

KNOWLEDGE REGARDING AN ACCESS TO UNIVERSAL COVERAGE
SCHEME AMONG THE ELDERLY IN AMPHOE MUANG
RATCHABURI PROVINCE THAILAND

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บทคัดย่อและแฟ้มข้อมูลฉบับเต็มของวิทยานิพนธ์ตั้งแต่ปีการศึกษา 2554 ที่ให้บริการในคลังปัญญาจุฬาฯ (CUIR)
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ความรู้เกี่ยวกับการเข้าถึงสิทธิประโยชน์ในระบบประกันสุขภาพถ้วนหน้าในผู้สูงอายุ
อำเภอเมือง จังหวัดราชบุรี ประเทศไทย



วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาสาธาณสุขศาสตรมหาบัณฑิต
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จิตาพัทธ์ ชูทอง : ความรู้เกี่ยวกับการเข้าถึงสิทธิประโยชน์ในระบบประกันสุขภาพถ้วนหน้าในผู้สูงอายุ อำเภอเมือง จังหวัดราชบุรี ประเทศไทย (KNOWLEDGE REGARDING AN ACCESS TO UNIVERSAL COVERAGE SCHEME AMONG THE ELDERLY IN AMPHOE MUANG RATCHABURI PROVINCE THAILAND) อ.ที่ปรึกษาวิทยานิพนธ์หลัก: รศ. ดร. ประเทือง หงสรานากร, 72 หน้า.

ความรู้เกี่ยวกับสิทธิประโยชน์ในระบบประกันสุขภาพถ้วนหน้าในผู้สูงอายุ อำเภอเมือง จังหวัดราชบุรี ประเทศไทย เป็นการสำรวจภาคตัดขวางระหว่างเดือนเมษายน-มิถุนายน 2558 เพื่อประเมินระดับความรู้เกี่ยวกับสิทธิประโยชน์ในระบบประกันสุขภาพถ้วนหน้าในผู้สูงอายุ กลุ่มตัวอย่าง มีจำนวน 440 คน (ชาย 178 คนและหญิง 262 คน) ซึ่งเป็นผู้สูงอายุที่มีอายุตั้งแต่ 60 ปีขึ้นไป ด้วยการใช้เทคนิคการสุ่มตัวอย่างแบบง่ายจากผู้สูงอายุที่มีสิทธิหลักประกันสุขภาพถ้วนหน้า ใช้การสัมภาษณ์เมื่อตอบแบบสอบถาม มีการใช้สถิติเชิงพรรณนาและวิเคราะห์ด้วยสถิติเชิงอนุมานเพื่อหาความสัมพันธ์โดยใช้การวิเคราะห์ความแปรปรวนทางเดียว (One-Way ANOVA) ผลศึกษาพบว่ากลุ่มตัวอย่างมีอายุระหว่าง 60 – 92 ปี โดยร้อยละ 61.8 อยู่ในกลุ่มอายุ 60 – 69 ปี เมื่อประเมินระดับความรู้เกี่ยวกับสิทธิประโยชน์ในระบบประกันสุขภาพถ้วนหน้าพบว่า ระดับความรู้เกี่ยวกับสิทธิประโยชน์ในระบบประกันสุขภาพถ้วนหน้าอยู่ในระดับปานกลางและระดับสูง (ร้อยละ 55.7) โดยมีค่าเฉลี่ยเท่ากับ 12.46 และยังพบอีกว่า อาชีพ (p-value 0.020) ระดับการศึกษาสูงสุด (p-value 0.000) และ จำนวนผู้อยู่อาศัยในแต่ละครัวเรือน (p-value 0.010) มีความสัมพันธ์กับระดับความรู้เกี่ยวกับสิทธิประโยชน์ในระบบประกันสุขภาพถ้วนหน้าในผู้สูงอายุแตกต่างกันอย่างมีนัยสำคัญทางสถิติที่ระดับ p-value <0.05 จาก Post-hoc test พบว่า อาชีพเกษตรกรมีระดับความรู้ฯ สูงกว่าอาชีพลูกจ้างและเจ้าของธุรกิจหรือพ่อค้า; ผู้ที่สำเร็จการศึกษาระดับประถมศึกษามีระดับความรู้ฯ สูงกว่าผู้ที่ไม่ได้ศึกษา; ระดับความรู้ฯ ไม่แตกต่างกันในผู้ที่สำเร็จการศึกษาที่สูงกว่าระดับประถมศึกษา (มัธยมศึกษา ปวช. ปวศ. ปริญญาตรี) และสำหรับจำนวนผู้อยู่อาศัยในแต่ละครัวเรือนนั้นพบว่า ผู้สูงอายุที่อยู่คนเดียว (สมาชิกครอบครัว 1 คน) มีระดับความรู้ฯ สูงกว่าผู้สูงอายุที่อาศัยกับครอบครัวใหญ่ (สมาชิกครอบครัวมากกว่า 5 คน) กล่าวโดยสรุปควรจัดให้มีการให้ความรู้ฯ การเพิ่มความตระหนักรู้ในสิทธิประโยชน์ฯ การมีกิจกรรมร่วมกันระหว่างผู้สูงอายุและผู้ดูแล ตลอดจนการรณรงค์ส่งเสริมสุขภาพในผู้สูงอายุเกี่ยวกับสิทธิประโยชน์ต่างๆในระบบประกันสุขภาพถ้วนหน้า เพื่อเพิ่มระดับคุณภาพชีวิตของผู้สูงอายุในฐานะที่ประเทศไทยกำลังก้าวเข้าสู่สังคมผู้สูงอายุ เพื่อเป็นการเอื้อต่อการเป็นผู้สูงอายุ และเพื่อพัฒนาประสิทธิภาพของระบบประกันสุขภาพถ้วนหน้าอย่างเป็นระบบต่อไปในอนาคต นอกจากนี้ งานวิจัยนี้ยังได้ให้ข้อเสนอแนะสำหรับการศึกษาในอนาคตเกี่ยวกับปัจจัยด้านคุณภาพและด้านปริมาณในการใช้สิทธิประโยชน์ในระบบประกันสุขภาพถ้วนหน้าในจังหวัดอื่นๆ และเขตภูมิภาคอื่นๆ ด้วย

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KEYWORDS: KNOWLEDGE / UNIVERSAL COVERAGE / ACCESS TO HEALTH CARE / ELDERLY / THAILAND

CHISAPATH CHOOTHONG: KNOWLEDGE REGARDING AN ACCESS TO UNIVERSAL COVERAGE SCHEME AMONG THE ELDERLY IN AMPHOE MUANG RATCHABURI PROVINCE THAILAND. ADVISOR: ASSOC. PROF. PRATHURNG HONGSRANAGON, Ph.D., 72 pp.

Knowledge regarding an access to universal coverage scheme (UCS) among the elderly in Amphoe Muang, Ratchaburi Province, Thailand, was the cross-sectional study conducted during April – June 2015 in order to assess the level of knowledge regarding an access to universal coverage scheme. There were 440 respondents (178 males and 262 females) who were the elderly aged 60 years and over. Simple random sampling technique was used from all elderly with the universal coverage scheme. Face-to-face interview was used. Descriptive statistics and inferential statistics of One-Way ANOVA were employed to find the association among the variables. The result indicated that the elderly were 60-92 years old with 61.8% in the age bracket of 60-69 years old. When assessed the level of knowledge, it was on the moderate and high levels (55.7%) with the average mean of 12.46. It was also found that occupation (p-value 0.020), highest level of education obtained (p-value 0.000), and numbers of household members (p-value 0.010) were statistically significant with the level of knowledge at the level of p value < 0.05. From Post-hoc test, the result illustrated that agriculture had higher level of knowledge than employees and business owners or traders; those with primary school education had higher level of knowledge than those with no education; the level of knowledge was not different among those with higher education than primary school (secondary school; vocational school; higher vocational school; bachelor's degree). For the numbers of household member, the result revealed that those who stayed alone (one household member) had higher level of knowledge than those from large household (more than five household members). It was concluded that providing knowledge; increasing awareness of the UCS right; having mutual activities between the elderly and their care-takes; as well as having campaigns for health promotion regarding various UCS rights, will heighten the quality of the elderly's life as Thailand is approaching aging society, to become age-friendliness, and to improve the efficiency of the UCS As for future studies, the qualitative and quantitative studies on the rights of UCS to cover other provinces and other regions were recommended.

Field of Study: Public Health

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Student's Signature

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LIST OF ABBREVIATIONS

UCS	Universal Coverage Scheme
US	United States
ID	Identification Card
NHSO	National Health Security Office
GNI	Gross National Income
GDP	Gross Domestic Products
MoPH	Ministry of Public Health
CSMBS	Civil Servant Medical Benefit Scheme
SSS	Social Security Scheme
DRG	Diagnosis Related Groups
ILO	International Labour Organization
ANC	Antenatal Care
PNC	Postnatal Care

CHAPTER I

INTRODUCTION

1.1 Background and Rationale

There are 1.3 billion people having the deficient access to reasonable and proficient health care organization worldwide. 44 million in 150 million households are facing indigent disaster financially, and over 100 million households encounter this problem through the requisition of the payment for health care services (Olive Shisana 2006). The balance and maintenance of cost and having a sufficient response to the health needs of the population is a challenge of every government. In various situations of the different of schemes, the scale of expenditure and the insufficiency of resources have to share from the development areas (Deutsche Gesellschaft für Technische Zusammenarbeit 2007). Nearly one-third of the world's population is facing the problems of accessing health facilities and other imperative medical services without social health protection. Many of this population live in low-income countries (Scheil-Adlung 2004).

The population in Asia is growing in a faster pace because of the increase in number of years of lifespan and a drop in fertility rate. With an increased amount of older people residing in this region, Asia has become the home of the elderly. Yet, insufficient and ineffective social health protection schemes and poverty among the population are major problems occurring in Asia. Therefore, not only the population that lack the access to health facilities impact the health care system, but the rapidly growing ageing population is another problem that poses a significant threat on every system, especially the health care system (Sri Wening Handayani 2012).

Thailand, one of the countries in the Asia region, also has well-documented data in regard to the inequality between rich and poor people. Millions of casual workers and their families were considered deficient in the health insurance scheme. Universal coverage is one of the methods conceived to ameliorate this predicament (Supasit Pannarunothai 2004). Thailand has been categorized as an upper-middle income country since 2011 which has a capita income beyond the lower boundary of 3,976 U.S. dollars per capita GNI (Gross National Income) organized by World Bank (Bank 2014). Twelve percent of the nominal GDP was accounted in the Thai economy's 2010 GDP (Gross Domestic Products). Thai agriculture accounted for the largest means of employment

around 42 percent in 2009 (Siripen Supakankunti 2013). Thailand's population was recorded 65.9 million people in 2014 (NHSO 2014) and became the second highest ageing population country in South East Asia classified by UNFPD in 2006. In term of health outcome, Thailand had an infant mortality rate of 11 per 1,000 live births in 2010 and a maternal mortality rate of 48 per 100,000 live births in 2008. Increase in life expectancy (74.01 years at birth) indicated that females had longer lasting lives more than that of males. The crucial reflection of changes was the numerical values of high-cost care services, which increased during 2007 and 2008. An increase of expenditure is depended on GDP that flashed an increase in finance of universal coverage service scheme (Siripen Supakankunti 2013).

The National Health Security Act B.E. 2545 (2002) prescribed that all Thai citizens have the right to health care under a public health protection scheme as the gist of Universal Coverage Scheme with the presence of the National Health Security Office (NHSO) and the National Health Security Fund (Sakunphanit 2008). Universal health coverage has been described in such a way that all people can get access to the benefits of health care services whenever their needs arise and ensures that the use of services would not drive the providers to financial difficulty. The service use needs to be effective with sufficient quality of services (WHO 2014). Similar to many other countries, health care coverage in Thailand has three main schemes. The first scheme of the health security scheme is the Civil Servant Medical Benefit Scheme (CSMBS) managed by the Ministry of Finance to cover all civil servants in the country. Secondly, the Social Security Scheme (SSS) operated by Social Security Office of Thailand that began in 1992 (Siripen Supakankunti 2013). Thirdly, Universal Coverage Scheme (UCS) that was started in 1996 through the project of health care reformed by Thailand Ministry of Public Health (MoPH). UCS was implemented by the Thai Rak Thai government was by the name of 30 Baht Scheme in 2001 under the responsibilities of the National Health Security Office (NHSO). The 30 baht scheme fulfilled the gaps in health security scheme for people who are not covered by CSMBS and SSS. The scheme was phrased as "The 30-baht Universal Coverage treats all diseases" (Promasatayaprot 2011). The benefits of UCS include the services of Thai traditional alternative medicine, rehabilitation, disease prevention, health promotion, and curative services. The benefits of UCS include the services of Thai traditional alternative medicine, rehabilitation, disease prevention, health promotion, and curative services. The health expenditure for most preventive and ambulatory services are

through capitation with an indication of an increased trend that was 51 billion Baht in 2002 (or 1,202 baht per capita) and disbursed up to 91 billion Baht (or 1,988 baht per capita) in 2007 (Sakunphanit 2008).

After ten years of UCS experiences, many studies had surveyed the perception, awareness and concerns of the insured. In rural areas in particular, there had been a 100 percent increase in the number of out-patients-department visits. This raised the question of appropriate medical-seeking behaviors. On the contrary, in urban areas, fewer demands were shown. Increasing of use of UCS had caused some undesired effects. Stian (2011) stated that not only is the required fairness indicating a need for an integration of the three schemes, but it also the private out-of-pocket expenditure (Stian H. Thoresena 2011). In term of public policy, Yot described that more transparent criteria for deciding the use of universal coverage scheme is required, and political pressure and people acceptability need to be considered (Yot Teerawattananon 2008). Most importantly, Chutima indicated an association between insurance status and health care use that the socioeconomic factors and consumer preference play a key role in the inequity of health care utilization (Chutima Suraratdecha 2005). Such that the inappropriate use of universal coverage scheme had become a critical public issue and the user's knowledge should be one of the key to be concerned for public policies.

Ratchaburi Province is an area in the central region of Thailand with the second highest numbers of the elderly, ranked under Nonthaburi Province and excluding Bangkok. Ratchaburi had a recorded population of 115,645 elderly people in 2007 (Thai Health 2015). As the elder normally require more health care due to non-communicable diseases and chronic diseases, Ratchaburi occupied the first to third highest rank of the number of in-patient in many non-communicable diseases with- 3rd highest in diabetes mellitus, 1st in hypertension, 1st in myocardia infraction, 2nd in bronchitis, 3rd in stroke, and 1st in asthma; the death rate and mortality rate in non-communicable disease and road accidents in health service area was ranked fifth in 2013 - 1st in liver disease, 1st in cervical cancer, 2nd in breast cancer, 1st in lung cancer, and 3rd in road accidents(NHSO 2014, Thai Health 2015) .

Due to the background information described above, the researcher is interested to study and investigate on the knowledge regarding the access to Universal Coverage Scheme among the elderly in Amphoe Muang, Ratchaburi Province, Thailand.

1.2 Research Questions

- 1.2.1 What is the level of knowledge about the universal coverage scheme (UCS) among the elderly in Amphoe Muang, Ratchaburi Province, Thailand?
- 1.2.2 What are the factors associated with the knowledge about the universal coverage schemes (UCS) among the elderly in Amphoe Muang, Ratchaburi Province, Thailand?

1.3 Research Objectives

- 1.3.1 To assess the level of knowledge about the USC among the elderly in Amphoe Muang, Ratchaburi Province, Thailand.
- 1.3.2 To examine the factors associated with the knowledge about the UCS among the elderly in Amphoe Muang, Ratchaburi Province, Thailand.

1.4 Research Hypothesis

The socio-demographic characteristics are associated with the level of knowledge of UCS among the elderly in Amphoe Muang, Ratchaburi Province, Thailand.

$$H_0 = \mu_1 = \mu_2 = \mu_3 = \dots = \mu_k$$

$$H_1 = \text{At least 2 of } \mu_i \text{'s are different.}$$

1.5 Conceptual Framework

Independent Variables

Dependent Variable

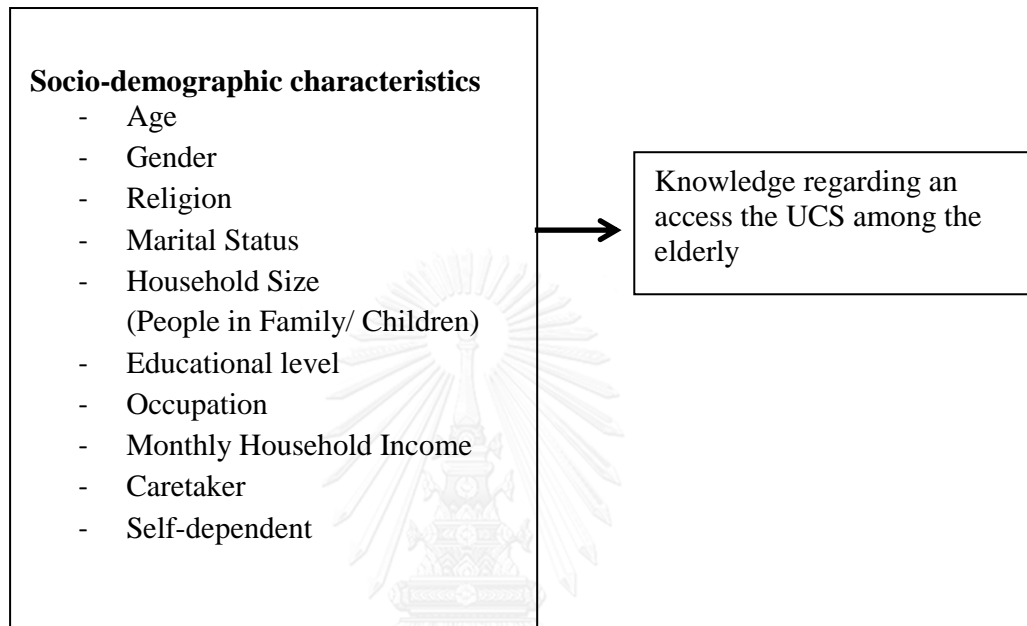


Figure 1: Conceptual Framework

1.6 Operational Definition

The following are terms and definitions, which have been used in this study at Ratchaburi Province, Thailand that defined for graceful and well understanding.

- 1.6.1 Knowledge about UCS means being aware of and understand about their own benefits in universal health coverage scheme.
- 1.6.2 Marital Status states the status of being single, married, widowed, divorced, separated and other.
- 1.6.3 Education level refers the highest education in each person classified by: elementary school, secondary school, high school, diploma, bachelor's degree, not educated, and other.
- 1.6.4 Occupation is classified into agriculture, employee, business/ trader, not working, and other.
- 1.6.5 Monthly household income refers household income per capital per month, and is categorized as < 10,000 baht, 10,001-20,000 baht, 20,001-30,000baht, > 30,000 bath, and other.
- 1.6.6 Care taker refers to the people who look after the elderly with severe physical disabilities or mental disabilities such as daughter, son, nephew and other
- 1.6.7 Self-dependent means the ability of elderly to do their own routine activities like produce food, home cleaning, wearing cloths and other.

CHAPTER II

REVIEW OF LITERATURE

The topic of this thesis is “Knowledge Regarding an Access to Universal Coverage Scheme among the Elderly in Amphoe Muang, Ratchaburi Province, Thailand.” In order to determine approaches to this thesis, the researcher has studied the following concepts:

- 2.1 Background of Thailand/Ratchaburi Province regarding the Elderly
- 2.2 Current Status of Social Health Protection in Thailand
- 2.3 Concepts of Knowledge about Social Health Protection
- 2.4 Related Articles on Knowledge about Social Health Protection

2.1 Background of Thailand/Ratchaburi Province regarding the Elderly

Thailand has the infant mortality rate of 11 per 1,000 live births in 2010 and a maternal mortality rate 48 per 100,000 live births in 2008. Increasing life expectancy during the last decade reflects the epidemiological transition and better quality of health care in Thailand. Data shows that females have longer life expectancies at birth when compared to male. The crucial reflection of changes in the numbers of high cost care services were increased in both 2007 and 2008, and an increase in medical expenditure depending on GDP highlights the increase in financing services of universal coverage scheme (Siripen Supakankunti 2013). The increasing trend of the elderly aged 60 years old and above in Thailand is estimated to grow by 20% in the coming 25 years. It is projected that one third of the population in Thailand in 2050 will be the people aged 60 and above, and that Thailand is entering in the period of “Ageing society” (Sakunphanit 2008).

The World Health Organization (WHO) recognized that non-communicable disease is the major disease that deteriorates the statistics of deaths (mortality rate) steadily. Globally, non-communicable diseases account for 63% of the disease that causes morbidity in patients, and more importantly, more than 80% of the population is found in developing countries (Thai Health 2015). So nowadays, non-communicable disease is the biggest problem worldwide, especially in Thailand. This trend can affect a country's

future health, and can be the reason of increased disability and mortality rate caused by global health behaviors. The increasing number of the elderly within the country also contributes to the rise in number of non-communicable diseases. The most important non-communicable diseases are diabetes mellitus, hypertension and myocardia infraction, stoke and chronic obstructive pulmonary diseases such as asthma. The older the ageing population gets is reported to have more chronic diseases and non-communicable diseases when compared to the emerging ageing population due to body's degeneration (Chronic Diseases Surveillance Report, 2012).

Ratchaburi Province is the area inside the central region of Thailand with the 2nd highest numbers of the elderly, second from Nonthaburi Province with the exclusion of Bangkok City. Number of the elderly by province in 2007 has reached 115,645 people (Thai Health 2015). Ratchaburi occupies the first to third rankings of number of in-patient in many non-communicable diseases- 3rd in diabetes mellitus, 1st in hypertension, 1st in myocardia infraction, 2nd in bronchitis, 3rd in stoke, and 1st in asthma; number of death from non-communicable disease and road traffic accidents ranks the 5th among the other provinces in Thailand at 2013 with 1st in liver disease, 1st in cervical cancer, 2nd in breast cancer, 1st in lung cancer, and 3rd in road accidents (Bureau of Non Communicable Disease 2013).

2.2 Current Status of Social Health Protection in Thailand

Thailand has a long history of social health protection or social health insurance background for some part of the population more than half decade ago before launching the universal coverage (UCS) in 2002 (Sakunphanit 2008). Before the achieving of universal coverage in 2002, Thai population was covered by insurances such as the Medical Welfare, the Social Security Service (SSS), the Civil Servant Medical Benefit Scheme (CSMBS) and publicly subsidized voluntary health insurance from the informal sectors. In 2011, almost 4.5 million people were covered by CSMBS, nearly 10 million people by SSS, and around 50 million people were covered by UCS. The cost of each health insurance was also different. UCS per one person in 2011 was 2,091 baht; SSS was 2,562 baht; and CSMBS was 14,056 baht.

Chronological Development of Health Insurance Systems in Thailand

Year	Private formal sector employee	Government employee	Population covered by Universal Coverage Scheme (UCS)		
			Poor people	Near poor	Uninsured
Before 1974				Fee Exemption System	
1974	WCF				
1975			LIS		
1978		CSMBS			
1981				Type B fee exemption	
1983					HCS
1990					I
1991					II
1994			MWS		IV
1999			SIP in 6 provinces		V
Apr. 2001			UCS in pilot 6 provinces		
Apr. 2002			UCS implemented nationwide		

Figure 2: Chronological Development of the Health Insurance Systems

Universal coverage for health care was stated as a national strategic policy in 2001 by the procedures of technocrats and civil societies. There was the commitment to swiftly promoting one of the key campaigns for the coverage of health care to all Thai citizens under the slogan “30 baht to cure every disease.” (Sakunphanit 2008). It was aimed to cover the Thais who were not covered by the SSS or the CSMBS. At that time, people had to pay 30 baht (approximate 1 U.S dollar) as a co-payment per one medical visit. The strategic purchasing of health services (closed-end payment) and demand-side health care financing was a major implementation reform for this policy.

The health insurance expenditure or health funding of universal coverage scheme was based on the size of the health care organization, number of staff, number of patients,

and its historical performance. UCS was based on its payment of the number of people under their responsibility (or contracting unit) (Hanvoravongchai 2013).

The universal coverage scheme provides the three main comprehensive benefits for Thai people - drugs, outpatient care, and inpatient care (Hanvoravongchai 2013). In details, it includes curative services, health promotion and disease prevention services, rehabilitation services, and services provided for Thai traditional medicine (Sakunphanit 2008). Health facilities have to register to the scheme. The registered providers will be classified as primary medical care unit, secondary medical care unit, or tertiary medical care unit depending on their performances. The policy of this scheme is to have the primary medical care unit provide the ambulatory services for the beneficiaries, and to serve as the first contact point for the beneficiaries in receiving further medical services. The beneficiaries are not allowed to go directly to secondary or tertiary care facilities without a referral from the primary medical care unit, except accidental or emergency situations (Sakunphanit 2008).

The total health budget for UCS in 2002 was 51 billion baht (or 1,202 baht per capita). In 2007, the government spent up to 91 billion baht (or 1,988 baht per capita) from general taxation for medical health care. Different payment mechanisms are used for specific type of services. Capitation is used for most of prevention services and ambulatory care. In-patient services are reimbursed using case-mixed system, DRG. However, the UCS approach is different from “original” DRG payment system as the global budget for in-patient is calculated, and total relative weight of DRG is used to allocate the amount of money paid to hospitals. Other expenditure of the scheme is the capital replacement cost, which is related to the expenditure incurred by contracted hospitals for capital replacement (e.g. hospital facilities, medical instruments, equipment, etc.). No fault liability is related to the compensation money paid by NHSO to settle patient claims regarding problems from medical practice. Figure 3 below demonstrates the expenditure of the UCS.

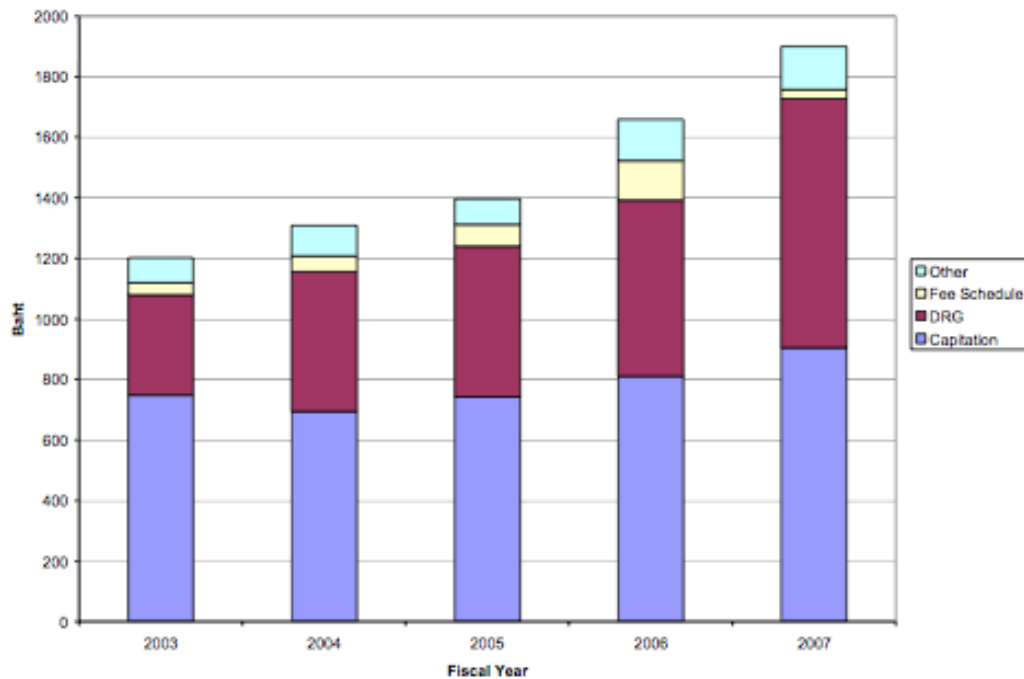


Figure 3: Expenditure of Universal Coverage Scheme (UCS)

From the user fee with exemption and slightly movement of out-of-pocket payment, all kinds of payment systems were tested and recommended to Thailand. Terms of contribution, public subsidies, benefit and quality of services indicate huge differences among these implementations. Though UCS is now free-of-charge, there are still weak points in terms of efficiency, quality, and equity of health care services (Sakunphanit 2008).

2.3 Concept of Knowledge about Social Health Protection

The recent economic downstream and financial crises cause many people to lose their jobs and the livestock of millions of people have been threatened. Some of them lost their access to expensive health care when they focus on more important factors such as education and housing. In other words, they literally lost their social protection of all family members. This economic depression hits harder in low-income countries where twenty-five of the population have to live under U.S \$1.25 a day. In the light of economic depression, health insurance is a savior for the people from having social and economic crisis. It is also a promoter for the country's development. This is contributed to by the connections between labor markets, the health sector, and the new generation - increasing skilled workers in the health sectors to reduce the burden of the disease, and increasing

the quantity of the workers in the health care market. By understanding this concept, we can assume that reduced access to health facility and medical treatment may cause profound damage to both economic and social aspects of the people and country (Scheil-Adlung Xenia 2014).

Social Health Protection is a chain of public oriented or community base strategy against economic distress and social lost resulting from loss of income or reducing productivity, aiming to amend the cost of the essential treatment from the medical expend. It is organized with the different financial sources and options aimed to supply the sufficient benefit package against the medical cost that could end up in tragedy. Achieving universal coverage and social protection can be regarded. Financial range is difficult for every government. The low-income co-protection can be regarded as the minimal access to the cost effective quality health care and risk protection in case of illness- is a main target for the ILO Social protection in the health to be considered as (Social Security Department International Labour Office 2008)

- Geographical and financial accessibility of covered services;
- Size of the population covered;
- Adequacy and quality of services covered;
- Extent to which costs of a benefit package are covered.

Health care system social protection is aimed to answer the needs of the people while protecting them within affordable financing. This type of protection is needed to tackle these situations, a limited resources need to be distributed fairly and equally with other areas (Deutsche Gesellschaft für Technische Zusammenarbeit 2007). Social protection has for long been considered a vital tool in industrialized countries and is being increasingly recognized as an essential instrument for poverty reduction in low and middle-income nations. Different agencies and institutions have defined social protection in various ways by reflecting different objectives and approaches. Social protection has been defined as “a sub-set of public actions, carried out by the State or private that address risk, vulnerability and chronic poverty”.

The International Labour Organization (ILO) has defined social protection (SHP) as the key measurement in developed countries and has been considered as the vital tool for protection instrument from the poverty in middle and low-income countries. Different

institutions and organizations have different approaches and different definition for the SHP indication through different methods and objectives. On example of these approaches includes the series of public action that a state provides for its people to reduce or relieve themselves from social and economic risk that could be the result of the emergencies or loss of the income or jobs (maternity, work related injuries and sickness). The general objective of the SHP is lowering the risk of poverty and vulnerability. The important components of the each SHP vary from one to another. The main idea is to prevent risky people from dipping into the poverty due to the effects of tremendous life changes. To be effective, the tools need to be empirical and vary to address every issue throughout the life cycle. The prioritization of the government agenda is the best way to get access to the affordable quality healthcare in low and middle-income countries (Harshad Thakur 2013).

2.4 Related Articles

Social Health Protection in many countries.

In low and middle-income countries, the SHI system is the super remedy to treat poverty, and is also the road that leads to development. Many developed and high-income countries prioritized SHI as the base to develop the entire health care system. There is proof of successful stories from the local state government in China and Brazil to balance the globalization in term of public health aspects by using SHI. Some European researchers found that social risk protection could be the supportive pillar in shaping the social development of other area in Asia, Africa and Latin America (Deutsche Gesellschaft für Technische Zusammenarbeit 2007).

Belgium: In Belgium, the way to achieve universal health coverage was twisted and long, but it has been stable for few decades where it covers everyone in the country. However, new hinderers emerged as increasing illegal migrants from neighbors (les 'Sans papiers') to cope with the issues of services affordable for the increased amount of older population. These are the evidence that the UCS is the lifelong demanding work for every government rather than one stop achievement. In the stage of UCS, Belgium has many roles that it needs to perform: the role as a leader, supporter or technical provider and a global player. The government has to perform the role as coordinator and advocate with the other players at the global and national level as rearguard or guardian of UCS (Social Security Department International Labour Office 2008).

South Africa: In South Africa, social health protection is divided into the private and public sector. The majority of the population (83.7%) is covered by the public sector where the financial contributor is the state government and it covers the basic health care in proportion to the income. Medical expenditure of the government provides the services users' fees to different providers at different regions. The private sectors operate based on the medical schemes where they rank the communities into the different rating depending upon their environment risk factors. However, SHI is a hot issue to discuss recently, and risk sharing based on the employment group private insurance is the popular and most common scheme in the country (Xenia Scheil-Adlung 2006).

Indonesia: Up to now, only 40% of the Indonesians are covered by the SHI. And the rest of the population use out-of-pocket money to finance medical costs. Not enough input to existing schemes and less efficacy in the output of the schemes are the weaknesses found. As most people are self-financing, the poor people suffer from the expensive costs of the medical treatment. This condition points out the relation between poverty and health where variety of health indicators are observed in the people with the different social status and different demographic area (Scheil-Adlung Xenia 2014).

Nepal: The three main sources for health financing in Nepal are government, household and external development supporters; while the minority of the population is supported by the other government corporates and self-organized civil society. Projected health expenditure in Nepal for is US\$ 24 per capital, which is 45% lower than the resources needed to fulfill the minimal health care. Approximately sixty percent of the population don't have the access to the quality healthcare and is lack of basic health care services such as ANC and PNC. However, due to the focus effort of the government to offer the free of charge of services, health delivery service is slowly expanding. The gap between the rich and poor is persistent and the critical need for the extra resources still exists (Technical Working Group on Health Care Financing Kathmandu 2011).

CHAPTER III METHODOLOGY

3.1 Research Design

This study was a cross-sectional survey research.

3.2 Study Population

The population in this study was the elderly with aged 60 years old and above for both sexes, with Thai nationality and have been living in Amphoe Muang, Ratchaburi Province, for more than 6 months. Total number of elderly populated in Amphoe Muang, Ratchaburi Province, Thailand, was 87,126 dwellers by Thailand Ministry of Interior, June 2555. Thus the participants were chosen through simple random sampling technique and TARO YAMANE formula was used in this part of calculation for the sample size. (Taro Yamane 1973),

Sample and Sample size

$$\text{Formula of TARO YAMANE} \quad n = \frac{N}{1 + Nd^2}$$

Where n = Total sample size of unit
 N = Total population
 d = Significant level

When N = 87,126
 d = 0.05

$$\text{Therefore} \quad n = \frac{87,126}{1 + (87,126 (0.05)^2)} = 398.17$$

By using the TARO YAMANE formula, approximately 400 samples were drawn. After adding additional 10% of non-response and not-complete response cases, the total of samples for the research were 440 (398.17 + 10%) samples.

3.3 Sampling Method

The elderly were selected by simple randomize technique. The inclusion criteria and exclusion criteria are explained below.

3.3.1 Inclusion Criteria

- Male and female who are Thai.
- Have been living in the area for more than 6 months.
- Aged 60 years old and above.
- Using the UC health benefit as their right at health care facilities.

3.3.2 Exclusion Criteria

- Elderly who does not want to participate in this study.
- Elderly patients who are bed ridden.

3.4 Measurement Tools

A STRUCTURED questionnaire in Thai version was used for this study (Appendix B). Two parts of closed-ended questions were included in the questionnaire. The first part was about the general information of the participants like socio-demographic characteristics of elderly, and second part was the knowledge about Universal Coverage Scheme among elderly in Amphoe Muang, Ratchaburi Province, Thailand.

Part 1- Socio-demographic characteristics of elderly consisted of 11 questions, about the gender, age, religion, highest education level, occupation, family member, children in family, monthly family income, care-taker and self-dependent.

Part 2- Knowledge about Universal Coverage Scheme consisted of 20 questions in total with 13 positive statement questions and 7 negative statement questions. The questions focused on the “knowledge regarding an access to Universal Coverage Scheme” which related to elderly. As the questionnaire consists of both statements (positive and negative) with three answers; true, false and don’t know.

The rating was scored as follow

Positive statements (+)		Negative statements (-)	
Answer	Scores	Answer	Scores
Correct	1	Correct	0
Wrong	0	Wrong	1
Do not know	0	Do not know	0

And the total score were grouped into 3 levels as follow (Bloom BS 1975):

0 - 12 scores (less than 60%)	=	Low level of knowledge
13 – 16 scores (60-80%)	=	Moderate level of knowledge
17 - 20 scores (81-100%)	=	High level of knowledge

3.5 Validity Test

Four experts were consulted for validity review of the questionnaire content that showed the total IOC score was 0.75.

3.6 Reliability Test

Reliability of the questionnaire was accessed through 40 sets of pilot tests among elderly in Amphoe Muang, Kanchanaburi Province, Thailand, where socio-demographic characteristics of the elders are similar to Amphoe Muang, Ratchaburi Province, Thailand. The internal consistency of the rating scales was performed by Kuder-Richardson test (KR-20) for the analysis of knowledge was found with reliability scores of alpha at 0.814.

3.7 Data Collection

The quantitative data-collection was conducted in this study. Four hundred and forty participants were interviewed in this study by the researcher and 15 local research assistants who were Village Health Volunteers in Ratchaburi Province. The local research assistants were trained for a half-day by the researcher before the face-to-face interview. In this step, the research assistances played important role to interview the elderly, they had to explain the objectives of the study, the components of the questionnaire, importance of confidentiality and ethical consideration (AF04-07, AF05-07) and asking for acceptance to willing participated in this study after that face-to-face interview

provided within 10-20 minutes by using polite local familiar languages with the participants during conversation to avoid bias. The data collection was done during April – June 2015. After the participants completely answered the questionnaires, the researcher and local researcher assistants had given the right answer to all participants for education purpose.

3.8 Data Analysis (statistics)

After the data collection, cleaning data was computed by using SPSS program for window version 17, licensed for Chulalongkorn University. The descriptive statistics of frequency, percentage, mean, standard deviation, minimum and maximum values were used to describe the socio-demographic characteristics for all population in this study. For analytic statistics, One-Way ANOVA was used to describe the association different between the socio-demographic characteristics and level of knowledge regarding an access to universal coverage scheme in part II of questionnaire (Appendix A) with the statistical significance of $p < 0.05, 0.01$.

3.9 Ethical Consideration

This study was approved by the Ethics Review Committee for Research Involving Human Research Subjects, Health Sciences group, Chulalongkorn University, Thailand (certificated code number No.064.01/2015). The review from committees sought prior to full-scale data collection to ensure that this study wouldn't do any harm to the participants. Furthermore, before the interview process, the participants were clearly and completely explained by the researcher and research assistants about the study. All participants signed off or had their finger stamped on the consent form in prior to voluntarily participate in this study.

CHAPTER IV

RESEARCH RESULTS

This chapter provides the detail of the results that were obtained from the analysis in descriptive and analytic of statistics on the cross-sectional survey of “Knowledge regarding an access to universal coverage scheme among the elderly in Amphoe Muang, Ratchaburi Province, Thailand”. The independent variables were described using simple statistics such as percentages, means, and standard deviations depending on the nature of each variable. Starting with the socio-demographic characteristics followed by the sequence of each section in the questionnaire (see in appendix A).

4.1 Socio-demographic Characteristics of the Elderly

In this study, there were 440 participants (178 male and 262 female) involved during April – June 2015. All of them were elders who live in Ratchaburi (study area). Both male and female were interviewed face-to-face by researcher and researcher’s assistants. The information of socio-demographic part was illustrated in table 1.

The proportion between male and female participants in this study was 40.5% and 59.5% respectively. The sole religion was Buddhist (100.0%). The majority of the age of respondents in this study was between 60 - 69 years old (61.8%). The main result of marital status was marriage (59.3%). The majority of number of people in each family was more than 5 people (27.7%). The total number of the participants who have children was 389 with the majority of them having 2 offspring (28.3%). Approximately 87.7% graduated in elementary school. Most of the elders are not working at this age (33.0%). Among all participants, 60.7% of participants’ family incomes were less than 10,000 Baht per month. The proportion of the elderly with their own care takers (mostly was their descendants) was 93.4%. And majority of 80.5% are self-dependent in routine activities.

Table 1 Socio-demographic Characteristics

Characteristics		Number (N)	Percentage (%)
1. Gender (N=440)	Male	178	40.5
	Female	262	59.5
2. Religion (N=440)	Buddhist	440	100.0
3. Age (N=440)	60-69 years old	272	61.8
	70-79 years old	115	26.2
	80-89 years old	48	10.9
	> 90 years	5	1.1
4. Marital Status (N=440)	Single	43	9.8
	Married	261	59.3
	Windowed	127	28.9
	Divorced	3	0.7
	Separated	5	1.1
	Other	1	0.2
5. Member in Family (N=440)	1 member	26	5.9
	2 members	75	17.0
	3 members	79	18.0
	4 members	55	12.5
	5 members	83	18.9
	> 5 members	12	27.7

Characteristics		Number (N)	Percentage (%)
6. Number of Children (N=389)	1 people	48	12.3
	2 people	110	28.3
	3 people	91	23.4
	4 people	68	17.5
	5 people	38	9.8
	> 5 people	34	8.7
7. Highest Education (N=440)	Elementary School	386	87.7
	Secondary School	18	4.1
	High School	6	1.4
	Diploma	1	0.2
	Bachelor's Degree	7	1.6
	Not Study	22	5.0
8. Occupation (N=440)	Agriculture	109	24.8
	Employee	137	31.1
	Business/Trader	47	10.7
	Not Working	145	33.0
	Other	2	0.4
9. Family Income (Monthly/ Bath) (N=440)	< 10,000	267	60.7
	10,000 – 20,000	114	25.9
	20,001 – 30,000	28	6.4
	> 30,0001	19	4.3
	Other	12	2.7

Characteristics		Number (N)	Percentage (%)
10. Care Taker (N=440)	Have	411	93.4
	Don't have	29	6.6
11. Self-Dependent (N=440)	Some Activities	86	19.5
	All Activities	354	80.5



4.2 Knowledge Regarding an Access to Universal Coverage Scheme

Table 2 to 21 show the percentage of responses to each item by each group of the participants in each question of knowledge regarding access to universal coverage schemes among the elderly in Amphoe Muang, Ratchaburi province, Thailand.

Benefits of general illness in UCS

Table 2 Knowledge Question 1

Knowledge Question 1	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	336	59	45
(100.0)	(76.4)	(13.4)	(10.2)

The benefits of universal coverages allow people with universal coverage to access the public health care center for general illness, emergency illness, and accident. The proportion of the participants that answered correctly was 76.4%, participants who had wrong answer made up 13.4%, and participant who don't know this benefit of universal coverage was counted 10.2%.

Table 3 Knowledge Question 2

Knowledge Question 2	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	398	30	12
(100.0)	(90.5)	(6.8)	(2.7)

The benefits of universal coverage include treatment in the case of general illness to covered patients by means of primary medical care (health promoting hospital or hospital). The answer from the respondents was 90.5%, 6.8% answered false and only 2.7% answered didn't know for this statement.

Benefits of emergency illness and accidents in UCS

Table 4 Knowledge Question 4

Knowledge Question 4	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	147	253	40
(100.0)	(33.4)	(57.5)	(9.1)

*Negative statement

The benefits of universal coverage in emergency cases allow patients to access health care organizations (government based UCS) without limitation of frequency. As this question is a negative question, respondents with the wrong assumption and answer “True” was 33.4%, while the percentage of respondents with the correct knowledge but answered “False” was 57.5%, while the rest of the 9.1% chose “Don’t know” as their answers.

Table 5 Knowledge Question 6

Knowledge Question 6	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	209	153	78
(100.0)	(47.5)	(34.8)	(17.7)

*Negative statement

The benefits of universal coverage state that in case of accidents, patient can get access to any government hospital in any province. As this statement was negative, participants who answered “True” (47.5%), “False” (34.8 %) as their answer, and 17.7% responded with, “Don’t know”.

Table 6 Knowledge Question 7

Knowledge Question 7	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	226	70	144
(100.0)	(51.4)	(15.9)	(32.7)

The details of the benefit of universal coverages stated that in case of car accidents, patients can use the universal coverage health benefits after using the car insurance fund (Por Ror Bor Rat Yon) first. The result of the participants in this policy showed a bit higher than half of the participants (51.4%) replying with true, while don't know for this statement was 32.7%, and false for this statement was 15.9%.

Table 7 Knowledge Question 8

Knowledge Question 8	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	133	226	81
(100.0)	(30.2)	(51.4)	(18.4)

*Negative statement

The benefits of universal coverage stated that in the case of emergency accidents, patients can access health care organizations (government based UCS) without limited frequency. As this was a negative statement, participants who answered false (51.4%) were right, 30.2 % gave incorrect answers and 9.1% didn't know about frequency of these benefits.

Health Benefits related to Elderly in UCS

Table 8 Knowledge Question 9

Knowledge Question 9	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	238	74	128
(100.0)	(54.1)	(16.8)	(29.1)

The health promotion of universal coverages stated that plastic denture bases are also one of oral health provisions that are supported for the elderly. The result of the participants that knew this was 54.1%, didn't know was 29.1% which was a higher percentage than those participants who replied with the false answer (16.8%).

Table 9 Knowledge Question 10

Knowledge Question 10	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	346	15	79
(100.0)	(78.6)	(3.4)	(18.0)

The health rehabilitation benefits of universal coverage stated that cataract surgery is also one of health rehabilitation benefits that the elderly are provided with. Most participants knew this statement to be true and this showed in the results (78.6%), with only 3.4% of participants responding with a the false answer, and don't know (18.0%) in the table above.

Table 10 Knowledge Question 11

Knowledge Question 11	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	290	38	112
(100.0)	(65.9)	(8.6)	(25.5)

The benefits of health in universal coverage stated that anti-retrovirus treatment is included in this coverage. Most of the participants known this statement then shown the percentage of true (65.9%), false (8.6%) and don't know (25.5%).

Table 11 Knowledge Question 12

Knowledge Question 12	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	247	52	141
(100.0)	(56.1)	(11.8)	(32.1)

The benefits of health rehabilitation of universal coverage stated that end-stage renal disease is also one of health re-habitation benefits. Most of the participants know this statement then shown the percentage of correct answer (56.1%), false (11.8%) and don't know (32.1%) in the following table.

Table 12 Knowledge Question 13

Knowledge Question 13	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	156	173	111
(100.0)	(35.5)	(39.3)	(25.2)

*Negative statement

The benefits of health rehabilitation of universal coverages scheme state that cancer treatment is one of benefits that is included in universal coverage. As this was a negative statement, 39.3% of the participants answered that it was a false statement but 35.5% of them thought it was true. There was a 3.8 % difference between correct and wrong answers. 25.2% of the respondents chose the answer “Don't know”.

Table 13 Knowledge Question 14

Knowledge Question 14	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	230	75	135
(100.0)	(52.3)	(17.0)	(30.7)

The benefits of health rehabilitation of universal coverages scheme states that heart surgery is one of health benefits that cover the elderly. Most participants knew this statement and this showed in the results. 52.3% answered true, 17.0% false, and don't know was 30.7% in the table above.

In-patient Hospitalized and Referral Benefits in UCS**Table 14** Knowledge Question 16

Knowledge Question 16	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	315	70	55
(100.0)	(71.6)	(15.9)	(12.5)

Details of the benefits of the universal coverage scheme included that food would be supported in case that the patient is hospitalized. Most of the participants were aware of this benefit (71.6%), and the percentage of participants that answered false was 15.9%, and the percentage of participants that didn't know of this benefit was 12.5%.

Table 15 Knowledge Question 17

Knowledge Question 17	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	74	299	67
(100.0)	(16.8)	(68.0)	(15.2)

*Negative statement

The benefits of universal coverages scheme do not cover the room charges for the patients who might choose to have suites or seperated rooms. This was a negative statement and most participants knew this to be false (68.0%), the percentage of patients who said this to be true was (16.8%), and the percentage of participants who didn't know about this benefit was (15.2%).

Table 16 Knowledge Question 18

Knowledge Question 18	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	182	155	103
(100.0)	(41.4)	(35.2)	(23.4)

*Negative statement

The benefits of universal coverages state that a referral is included with full-option benefits. This was a negative statement, and most participants knew this statement as false (35.2%), the percentage of participants who answered true was (41.4%) and the percentage of participants who didn't know of this benefit was 23.4%.

Processes to Access Benefits in UCS

Table 17 Knowledge Question 3

Knowledge Question 3	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	372	47	21
(100.0)	(84.5)	(10.7)	(4.8)

A requirement to access universal coverage is that when people intend to access or use universal coverage, people must show their Gold card and ID card, or birth card for children aged < 15 years old to the health officer at the health center where they want to use the benefits. The participants in this study showed 84.5% as answering "true", 10.7% as "false", and only 4.8% didn't know about this statement.

Table 18 Knowledge Question 5

Knowledge Question 5	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	411	17	12
(100.0)	(93.4)	(3.9)	(2.7)

The present policy of universal coverage states that people can use their ID card as a substitute for the Gold card. The result of the participants that knew of this policy showed a high percentage of participants knowing this as true (93.4%) with small percentages of participants knowing this as false and “don't know”, 3.9% and 2.7% respectively.

Table 19 Knowledge Question 15

Knowledge Question 15	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	93	114	233
(100.0)	(21.1)	(25.9)	(53.0)

*Negative statement

The benefits of universal coverages states that people within the universal coverage scheme can change their main healthcare center 4 times per year. This was a negative statement, and most participants who answered this question knew this statement to be false (25.9%), this was not much different with people who knew this statement to be true (21.1%). There was a high proportion of participants that didn't know the answer to this statement (53.0%).

Table 20 Knowledge Question 19

Knowledge Question 19	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	337	58	45
(100.0)	(76.6)	(13.2)	(10.2)

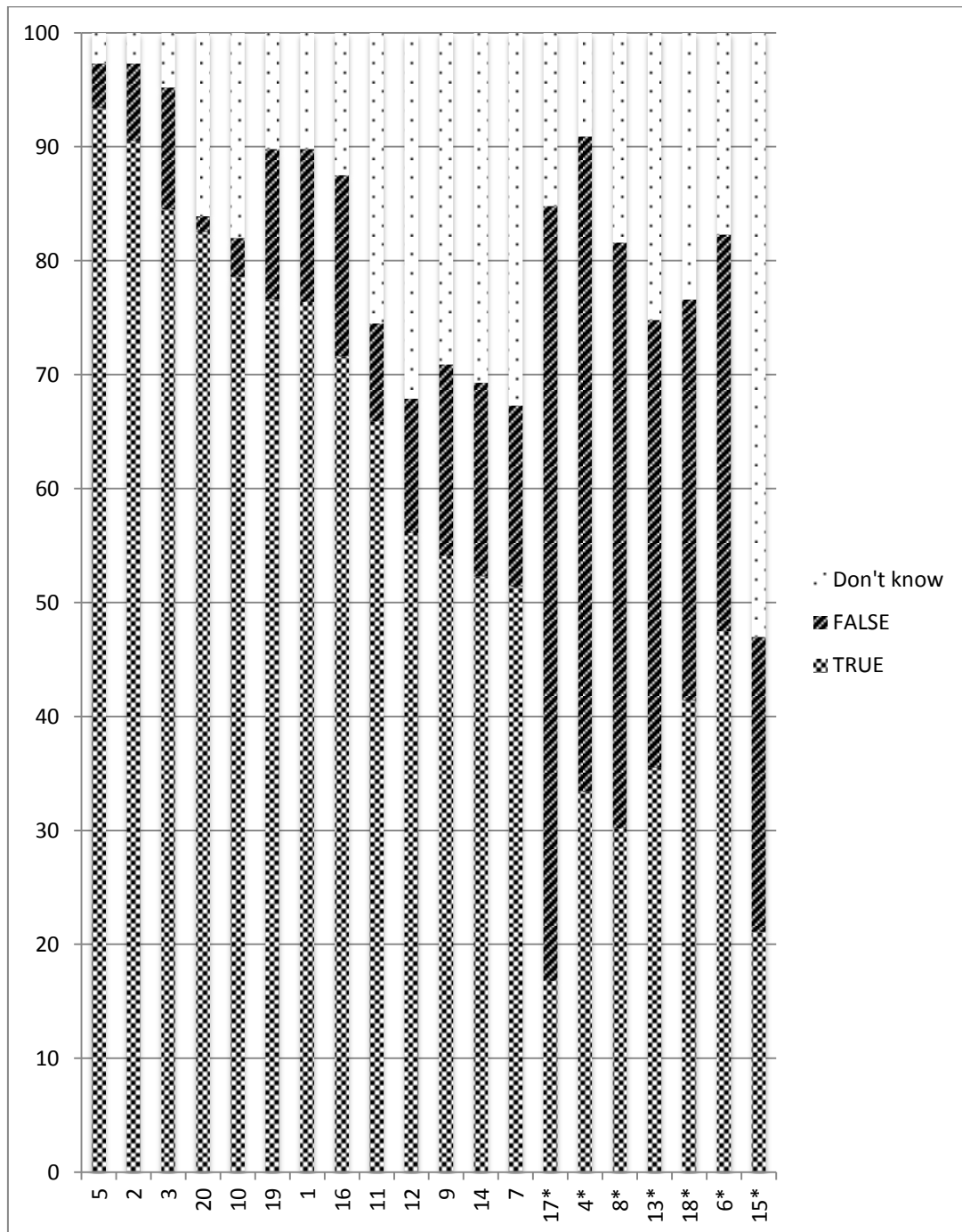
The policy of the universal coverage scheme states that beneficiaries use the scheme free of charge. Many participants responded that this statement was true (76.6%). 13.2% responded with false and the rest (10.2%) responded with “Don’t know”.

Table 21 Knowledge Question 20

Knowledge Question 20	True	False	Don't know
N	N	(N)	(N)
(%)	(%)	(%)	(%)
440	363	6	71
(100.0)	(82.5)	(1.4)	(16.1)

The policy of universal coverage schemes stated that capitation payment is used for most medical practises. The percentage of participants responded that this statement was true was 82.5%, with only 1.4% responding with false as their answer. The percentage of participants that responded with “Don’t know” as their answer was 16.1%.

The top five positive questions with right answers were question numbers 5, 2, 3, 20 and 10 respectively. The top five negative questions with right answers were question numbers 17, 4, 8, 13, and 18 respectively. The top five “don’t know” answers from both positive and negative questions were question numbers 15, 7, 12, 14, and 9 respectively. (Questionnaire in Appendix A).



*Negative statement

Figure 4: Percentages of Answering in each Question about UCS

In the area of this study, Amphoe Muang, Ratchaburi Province, Thailand, the elderly population proved that they have knowledge regarding access to the universal coverage scheme. The table 22 that illustrated the information from 20 questions which are composed of 13 positive questions and 7 negative questions. The ranking score is 0 to 19 (minimum is 0 and maximum is 19). The average score of the knowledge regarding an access to universal coverage scheme among the elderly was 12.46 (SD = 3.398) showed in the following in table, Table 22.

Table 22 Score of Knowledge in UCS

Knowledge in UCS	N = 440
Minimum Score	0
Maximum Score	19
Mean	12.46
Std. Deviation	3.398

Table 23 Percentages of Right Answer in UCS

Question	Correct	
	Number (N = 440)	Percentage (%)
1. UCS can be used for general illness, emergency illness, and accident.	336	76.4
2. In case of general illness, patients have to go to primary medical care (health promoting hospital or hospital where patient registered in UCS) first.	398	90.5
3. When people intent to use the UCS, the ID card or Birth card (for children aged < 15 years old) and Gold card. All cards must be presented.	372	84.5
4. In emergency cases, patients have limited access to health care organization participated	253	57.5

Question	Correct	
	Number (N = 440)	Percentage (%)
the UCS program.*		
5. People can use the ID card as a substitute for the Gold card.	411	93.4
6. In case of an accident, patient can get an access to any hospitals (Government hospitals and Non-government hospital) in any province.*	153	34.8
7. In case of an accident, patient can use the UCS health benefits after using the car insurance fund (Por Ror Bor Rot Yon) first.	226	51.4
8. In case of emergency accident, patients have limited access to health care organization participated in UCS program.*	226	51.4
9. Benefits from the UCS in health promotion of oral health ex. plastic denture base	238	54.1
10. Benefit from the UCS is including cataract surgery.	346	78.6
11. Benefits from the UCS are including anti-retrovirus drug.	290	65.9
12. Benefit from the UCS is including end-stage renal disease.	247	56.1
13. Cancer is not covered in UCS*	173	39.3
14. Heart surgery is covered in UCS	230	52.3
15. People can change main health care center 3 times per year.*	114	25.9
16. Food is also included at hospital in term of in-patient.	315	71.6

Question	Correct	
	Number (N = 440)	Percentage (%)
17. UCS right covers expenses on special room at the hospital (In-patient).*	299	68.0
18. When referral, UCS insurer cannot use full-option benefits.*	155	35.2
19. UCS is now free-of-charge	337	76.6
20. Capitation is used for most medical practice in UCS	363	82.5

* Negative statements

Table 24 Knowledge Levels in UCS

Knowledge levels	Number (N = 440)	Percentage (%)
High level (17 - 20scores)	45	10.2
Moderate level (13 - 16 scores)	200	45.5
Low level (0 - 12 scores)	195	44.3

The level of knowledge regarding access to universal coverage scheme among the elderly in the study population showed that 10.2% of respondents had “High level of knowledge”, the rest of them were 45.5% and 44.3% had “Moderate and low level of knowledge” respectively.

4.3 The Association between Socio-demographic Characteristics and Knowledge Regarding an Access to Universal Coverage Scheme

The percentage of high level of knowledge was the highest in age group of 60-69 years (59.6%). Similarly, the high level of knowledge distributed in both male (53.9%) and female (56.9%). Regarding marital status, the highest knowledge showed optimum value in single (62.8%), other types of relationship (56.6), and marriage (54.0%). The consideration of number of people in each family stated the highest score of knowledge in family which have only 1 member (69.2%). In the same way, the number of children in each family stated the high level of knowledge in family which have only 1 child (68.8%). Level of education informed that there was a high level of knowledge at the elementary school level (57.5%) which was higher than those with a higher level of education such as those with a high school, diploma, and bachelor's degree (50.0%). There was a high level of knowledge in agriculture (62.4%), employee (56.2%), and not working (53.8%). We were informed that the monthly family income that were the most prevalent were the families which have an income around 10,001 – 20,000 baht (57.9%), < 10,000 baht (56.6%), 20,001 – 30,000 baht (50.0%), and > 30,000 baht (47.4%). Responsibility for the elderly, focusing on the care taker (consentants) had the high level of knowledge of elderly who don't have the care taker (65.5%) and elderly who have the care taker (55.0%). Not much different in high level of knowledge in elderly who is self-dependent in routine activities (wearing cloths, cooking foods, cleaning their house), elderly who can do all activities (56.2%) have greater percentage than elderly who can do some activities (53.5%) as showed in table 25.

One-Way ANOVA test that showed the association between socio-demographic characteristics of the study population and knowledge regarding an access to universal coverage scheme. It was found that people in each family, highest education, and occupation were associated significantly with the knowledge level regarding an access to universal coverage scheme among the elderly in Amphoe Muang, Ratchaburi province, Thailand (p-value = 0.020, 0.000, and 0.010) respectively showed in table 26.

Table 25 Association between Socio-demographic and Knowledge of UCS

Characteristics	Total Respondents (N)	Knowledge N (%)	
		High + Moderate	Low
Gender	440		
Male	178	96 (53.9)	82 (46.1)
Female	262	149 (56.9)	113 (43.1)
Age	440		
60-69	272	162 (59.6)	110 (40.4)
70-79	115	58 (50.4)	57 (49.6)
80 >	53	25 (47.2)	28 (52.8)
Marital Status	440		
Single	43	27 (62.8)	16 (37.2)
Married	261	141 (54.0)	120 (46.0)
Other	136	77 (56.6)	59 (43.4)
People/Family	440		
1	26	18 (69.2)	8 (30.8)
2	75	43 (57.3)	32 (42.7)
3	79	48 (60.8)	31 (39.2)
4	55	33 (60.0)	22 (40.0)
5	83	44 (53.0)	39 (47.0)
> 5	122	59 (48.4)	63 (51.6)

Characteristics	Total Respondents (N)	Knowledge N (%)	
		High + Moderate	Low
Children/ Family	389		
1	48	33 (68.8)	15 (31.2)
2	110	58 (52.7)	52 (47.3)
3	91	57 (62.6)	34 (37.4)
4	68	31 (45.6)	37 (54.4)
5	38	21 (55.3)	17 (44.7)
> 5	34	10 (29.4)	24 (70.6)
Highest Education	440		
Elementary School	386	222 (57.5)	164 (42.5)
> Elementary school	32	16 (50.0)	16 (50.0)
Not Study	22	7 (31.8)	15 (68.2)
Occupation	440		
Agriculture	109	68 (62.4)	41 (37.6)
Employee	137	77 (56.2)	60 (43.8)
Business/Trader	47	21 (44.7)	26 (55.3)
Not Working	145	78 (53.8)	67 (46.2)
Other	2	1 (50.0)	1 (50.0)

Characteristics	Total Respondents (N)	Knowledge N (%)	
		High + Moderate	Low
Family Income	440		
< 10,000	267	151 (56.6)	82 (43.4)
10,001-20,000	114	66 (57.9)	113 (42.1)
20,001-30,000	28	14 (50.0)	14 (50.0)
> 30,000	19	9 (47.4)	10 (52.6)
Other	12	5 (41.7)	7 (58.3)
Care Taker	440		
Have	411	226 (55.0)	185 (45.0)
Don't have	29	19 (65.5)	10 (34.5)
Self-dependent	440		
Some activities	86	46 (53.5)	40 (46.5)
All activities	354	199 (56.2)	155 (43.8)

Table 26 One-Way ANOVA Test

Characteristic	Sum of Squares	df	Mean Square	f	Sig.
Gender					
Between group	.813	1	.813	.070	0.791
Within group	5068.451	438	11.572		
Total	5069.264	439			
Age					
Between group	53.295	2	26.647	2.322	0.099
Within group	5015.969	437	11.478		
Total	5069.264	439			
Marital Status					
Between group	17.612	2	8.806	.762	0.467
Within group	5051.651	437	11.560		
Total	5069.264	439			
People/Family					
Between group	153.190	5	30.638	2.705	0.020*
Within group	4916.073	434	11.327		
Total	5069.264	439			

Characteristic	Sum of Squares	df	Mean Square	f	Sig.
Children/Family					
Between group	106.273	5	21.255	1.886	0.96
Within group	4315.264	383	11.267		
Total	4421.537	388			
Highest Education					
Between group	184.146	2	92.073	8.236	0.000**
Within group	4885.117	437	11.179		
Total	5069.264	439			
Occupation					
Between group	153.279	4	38.320	3.391	0.010**
Within group	4915.985	435	11.301		
Total	5069.264	439			
Family Income					
Between group	27.596	4	6.899	.595	0.666
Within group	5041.668	35	11.590		
Total	5069.264	439			
Care Taker					
Between group	12.890	1	12.890	1.117	0.291
Within group	5056.373	438	11.544		
Total	5069.264	439			

Characteristic	Sum of Squares	df	Mean Square	f	Sig.
Self-dependent					
Between group	17.184	1	17.184	1.490	0.223
Within group	5052.079	438	11.534		
Total	5069.264	439			

P-value < 0.05 *, P-value < 0.01 **

For the multiple comparison (Post Hoc) of the socio-demographic characteristics (family member, occupation and highest education) were computed, the result showed associated significant at the mean level (p-value < 0.05) with knowledge regarding an access to universal coverage scheme among the elderly in Amphoe Muang, Ratchaburi province, Thailand shown in table 27, 28, and 29 as followed:

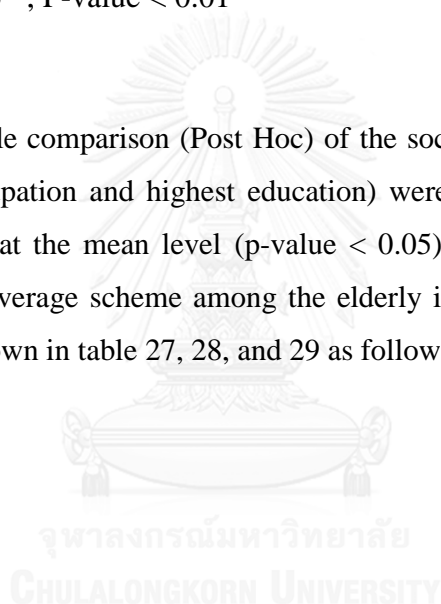


Table 27 Post-Hoc between Family Member and Level of Knowledge UCS

(I)	(J)	Mean			95% Confidence Interval	
		Difference (I-J)	Std. Error	Sig.	Lower Bond	Upper Bond
1	2	1.570	.766	.614	-.69	3.82
	3	1.798	.761	.278	-.45	4.04
	4	1.186	.801	1.000	-1.18	3.55
	5	1.246	.756	1.000	-.99	3.48
	> 5	2.323 ^a	.727	.022*	.18	4.47
2	1	-1.570	.766	.614	-3.83	.69
	3	.228	.543	1.000	-1.37	1.83
	4	-.384	.597	1.000	-2.15	1.38
	5	-.325	.536	1.000	-1.91	1.26
	> 5	.753	.494	1.000	-.91	2.21
3	1	-1.798	.761	.278	-4.04	.45
	2	-.228	.543	1.000	-1.83	1.37
	4	-.612	.591	1.000	-1.13	1.13
	5	-.553	.592	1.000	-2.11	1.01
	> 5	.524	.486	1.000	-.91	1.96

(I)	(J)	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bond	Upper Bond
4	2	- 1.186	.801	1.000	- 3.55	1.18
	3	.384	.597	1.000	- 1.38	2.15
	4	.612	.591	1.000	- 1.13	2.36
	5	.060	.585	1.000	- 1.67	1.79
	> 5	1.137	.547	.572	- .48	2.75
5	2	- 1.246	.756	1.000	- 3.48	.99
	3	.325	.536	1.000	- 1.26	1.91
	4	.553	.529	1.000	- 1.01	2.11
	5	- .060	.585	1.000	- 1.79	1.67
	> 5	1.077	.479	.375	- .34	2.49
> 5	2	- 2.323 [*]	.727	.022 [*]	- 4.47	- .18
	3	- .753	.494	1.000	- 2.21	.71
	4	- .542	.486	1.000	- 1.96	.91
	5	- 1.137	.547	.572	- 2.75	.48
	> 5	- 1.077	.479	.375	- 2.49	.34

* The mean difference is significant at the p-value < 0.05 level.

Family Members were significantly different with level of knowledge regarding access to universal coverage scheme among the elderly at Amphoe Muang, Ratchaburi Province. The level of knowledge regarding access to universal coverage among participants who have 1 family member had a significant different with the level of knowledge regarding an access to universal coverage among participants who have > 5 family members (p-value = 0.022) at the mean difference is significant at p-value < 0.05 level.

Table 28 Post-Hoc between Occupation and Level of Knowledge UCS

(I)	(J)	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bond	Upper Bond
Agriculture	Employee	.223	.431	1.000	-.99	1.44
	Business/trader	1.891 [*]	.587	.014*	.24	3.55
	Not working	.887	.426	.379	-.32	2.09
	Other	-.982	2.399	1.000	-7.75	5.79
Employee	Agriculture	-.233	.431	1.000	-1.44	.99
	Business/trader	1.668 [*]	.568	.035*	.06	3.27
	Not working	.665	.401	.978	-.47	1.79
	Other	-1.204	2.394	1.000	-7.69	5.55
Business/ Trader	Agriculture	-1.891 [*]	.578	0.14*	-3.35	-.24
	Employee	-1.668 [*]	.568	0.35*	-3.27	-.06
Trader	Not working	-1.003	.564	.761	-2.60	.59
	Other	-2.872	2.427	1.000	-9.72	3.98

(I)	(J)	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bond	Upper Bond
Not working	Agriculture	-.887	.426	.379	- 2.09	.32
	Employee	-.665	.401	.978	- 1.79	.47
	Business/trader	1.003	.564	.761	-.59	2.60
	Other	- 1.869	2.393	1.000	- 8.62	4.88
Other	Agriculture	.982	2.399	1.000	- 5.79	7.75
	Employee	1.204	2.394	1.000	- 5.55	7.96
	Business/trader	2.872	2.427	1.000	- 3.98	9.72
	Not working	1.869	2.393	1.000	- 4.88	8.62

* The mean difference is significant at the p -value < 0.05 level.

Occupation was significantly different with level of knowledge regarding access to universal coverage scheme among the elderly at Amphoe Muang, Ratchaburi Province. The level of knowledge to access universal coverage among participants and agriculture were associated with significant levels of knowledge regarding access to universal coverage among participant who are business man or woman/ trader (p -value 0.014) and the level of knowledge to access universal coverage among participants who are employees were associated significant levels of knowledge regarding an access to universal coverage among participant who are business man or woman/ trader (p -value 0.035) at the mean difference is significant at the p -value < 0.05 level.

Table 29 Post-Hoc between Highest Education and Level of Knowledge UCS

(I)	(J)	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bond	Upper Bond
Elementary	> Elementary	.619	.615	.944	-.86	2.10
	Not study	2.923 ^a	.733	.000**	1.16	4.68
> Elementary	Elementary	-.619	.615	.944	-2.10	.86
	Not study	-2.304 ^a	.926	.040	.08	4.53
Not study	Elementary	-2.923	.733	.000**	-4.68	-1.16
	> Elementary	-2.304	.926	.040	-4.53	-.08

** The mean difference is significant at the p-value < 0.01 level.

Highest education level was significantly different with level of knowledge regarding an access to universal coverage scheme among the elderly at Amphoe Muang, Ratchaburi Province. The level of knowledge concerning access to universal coverage among participants with elementary education had the strong significant different with the level of knowledge regarding access to universal coverage among participants who didn't study at all (p-value = 0.000) at the mean difference is significant at the p-value < 0.01 level.

Box-plot of Post-Hoc Analysis Result

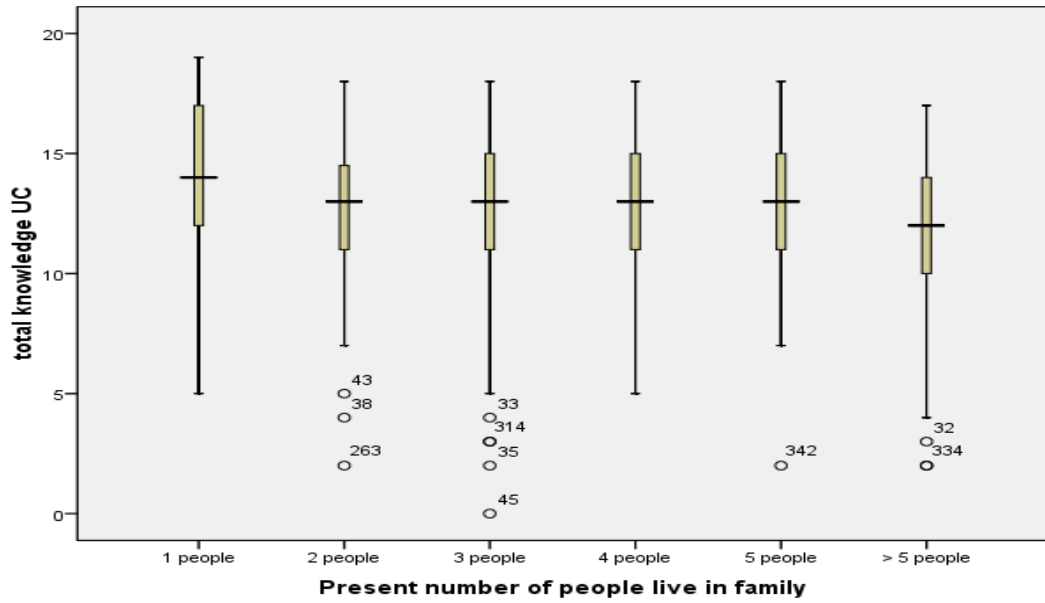


Figure 5: Box-plot between Family Member and Knowledge of UCS

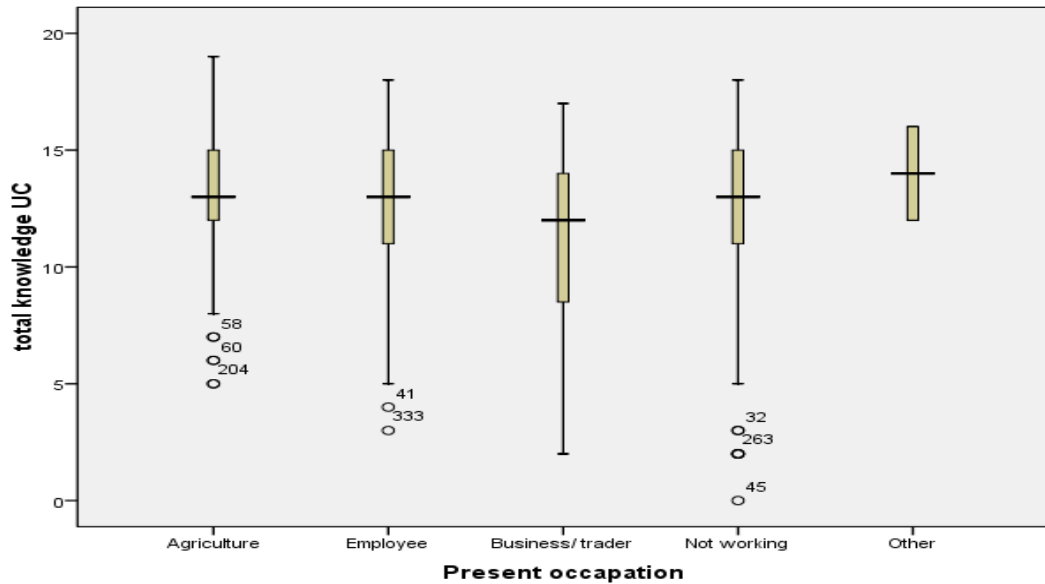


Figure 6: Box-plot between Occupation and Knowledge of UCS

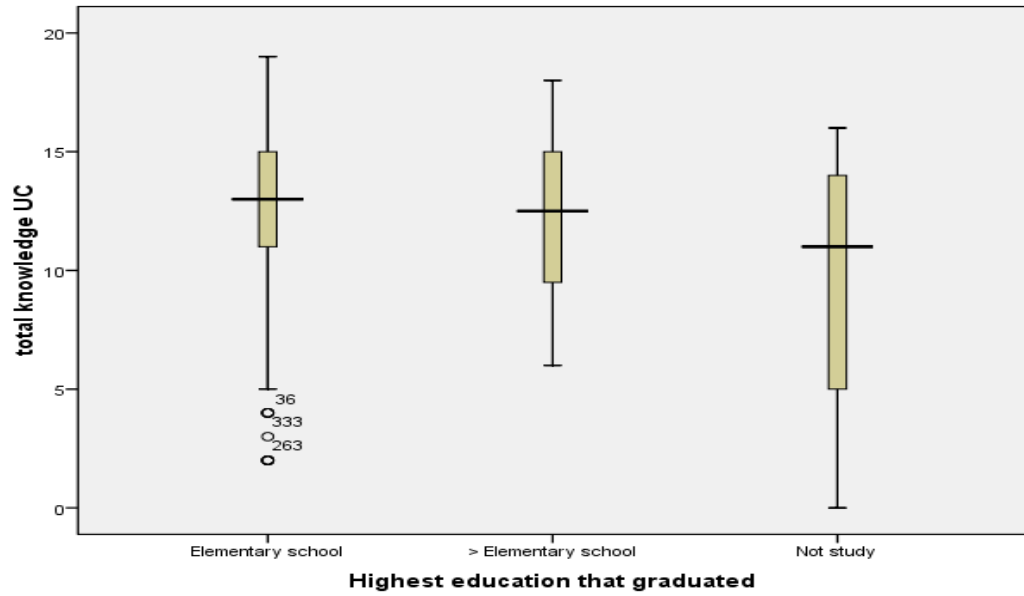


Figure 7: Box-plot between Highest Education Level and Knowledge of UCS



CHAPTER V

DISCUSSIONS

5.1 Socio-demographic Characteristics

Elderly in Amphoe Muang, Ratchaburi province who participated in this study were mostly were female (59.5%). This result was similar with the survey of public opinion and the health provider about universal coverage scheme in 2011 and 2013 by National Health Security Office collaborated with Happiness Community Center, Assumption University that were female participants 52.2% in 2011 and 51.6% in 2013. Buddhism was the one and only religion among the participants (100%) (National Health Security Office 2011), (National Health Security Office 2013) that accorded with the majority result from Vicharn Boonkham was Buddhist (95.7%). The majority of aged group of 60 - 69 years old (61.8%), 70 -79 years old (26.1%), and 80 years old and above (13.0%) (Boonkham 2014) and another study of Arpirapon mentioned that female who participated in his study was 52% (Deevit 2011) and result came from Taddao and Porchom that were 60.7% (Khamyodjai 2013) and 58.0% (Nibooneerana 2013) in series. The result of this study were in line with Bunlu Siripanich M.D. who stated in the conference of on Primary Care on Development Aging Care in his topic of The healthy development in aging paradigm, Thailand that elderly aged 60 – 69 years old was the most group (58.8%) from another two aged group 70 – 79 years old (31.7%) and 80 years old and above (9.5%) in 2007 respectively(Siripanich 2009). For the result of marital status of the respondents in this study showed (59.3%) of them were married, in alliance with Siriwan Siriboon research which mentioned that elderly have marriage status 62.0% in year 2008 (Siriboon 2009), Porchom defined that patient who used befits of universal coverage in Kohka hospital, Lamphang Province mainly was married (68.0%) (Nibooneerana 2013). Like the survey from National Health Security Office collaborated with Happiness Community Center, Assumption University that described the amount of married status and belong together in 69.8% and 66.7% in year 2011 and 2013 serially (National Health Security Office 2011), (National Health Security Office 2013).

With regard to the number of people in family in this study, our results indicated that participants generally had more than 5 people (27.7%) in each family and not

different much with the study of Porchom found mostly had the 3-5 people in the household (74.0%) and more than 5 people in the household was 22.0%. And most the number of children of the participants in this study was 2 people (28.3%) (Nibooneerana 2013).

The highest education of participants was graduating elementary school (87.7%). This finding was identical result in Porchom explained that laegly participant graduated in elementary school (68.0%) (Nibooneerana 2013) and in the survey of National Health Security Office collaborated with Happiness Community Center, Assumption University that described the educaton was elementary school in 46.0% and 42.1% from year 2011 and 2013. Chiefly, the occupation of these participants in this study were not working (33.0%) (National Health Security Office 2011), (National Health Security Office 2013), same with the study of factors affect to access to health care among elderly in government hospital, Amphoe Muang, Chiang Mai by Taddao , that 66% of the elderly were not working (Khamyodjai 2013). The information about family income of the participants in this study was less than 10,000 baht/monthly (60.7%) that duplicated with the result from many studies from National Health Security Office collaborated with Happiness Community Center, Assumption University in 2011 and 2013 (National Health Security Office 2011), (National Health Security Office 2013), Arpirapon (Deevit 2011) and Taddao (Khamyodjai 2013) mentioned were 86.9%, 44.6%, 62.0% and 62.7% suscessively.

The ageing of the population is rapidly increasing in Thailand. This study also focuses on caretakers of the elderly that stated mostly of the participants had the caretaker (93.4%) corresponding with the majority of respondents in a study by Dusit Janthayanont, that described the elderly have been staying with other (81.60%) (Dusit Janthayanont 2011), most of them were daughters, nephews/nieces, sons or children-in-law (Suwanrada 2014). These result were affected with the estimated of Siriwan Siriboon, that in year 2013 will have the caretaker (in working period) 2.4 people per 1 elderly that the proportion of the care of elderly decrease (Siriboon 2009). They were self-dependent by doing in all activities in routine (80.5%) and rest of them were can doing in some routine activities (19.5%) that vertically result of Dusit Janthayanont that showed the result of prevalence of the elderly dependency in Phra Nakhon Si Ayutthaya Province about activity daily without living dependency was 94.20% and with living dependency was 5.67% (Dusit Janthayanont 2011).

5.2 Knowledge Regarding an Access to Universal Coverage Scheme

Overall, the participants in this study had “moderate level of knowledge” (45.5%) regarding access to universal coverage scheme among the elderly in Amphoe Muang, Ratchaburi Province, Thailand. The study’s result aligned with Kanittha Chamroonsawasdi’s in the report, “Factors Influencing Health Promoting Behaviors among the Elderly Under the Universal Coverage Program, Buriram Province, Thailand” stating that elderly had health promotion behavior at a moderate level (53.7%) (Kanittha Chamroonsawasdi 2010), in the straightway with Samita Pokhrel, in the study of “Factors influencing annual health checkup among older adults in Kanchanaburi demographic surveillance system, Thailand” stated that “health information” of the participants revealed that 70.9% in past one year received the health information in the past year while the rest of them 29.1% didn’t not got the it. (Pokhrel 2013).

The result of this study was in contrast with the study of “Attitude and knowledge regarding health care policy and systems: a survey of medical students in Ontario and California” by Sherif Emili that support for universal health care coverage was higher in Ontario (86.8%) than California (51.1%) $p < 0.001$ (Sherif Emil MDCM 2014). The result of community perception of health insurance and their preferred design features: implications for the design of universal health coverages in Kenya by Stephen Mulupi described that there was high awareness of health insurance scheme but limited knowledge of how health insurance functions as well (Stephen Mulupi 2013).

Considering some questions regarding access to universal coverage scheme among the elderly in this study, top 1 of the positive questions “People can use the ID card as a substitute for the Gold card” is now policy reached to 93.4% that coincided with the survey of National Health Security Office collaborated with Happiness Community Center, Assumption University in 2011 was 82.4%. Top 2 of the positive questions “In case of general illness, patients have to go to primary medical care that health promoting hospital or hospital where patient registered in UC first ” was 90.5% (National Health Security Office 2011) that coincided with the survey of National Health Security Office collaborated with Happiness Community Center, Assumption University in 2013 were 82.3 and 84.2 respectively (National Health Security Office 2013). And top 1 question that the participants didn’t know or not sure was “People can change main health care center 3 time per year”, that the result show 25.9%. The survey of National Health Security Office collaborated with Happiness Community Center, Assumption University

in 2011, mention in not sure result was 21.2% in term of people can change main health care center 3 time per year but in 2013 survey of these organization showed 28.3% in not sure answer that people can change main health care center 4 time per year (National Health Security Office 2011).

Another specific questions in this study, showed the result that not much different between the false answer and don't know answer. Then the health care provider should concerning in each subject matter that the result from the survey of National Health Security Office collaborated with Happiness Community Center, Assumption University, in 2011 and 2013 reflected that people need to know their benefits in UC (75.8% and 72.3%), how to use their benefit in emergency case or another place where not their primary health care hospital (56.8% and 61.1%), how to change the primary health care (51.7% and 55.6%) considerably (National Health Security Office 2011), (National Health Security Office 2013).

5.3 Association between Socio-demographic Characteristics and Knowledge Regarding an Access to Universal Coverage Scheme

The result of the association between socio-demographic information and knowledge regarding access to the universal coverage scheme among the elderly in Amphoe Muang, Ratchaburi Province, Thailand, displayed that number of people in family, highest education, and occupation were associated significantly with the knowledge level regarding access to universal coverage scheme among the elderly in Amphoe Muang, Ratchaburi province, Thailand (p-value = 0.020, 0.000, and 0.010) respectively. Moreover, the association between the number of people in each family and level of knowledge regarding access to the universal coverage scheme gave the negative direction that the increasing of members of family lived at same time, the level of the participant's knowledge will be decreased. For the association between the occupation and knowledge regarding access to the universal coverage scheme could explain that agriculture, employee, and other had higher than business/trader's level of knowledge regarding access to universal coverage scheme. And the association between the highest education level and knowledge regarding access to the universal coverage scheme mentioned the positive direction of association that elderly who graduated in elementary school had the higher level of knowledge regarding access to the universal coverage scheme than the one who does not study. Another factors like the age, gender, marital status, occupation, monthly family income, number of people in the family, care taker and

self-independent didn't have the effects on level of knowledge. While Nathalie et. al. found that the level of knowledge was significantly associated with household income in US but not in Canada (Nathalie Huget 2008). The roles of access to health care and socioeconomics inequality in US and Canada were giving the positive linear relationship with the level of knowledge. Kanittha et. al. mentioned factors that can predict the health promotion behaviors of the elderly were occupation, knowledge, current illness, knowledge information from health personnel and family (all factors shown p -value < 0.01) (Kanittha Chamroonsawasdi 2010) that compliance with Samita that health behaviors, health literacy, economic status, education, and sex associated with level significantly at p -value < 0.001 (Pokhrel 2013). Similarly with Magan et. Al. that gender had statistically significant association ($p < 0.05$) in hospitalization of the elderly in Spain (Purificacion Magan 2008).

5.4 Conclusion

In this cross-sectional study, aiming to assess and examine the level of knowledge and the factors associated with knowledge regarding access to universal coverage scheme among elderly in Amphoe Muang, Ratchaburi Province, Thailand. Data collection was conducted during April and May 2015, the statistical method that were used as number, percentage, mean, standard deviation, and Chi-square Test, and result of this study can be concluded as following.

1. The participants in this study were both male and female. Most of them were female (59.5%), buddhism (100%), and their most aged ranking was 60 – 69 years old (61.8%). Most of them were married (59.3%) and graduated in elementary school (87.7%). Chiefly of the participants in this study do not work (33.0%), in the concerning about family income of the participants in this study was less than 10,000 baht/monthly (60.7%) even the generally participant have number of people who lived in present time more than 5 people (27.7%) and most of them had 2 children (28.3%) in each family then affected that mostly of the participants had the care taker like a druahther, nephew/niece, son and child-in-law (93.4%) even most of the participants have their care taker but mainly they were self-dependent by doing in all routine activities (80.5%).

2. The level of knowledge regarding access to universal coverage scheme among the elderly in Amphoe Muang, Ratchaburi Province, Thailand was in high and moderate level (55.7%). Most of them knew about the general benefits regarding an access to

universal coverage scheme but small percentage of them did not aware of some specific benefits related in regarding an access to universal coverage scheme among elderly.

3. The socio-demographic characteristics that associated with level of knowledge regarding access to universal coverage scheme of this study population were the number of people in family (p-value = 0.020), occupation (p-value = 0.010) , and highest education (p-value = 0.000).

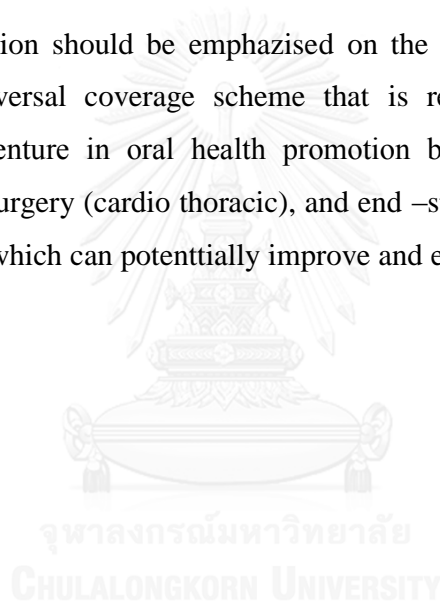
5.5 Contribution of this study

This research represents the level of knowledge regarding the access to universal coverage scheme among the elderly in Amphoe Muang, Ratchaburi Province, Thailand. This is the first study regarding knowledge about an access to universal coverage scheme that focused on elderly benefits about the universal coverage scheme, as well as the first one to assess the knowledge about their benefits of the universal coverage, the level of knowledge and factors that are related with knowledge in the study area. Other studies can adopt or apply these result from this study for information used. Furthermore, the reccommendation for future study is to add more comparing factors such as socio-demographic factors, frequency of visit health care in last 6 months, and other medical history, that are related to knowledge reagrding an access to universal coverage scheme among elderly in difference area of Thailand.

5.6 Recommendations

Based on the finding of this study, the researcher provided some of the policy recommendations related to universal coverage scheme, as the following:

1. Health education about the benefits regarding an access to universal coverage scheme must be considered for the elderly with the low or no education, have the family members > 5 people and have business or being the trader need to be improve the knowledge regarding an access to universal coverage scheme to them. So they can access to health care facilities when they sick and deserve the better quality of service and have better elderly life.
2. Health promotion should be emphasized on the specific benefits regarding the access to universal coverage scheme that is related to the elderly such as plastic'base denture in oral health promotion benefits, health rehabilitation in cancer, heart surgery (cardio thoracic), and end –stage of renal disease (< 60% of right answer) which can potentially improve and ensure their quality of life in the elders.



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APPENDIX



จุฬาลงกรณ์มหาวิทยาลัย
CHULALONGKORN UNIVERSITY

Appendix A

Questionnaire

Survey Title: Knowledge of Universal Coverage Scheme Among Elderly

Survey Objectives: To assess the level of knowledge about the UCS among the elderly in Amphoe Muang, Ratchaburi province, Thailand and to examine the factors associated with the knowledge about the UCS among the elderly in Amphoe Muang, Ratchaburi Province, Thailand by the College of Public Health Sciences Master's degree student, Chulalongkorn University.

Questionnaire Code: [.....] (Code by Researcher)

Date: .../.../... (Code by Researcher)

Information for the respondent:

We wish to know your knowledge about the Universal Coverage Scheme (UCS). Your information will be useful for local health service and action.

Your answer will not be released to anyone and will remain anonymous. Your name will not be written on the questionnaire or be kept in other records. The presentation of this research, result is an overall summary and does not refer to an individual reporting.

There are 2 pages in this questionnaire, which consists of 2 parts:

- | | | |
|--------|--|--------------|
| Part 1 | Socio-demographic characteristics of elder | 11 questions |
| Part 2 | Knowledge about Universal Coverage Scheme | 20 questions |

Thank you for your time and kind assistance.

Part1: Socio-demographic characteristics of elderly

1. Gender

[...]	1.1 Male	[...]	1.2 Female
-------	----------	-------	------------
2. Religion

[...]	2.1 Buddhist	[...]	2.2 Christ
[...]	2.3 Islam	[...]	2.4 Other ...
3. Age

[...]	3.1 60-69 years old	[...]	3. 2 70-79 years old
[...]	3.3 80- 89 years old	[...]	3. 4 90 years old and above
4. Marital Status

[...]	4.1 Single	[...]	4.2 Married
[...]	4.3 Widowed	[...]	4.4 Divorced
[...]	4.5 Separated	[...]	4.6 Other ...
5. How many people in your family?

[...]	5.1 1 people	[...]	5.2 2 people
[...]	5.3 3 people	[...]	5.4 4 people
[...]	5.5 5 people	[...]	5.6 More than 5 people
6. How many children do you have?

[...]	6.1 1 people	[...]	6.2 2 people
[...]	6.3 3 people	[...]	6.4 4 people
[...]	6.5 5 people	[...]	6.6 More than 5 people
7. What's your highest education level?

[...]	7.1 Elementary school	[...]	7.2 Secondary school		
[...]	7.3 High school	[...]	7.4 Diploma		
[...]	7.5 Bachelor's Degree	[...]	7.6 Not study	[...]	7.7 Other
8. What's your occupation?

[...]	8.1 Agriculture	[...]	8.2 Employee		
[...]	8.3 Business/ trader	[...]	8.4 Not working	[...]	8.5 Other
9. What is your monthly family income?

[...]	9.1 < 10,000 baht	[...]	9.2 10,001 – 20,000 baht		
[...]	9.3 20,001 – 30,000 baht	[...]	9.4 > 30,001 baht	[...]	9.5 Other
10. Do you have caretaker?

[...]	10.1 Have	[...]	10.2 Don't have
-------	-----------	-------	-----------------
11. Do you have self- dependent in routine activities?
(Wear cloth, provide food, and clean house)

[...]	11.1 some activities	[...]	11.2 all activities
-------	----------------------	-------	---------------------

Part 2: Knowledge about Universal Coverage Scheme (UCS)

Please x for the column of your answers.

Question Statement	True	False	Don't know
1. UCS can be used for general illness, emergency illness, and accident.			
2. In case of general illness, patient has to go to primary medical care (health promoting hospital) first.			
3. When people intention to use the UCS, the ID card or Birth card (for children aged < 15 years old) and Gold card all must be presented.*			
4. In general illness, patients have limited access to health care organization participated the UCS program.*			
5. People can use the ID card as a substitute for the Gold card.			
6. In case of an accident, patient can get an access to any hospitals in the province.			
7. In case of a car accident, patient can use the UCS right after using the car insurance fund (Por Ror Bor Rot Yon) first.			
8. In case of the emergency accident, patients have limited access to health care organization participated the UCS program.*			
9. Benefits from the UCS in oralhealth promotion (Ex. Plastic's base denture)			
10. Benefit from the UCS is including cataract surgery.			
11. Benefits from the UCS are including anti-retrovirus drug			
12. Benefit from the USC is including end-stage renal disease.			
13. Cancer is not coverage in UCS*			

Question Statement	True	False	Don't know
14. USC right covers expenses on food (in-patients).			
15. People can change main health care center 3 times per year.*			
16. Food also include at hospital in term of in-patient.			
17 UCS right covers expenses on special separate room at the hospital (In-patient).*			
18. When referral, UCS insurer cannot use full-option benefits.*			
19.UCS is now free-of-charge			
20. Capitation is used for most medical practice in UCS			

Appendix B

Questionnaire Thai Version

เลขที่แบบสอบถาม :.....

วันที่...../...../.....

คำชี้แจง:

แบบสอบถามชุดนี้จัดทำขึ้นเพื่อประเมินระดับความรู้เกี่ยวกับหลักประกันสุขภาพถ้วนหน้าในผู้สูงอายุ และพิจารณาความสัมพันธ์ของปัจจัยที่เกี่ยวข้องกับระดับความรู้ของผู้สูงอายุในเขตอำเภอเมือง จังหวัดราชบุรี ประเทศไทย ผลการศึกษาที่ได้จากการตอบแบบสอบถามในครั้งนี้ จะถูกนำไปใช้พัฒนาข้อเสนอแนะต่อการวางแผนสาธารณสุขชุมชนในอนาคตต่อไป

ข้อมูลที่เกี่ยวข้องกับท่านจะเก็บเป็นความลับ หากมีการเสนอผลการวิจัยจะเสนอเป็นภาพรวม ข้อมูลใดที่สามารถระบุถึงตัวท่านได้ จะไม่ปรากฏในรายงาน

แบบสอบถามมีทั้งหมด 2 หน้า รวมทั้งหมด 31 คำถาม แบ่งออกเป็น 2 ส่วน ดังนี้

ส่วนที่ 1 ข้อมูลทั่วไป	จำนวน	11	คำถาม
ส่วนที่ 2 ความรู้เกี่ยวกับระบบหลักประกันสุขภาพถ้วนหน้า	จำนวน	20	คำถาม

ขอขอบคุณในการตอบแบบสอบถาม

ส่วนที่ 2 ความรู้เกี่ยวกับระบบหลักประกันสุขภาพถ้วนหน้า กรุณาทำเครื่องหมาย X ในช่องคำตอบที่ท่านเลือก

รายการคำถาม	ถูก	ผิด	ไม่ทราบ
1. หลักประกันสุขภาพถ้วนหน้า สามารถใช้สิทธิเมื่อ เจ็บป่วยทั่วไป เจ็บป่วยฉุกเฉิน กรณีอุบัติเหตุ			
2. ในกรณีเมื่อเจ็บป่วยปกติ ผู้ป่วยต้องเข้ารับบริการที่โรงพยาบาลส่งเสริมสุขภาพตำบล (อนามัย) หรือโรงพยาบาลที่ได้ลงทะเบียนเป็นสถานบริการหลักในหลักประกันสุขภาพถ้วนหน้าก่อน			
3. เมื่อมีความจำเป็นในการใช้สิทธิหลักประกันสุขภาพถ้วนหน้า เอกสารหลักฐานที่จำเป็นต้องเตรียมให้ครบถ้วนประกอบไปด้วย บัตรประจำตัวประชาชน สุนัขบัตร (ในเด็กอายุต่ำกว่า 15 ปี) และบัตรทอง			
4. มีการจำกัดจำนวนครั้งของผู้ป่วยในการเข้ารับบริการ ในกรณีเจ็บป่วยทั่วไป ในสถานพยาบาลที่เข้าร่วมในระบบหลักประกันสุขภาพถ้วนหน้า			
5. นโยบายในปัจจุบันประชาชนสามารถใช้บัตรประจำตัวประชาชนแทนบัตรทองได้			
6. ในกรณีอุบัติเหตุ ผู้ป่วยสามารถเข้ารับบริการจากสถานพยาบาล (ทั้งรัฐและเอกชน) ใดก็ได้			
7. ในกรณีของอุบัติเหตุฉุกเฉิน ผู้ป่วยสามารถใช้สิทธิหลักประกันสุขภาพถ้วนหน้าได้ต่อเนื่อง หลังจากการชดเชยค่าเสียหายเบื้องต้นที่กองทุนทดแทนผู้ประสบภัยจากรถ (พรบ.) หรือบริษัทประกันเป็นผู้จ่าย			
8. มีการจำกัดจำนวนครั้งของผู้ป่วยในการเข้ารับบริการ ในกรณีเจ็บอุบัติเหตุฉุกเฉิน ในสถานพยาบาลที่เข้าร่วมในระบบหลักประกันสุขภาพถ้วนหน้า			
9. สิทธิประโยชน์ของประชาชนในหลักประกันสุขภาพถ้วนหน้า ได้แก่ การส่งเสริมสุขภาพ การส่งเสริมป้องกันสุขภาพช่องปาก เช่น ฟันปลอมฐานพลาสติก			
10. สิทธิประโยชน์ของผู้สูงอายุในหลักประกันสุขภาพถ้วนหน้า รวมถึงการผ่าตัดต่อกระดูก			
11. สิทธิประโยชน์ของประชาชนในหลักประกันสุขภาพถ้วนหน้า รวมถึงยาด้านไวรัสในผู้ติดเชื้อ			
12. การรักษาไปตวาวหรือรังษะสุดท้ายด้วยการล้างไต ได้ถูกกำหนดไว้ในบริการที่คุ้มครอง			
13. การรักษามะเร็ง <u>ไม่ได้ถูกกำหนด</u> ไว้ในบริการคุ้มครองโรคค่าใช้จ่ายสูงในหลักประกันสุขภาพถ้วนหน้า			
14. การผ่าตัดหัวใจ <u>ได้ถูกกำหนด</u> ไว้ในบริการคุ้มครองในสิทธิหลักประกันสุขภาพถ้วนหน้า			
15. ประชาชนสามารถเปลี่ยนหน่วยบริการหลักได้ และมีข้อจำกัดการเปลี่ยน <u>ปีละไม่เกิน ๓ ครั้ง</u>			
16. <u>กรณีผู้ป่วยใน</u> สิทธิประกันสุขภาพถ้วนหน้าครอบคลุมถึงค่าอาหารฟรี			
17. <u>กรณีผู้ป่วยใน</u> สิทธิประกันสุขภาพถ้วนหน้าครอบคลุมถึงค่าห้องพักผู้ป่วยพิเศษ			
18. หลักประกันสุขภาพถ้วนหน้า <u>ไม่ได้ครอบคลุมกรณีส่งต่อผู้ป่วย</u> (มีค่าใช้จ่ายหากมีการส่งต่อ)			
19. สิทธิประกันสุขภาพถ้วนหน้าในปัจจุบัน <u>ไม่ต้องเสียค่าใช้จ่ายใดๆ</u> ทั้งสิ้น			
20. ภาครัฐได้จัดสรรค่าใช้จ่ายด้านสุขภาพต่อหัวของคนไทยมาใช้ในหลักประกันสุขภาพถ้วนหน้า			

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Elderly Care

Quality of Life