CHAPTER II

LITERATURE REVIEW

1. Introduction

The literature review is based on the evolving health care reforms in the world and the Thai Heath Care System in particular that express the major changes in the face of increasing health care cost against the backdrop of socio-economic transition. Most of the countries, especially those in the developing ones, had to respond to the economic changes and devise a mechanism to contain the cost of health care. Health sector is a social sector and involves a huge sum of money, for which every government had to worry.

Similarly, Thailand had constant changes in the way the health care system was managed financially and structurally ever since the modern heath care came into being. The Thai Government tried and still tries to put its best effort to provide health care to everyone in the best possible manner. Thus, it has been estimated that more than 70 % of population are within reach of the health care system through various health insurance schemes. There are health insurance schemes that cover poor, elderly, handicapped, children, government servants, and other employers. Owing to insufficient health coverage among some population, Prime Minister Taksin's government endorsed a policy of universal health coverage in early 2001.

The literature, mostly, explored the main theme of this study, namely utilization and satisfaction. One or two studies have been carried out to see the satisfaction of people regarding the new method of accessing health care in hospitals. Although coverage of the new scheme is 100% all over the country, it is too early to determine the long-term effect of it. This study covers some studies done on the 30-Baht policy and literature on satisfaction and utilization.

2. Health Care Financing Policy

Health is important for all to live happily. Health care is a fundamental right for human's well being; everyone has the right to free from pain and suffering, and health care produces health that supports a healthy and good life. Although health care is the basic necessity for all, not every person can afford or have access to it. Thus, it becomes the responsibility of the government to devise a health care system and its sustainable financing mechanism to make health care available by everyone. But, Bobadilla et. al, (1994) said honestly that no country in the world can provide health services to meet all the possible needs of the population. Due to the past decades of economic, demographic, epidemiological, socio-cultural and political changes, people's health needs have changed too, posing a big challenge to the financing of health care. Financing health care received attention internationally, particularly in the developing world (Goodman and Waddington, 1993). Economic crises led to widespread decline in the economic performance of many low-income countries. These forced them to undergo an economic stabilization and structural adjustment. Health care reform was high on the policy-making agenda in many countries in 1990s (Goodman and Waddington, 1993).

Many countries in the world feel the health sector reforms necessary, as expenditure on the health care is high and quite unsustainable at many occasions. And with this view in mind, health reforms are underway in many countries as governments and donors seek to meet the needs of rapidly changing populations and health needs. In theory, health reforms are intended to decentralize health systems, reduce bureaucracy, and increase cost-effectiveness and efficiency, streamlining management and allocating resources to better meet health needs. Such reforms in the long run ensure equity, access to care, quality of services, efficiency in use of resources, and assure financial sustainability. Even a small Himalayan country like Bhutan, where the health care is completely free, is going to introduce an alternative mechanism for financing health care such as user fees (Bhutan Vision 2020, 2000).

"Health care financing" is any feasible approaches used to mobilize funds for health care. Hsiao et al (2000) says that health care financing is a means to an end; an instrument chosen to achieve specific societal goals. And health care financing policy has a significant impact on the structure and organization of health care delivery. It

also determines who will have access to basic health care, what services are offered and their quality. Thus, it is also a major determinant of whether a society provides equal access to basic health care for its people. The extent of financial resource mobilization depends upon health care financing policy. Financing is the principal instrument with which to determine resource flows, distribution of resources and incentive structures for health providers (Hsiao, 2000). But how much to spend on health care depends, as cited by some studies, on health conditions of people, nutritional status, educational attainment, and availability of resources.

Health care financing mechanisms provide an understanding of alternative health care reform strategies. The mechanisms such as taxation, trust fund, social insurance, user fees etc. are used in designing alternatives for government health care financing.

Everyone in government thought reform was the answer for the burgeoning health care expenditures. But health care systems differ enormously across countries, in particular according to a nation's socio-economic development. What works in UK may not work in Tanzania. That is why Peet (1991) puts it pessimistically that reform was taken as a fancy experiment to work with, not knowing whether ideas started somewhere else would bring the same effect. Certain financing mechanisms successfully applied in one country could not work in some other countries due to difference in context. When a nation adopts a particular financing approach, it often changes the access to health care for particular population groups and frequently transforms the organization of health care delivery. But Wagstaff et al. (1993) noted that some researches carried out in countries like Britain, Sweden, the US, the Netherlands etc have done much to increase the awareness of international differences and similarities in health care financing and delivery system, enhancing understanding about one's situation and deciding for adoption of financing health care policy.

Policy makers in European countries had the notion that all citizens should have access to health care. Denmark's policy statement says "access to health care in the event of illness ought to be open automatically to the whole population" or Franch health policy states that "the Nation guarantees to everyone the protection of health". Access gives people the opportunities to receive health care.

3. Thai Health Care System

Thailand experienced many changes in the health care system over the past centuries. Crude medical herbs in the Sukothai period to Indian Ayurveda and Chinese traditional medicine principles were used to heal diseases and sickness (MoPH, 2002). Western medicine came only in 1828 during the reign of the king Rama III. The first hospital was established in 1888, where the vaccination for smallpox started. Rapid health infrastructure expansion began in 1900s. The Ministry of health was formally established and many hospitals were constructed. Human resource development was given much emphasis. By 1950, each province had its own provincial hospital (Bureau of Health Policy and Planning, 2002).

Ministry of Public Health (MoPH) is the chief agency that promotes, supports, controls and coordinates all health services activities in the country. Besides, the Ministry of Education, Ministry of Defense, the Bangkok Metropolitan Administration, and the private sector are involved in implementing the planned activities of MoPH.

Thailand has a population of 61.8 and 76 provinces. So, administratively, there are two levels of authority in the Ministry of Public Health: Central Administration that has the Office of Permanent Secretary and Regional Administration that is under the command of the provincial governor. And further down the line, it gets to the district, sub-district and village levels. There are 29 general hospitals and 19 specialized hospitals on Bangkok; 25 regional hospitals and 38 specialized hospitals; 123 general hospitals in provinces; 715 community hospitals in districts and 9704 health centers in sub-districts. Also there are 67,472 rural and 2,470 urban primary health care centers. In addition to the public facilities, there are 461 private hospitals. All these facilities provide the three levels of health care services depending upon the type of services (Bureau of Policy and Strategic Planning, 2002).

4. Thailand's Health System Reform

Health is an important element of well-being and quality of life, and to promote health for all the population is a big challenge for every country. It is also essential in the national development of the country.

Thailand faces many challenges as a result of the successes in the past and due to the broader social and economic changes. New demands for specialized services related to chronic disease and lifestyle changes are on the rise.

The key demands to reform were created by the high cost of health expenditure, unbalanced economic development and political and social reforms in Thailand (Wiput Phoolcharoen, 2001). He further explains that Thais depend more upon the facility-based services with inefficient spending. Meanwhile the unbalanced development brought in disparities among the marginalized people, erosion of social and cultural capital, and environmental pollution.

Prawase Wasi (2001) described once that the Thai health care system as a "system in crisis", very much in need of reform. He recommended that the passive ill-health-oriented system to be changed to good-health-oriented system.

The Government committed itself to the goal of universal health coverage policy (MoPH, 2001). Many developed and developing countries are undergoing changes in policies in terms of health care financing, and health coverage is the main issue in any reforms. Countries like Britain, Canada, Australia, France, Sweden and the Netherlands have already adopted the policy of universal health coverage. Such policy is expected to increase access to high standard health services and it has been found that health expenditure becoming more affordable (APHEN, 2001).

Thaworn Sakunphanit (2001) remarked that "although various forms of health insurance exist in Thailand, there are huge differences in terms of contribution, public subsidy, benefits and quality of services". Around 30% of population remained still uninsured, so government has taken a firm stand by adopting a policy that will help every Thai person to receive the health care service according to their health needs and regardless of income level or social status (as stated in the Constitution, 1997). And the 30 Baht policy was chosen as a vehicle to reach universal health coverage in 2001 by the Thaksin Government. The idea behind this reform is to cover mainly those people who do not fall under any other insurance schemes. However, other forms of health insurance will be continued and maintained.

The policy of 30 baht scheme is being implemented all over the country with the first phase being successfully piloted in six provinces for a year (MoPH, 2002). The ultimate goal of this policy is to increase equity, efficiency, quality and good health for all. It is a safety net for the poor people and those who are underserved.
The impact studies of the 30 Baht scheme are going on. It is been a year since this scheme was launched, and it might take sometime to pick up momentum. Yet there are some signs of positive developments (MoPH, 2002)

5. Health Insurance System and Related Problems

Even in 1940s, there were some practices of charging people for drugs and medical services in public health facilities. But at the same time, exemption was considered for the poor people. Thai Government started issuing health cards to people below the poverty line. And the government servants and retirees also get the free health care services.

According to the Health Insurance System in Thailand (2001), there are four kinds of health insurance schemes - i) Medical Welfare Scheme (for the poor, the elderly, students, the disabled, monks, community leaders, health volunteers and their family), ii) Civil Servant Benefit Scheme (for government employees and their dependents) iii) Compulsory Social Insurance (for formal sector employers), and iv) Voluntary schemes (like private insurance and health card scheme).

By 1999, 80% of the population was insured (Office of National Statistics, Health and Welfare Survey, 1999). The unsured were mainly low-income people or within the income bracket of 2001-8000 - most of them are transport operators and traders.

But health insurance schemes are characterized by fragmentation, duplication and inadequate coverage (HSRI, 2001). Inequity was largely demonstrated by inequitable per capita tax subsidy, and gaps in the benefit package. CSBS had a problem with the cost escalation and inequity of per capita budget subsidy. Social security patients had to face a cost quality trade-off. The poor are more or less protected by MWS, while the marginally poor are not entitled to free health care cards but would generally be partially or totally exempted from large inpatient bills in public hospitals. The

voluntary health card scheme has a limited capacity for coverage extension due to its voluntary nature and financial non-viability.

6. Chulalongkorn Memorial Hospital

The King Rama VI established King Chulalongkorn Memorial Hospital in 1914 and the hospital is the part of the Red Cross Society. It is located in the Patumwan District, Bangkok. Its philosophy of operation is "With responsibility, humanity and unity together, we stand for excellence in services" (www.md.chula.ac.th/ehospital).

The 1500-bed Hospital with 907 doctors and 1549 nurses provides both out-patient and in-patient services like medicine, orthopedic, obstetrics-Gynecology, rehabilitation, preventive medicine, surgery, pediatric, ENT, ophthalmology etc. The hospital provides medical services with the latest modern technology and conducts research. In addition, the hospital also serves as a training venue for medical students, residents, and fellows of the Faculty of Medicine (www.md.chula.ac.th/ehospital).

Besides, the hospital gives immense focus on quality care and tries improving medical services by applying the Hospital Accreditation process. Through surveys, it has been reported that satisfaction of consumers with the services is comparatively higher than some other public hospitals. The patient satisfaction level is around 75% to 85%. Although its catchment population is mainly in the Patumvan district, patients from far and near visit hospital.

The average number of patients per day at OPD is 3000, while the 30-Baht patients are 510 a month. But the number of non-registered 30-baht patients is in average 1300 per month (Chula 30-Baht Project, 2003). Patients prefer coming to Chulalongkorn hospital rather than using their own hospital of registration. The utilization rate of hospital services among the registered 30-Baht patients is only around 29%.

7. Utilization

Utilization is defined as "act of coming in contact with or accessing the health care services at health care facility through certain financing means. And utilization of health care has been identified as one of the determinants to look at the health status

and disease within a population. However, utilization of health care services by people depends on many factors. Factors that make persons patients and leading to utilization of health services depend mainly upon health status and need, demographic characteristics, physician availability, organizational features and financing mechanism (Anderson, 1968 and Hulka & Wheat, 1985). Improved access to health care, availability of physicians, expansion of infrastructure increased utilization quantitatively (Hulka, 1985). Both health status and need for medical care play a major role in determining health services utilization (Anderson, 1968). Among others, perceptions of people towards their health, type of service, and insurance support weigh a lot in influencing their health-seeking behavior. Utilization of services also depends on the satisfaction levels of patients and quality of care. Demographic characteristics like gender and age are considered important independent predictors of utilization.

Rosenstock (1966) showed utilization depends on perceptions and belief of individuals regarding their health, while Anderson (1968) pointed out that the use of health service is a function of predisposing, enabling and need components, which stressed more on behavioral theories. Another model by Aday and Anderson (1974) says that utilization depends on health policy and characteristics of the health delivery system.

A number of studies have shown positive association between insurance coverage and utilization, like increases in the physician visits, hospitalization, ambulatory care visits, admission rates etc. The World Bank and International Labour Organization have also advocated national health insurance as a solution to inadequate health financing in developing countries (Ron, Abel-Smith & Tamburi, 1990). Bachmann (1993) indicate that insured people usually have more and better health care than do the uninsured, and coverage is found to be invariably higher in urban areas than in rural areas for instance in Korea, Peru and Brazil. Insured workers tend to utilize health services more than uninsured ones, and it was found that an uninsured low income group in Pattani, Thailand showed the lowest utilization rate (Kovindha, 1997). But Beck (1974) said that insurance with copayment mechanism brings a fall in utilization, particularly for poor families. Also he went on to explaining that utilization is dependent upon the "form of insurance" and specifically consumption

increases as out-of-pocket expenses decrease. As such, Thailand is not new to the health care reform, and recently it has launched a new method to financing health care called 30-Baht policy (Policy and Planning Bureau, 2001). This scheme increases financial accessibility, which in turn might increase utilization. MoPH provincial health survey (1996) showed 26-31% of each income bracket was uninsured. Farmers, transport operators and traders had the highest share of the total uninsured. Thus, this scheme will give opportunity to seek quality health care with a copayment of just 30 Baht, ensuring full coverage of treatments. Unlike Waddington (1992) who puts it that introduction of copayment affects the specific rural and age groups. In Thailand, it is speculated that the use of services will increase, as the scheme is readily affordable and available. But so far, not much study had been carried out on the utilization and satisfaction of the services in terms of 30 Baht policy.

Some studies found differences in the utilization of health care by socio-economic status and the income effect. They become important barriers to the utilization to care services. But improving access to health infrastructure in less developed areas is found to be equity enhancing. Thus, utilization is not only determined by need, but also affected by access to service, including availability and price (Jun Gao et al., 2002).

Health needs, health beliefs, consumer attitudes, health provider behavior, economics, pharmaceutical companies, and social problems play influencing role in changing consumers behavior towards using health services (Payer, 1992).

However, no matter whatever the reasons, it must be acknowledged utilization varies even with optimal conditions in terms of services distribution and proximity. Even when health services are used, they vary in frequency.

8. Some Models of Health Services Utilization

People tried explaining health services utilization through various models. These were based on characteristics of services and population and other variables. Such models are important to predict the utilization behavior of people.

8.1. Rosenstock Model (1959-1966)

This model explains that emotional beliefs of a person help in understanding the utilization pattern of services. People believing to be sick or susceptible to a disease are more likely to seek health care than those who do not believe. However, this model also suggests explanations of health behavior in which healthy people seek care to avoid illness. This model is further developed as the health belief model (Rosenstock, 1966). He explains that the individual is psychologically ready to take action relative to a particular health condition. The individual believes that the preventive behavior is both feasible and appropriate for him or her to use, as it would reduce either his or her perceived susceptibility to or the perceived severity of the illness without any serious psychological barriers.

8.2. Suchman Model (1964-1966)

This model is based on the socio-cultural and environmental determinants that influence people on utilization. Critical determinants of utilization behavior are the social network of family and friends and the scientific orientation to health and medicine of the individual. The knowledge of health among relatives and friends are important in influencing utilization. Moreover, it is noted that attitudes towards illness and the awareness of treatment may vary considerably among cultural groups as well as socioeconomic status.

8.3. Anderson Model (1968)

This has been referred to frequently in utilization research as the behavioral model. Anderson says that use of health services is dependent upon the predisposing factor (age, gender, marital status, social class), the enabling component (income, health insurance, access to a source of care), and the need component (presence of symptoms or disease, morbidity). The enabling component indicates that though the individual may be predisposed to use health services, the individual must also have some means of obtaining them. These may promote or hinder the use of health services. Predisposing and enabling components, however, are not sufficient to affect the use of health services. What ultimately is required is an individual perception of some illness need before health care is sought. This need is the most crucial factor that effects choice of health service utilization.

8.4. Gross Model (1972)

It is very much like the Anderson Model, except the accessibility factors like distance and waiting time, and the individuals perceived health level. Gross explains the utilization of various services by an individual as a function of enabling factors, predisposing factors, accessibility factors, perceived health level of individuals, and socio-demographic factors.

8.5. Aday and Anderson Model (1974)

This model takes into account the national health policy, the characteristics of the delivery system and consumer satisfaction as in-puts. It then defines utilization as an output. Consumer satisfaction could be considered an outcome of the system. Unlike other models, this model emphasizes the importance of health policy and the health care delivery system when analyzing utilization of any given health services.

8.6. Utilization and Consumer Behavior

Ware and Davis (1983) found out that consumer satisfaction or dissatisfaction with their practitioner contributes significantly to the consumers behavior and is an effective indicator of predicting whether they are likely to change the source of their health services. With the growing concern about increasing costs, unnecessary and over utilization of health services, it is necessary to understand the effect these influences have on increased use. In order to control rising health service utilization and costs it is necessary to understand consumer behavior and consumer health care needs.

8.7. Consumer Satisfaction and Utilization

Consumer attitudes and behaviors are considered to have higher importance as contributors to health service utilization. Consumer attitudes towards health care providers have changed in such a way that consumers are becoming more discriminating in their choices of health care providers (Kasteler et al.,1976). The patients have the tendency to shop for the doctors in whom they have confidence and are satisfied with their services. Doctors with impressive qualities will be more likely to have patients coming to them those than who are hostile toward them. While patients who are dissatisfied with the cost of services, quality of services, the inconvenience of location, office hours and the length of waiting time will be more

likely to go to another health facility with more satisfying conditions (Kasteler et al., 1976). Individuals with a poor perception of their own health utilize health services more often those with a good perception, whether they are actually ill or not. (Connelly et al., 1989). However, disease conditions such as chromic illness may also increase in use of hospital services.

9. Some of the findings on the utilization behavior:

- Patients dissatisfied with physician's performance will be more likely to opt for another doctor who could fulfill their expectation. High cost of services, the inconvenience of location and longer waiting time will create negative impression on patients and utilization may be reduced. Patients with more self-reliance, higher tendency to adopt the sick role will show a higher tendency to shop for doctors (Kasreler et al., 1976).
- Ware and Davis (1971) found out that consumer satisfaction and dissatisfaction contributes significantly to the consumers behavior and is an effective indicator of predicting whether a consumer is likely to change sources of health services.
- Individuals with poor perception of their own health utilize health services more often than those with a good perception, whether they are actually ill or not (Connelly et al, 1989).
- Bice and White (1965) said that individuals with high levels of perceived morbidity seek out health care more frequently than those with a low perceived morbidity.
- Proximity and accessibility of health services are two more factors that influence consumer utilization behaviour. Urban populations with freer and greater access to health services than population in rural areas have higher rates for consumer use of services.
- Walk-in or medical clinics offering extended hours contribute to the increase in consumer utilization of health services as consumers do not have make an appointment as they operate on the first come basis and are open longer.
- Insurance plans make consumers unaware of the costs of services. Hibbard and Pope (1983) states that consumers cannot be expected to be cost-sensitive, if they are not aware of the economic consequences.

- Shapiro et al (1986) found out that individuals who are assigned to a cost sharing group were one third less likely to utilize health services for minor illness, while the use of major illness did not differ significantly.
- Beck (1971) pointed out that user charges resulted in a reduction of utilization for health services. The decrease in utilization over the period of copayment was approximately 16% of the average family use.

10. Reports on Universal Health Coverage (Dr. Viroj Narang and Ansana Narong, 2002) - Health System Research Institude.

- OPD utilization was found to be 2.876 times per person per year (Health and Welfare Survey, 1996).
- Inpatient utilization rate was 0.066 time per person per year
- Illness rate: 4.597 time per year
- Demographic changes over the last decades must have accelerated utilization
- Increased level of education among the masses must have increased utilization.
- The 30 Baht scheme makes health services available to everyone and more utilization is expected.

11. Summary Report of a Two Year Universal Coverage Policy (MoPH, 2003)

The 30 Baht policy was formulated and implemented by MoPH. It started with a pilot study in six provinces in April 2001, whereby 1.39 million people were covered. Later on, the scheme was extended to 75 provinces and Bangkok. By October 2001, it covered 38.8 million people, and further by April 2002 a total of 45 million persons were covered. It was implemented in all public hospitals and some private hospitals (voluntarily). 914 public and 103 private hospitals were under this scheme by October 2002.

Thus, this policy is 100% successful in terms of coverage, making the health services accessible to all people who were previously not insured. In addition, it has mede health care affordable since the copayment fixed is very minimum. It is presumed that more people will now use the services.

12. Satisfaction

The Oxford dictionary describes satisfaction as "gratification of desire; contentment in possession and enjoyment; repose of mind resulting from compliance with its desires or demands". In the similar line, Walman (1973) defined satisfaction as the feelings of happiness on the fulfillment of desires, while Davis (1967) said it was the maintenance of sense of balance both physically and mentally.

Literally, patient's satisfaction is the expectation of receiving attention from the provider for medical care and the proportion of fulfillment. It is quite reasonable that satisfaction brings people to utilize health services, and if the situation is satisfactory, it increases and determines the quality of medical services and the organization system. Dissatisfaction is found to be a barrier to future utilization.

Broadly speaking, both satisfaction with and utilization of health services depend on the patient factor, provider factor and health care system. Aday and Anderson (1974) explained consumer satisfaction as an input to utilization. Doctor-patient communication, waiting time, availability of needed services, quality care, demographic features, and access to information are some of the specific areas of exploration to find out the satisfaction among users.

Patient satisfaction is one of factors that affect the quality service of health care. Medical care is supply-determined, and expectation for quality usually is high among the users.

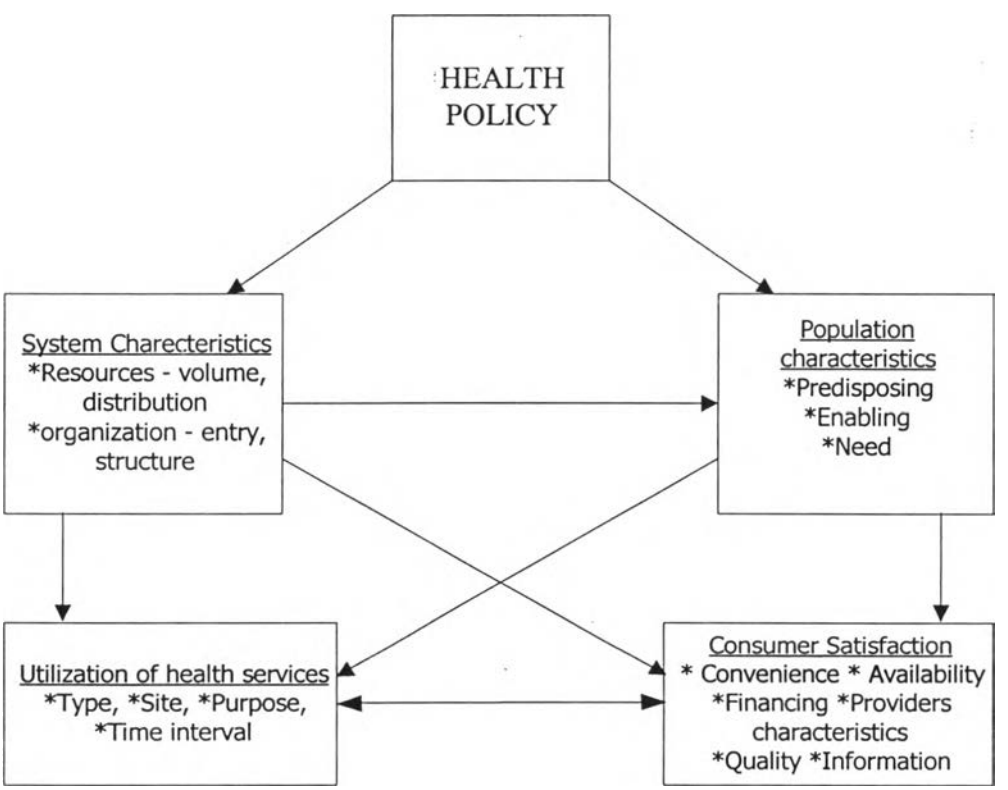
Orapin Chaipayom (1999) found the satisfaction with courtesy and out of pocket cost were at high level. Satisfaction with quality of care, medical information, coordination was at moderate level. The author said that explanation, courtesy from providers, suggestions about how to use drugs, using technology as well as providing pleasant, polite and friendly service contributed to increasing client satisfaction.

Oliver (1980) explains that satisfaction is the matter of preference. The author says it is a transaction-specific and emotional reaction. The satisfaction is expressed by an instant emotional response in the act of using services in a certain condition.

Consumer satisfaction is an experience-based attitude. Fornell (1992) points out that satisfaction is a consumptive formation and the level of satisfaction is indicated by the utilization of services. Westbrook (1980) elucidates that expectation has direct relationship with services. As services meet or exceed consumer requirements, the satisfaction appears. He goes on explaining if expectation is reached or exceeded by the services rendered, there will be repeated use of services. This is to say that more the satisfaction, the more the utilization.

Chang Yung liu (2002) remarks that "when a lot has been promised and more is being delivered, this will always create satisfied customers". Thus satisfaction is a function of performance relation to the customer's expectations. Service providers should orient themselves in relative to the expectations of customers. In terms of business, when the service contents exceed the consumer's expectations, they add more value to the consumer benefits.

Figure 5 Aday and Anderson Model (1974)



Source: Aday and Anderson (1974)

According to Chang (2000), the American Customer Satisfaction Index (ACSI) measures the quality of the goods and services as experienced by the customers that consume them. Although satisfaction measures one particular product, overall customer satisfaction is a more fundamental indicator of the firm's past, current and future performance. Chang explains that the customer satisfaction has three scores: perceived quality, perceived value, and customer's expectations. The customer's expectation represent both their prior consumption experience with the firm's offering as well as a forecast of the supplier's ability to deliver quality and consequently to perceived value. An increase in overall customer satisfaction should decrease the incidence of complaints and increase the customer loyalty.

Once a Chinese General named Sun Tzu wrote in 500 BC " if you know your enemy and yourself, you will win battles". Perhaps, Bumrungrad hospital knows it better. That's why the consumer satisfaction at this hospital is over 90%. The hospital's motto is "world class medicine and world class service". The hospital, established as a cardiac treatment center, is the number one private hospital in Southeast Asia (Bumrungrad, 2003).

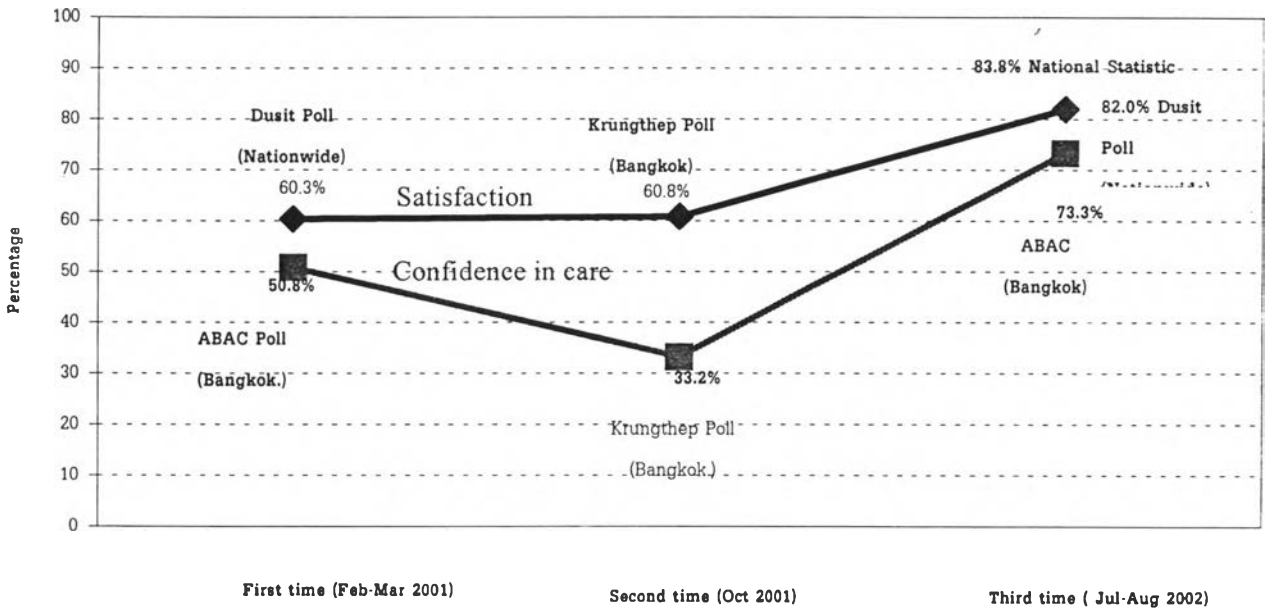
Satisfaction level in Chulalongkorn Hospital is in between 75% to 85%. It is said that patients refer to this hospital mainly due to availability of highly skilled, professional doctors and nurses. People think this hospital is far advanced, well equipped and trustworthy. The doctor's sense of professionalism is appreciated the most.

13. Satisfaction Survey on the 30 Baht Scheme (MOPH, 2003)

Despite short preparatory time, the first survey showed more than 50% of people are satisfied with this scheme and the number of satisfied people in using health services under the 30-baht is increasing. The latest (second) survey in July 2002 showed that the satisfaction has increased to more than 80%, although the confidence in the quality of care services is bit low. The trend to use the gold card in hospitals is reported to be is increasing.

Two surveys were conducted by National Statistic Institute - the first time in May 2002 only in Bangkok and second time in July 2002 as a nationwide survey. The

Figure 6 Result of Satisfaction Survey on Universal Coverage Policy



Source: Bureau of Policy and Strategy Planning, MoPH, Thailand.

results of these two surveys suggested that the Government's policy on universal coverage worked to the highest satisfaction (refer figure 6).

14. Conclusion

In actuality, there is less literature on the satisfaction among the gold card users. Thus, there are many areas in which research could be carried out. In an attempt to find some more facts on the attitude and expectation of people under the 30-baht scheme, this study tries to explore the level of satisfaction among the users of gold card in accessing health care, and attempts relating this aspect to utilization of health care services. All the gold card users are registered in the particular hospital where they have to receive the care. However, there are 30-Baht people who use services in different hospitals other than they are registered in. And such people had to pay for the services they receive. In this context, the present study uses the 30-baht patients, both registered and Self-referred at Chulalongkorn hospital to find out their attitudes towards the use of the gold card, its utilization and satisfaction with the health care services provided under this scheme.