development in Thailand

Health insurance in Thailand was run by the private company in the reign of King Rama the fifth but it didn't succeed. The health insurance had been developed again in 1929 by the foreign company. Ten years later, Thai insurance company had taken. The government by ministry of public health had health welfare and health insurance as follow.

3.2.1 The first system: Social welfare on health for low income and the vulnerable people. This system paid by the government which covered 43.90 percent of total population who was low income persons (lower than 2,000 bath for the whole family and 1,500 bath for a single), aging people older than 60 years, primary students, 0-12 years children, disability people, monks, veterans and their families, and unemployment people. This system covered 30.3 million or 50 % (Surasak Niempan, 2001)

3.2.2 The second system: Social welfare on health for government officers permanent employees and state enterprise officers. This welfare covered their spouses parents and children. The system covered 6.7 million people or 13 % (Vinai Leesmith & Supasit Pannanurothai, 1999)

3.2.3 The third system: A voluntary health insurance system which had 2 kinds as the following.

3.2.3.1 To buy health insurance from the private companies. Health insurance business was run by the private enterprise since King Rama 5 but didn't succeed. Health insurance had reestablished by Thai company in 1978. According to Thai law, there were 2 kinds of insurance; life insurance and disaster insurance while health insurance was separated in other kinds of insurance. In practical, people usually bought health insurance with life insurance. The weak point of health insurance was the expensive premium, low protection, and high management cost. The health insurance covered only 900,000 people or 2% in 1999.

3.2.3.2 The health card scheme. This was an innovation that was accepted both in Thailand and other countries. Because it was a concrete of fund mobilizing for health development in developing countries.

The development of health card scheme

The health card scheme was started at the beginning of the fifth plan of health development (1982-1986) The development of health card scheme was as following

Phase1: This project called Children and Mother Health Development Foundation Scheme was run by Hygiene Department. The basic concepts of the project were as follow:

1) Concept on primary health care development that people were able to care themselves. Change health providers' roles to facilitate community to help themselves, build management ability, to empower villagers for bargaining, and support some money to health service centers.

2) Concept on care. All care should start at the community level and refer to district and provincial level. This project would begin at drug foundation in the village, health center and hospital. The project's goal was one district each province.

Phase 2: The health card scheme had started in 1984, expanded cover all areas and changed some detail such as types, price, conditions, right and protection.

Phase 3: The health card scheme had expanded to cover all districts and developed operating strategies, services, conditions, and card price. Expanded benefit to all diseases and extended maximum care price at 2,000 baht/person.

3.2.4 The fourth system: Forcing health insurance

The problems both found in developing and developed countries were people had not enough income when they were ill, disable, could not work or died. The government arranged 2 kinds of social welfare as follow:

3.2.4.1 Non contributory system

1) People or employees received welfare with free of charge which was managed by Department of Social Welfare.

2) The welfare that provided by employers such as Compensation, cost of living and podium etc.

3.2.4.2 Contributory system

The social security office had arranged welfare foundation for employees such as social security foundation, compensate foundation, vehicle protection foundation etc.

4. Universal coverage health insurance scheme (30 baht full health coverage)

The government established universal coverage health insurance scheme (30 baht full health coverage) for people who had no any health insurances. The project was started in the first of April, 2001 in 6 provinces and then expanded all provinces in 2002.

4.1 Means and concept of universal coverage health insurance

Universal coverage health insurance meant Thai people's right to equally receive standard and quality health service no regarding of expenses.

Concept of universal coverage health insurance are as the following:

4.1.1 All people should participate in all level of universal coverage health insurance and feel as ownership.

4.1.2 People should be protected to receive quality health service. They have right to register and use health service from nearby clinics.

4.1.3 Both government and private health service centers must have standard and quality accreditation.

4.1.4 Health insurance system emphasized on available and uses of primary care units which were the first complementary health centers, treatment, promotion, prevention, and rehabilitation. In case of a serious cases, the PCU have to refer to the other health service centers.

4.1.5 Supporting cooperation among PCU and other health centers as provider networks.

4.1.6 Financial system must control a containment system and overuses service.

4.1.7 Benefit or pattern of payment mechanism must be the same standard.

4.2 Organizational structure.

Early stage, before establishing an organization to response this project, in the central, health insurance office, Ministry of public health. The ministry of public had duty to formulate the patterns and methods of registration, budget allocation, project administration under universal coverage health insurance committees and health insurance rotated- money committees.

In the provincial level, there was a committee comprised representatives of government unit, local organization, professional, experts and civil society. The committee's duty was to formulate policy and health development plan accordance with the national health policy. To set strategic plan and action plan to develop health in the area and formulate criteria and allocate health resource to health centers (Health Insurance Office, 2001: 1-3)

4.3 Health service system

Health service system was managed by network system. The principal of building network concerned of quality, efficiency, integration, distribution, responsibility, and cooperation between government and people (Health Insurance Office, 2001: 3-4)

The universal coverage health insurance system emphasized people to use at primary care unit near their houses as the frontline service. The primary care unit can provide comprehensive care, treatment, health promotion, prevention and rehabilitation. The health centers under the universal coverage health insurance system had three groups as following:

4.3.1 Contracting Unit for Primary Care, CUP. This health service unit provided general and comprehensive care for out patients. Main contractor of these units must establish primary care unit or community health center where people were able to register for family health care unit. (Health Insurance Office, 2002: 44)

4.3.2 Contracting Unit for Secondary Care, CUS. These units, community hospitals, Regional hospitals, and university hospitals and private hospitals participated in the project. These units would admit patients referred from primary care unit.

4.3.3 Contracting Unit for Tertiary Care, CUT. These units, regional hospitals, university hospitals and special hospital such as Institute of National Cancer, Dermatitis Institute, and National Child Health Institute, provided special care using high technology.

5. Universal coverage health insurance of Maharaj Nakorn Ratchasima Hospital

Public health administrative structures were divided in 3 levels which were primary care (health center) in sub-district, secondary care community hospital in district level, and tertiary care (central hospital or general hospital) in provincial level. According to decentralization to local administrative organization Act, sub district health center worked under community hospital so the health insurance administrative office was settled in the district and managed by district committee.

Maharaj Nakhorn Ratchasima Hospital had formed 11 working committee, namely public relation and complain, registered and cooperated health contractor network, information technology, nursing care welfare center, clinical practice guidelines, organizational structure re-engineering, health service, research and evaluation, and health care reform and decentralization.

5.1 Public relation and complain committee.

Since Universal coverage health insurance was a new issue for both the patients and health providers so it was very important to inform service steps to all people concern by using all media such as pamphlet, poster, radio, TV, and personnel media. Patients have no convenience or any problem can complain all the time.

5.2 Registered and cooperated health contracting network.

The working group would survey the target group of UC from family folder, separate responsible area and UC or gold card registration.

5.3 Information technology

The IT committee would collect UC patient statistic by co-working with registration and financial unit

5.4 Nursing care welfare center

The center had responsible for patients from other provinces using service at Maharaj Nakhorn Ratchasima Hospital. The majority of the patients out of Nakhorn Ratchasima province were emergent or accident cases. The patients had to show referral, UC, and ID card or house registration to verified card number with 13 number in ID card. Real expense was depend on diagnosis related group under the control of doctors. The invoice would be sent to Nakhorn Ratchasima Provincial Public Health Center to send to the patients Provincial Public Health Center for payment.

In case of emergency; the patients with nine expensive diseases, in and out of the province, would be claimed from National Health Security Office (NHSO).

5.5 Clinical practice guidelines

Clinical practice guidelines was now going on the process.

5.6 Finance

UC project used financial criteria to urge health care reform. So the first priority to make clear between provincial contractors was financial management

5.7 Organizational structure re-engineering

The organizational structure was re-engineered for more efficiency. The previous organization's structure of health insurance in Maharaj Nakorn Ratchasima Hospital had detail as following:

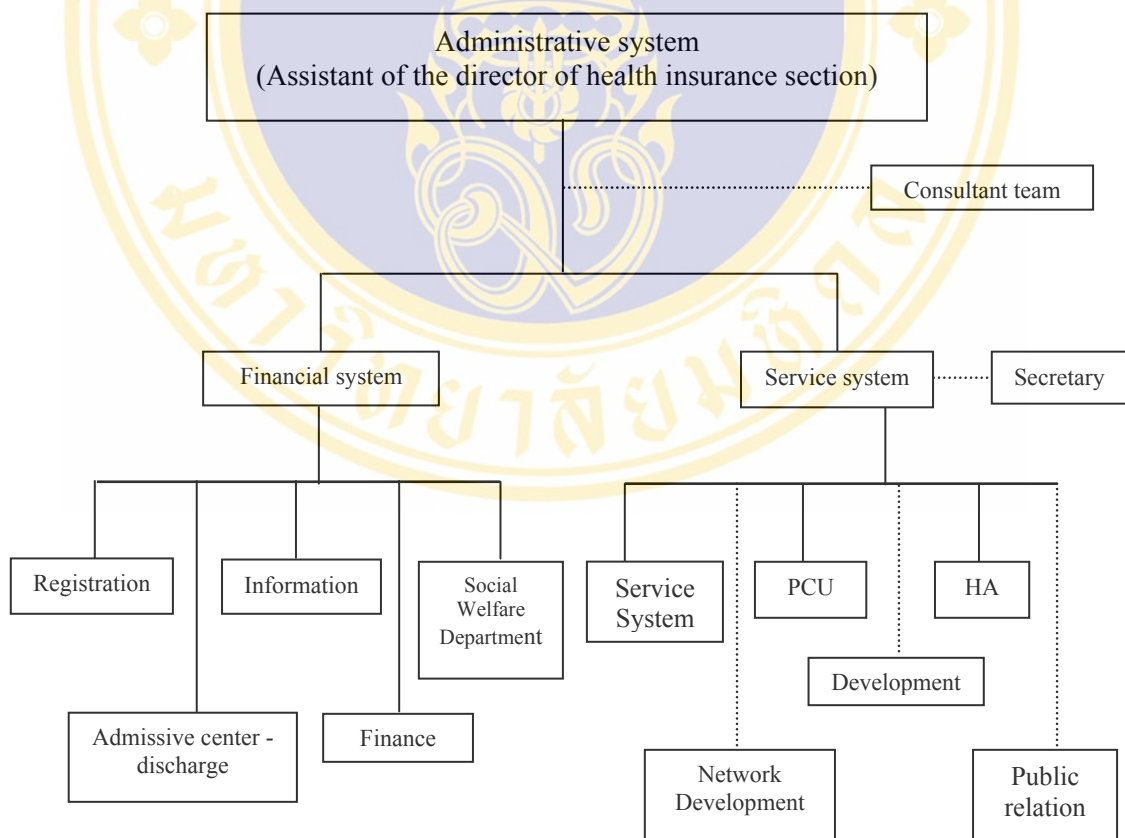


Figure 1 The organizational structure of universal coverage health insurance section in Maharaj Nakorn Ratchasrima Hospital.

5.8 Primary care unit development and promotion

The important of universal coverage health insurance was the network of Contacting Unit for Primary Care or CUP. Each CUP would take care Primary Care Unit or PCU in the network. For example, Maharaj Nahorn Ratchasima Hospital looked after not only people in Nakorn Ratchasima Municipality but also 29 community health centers.

5.9 Service system

To develop hospital service system, each work had to coordinate.

5.10 Research and evaluation

The evaluation was done by research and evaluation unit. The result would be reported to the hospital committee in order to develop service quality

Part 2: Review literature

The literature review on universal coverage health insurance was divided into 3 groups as following 1) individual or patient factors affecting on universal coverage health insurance scheme 2) health center factors and 3) problems and obstacles in this project. The detail was as following:

1. Individual factors affecting on universal coverage health insurance scheme.

Phelps (1975) studied health insurance in USA. And found that people with health insurance had health service more than people without it. The more the benefit of insurance, the more the need for health service. He also found that age and health condition effected frequency of using service.

Praphatsorn Leawpairoj (1980) studied demand on medical service and found that education effected medical health service need. The high educated person were always interested in health, to prevent and promote their health, more than low educated ones.

Sommart Phrompakdee (1980) studied factors affecting using health insurance card among people in Uthaitхани, Kamphangpet, and Pisanulok Province. The results stated that factor on sensibility toward universal coverage health insurance project influenced member application. The distance between house and hospital, service satisfaction were the important factor affecting the continuous of member status.

Linn, et al., 1982 (cited in Wanthanee Watthana, 1994) found that number of using service was the indicator of patients' satisfaction.

Evashwick, et al. (1984: 357–381) studied factors influencing health service form various health centers among 1,317 older people in USA and found that health need factor, status recognition, type of diseases, could predict the frequency of using medical service.

Viroj Tangcharearnsatien, et al. (1993) studied health behavior of insurance people in Samhitprakan Province found that when getting ill, 31.0% of insurance persons went to clinic and hospital, 26.0 % bought drug from pharmacy. 80.0% of persons with severe illness went to private main contractor, only 12.0% went to Samhutprakan governmental hospital. Before having insurance, 42.0% had medicine, 27.0% went to the clinic, 24.0% went to the clinic in the office. 75.0% of the severe illness went to the hospital and 22.0% went to the clinic. It also found that 77.0% of insurance persons didn't know about types of illness cover by insurance. In case of out-patient; factors relating to use service at main contractor were income, benefit knowledge, and transportation cost.

Suphinda Chotkiratiwet (1993) studied health behavior of 6,286 insurance persons at Samutphrakan Province found that out-patient rate use was 2.88 times per person per year, in-patient rate use was 0.67 times per person per year, out-patient non use rate with contractor was 1.2 times per person per year and in-patient was 0.4 times per person per year. Factors relating out-patient use were educational level, income, benefit knowledge, district of living main contractor, size of enterprise, and clinic in the office.

Nareerat Bunyawet (1994) studied factors affecting medical service use at Muang Pranakornsriyudya medical service center showed that occupation, education, marital status, family responsibility and residence had associated with use or non use services. In addition, people in responsible area using service had positive attitude toward this center. The reasons were nearby their houses, easy to access, low expense, 24 hours service with convenience and the officers were friendly.

Phornpha Wongnoi (2002) studied insurance person's satisfaction to dental service under 30 baht full health coverage scheme in Bangkok. The objectives were to evaluate satisfaction among 400 customers and association between individual factors and project satisfaction. The results revealed that the samples had moderate satisfaction to the whole project and high satisfaction on convenience of service. The individual factors, comprised gender, age, education, occupation, income, had no association with the satisfaction as a whole.

Phalasak Srisomboon (2002) studied customers' satisfaction on 30 baht full health coverage at Bangbuathong Hospital, Nonthaburi Province. It was a quantitative research using questionnaire for collecting data. The samples were 385 out of 10,200 population. The results showed that the samples had satisfaction all services. The satisfaction of the quality and standard of service were moderate level.

2. Health center's factors

Piyaporn Nota (1992) studied knowledge, opinion and using medical service among 224 social security customers at Chaing-Mai Maharat Hospital. The results showed that the rate of service use at this hospital was very low, only 9.8 or 1.08 times/ person/ year. Most of the samples had moderate satisfaction. The samples wanted to select health centers by themselves and suggested that hospital service should be convenience and easy to access.

Sinenaj Preechacha (1994) evaluated the using service of 296 employees in 29 medium size enterprises at Muang Chaing-Mai, Chaing-Mai Province. The results showed that 41.50% of employees never use service at main contractor and only 29.20 % used medical service at main contractor. The reasons of non use were was; distance of the health center, slowly and quality of service.

Somchai Yimwilai (1994) studied satisfaction of 1,220 customers to medical service of Nopharat Rajthanee Hospital. The results showed that the patients were unsatisfied with out patient unit officer's behavior, the slow diagnosis step, tardy of emergency section, registration step for new patients was difficult, physician service was not punctual, tardy drug section, insufficient wheel-chair and cradle, out of modern instruments, and not enough nurses, unwilling physician for service and afraid of low quality drug.

Siriphorn Prangprasit (1993) studied factors affecting use medical service among patients at Pranakornsriayudya. The sample was 400. The results showed that an important reasons to use this hospital because the company selected for them, nearby their house, easy to access, and severe illness. The reasons to use private were good service. Problems and obstacles were registration section, short time diagnosis of the physicians, waiting so long at pharmaceutical unit.

3. Problems and obstacle of health insurance project

Sanguen Nittayaramphong, et al. (1992) studied medical service under Social Insurance Enact 1990. The study objective was to analyze current situation by survey main contractors all over the country about 134 hospitals. The results showed that most of hospitals tried to develop medical service system to provide convenience to the patients. But problems and obstacles were still exist as following:

- 1) Both employees and employers did not understand benefit and protection.
- 2) Misunderstanding the service step at the hospital.
- 3) Hospital was not well prepared for service.
- 4) Hospital was unable to use capitation budget to operate the service.
- 5) Employees understood drug in National Essential Drug was not good.

Mills, at al., 1999 (cited in Sanguen Nittayaramphong, 2001: 28) studied the quality service showed that there were more complain on medical service, patients spent a lot of time waiting for physicians, at cashier, and at pharmaceutical section. These problems were still existat the present, especially at the governmental hospitals.

The service of private hospitals was quicker, service standard was flexible depend on patient's status. Patients with universal care coverage would received different service from other patients.

Wijit Rawiwong, et al. (2001) studied many kinds of health insurance's service problems found that customers had to have at least one problem. Ministry of Public Health card, a physician would not refer an expensive case to other hospital, didn't cover the instrument or essential expensive drug, often changed rule, vulnerable people always bought health card so the hospital ran at a loss.

Social security for the poor and vulnerable people, health center didn't take care without referral document, leaking confidential of patient during referral, and small amount of capitation.

Public Health Plan and Policy Bureau, Permanent Office of Public Health Ministry (2001) evaluated the policy and strategies of health for all in 2000 found that about 17% of people with free health card had to pay when getting ill because the government security or the card didn't cover all expense, and the quality of service and drug were not good.

Suwat Chaliyalerts, et al., (2002) surveyed 50,000 households in 8 provinces showed that people with UC card and getting ill. During the last 2 weeks didn't use UC card especially acute diseases. The result reminded that all concern organizations must find out causes.

Nalong Yanprapas (2003) studied "Problem of 30 baht full health coverage: a case study of Muang Chonburi district". It was a qualitative research using indept interview. The results showed 5 problems as following:

- 1) Lacking budget and late allocation affected the quality of operation.
- 2) Health providers were not enough to provide good service. The hospital was unsatisfied with this project due to more responsibility but lower reward. The staffs in health center were satisfied people received more benefit.
- 3) The hospital and health center were crowded.
- 4) Referral system had problem due to expensive expense.
- 5) Management, registration were overlapped and database system was not up to date the UC right.

Nithima Noiarun (2003) studied “knowledge and opinion of people on 30 baht covered all diseases project of Public Health Ministry”. Collecting data by using questionnaire from 400 people with UC card. The results showed that most of the sample had not knowledge about this project. The samples with different age, education, income and residence had different knowledge. They weren’t sure about this project.

Sawat Thongpha (2004) studied on universal coverage project assessment, Muang-Ubon, Ubon Rachathani Province. The studied samples were 60 health providers who performed in this project in Muang Ubon and 375 people with UC card. Data collection was questionnaire, group discussion, and public health report. The health providers thought that the project was mostly benefit to people. Health providers were ready to give service. People were mostly satisfied with the price, service, and equity to access health service.

The review literature had concluded 3 groups of problem as follow;

Knowledge on UC. It found that people lack UC knowledge both in right benefit, service procedures, referral system, misunderstood of standard of treatment and drug, and people did not have chance to access UC information.

Health service problems, the review found that health providers were not enough which affected the quality of service. People lacked participation on treatment procedures, a lot of time waiting for treatment, payment, drug, different quality of services, extra payment for non national essential drug, and inconvenience of service places.

Health service management, the health centers were not ready enough for the project because of the small amount of budget, complicated of budget allocation, in satisfaction with community health center service lead people to secondary and tertiary health center, secondary and tertiary health center rejected referral patients, primary health center did not refer patients, and referral system problem on cash claim.

The individual factors affected on service of UC project and knowledge on UC were sex, age, educational level, occupation, income.

The result from review literature could design as a conceptual framework as follow:

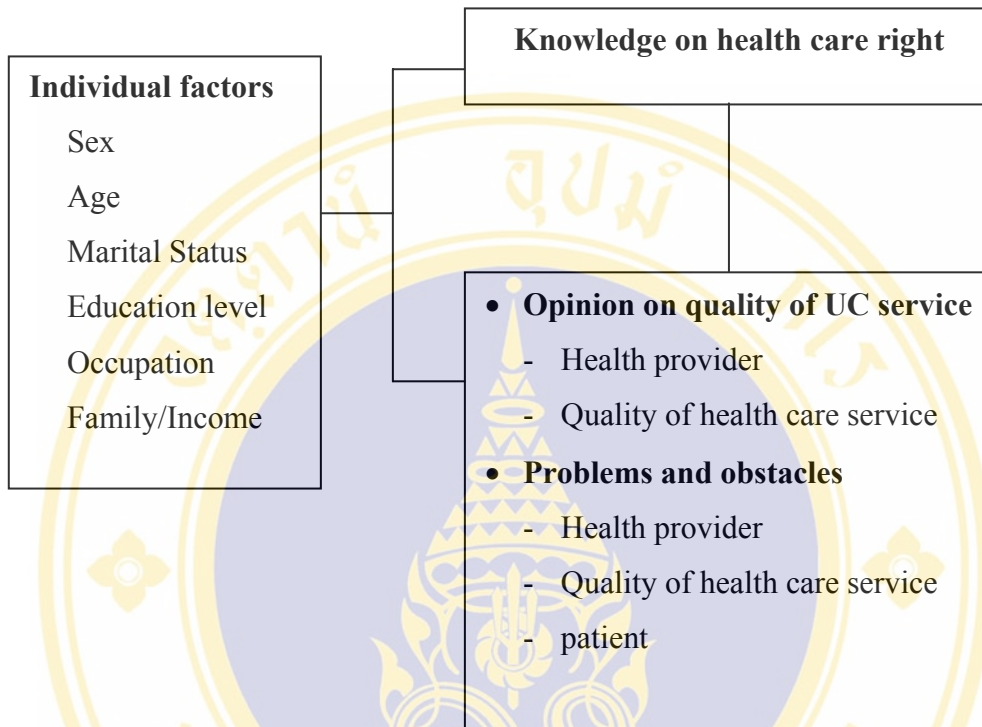


Figure 2 Conceptual Frame Work

CHAPTER 3

RESEARCH METHODOLOGY

This research aimed to study (1) the knowledge of patients about their right on the Universal Coverage Health Insurance Scheme, (2) the attitude on health care service of patients who used the 30 baht health scheme card, and (3) the problems and impediments of the use of the 30 baht health scheme card. The research methodology was described as follows.

3.1 Population and sample

Population for this research were the out-patients who used the health care services under the Universal Coverage Health Insurance Scheme. The samples were elicited from the out-patient who had physician visit at 10 sections of out-patient department consisted of medical section, pediatric section, surgical section, orthopedic section, larynx section, dental section, gynecological section, obstetrical section and psychological section of Maharaj Nakorn Ratchasima Hospital, Nakorn Ratchasima Province.

3.1.1 Sample size The formula proposed by Yamane (1973: 725) was employed to calculate the number of sample size. The formula was described below.

$$n = \frac{N}{1 + Ne^2}$$

n = Sample size

N = Population

e = Erro

The number of population in this calculation obtained from the out-patient record in 2003. There were 414,987 cases. The error for sample size estimation was set at 0.5. Thus, the number of sample size of this study were 400 cases.

$$n = \frac{414,987}{1 + 414,987 (0.05)^2}$$

$$= 399.67$$

3.1.2 Sampling methods: The samples obtained from 10 sections as noted above in which the number of each section calculated by proportional to size and selected the cases by using the simple random technique. The number of samples of each section was shown in table 2.

Table 2 The number of sample in each section

No.	Section	Peoples	Samples
1	Medical Section	141,369	136
2	Pediatrician Section	45,123	43
3	Surgical Section	57,934	56
4	Orthopedic Section	43,690	42
5	Optical Section	32,704	32
6	Dental Section	36,249	35
7	Larynx Section	21,683	21
8	Gynecological Section	24,229	23
9	Obstetrical Section	8,951	9
10	Psychological Section	3,055	3
Total		414,987	400

3.2 Research instruments

The data was collected by questionnaire which constructed according to the theories and previous researches. The questionnaire comprised of 4 parts as follows.

Past 1 : Personnel data of the samples consisted of gender, age, marital status, educational level, main occupation, average income of the household and sickness. The questionnaire of this part was multiple choices numbering 8 items.

Past 2 : Knowledge about the rights of patient under Universal Coverage Health Insurance Scheme (The 30-baht health care program). There were 20 items measured the knowledge of respondents. The measurement of scores are as follows.

Corrected answer	score
Yes	1
No	0
In corrected answer	
Yes	0
No	1

The total scores of 20 items were divided into 3 groups by obtaining the calculation method from Saeree Larcharoch (1994: 65-68).

0 – 11 scores (lower than 60 percent of full score) referred to low level of knowledge

12 – 15 scores (60 – 79.9 percent of full score) referred to moderate level of knowledge

16 – 20 scores (higher than 80 percent of full score) referred to high level of knowledge

Past 3 : The attitude of patient on quality of health care service under Universal Coverage Health Insurance Scheme (the 30-baht health care program). The attitude was measured on the quality of services under using the 30 baht health scheme card (21 items) and the quality of service system organized under Universal Coverage Health Insurance Scheme (12 items). The total questions in this part were 33 items. The answers provided in a rating scale (5 levels): highest, high, moderate, low and lowest. The criterion of scoring described below.

The question for positive attitude answers	score
Highest	5
High	4
Moderate	3
Low	2
Lowest	1

The question for positive attitude answers	score
Highest	1
High	2
Moderate	3
Low	4
Lowest	5

The total attitude scores transferred into 3 groups by using the method of calculation as below.

$$\begin{aligned}
 \text{Rang} &= \text{Maximum} - \text{Minimum} \\
 &= 5 - 1 \\
 &= 4 \\
 \text{Mean} &= \text{Rang/Number of Interval} \\
 &= 4/3 \\
 &= 1.33
 \end{aligned}$$

The level of attitude of patients on quality of health care service

Mean score 1.00 – 2.33 referred to the quality of services is poor

Mean score 2.34 – 3.67 referred to the quality of services is fair

Mean score 3.68 – 5.00 referred to the quality of services is good

Past 4: Problems of the use of the 30 baht health scheme card and recommendation.

The questions of services problems were emphasized on the knowledge of patient on their rights under Universal Coverage Health Insurance Scheme, the process of services, and service providing at register section, financial section, and medical section as well as the problems on services of nurses, physicians, and other health providers as well. The answer choices provided yes and no problem, if respondents replied “yes”, they have to specified the problem. The recommendations were open-end questions that the respondents could be proposed their opinions for solving problems on Universal Coverage Health Insurance Scheme.

3.3 The quality of the instruments

The questionnaire was tested its validity and reliability as following.

3.3.1 Content validity: The questionnaire was check the content validity by 2 experts. After a check on content validity, certain mistakes were revised following the comments of the experts.

3.3.2 Reliability: The questionnaire was tested its reliability by try-out with 30 respondents who have similar characteristic to the samples of this study. After the test, the coefficient alpha was calculated in the part of the knowledge about the rights of patient under Universal Coverage Health Insurance Scheme (part 2), and the attitude of patient on quality of health care service under Universal Health Insurance Scheme (part 3) by using Cronbach' s method. The coefficient of part 2 was 0.77, and 0.92 for part 3.

3.4 Data collection

First, the researcher requested a permission from the provincial director, the director of public health office and the director of Maharaj Nakorn Ratchasima Hospital for collecting the data. Then, the research informed the objective of the study and data collecting method to the sub-director of nursing department and head nurse of out-patient department. After that collecting the data according to the research design was performed by using the questionnaire. In the case of patients who were unable to participate in interview, the relative was interviewed instead.

3.5 Data analysis

Data analysis was done as following:

3.5.1 Coding the data by using Statistical Package for Social Science (SPSS).

3.5.2 Descriptive statistic used for analysis the data in the parts as follow.

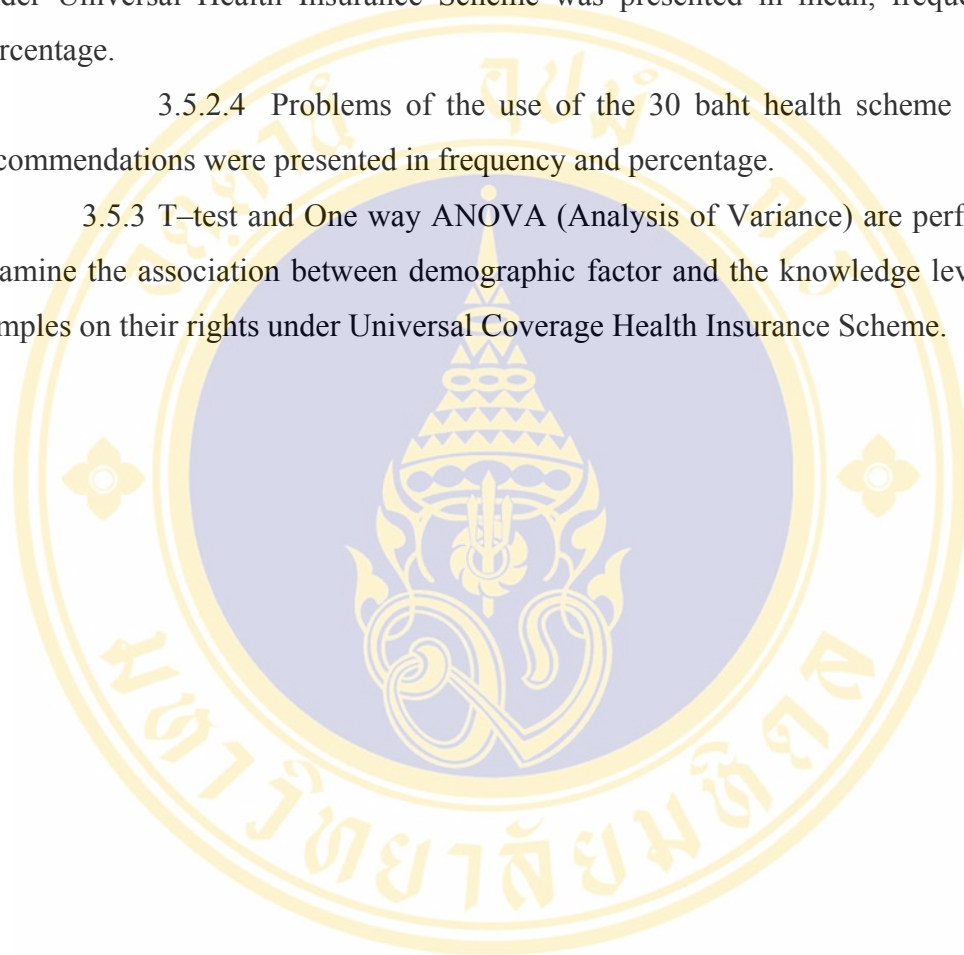
3.5.2.1 The personnel data was presented in frequency, percentage, mean, and maximum-minimum value.

3.5.2.2 The knowledge level of the sample on their rights under Universal Coverage Health Insurance Scheme was presented in frequency, and percentage.

3.5.2.3 The attitude level of patient on quality of health care service under Universal Health Insurance Scheme was presented in mean, frequency and percentage.

3.5.2.4 Problems of the use of the 30 baht health scheme card and recommendations were presented in frequency and percentage.

3.5.3 T-test and One way ANOVA (Analysis of Variance) are performed to examine the association between demographic factor and the knowledge level of the samples on their rights under Universal Coverage Health Insurance Scheme.



CHAPTER 4

RESULTS

This chapter presented the findings of the analysis. The results were divided into five sections. The first section displayed the socio-economic and demographic characteristic of the samples. The second section presented the knowledge level of patients on the rights under Universal Coverage Health Insurance Scheme. The association between demographic factor and the knowledge level of the samples on their rights under Universal Coverage Health Insurance Scheme was presented in the third section. The fourth section showed the attitude level of patient on quality of health care service under Universal Health Insurance Scheme, and the last section proposed the problems of the use of the 30 baht health scheme card and recommendations for solving the problems.

4.1 Socio-economic and demographic characteristics

The univariate analysis employed to describe the frequency distribution of the socio-economic and demographic characteristics of the sample including age, sex, marital status, education, and income.

Table 3 presented the sex distribution of the respondents that 63.5 percent of respondents were female and 36.5 percent were male. Female were slightly higher than male. Most of respondents were age group 31-40 or 36 years old in average. Among 400 respondents, 65.2 percent were married, 24.5 percent were single, and the rest were widow, divorce, and separate. The majority of respondents had primary school as their highest educational level followed by secondary school, whereas 2.3 percent had no educational attainment.

Among this sample, there were two main occupations, approximately 29.8 percent were wage-earners, and 24.3 percent were agriculturist, while other occupation presented in small proportion. Around 4.3 percent were unemployment.

Most of respondents had an average income of household less than 3,000 baht per month followed by 3,001-5,000 baht per month and 5,001 – 10,000 baht per month respectively.

Table 3 Percentage distribution of respondents by socio-economic and demographic characteristics

Socio-economic and demographic characteristics	Number (n=400)	Percentage
Sex		
Male	146	36.5
Female	254	63.5
Age		
Lower than 20 years	37	9.3
21 – 30 years	94	23.5
31 – 40 years	138	34.5
41 – 50 years	81	20.3
51 – 60 years	47	11.8
More than 60 years	3	0.8
\bar{x} 36 years minimum 13 years maximum 62 years		
Marital status		
Single	98	24.5
Married	261	65.2
Widow/ divorce/ separate	41	10.3
Highest education level		
No schooling	9	2.3
Primary school	167	41.8
Secondary school (grade 9)	82	20.5
High school (grade 12)/vocational	79	19.8
Under graduate/ diploma	22	5.5
Bachelor degree or higher	41	10.3

Table 3 Percentage distribution of respondents by socio-economic and demographic characteristics. (cont.)

Socio-economic and demographic characteristics	Number (n=400)	Percentage
Main occupation		
Unemployed	17	4.3
Wage-earner	119	29.8
Agriculturist (farming/ gardening)	97	24.3
Merchant/ private business	72	18.0
Civil servant/ state enterprise	16	4.0
Housewife	45	11.3
Others	34	8.5
Family average income		
Less than 3,000 baht/month	161	40.2
3,001 - 5,000 baht/month	113	28.3
5,001 - 10,000 baht/month	69	17.3
10,001 - 15,000 baht/month	26	6.5
More than 15,000 baht/ month	31	7.7

4.2 The knowledge level of patients on the rights under Universal Coverage Health Insurance Scheme

The knowledge level of patients on the rights under Universal Coverage Health Insurance Scheme was classified into 3 groups, high, medium, and low. The results reveal that 88.8 percent of respondents had the knowledge on the rights at the low level, and only 0.8 percent that had the knowledge at high level.

Table 4 Percentage distribution of respondents by the knowledge level on the rights under Universal Coverage Health Insurance Scheme

Knowledge level	Number	Percentage
High	3	0.8
Medium	41	10.4
Low	352	88.8
Total	396	100.0

When the analysis focused on the knowledge of respondents in each item, the results indicate the top five questions that respondents were able to and unable to give the correct answer are as following:

Questions: able to give correct answer

Item 2: At any time, if you would like to get the rights under the 30-baht health care program, you should show the 30 baht health scheme card and ID card to health care providers (92.3%).

Item 1: The 30-baht health care program proposes that everyone should have health insurance and access to health care service equally whether rich or poor (92.0%).

Item 18: The 30-baht health care program is not cover for recovering patient who addicted to drug (63.8%).

Item 15: The pregnant women with HIV-infected can be use the 30 baht health scheme card to take ARV (62.9%).

Item 17: The 30-baht health care program is not cover for organ transplantation (61.5%).

Questions: unable to give correct answer

Item 10: Patients who has the 30 baht health scheme card should pay 30 baht when got anti-natal care, vaccination, or contraceptive service (5.8%).

Item 9: According to the 30-baht health care program (in and out patient department), you should pay 30 baht when you got health care service (6.8%)

Item 16: AIDS patients are unable to use the 30 baht health scheme card for curing complications (20.8%).

Item 2: Chronic renal failure patient can be obtain renal dialysis with artificial renal machine by using the rights of the 30-baht health care program (21.5%).

Item 12: For tooth extraction, filling, scaling and polishing, the patients who the 30 baht health scheme card can get free services (25.3%).

Table 5 Percentage distribution of respondents by the knowledge on the rights under the Universal Coverage Health Insurance Scheme (n=400)

Statement	Know		Don't know	
	Number	Percentage	Number	Percentage
1. The 30-baht health care program proposes that everyone should have health insurance and access to health care service equally whether rich or poor.	368	92.0	32	8.0
2. At any time, if you would like to get the rights under The 30-baht health care program, you should show the 30 baht health scheme card and ID card to health care providers.	369	92.3	31	7.8
3. The patients who has the 30 baht health scheme card are able to get health care service from the hospitals all over the country without any condition.	197	49.3	203	50.8
4. The patients who hold the rights on the 30-baht health care program do not able to get the health care service form other rights of governmental sector.	184	46.1	215	53.8
5. People who are civil servants or people who has an social security card have the rights to use the 30 baht health scheme card.	127	31.8	272	68.2

Table 5 Percentage distribution of respondents by the knowledge on the rights under the Universal Coverage Health Insurance Scheme (n=400) (cont.)

Statement	Know		Don't know	
	Number	Percentage	Number	Percentage
6. People who had injury by car-accidence are able to use an insurance health card (The 30-baht scheme), even though they can use the rights on treatment from vehicle enactment .	113	28.3	287	71.8
7. In the case of accidence or emergent sickness which occurred in unusual place of residence, you are able to get the treatment at any hospital all over the country which collaborated with the 30-baht health care program.	195	48.8	205	51.3
8. You can make a new registration with other hospitals for the health care service when you move your place of residence, but not more than 2 times per year.	138	34.5	262	65.5
9. According to the 30-baht health care program (in and out patient department), you should pay 30 baht when you got health care service.	27	6.8	373	93.3
10. Patients who has the 30 baht health scheme card should pay 30 baht when got anti-natal care, vaccination, or contraceptive service.	23	5.8	377	94.3
11. For delivery, the patients should pay 30 baht but not more than 2 times per person.	140	35.0	260	65.0
12. For tooth extraction, filling, scaling and polishing, the patients who the 30 baht health scheme card can get free services.	174	43.5	226	56.5

Table 5 Percentage distribution of respondents by the knowledge on the rights under the Universal Coverage Health Insurance Scheme (n=400) (cont.)

Statement	Know		Don't know	
	Number	Percentage	Number	Percentage
13. Patient who are infertile and would like to have an accessed reproductive technology can be use the rights on the 30-baht health care program by paying 30 baht.	119	29.8	281	70.3
14. The 30-baht health care program is cover for patient stay over night at hospital in private room, but the patient have to pay 30 baht per night	216	54.0	184	45.0
15. The pregnant women with HIV-infected can be use the 30 baht health scheme card to take ARV.	251	62.9	148	37.1
16. AIDS patients are unable to use the 30 baht health scheme card for curing complications.	83	20.8	317	79.3
17. The 30-baht health care program is not cover for organ transplantation.	94	23.5	306	76.5
18. The 30-baht health care program is not cover for recovering patient who addicted to drug.	78	19.5	322	80.0
19. Women who has the 30 baht health scheme card are able to get investigation for cervix cancer (pep'smear).	235	58.8	165	41.3
20. Chronic renal failure patient can be obtain renal dialysis with artificial renal machine by using the rights of the 30-baht health care program.	86	31.5	314	78.5

In sum, most of respondent who used the 30 bath health scheme card at out-patient department of Maharaj Nakorn Ratchasima Hospital had the knowledge on the rights under the Universal Coverage Health Insurance Scheme at the low level. They lack of knowledge related to the treatment expenditure. Some sorts of health services do not cover by the universal coverage health insurance scheme and some kind of health services they have to pay 30 baht. Moreover, patients also confused about the list of health services, which kind of health service that an insurance agreement are covered, such as anti-natal care, vaccination, family planning, treatment on some chronic diseases, and dental services.

4.3 The association between demographic factor and the knowledge level of the sample on their rights under the Universal Coverage Health Insurance Scheme

The bivariate analysis illustrates the association between demographic factors such as age, sex, marital status, education, occupation, and income and the knowledge level on the rights under the Universal Coverage Health Insurance Scheme. The detail shows as following.

4.3.1 Association between sex and the knowledge level on the rights under the Universal Coverage Health Insurance Scheme.

According to the table 6, the knowledge mean score of female (8.2) was slightly higher than male (7.7). But the t- test analysis shows no significant difference of the knowledge on the rights under the Universal Coverage Health Insurance Scheme among male and female.

Table 6 Association between sex and the knowledge level on the rights under the Universal Coverage Health Insurance Scheme (n = 397)

Sex	Number	(\bar{x})	SD	t	p – value
Male	145	7.7	2.4	- 1.94	0.053
Female	252	8.2	2.7		

4.3.2 Association between age group and the knowledge level on the rights under The Universal Coverage Health Insurance Scheme.

The results showed that the sample having age ranging 31-40 years old had highest knowledge mean score ($\bar{x} = 8.5$) followed by 60 years old and 21 – 30 years old ($\bar{x} = 8.3$ and 8.0 respectively) whereas, the sample having lowest knowledge mean score was lower than 20 years old ($\bar{x} = 7.2$). The analysis shows that the knowledge among the sample in each age group was not different significantly. The detail shows in table 7

Table 7 Association between age group and the knowledge level on the rights under the Universal Coverage Health Insurance Scheme (n = 397)

Age group	Number	Mean (\bar{x})	SD	F	p – value
Lower than 20 years	37	7.2	2.6	1.99	0.079
21 – 30 years	94	8.0	2.6		
31 – 40 years	137	8.5	2.8		
41 – 50 years	80	7.9	2.5		
51 – 60 years	46	7.6	2.1		
More than 60 years	3	8.3	2.9		

4.3.3 Association between marital status and the knowledge level on the rights under the Universal Coverage Health Insurance Scheme.

One-way ANOVA shows that there was statistical significance (p-value 0.01), the sample with different marital status had different knowledge on the rights under The Universal Coverage Health Insurance Scheme. The sample who were married had highest knowledge mean score ($\bar{x} = 8.3$) followed by widow/divorce/separate ($\bar{x} = 8.2$). Whereas, single had lowest knowledge mean score ($\bar{x} = 7.3$).

Table 8 Association between marital status and the knowledge level on the rights under the Universal Coverage Health Insurance Scheme (n = 397).

Marital status	Number	Mean (\bar{x})	SD	F	p – value
Single	96	7.3	2.7	4.88	0.008**
Couple	260	8.3	2.6		
Widow/divorce/separate	41	8.2	2.4		

** Statistical significance at p-value =0.01

4.3.4 Association between education and the knowledge level on the rights under the Universal Coverage Health Insurance Scheme

The results in table 9 shows that the sample with bachelor degree or higher had the highest knowledge mean score (\bar{x} = 9.0) followed by no schooling and high school (\bar{x} = 8.7 and \bar{x} = 8.5, respectively). The sample with diploma or undergraduate level had the lowest knowledge mean score (\bar{x} = 7.3). One-way ANOVA shows that there was statistical significance (p-value 0.05), the sample with different educational level had different knowledge on the rights under the Universal Coverage Health Insurance Scheme. But, the respondents with high educational level were not had high knowledge score consistency.

Table 9 Association between education and the knowledge level on the rights under the Universal Coverage Health Insurance Scheme (n = 397).

Education level	Number	Mean (\bar{x})	SD	F	p–value
No schooling	9	8.7	2.4	2.71	0.02*
Primary school	166	7.8	2.5		
Secondary school	81	7.7	2.5		
High school	79	8.5	2.6		
Diploma./ Under graduate	22	7.3	2.9		
Bachelor degree or higher	40	9.0	3.0		

* Statistical significance at p-value = 0.05

4.3.5 Association between occupation and the knowledge level on the rights under the Universal Coverage Health Insurance Scheme.

The results in table 10 show that the sample who were housewife had highest knowledge mean score ($\bar{x} = 8.7$) followed by civil servant/ state enterprise and merchant/private business ($\bar{x} = 8.6$ and $\bar{x} = 8.4$) whereas, an unemployment had the lowest knowledge mean score ($\bar{x} = 7.1$). The analysis reveals that the knowledge among various occupation was not different significantly.

Table 10 Association between occupation and the knowledge level on the rights under the Universal Coverage Health Insurance Scheme (n = 397)

Occupation	Number	Mean (\bar{x})	SD	F	p – value
Unemployed	17	7.1	3.3	1.706	0.118
Wage-earner	119	7.8	2.7		
Agriculturist (farming, gardening)	95	8.1	2.2		
Merchant/ Private business	71	8.4	2.5		
Civil servant/ state enterprise	16	8.6	2.7		
Housewife/ unemployed	45	8.7	2.8		
Others	34	7.3	2.6		

4.3.6 Association between income and the knowledge level on the rights under the Universal Coverage Health Insurance Scheme

One-way ANOVA shows that there was statistical significance (p-value 0.01), the sample with different income level had different knowledge on the rights under the Universal Coverage Health Insurance Scheme. The results in table 11 reveals that the respondents with income 5,001 – 10,000 baht/month had the highest mean score of knowledge ($\bar{x} = 8.9$) followed respondents who had income more than 15,000 baht/month and 10,001 – 15,000 baht/ month ($\bar{x} = 8.5$ and $\bar{x} = 8.4$, respectively). The lowest income was the group which had the lowest mean score of knowledge ($\bar{x} = 7.8$).

Table 11 Association between income and the knowledge level on the rights under the Universal Coverage Health Insurance Scheme (n = 397).

Average income	Number	\bar{x}	SD	F	p – value
Less than 3,000 baht/ month	154	7.8	2.5	4.10	0.001**
3,001 - 5,000 baht/ month	112	7.9	2.5		
5,001-10,000 baht/ month	69	8.9	2.7		
10,001-15,000 baht/ month	26	8.4	2.4		
More than 15,000 baht/ month	29	8.5	2.9		

** Statistical significance at p-value = 0.01

As a result, the demographic factors significant associated with the knowledge level on the rights under the Universal Coverage Health Insurance Scheme in this study were marital status, education, and income.

4.4 The attitude level of patient on quality of health care service under the Universal Health Insurance Scheme

The attitude was measure on the quality of health services under using the 30 baht health scheme card (21 items) and the quality of service system organized under Universal Coverage Health Insurance Scheme (12 items). The attitude scores were classified into 3 levels: good, fair, and poor. The results present in table 12 and table 13

4.4.1 Attitude on the quality of health services

A half of respondents perceived that the health services under the Universal Health Insurance Scheme were fair, 48.5 percent were good, and 0.5 percent were poor.

Table 12 Percentage distribution of respondents by the attitude level on the rights under the Universal Coverage Health Insurance Scheme

Attitude level	Number	Percentage
Good	189	48.5
Fair	199	51.0
Poor	2	0.5
Total	400	100.0

The analysis also focused on the attitude of respondents in each item. There were 5 items for positive attitude and 3 items for negative attitude which have high mean score.

Positive attitude

Item 13: The physician has great skill and experience in treatments ($\bar{x} = 4.19$).

Item 21: The pharmacist gave a good advise on drug instruction ($\bar{x} = 3.98$).

Item 19: The physician gave a good advises to patients ($\bar{x} = 3.95$).

Item 11: Nurses can give a take care to severe patients efficiently ($\bar{x} = 3.72$).

Item 16: The physician has done physical examination carefully ($\bar{x} = 3.69$).

Negative attitude

Item 14: The physician usually express moodiness to patients ($\bar{x} = 4.13$).

Item 15: The physician ignored to listen to patients when they explained their symptoms ($\bar{x} = 4.00$).

Item 10: Nurses ignored to give some necessary advises to patient ($\bar{x} = 3.73$).

For the questions which have moderate mean score, there were 13 items. The results presented as below elicited only top five items.

Item 5: Health care providers gave a good take care and try to help the patient to get a fast service ($\bar{x} = 3.12$).

Item 8: Nurses expressed empathy on patient's illness ($\bar{x} = 3.22$).

Item 20: The pharmacist was not gave enthusiastic service. The patients wasted the time to wait for medicines ($\bar{x} = 3.26$).

Item 6: Nurses has a good communication and manner ($\bar{x} = 3.34$).

Item 12: The physician works on time ($\bar{x} = 3.35$).

Table 13 The mean score of the attitude of respondents on the quality of health care services under The Universal Coverage Health Insurance Scheme

Statement	Number	Mean score	SD
Quality of health care services			
1. Health care providers are friendly and willing to help you.	400	3.58	0.90
2. Health care providers informed the service procedures unclearly.	400	3.44	1.07
3. Health care providers were seem impolite when communicated with patient.	399	3.59	1.13
4. When you had problem and requested for some recommendations from health care providers, they were unsatisfied.	398	3.66	1.15
5. Health care providers gave a good take care and try to help the patient to get a fast service.	400	3.12	1.09
6. Nurses has a good communication and manner.	398	3.34	1.05
7. Nurses asked your illness history carefully and intended to listen to your answers.	398	3.63	0.94
8. Nurses expressed empathy on patient's illness.	397	3.22	1.02
9. Nurses tested your body temperature, measure your blood pressure, or weigh your weight carelessly.	399	3.61	1.00
10. Nurses ignored to give some necessary advises to patient.	399	3.73	1.12
11. Nurses can give a take care to severe patients efficiently.	399	3.72	0.95

Table 13 The mean score of the attitude of respondents on the quality of health care services under The Universal Coverage Health Insurance Scheme (cont.)

Statement	Number	Mean score	SD
12.The physician works on time.	399	3.35	1.13
13.The physician has great skill and experience in treatments.	400	4.19	0.75
14.The physician usually express moodiness to patients.	400	4.13	0.95
15.The physician ignored to listen to patients when they explained their symptoms.	400	4.00	1.01
16.The physician has done physical examination carefully.	400	3.69	0.94
17.The physician explained a pathology of diseases to patients by using the words which are difficult to understand.	400	3.54	1.12
18.The physician ignore to give some information about patient's sickness and limited the opportunity for asking questions.	400	3.60	1.12
19.The physician gave a good advises to patients.	400	3.95	0.88
20.The pharmacist was not gave enthusiastic service. The patients wasted the time to wait for medicines.	399	3.26	1.24
21.The pharmacist gave a good advise on drug instruction.	400	3.98	0.88

4.4.2 Attitude on the quality of health service system

The study on attitude of respondents about the quality of health service system organized under the Universal Coverage Health Insurance Scheme comprised of 12 items. Approximately 63.7 percent of respondents accepted that the quality of the service system was fair, and 33.7 percent indicated that it was good. While poor level was proposed by 2.6 percent of respondents.

Table 14 Percentage distribution of respondents by the attitude level of health service system under the Universal Coverage Health Insurance Scheme

Attitude level	Number	Percentage
Good	132	33.7
Fair	249	63.7
Poor	10	2.6
Total	391	100.0

The mean score in each item indicated the attitude of respondents on the quality of health service system. The top five of high mean scores present as follows. The mean score of all items show in table 15.

High mean score item

Item 12: You got a good service and high quality treatment from Maharaj Nakorn Ratchasima Hospital ($\bar{x} = 4.14$).

Item 10: The patients who use the 30 baht health scheme card and other patients are treated by medical principle as equals ($\bar{x} = 3.91$).

Item 6: Although the patient would depend the right in UC card (30 baht), they would be treated and cured ($\bar{x} = 3.90$).

Item 11: The patients under the 30 baht health care program get an appointment for follow-up the progress of symptoms as other patients ($\bar{x} = 3.98$).

Item 1: The service system of the hospital is well organized under The 30-baht health care program ($\bar{x} = 3.71$).

Table 15 The mean score of the attitude of respondents on the quality of health services system under the Universal Coverage Health Insurance Scheme

Statement	Number	Mean	SD
Quality of the health service system			
1. The service system of the hospital is well organized under the 30-baht health care program.	400	3.71	0.87
2. Using the 30 baht health scheme card has more complex procedures than using other health insurances.	399	2.86	1.30
3. The patient who use the 30 baht health scheme card takes a lot of time to wait for physician than other patients.	400	2.90	1.27
4. The patients who use the 30 baht health scheme card has less disease investigation than other patients.	400	3.22	1.21
5. The patients who use the 30 baht health scheme card and other patients are treated by modern medical instruments as equals.	400	3.56	1.00
6. Confidently, patients under the 30-baht health care program get effective treatments.	400	3.90	0.90
7. Because of a lot of patients under the 30-baht health care program, the health services are not cover all of patients and low quality.	398	3.20	1.07
8. For severe sickness, the 30 baht health scheme card is not eligible to use for treatments.	397	3.31	1.23
9. The patients who use the 30 baht health scheme card would be got low quality medicines.	398	3.18	1.30
10. The patients who use the 30 baht health scheme card and other patients are treated by medical principle as equals.	399	3.91	0.90
11. The patients under the 30 baht health care program get an appointment for follow-up the progress of symptoms as other patients.	399	3.89	0.90
12. You got a good service and high quality treatment from Maharaj Nakorn Ratchasima Hospital.	398	4.14	0.77

For the health service system under the Universal Coverage Health Insurance Scheme, the respondents perceived that Maharaj Nakorn Ratchasima Hospital has well organized. The respondents rather confident that they obtained the effective treatment equal as patients who did not use the 30 baht health scheme card.

The analysis combined both of the attitude on quality of health care services and health service system to represent the whole quality of the Universal Coverage Health Insurance Scheme of Maharaj Nakorn Ratchasima Hospital. The results state that more than a half of respondents who used the 30 baht health scheme card at out-patient department indicated that the quality of this program was fair and 42.0 percent indicated that it was good. Only 0.2 percent proposed that the program was poor and should be improved.

Table 16 Percentage distribution of respondents by the attitude level on the quality of the Universal Coverage Health Insurance Scheme (n = 386)

Attitude level	Number	Percentage
Good	162	42.0
Fair	223	57.8
Poor	1	0.2
Total	386	100.0

4.5 Problems of the use of the 30 baht health scheme card and recommendation

This section presents the problems of the use of the 30 baht health scheme card beyond the problems which already proposed in the former sections. The problems were related to the knowledge about patient' s rights under the program, service process, services at registry section, financial section, and pharmacy section, and health care providers, as well as other problems. The respondents specified their problems extensively in open-end questions. The results state that 80.0 percent of respondents had no problem. According to table 17, the most problems indicated by the small proportion of respondents were lacking of knowledge on the rights under the

program (20.8%), followed by service problems at registry section (14.5%), and problems on health care providers (12.6%).

Table 17 Percentage distribution of respondents by problems under The Universal Coverage Health Insurance Scheme

Problem/impediment	No		Yes		Total
	number	percentage	number	percentage	
1. Knowledge on the rights under the Universal Coverage Health Insurance Scheme	317	79.3	83	20.8	400
2. Service process	365	91.3	35	8.8	400
3. Service problems					
3.1 Registry section	341	85.5	58	14.5	399
3.2 Nurse	348	87.4	50	12.6	398
3.3 Physician	358	90.2	39	9.8	397
3.4 Financial section	383	96.5	14	3.5	397
3.5 Pharmacy section	367	92.7	29	7.3	396
4. Other problems	328	85.0	58	15.0	386

The detail of the problem are as follows:

1. Problem on knowledge about the rights under the Universal Coverage Health Insurance Scheme.

The sample lacked of knowledge about the benefit that they could obtained form the program (60.2%).

2. Problem on service process.

The sample did not understanding in the step of available service in the hospital numbering 15 samples (at rate 42.9).

3. Problem on service

3.1 Registration room

- The respondents spent a mount of time for hospital registry (65.5%).

- The communication of health officers of this section was implicit and impolite (15.5%).

3.2 Nurse

- Some of nurses were impolite and unfriendly with the patient and their relatives (58.0%).

- Nurses were lacked of enthusiasm to take care the patients (8.0%).

- The number of nurses were limited to provide the health care services (8.0%).

3.3 Physician

- The respondents spent a mount of time to wait for the physician (59.0%).

- The physician did not work on time (20.5%).

- The physician lacked of awareness in physical examination a (15.4%).

- The number of physicians were insufficient for providing the services (12.8%).

- Some of physicians were unfriendly and did not informed beneficial information to patients (10.3%).

3.4 Financial section

- The health officer was insufficient, thus the patient had to wait for a long time (35.7%).

- The financial section had small space. Hence, it too crowd and inconvenient for patients (28.6%) .

3.5 Pharmacy section

- The respondents spent a mount of time to wait medicine (69.0%).

- The pharmacist did not explain about drug instruction to the patients (13.8%).

4. Other problems

4.1 Referral system (25.9%).

4.2 Waiting for a long time (22.4%).

4.3 Low hygiene and insufficient number of toilet and seats (15.5%).

4.4 Complexity of service process (6.9%).

4.5 Inconvenient to travel to the hospital (6.9%).

4.6 Recommendations for improving the services of the Universal Coverage Health Insurance Scheme

The sample who used the service at out-patient department under the rights of the Universal Coverage Health Insurance Scheme, Maharaj Nakorn Ratchasima Hospital, Nakorn Ratchasima province proposed recommendation for improving this program in various aspects as follows:

1. The patient should use the 30 baht health scheme card at every hospitals with no any conditions (18.13%).
2. The hospital should reduced the time which patients have to spent in each section properly (16.88%).
3. The hospital should distributed more information about the rights of patient under the Universal Coverage Health Insurance Scheme (15.63%).
4. The nurse and other health care providers should give a good service and a good manner to the patients (13.75%).
5. The rights on this health insurance program should cover all diseases (8.75%).
6. The government should provided more specialist to all hospitals (7.50%).
7. The quality of treatment or medicine given to the patient with 30 baht health scheme card should be equal to other patients (6.25%).
8. The hospital should more informed about service process to the patients (4.38%).
9. The hospital should be renovate certain area of the building into a good condition, such as toilet, lobby, and so forth (4.38%).
10. The hospital should have screening system for the severe patients (3.75%).
11. The hospital should provided more health care personnel (3.75%).
12. The physician should work on (2.50%).

In conclusion, the results of data analysis on knowledge about the rights, attitudes, problems, and recommendations under the Universal Coverage Health Insurance Scheme were summarized as following:

1. The samples who use the 30 baht health scheme card at out-patient department of Maharaj Nakorn Ratchasima had the knowledge on their rights under the program at low level.

2. The demographic factors among the sample which associated significantly with the knowledge on the rights under the Universal Coverage Health Insurance Scheme were marital status, education level and income.

3. The attitude on the quality of health care services and health service system of samples who use the 30 baht health scheme card at out-patient department of Maharaj Nakorn Ratchasima was at fair level.

4. Most of the sample who use services under the 30 baht health scheme program had no problem. Some of those who had problems identified that their problems were lacking of knowledge about the rights under the program, service process, and poor services of health care providers. For improving the program, the respondents recommended that the rights under the Universal Coverage Health Insurance Scheme should cover all diseases and can be use the card at every hospital. Moreover, the hospital should improves on the services and provides more information related to under the Universal Coverage Health Insurance Scheme.

Whereas, the recommendations were they would like to use UC card (30 baht) in every hospital without any exception and should more develop providing service.

CHAPTER 5

RESULTS, DISCUSSIONS AND RECOMMENDATIONS

The study of medical care impediments in Universal Coverage Health Insurance Scheme: a case study of Maharaj Nakorn Ratchasima Hospital, Najorn Ratchasima Province aimed to investigate knowledge of the patients about treatment right, idea on quality of providing service, impediment and association between individual factors and knowledge on treatment right in Universal Coverage Health Insurance Scheme. The samples, 400 UC card patients at OPD of Maharaj Nakorn Ratchasima Hospital, Nakorn Ratchasima province, of this cross-sectional descriptive study was random sampling from 414,987 UC card patients of every section of OPD in 2004. The instrument for collecting data was questionnaire which consisted of 4 parts; 1) socio-demographic of the sample, 2) knowledge on treatment right in Universal Coverage Health Insurance Scheme, 3) idea on quality of providing service and 4) problem, impediment and recommendations. The questionnaire content was checked by 2 experts and tested reliability and validity with 30 samples a by using coefficient alpha of Cronbach. The results of reliability showed that knowledge about treatment right was 0.77; idea on providing service was 0.92. The tested questionnaires were filled by 400 samples and returned rate was 100 %. The results of this study were shown as following:

5.1 Research results

5.1.1 Socio economic characteristic of the samples

About 63.5 percent of samples were female and 36.5 percent were male. Most of them were age group 31-40 or 36 years old in average. The youngest was 13 years while the oldest was 62 years. Among 400 respondents, 65.2 percent were married, 24.5 percent were single, and the rest were widow, divorce, and separate. The majority of respondents had primary school as their highest educational

level followed by secondary school, whereas 2.3 percent had no educational attainment. Among this sample, there were two main occupations, approximately 29.8 percent were wage-earners, and 24.3 percent were agriculturist, while other occupation presented in small proportion. Around 4.3 percent were unemployment. Most of respondents had an average income of household less than 3,000 baht per month.

5.1.2 Knowledge level of patients on the rights under Universal Coverage health Insurance. The results revealed that 88.8 percent of respondents had the knowledge on the rights at the low level, 10.4 percent at the medium level and only 0.8 percent that had the knowledge at high level. When analysis by item, it showed that the respondents had lowest knowledge on the following items

Item 10: Patients who has the 30 baht health scheme card should pay 30 baht when got anti-natal care, vaccination, or contraceptive service (5.8%).

Item 9: According to the 30-baht health care program (in and out patient department), you should pay 30 baht when you got health care service (6.8%).

Item 16: AIDS patients are unable to use the 30 baht health scheme card for curing complications (20.8%).

Item 2: Chronic renal failure patient can be obtain renal dialysis with artificial renal machine by using the rights of the 30-baht health care program (21.5%).

Item 12: For tooth extraction, filling, scaling and polishing, the patients who the 30 baht health scheme card can get free services (25.3%).

5.1.3 Association between demographic factors and knowledge level on the rights under Universal Coverage Health Insurance Scheme. The study showed that individual factors such as marital status, education level and income, had association with knowledge level. The samples with married status had higher knowledge than the single. The samples with bachelor degree and high school had higher knowledge level than primary and secondary school. The samples having more income had higher knowledge level than the low income.

5.1.4 Attitude on the quality of health services

The attitude was measured on the quality of health services under using the 30 baht health scheme card and the quality of service system organized under Universal Coverage Health Insurance Scheme.

The results showed that a half of respondents perceived that the quality of health services under The Universal Health Insurance Scheme were fair, 48.5 percent were good, and 0.5 percent were poor. While the study on attitude of respondents about the quality of health service system organized under the Universal Coverage Health Insurance Scheme showed that approximately 63.7 percent of respondents accepted that the quality of the service system was fair, and 33.7 percent indicated that it was good. While poor level was proposed by 2.6 percent of respondents.

5.1.5 Problem, impediment of available service in Universal Coverage Health Insurance Scheme at OPD, Maharaj Nakorn Ratchasima Hospital, Nakorn Ratchasima Province. The study showed that majority of the samples (more than 80 percent) had no problem and impediment. Only some samples had problems which were arranged in orderly as following; 1) Patients lacked knowledge and understanding on the right under Universal Coverage Health Insurance Scheme 2) the registration service and 3) the nursing service.

5.1.6 Recommendations. The respondents recommended on service under Universal Coverage Health Insurance Scheme at OPD, Maharaj Nakorn Rachasima Hospital as the following 1) the 30 baht UC card patients should have right to use services at any hospital with no exception. 2) Improve the steps of service as quickly as possible and 3) The hospital should provide public relation on health services under using the 30 baht health scheme card and enhance understanding about the right under Universal Coverage Health Insurance Scheme.

5.2 Discussions

5.2.1 The results showed that most of the respondents had low knowledge level on the right under Universal Coverage Health Insurance Scheme even with the basic service as anti-natal care, vaccination, or contraceptive service. The respondents were not sure whether they had to pay 30 baht for service or not. While they realized the concept of the Universal Coverage Health Insurance Scheme and the steps of using the service because it was the important project of the government. This result was consistent with the survey of National Statistic Office in 2004 that the people had slightly knowledge and understanding in UC card. The result was also consistent with the study of Nithima Noiarun (2003) which showed that most of the samples had no knowledge about the detail of 30 baht full health coverage this project.

5.2.2 The results showed that demographic factors of the samples had association with knowledge in the right under Universal Coverage Health Insurance Scheme such as marital status, education and income. The married had more knowledge than the single because the married had to responsibility for the health of their family members. While the high educated had more knowledge than the lower since the high educated could access information easier than the low ones.

As for income, the result showed that the sample had moderate income (5,000 – 10,000 baht/ month), had more knowledge than the sample with low income (not over 3,000 baht/month) since the moderate income respondents had high educated comparison with the low income.

5.2.3 The attitude on the quality of services under Universal Coverage Health Insurance Scheme was 57.8 percent fair and about 42.0 was good. It could be concluded that the respondents had positive attitude on quality of service or they had satisfaction on the service because this project responded to people's need to have health insurance when they got ill.

5.2.4 The problem and impediment of Universal Coverage health Insurance Scheme. The study revealed that most of the samples (more than 80 percent) had no problem on available service. Because Maharaj Nakorn Ratchasima Hospital was the centered hospital with many specialists and health providers, high technological equipments. It was also health promoting hospital and got certification on Hospital Accreditation. However, it still had many problems appear such as the lack of right under Universal Coverage Health Insurance Scheme, problem at registration service. The respondents complained that they had to wait for so long time and the staffs had no service mind, impolite and lacked social relationship. These results were in accordance with the study of Sanguan Nittayarumphong (2001) that most of Thai people was unpleased to waiting for treatment and the study of Sutthichat Jamsawang (2003) stated that problem and impediment of the patient were understanding in step of the services and right in services, the study of Ampha Deeseephan (1996) stated that problem and impediment of the patient at OPD of Maharaj Nakorn Chiangmai were impolite speaking of the staff and no service mind. Somchai Yimwilai (1994) found that impediment the patient faced at OPD was the impolite manner of the staff, boring manner when asked by the patients, the slow service, many steps for a new patient, uninterested nurse to follow up patient's symptom and afraid of low quality drug.

5.2.5 The recommendations.

1) The respondents recommended that the patients with 30 baht UC card could go to get service at any hospital they preferred. This recommendation was impossible in practice because of not only the budget allocated from the government to the hospital but also the concept of health insurance to decentralize health service. If the patients could select hospital, some hospitals would have over patients and some didn't.

2) The hospital should develop the time for health service in many section such as registration, diagnosis and drug section. The recommendation was the same as the result of hospital survey so the hospital should try to solve these problems.

3) To develop hospital public relation on Universal Coverage Health Insurance Scheme because enhancing knowledge was important to the patient, they should understand their right of 30 baht full health coverage. The hospital should consider to provide the information to patients.

5.3 Recommendations

5.3.1 Recommendations for the hospital.

The hospital should set up program supporting knowledge to the people under various patterns in the hospital such as:

- 1) Changing Universal Coverage Health Insurance Scheme exhibition corner to diagnosis section areas so the patient could spend the time at the exhibition while waiting for the physician.
- 2) There should have staff who have explicitly knowledge about policy of Universal Coverage Health Insurance Scheme, various regulations, and had positive attitude toward this project to receive patients' complaint.
- 3) To have video presentation about Universal Coverage Health Insurance Scheme in the patients waiting areas such as drug, X-ray and diagnosis section.
- 4) The result of this study showed that almost of the respondents were satisfied with the hospital service system and the quality of service so the hospital should maintain this quality and continued development of the good image.

5.3.2 Recommendations for further study

- 1) There should study this issue again under different context such as to compare between centered hospital or general hospital and community hospital or cup (Contracting Unit for Primary Care) and health center/ PCU (Primary Care Unit). To investigate providing service in various levels whether the patients' knowledge and impediment will be the same or different.
- 2) To study opinion of the staffs such as physicians, nurses and other staffs towards Universal Coverage Health Insurance Scheme to get more information to solve problems and develop Universal Coverage Health Insurance Scheme services.
- 3) To study the in-patients for Universal Coverage Health Insurance Scheme by using qualitative method.

BIBLIOGRAPHY

In English

- Evashwick, C., et al. (1984). Factors explaining the use of health services by the elderly. Journal of Health Services Research, 19, (August), 357 – 381.
- Linn, M. W., Linn, B. S. & Stein S. R. (1982). Satisfaction with ambulatory care and compliance. Older patients, Medical care, 20, (June).
- Mills, A., et al., (1999). Payment Mechanisms, Efficiency and Quality of Care in Public and Private Hospital in Thailand. Report of Approved Project to the European Commission.
- Phelps, C. E. (1975). Effect of Insurance on Demand for Medical Care. In Renold, Krasits & Anderson (Eds.), Health Services. Cambridge, England: Cambridge Ballinger Publishing.
- Somers, H. M. (1961). Doctor Patients and Health Insurance. The Organization and Financing Medical Care. Washington D.C., USA: Bookings Institution.
- Tull, D. S. & Hawkins, D. I. (1984). Marketing Research: Measurement and Method. New York: Macmillan Publishing.
- Ware, D. A. & Stewart, A. L. (1978). The measurement and meaning of Patient Satisfaction. Health in medical care service review, (January), 1.
- WHO. (1997). Health Insurance scheme for people outside formal sector employment: GUIDELINE FOR GOVERNMENT. Geneva, Switzerland : n.p.
- Yamane, Taro. (1973). Statistics: And Introductory Analysis. New York: Harper & Row Publisher. inc.

In Thai

- กระทรวงสาธารณสุข สำนักงานประกันสุขภาพ. (2536). ผลการดำเนินงานสำนักงานประกันสุขภาพ ปี 2535. นนทบุรี: สำนักงานประกันสุขภาพ กระทรวงสาธารณสุข.
- กาญจนา บุตรชน. (2536). การศึกษาสภาพปัจจุบัน และความคาดหวังของประชาชนจังหวัดร้อยเอ็ด ต่อการบริการพยาบาลในโครงการบัตรประกันสุขภาพ. วิทยานิพนธ์ปริญญาปรัชญาดุษฎีบัณฑิต, สาขาวิชาการพยาบาล บัณฑิตวิทยาลัย จุฬาลงกรณ์มหาวิทยาลัย.
- เกษมศิริ นันทเวชสันติ. (2545). การปฏิบัติงานสังคมสงเคราะห์ทางการแพทย์ ในการดำเนินงานประกันสุขภาพถ้วนหน้า. กรุงเทพมหานคร: งานสังคมสงเคราะห์ กลุ่มงานเวชกรรมสังคม โรงพยาบาลราชวิถี กระทรวงสาธารณสุข.
- คณะทำงานพัฒนานโยบายหลักประกันสุขภาพถ้วนหน้า. (2544). ข้อเสนอระบบหลักประกันสุขภาพถ้วนหน้า รายงานการศึกษาประกอบการปฏิรูประบบสุขภาพ และร่างพระราชบัญญัติสุขภาพแห่งชาติ พ.ศ.---. กรุงเทพมหานคร: สถาบันวิจัยระบบสาธารณสุข
- จันทนา วรรณเพิ่มสุข และคณะ. (2544). รายงานการวิจัยเรื่อง การประเมินผลการดำเนินงานตามนโยบายรัฐบาล 30 บาทรักษาทุกโรค กรณีศึกษาจังหวัดนนทบุรี. กรุงเทพมหานคร: คณะรัฐประศาสนศาสตร์ สถาบันบัณฑิตพัฒนบริหารศาสตร์.
- จิรภา รัตนเพ็ญตระกูล. (2543). หลักประกันสุขภาพถ้วนหน้า: ศึกษาความสัมพันธ์ระหว่างความเสี่ยงต่อการเจ็บป่วยกับความสามารถในการดูแลสุขภาพของประชาชน. วิทยานิพนธ์ปริญญารัฐประศาสนศาสตรมหาบัณฑิต, สาขารัฐประศาสนศาสตร์ บัณฑิตวิทยาลัย จุฬาลงกรณ์มหาวิทยาลัย.
- จิราพร สุวรรณธีรางกูร. (2535). รายงานการวิจัยเรื่อง การประกันสุขภาพสำหรับชาวบ้านในชนบท ด้านความเจ็บป่วยและค่าใช้จ่ายบริการรักษา. อุดรธานี.
- จิราพร สุวรรณธีรางกูร. (2535). ปัจจัยที่มีอิทธิพลต่อการเลือกซื้อบัตรสุขภาพของประชาชนกรณีศึกษาอำเภอแม่ริม จังหวัดเชียงใหม่ พ.ศ. 2533 – 2534. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาการพัฒนาสุขภาพ บัณฑิตวิทยาลัย จุฬาลงกรณ์มหาวิทยาลัย.
- ชื่นชม เจริญยุทธ. (2522). ปัจจัยที่กำหนดการเลือกใช้บริการด้านสาธารณสุขประเภทต่าง ๆ ของประชาชนในชนบท. วิทยานิพนธ์ปริญญาสังคมศาสตรมหาบัณฑิต, สาขาสังคมศาสตร์ การแพทย์และสาธารณสุข บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ชัยณรงค์ อิมใจ. (2537). ปัญหาและอุปสรรคของเจ้าหน้าที่สาธารณสุขตำบล ในการดำเนินการโครงการบัตรสุขภาพในจังหวัดอ่างทอง. ภาคนิพนธ์, คณะสาธารณสุขศาสตร์ มหาวิทยาลัยมหิดล.

- เชื้อทอง ชรรรมมาลา และคณะ. (2527). รายงานการวิจัยเรื่อง การศึกษาความคิดเห็นของผู้มีบัตรประกันสุขภาพที่มีต่อบริการสาธารณสุขของประชาชนในจังหวัดลำพูน. อุดลำเนา.
- ณรงค์ ญาณประภาส. (2546). ปัญหาการนำนโยบาย 30 บาทรักษาทุกโรคไปปฏิบัติ: ศึกษาเฉพาะกรณีอำเภอเมือง จังหวัดชลบุรี. วิทยานิพนธ์ปริญญารัฐประศาสนศาสตรมหาบัณฑิต, สาขาวิชาการบริหารทั่วไป บัณฑิตวิทยาลัย มหาวิทยาลัยบูรพา.
- ดุสิต สุจิรารัตน์. (2541). การวิเคราะห์ข้อมูลด้วยโปรแกรม SPSS for WINDOWS. (พิมพ์ครั้งที่ 2). กรุงเทพมหานคร: จุฑทอง.
- เทียนฉาย กิระนันท์. (2529). แนวคิดเรื่องการประกันสุขภาพในประเทศไทย. เอกสารประกอบการบรรยาย เรื่อง การประกันสุขภาพสำหรับประเทศไทย วันที่ 10 – 12 มิถุนายน 2529. ชลบุรี: โรงแรมแกรนด์พาเลซ.
- นาริรัตน์ บุญยเวช. (2537). ปัจจัยที่ทำให้ประชาชนมารับบริการและไม่มารับบริการจากศูนย์การแพทย์ชุมชนเมืองนครศรีอยุธยา. วิทยานิพนธ์ปริญญาตั้งคมสงเคราะห์ศาสตรมหาบัณฑิต, คณะสังคมสงเคราะห์ศาสตร์ มหาวิทยาลัยธรรมศาสตร์.
- นิตยา ชัยวิมล. (2538). การประเมินความพึงพอใจของผู้รับบริการต่อการให้บริการผู้ป่วยนอกโรงพยาบาลศรีษะเกษ. อุดลำเนา.
- นิธิมา น้อยอรุณ. (2546). ความรู้และความคิดเห็นของประชาชน จังหวัดนนทบุรี ที่มีต่อโครงการ 30 บาทรักษาทุกโรค ของกระทรวงสาธารณสุข. วิทยานิพนธ์ปริญญาโทเศรษฐศาสตรมหาบัณฑิต, สาขาวิชาเศรษฐศาสตร์พัฒนาการ บัณฑิตวิทยาลัย มหาวิทยาลัยธุรกิจบัณฑิต.
- เนตรชนก บัวเล็ก. (2538). การศึกษาปัจจัยที่มีผลต่อการไม่ได้รับการประกันสุขภาพ ศึกษาเฉพาะกรณีผู้มารับบริการในโรงพยาบาลบางใหญ่ อำเภอบางใหญ่ จังหวัดนนทบุรี. วิทยานิพนธ์ปริญญาตั้งคมสงเคราะห์ศาสตรมหาบัณฑิต, คณะสังคมสงเคราะห์ศาสตร์ มหาวิทยาลัยธรรมศาสตร์.
- บุญธรรม กิจปรีดาบริสุทธิ์. (2540). ระเบียบวิธีการวิจัยทางสังคมศาสตร์. (พิมพ์ครั้งที่ 7). กรุงเทพมหานคร: โรงพิมพ์และทำปกเจริญผล.
- _____. (2546). คู่มือการวิจัยการเขียนรายงาน การวิจัยและวิทยานิพนธ์. (พิมพ์ครั้งที่ 7). กรุงเทพมหานคร: จามจุรีโปรดักท์.
- บุญเลิศ วรรักษ์วงศ์. (2539). รายงานการการศึกษาส่วนบุคคล เรื่อง ปัญหาและอุปสรรคการรับบริการทางการแพทย์ของผู้ประกันตน. ม.ป.ท.

- บุญนันท์ คลังทรัพย์. (2525). ทัศนะของผู้นำชุมชนต่อการประกันการเจ็บป่วยในประเทศไทย. วิทยานิพนธ์ปริญญาศิลปศาสตรมหาบัณฑิต, สาขาสังคมสงเคราะห์ คณะสังคมสงเคราะห์ศาสตร์ มหาวิทยาลัยธรรมศาสตร์.
- บุชา บัวภา. (2544). รายงานการวิจัย เรื่อง การรับรู้ของประชาชนต่อโครงการ 30 บาทรักษาทุกโรค ศึกษากรณี: ตำบลมะปราง อำเภอนาทม จังหวัดร้อยเอ็ด. ร้อยเอ็ด: สถานีอนามัย บ้านหวาย. อัดสำเนา.
- ประภัสสร เลียวไพโรจน์. (2523). อุปสงค์ต่อการบริการทางการแพทย์. กรุงเทพมหานคร: คณะเศรษฐศาสตร์ มหาวิทยาลัยธรรมศาสตร์.
- ประภาพรรณ อุ๋นอบ. (2544). ความสัมพันธ์ระหว่างสถิติกับการวิจัย เอกสารประกอบการสอน วิชากลยุทธ์และกลวิธีในการวิจัยทางประชากรศึกษา (SHPE 515). นครปฐม: คณะสังคมศาสตร์และมนุษยศาสตร์ มหาวิทยาลัยมหิดล. อัดสำเนา.
- ประวีณา ยงประพัฒน์. (2544). การใช้สิทธิประโยชน์ในระบบบริการทางการแพทย์ของผู้ประกัน. วิทยานิพนธ์ปริญญาศิลปศาสตรมหาบัณฑิต, สาขาวิชาสังคมวิทยาการพัฒนา บัณฑิตวิทยาลัย มหาวิทยาลัยขอนแก่น.
- _____. (2532). แนวทางและกลยุทธ์ของระบบประกันสุขภาพในประเทศไทยในระบบประกันสุขภาพในประเทศไทย. กรุงเทพมหานคร: สำนักพิมพ์แสงแดด.
- _____. (2532). ระบบประกันสุขภาพของไทย. นครปฐม: ศูนย์ศึกษานโยบายสาธารณสุข มหาวิทยาลัยมหิดล.
- _____. (2533). ระบบประกันสุขภาพของไทย. กรุงเทพมหานคร: ศูนย์บัตรสุขภาพ กระทรวงสาธารณสุข.
- _____. (2534). ระบบประกันสุขภาพของไทย. กรุงเทพมหานคร: โรงพิมพ์แสงแดด.
- ปิยพร โนตา. (2535). ความรู้ ความคิดเห็น และการใช้บริการทางการแพทย์ของผู้ประกันตนตามพระราชบัญญัติประกันสังคม พ.ศ. 2533 กรณีศึกษาผู้ประกันตนที่ขึ้นทะเบียนกับโรงพยาบาลมหาราชนครเชียงใหม่. การค้นคว้าอิสระปริญญาสาธารณสุขศาสตรมหาบัณฑิต, บัณฑิตวิทยาลัย มหาวิทยาลัยเชียงใหม่.
- ปิยะชาติ เจริญวัฒนาพานิช. (2537). พฤติกรรมการใช้บริการทางการแพทย์ของผู้ประกันตนในนิคมอุตสาหกรรมแหลมฉบัง. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาเวชศาสตร์ป้องกันและสังคม บัณฑิตวิทยาลัย จุฬาลงกรณ์มหาวิทยาลัย.

- ปรีชา ผาคีชล. (2538). พฤติกรรมการเลือกสถานพยาบาล และการใช้บริการรักษาพยาบาลของผู้ประกันตนในโครงการประกันสังคมจังหวัดนนทบุรี. วิทยานิพนธ์ปริญญาเศรษฐศาสตรมหาบัณฑิต, คณะเศรษฐศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยธรรมศาสตร์.
- พรฟ้า วงศ์น้อย. (2545). ความพึงพอใจของประชากรที่มีต่อบริการด้านทันตกรรมของโครงการ 30 บาทรักษาทุกโรค กรุงเทพมหานคร. วิทยานิพนธ์ปริญญาบริหารธุรกิจมหาบัณฑิต, บัณฑิตวิทยาลัย มหาวิทยาลัยเอเชียอาคเนย์.
- พลศักดิ์ ศรีสมบูรณ์. (2545). เปรียบเทียบความพึงพอใจของผู้รับบริการก่อนและหลังเข้าโครงการ 30 บาทรักษาทุกโรค โรงพยาบาลบางบัวทอง จังหวัดนนทบุรี. ภาคนิพนธ์ปริญญาบริหารธุรกิจมหาบัณฑิต, สาขาการจัดการทั่วไป บัณฑิตวิทยาลัย สถาบันราชภัฏสวนดุสิต.
- ไพจิตร ปวะบุตร. (2536). แนวคิด นโยบาย กลวิธี และการสนับสนุนการพัฒนาระบบประกันสุขภาพในความรับผิดชอบของกระทรวงสาธารณสุข. วารสารเพื่อพัฒนาคุณภาพชีวิตชาวอีสาน สาธารณสุขมูลฐาน, 8 (8), 8.
- โยธิน แสงวงดี, พิมลพรรณ อิศรศักดิ์ และมาลี สันภูวรรณ. (2543). ปัญหาและทุกข์ของประชาชนเมื่อใช้บริการสถานบริการสาธารณสุข. นครปฐม: โครงการวิจัยสถาบันระบบสาธารณสุข สถาบันวิจัยประชากรและสังคม มหาวิทยาลัยมหิดล
- โรงพยาบาลมหาราชนครราชสีมา. (2545). เอกสารการตรวจราชการและนิเทศงานกรณีปกติ รอบที่ 2 ประจำปี 2545 ฉบับ วันที่ 5 – 7 มิถุนายน. อัดสำเนา.
- โรงพยาบาลมหาราชนครราชสีมา. (2547). เอกสารระบบบริการคลินิกทั่วไป – คลินิกพิเศษ ตึกผู้ป่วยนอก. อัดสำเนา.
- โรงพยาบาลมหาราชนครราชสีมา. (ม.ป.ท.) คู่มือการบริการ. นครราชสีมา: มิตรภาพการพิมพ์.
- วสิน ทัฬหาวณิช, ผ่องพรรณ ชีระวัฒนศักดิ์ และจิรยุทธ คงนุ่น. (2545). ความคาดหวังของประชาชนต่อคุณภาพบริการในโครงการหลักประกันสุขภาพถ้วนหน้า จังหวัดพิจิตร. กรุงเทพมหานคร: โครงการหลักประกันสุขภาพถ้วนหน้า สำนักงานวิชาการสาธารณสุข สำนักงานปลัดกระทรวงสาธารณสุข.
- วิจิตร ระวิวงศ์ และคนอื่น ๆ. (2527). การประกันสังคมในประเทศไทย: แนวคิดในการจัดดำเนินการ. กรุงเทพมหานคร: มหาวิทยาลัยธรรมศาสตร์.
- _____. (2544). การศึกษาลักษณะปัญหาการรับบริการสุขภาพภายใต้ระบบประกันสุขภาพต่าง ๆ. ม.ป.ท.

- วินัย ลีสมีนทร์ และสุภลลิตี พรธรรณารุโณทัย. (2542). หลักประกันสุขภาพถ้วนหน้ากับการปฏิรูปสุขภาพในประเทศไทย: ทางเลือกสำหรับการมีส่วนร่วม ขององค์กรปกครองส่วนท้องถิ่น. พิษณุโลก: ศูนย์วิจัยและติดตามความเป็นธรรมทางด้านสุขภาพ คณะแพทยศาสตร์ มหาวิทยาลัยนเรศวร.
- วิโรจน์ ตั้งเจริญเสถียร และคนอื่นๆ. (2536). พฤติกรรมการใช้บริการทางการแพทย์ ของผู้ประกันตน ในจังหวัดสมุทรปราการ หนังสือชุดประกันสุขภาพเล่มที่ 6. กรุงเทพมหานคร: สำนักนโยบายและแผนสาธารณสุข กระทรวงสาธารณสุข.
- วิไลเดือน พรอนันต์. (2535). ความรู้ ทักษะ และการปฏิบัติตนของผู้ประกันตนต่อการได้รับความคุ้มครองกรณีประสบอันตรายหรือเจ็บป่วยตามพระราชบัญญัติประกันสังคม พ.ศ. 2533 ในจังหวัดสมุทรสาคร. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต (สาธารณสุขศาสตร์), สาขาวิชาเอกบริหารสาธารณสุข บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- วันทนี วัฒนะ. (2537). การใช้บริการอนามัยของประชาชนในชุมชนแออัดในเขตรับผิดชอบของศูนย์บริการสาธารณสุข 11 กรุงเทพมหานคร. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, จุฬาลงกรณ์มหาวิทยาลัย.
- ศิริพร ปรางประสิทธิ์. (2536). ปัจจัยที่มีอิทธิพลต่อการใช้บริการทางการแพทย์ของผู้ประกันตน ณ โรงพยาบาลพระนครศรีอยุธยา ตามพระราชบัญญัติประกันสังคม พ.ศ. 2533. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต (สาธารณสุขศาสตร์), สาขาวิชาเอกบริหารสาธารณสุข บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- _____. (2538). ปัจจัยที่มีอิทธิพลต่อการใช้บริการทางการแพทย์ของผู้ประกันตน ณ โรงพยาบาลพระนครศรีอยุธยา ตามพระราชบัญญัติประกันสังคม พ.ศ. 2533. วารสารวิชาการสาธารณสุข, 1 – 11.
- ศรีพิจิตร ธาตุเพชร. (2543). เหตุผลของผู้มีบัตรประกันสุขภาพในการใช้บริการทางการแพทย์ ณ โรงพยาบาลชุมชน ด้วยโรคที่สามารถรักษาได้ที่สถานอนามัยในเขตอำเภออมลาลัย จังหวัดกาฬสินธุ์. วิทยานิพนธ์ปริญญาสาธารณสุขศาสตรมหาบัณฑิต บัณฑิตวิทยาลัย มหาวิทยาลัยขอนแก่น.
- สุภชัย คุณารัตนพุกภัย และดวงสมร บุญผดุง. (2532). รายงานการวิจัย เรื่อง การศึกษาความพึงพอใจของผู้มารับบริการด้านรักษาพยาบาลในโรงพยาบาลทั่วไป. อุดรธานี.
- สุภลลิตี พรธรรณารุโณทัย. (2543). ความเป็นธรรมของการใช้บริการสุขภาพ ความเป็นธรรมในระบบสุขภาพ. กรุงเทพมหานคร: บริษัท ดีไซร์ จำกัด.

- ศุภสิทธิ์ พรรณารุโณทัย, ดิเรก ปัทมสิริรัตน์ และสัมฤทธิ์ ศรีธำรงสวัสดิ์. (2543). หลักประกันสุขภาพถ้วนหน้าในประเทศไทย ทางเลือกและความเป็นไปได้. นนทบุรี: สำนักโครงการปฏิรูประบบบริการสาธารณสุข.
- สมใจ ยิ้มวิไล. (2537). การศึกษาความพึงพอใจของผู้ประกันตนต่อบริการทางการแพทย์: กรณีศึกษาโรงพยาบาลนพรัตน์ราชธานี. วารสารโรงพยาบาลนพรัตน์ราชธานี, 129 – 137
- สมมาตร พรหมภักดี. (2523). รายงานการวิจัย เรื่อง การศึกษาปัจจัยที่มีผลต่อการใช้บริการประกันสุขภาพของประชาชนชนบทไทยจังหวัดอุทัยธานี กำแพงเพชร และพิษณุโลก. อุดรธานี. สมมาตร พรหมภักดี และประสิทธิ์ ลีระพันธ์. (2529). รายงานการวิจัย เรื่อง พฤติกรรมการใช้บริการสาธารณสุขในโครงการบัตรสุขภาพ. อุดรธานี.
- สวนดุสิตโพล. (2541). การบริหารโรงพยาบาลรัฐสำหรับสถาบันวิจัยระบบสาธารณสุข. กรุงเทพมหานคร: สถาบันราชภัฏสวนดุสิต.
- สงวน นิตยารัมภ์พงศ์. (2535). การจัดบริการทางการแพทย์ภายใต้พระราชบัญญัติประกันสังคม พ.ศ. 2533: วิเคราะห์สถานการณ์ปัจจุบัน. กรุงเทพมหานคร: กองแผนงานสาธารณสุข กระทรวงสาธารณสุข.
- _____. (2543). แนวคิดใหม่ในการปฏิรูประบบบริการสุขภาพไทย. วารสารสังคมศาสตร์การแพทย์, 11 (2), 22 – 23.
- _____. (2544). การปฏิรูประบบบริการสุขภาพไทย. กรุงเทพมหานคร: สำนักงานโครงการปฏิรูประบบบริการสาธารณสุข.
- สงวน นิตยารัมภ์พงศ์ และคนอื่น ๆ. (2535). หนึ่งปีของการประกันสังคม ผลกระทบต่อระบบบริการทางการแพทย์และสาธารณสุข. กรุงเทพมหานคร: โรงพิมพ์องค์การสงเคราะห์ทหารผ่านศึก.
- สงวน นิตยารัมภ์พงศ์, ศุภสิทธิ์ พรรณารุโณทัย และสัมฤทธิ์ ศรีธำรงสวัสดิ์. (2544). สู่การสร้างหลักประกันสุขภาพถ้วนหน้า. (พิมพ์ครั้งที่ 3). กรุงเทพมหานคร: สุพีริยมพริ้นติ้ง.
- สถาบันบัณฑิตพัฒนบริหารศาสตร์. (2537). รายงานการประเมินผลการให้บริการทางการแพทย์แก่ผู้ประกันตนตามกฎหมายประกันสังคม. กรุงเทพมหานคร: โรงพิมพ์ภาพพิมพ์.
- สถาบันวิจัยระบบสาธารณสุข. (2541). การปฏิรูประบบบริการสุขภาพไทย. กรุงเทพมหานคร: สำนักงานโครงการปฏิรูประบบบริการสาธารณสุข กระทรวงสาธารณสุข.
- สถาบันวิจัยระบบสาธารณสุข. (2543). เมื่อสังคมป่วย ฝ่าวิกฤตสุขภาพ. กรุงเทพมหานคร: กระทรวงสาธารณสุข.

- สวัสดิ์ ทองผา. (2547). การประเมินโครงการหลักประกันสุขภาพถ้วนหน้า อำเภอเมืองอุบล จังหวัดอุบลราชธานี. การศึกษาค้นคว้าอิสระปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาการจัดการระบบสุขภาพ บัณฑิตวิทยาลัย มหาวิทยาลัยมหาสารคาม.
- สันทัด เสริมศรี และคนอื่น ๆ. (2546). การใช้สถานพยาบาลของรัฐของคนจนในชนบท. กรุงเทพมหานคร: สามเจริญพาณิชย์ (กรุงเทพ).
- สระไกร กิ่งกากล. (2545). ความพึงพอใจของผู้ใช้บัตรทองในโครงการหลักประกันสุขภาพถ้วนหน้า (โครงการสามสิบบาท) ต่อบริการด้านสุขภาพในโรงพยาบาลชุมชน จังหวัดหนองบัวลำภู. วิทยานิพนธ์ปริญญาศิลปศาสตรมหาบัณฑิต, คณะศิลปศาสตรมหาวิทยาลัยธรรมศาสตร์
- สินีนานู ปรีชาจารย์. (2537). การประเมินผลการใช้พระราชบัญญัติประกันสังคม พ.ศ. 2533 ในสถานบริการขนาดกลาง อำเภอเมือง จังหวัดเชียงใหม่. วิทยานิพนธ์ปริญญารัฐประศาสนศาสตรมหาบัณฑิต, บัณฑิตวิทยาลัย มหาวิทยาลัยเชียงใหม่.
- สุจริต ศรีประพันธ์ และสงวน นิตยารัมภ์พงศ์. (2534). รายงานการวิจัย เรื่อง ผลกระทบของการประกันสุขภาพต่อระบบบริการสาธารณสุข. กรุงเทพมหานคร: มหาวิทยาลัยธรรมศาสตร์.
- สุดารัตน์ เกษราพันธ์. (2544). แนวทางการบริหารจัดการด้านการเงิน และทรัพยากรสุขภาพภายใต้ระบบประกันสุขภาพถ้วนหน้า. นนทบุรี: คณะทำงานพัฒนาความร่วมมือด้านบริหารทรัพยากรของสถานพยาบาล กระทรวงสาธารณสุข.
- สุทิสภา อาภาเกษัช. (2544). คุณภาพของบริการที่ให้แก่ผู้ถือบัตรประกันสุขภาพของโรงพยาบาลในจังหวัดสุพรรณบุรี. ภาคนิพนธ์ปริญญาศิลปศาสตรมหาบัณฑิต (พัฒนาสังคม), คณะพัฒนาสังคม สถาบันบัณฑิตพัฒนบริหารศาสตร์.
- สุพินดา โชติกิริติเวช. (2536). พฤติกรรมการใช้บริการทางการแพทย์ของผู้ประกันตนของโครงการประกันสังคมในจังหวัดสมุทรปราการ. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, ภาควิชาเวชศาสตร์ป้องกันและสังคม บัณฑิตวิทยาลัย จุฬาลงกรณ์มหาวิทยาลัย.
- สุวิมล ปานะชา. (2541). ปัจจัยที่มีผลต่อการเป็นสมาชิกและไม่เป็นสมาชิกโครงการประกันสุขภาพ โดยความสมัครใจของประชาชนในจังหวัดสุพรรณบุรี. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต (สาธารณสุขศาสตร์), สาขาวิชาบริหารสาธารณสุข บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.

- สุรศักดิ์ เนียมปาน. (2544). พฤติกรรมการใช้บริการสุขภาพของประชาชนในโครงการหลักประกันสุขภาพถ้วนหน้า กรณีศึกษาอำเภอบางกรวย จังหวัดนนทบุรี. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาเวชศาสตร์ชุมชน ภาควิชาเวชศาสตร์ป้องกันและสังคม คณะแพทยศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย.
- สุทธิชาติ แจ่มสว่าง. (2546). การติดตามผลการปฏิบัติงาน ภายใต้โครงการหลักประกันสุขภาพถ้วนหน้า (30 บาทรักษาทุกโรค) ศึกษาเฉพาะกรณีโรงพยาบาลราชบุรี. วิทยานิพนธ์ปริญญาศิลปศาสตรมหาบัณฑิต, สาขาวิชาการบริหารองค์การ บัณฑิตวิทยาลัย มหาวิทยาลัยศรีปทุม
- สุวัฒน์ จรียาเลิศศักดิ์. (2545). 30 บาทรักษาทุกโรค โชคหรือเคราะห์ของใคร: หลากหลายมุมมองจากผู้ให้ ผ่านผู้รับ ผู้ประเมิน ถึงผู้อ่าน การติดตามประเมินผลหลักประกันสุขภาพถ้วนหน้า ปี 2545. นนทบุรี: สถาบันวิจัยระบบสาธารณสุข.
- เสรี ลาซโรจน์. (2537). การบริหารโรงเรียนมัธยมฯ กรมสามัญศึกษา. (พิมพ์ครั้งที่ 2). กรุงเทพมหานคร: อักษรสมัย.
- เสาวคนธ์ รัตนวิจิตราศิลป์. (2544). ระบบหลักประกันสุขภาพ : ประสพการณ์จาก 10 ประเทศ. กรุงเทพมหานคร: สถาบันวิจัยระบบสาธารณสุข.
- เสาวภา พรศิริพงษ์ และคณะ (2536). รายงานการวิจัย เรื่อง ประกันสังคม: ความพร้อมของโรงพยาบาลของรัฐและเอกชน ในเขตกรุงเทพมหานคร และปริมณฑล. นครปฐม : สถาบันวิจัยภาษาและวัฒนธรรมเพื่อพัฒนาชนบท มหาวิทยาลัยมหิดล.
- สำนักงานโครงการปฏิรูประบบบริการสาธารณสุข (บรรณาธิการ). (2544). แนวทางการสร้างหลักประกันสุขภาพถ้วนหน้าในระยะเปลี่ยนผ่าน: ผลสรุปคณะทำงานเพื่อเตรียมระบบประกันสุขภาพถ้วนหน้า พฤษภาคม 2544. กรุงเทพมหานคร: องค์การรับส่งสินค้าและพัสดุภัณฑ์.
- สำนักงานจังหวัดนครราชสีมา ฝ่ายข้อมูลและติดตามประเมินผล. (2544). ข้อมูลทั่วไปจังหวัดนครราชสีมา. อุดรธานี.
- สำนักงานปฏิรูประบบสุขภาพแห่งชาติ. (2544). (ร่าง) กรอบแนวคิดระบบสุขภาพแห่งชาติ. กรุงเทพมหานคร: ดีไซร์.
- _____. (2544). 30 บาทรักษาทุกโรค ผู้หลักประกันสุขภาพถ้วนหน้า. กรุงเทพมหานคร: องค์การรับส่งสินค้าและพัสดุภัณฑ์.

- สำนักงานปฏิรูประบบสุขภาพแห่งชาติ. (2545). บริการใกล้บ้าน – ใกล้ใจ คนไทยขนรับแค่ไหน? เอกสารชุด “รวมพลังความคิดสู่ พ.ร.บ. สุขภาพแห่งชาติ” เรื่องที่ 5 การบริการระดับต้น. นนทบุรี: สถาบันวิจัยระบบสาธารณสุข. หน้า 3
- สำนักงานประกันสุขภาพ กระทรวงสาธารณสุข. (2544). คู่มือการดำเนินงานประกันสุขภาพถ้วนหน้าสำหรับผู้ปฏิบัติงาน. นนทบุรี: กองบรรณาธิการ ฝ่ายบริหารและพัฒนาระบบประกันสุขภาพ.
- สำนักงานปลัดกระทรวงสาธารณสุข กระทรวงสาธารณสุข. (2544). การดำเนินงานโครงการสร้างหลักประกันสุขภาพถ้วนหน้า (30 บาทรักษาทุกโรค). อุดรธานี.
- สำนักงานสถิติแห่งชาติ. (2545). โครงการพิเศษการสำรวจความคิดเห็นของประชาชนต่อโครงการ 30 บาทรักษาทุกโรค ระหว่างวันที่ 15 – 19 กรกฎาคม พ.ศ. 2545. อุดรธานี.
- _____. (24 กุมภาพันธ์ 2548). โครงการสำรวจความคิดเห็นของประชาชนเกี่ยวกับการประกันสุขภาพถ้วนหน้า (30 บาทรักษาทุกโรค) พ.ศ. 2547. หนังสือพิมพ์ประชาชาติธุรกิจ, หน้า 6.
- สำนักนโยบายและแผนสาธารณสุข กระทรวงสาธารณสุข. (2544). การประเมินนโยบายและยุทธศาสตร์การบรรลุเป้าหมายสุขภาพดีถ้วนหน้า ปี 2543. กรุงเทพมหานคร: อุกการพิมพ์.
- สำนักวิจัยเอแบคโพลล์ มหาวิทยาลัยอัสสัมชัญ. (2546). ผลสำรวจเรื่อง ความคิดเห็นของประชาชน ต่อโครงการหลักประกันสุขภาพถ้วนหน้า: กรณีศึกษาตัวอย่างผู้ใช้บัตรทองอายุ 15 ปีขึ้นไปจาก 13 จังหวัดทั่วประเทศ ระหว่างวันที่ 21 พฤษภาคม ถึง 30 มิถุนายน 2546. อุดรธานี.
- สำเริง แหงกระโทก (บรรณาธิการ). (2544). แนวทางการดำเนินงานหลักประกันสุขภาพถ้วนหน้า. นครราชสีมา: สำนักงานสาธารณสุขจังหวัด.
- อรชร ศาสตราวหะ. (2528). รูปแบบการใช้บริการทางการแพทย์ของชุมชนที่มีผลจากนโยบายการใช้บัตรสุขภาพ. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต (สาธารณสุขศาสตร์), สาขาการบริหารสาธารณสุข คณะสาธารณสุขศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- อรทัย รวยอาจิน และคนอื่นๆ. (2528). รายงานการวิจัย เรื่อง สุขภาพและการวางแผนครอบครัวในเขตชานเมืองกรุงเทพมหานคร. นครปฐม: โครงการสังคมศาสตร์การแพทย์และสาธารณสุข คณะสังคมศาสตร์และมนุษยศาสตร์ มหาวิทยาลัยมหิดล.
- อรพรรณ หันจางสิทธิ์. (2522). ทัศนคติของประชาชนต่อการประกันสุขภาพตามโครงการประกันสังคมแห่งประเทศไทย : ศึกษาเฉพาะเขตกรุงเทพมหานคร. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาสังคมศาสตร์การแพทย์ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.

- อนุวัฒน์ ศุภชุติกุล. (2537). ระบบประกันสุขภาพ. วารสารการวิจัยระบบสาธารณสุข, 2 (เมษายน–มิถุนายน 2537), 115 – 124.
- อนันต์ ลากสมทบ และคนอื่น ๆ. (2527). รายงานการวิจัย เรื่อง ความคิดเห็นของผู้มีบัตรสุขภาพที่มีผลต่อบริการสาธารณสุขจังหวัดลำพูน. นนทบุรี: สำนักงานปลัดกระทรวงสาธารณสุข กระทรวงสาธารณสุข.
- อัมมาร สยามวาลา. (2544). ระบบประกันสุขภาพในประเทศไทย. เอกสารวิชาการประกอบการสัมมนาาระบบหลักประกันสุขภาพของเอเชีย. นนทบุรี: ดีไซน์.
- อำนาจ กาจันะ และคนอื่น ๆ. (2543). รายงานผลการศึกษารวมการบริหารจัดการระบบประกันสุขภาพโครงการบัตรประกันสุขภาพ และโครงการสวัสดิการประชาชนด้านการรักษาพยาบาล (ส.ป.ร.). นนทบุรี: สำนักงานประกันสุขภาพ กระทรวงสาธารณสุข.
- อำภา ดีสีปาน. (2539). ความคิดเห็นของผู้ป่วยประกันสังคม ต่อระบบบริการแผนกผู้ป่วยนอกโรงพยาบาลมหาราชนครเชียงใหม่. การค้นคว้าแบบอิสระปริญญาสาธารณสุขศาสตรมหาบัณฑิต, บัณฑิตวิทยาลัย มหาวิทยาลัยเชียงใหม่.



Reliability of questionnaire

Reliability analysis of the questionnaire by using computer and SPSS for Windows. The result was shown reliability as following:

1. Questionnaire; Knowledge on the right under Universal Coverage Health Insurance Scheme (30 baht full health coverage). The reliability coefficients was 0.77
2. Questionnaire; attitude on providing service and quality of service system under Universal Coverage Health Insurance Scheme (30 baht full health coverage). The reliability coefficients was 0.92

Reliability

***** Method 1 (space saver) will be used for this analysis *****

RELIABILITY ANALYSIS - SCALE (ALPHA)

Item – total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item – Total Correlation	Alpha if Item Deleted
K1	37.1667	45.9368	-.1453	.7855
K2	37.0667	45.3057	.0000	.7780
K3	37.8667	45.3609	-.0619	.7918
K4	38.0000	45.5862	-.0882	.7971
K5	37.8667	44.8782	-.0149	.7889
K6	38.0000	40.9655	.3029	.7697
K7	37.7667	42.3920	.1741	.7797

Scale	Scale	Corrected	
Mean	Variance	Item –	Alpha
if Item	if Item	Total	if Item
Deleted	Deleted	Correlation	Deleted

K8	38.0667	39.2368	.4146	.7610
K9	37.3667	43.3437	.1793	.7757
K10	37.8667	39.2920	.4223	.7603
K11	38.3667	39.2747	.5424	.7523
K12	38.2333	39.2885	.5833	.7504
K13	38.6333	39.4126	.7806	.7451
K14	38.5000	42.7414	.3506	.7676
K15	38.3667	39.7575	.3865	.7633
K16	38.4667	39.0851	.5844	.7498
K17	38.6667	38.3678	.7151	.7422
K18	38.6333	39.2747	.6029	.7496
K19	37.8333	37.4540	.5810	.7464
K20	38.5333	40.4644	.4293	.7605

Reliability Coefficients

N of Cases = 30.0

N of Items = 20

Alpha = .7758

***** Method 1 (space saver) will be used for this analysis *****

RELIABILITY ANALYSIS - SCALE (ALPHA)

Item – total Statistics

Scale	Scale	Corrected	
Mean	Variance	Item –	Alpha
if Item	if Item	Total	if Item
Deleted	Deleted	Correlation	Deleted

A1	116.4333	349.4264	.6087	.9213
A2	116.9667	357.7575	.1362	.9267
A3	116.2333	346.4609	.6053	.9209
A4	116.2000	359.8897	.1615	.9250
A5	116.7333	345.3747	.6712	.9204
A6	116.7333	344.1333	.5031	.9217
A7	116.2333	345.9092	.4194	.9228
A8	116.7333	349.3747	.5652	.9215
A9	116.7000	340.7000	.5918	.9206
A10	116.1000	333.5414	.4833	.9230
A11	116.4000	351.8345	.4526	.9224
A12	116.9000	344.5759	.5015	.9217
A13	116.1667	360.7644	.1487	.9250
A14	116.1000	346.2310	.5315	.9215
A15	116.2333	345.2885	.5823	.9210
A16	116.5667	347.1506	.5246	.9216
A17	116.7333	343.9954	.4618	.9223

Scale	Scale	Corrected	
Mean	Variance	Item –	Alpha
if Item	if Item	Total	if Item
Deleted	Deleted	Correlation	Deleted

A18	116.3333	343.6092	.5346	.9213
A19	116.6000	349.1448	.4399	.9224
A20	116.8333	327.5920	.7053	.9187
A21	116.5667	348.1851	.5178	.9217
A22	116.5667	346.9437	.4501	.9223
A23	116.9667	329.5506	.6753	.9192
A24	117.0333	327.4126	.7008	.9187
A25	116.9333	333.2368	.6989	.9190

A26	116.6667	341.0575	.7064	.9197
A27	116.5333	340.3954	.4867	.9221
A28	116.9667	339.2747	.6107	.9203
A29	116.2333	338.8747	.4170	.9239
A30	116.9000	330.1621	.6316	.9199
A31	116.4667	356.0506	.3376	.9234
A32	116.5333	351.0161	.3898	.9230
A33	116.1000	348.5759	.5087	.9218

RELIABILITY ANALYSIS - SCALE (ALPHA)

Reliability Coefficients

N of Cases = 30.0

N of Items = 33

Alpha = .9239

Association between demographic factors among the respondents on the right under Universal Coverage Health Insurance Scheme (30 baht full health coverage)

1. Association between sex and knowledge

T-Test

Group Statistics

	SEX	N	Mean	Std. Deviation	Std. Error Mean
Knowledge	1	145	7.70	2.393	.199
	2	252	8.22	2.717	.171

Independent Samples Test

Knowledge

	Levene's Test for Equality of Variances		t-test for Equality of Means						
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
								Lower	Upper
Equal variances assumed	2.348	.126	-1.937	395	.053	-.53	.271	-1.059	.008
Equal variances not assumed			-2.004	332.081	.046	-.53	.262	-1.042	-.010

2. Association between age and knowledge

One - way

Descriptive

Knowledge

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Lower than 20	37	7.19	2.602	.428	6.32	8.06	2	13
21-30	94	8.01	2.617	.270	7.47	8.55	1	16
31-40	137	8.50	2.797	.239	8.03	8.98	3	16
41-50	80	7.85	2.455	.274	7.30	8.40	2	13
51-60	46	7.63	2.101	.310	7.01	8.25	4	12
More than60	3	8.33	2.887	1.667	1.16	15.50	5	10
Total	397	8.03	2.613	.131	7.77	8.29	1	16

ANOVA

Knowledge

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	67.140	5	13.428	1.991	.079
Within Groups	2636.497	391	6.743		
Total	2703.637	396			

3. Association between marital status and knowledge

One - way

Descriptive

Knowledge

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Single	96	7.31	2.661	.272	6.77	7.85	1	15
Couple	260	8.27	2.589	.161	7.95	8.58	2	16
Widow/ divorce/separate	41	8.22	2.393	.374	7.46	8.97	4	13
Total	397	8.03	2.613	.131	7.77	8.29	1	16

ANOVA

Knowledge

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	65.299	2	32.650	4.876	.008
Within Groups	2638.338	394	6.696		
Total	2703.637	396			

Multiple Comparisons

Dependent Variable : Knowledge

	(I) STAUS	(J) STAUS	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
LSD	Single	Couple	-.95 (*)	.309	.002	-1.56	-.35
		Widow/Divorce/Separate	-.91	.483	.061	-1.86	.04
	Couple	Single	.95 (*)	.309	.002	.35	1.56
		Widow/Divorce/Separate	.05	.435	.916	-.81	.90
	Widow/Divorce/Separate	Single	.91	.483	.061	-.04	1.86
		Couple	-.05	.435	.916	-.90	.81

*The mean difference is significant at the .05 level.

4. Association between education and knowledge

One - way

Descriptive

Knowledge

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
					Non-education	9		
Primary school	166	7.82	2.450	.190	7.44	8.19	2	15
Secondary school	81	7.65	2.476	.275	7.11	8.20	3	14
High school	79	8.51	2.645	.298	7.91	9.10	2	14
Diploma	22	7.27	2.947	.628	5.97	8.58	1	16
Bachelor degree	40	9.00	3.030	.479	8.03	9.97	3	16
Total	397	8.03	2.613	.131	7.77	8.29	1	16

ANOVA

Knowledge

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	90.628	5	18.126	2.712	.020
Within Groups	2613.010	391	6.683		
Total	2703.637	396			

Multiple Comparisons

Dependent Variable : Knowledge

(I) EDU	(J) EDU	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Non-education	Primary school	.85	.885	.339	-.89	2.59
	Secondary school	1.01	.908	.266	-.77	2.80
	High school	.16	.909	.860	-1.63	1.95
	Diploma	1.39	1.023	.174	-.62	3.40
	Bachelor degree	-.33	.954	.727	-2.21	1.54
Primary school	Non-education	-.85	.885	.339	-2.59	.89
	Secondary school	.16	.350	.638	-.52	.85
	High school	-.69	.353	.053	-1.38	.01
	Diploma	.55	.587	.352	-.61	1.70
	Bachelor degree	-1.18 (*)	.455	.010	-2.08	-.29
Secondary school	Non-education	-1.01	.908	.266	-2.80	.77
	Primary school	-.16	.350	.638	-.85	.52
	High school	-.85 (*)	.409	.038	-1.66	-.05
	Diploma	.38	.622	.540	-.84	1.60
	Bachelor degree	-1.35 (*)	.500	.007	-2.33	-.36

(I) EDU	(J) EDU	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
High school	Non-education	-.16	.909	.860	-1.95	1.63
	Primary school	.69	.353	.053	-.01	1.38
	Secondary school	.85 (*)	.409	.038	.05	1.66
	Diploma	1.23 (*)	.623	.048	.01	2.46
	Bachelor degree	-.49	.502	.326	-1.48	.49
Diploma	Non-education	-1.39	1.023	.174	-3.40	.62
	Primary school	-.55	.587	.352	-1.70	.61
	Secondary school	-.38	.622	.540	-1.60	.84
	High school	-1.23 (*)	.623	.048	-2.46	-.01
	Bachelor degree	-1.73 (*)	.686	.012	-3.08	-.38
Bachelor degree	Non-education	.33	.954	.727	-1.54	2.21
	Primary school	1.18 (*)	.455	.010	.29	2.08
	Secondary school	1.35 (*)	.500	.007	.36	2.33
	High school	.49	.502	.326	-.49	1.48
	Diploma	1.73 (*)	.686	.012	.38	3.08

* The mean difference is significant at the .05 level.

5. Association between occupation and knowledge

One - way

Descriptive

Knowledge

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Unemployed	17	7.12	3.295	.799	5.42	8.81	1	12
Hiring	119	7.83	2.713	.249	7.34	8.32	2	15
Agriculturist(farming, gardening, เลี้ยงสัตว์)	95	8.08	2.244	.230	7.63	8.54	3	14
Merchant/private bussiness	71	8.35	2.485	.295	7.76	8.94	4	16
Civil servant/ state enterprise	16	8.56	2.732	.683	7.11	10.02	5	14
Housewife/unemployed	45	8.67	2.820	.420	7.82	9.51	3	16
Others	34	7.26	2.609	.447	6.35	8.18	2	13
Total	397	8.03	2.613	.131	7.77	8.29	1	16

ANOVA

Knowledge

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	69.155	6	6	1.706	.118
Within Groups	2634.482	390	390		
Total	2703.637	396	396		

6. Association between income and knowledge

Descriptive

Knowledge

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
< 3,000	154	7.75	2.472	.199	7.36	8.15	1	15
3,001 –5,000	112	7.86	2.518	.238	7.39	8.33	3	15
5,001 –10,000	69	8.90	2.745	.330	8.24	9.56	2	16
10,001 – 15,000	26	8.42	2.419	.474	7.45	9.40	5	13
> 15,000	29	8.45	2.947	.547	7.33	9.57	4	16
Total	397	8.03	2.613	.131	7.77	8.29	1	16

ANOVA

Knowledge

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	134.634	5	26.927	4.098	.001
Within Groups	2569.003	391	6.570		
Total	2703.637	396			

Multiple Comparisons

Dependent Variable : Knowledge

(I) INCOME	(J) INCOME	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
< 3,000	3,001 - 5,000	-.10	.318	.744	-.73	.52
	5,001 - 10,000	-1.15 (*)	.371	.002	-1.88	-.42
	10,001-15,000	-.67	.543	.219	-1.74	.40
	> 15,000	-.70	.519	.181	-1.72	.33
3,001 - 5,000	< 3000	.10	.318	.744	-.52	.73
	5,001 - 10,000	-1.04 (*)	.392	.008	-1.81	-.27
	10,001-15,000	-.57	.558	.311	-1.66	.53
	> 15,000	-.59	.534	.269	-1.64	.46
5,001 - 10,000	< 3,000	1.15 (*)	.371	.002	.42	1.88
	3,001 - 5,000	1.04 (*)	.392	.008	.27	1.81
	10,001-15,000	.48	.590	.421	-.68	1.64
	> 15,000	.45	.567	.428	-.66	1.57
10,001 - 15,000	< 3000	.67	.543	.219	-.40	1.74
	3,001 - 5,000	.57	.558	.311	-.53	1.66
	5,001 - 10,000	-.48	.590	.421	-1.64	.68
	> 15,000	-.03	.692	.971	-1.39	1.34
> 15,000	< 3,000	.70	.519	.181	-.33	1.72
	3,001 - 5,000	.59	.534	.269	-.46	1.64
	5,001 - 10,000	-.45	.567	.428	-1.57	.66
	10,001-15,000	.03	.692	.971	-1.34	1.39

* The mean difference is significant at the .05 level.

**Part 2: Knowledge about the rights of patient under Universal Coverage
Health Insurance Scheme (The 30-baht health care program)**

Statement	Yes	No	Don't know
1. The 30-baht health care program proposes that everyone should have health insurance and access to health care service equally whether rich or poor.			
2. At any time, if you would like to get the rights under The 30-baht health care program, you should show the 30 baht health scheme card and ID card to health care providers.			
3. The patients who has the 30 baht health scheme card are able to get health care service from the hospitals all over the country without any condition.			
4. The patients who hold the rights on the 30-baht health care program do not able to get the health care service form other rights of governmental sector.			
5. People who are civil servants or people who has an social security card have the rights to use the 30 baht health scheme card.			
6. People who had injury by car-accidence are able to use an insurance health card (The 30-baht scheme), even though they can use the rights on treatment from vehicle enactment .			
7. In the case of accidence or emergent sickness which occurred in unusual place of residence, you are able to get the treatment at any hospital all over the country which collaborated with the 30-baht health care program.			
8. You can make a new registration with other hospitals for the health care service when you move your place of residence, but not more than 2 times per year.			

Statement	Yes	No	Don't know
9. According to the 30-baht health care program (in and out patient department), you should pay 30 baht when you got health care service.			
10. Patients who has the 30 baht health scheme card should pay 30 baht when got anti-natal care, vaccination, or contraceptive service.			
11. For delivery, the patients should pay 30 baht but not more than 2 times per person.			
12. For tooth extraction, filling, scaling and polishing, the patients who the 30 baht health scheme card can get free services.			
13. Patient who are infertile and would like to have an accessed reproductive technology can be use the rights on the 30-baht health care program by paying 30 baht.			
14. The 30-baht health care program is cover for patient stay over night at hospital in private room, but the patient have to pay 30 baht per night			
15. The pregnant women with HIV-infected can be use the 30 baht health scheme card to take ARV.			
16. AIDS patients are unable to use the 30 baht health scheme card for curing complications.			
17. The 30-baht health care program is not cover for organ transplantation.			
18. The 30-baht health care program is not cover for recovering patient who addicted to drug.			
19. Women who has the 30 baht health scheme card are able to get investigation for cervix cancer (pep'smear).			
20. Chronic renal failure patient can be obtain renal dialysis with artificial renal machine by using the rights of the 30-baht health care program.			

Part 3: The attitude of patient on quality of health care service under Universal Coverage Health Insurance Scheme (The 30-baht health care program)

Statement	Service level				
	Highest	High	Moderate	Low	Lowest
Quality of health care services					
1. Health care providers are friendly and willing to help you.					
2. Health care providers informed the service procedures unclearly.					
3. Health care providers were seemed impolite when communicated with patient.					
4. When you had problem and requested for some recommendations from health care providers, they were unsatisfied.					
5. Health care providers gave a good take care and try to help the patient to get a fast service.					
6. Nurses have a good communication and manner.					
7. Nurses asked your illness history carefully and intended to listen to your answers.					
8. Nurses expressed empathy on patient's illness.					
9. Nurses have tested your body temperature, measure your blood pressure, or weigh your weight carelessly.					
10. Nurses ignored to give some necessary advise to patient.					
11. Nurses can take care a severe patient efficiently.					
12. The physician works on time.					

Statement	Service level				
	Highest	High	Moderate	Low	Lowest
13. The physician has great skill and experience in treatments.					
14. The physician usually express moodiness to patients.					
15. The physician ignored to listen to patients when they explained their symptoms.					
16. The physician has done physical examination carefully.					
17. The physician explained a pathology of diseases to patients by using the words which are difficult to understand.					
18. The physician ignore to give some information about patient's sickness and limited the opportunity for asking questions.					
19. The physician gave a good advises to patients.					
20. The pharmacist was not gave enthusiastic service. The patients wasted the time to wait for medicines.					
21. The pharmacist gave a good advise on drug instruction.					

Statement	Service level				
	Highest	High	Moderate	Low	Lowest
Quality of the health service system					
1. The service system of the hospital is well organized under The 30-baht health care program.					
2. Using the 30 baht health scheme card has more complex procedures than using other health insurances.					
3. The patient who use the 30 baht health scheme card takes a lot of time to wait for physician than other patients.					
4. The patients who use the 30 baht health scheme card has less disease investigation than other patients.					
5. The patients who use the 30 baht health scheme card and other patients are treated by modern medical instruments as equals.					
6. Confidently, patients under the 30-baht health care program get effective treatments.					
7. Because of a lot of patients under the 30-baht health care program, the health services are not cover all of patients and low quality.					
8. For severe sickness, the 30 baht health scheme card is not eligible to use for treatments.					

Statement	Service level				
	Highest	High	Moderate	Low	Lowest
9. The patients who use the 30 baht health scheme card would be got low quality medicines.					
10. The patients who use the 30 baht health scheme card and other patients are treated following by medical principle as equals.					
11. The patients under the 30 baht health care program get an appointment for follow-up the progress of symptoms as other patients.					
12. You got a good service and high quality treatment from Maharaj Nakorn Ratchasima Hospital.					

Part 4: Problems of the use of the 30 baht health scheme card and recommendation

4.1 Problems

1. Do you know about your rights on The Universal Coverage Health Insurance Scheme?
 - () 1. No
 - () 2. Yes please specified.....
2. Do you know about the service process of Maharaj Nakorn Rachasima Hospital?
 - () 1. No
 - () 2. Yes please specified.....
3. Service problems : Do you have any service problem with the following items?
 - 3.1 Hospital registry section
 - () 1. No
 - () 2. Yes please specified.....
 - 3.2 Nurse
 - () 1. No
 - () 2. Yes please specified.....
 - 3.3 Physician
 - () 1. No
 - () 2. Yes please specified.....
 - 3.4 Financial section
 - () 1. No
 - () 2. Yes please specified.....
 - 3.5 Pharmacy section
 - () 1. No
 - () 2. Yes please specified.....
4. Other problems
 - () 1. No
 - () 2. Yes please specified.....

4.2 Please give your recommendation in order to solve the problems of the Universal Coverage Health Insurance Scheme.

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....



BIOGRAPHY

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