

**KNOWLEDGE, ATTITUDE AND ACCEPTANCE OF 30 BAHT
SCHEME AMONG HEALTH CARE PROVIDERS AT
COMMUNITY HOSPITALS, SAKAEO PROVINCE, THAILAND**



**A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF PRIMARY HEALTH CARE MANAGEMENT
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MAHIDOL UNIVERSITY**

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entitled

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SAKAEO PROVINCE, THAILAND**



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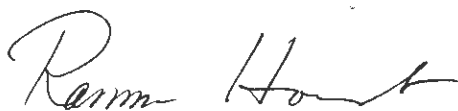
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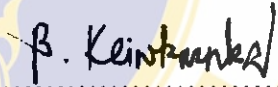
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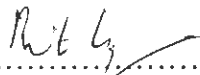
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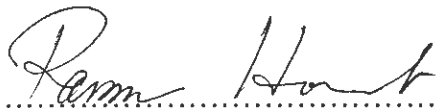
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Charun Boonyarithikarn

KNOWLEDGE, ATTITUDE AND ACCEPTANCE 30 BAHT SCHEME AMONG HEALTH CARE PROVIDERS AT COMMUNITY HOSPITALS, IN SAKAEO PROVINCE, THAILAND.

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ABSTRACT

A cross-sectional descriptive study aimed to assess knowledge, attitude and acceptance of the 30 baht government health care scheme among health care providers at six community hospitals in Sakaeo province, Thailand. It was conducted among 316 health care providers during February 1-14, 2004 by using a self-administered questionnaire. The study sample consisted of doctors, dentists, pharmacists, registered nurses and technical nurses.

The study results revealed that most of the health care providers were females and the majority were professional registered nurses. The knowledge of the thirty baht scheme was good while the attitude towards the scheme was fair. The acceptance of the 30 baht scheme level was self-assessed, about 41.5% of respondents had high acceptance while low acceptance was at about 58.5%. In identifying factors associated with level of acceptance, it was found that doctors had the least acceptance. Among socio-demographic factors, there is a significant relationship between the acceptance and duration of time spent working on the 30 baht scheme.

The findings suggested that the improvement of level of acceptance may be focus on management and financial management. In addition, there must be a supportive system in order to improve quality of service.

KEY WORDS : ACCEPTANCE OF 30 BAHT SCHEME

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CONTENTS

	Page
ACKNOWLEDGEMENTS.....	iii
ABSTRACT.....	iv
LIST OF TABLES.....	vii
LIST OF ABBREVIATIONS.....	x
CHAPTER	
I INTRODUCTION	
1.1 Rationale and justification.....	1
1.2 Research question.....	5
1.3 Research objective.....	5
1.4 Conceptual framework.....	6
1.5 Operational definition.....	7
1.6 Scope of the study.....	8
1.7 Limitation of the study.....	8
II LITERATURE REVIEW	
2.1 Universal Coverage of health care.....	10
2.2 The Universal Coverage Policy of Thailand.....	13
2.3 Overview of Thai health insurance.....	15
2.4 30 Baht scheme (TBS).....	23
2.5 Primary Care Unit or PCU.....	25
2.6 Status and role change-Theoretical Concept.....	28
2.7 Problems and obstacle in 30 baht scheme.....	30
2.8 Reviewed the related research on thirty baht scheme.....	33
III RESEARCH METHODOLOGY	
3.1 Study design.....	36
3.2 Study population.....	36
3.3 Sample size.....	36
3.4 Place of study.....	37
3.5 Research Instrument.....	38
3.6 Data collection.....	39
3.7 Data analysis.....	40
IV RESULTS	
Results.....	41
V DISCUSSION	
Discussion.....	68

CONTENTS (Cont.)

	Page
VI CONCLUSION & RECOMMENDATION	
Conclusion	73
Recommendation	74
REFERENCES	77
APPENDIX	
A. Questionnaire	81
BIOGRAPHY	89



LIST OF TABLES

TABLE		Page
1	Number of doctors had resigned from the government service, 1999-2003.....	30
2	CUP and PCU in Sakaeo Province.....	32
3	Numbers of Sakaeo health care providers at community hospitals.....	37
4	Number and Percentage distribution of health care providers by socio-demographic characteristics.....	43
5	Number and percentage distribution of health care providers by types of professional	45
6	Distribution of correct answers to knowledge questions of thirty baht scheme classified by types of professional.....	48
7	Level of knowledge on thirty baht scheme	51
8	Distribution of correct answers to knowledge questions of thirty baht scheme classified by types of professional.....	52
9	Levels of total knowledge scores classified by types of professional.....	55
10	Attitude on thirty baht scheme.....	56
11	Number and Percentage of level of attitude on thirty baht scheme.....	58
12	Level of total attitude scores classified by types of professional.....	59
13	Acceptance of 30 baht scheme.....	59
14	Level of Acceptance on thirty baht scheme.....	61
15	Acceptance of 30 baht scheme by types of professional	62
16	Number and Percentage of level of acceptance on 30 baht scheme by types of professional	65
17	Health care provider characteristics by level of acceptance on 30 baht scheme.....	66
18	Health care provider characteristics by level of acceptance.....	67
19	Correlation coefficient between characteristic of health care provider an acceptance of 30 baht scheme.....	67

LIST OF ABBREVIATION

ANC : Antenatal Care

CUP : Contracting Unit of Primary care

CUS : Contracting Unit of Secondary Care

CUT : Contracting Unit of Tertiary care

HCP : Health Care Providers

MoPH :Ministry of Public Health.

PCU : Primary care unit

PPHO : Provincial Public Health Office.

WHO : World Health Organization.



CHAPTER I

INTRODUCTION

1.1 Rationale and justification of the study

During a past few decades, the National Social and Development Plan was only emphasize on the expansion of economic growth from industrialization that let people migrated from rural to urban and the income generation gap were widely between the rich and the poor. The present society induced Thai people to be facing with more chronic health problems and diseases related to life style. The Thai government had spent a huge amount of budget on curative aspects for these diseases rather than proactive activities (1).

In 1997, Thailand had been facing with economic recession that affected the development of country in all aspects. This effect of the economic problem let the Thai government intended to motivate and launch the policy to develop health system management especially on health resources management (2).

Moreover, the major problems of Thailand health care systems are also a main issue for the Thai government to reorganize the health care system. The major problems composed of: 1) Inequality in resources allocation where most of health manpower, infrastructure, medical technologies and health care budgets are mal distributed among different regions. Most of the resources are allocated to central level and among the big cities while less are provided among the rural area where most of population are suffering with various health problems; 2) Inequity in accessibility to health care service between the rich and the poor; 3) Inequity in health status among different population especially between the urban and rural areas; 4) In equity in health expenditure burden undertaking did not rely on the ability to pay of people; 5) Problems of health service efficiency because most of budget were spent on the curative aspects rather than promotion and preventive aspects; 6) Problems of

investment are largely found in the big hospitals; and 7) Problem of quality of health care services especially wide gap of quality was found between public and private hospitals (1).

According to the 8th National Health Development Plan (1997-2001), the emphasis is on the human being as a center for development. The ultimate goal for human centered development is to facilitate human beings in their struggle to obtain happiness and a high quality of life. The most important human investment is focused on health investment (4). After the 8th Plan, the 9th National Health Development Plan also continued to declare the human center as a crucial part of human development. This plan has four main objectives as follows : 1) To foster proactive health promotion, consumer protection, food safety and food security, occupational health and environment protection, disease prevention and control, 2) To establish health security and equal access to quality, 3) To build up people's capability in health promotion and in health system management and 4) To establish mechanism and measures in generating knowledge through research and development utilizing path local and international health wisdom (3).

From The Constitution of the Kingdom of Thailand, B.E. 2540, section 52 was emphasis on the right of Thai people to reach basic needs in relation to the equal access to the standard health service (4). By this reason, the Ministry of Public Health (MoPH) was expanded the health insurance system to cover all Thai citizen to achieve essential treatment and care under the universal coverage where the poor may have chance to received free services.

From all of the reasons mentioned above, the Thai government decided to launch the new health insurance policy to expand the coverage for all Thai people under the slogan “ 30 baht for curing every disease”. It had announced the 30 baht scheme in the parliament on 26th February 2001 and started to implement this program.

Apart from the coverage of health care, the MoPH has tried to integrate health care reforms into the project. The expected results should not only be the social safety net and to decrease the burden on household expenditures during the economic crisis, but also emphasizes on health promotion, prevention and primary care (gate keeper) activities. In addition, it also focuses more efficient health system with long term cost containment in the total health expenditures.

The implementation of this program was launched since April 2001 in 6 provinces and expanded quickly to cover all nationwide in April 2002. The new health insurance scheme is covered total number of target population from several sources of the previous schemes together, composed of social welfare (27.5 millions) and voluntary public health insurance (8.5 millions). While the rest of people who did not covered by any schemes(46.6 millions), civil servant medical benefit scheme (6.6 millions) and the social security fund (5.2 millions) , are not involved into this new scheme and independently to manage. The financing system under the new scheme is redesigned as the per capita basis and allocated to those health care providers who directly response to the population in each catchment area. Total budget was 99,367.84 million baht in 2002. The unit cost was calculated from previous information to be 1,202.40 baht / capita / year, or accounted for 56,031.84 million baht for all 46.6 millions people who are covered by this new scheme. Administration and human resources development cost was planned for 5,168 million baht, and another 5,168 million baht for contingency fund. The contingency fund was designed to support some hospital that might be facing deficit during the 2-3 years of transforming period. There has been some personal dissatisfaction due to the new payment mechanism and the new working system. All the problems have been dealt and solved meticulously, so when time goes by, there are not much obstacle left. The government decided to propose the “ National Health Insurance Bill” which was recently approved by the parliament.

After launching this policy since last three years, it still have not solved a lot of problems although the MoPH try to manage into the best way. The serious problems consists of over crowded patients, shortage of human resources, inequity of

budget allocation, unsatisfied from health care providers, not perception and acceptance from public health professionals and health managers. However, many findings are supported on clients' satisfaction on 30 baht scheme and it is most successful policy of this government. While, among the health providers its self, still not yet to verify (5).

Sakaeo Province is one of the second groups to start the 30 baht scheme on 1st July 2001. The second group there were 15 provinces started on 1st June 2001. Those are Sakaeo, Nontaburi, Saraburi, Petchaburi, Nakhonratchasima, Surin, Nongbualampoo, Ubonrajchatani, Amnatcharoen, Srisaket, Sukhothai, Phrae, Chiang Mai, Phuket and Narathivas.

Because Sakaeo province is located in the rural area, shortage and inequity distribution of human resources and brain drain are still the major problems of this province. Thus, limited number of the health care providers at community hospital who have been working closely and good relationship to provide services to community people, they need to work hard in order to increase more accessibility and equity to obtain health services among their target population. In addition, the quality of services should be the key responsibility that those health providers in Sakaeo province are considered and try to implement.

Beyond their responsibilities and duties to provide healthy life among their target population, knowledge, attitude, perception and acceptance of the health providers regarding 30 baht health care scheme are essential elements to be identified. The clients' satisfaction on quality of medical care under the 30 baht scheme is an important issue that those health care providers in Sakaeo province would like to achieve. The health providers can create high satisfaction and happiness among their clients based on their good knowledge, positive attitude and acceptance toward the 30 baht scheme and will be directly affected to enhance equity and efficiency of budget allocated to provide health service in the target area.

The fruitful from this findings will be us as a baseline information to plan how to enhance health providers to have more knowledge, positive attitude and acceptance on 30 baht scheme. Moreover, it will be use to plan how health care providers in Sakaeo province would like to do in future to improve their services activities to serve needs of the target population appropriately.

1.2 Research questions

What are the knowledge, attitude and acceptance on 30 baht scheme among health care providers at community hospitals in Sakaeo province?

1.3 Research Objectives

1.3.1 General objective

To assess the knowledge, attitude and acceptance on 30 baht scheme among health care providers at community hospitals in Sakaeo province.

1.3.2 Specific objectives

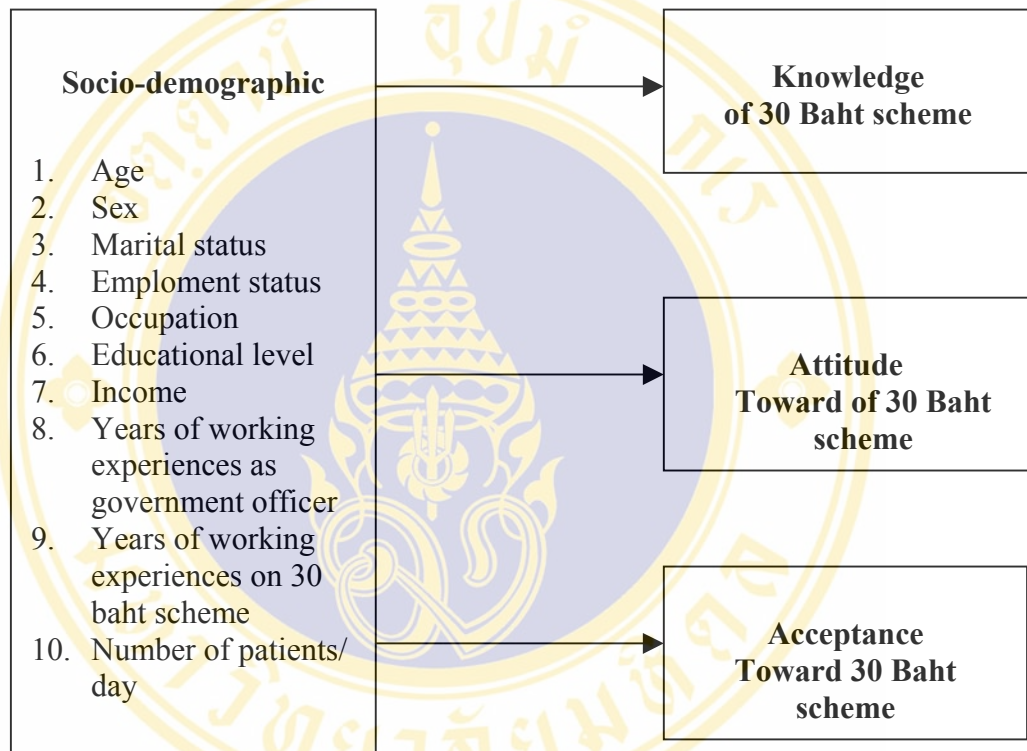
1.3.2.1 To describe the socio-demographic characteristics among health care providers at the community hospitals in Sakaeo province.

1.3.2.2 To assess the knowledge, attitude and acceptance on 30 baht scheme among health care providers at community hospitals in Sakaeo Province.

1.4 Conceptual framework

Independent Variable

Dependent Variable



1.5 Operational definition

1.5.1 Socio-demographic data

Refers to the age, sex, marital status, professional types, occupation, income, educational level, working years of experiences as government officers and working years of experiences on 30 baht scheme.

1.5.2 Knowledge

Refers to the respondent's general understanding of 30 baht scheme.

1.5.3 Attitude

Refers to the health care providers' perception toward thirty baht scheme after it had launched at the community hospitals in Sakaeo Province. Their perception are included on the attitude toward principles, management, workload, accountability, performance and evaluation, financing, etc.

1.5.4 Number of patients/day

Refers to the average number of patient that had been taken care by the health care providers in one day. This included of both out patients who were visit each day and in-patients who were admitted in the hospital during the period of study.

1.5.5 Employment status

Refers to types of health care providers, classified into 2 groups as government officers and government employees.

1.5.6 Occupation

Refers to the doctors, dentists, pharmacists, registered nurses and technical nurses who directly provided services for the patients and use their professional knowledge and skills on their work for the patient at the community hospitals under the 30 baht scheme in Sakaeo province.

1.5.7 30 baht scheme

Thirty baht scheme is the health program for Thai people who had registered the golden card at the primary care unit and got the appropriate medical care by pay 30 baht per visit to the community hospitals where define the name on the gold card. Thirty baht scheme had launched in Sakaeo Province since 1 June 2004.

1.5.8 Community hospital

Refer to the hospital at the district level in Sakaeo province, composed of Aranyapathet, Wattananakon, Tapaya, Klonghad, Wangnamyen and Khaochagun hospitals.

1.5.9 Acceptance

Refer to the opinions on principles, management, and financing of 30 baht scheme among the health care providers who have been working under 30 baht scheme at all community hospitals in Sakaeo Province whether they are agreed or not agreed with the principle and management of 30 baht scheme after they have worked with this project.

1.6 Scope of the study

This study, was done among all health care providers who have been working under the 30 baht scheme in six community hospitals of Sakaeo province.

1.7. Limitation of study

1. Health care providers at the community hospitals worked their jobs in shift. They worked both daytime and nighttime. It may effect their jobs to answer the questionnaire because they had no time and work hard. This study was used self-administered questionnaire, so the results were indirect measures to assess the knowledge, attitude and acceptance on 30 baht scheme among the target population.

2. The target population was purposively selected among 6 community hospitals in Sakaeo province and they were the health personal who were working on 30 baht scheme under the government policy.



CHAPTER II

LITERATURE REVIEW

This study the researcher has reviewed the following

1. Universal Coverage (UC) of health care
2. The Universal Coverage Policy of Thailand
3. Overview of Thai health insurance schemes
4. 30 baht scheme (TBS)
5. Primary Care Unit (PCU)
6. Status and role change-Theoretical Concept
7. Problems and obstacles on 30 baht scheme
8. Reviewed the related research on thirty baht scheme

2.1 Universal Coverage of health care

Since the concept of primary health care (PHC) was defined and given international recognition at Alma-Ata conference since 1978 (6), primary health care has become the main focus for the promotion of world health. The vision of PHC elaborated at Alma-Ata grew out of a synthesis of ideas and experiences from various geographical regions and marked the dawn of a new strategy to improve the health of the people of the world (7). Four basic principals underlie the primary health care approach are universal accessibility and coverage on the basis of need, community and individual involvement and self reliance, intersectional action for health, and appropriate technology and cost effectiveness in relation to the available resources.

The fundamental aim of primary health care is to ensure universal accessibility to available resources and services in order to provide adequate coverage of the most important health needs populations. This means not only securing additional resources

for health, where possible, but also reallocating existing health and social resources to those whose needs are greatest.

The economic crisis of the 1980s have increased the disparities in health status between the “have” and the “have not” in many countries, giving rise to concern about the slow progress being made towards meeting health for all goals (8).

Expenditures of people for health from World Health Report 2000 showed the figures in The United Kingdom 3.1%, Germany 22.5%, France 23.1%, Australia 28.0%, Malaysia 42.4%, Sri Lanka 54.7%, The United States of America 55.9% and Singapore 64.2% (9). The high cost of medical care makes the patient suffering from their out-of-pocket expenditure. The least organized and most inequitable way of paying for health care is on an out-of-pocket basis – with people paying for services whenever they use them. The WHO report points out that the financing burden on the poorest and restricts their access to health services – despite their need being typically higher (10).

One key recommendation from the report is for countries to extend health insurance to as large a percentage of the population as possible. WHO says that it is better to make "pre-payments" on health care as much as possible, whether in the form of insurance, taxes or social security.

While private health expenses in industrial countries now average only some 25 percent because of universal health coverage (except in the United States, where it is 56%), in India, families typically pay 80 percent of their health care costs as "out-of-pocket" expenses when they receive health care.

"It is especially beneficial to make sure that as large a percentage as possible of the poorest people in each country can get insurance," says Dr Frenk. "Insurance protects people against the catastrophic effects of poor health. What we are seeing is that in many countries, the poor pay a higher percentage of their income on health care than the rich."

"In many countries without a health insurance safety net, many families have to pay more than 100 percent of their income for health care when hit with sudden emergencies. In other words, illness forces them into debt" (11).

Now we live in a world fraught with risk, and one such risk is the incidence of illness and adverse events that can cause physical pain and catastrophic financial losses. Insurance is an economical way to deal with the risk of unexpected random events in life by pooling financial resources from a large number of people to pay for the resulting financial losses. Thus the way to solve these problems is universal coverage (12).

Universal coverage definition is Health insurance coverage for all persons in a state or country, rather than for some subset of the population. It may extend to the unemployed as well as to the employed; to aliens as well as to citizen; for pre-existing conditions as well as for current illnesses; for mental as well as for physical conditions (13).

The goal: universal access

An approach to the development of health care systems driven by primary health care must aim at universal access to quality health care services. Speeding the historical movement towards universal coverage will ensure that general health systems improvement does not mask or contribute to widening health inequalities.

There are many obstacles to this goal, including limitations in financial resources, education and skilled personnel. But strong stewardship plays a significant role in dealing with these constraints. How rapidly countries advance towards universal coverage depends on whether governments accept a situation in which health benefits gradually trickle down from the rich to the poor, or whether they accelerate actions to ensure a fair distribution of health care resources and benefits to all social groups (14).

2.2 The Universal Coverage Policy of Thailand.

Health expenditure in Thailand has dramatically increased since 1980 from 3.82% of GDP to 6.21% in 1998. During this period the health expenditure per capita increased from 544.90 baht in 1980 to 4662.83 baht in 1998. In the mean time, about 20 million or about 30% of the total 60 million Thai population remain uninsured. What should these people do when they are confronted with high cost care for their illness? Section 52 of the Constitution (1997) states that “ All Thai people have an equal right to access the quality health services...” However, after the declaration of the new Constitution, no law has been enacted to support this Article. Later on, a legal process was initiated which will soon be completed to serve as a vehicle toward the implementation of the Constitutional health policy. Further more, due to the problems with asymmetric information and imperfect health care market, consumers cannot make rational choices and in other instance, they do not have adequate choice of health services. At the same time the cost of health care is rising rapidly even if the health system has not been able to provide equal access and equitable financing to all. Therefore there is a need for institution of universal healthcare coverage.

Many developed countries, such as United Kingdom, Canada, Australia, France, Sweden, Netherlands have already launched policies of universal healthcare coverage. Such a policy provides their people with access to high standard health services and in many cases their personal health expenditure has become more affordable than before. We should ask whether it is the right time to adapt this idea for Thailand, i.e. to introduce universal healthcare coverage in which all Thai people have the same right to access quality health care services and the health care expenditure is not a constraint in obtaining the health services. The main objectives for universal coverage are as follows:

1. **Equity:** An equal sharing of health care expenditure and equity of access to the same quality of health services.
2. **Efficiency:** Efficient use of resources by good administrative and management practices.

3. **Choice:** People have the right to choose their health services in order to reduce the problem of an imperfectly competitive market.

4. **Good health for all:** Universal healthcare coverage aims not only to provide curative care but also to provide disease prevention and health promotion where appropriate.

The Thai Ministry of Public Health has been examining the possibility of this idea for several years. Based on research, discussions and brainstorming sessions, the ideal universal coverage health system should have the following characteristics: · Easy access and simplicity in order to benefit from this programme.

People should be the part of the ownership, overseeing, access and cost sharing of health services. · The universal healthcare coverage should reduce the problem of overlap and inequity of healthcare schemes. · It should be a transparent system. The providers, consumers and third parties/ payers/ purchasers must be able to check easily the effectiveness, and the administrative power should be balanced among the three partners. · There should be efficiency and equity of budgeting, planning, and development of the health services based on evidence and information. · It should have appropriate methods of co-payment It should institute a reasonable role for insurers in order to pool the risks. · Lastly, it should be a accountable, reliable and accepted scheme. (15)

In each country has different system for universal coverage. It depends on the economic of the country. In developing countries the high income per capita is much more than developing countries. The strength of economic is very important for the people who get sick can help themselves by pay the money for medical services. Thailand is one of developing country which facing the economical health problems and the people cannot help themselves especially underprivileged groups. The democracy country, the people can take role in politics and movable their ideas to change the laws or regulations that can not be served their needs. The constitution of Thailand had changed and improved the content many times. At present, Section 52 of Thai constitution 1997 provides that “A person shall enjoy an equal might to

receive standard public health, services and the indigent shall have the right to receive free medical treatment for public health facilities of the state, as provided by laws.” The public health services by the state shall be provided through and efficiently and for this purpose, participation by the local government organizations and the private sector (16).

2.3 Overview of Thai health insurance

Health insurance provides two basic functions access to effective health care services when needed, and effective protection of family income and assets from the financial costs of expensive medical care Tax-based welfare schemes are also considered health insurance. Supachutikul classified various health insurance schemes in Thailand into four categories accordingly to their nature and objectives.

2.3.1 Medical Welfare Scheme (MWS)

This scheme provided free medical care for the indigence for example the poor, the elderly and children up to secondary school and the disabled. It also extends to monks, community leaders, health volunteers and their family.

2.3.2 Civil Servant Medical Benefit Scheme (CSMBS)

This is a fringe benefit to government employees and dependents to compensate low public salary.

2.3.3 Compulsory Social Insurance

Social Security Scheme (SSS) - a tripartite contribution scheme by the employer, the employee and the government ensures health security formal sector employees.

Workmen Compensation Scheme (WCS) - an employer liability scheme to protect the employee from work-related injuries, illnesses and funeral grants. Traffic Accident Insurance - ensures access to care by traffic accident victims through compulsory premium paid by all car owners to private insurance firms

2.3.4 Voluntary Schemes

Private Health Insurance - a voluntary risk related premium contribution covers mainly the better off

Government Health Card Scheme (HCS) - a voluntary alternative for the uninsured, e.g. rural informal sector workers who are not eligible for low income scheme, the self-employed and employee in small firms of less than 10 employees who are not eligible for the social insurance scheme. Several small scale community financing, saving schemes provide limited health benefits to its members. Payments are made retrospectively to members at the end of the year according to the funds available. Self-help funeral grants are more common than health benefits (2).

2.3.5 The process of universal coverage in Thailand

It must be the government policy. The process of universal coverage related to the other organizations. The government is the highest level for making decision and launched the program.

2. Law or regulation must be done for health care reform, financial regulation and changing role of public sectors

3 Management must be give convenience of working

4. The information and educational system must be use technology

1) The Principles of Health Service System Settlement:

- To originate the distribution of qualified health services. So that people can easily access to those services.
- To initiate the efficient and holistic health service system with good referral system and fully covered basic health services in accordance with the benefit package under the UC project
- To initiate the establishment of qualified health services due comprehensive health services in curative, promote preventive to the regulated standard and provide those services for people continuously.
- To initiate the, and rehabilitative services due to health needs of people.

- To originate responsibilities of health facility's network for people's health in the long run.
- To originate co-operation of public and private sectors, and people in health services provided (17).

2) Health Facility under the UC

project can be classified into 3 groups as follows

- **Contracting unit for primary care (CUP) :**

CUP is the organization-providing curative, promote, preventive, and rehabilitative services as ambulatory care, home care, and community care excluding specialized services. CUP is needed to have distinct registered population and primary care unit which may provide health services as single health facility or primary care network.

In case of providing health services as primary care network, it is called "main contractor" if it can provide comprehensive services by completion of medical doctors and health staffs due to the standard; if not, it is called "sub-contractor" which cannot make the registration of beneficiary.

- **Contracting unit for secondary unit CUS :**

CUS is the organization providing general care in inpatient services, which are community hospitals, regional hospitals, general hospitals, and university hospitals including those public hospitals outside MOPH and private hospitals. CUS is responsible for those patients referred from primary care unit as in-patients.

- **Contracting unit for tertiary care, CUT**

CUT is the organization providing specialized care with high technology and expensive care. It can be regional hospitals, university hospitals or specialized health institutes.

Each health facility can be main contractor more than one level if it could provide comprehensive care according to the standard of each level required.

Significant characteristics of health services in each level are:

1) Characteristics of primary care service

- a. Front-line care
- b. Ongoing/longitudinal care from birth to death
- c. Comprehensive care
- d. Coordinated care

2) Characteristics of secondary and tertiary service

- a. Provide complicated medical care
- b. Provide emergency and accidental care
- c. Provide efficient referral system
- d. Monitor and develop quality of care continuously
- e. Provide qualified service by standardized health personal and medical equipment (18).

Hospital Accreditation Institute, which will be developed to be "Health Care Accreditation Institute" in the future, will be principal organization in development and accreditation of health care including primary care. In transitional period, for province launching universal coverage in June 2001, Hospital Accreditation Institute will prescribe guideline of primary standard evaluation for co-providing hospitals. Division of Medical Registration and mechanism of provincial level established by Area Health Board are mechanism for primary standard evaluation. Team of survey and visit from Hospital Accreditation Institute will re-survey to control the process to be standardized in the suitable period.

In order to complete the implementation of Universal Coverage within the prescribed condition of time, all public hospitals are deemed standardized service hospitals. But private hospitals must be evaluated primary standard.

Co-providing private health facilities, in case of primary care health facilities such as clinic, are required to be as prescribed qualifications and can provide registration for people in district they located or district adjacent to district they located. Private hospitals providing primary care must set the system for holistic services under the prescribed conditions (19).

3) Service delivery system

Under the Ministry of Public Health, there are three levels of health care provision: primary health care, including health centers; secondary care, including community and general hospitals; and tertiary care, including general, specialized, and regional hospitals. A greater proportion of money is spent on curative care than on health promotion or preventive care. However, a large number of programs have been developed in the latter areas. Service delivery through the MOPH is comprised of health centers and community, regional and general hospitals. Health centers provide primary care at the Tambon level and referrals to higher levels of service. The centers are staffed by junior sanitarians and technical nurses and have, on average 3.5 personnel per center. Their catchment areas cover a population of 5000. They deliver mostly preventive and health promotion services, e.g. nutritional, dental, and MCH programs, mainly through an outreach community-based approach with village volunteers. The centers also provide basic curative care under supervision of community hospital doctors. Staff members are assessed through a monitoring system set up by planning departments.

Health centers have little autonomy, due to central planning and budgeting. although this has improved because of the new universal style health coverage that will encourage them to perform in a manner similar to high quality primary care units (PCUs) under the supervision of community hospitals. Additionally, their autonomy will be encouraged by a newly codified right to keep some of the new revenue generated by a budget allocation method that allows them to be less dependent on central department programs and projects.

Community hospitals serve as the first referral level for curative care. The number of beds in these facilities ranges from 10 to 120. Their major roles are to provide comprehensive services to the population in their immediate catchment areas. They have a greater potential than the health centers for outreach services and innovative programme development. The main staff is comprised of doctors, nurses, dentists, pharmacists, junior sanitarians and general supportive personnel. There are no specialist posts in community hospitals.

General and regional hospitals are located at the provincial level. The number of beds in such facilities ranges from 200 to 700. Their main responsibility is to provide secondary and tertiary care. They serve as referral centers for specialized medical services. One of their roles is to provide comprehensive health services to people in the catchment area through their departments of social medicine. Staffing is similar to that in community hospitals but includes specialists as well as physiotherapists, laboratory technicians, etc. Because these facilities have a larger pool of staff and a greater potential to generate revenue, they are more autonomous and have the ability to provide newer types of health services including outreach and institutional care. Funds from the central ministry account for 30–70 % of their total revenues. Traditional Thai medicine is practiced both in and outside hospitals. Other alternative medicines also exist in the community, with supervision by the Medical Registration Division. Traditional Thai medicine and other alternative methods practiced in Thailand are generally not covered by any insurance schemes and require private payment. However, in some parts of Thailand traditional healers and healing facilities (e.g. centers for traditional Thai massage) may receive financial assistance from local health centers. In general, Thai people seek professional health care, at various facilities, for 70% of their illness episodes. Seventeen per cent of the population self-prescribes, and 14% seek treatment through traditional healers. Average utilization rates are 2.8 for outpatient visits and 0.08 for admissions per person per year (1).

4) Access to care

Access to care is problematic in many parts of Thailand due to the absence of affordable public transportation and the lack of adequate facilities nationwide. People living in Bangkok and the local vicinity have better access to care than people living in other parts of the country. In general, people living in certain big cities of regional importance, with more developed health facilities and greater levels of economic development, tend to have better service facilities in their localities. Long-term care services, on the other hand, vary from region to region. There is also differential access to care due to the competition that has arisen between service providers under the Social Security Scheme. Beneficiaries have access to public health facilities and are also entitled to use private facilities that contract with the Social Security Fund. Payment for such care is done through capitation. This scheme has also brought into focus the issue of regulating quality of care in public and private hospitals. As health services organizations in Thailand are mostly public, the entitlement types of health services available to the Thai population should, in theory, be relatively uniform throughout the country. In reality, however, there are differences in the types of health services available to people in various localities and to those with various levels of social status.

5) Variation due to service availability

Public hospitals in various provinces and districts vary in the range of health services they provide. Tertiary care is available to the population in only 14 of the 75 provinces. Rehabilitation services are not available in all provinces. In certain provinces and districts, there are medical school hospitals or military hospitals where certain types of health services may be more readily available. Facilities for radiation therapy for people with cancer may not be available in many provinces as there is a total of only 36 units in the country. Psychiatrists are also not readily available in all provinces. Facilities in Bangkok have the broadest possible range of services and expertise available in the country.

6) Rehabilitation services

Rehabilitation services are part of hospital services, although not all hospitals have such services available. All of the hospitals at the provincial level, and

approximately 80 community hospitals offer such services. There is a national center for rehabilitation in the Ministry of Public Health. However, its scope of services and coverage is limited by its location near Bangkok, as well as by the limited budget and personnel available. Its mandate has been somewhat broadened by the legislation on the rehabilitation of the disabled introduced in 1990, but its capacity still remains quite limited. Even though auxiliary personnel for physical therapists exist in the Thai health system, their numbers are few. Moreover, most work with professional physical therapists rather than in the rural areas, where professional personnel may be lacking.

7) Home care

Home-based care is a recent development in the Thai health system. These services – offered through targeted development projects – are organized and managed by two different divisions of the Ministry of Public Health. One home care program covers exclusively public hospitals of the Ministry of Public Health. All 92 provincial hospitals, but fewer than 10% of community hospitals, provide home-based care. One of the initiatives emphasizing home-based care is the ‘health promoting hospital’. The aim is to reorient hospitals so that they build a continuum of services that range from health promotion to rehabilitation. The key strategies consist of public mobilization as well as system development for identification of patients for early discharge along with continuous home-based care. Although the initiative does not target people with needs for long-term care as the primary objective, it has the potential to develop a system for public hospitals that can evolve and meet the health needs of such target groups. Currently, there are 350 MOPH hospitals enrolled in the health promoting hospitals program. A second initiative emphasizes proactive care provision aimed at the development of health teams that provide continuous health care to people with a wide range of health problems such as tuberculosis, hypertension, diabetes mellitus, cerebrovascular accidents, etc. This initiative also has the potential to address more effectively the health needs of those requiring.

8) Emergency care service

An emergency home service exists for elderly people who are experiencing severe family stress and want to separate themselves temporarily; for elderly people from the provinces who need to go to hospitals in Bangkok but have no accommodation there, for elderly people who are waiting for their relatives to return home after medical treatment in hospitals in Bangkok; for elderly people who are waiting to enter institutional care, and for elderly people from regional provinces who come to stay in Bangkok. The funded length of stay does not exceed 15 days and the basic maintenance and social work services are provided (2).

2.4 30 Baht scheme (TBS)

The present government is the first administration elected under the provisions of the new constitution, known to many Thais as the “people constitution.” It is also the first time since the establishment of a constitutional government in 1932 that the single party has won the election in the House of Representatives, capturing firm popular support across the nation. After one year of administration political stability has been reinforced the government has given full potential to implementation of campaign promises that serve as its mandate handed over from the Thai people. The government has laid a firm foundation for sustained and balanced economic growth. First focusing on the supply side of economic stimulation in order to enhance the competitiveness of the real sectors, and secondary stimulating the demand side through poverty reduction, job creation and income creation at the grass root level known as “one tambon one product. The government has embarked upon a course to improve quality of life for all segments of society in which the Ministry of Public Health plays a vital role to implement the “30 Baht universal health care policy (20).

It is one of the major policies of the present government. This policy is focused on creating universal health insurance, coverage of the whole population. Before the implementation of this policy, there were 20 % of the population universal by any scheme. During the first phase April 2001, the 30 baht scheme started with 6 provinces, then the second phase in June 2001 expanded to 21 provinces, then the third

phase in October 2001 when all the scheme in January 2002 the whole country was covered in April 2002. At present, there are 45 million people by this scheme. The rest are 10 million civil servants with spouses and parents and 8 million workers under the civil servant medical benefit scheme and social security health insurance scheme respectively. The health service benefit package includes inpatient/ outpatient treatment at the registered primary care facility (except emergency cases), dental care health promotion/ prevention services and drug prescription with user fee of 30 baht per visit. After the first year of implementation, the household survey revealed that the policy was highly supported by both the rich and the poor. 30 baht scheme is under national health system. The primary care unit is the first health service which is closest to the community. The people in the community and the health personnel look like relatives. The advisement, health knowledge and holistic approach were occurred. The registered for golden card establishment at this level. The budget system is essential for health insurance system, the minimum cost =1,202.40 baht per capita (exclude the social insurance and government service)

The detail of budget 1,202.40 baht /capita / year

1) Treatment

1.1 outpatient treatment	574 baht
1.2 inpatient treatment	303 baht
1.3 high cost treatment	32 baht
1.4 accident and emergency	25 baht

2) health promotion, prevention and control disease 175 baht

3) capital budget 93.40 baht

The budget allocation for the provincial level 1,052 baht/capita and the central budget for the high cost, accident and emergency cases =150.40 baht /capita called central fund (21).

2.5 Primary Care Unit or PCU

Primary care unit is a unit for health service under contracting unit of primary care. It is located both in hospitals and outside hospitals, which was managed by contracting unit of primary care (CUP). The population who had registered at primary

care unit (PCU) of their definite catchment areas can receive medical services from the PCU. The PCU is an instrument for conduct health activities and closet the communities. The standardization of PCU under the health insurance project is

- 1) Primary care unit responsibility 10,000 population
- 2) The people can come to use service in 30 minutes by car
- 3) Facility of PCU: Many aspects of the services, holistic care consists of health promotion, prevention and disease control, curative and treatment the diseases, rehabilitation Time working 56 hours of services / week, dental service 40 hours / week educational service, ANC, postpartum care, family planning, up system 1-2 day / week, child health care 1-8 day / week , home visit ,community working for closely relations with the people, family evaluation, health promotion at least 10-15 hours/ week, pharmaceutical service – drugs provided, drug distribution and drug educational service, basic laboratory support and good refer system
- 4) Human health resources: Doctor 1:10,000 population, nurse 1:1250 population, dentist 1:20,000 population, pharmacist 1:15,000 population
- 5) Health infrastructure and equipment, essential equipment for health promotion, prevention and control disease, curative and treatment, rehabilitation, effectiveness communication system, arrangement transportation for refer system in emergency cases.
- 6) Management: Registration of responsibility population system, continuous of service, data and information system to support health promotion and prevention and control disease, monitoring and evaluation system, pharmaceutical management
- 7) information systems: The database of population and health of personal record must be done at the PCU. The family folders are recorded all essential data in each households. The health personal can use these database for planning and implementation of holistic care at PCU. (1, 2)

The PCU service is benefit for personal and family members. It consists of basic services in preventive, promotion health services as well as treatment and

rehabilitation. The activities of health care services such as home care visit, personal and family preventive and promotion service are done by the PCU.

Hospital health professional: The hospital has a clear philosophy: successful health action is measured not just by what was done inside the hospital but, more importantly, by the initiatives taken within the hospital's area of influence. Consequently, it is the hospital's responsibility to extend health activities, improve health standard beyond its own walls. This calls for dedication not only to curative and preventive medicine but also to an understanding that the latter is above all matter for individuals and communities (22).

1) Hospitals

The case mix was varied, interesting and challenging. But it was also a responsibility that at times was a source of great stress. The reason for this was that in a rural area one quickly becomes aware of how important hospital services are to the local population. A bad hospital service can lead to a high perinatal and maternal death rate; children dying on the wards from preventable diseases; surgical patients dying from post-operative bleeding or sepsis; a fractured limb being permanently disfigured because it wasn't properly reduced; a young boy losing a leg from a snakebite because a fasciotomy wasn't performed; or an infant crying in agony because inadequate analgesia was provided for his/her second degree burns. In many parts of the country, the lack of skilled staff and equipment, as well as the unavailability of a back-up service means that there is a low margin for error. As a result, because of the inadequate standard of care in some district hospitals, there are many patients dying from treatable conditions, and from omissions or mistakes in health care. On the other hand, a good District Hospital is a source of pride for both staff and with community (23).

2) Nurses

Registered nurses care for the sick and help people stay well. Typical concern with the whole person, registered nurses provide for the physical, mental, and

emotional needs of their patients. They observe, assess and record symptoms, reactions and progress, administer medications, assist in convalescence and rehabilitation, instruct patient and their families in proper care and help individual and groups take steps to improve or maintain their health (24).

3) Doctors

Physicians are involved with treatment and prevention of human disease. The physician has the primary role in diagnosing human disease and in formulating a treatment plan for the patient. Physicians also research control and cure disease. Physicians are classified type of practice or specific area of specialization. They must be familiar with all types of instruments, medical test. Physician may perform surgery. The prescribe and given medication (25).

4) Pharmacists

Pharmacists advise the public on the proper selection and use of medicines. They also advise physicians and other health professionals. The special knowledge of the pharmacists is needed because of the complexity and potential side effects of the large growing number of pharmaceutical products on the market. In addition to providing information, pharmacists dispense drugs and medicines prescribed by health practitioner, such as physicians, dentists. Pharmacists must understand the use composition, and effects of drugs and how they are tested for purity and strength (25).

5) Dentists

Dentists diagnose and treat problems of teeth and tissue of the mouth. To accomplish these tasks, they may take x-rays, place protective plastic sealants on children's teeth, fill cavities straighten teeth, repaired fractured teeth, and treat gum disease. Dentists remove teeth only when necessary and may provide dentures to replace missing teeth. They also perform corrective surgery of the gums and supporting bones. Increasingly, dentists are concerned with preventing dental problems. In addition to cleaning teeth and providing instruction in flossing and other aspects of dental care, they may suggest ways to prevent dental disease (24).

2.6 Status and role change-Theoretical Concept

Through out life, a person is constantly in process of joining and leaving social groups related to family, occupation, recreation, education,, church, and so forth. Status within each of these groups is determined by relative right and duties that society assigns to the position. Role is determined by the expectation of society that the person will carry out the duties of his position. If the member's position is changed within group, his status and role also change.

Allport (1961) cites four interrelated meaning of the term role. The first, role expectation, is what society expects of individual. Role conception means how the individual perceives the effect of the role on his self concept. He defines the role according to his perception and his needs, which are influenced by life goals, basic values, and congruency with other roles he is expected to perform. Role acceptance, like role conception, is a highly subjective matter. Not all roles are willingly altered. The political process is one example of the kind of pressure that society can exert to force a role change. Reciprocal role changes occur for all, dependent on winners' (and losers) new status.

Role performance depends on role expectation, conception, and acceptance. The performance of the role meets the expectation of society only to the degree that there has been mutual communication and understanding throughout the process. The greater the disagreement in any area of understanding, the greater the possibility of failure in the performance.

A person tends to perceive a role from his view of how it relates to his self-concept. The self might be defined as the image the person builds of himself through interpretation of what he thinks others are judging him to be. It is also derived from the reflected values that other place on him and the values that he places on himself in social roles. As new evaluations are perceived, he is obliged to reconcile these new concepts with preexisting ones. Increasing conflict appraisals of the self result in

increased tension and anxiety, leading to a state of disequilibrium. A person tries to avoid accepting a role that might threaten the security of the self-concept. Various defensive mechanisms are used to escape conflict and to ensure the integrity of self. Danger occurs when an unacceptable change in role is forced by society and cannot be avoided. For example, in the sudden death of a husband, the existing role of wife ceases to exist, the position is gone and its status with it. Without husband, there is no wife role. Similar loss situations occur in occupations and other groups, a business closes or a position is abolished, and the need for certain roles no longer exists.

The individual's feelings of loss are in accordance with the value that he places on the role. Effects of the loss are viewed in relation to the self-image, and this involves consideration of the negative factors that might cause conflicting appraisals from others. The greater the conflict between self-concept and expectations, as a result of role change, the more painful is the decision-making experience.

Changes in role related to loss of status are particularly critical because they represent a direct threat to self to self-esteem and may encourage the development of a negative self-concept. If defensive in effective in protecting the integrity of the self, anxiety and tension rise, and the balance of equilibrium is distributed (Malony, 1990) coping mechanisms (such as projection or rationalization) prove (26).

2.7 Problems and obstacle in 30 baht scheme

30 baht scheme is the new one of the government policy. It is the opportunity for health care reform in health services management, financing, structural administration but it has the wide impact for health system. At the beginning provincial level lack of knowledge and understanding in this project about financial system and medical care benefit of patient. The information system of population database and misunderstanding in medical services. The salary of public health personnel included in budget 45% and 55% for management (1, 2).

2.7.1 Doctors Situation in Thailand

Problem of doctors resigned working from the MoPH. The doctors in Thailand have resigned from the government hospitals increasing every year.

Table 1 Number of doctors had resigned from the government service, 1999-2003

Year	MoPH	Other Ministry	Total
1999	210	140	350
2000	221	161	382
2001	329	188	517
2002	599	203	802
2003	177	157	334
total	1536	849	2385

Source: medical Council 2003

Most doctors who had resigned are specialists with a lot of knowledge and experience. In each year the new doctors will come to work 1200-1300 doctors and must be distributed for every Ministry. The result of medical council meeting in September 2003, there are

1. Workload and Working hour

high quantitative of patients, 100-300/days (social insurance scheme standard 12 patients/hour)

2. Night time and holiday working they must have overtime working more than 10 days / month, lack of rest

3. Low salary and income the new doctors in Thailand gets salary from the government 8,190 baht and after 10 years working they will get 15,000 baht/month

4. high risk for the patients or relatives take the law and ask for the money from the doctors who had medical error treatment to the patients

5. The salary of doctors is included by capitation of population on thirty baht scheme

6. The hospitals cannot pay full overtime money and decrease 20-25 % of their overtime income

7. The position of doctor is not the government officer. It was started in 1997

8. The high expectation of the people for medical treatment and lack of information systems (27).

There are hospitals in Thailand joined in this project 840 hospitals under MOPH and 72 hospitals under the other Ministry and 91 private hospitals (17).

At present, the coverage in Sakaeo province is 95.16% and 416,989 population had registered in September 2003. There are 7 hospitals join in this project. At the beginning only 40% of the target population had registered (28).

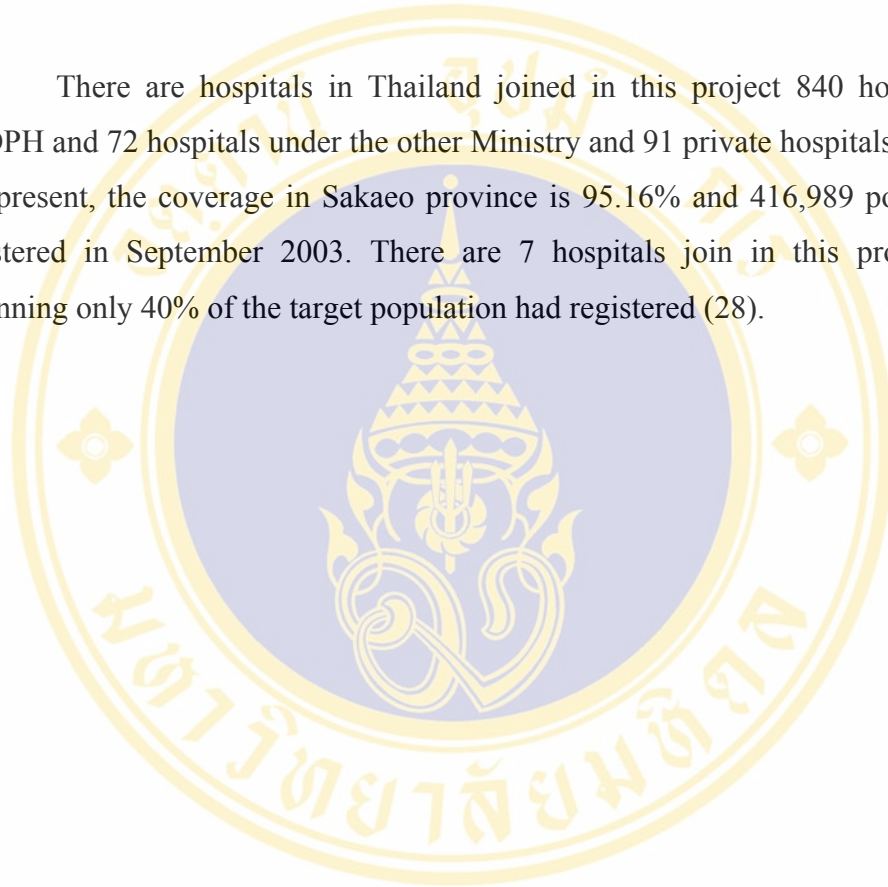


Table 2 Cup and PCU in Sakaeo Province

CUP	PCU	PCU Population.	CUP Population
1.Sakaeo Crown Prince	1.Sakaeo	17,258	105,341
	2.Salalamduan	10,874	
2.Aranyapathet	3.Aran	15,932	86,286
	4.Klongnamsai	5,138	
	5.Nongmuang	9,282	
3.Tapraya	6.Tapraya	12,258	51,498
	7.Nawamin	8,808	
	8.Kudwein	17,258	
	9.Koklan	12,258	
	10.Naknam	4,936	
	11.Kokprek	17,258	
4.Klonghad	12.Klongkaithiern	10,413	34,083
	13.Bannadee	8,758	
	14.Nongwaeng	7,535	
5.Wangnamyen	15.Wangsomboon	10,161	96,223
	16.Talangnai	12,834	
	17.Tungmahacharoen	17,700	
	18.Kloghinpoon	9,386	
	19.Tungkabin	11,499	
	20.Chalermprakait	12,270	
6.Khaochagun	21.Khaochagun	7,940	56,883
	22.Klongcharoen	6,103	
	23.Submanow	8,733	
7.Wattananakon	24.Wattananakon	17,258	79,381
	25.Saeor	14,456	
8..MilitaryHospital (Surasinghanat)	NO PCU	17,987	17,987
TOTAL	25 PCU	304,293	527,682

The primary care unit in this province should have 40 unit but at this time it has only 29 units (29). The 3 hospitals can establish PCU in the hospital but the 4 hospitals lack of medical doctors and nurses. They stopped running PCU in the hospital this year by combine into the out patient department in the hospitals. The outsides of hospitals it should have PCU by upgrade the health center It still have not

achievement the standardized criteria. The critical period will happen from budget allocation this year because of the new budget allocation method cut some budget from this province for the other hospitals which financial problems. It is the first year 2 hospitals ask for contingency fund from the central level after 2 years of the 30 baht cure every disease.(28, 29)

2.8 Reviewed the related research on thirty baht scheme

- 1) Survey of Satisfaction in health care delivery at Sappasitthiprasong hospital under the universal coverage scheme. Found that 62.7% of the clients had satisfaction on universal coverage scheme
- 2) Satisfaction with universal Coverage Program among Villagers in Pathum Thani Province, Thailand by Naomi Shimizu. Revealed that 50.7% of the subjects were satisfied with universal health card. The hospital provision utilization rate has increased to 59% as compared to the study done by Mr. Piyada at 45% in 6months The study also cited the high expectation of people that stood at 51.7% and high regard of 53.1% on thirty baht scheme.
- 3) Evaluation of the opinion of Administrator and Health Staff Towards Health for All Insurance Project (30 baht curing every disease/TBHCS) in Suphanburi, Thailand by Suchitra Ninles, demonstrated 26.8% of health staff and 27.3% of Administrators had knowledge and 49.2% of staff ,40.6% of Administrators had satisfaction on thirty baht scheme.
- 4) Knowledge and Attitude of Doctors and Nurses to the thirty baht health care scheme in the community hospitals in Suphan buri, Thailand by Teresita D.Foman-Eg, showed that 163 subjects, majority had fair and good knowledge on thirty baht scheme. Most of them had moderate to high knowledge on the principles. Further, they had fair attitudes towards

the thirty baht scheme. Moreover , many accepted that thirty baht scheme gives people access to hospital service

- 5) Knowledge and understanding of the people in the community about their rights, roles and functions designated under the program Nitaya Wongsangiem, Chonticha Atitayamontal, Kitiya Totong: The results showed that 70 and 96.9 % of the people and the community leader respectively have already received the UC card (the gold card) and 70 % of lay people in the community and 91.45 % of the community leaders had basic knowledge of the usage namely the required accompanying personal identity card with the gold card, the reserved usage coverage in designated health centers only ect. However, the specific details of the UC coverage and usage for examples the exempt of hemodialysis, the limited use of medications in the essential drug list only ect. were acknowledged by only 43.68 - 81.78 % of the foremention groups respectively. The main policy objective of providing good quality primary health care at the local health center is not seen as success yet because only 40.5 % use their local health center service when fell ill. The rest do not entrust their health to the health personnel in the health center.
- 6) Evaluation of the medical services under the universal health coverage scheme: a case study of Phitsanulok province Orathai Kheawcharoen presented as followed :

There are 4 sample groups; namely, a group of 25 administrators, a group of 621 health providers, a group of 1,000 service users ,and a group of 1,861 people at the household level during May and June 2002. Findings of the study are summarized in the following key areas:1. Context: Providers had a good understanding on the universal health coverage scheme and agree with the policy and regulations of the scheme at moderate level. The service users moderately agreed with the policy and regulations of the scheme.2. Input: The capitation budget was insufficient. Also, personnel was not sufficient.3. Process: The system was well prepared and organized

in accordance with the scheme's guidelines. The total capitation budget was directly allocated to contracting units for primary care (Inclusive capitation). Fifteen primary care units (PCUs) were set up. Curative and rehabilitative care was provided according to the scheme guideline at a 100% of total health facilities. In addition, health promotion and prevention services was aligned with the provincial policy, as well as complaint handling should be provided. More than 60 % of health facilities set up the complaint handling system. There were many practical problems raised during the preparation period but problems occurred at moderate level during project implementation.4. Product: Health insurance coverage expanded. In terms of accessibility, 93.6% of clients had convenient access to care. Compliance to their health benefit (30 baht scheme) was 81.6 % for illness not required hospitalises while the rate was only 65.7 % for inpatient severe. Output of services, number of out-patient visits and dental patients rose whereas number of in-patients and vaccinations declined. The quality of the services was generally improved. However, some indicators did not meet the established standards. From the clients' perspectives, the service quality provided was at a fair with a high level of satisfaction. The recurrent costs per out-patient and costs per in-patient decreased at the regional hospital but increased at the community hospitals and primary care units. In terms of equity, most people (69.7 % of total) considered that there was no difference in services rendered by the 30 baht scheme or by others. Regarding service behaviors, admission rate, referred patients and total admission days were lower than the previous year while the average length of stay increased. For non-hospitalized illness, most of the people went to health centers 46.3 %. For hospitalized illness most people 45.4 % went to the regional hospital. Utilization of chronic patients at health center went up while that at the community hospital and regional hospital decreased.

CHAPTER III

RESEARCH METHODOLOGY

3.1 Study design

The study was a cross sectional descriptive study designed to assess knowledge, attitude and acceptance on 30 baht scheme among health care providers at community hospitals in Sakaeo province.

3.2 Study population

The study population included all professional types of health care providers consisted of medical doctors, dentists, pharmacists registered nurses and technical nurses who were directly been working and provided care and services to all clients who utilized health care services under the 30 baht scheme at six community hospitals in Sakaeo Province during February 2004. Total population is 316 health care providers.

3.3 Sample size

This study is the purposive sampling technique. They are health care providers who are working at the community hospitals in Sakaeo province. The total target of sample size is 316 health care providers. There are 19 doctors, 14 dentists, 21 pharmacists, 221 registered nurses, and 41 technical nurses. All of them were selected to be the sample.

Table 3 Numbers of Sakaeo health care providers at community hospitals

Occupation	Hospital						
	Aranya pathat	Wangnam yen	Taphaya	Kao chagun	Wattana	Klonghad	Total
Doctors	6	3	2	1	2	3	17
Dentists	2	2	1	2	2	2	11
Pharmacists	4	4	3	1	4	3	19
Registered nurses	54	33	27	20	34	23	191
Technical nurses	37	13	5	4	15	13	87
TOTAL	98	58	38	30	58	34	316

Source: Sakaeo Provincial Health Office, 2003

3.4 Place of Study

Sakaeo Province is the 74th province of Thailand. It divided into 9 districts, 59 tambons, 637 villages, 1 Provincial Administrative Organization, 8 municipalities and 58 Tambon Administrative Organizations. It had 7,195.436 square kilometers 531,149 population, 267,963 male 263,186 female. The province was composed of 1 general hospital 231 beds, 1 military hospital 90 beds, 1 community hospital 120 beds, 2 communities hospitals 60 beds, 3 communities hospitals 30 beds and 109 health centers (6). There were 7 contracting units for primary care, these are consisting of 1) Sakaeo Crown Prince 2) Aranyapathet 3) Taphaya 4) Wangnamyen 5) Klonghad 6) Wattananakorn 7) Khaochagun. Under the total number of universal coverage registration in September 2003, total number of population was 443,400 persons. Total number of primary care units in this province comprised of 29 units (28, 29, 30).

Six community hospitals from 6 districts in Sakaeo Province were the selected places of study. These community hospitals are under administration of Sakaeo Provincial Health Office. These hospitals were composed of Aranyapathet, Taphaya, Wangnamyen, Klonghad, Wattana Nakorn and Khaochagun community hospital. Sakaeo Province is far from Bangkok 236 kilometers by bus.

3.5 Research Instrument

It was a self-administered questionnaire. The questionnaire consisted of 4 parts as follows:

1) Socio-demographic characteristics of health care providers

Regarding age, sex, marital status, employment status, educational level, occupation, income, working years of experiences as government officers and working years of experiences under the 30 baht scheme. It comprised of 9 questions, with filled in the blank space and multiple choices questions.

2) Knowledge on 30 baht scheme of health care providers

This part comprised of 30 statements of knowledge on 30 baht scheme filled in the blank of answer in front of the statements. The statements had 2 answers choices either true or false. One mark was given for the correct answer, and zero for the wrong answer. Total scores of knowledge are summarized and divided into 3 levels by using the cut of point as follows:

< 60 % of total scores:	Poor
60-80 % of total scores:	Fair
> 80 % of total scores:	Good

3) Attitude

This part covered 38 statements of health care providers feeling about 30 baht scheme after they had worked on this program. The attitude part was using 5 rating scales of Likert. There were consisted of both positive and negative statements. Among the positive statements, the scores were ranked from Strongly agree = 5, agree

with statements = 4, Uncertain = 3, Disagree = 2, and Strongly disagree =1. While, among the negative statements the score were vise versa.

The sum of all items of attitude score constituted the measurement of attitude grouping according to Bloom's formula (31). There were 3 levels of total attitude scores as presented below.

$$\text{Difference} = \frac{\text{Maximum score} - \text{Minimum score}}{3}$$

Minimum \pm 3 times difference:	Good
Minimum \pm 2 times difference:	Fair
Minimum \pm difference:	Poor

4) Acceptance of health care providers

There were 20 statements and filled in the blank behind each statement. These were the statements of thirty baht scheme regarding principles, management, performance and evaluation and financing. The answer "Yes" was mean that the health care providers agreed on the statements. While, "No" was mean they did not agree with those statements.

Total acceptance scores toward 30 baht scheme were classified into 2 groups as:

Low level:	\leq Median score
High level:	$>$ Median score

3.6 Data collection

The questionnaire was first prepared in English and translated into Thai language. The completeness of the questionnaire was revised according to the thesis committee before distributed for pre-test prior the real data collection.

The pre-test was done among 30 respondents at Kabinburi community hospital, Kabinburi district in Prachinburi Province.

After the pre-test was performed,, some improper questions were revised under the close supervision of the thesis committee and distributed to all target population to fill up their answers by themselves. The returned questionnaires were gathered by Sakaao Public Health Office and Sakaao Crown Prince Hospital staffs.

3.7 Data analysis

The MINITAB program was used to input data. It used to analyze the data. The data was edited, coded and analyzed by descriptive statistics of socio-demographic characteristic of the healthcare providers, knowledge, attitude and convenience of referral system and number of patient per day perform by percentage, sum, mean, and standard deviation, minimum.

CHAPTER IV

RESULTS

This study was a cross sectional study. The objective was to assess the acceptance of 30 baht scheme among health care providers at six community hospitals in Sakaeo Province, Thailand. The data collection was performed by using a self-administered questionnaire during February 1 – 14, 2004. A total of 316 health care providers of six community hospitals who had been working at the target hospitals during the study period were selected. All of them are doctors, dentists, pharmacists, registered nurses and technical nurses. The results of the study are presented into 4 parts as follows:

- PART 1: Socio-demographic characteristics
- PART 2: Knowledge of 30 baht scheme
- PART 3: Attitude of 30 baht scheme
- PART 4: Acceptance of 30 baht scheme

4.1 Socio-demographic characteristics

As shown in table 4 the results shown that the general characteristics of health care providers includes age, sex, marital status, personal type, occupation, education level, years of working experience as government officer, years of working experience on 30 baht scheme.

Regarding age of the health care providers, they were classified into 4 groups as: 20-29, 30-39, 40-49, and 50-59 years. The majority of health care providers were found in the age group 20-29 years old (57.3%). The highest age was 58 years old and the lowest age was 20 years old. An average age was 32 years (SD = 8).

Majorities of the health care providers were female (85.1%). Most of them were single (50.0%), followed by married 45.9% and divorced 4.1%. There were 2 types

of employee status as government officers and government employees. It was found that the government officers were accounted for 63.0% of the total study group.

Majorities of the health care providers were registered nurses which accounted for 69.9% while the rests were doctors 6.0% dentists 4.4%, pharmacist 6.7%, and technical nurses 13.0%.

The education level of the health care providers indicated that most of them (85.5%) had their education background as bachelor degree while the rest were diploma 12.0% and higher than bachelor degree 2.5%

Nearly half of the respondents (48.7%) had their income per month between 10,000-20,000 baht. The others were less than 10,000 baht per month or accounted for 26.9% and more than 20,000 baht per month were found to be 24.4%. The maximum monthly income was 50,000 and the minimum was 5,380 baht per month.

Working years of experiences as health care providers was found to be very broaden in gap. The maximum of working years was 38.8 years, the minimum was only 7 months. Majority of them (64.6%) had been working less than 10 years. The average years of working as the health care providers was equal to 9.7 years (SD =8.4). While the working years of experiences under the 30 baht scheme was found to be most among those who worked at the beginning of the project or 3 years of working experiences (57.6%). The maximum years of working under the 30 baht scheme was 3 years and the minimum was found to be only 2 months. The average years of working under the 30 baht scheme was 1.9 years (SD = 0.98)

Table 4 Number and Percentage distribution of health care providers by socio-demographic characteristics

Socio-demographic characteristics	N=316	Percentage
Age groups (years old)		
20-29	181	57.3
30-39	69	21.8
40-49	58	18.4
50-59	8	2.5
Mean = 32, SD= ± 8.0 , Min = 20, Max=58		
Sex		
Male	47	14.9
Female	269	85.1
Marital status		
Single	158	50
Married	145	45.9
Divorced	13	4.1
Employee status		
Government officer	199	63.0
Government employee	117	37.0
Education level		
Diploma	38	12.0
Bachelor	270	85.5
Higher than Bachelor	8	2.5
Income (baht per month)		
<10,000	85	26.9
10,000-20000	154	48.7
>20,000	77	24.4
Median = 13,000, Min = 5,380, Max = 50,000		

Table 4 Number and Percentage distribution of health care providers by socio-demographic characteristics. (cont.)

Socio-demographic characteristics	N=316	Percentage
Professional types		
Doctors	19	6.0
Dentists	14	4.4
Pharmacists	21	6.7
Registered nurses	221	69.9
Technical nurses	41	13.0
Years of working experiences as government officer		
< 10	204	64.6
10 - 19	51	16.1
20 - 29	55	17.4
30 - 39	6	1.9
Median = 6.8 Min = 7 month Max = 38.8		
Years of working under 30 baht scheme		
< 1	24	7.6
1 - 2	110	34.8
3	182	57.6
Mean = 1.9 (SD = 0.98) Min = 2 month Max = 3 yrs.		

Table 5 Number and percentage distribution of health care providers by professional

Characteristics	Professional types				
	Doc. N (%)	Dent. N (%)	Phar. N (%)	RN n (%)	TN n (%)
Age groups					
20-29	9 (47.4)	10 (71.4)	18 (85.7)	107 (48.4)	16 (39.0)
30-39	3 (15.8)	4 (28.6)	3 (14.3)	60 (27.2)	10 (24.4)
40-49	5 (26.3)	0	0	46 (20.8)	13 (31.7)
50-59	2 (10.5)	0	0	8 (3.6)	2 (4.9)
Sex					
Male	5 (26.3)	5 (35.7)	8 (38.1)	20 (9.1)	0
Female	14 (73.7)	9 (64.3)	13 (61.9)	201 (90.9)	41 (100)
Marital status					
Single	8 (42.1)	12 (85.7)	19 (90.5)	104 (47.1)	15 (36.6)
Married	11 (57.9)	2 (14.2)	2 (9.5)	105 (47.5)	25 (61.1)
Divorced	0	0	0	12 (5.4)	1 (2.4)
Employment status					
Government officer	11 (57.9)	4 (28.6)	3 (15.8)	147	34
Government Employee	8 (42.1)	10 (71.4)	18 (85.7)	74 (33.5)	7 (17.1)
Education level					
Diploma	0	0	0	0	30 (73.2)
Bachelor	16	13	21	217	11
Higher than Bachelor	3 (15.8)	1 (7.1)	0	4 (1.8)	0
Income (baht per month)					
≤10,000	0	0	0	90 (40.7)	24 (58.5)
10,001-20,000	0	4 (28.6)	17 (81.0)	107 (48.4)	16 (39.0)
20,001-30,000	7 (36.9)	7 (50.0)	4 (19)	23 (10.4)	1 (2.5)
30,001-40,000	7 (36.8)	3 (15.8)	-	1 (0.5)	
40,001-50,000	5 (26.3)	0	0	0	0

Table 5 Number and percentage distribution of health care providers by professional Type. (cont.)

Characteristics	Professional types				
	Doc. N (%)	Phar. N (%)	Dent. N (%)	RN n (%)	TN n (%)
Working years as government officer					
< 10	10 (52.6)	11 (78.6)	18 (85.7)	84 (38.0)	11 (26.8)
10 - 19	1 (5.3)	2 (14.3)	2 (9.5)	56 (25.3)	13 (31.7)
≥ 20	8 (42.1)	1 (7.1)	1 (4.8)	81 (36.7)	17 (41.5)
Working years as government employee					
< 1	4 (28.6)	3 (15.8)	7 (33.3)	16 (7.2)	2 (4.9)
1 - 2	2 (10.5)	10 (71.4)	9 (42.9)	71 (32.1)	10 (24.4)
3	13 (68.4)	1 (7.1)	5 (23.8)	134 (60.6)	29 (70.7)
Workload (Median number of patient/day)	80	15	150	30	30

4.2 Knowledge on 30 baht scheme

The frequency and percentage of corrected answer in each statement of knowledge are presented in table 6. There are 30 knowledge statement on 30 baht scheme. There are 20 corrected statements (No. 1, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 19, 21, 22, 23, 24, 26, and 28) and 10 uncorrected statements. (No. 2, 4, 14, 17, 18, 20, 25, 27, 29 and 30)

The results in table 6 indicated that score of knowledge were ranged between 31.0% -99.4%. Majority of health care providers has high knowledge toward thirty baht scheme. For example the statement No. 1 as “Thirty baht scheme is government policy under universal coverage” accounted for 99.4%. No. 19 “Family folder is fundamental need for data record in every households” accounted for 98.4%. No. 24 “30 baht scheme has PCU which prepared essential drugs for patient by supporting from community hospitals and drugs items define by the CUP committee” accounted for 97.8%. No. 11 accounted 96.5% for “CUP has duties to take care with holistic approach by physical, mental and social and integration with curative health promotion, curative and treatment, prevention and control disease and rehabilitation”

There are only 4 items that health care providers couldn't answer very well (lower than 50%). For example: No. 2 accounted for 31.0% on “The objective of 30 baht scheme is mainly for the poor.” No. 14 accounted for 35.4% on “Primary Care Unit is the service unit for registered 12,000 population under CUP in its catchment area”. No. 20 accounted for 34.5% for “Family folder should be updated data every 3 years”. No. 30 accounted for 41.8% for “30 baht scheme has not cover to take care 15 diseases.”

4.1.1 Distribution of correct answers to knowledge questions

Table 6 Distribution of correct answers to knowledge questions of thirty baht scheme.

Knowledge statement	N=316	Percentage
1. 30 Baht is the government policy under universal coverage principle	314	99.4
2. Main objectives of 30 Baht is to provide the coverage of health insurance for the poor.	98	31.0
3. 30 Baht has 2 types of golden card, T and non T	296	93.7
4. Person holding T gold card has to pay 30 Baht when using hospital service.	279	88.3
5. National health insurance office is the main central unit for universal coverage to provide information allocate budget, monitor and registration	291	92.1
6. The government allocated the budget by capitation at the rate 1,308.50 Baht/person / year	299	94.6
7. Salary of staffs, budget for in and out patients, emergency and investment were included in capitation	234	74.1
8. Salary of the staffs were innitially isolated and kept at MOPH before reallocation to province.	259	81.9
9. MOPH allotted budget of 30 Baht to province and province allotted to CUP within 15 days	218	68.9
10. CUP received budget for running the activities of inside hospital PCU and outside hospital PCU.	292	92.4
11. CUP responsible for holistic health care of the people, including physical, mental & social- intern of integrated care (curation, promotion, prevention and rehabilitates)	305	96.5

Table 6 Distribution of correct answers to knowledge questions of thirty baht scheme. (cont.)

Knowledge statement	N=316	Percentage
12. District health officer, and team CUP committee consisted of director of district hospital and team	295	93.4
13. CUP committee had function to develop policy making decision and solving the problem of 30 Baht at district level	270	85.4
14. Primary Care Unit is the health service unit under population in responsible area.	112	35.4
15. Four main functions of Primary Care Unit are providing health service, conducting community survey, using family folders, coordinating community activities and home care.	285	90.2
16. Primary Care Unit received budget, drug supplies, medical supplies, technical assistance and counselling from CUP.	296	93.7
17. Primary Care Unit provided service 40 hours per week.	122	38.6
18. Primary Care Unit provided services to people of all age groups in responsible area except government officials	266	84.2
19. Family folder is fundamental need for collecting data of family members.	311	98.4
20. Family folder should update data every 3 years	109	34.5
21. 30 baht provide Ante natal care for pregnant women to get service at least 4 times before delivery	258	81.7

Table 6 Distribution of correct answers to knowledge questions of thirty baht scheme. (cont.)

Knowledge statement	N=316	Percentage
22. 30 Baht provide Immunization services for < 12 yrs old children to get vaccination on Polio, DPT, TB, Measle, Mump and Virus hepatitis B.	278	87.9
23. 30 Baht provide fundamental laboratory services at Primary Care Unit including CBC, U/A and stool Exam.	222	70.1
24. 30 Baht provide essential drug supplies at Primary Care Unit under the support of DH. and CUP.	309	97.8
25. 30 Baht provide dental care service at Primary Care Unit including filling, extracting, scaling and denture.	194	61.4
26. 30 baht provide follow up & continuing care for chronic patients including DM, hypertension at Primary Care Unit	300	94.9
27. Health personnels working at Primary Care Unit do not necessary knowing patients or their relatives.	244	77.2
28. Home care services is necessary for the patients who are inconvenient or unable to see the doctors at Primary Care Unit, they should be followed up and rehabilitated continuously at home.	303	95.9
29. The patients can be referred to any hospital in case that inquired higher knowledge, technique and skill for caring.	223	70.6
30. 30 Baht services do not covered 15 diseases	132	41.8

4.2.2 Level of total knowledge scores

Table 7 presented level of total scores of knowledge from 30 statements. The levels of total knowledge scores were divided into 3 levels. These are composed of greater than 80% or good, between 60-80% were fair, and lower than 60% were poor. The highest score was 99.4% the lowest score was 31.0%. Majority of health care providers had good and fair level of knowledge (52.6% and 46.8%) while only 0.6% had poor knowledge level.

Table 7 Level of knowledge on thirty baht scheme

Level of knowledge	N=316	Percentage
Good (>80%)	166	52.56
Fair (60-80%)	148	46.84
Poor (<60%)	2	0.63

Table 8 Distribution of correct answers to knowledge questions of thirty baht scheme classified by types of professional

Knowledge statement	Doc N=19	Den N=14	Phar N=21	RN N=221	TN N=41
1. 30 Baht is the government policy under universal coverage principle	19 (100)	14 (100)	21 (100)	219 (99.1)	41 (100)
2. Main objectives of 30 Baht is to provide the coverage of health insurance for the poor.	12 (63.2)	6 (42.9)	6 (28.6)	69 (31.2)	5 (12.2)
3. 30 Baht has 2 types of golden card, T and non T	19 (100)	13 (92.9)	20 (95.2)	204 (92.3)	40 (97.6)
4. Person holding T gold card has to pay 30 Baht when using hospital service.	14 (73.7)	13 (92.9)	20 (95.2)	202 (91.4)	30 (73.2)
5. National health insurance office is the main center unit for universal coverage to provide information allocate budget, monitor and registration	18 (94.7)	14 (100)	19 (90.5)	202 (91.4)	38 (92.7)
6. The government allocated the budget by capitation at the rate 1,308.50 Baht/person / year	18 (94.7)	10 (71.4)	18 (85.7)	213 (96.2)	40 (97.6)
7. Salary of staffs, budget for in and out patients, emergency and investment were included in capitation	11 (57.9)	8 (57.1)	13 (61.9)	171 (77.4)	31 (75.6)
8. Salary of the staffs were ininitially isolated and kept at MOPH before reallocation to province.	16 (84.2)	11 (78.6)	19 (90.5)	181 (81.9)	32 (78.1)
9. MOPH allotted budget of 30 Baht to province and province allotted to CUP within 15 days	15 (78.9)	4 (28.6)	17 (80.9)	154 (69.7)	28 (68.3)
10. CUP received budget for running the activities of inside hospital PCU and outside hospital PCU.	19 (100)	14 (100)	20 (95.2)	200 (90.5)	39 (95.1)
11. CUP responsible for holistic health care of the people, including physical, mental & social- interm of integrated care (curation, promotion, prevention and rehabilitates)	19 (100)	14 (100)	21 (100)	212 (95.9)	39 (95.1)

Table 8 Distribution of correct answers to knowledge questions of thirty baht scheme classified by types of professional (cont.)

Knowledge statement	Doc N=19	Den N=14	Phar N=21	RN N=221	TN N=41
12. District health officer, and team CUP committee consisted of district of district hospital and team	18 (94.7)	11 (78.6)	21 (100)	206 (93.2)	39 (95.1)
13. CUP committee had function to develop policy making decision and solving the problem of 30 Baht at district level	19 (100)	14 (100)	18 (85.7)	184 (83.3)	35 (85.4)
14. Primary Care Unit is the health service unit under CUP, providing service for 12,000 registered population in responsible area.	13 (68.4)	7 (50)	8 (38.1)	69 (31.2)	15 (36.6)
15. Four main functions of Primary Care Unit are providing health service, conducting community survey, using family folders, coordinating community activities and home care.	17 (89.5)	12 (85.7)	16 (76.2)	204 (92.3)	36 (87.8)
16. Primary Care Unit received budget, drug supplies, medical supplies, technical assistance and counselling from CUP.	19 (100)	13 (92.9)	20 (95.2)	205 (92.8)	39 (95.1)
17. Primary Care Unit provided service 40 hours week.	4 (21.1)	6 (42.9)	10 (47.2)	84 (38.0)	18 (43.9)
18. Primary Care Unit provided services to people of all age groups in responsible area except government officials	16 (84.2)	13 (92.9)	20 (95.2)	184 (83.3)	33 (80.5)
19. Family folder is fundamental need for collecting data of family members.	19 (100)	14 (100)	20 (95.2)	218 (98.6)	40 (97.6)
20. Family folder should update data every 3 years	9 (47.4)	7 (50.0)	6 (28.6)	69 (31.2)	18 (43.9)
21. 30 baht provide Ante natal care for pregnant women to get service at least 4 times before delivery	18 (94.7)	9 (64.3)	18 (85.7)	181 (81.9)	32 (78.1)

Table 8 Distribution of correct answers to knowledge questions of thirty baht scheme classified by types of professional (cont.)

Knowledge statement	Doc N=19	Den N=14	Phar N=21	RN N=221	TN N=41
22. 30 Baht provide Immunization services for < 12 yrs old children to get vaccination on Polio, DPT, TB, Measle, Mump and Virus hepatitis B.	18 (94.7)	13 (92.9)	18 (85.7)	197 (89.1)	32 (78.1)
23. 30 Baht provide fundamental laboratory services at Primary Care Unit including CBC, U/A and stool exam.	15 (78.9)	13 (92.9)	15 (71.4)	152 (68.8)	27 (65.9)
24. 30 Baht provide essential drug supplies at Primary Care Unit under the support of DH. and CUP.	19 (100)	14 (100)	21 (100)	215 (97.3)	40 (97.6)
25. 30 Baht provide dental care service at Primary Care Unit including filling, extracting, scaling and denture.	9 (47.4)	4 (28.6)	8 (38.1)	149 (67.4)	24 (58.5)
26. 30 Baht provide follow up & continuing care for chronic patients including DM, hypertension at Primary Care Unit	18 (94.7)	14 (100)	19 (90.5)	214 (96.8)	35 (85.4)
27. Health personnels working at Primary Care Unit do not necessary knowing patients or their relatives.	15 (78.9)	14 (100)	20 (95.2)	167 (75.6)	28 (68.3)
28. Home care services is necessary for the patients who are inconvenient or unable to see the doctors at Primary Care Unit, they should be followed up and rehabilitated continuously at home.	19 (100)	14 (100)	21 (100)	210 (95.0)	39 (95.1)
29. The patients can be referred to any hospital in case that inquired higher knowledge, technique and skill for caring.	15 (78.9)	14 (100)	13 (61.9)	153 (69.2)	28 (68.3)
30. 30 Baht services do not covered 15 diseases	8 (42.1)	6 (42.9)	3 (14.3)	99 (44.8)	16 (39.0)

The levels of total scores of knowledge classified by types of professional are summarized as table 8 below.

Table 9 Levels of total knowledge scores classified by types of professional

Types of professional	Level of total knowledge scores					
	Good		Fair		Poor	
	N	%	N	%	N	%
Doctors	11	57.9	8	42.1	-	-
Dentists	9	64.3	5	35.7	-	-
Pharmacists	12	57.1	9	42.9	-	-
Registered nurses	119	53.9	101	45.7	1	0.5
Technical nurses	18	43.9	22	53.7	1	2.4

4.3 Attitude HCP on 30 baht scheme

Table 10 below, display the attitude of 30 baht scheme among the health care providers. There are 38 statements with positive and negative attitude. The group was divided into 3 levels as follows:

Good attitude is score $> 140-190$ or accounted for 3.26%

Fair attitude is score $89-139$ or accounted for 86.7%

Poor attitude is score $\leq 38-88$ or accounted for 10.1%

The majority had fair attitude (86.7%), high attitude was accounted only 3.2% and low attitude was 10.1%. Scoring was done by adding of deducting the difference of maximum from minimum score and then divided into 3 levels as low attitude which was equal to minimum score \pm difference, fair attitude is equal to the minimum score ± 2 times difference and good attitude is minimum ± 3 times of difference.

4.3.1 Distribution of correct answers to attitude questions

Table 10 Attitude on thirty baht scheme

Attitude Statements	Percentage(N=316)				
	SA	A	N	D	SDA
1. 30 Baht under universal coverage of the Thai government is appropriate for Thai health care system	5.0	35.4	34.8	17.4	5.0
2. 30 Baht should not cover the rich	8.0	20.0	10.8	26.3	35.1
3. Reduction 1,308.50 Baht from personnel's salary, at central level, before payment, make the organization losing benefit.	6.3	17.4	36.1	21.8	8.4
4. Schedule of per diem payment for HCP is considered appropriates	6.96	30.7	25.6	24.1	12.7
5. Budget received from 30 Baht was adequate for providing hospital services	0.6	12.3	34.5	31.7	20.9
6. Information on 30 Baht were fairly disseminated within your organization	3.2	36.4	32.0	23.1	5.4
7. Allocation of manpower in your hospital was accorded to specified 30 Baht criteria	1.6	22.2	35.4	29.1	11.7
8. Your workload was after heavier after the hospital had launched 30 Baht	1.6	13.6	15.2	44.6	25.0
9. After 30 Baht was implemented your hospital was often under supplied of drugs	3.8	21.8	26.2	29.4	18.7
10. Many times that you had to change the kind and amount of drugs prescribed for patients due to 30 Baht	12.3	26.9	24.7	25.0	11.1
11. 30 Baht had facilitate a good team work	2.2	23.4	47.8	18.4	8.2
12. After launching 30 Baht you received many complaints and pethition about HCS.	5.1	28.8	28.2	26.9	11.1
13. 30 Baht had weakend the morality of HCP.	2.2	26.3	35.1	22.5	14.0

Table 10 Attitude on thirty baht scheme (cont.)

Attitude Statements	Percentage(N=316)				
	SA	A	N	D	SDA
14. 30 Baht had justified the staff promotion appropriately.	1.0	11.1	52.2	21.8	13.9
15. System practically difficult of referring patients to higher facilities under 30 was practically difficult.					
16. Working at Primary Care Unit or HC, under 30 Baht of the staffs was appropriately justified.	15.2	52.9	21.8	8.5	1.6
17. 30 Baht create overuse and over demand of services among patients.	0.3	13.6	14.9	44.0	27.2
18. Budget allocation under 30 Baht was justified	1.3	11.7	53.5	24.1	9.5
19. Welfare, per diem and compensation provided under 30 Baht were adequated and appropriated.	1.3	7.9	26.0	39.2	25.6
20. Evaluation of work achievement under 30 Baht was an appropriate and justified idea.	3.5	20.6	44.6	25.6	5.7
21. 30 Baht provide you a readiness to take care of patients.	1.3	27.9	34.8	29.1	7.0
22. Carried out of 30 Baht had increased the quality development for health care services.	2.5	36.1	28.8	24.7	8.0
23. Application of HA for organization development under the condition of 30 Baht created difficulty in practice.	6.3	23.7	19.3	35.1	15.5
24. 30 Baht reduced service time for patients care and decrease service quality.	6.7	31.3	26.6	27.2	8.2

Table 10 Attitude on thirty baht scheme (cont.)

Attitude Statements	Percentage(N=316)				
	SA	A	N	D	SDA
25. 30 Baht promoted better coordination between staffs of hospital and health center.	7.3	43.0	35.4	9.2	5.1
26. 30 Baht provided adequate supply of drug, equipment and instruments to give qualified services.	1.3	16.5	35.1	33.0	14.2
27. Referral Networking system of 30 Baht was generally appropriated.	2.2	36.7	32.0	21.2	8.0
28. 30 Baht provided working satisfaction for staffs.	1.0	21.2	43.7	26.9	7.3
29. 30 Baht contained continuous activities of organization development with clear written guidelines.	3.8	42.1	33.9	16.5	3.8
30. 30 Baht had clear manuals documentation system, management standard and working guidelines	5.7	39.2	30.7	18.7	5.7
31. 30 Baht facilitated efficiency, quality, equity and quality of service.	6.3	39.9	34.5	13.6	5.7
32. 30 Baht could not pay full rate of perdiem and overtime for the HCP.	7.9	15.5	21.8	26.6	28.2
33. Conducting 30 Baht enable you to better understand the strategies, goal and working guidelines of CUP and PCU.	5.4	40.2	32.9	16.8	4.8
34. 30 Baht facilitated the organization to have continuous coordination in providing HCS.	4.4	37.0	41.5	14.2	2.9
35. 30 Baht enable good and continuous system of supervision, monitoring & evaluation.	2.5	31.0	44.0	15.5	7.0
36. 30 Baht improved patient's satisfaction toward HCS.	3.8	16.5	29.0	33.5	17.0
37. 30 Baht increased cost of HCS more than the past.	1.3	11.4	19.9	47.1	20.3
38. 30 Baht increased workload for reporting and recording more than the past.					

4.3.2 Level of total attitude score

Table 11 represents the results of 38 statements of attitude of health care providers on 30 baht scheme. The results in these statements demonstrated that most of health care providers had fair attitude on 30 baht scheme.

Table 11 Number and Percentage of level of attitude on thirty baht scheme

Level of attitude	N=316	Percentage
Good (140-190)	10	3.2
Fair (89-139)	274	86.7
Poor (38-88)	32	10.1

Regarding attitude of 30 baht scheme from the table the result showed that most of health care providers had fair level of attitude on 30 baht scheme at 86.7% and good level of attitude was at 3.2%.

Table 12 Level of total attitude scores classified by types of professional

Types of professional	Level of total attitude scores					
	Good		Fair		Poor	
	N	%	N	%	N	%
Doctors	0	0	12	65.2	7	36.8
Dentists	0	0	14	100	0	0
Pharmacists	0	0	18	85.7	3	14.29
Registered nurses	8	3.6	195	88.2	18	8.1
Technical nurses	2	4.9	35	85.4	4	9.8

The item consisted of four questions with yes or no answer. Majority of referral system by coordination to high facility hospital make rapidly to taken care the patient was 88.61%, the lowest one was higher facility hospital can suddenly take care patient when ambulance send patient arrived at the hospital accounted for 84.81%.

4.4 Acceptance of 30 baht scheme

Table 12 represents the result of acceptance of 30 baht scheme. It found to be very low in six items. The lowest acceptance was on weakness of organization budget and the security of financial status, accounted for 17.7%, the second lowest was regarding budget allocation 1,308.50 baht /person /year is enough number constituted at 18.04%. The third order was the rate of payment for medical service which was accounted for 25%.

Table 13 Acceptance of 30 baht scheme

Acceptance statements	N = 316	Percent
1. Policy of charging 30 B from patients as co-payment for golden card is right.	237	75
2. Allocation of budget by capitation is appropriate .	167	52.85
3. Allocation of budget at 1308.50 Baht/capita/year is sufficient.	57	18.04
4. Reserving salary at central level in order to use for sharing for other provinces is appropriate.	139	43.99
5. Consumers's ability to freely choose their registration at any hospital is a right approach.	228	72.15
6. Setting up PCU in the hospital is appropriate.	204	64.56
7. Sending Doctor, dentist, Pharmacist, and Nurses to work at PCU is appropriate.	252	79.75
8. Compensation rate for Doctor, Dentist, Pharmacists, and Nurses both on duty and off duty under 30 Baht is appropriate.	79	25
9. One PCU responsible for 10000 population is practicable .	170	53.80

Table 13 Acceptance of 30 baht scheme (cont.)

Acceptance statements	N = 316	Percent
10. Set up health team with the number of team number for PCU is practicable.	135	42.72
11. Including external resources and NGO to be PCU Broad members is proper idea	187	59.18
12. Networking of referral system in 30 Baht is a good management.	257	81.33
13. Information Communication and Technology system of the hospital enable speedy services.	229	72.93
14. Set up PCU outside the hospital decreasing the number of patients.	175	55.38
15. Using family folder in the hospital had facilitated the work.	205	64.87
16. Engaging Doctors, Dentist, Pharmacists, and Nurses in Preventive, Promotive and Rehabilitative activities is appropriate.	293	92.72
17. 30 Baht increased the number of patients to hospital .	253	80.57
18. Application of HA had improved the quality of service.	272	86.08
19. 30 Baht had increased the budget for patient's service and hospital's financial status.	56	17.72
20. Core package of benefit that does med. senia for patients with chronic kidney failure and AIDS is justified.	144	45.57

The total acceptance scores were summarized and classified into 2 groups using the median score (median = 12) as a cutoff point. The two groups were those who had score equal or less than 12 scores and the other group was equal or more than 12 scores. The results is presented in table 13.

Table 14 Level of Acceptance on thirty baht scheme

Level of acceptance	N= 316	Percentage
≤ Median (≤12 score)	185	58.54
> Median (13-20 score)	131	41.46

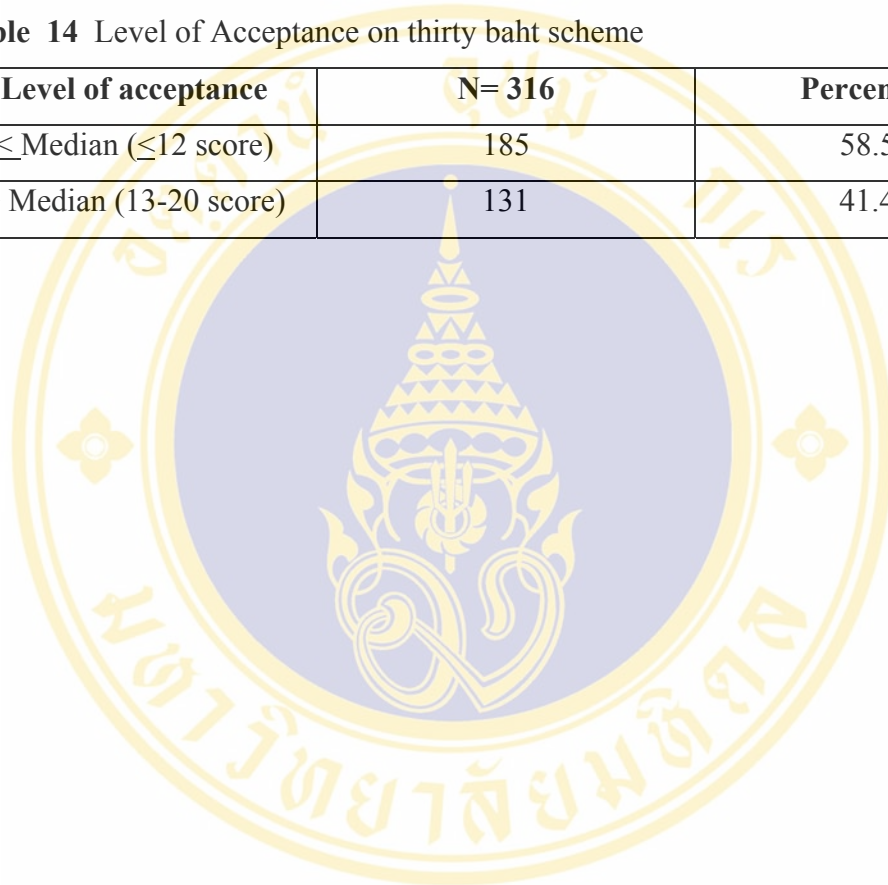


Table 15 Acceptance of 30 baht scheme

Acceptance statements	Doc	Den	Phar	RN	TN
	N=19	N=14	N=21	N=221	N=41
1. Policy of charging 30 B from patients as co-payment for golden card is right.	14 (73.7)	8 (57.1)	18 (85.7)	165 (74.7)	32 (78.1)
2. Allocation of budget by capitation is appropriate .	9 (47.4)	7 (50.0)	7 (33.3)	121 (54.8)	23 (56.1)
3. Allocation of budget at 1308.50 Baht/ capita/year is sufficient.	1 (5.3)	1 (7.1)	5 (23.8)	37 (16.7)	13 (31.7)
4. Reserving salary at central level in order to use for sharing for other provinces is appropriate.	6 (31.6)	6 (42.9)	8 (38.1)	97 (43.9)	22 (53.70)
5. Consumers's ability to freely choose their registration at any hospital is a right approach.	7 (36.8)	13 (92.9)	13 (61.9)	166 (75.1)	29 (70.7)
6. Setting up PCU in the hospital is appropriate.	10 (52.6)	10 (71.4)	8 (38.1)	147 (66.4)	29 (70.7)
7. Sending Dr., dentist, pharmacist, and nurse to work at PCU is appropriate.	11 (57.90)	10 (71.40)	21 (38.10)	177 (80.1)	33 (80.5)
8. Compensation rate for Doctor, Dentists, Pharmacists, and Nurses both on duty and off duty under 30 Baht is appropriate.	5 (26.3)	5 (35.7)	6 (28.6)	52 (23.5)	11 (26.8)
9. One PCU responsible for 10000 population is practicable .	14 (73.7)	9 (64.3)	13 (61.9)	108 (48.9)	26 (63.4)
10. Set up health team with the number of team number for PCU is practicable.	7 (36.8)	4 (28.6)	8 (38.1)	94 (42.5)	22 (53.7)
11. Including external resources and NGO to be PCU Broad members is proper idea	9 (47.3)	11 (78.6)	14 (66.7)	130 (58.8)	23 (56.1)

Table 15 Acceptance of 30 baht scheme (cont.)

Acceptance statements	Doc N=19	Den N=14	Phar N=21	RN N=221	TN N=41
12. Networking of referral system in 30 Baht is a good management.	14 (73.7)	11 (78.6)	18 (85.7)	181 (81.9)	33 (80.5)
13. Information Communication and Technology system of the hospital enable speedy services.	15 (78.9)	8 (57.1)	16 (76.2)	159 (71.9)	31 (75.6)
14. Set up PCU outside the hospital decreasing the number of patients.	12 (63.2)	5 (35.7)	9 (42.9)	120 (54.3)	29 (70.7)
15. Using family folder in the hospital had facilitated the work.	13 (63.2)	11 (35.7)	11 (42.9)	142 (64.3)	28 (68.3.7)
16. Engaging Doctors, Dentists, Pharmacists, and Nurses in Preventive, Promotive and Rehabilitative activities is appropriate.	18 (94.7)	14 (100.0)	20 (95.2)	204 (92.3)	90.2 (37)
17. 30 Baht increased the number of patients to hospital .	18 (94.7)	11 (78.6)	21 (100.0)	168 (76.0)	35 (85.4)
18. Application of HA had improved the quality of service.	16 (84.2)	12 (85.7)	20 (95.2)	189 (85.5)	35 (85.4)
19. 30 Baht had increased the budget for patient's service and hospital's financial status.	3 (15.8)	4 (28.6)	1 (4.8)	41 (18.6)	7 (17.1)
20. Core package of benefit that does med. senia for patients with chronic kidney failure and AIDS is justified.	10 (52.6)	4 (28.6)	11 (95.2)	102 (46.2)	17 (41.5)

Table 16 Number and Percentage of level of acceptance on 30 baht scheme by types of professional

Types of professional	Level of Acceptance			
	≤ median score		> median score	
	N	%	N	%
Doctors	6	31.6	13	71.4
Dentists	4	28.6	10	66.7
Pharmacists	7	33.3	14	57
Registered nurses	93	42.1	128	9
Technical nurses	21	51.2	20	48.8

4.4 Acceptance of 30 baht scheme

Table 16, 17, 18 and table 19 showed details of relationship between characteristics of the respondents and acceptance of 30 baht scheme by using Chi-square test and Spearman rank correlation. From the Chi-square test there were no variables to be related with the acceptance level. While the result from the Spearman rank correlation, it was found that duration of working years in 30 baht scheme was positively related to acceptance of them with p-value = 0.006. Although the value of correlation coefficient was low ($r = 0.153$). It reflected that among the health providers who worked under the 30 baht scheme longer had higher acceptance than those who work less long period. Where as duration of total working was not related to their acceptance score.

Table 17 Health care provider characteristics by level of acceptance on 30 baht scheme

Variables	Level of acceptance				χ^2 -test	p-value
	High		Low			
	No.	%	No.	%		
Sex					0.27	0.619
Male	27	57.5	20	42.6		
Female	144	53.5	125	46.5		
Marital status					1.262	0.532
Single	85	53.8	73	46.2		
Married	77	53.1	68	46.9		
Divorced	9	69.2	4	30.8		
Personal types					0.005	0.942
Government officer	108	54.3	91	45.7		
Government Employee	63	53.9	54	46.2		
Education level					1.450	0.484
Diploma	24	63.2	14	36.8		
Bachelor	143	53.0	127	47.0		
Higher than Bachelor	4	50.0	4	50.0		

Table 18 Health care provider characteristics by level of acceptance

Types of professional	Level of Acceptance				χ^2 - test	p-value
	High		Low			
	N	%	N	%		
Doctors	6	31.6	13	68.4	3.9	0.414
Dentists	4	28.6	10	71.4		
Pharmacists	7	33.3	14	66.7		
Registered nurses	93	42.1	128	57.9		
Technical nurses	21	51.2	20	48.8		

Table 19 Correlation coefficient between characteristic of health Care Provider and acceptance of 30 baht scheme

Variables	Acceptant correlation coefficient (r)	p-value
Age	0.008	0.888
Income	-0.036	0.527
Working years in government service	0.014	0.810
Working years under 30 baht scheme	0.153	0.006
Number of patient per day	0.049	0.383

CHAPTER V

DISCUSSION

The results revealed that level of acceptance of 30 baht scheme related to working years under 30 baht scheme and it did not relate to age, sex, marital status, employee types, professional types, workload by number of patient per day, working years of experiences as government service.

Thirty baht scheme in Thailand had established on April 1st, 2003 and after 2 months, Sakaeo Province followed this program and started to launch the program on 1st June in the same year to cover all 9 districts among 6 community hospitals and 1 military hospital.

At the beginning, the 30 baht scheme had conducted among all of the hospitals in Sakaeo Province. It was found some obstacles when launching this project due to its has launched very quickly after 6 months of the new government policy was established to create universal coverage for all Thai citizen. The main problems were toward shortage of health care providers, scarcity of budget, and lack of performance-based system for management. The most important issue was the low level of understanding and coordinating of the program among the health care providers in Sakaeo Province. However, the method to solve problems occurring during this program has been launching was based on problem-based solving process. After the final solution and appropriate way to manage were identified then these solutions were adapted as the strategic management after implementation.

Conventional approach for health care system management in the past decades was distinguishably among the management of human health resources, budget, and other financial support to provide the health services. But after the 30 baht scheme has been

launching, this new scheme affected total changes in the newly system of management of 30 baht scheme in order to achieve the goal of universal coverage. The new scheme was holistic approach to manage all relevant aspects together especially the human health resources with the financial resources. This study was performed to assess the acceptance of 30 baht scheme among health care providers at community hospitals in Sakaeo Province to identify the level of acceptance. In addition, some important factors associated with level of acceptance of this program such as socio-demographic characteristics, types of professional, knowledge, attitude, number of patients per day, years of working experiences and years of working under the 30 baht scheme.

5.1 The acceptance of 30 baht scheme among health care providers

The acceptance of 30 baht scheme among the health care providers revealed that the percentage of higher than median score and equal or lower than median score among the respondents were nearly equal (41.5% and 58.5%). In addition, it was found that nobody do not accept this program. The finding indicated that even though the health care providers found some difficulty to manage on the new system but most of them still having positive thinking toward this system. Because all benefits are directly affected to the target population and most of them try to provide the service best as they can.

In this study, the results found that there was only one factor related to acceptance of 30 baht scheme. This factors was working years of experiences under the 30 baht scheme. However, acceptance of 30 baht scheme was not related with age, sex, marital status, employee types, professional types, workload by number of patient per day, and working years of experiences as government service.

5.2 Factors related to acceptance of 30 baht scheme

5.2.1 General Characteristics

Most of health care providers under thirty baht scheme were female (85.1%), age groups 20-29 years old (57.3%), single (50%), the employment status as government officer (63.0%), type of professional as registered nurses (69.9%), having bachelor degree background (85.5%). In addition, most of them having income 10,000-20,000 baht/ month (48.7%), having years of working experiences as the government officers less than 10 years (64.6%) and most of them work at the beginning of 30 baht scheme (57.6%) in Sakaeo province. These findings were found to be similar with the study of T.D. Foman-eg (32) which was studied on the knowledge and attitude of the 30 baht scheme among the medical and nursing staff of the community hospital in Supan buri province in 2002. In the study of T.D. Foman-eg, it was found that most of the respondents were female (91.4%), age group 20-39 years old (77.9%), most of them were registered nurses (92.7%), and having bachelor degree (79.2%).

5.2.2 Knowledge of the health care providers on 30 baht scheme.

Regarding knowledge of the health care providers about 30 baht scheme, it revealed that slightly more than half of them (52.6%) had a good knowledge level and only 0.6% had low knowledge level. This finding was different from the study done by T.D. Foman-eg which was found that the knowledge of the study group were high level (11%) where as the poor level was found 9.2% but the remaining was accounted as fair level (77.3%).

5.2.3 Attitude of the health care providers on 30 baht scheme

The results of attitude of health care providers on 30 baht program revealed that the percentage of good attitude was 3.2% and fair attitude was 86.7%. This finding was similar to the study of T.D. Forman-eg which was found that the attitude of the medical and nurses in Supanburi province toward the 30 baht scheme was fallen into the fair group (65.6%) while the high groups was accounted only 16.6%. In addition, in this present study, it was found that the total attitude score was not related to acceptance of 30 baht scheme. While comparing among different types of professional, it was found to be

significant different with p-value =0.024 among the doctors. The level of attitude among the doctors was found to be in the fair and groups with no cases found in the high attitude level group. Among other groups, it was no significant different. This may reflect that among those doctors they had lower attitude score compared to other groups because of the new scheme may influence more tasks and responsibilities among them. Most of doctors have their patient per day approximately 80 cases per day that might let them have more workload and less acceptance score on this scheme.

5.2.4 Acceptance of health care providers on 30 baht scheme

The acceptance of health care providers on the 30 baht scheme was summarized that the percentage found among those who had acceptance score equal or less than median score and those who had score more than median score were accounted as 58.5% and 41.5%. The findings shown that among the target population their acceptance toward 30 baht scheme was low because the median score was found to be 12 scores compared to total 20 score or accounted for 60%. This indicated that the new scheme may affect the health services at the community hospital which induced more adaptation of the health care providers to work under this system. Regarding the acceptance statement on the budget allocation for 1308.5 baht/person/year is enough number, most of them did not accept to this statement because it was found only 18% to accept on this viewpoint. For other statements like to exclude salary at the MoPH is appropriate (43.9%); payment rate of medical services to doctors; dentists, pharmacists and nurses is appropriate (25%); health team preparation to work is enough number for the standard of 30 baht scheme (42.7%); thirty baht scheme increases your organization budget and security of financial status (17.7%) and core package of benefit for medical of 30 baht scheme does not cover chronic renal failure and AIDS is appropriate (45.5%), most of them where found to be lower percentage of acceptance or less than 50%. This phenomenon may indicate that most health care providers did not accept on the method of financial management under the 30 baht scheme especially the insufficiency support from the government. Most of them found to be insecure when working under the new

scheme. In addition, the newly system on performance-based budgeting system induce health care provider to pay more attention on their work and financial reports. They must plan and perform their tasks based on the performance-based system. Moreover, they need to be under the new evaluation system based on their performance recording system. (21) which might let them felt low acceptance on the 30 baht scheme.

5.2.5 Acceptance on 30 baht scheme by socio-demographic characteristics, knowledge, attitude, types of professional, working years of experiences, working years of experiences under 30 baht scheme and number of patients

It was found that the socio-demographic characteristics of the respondents were not related to the level of acceptance. This may explain as the reason that the socio-demographic characteristics was not the factors that influenced the acceptance of the health personnel on the 30 baht scheme but the other important factor was the types of professional. It was found that among the doctors, all of them had their acceptance score lower than other professional types. It might due to their workload and responsibility under the new scheme because when compare their patient per day to be response, among them were found to be greater than dentists and nurses. While concerning the working years under 30 baht scheme, it was found to be positive correlated with total acceptance scores even though the correlation coefficient was found to be low. This result indicated that the more the time they had been working, the more they would satisfy and try to adapt themselves to work under this scheme better than those who were beginning to work under this scheme. This explanation may explain by the study done by Suwanna L. (32) which found that among the nurses who had been working longer time, the more satisfaction was being found and more adaptation of themselves with their work compared to those who had less working time.

CHAPTER VI

CONCLUSION AND RECOMMENDATION

6.1 Conclusion

This study was a cross-sectional study aimed to assess the acceptance of 30 baht scheme among the health care providers at 6 community hospital in Sakaeo Province, Thailand. The data was obtained by using a self-administered questionnaire among 316 health care providers during February 1-14, 2004. The health care providers composed doctors, dentists, pharmacists, registered nurses and technical nurses.

The results revealed that majority of them were fallen into the age group 20-29 years old (57.3%) with the mean average 32 years old (SD = 8), most of them were female (85.1%), half of them were single (50.0%), more than half (63.0%) were government officers.

Regarding types of professional, majority of them (69.9%) was registered nurses. While their education background was found most (85.5%) as Bachelor degree. Their monthly income was found most between 10,000-20,000 baht (48.7%) with the mean average 15,380 baht per month (SD = 8421). Most of them had their working years of experiences as health care providers less than 10 years (64.6%) with the average years of working equal to 9.7 years (SD = 8.4). While the working years of experiences under the 30 baht scheme was found most (56.7%) among those who work for 3 years with average years of working under the 30 baht scheme was 1.9 years (SD = 0.98)

Regarding their knowledge on 30 baht scheme, it was found that majority of them had good and fair level of knowledge (52.6% and 46.8%) while only 0.6% had poor knowledge level.

When concerning their attitude toward 30 baht scheme most of health care providers (86.7%) had fair level of attitude on 30 baht scheme.

Regarding the respondents' acceptance score, it was found that more than half of them (58.54%) had their acceptance score equal or less than 12 score or accounted for equal or less than 60% of the total score.

6.2 Recommendation

6.2.1 Recommendations for action

1) Sakaeo public health office should improve the attitude of health care providers in the hospitals to enhance more cooperation from health care providers who have been working under 30 baht scheme.

2) Supervision, monitoring and evaluation of 30 baht scheme should be conducted regularly and planned as the year plan of the provincial health office in order to increase more efficiency of work and increase motivation to work among the target group.

3) For the new graduated and young staff, the provincial health office should support the readiness of their knowledge before working under the new scheme. This support may done through the arrangement of new staff orientation meeting on 30 baht scheme. This orientation may improve their knowledge and enhance their attitude toward the 30 baht scheme and on their job which will be benefit on their job performance in future.

4) More coordination among the health service system regarding all levels from central level, provincial level, and district level. This coordination may done through the supporting on financial management, human resources management, health service problem solving process. In addition, more coordination should be conducted among those related organizations such as Tambon Administrative Organization (TAO) Committee, municipality, Provincial Administrative

Organization (PAO) or other mass organization and change agents at the community level.

5) Sakaeo Public health office should realize about the importance of health care providers. The better understanding, the satisfaction and acceptance will make sustainable of this 30 baht project. When the health care providers are satisfied with their job and the support to run the 30 baht project, then this project will be sustained and expand to cover among the target population, and more improvement in the quality of services will be achieved in the nearby future.

6.2.2 Recommendation for further research

1) Further study on factors related acceptance of 30 baht scheme among health care providers at provincial or regional hospitals because in this study the target groups were difference in their characteristics and may difficult to verify the real picture of the acceptance. So in the next study, it should be conducted among specific type of the health care providers especially all doctors in Sakaeo province.

2) Further study should be conduct by using other method of data collection such as in-depth interview or focus group among the specific group of health care provider to identify more details of factors related their acceptance on the 30 baht scheme.

3) The impact of 30 baht scheme among health care provider should be conducted to evaluate for long term effects of this project in order to use as a guideline to improve the policy, strategic plan and management of the project.

4) Further study on the expectation and satisfaction of health care provider on 30 baht scheme. The outcome may help for appropriate planning of health manpower in organization in future.

5) Evaluation and standardization of Primary Care Unit on 30 baht scheme in Sakaeo Province should be done to assess the achievement of 30 baht scheme in

this province. This result will be use for further management of this project and use as a baseline information for the MoPH how to improve 30 baht policy in future.



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APPENDIX A

QUESTIONNAIRES

This questionnaire is a part of study of MPH M Mahidol University. There are 4 groups of health care providers to answer: doctors , dentists, pharmacists, and nurses who are working at community hospital under 30 baht scheme. Please fill in the blank that you choose. Thank you for your coordination.

- PART 1 Socio-demographics data
- PART 2 Knowledge of 30 baht scheme
- PART 3 Attitude of 30 baht scheme
- PART 4 Acceptance of 30 baht scheme

Socio-demographic data

- 1) Age.....Years
- 2) Gender
 - Male Female
- 3) Personal Types
 - Government officer Government Employee
- 4) Marital Status
 - Single Married
 - Widow Divorced / Separated
- 5) Occupation
 - Doctor Dentist
 - Pharmacist Registered Nurse Technical Nurse
- 6) Income (Include special income from your hospital).....Baht/ Month
- 7).Educational Level
 - Below Bachelor Degree Bachelor Degree Higher Bachelor Degree
- 8).Years of official WorkingYears Months
- 9).Years of working of 30 Baht schemeYears.....Months

PART 1 Knowledge of thirty baht scheme

Please fill ✓ if the statement is correct

Please fill × if the statement is wrong

- 1. Thirty baht scheme is government policy under universal coverage
- 2. The objective of 30 baht scheme is mainly for the poor.
- 3. 30 baht scheme there are Two types of gold cards with and without co-payment
- 4. The client without co-payment when using the medical services at the hospitals must pay 30 baht
- 5. The National health insurance office is the center at the central level has its main duties for information system, budget allocation, monitoring and registration
- 6. Government set the budget by capitation 1,308.50 baht/person / year
- 7. Salary, OPD, inpatient, emergency cases and capital all of them include capitation
- 8. Salary of health personal is exclude at the Ministry of public health and after that allocated to provincial level
- 9. Provincial level should allocated the 30 baht scheme budget to CUP in 15 days
- 10. CUP received budget for running the activities of inside hospital PCU and outside hospital PCU.
- 11. CUP has duties to take care with holistic approach by physical , mental and social and integration with curative health promotion, curative and treatment, prevention and control disease and rehabilitation
- 12. CUP has the district committee consists of director of community hospital, chief of district public health officer and from district public health office and community hospital
- 13. CUP committee has duty for define policy ,making decision and solve problems of 30 baht scheme at the district level
- 14. Primary Care Unit is the service unit for registered 12,000 population under CUP in its catchment area

-15. Primary care Unit has 4 main function community coordination and activity participation, community survey by use family folder and home health care
-16. Primary Care Unit got budget ,drugs medical supply,technical and supervision from CUP
-17. Open hours of primary Care Unit must be 40 hours/ week
-18 Primary Care Unit has the service for every age group except the government officer in its catchment area
-19. Family folder is fundamental need for record data in every households
-20. Family folder should be updated data every 3 years
-21. 30 baht scheme services for pregnant women at least 4 times before delivery
-22. 30 baht scheme services vaccine for children consists of polio, diphtheria, pertussis, tetanus BCG, Measles, Mumps, Viral Hepatitis B, for children under 12 years
-23. 30 baht scheme services for fundamental laboratory at Primary Care Unit; CBC, U/A, and stool exam
-24. 30 baht scheme has PCU which prepared essential drugs for patient by supporting from community hospitals and drugs items define
-25. Services of 30baht scheme for dental at Primary Care Unit is filling, extraction scaling and artificial teeth
-26. Services of 30 baht scheme for chronic diseases are Diabetes Mellitus, Hypertension should get medicine and follow up at Primary Care Unit
-27. Health Care Providers at Primary Care Unit no need to know the patient and relatives.
-28. Home health care is important activity for cases who does not convenience to meet doctors at Primary Care Unit because they have disability or must continue follow up and rehabilitation.
-29. Some patients who use services at Primary Care Unit can be send the patient to any hospitals for the diseases that must use knowledge and special care.
-30. 30 baht scheme is has not cover to take care 15 diseases

PART 3 Attitude on thirty baht scheme

Please fill / in the blank behind the statements that you choose.

5 = Strongly Agree 4 = Agree 3 = Not Sure 2 = Disagree 1 = Strongly Disagree

No.	<u>Statements</u>	5	4	3	2	1
1	30 Baht under universal coverage of the Thai government is appropriate for Thai health care system					
2.	30 Baht should not cover the rich					
3.	Reduction 1,308.50 Baht from personnel's salary, at central level, before payment, make the organization losing benefit.					
4.	Schedule of per diem payment for HCP is considered appropriate					
5.	Budget received from 30 Baht was adequate for providing hospital services					
6.	Information on 30 Baht were fairly disseminated within your organization					
7.	Allocation of manpower in your hospital was accorded to specified 30 Baht criteria					
8.	Your workload was after heavier after the hospital had launched 30 Baht					
9.	After 30 Baht was implemented your hospital was often under supplied of drugs					
10.	Many times that you had to change the kind and amount of drugs prescribed for patients due to 30 Baht					
11.	30 Baht had facilitate a good team work					
12.	After launching 30 Baht you received many complaints and pethition about HCP.					

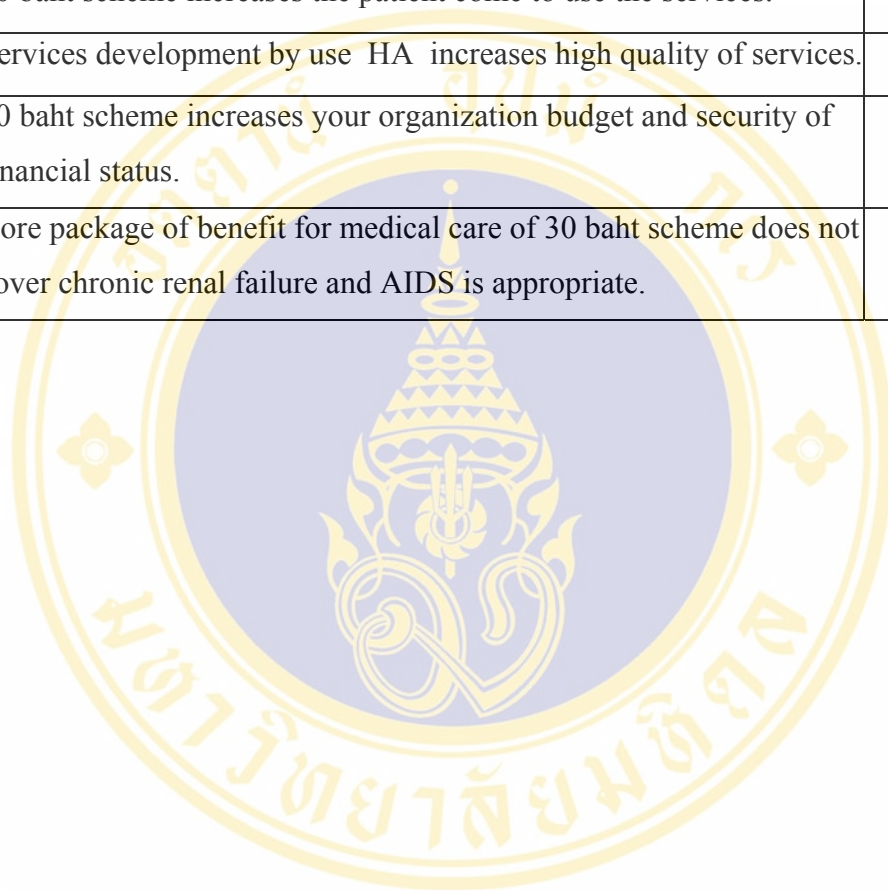
No.	<u>Statements</u>	5	4	3	2	1
13.	30 baht scheme makes the health care provider lack of motivation to work					
14.	30 baht scheme has made to making decision improve appropriate and justice to give the reward of working for health care providers					
15.	Referral system of 30 baht scheme from your hospital to higher facility hospital has not convenience difficulty when sending the patient .					
16.	To work at Primary Care Unit or go outside the hospital to work at the health center is appropriate to practice for health care providers.					
17.	30 baht scheme makes the patient overuse services and they often ask for their want which need to do.					
18.	It is justice enough for budget allocation to your hospital.					
19.	Welfare ,benefit, and your income of 30 baht scheme is enough and justice for you.					
20.	The method of measurement out come for your work is the appropriate concept and justice for you.					
21.	30 baht scheme makes you ready to take care patient and good services.					
22.	30 baht scheme makes you to have increase more quality of curative development .					
23.	To use HA in you organization development of 30 baht scheme make difficulty on your work.					
24.	30 baht scheme makes you have less time to take care patient and less quality of medical services					
25.	30 baht scheme makes good coordination between the personal of community hospital and health center personal					

No.	<u>Statements</u>	5	4	3	2	1
26.	30 baht scheme makes good quantity and quality of drugs, medical supply, and medical equipment enough for services.					
27.	Referral system of 30 baht scheme is appropriate in your province.					
28.	30 baht scheme makes the health care providers satisfaction to work.					
29.	30 baht scheme has activity for organization development and clear document guidelines.					
30.	30 baht scheme has handbooks document system and standardization of working guidelines.					
31.	30 baht scheme has the quality equity and justice of medical services					
32.	30 baht scheme you cannot get the full rate of payment day work and overtime.					
33.	30baht scheme you know the goal ,strategies and guidelines of CUP and Primary Care Unit					
34.	30 baht scheme makes you organization to have good coordination to take care the patient continuous.					
35.	30 baht scheme has good system of supervision , monitoring and evaluation					
36.	30 baht scheme has increase patient satisfaction the services					
37.	30 baht scheme increase cost more than the past.					
38.	30 baht scheme increases the report more than the past.					

Part 4 Acceptance of 30 baht sheme Please fill / in the blank that you choose behind the statement .

No.	Statements	Yes	No
1.	Payment 30 baht policy for co-payment of gold card patient is correct.		
2.	Calculation budget by use capitation of population is appropriate method.		
3.	Budget allocation 1308.50 Baht / person /year is enough number		
4.	To exclude the salary at the Ministry of Public Health and allocation to the other province is the appropriate method.		
5.	Freedom for the people to choose the registered unit is the correct method.		
6.	To established Primary Care Unit in the hospital is appropriate.		
7.	Doctors, Dentists, Pharmacists and Nurses go outsides hospital to work at Primary Care Unit is appropriate.		
8.	Rate of payment for medical services to doctors, dentists , Pharmacists and Nurses daytime and night time is appropriate.		
9.	Primary care unit responsibility in its catchment area is 10000 which can do this.		
10.	Health team preparation to work is enough number for the standard of 30 baht scheme.		
11.	The outsiders or non government come to be the CUP board committee to join with public health officer is appropriate.		
12.	To set referral network of 30 baht scheme is appropriate.		
13.	Information and technology system make medical service patient more quickly.		
14.	Primary Care Unit set outside hospital decrease the number of patient to the hospital.		
15	Family folder use in hospital make your work more convenience.		

No.	Statements	Yes	No
16.	Doctors, Dentists, Pharmacists and Nurses work with health promotion, prevention and control diseases and rehabilitation as well as curative and treatment should be done.		
17.	30 baht scheme increases the patient come to use the services.		
18.	Services development by use HA increases high quality of services.		
19.	30 baht scheme increases your organization budget and security of financial status.		
20.	Core package of benefit for medical care of 30 baht scheme does not cover chronic renal failure and AIDS is appropriate.		



BIOGRAPHY

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