CHAPTER II

REVIEW OF THE LITERATURE

In this study the researcher reviewed related theory for setting the outline of the study. This included:

1. Health insurance concepts.
2. Theory of health service behavior.
3. Factors relating to the manner of health seeking behavior at health care unit.
4. Theory of Medical Accessibility.
5. Related studies

1. HEALTH INSURANCE CONCEPTS

Definition of the health insurance means

The compensation of lost income when suffering from poor health, not only the cost to cure the disease but also the cost to prevent and promote health (Tienchi keranan, 1999).

The guarantee to the purchaser of health care, which can be divided into 2 component. Direct insurance which covers the costs to cure the disease, and indirect insurance which provides compensation for the loss of income incurred when ill health. (The Committee on Development of Health Insurance System and Strategy Approach in Thailand, 1989).

Sharing the risk of health with the purchaser or between individuals who are eligible to receive the health service. There are two types of health insurance; compulsory and voluntary. The program must have a large group of purchasers to disperse the risk, and to prevent revenues being lower than assets. (Rungtum Ladplee, 1989).

Ensure medical service accessibility to which the purchasers have a right. The condition is payment in advance to the provider. The insurance rate is related to the anticipated expense in the future, the amount of members and other joint income. The payment condition means the distribution of the risk that makes the payment in advance low compared to the cost of the anticipated expense. This can result in large numbers of members not receiving services because they have no illness.

The mechanics of financial administration to disperse the cost of the health services to other persons or other organizations that have joined the risk of that cost. It is the one method that subsidized the financial problem to pay for health care. (Sukonta Kongsil, 1997).

To volunteer or purchase the right to be the member of the curative fund. The agency has the understanding or health card and the handbook to the member to receive the right and the method to get that right. (Yongyoot Sahonchom, 1999).

The conclusion of Health Insurance is the financial mechanism that society builds for dispersing the cost of the health services to its members. It guarantees that if

a member becomes ill he does not need to hesitate to receive health services because of financial problems. It also guarantees to the provider, or the hospital, that they will really receive reimbursement for services rendered.

Universal Coverage has many meanings, depending on the country and the social context of the country. In Thailand it means the condition of society whereby every person can have access to basic health servicess regardless of financial, socio-economic, or geographical factors. A person can obtain insurance through tax, health insurance schemes or other mechanisms determined by the government. The method of financial administration and the source of financial resources are the key variables that determine the success of the insurance and its sustablility. (Nitayarumphong, 1998).

Universal Coverage means that all Thai people have right to receive standard health services equitably, and that financial or social constraints are not obstacles. (MOPH, 2000).

The creation of Universal Coverage means that all Thai people can access and can be satisfied with standard health services. It is a right outlined in section 52 of the constitution (1996) of Thailand. Accordingly Universal Coverage means that all Thai people have the right to have access to standard health services, and that financial or social problems should not interfere with this right.

Basic Concepts of Health Insurance and Universal Coverage

Health Insurance is built upon two basic concepts; one is socialism and the other is liberalism. Liberalism promotes marketing and endeavors to reduce the services provided by the government. It believes that if there is a large amount of people who can help themselves then the government doesn't need to directly provide this service. This concept encourages people to select Health Insurance that is provided in the market place. But this concept, is sometimes prob- lematic, especially in developing countries because the majority of the population cannot afford to pay for Health Insurance. Health Insurance is only available to a small group of people. Socialism provides for free services by the government, but in reality the government does not have a sufficient budget for free services delivery, especially in developing countries, because the budget constraints, the number of people in need of services, and the other resource limitations.

Fundamentals of Health Insurance

Health Insurance relies upon sharing the risk of distress and health. (Law of averages or social solidarity) The process is risk pooling, which can reduce the individual expense. On the other hand someone who is at lower risk, is not likely to buy health insurance, but they like to buy it if they can predict avoid having to pay higher expenses. (Jirut Srirattanaban, 2000).

In conclusion the health insurance has 2 tasks

1. To provided accessibility to health service if necessary
2. To protect individual or family assets (Abel-Smith B. 1998; Kutzin, 1998).

In Thailand the Ministry of Public Health has implemented Health Insurance schemes since 2526 B.E. (1983), by using the principle of Primary Health Care. Dr.Amorn Nonthasutta, the Permanent Secretary of the Ministry of Public Health started the MCH Promotion Program that encouraged pregnant woman to obtain ANC from medical personnel. This resulted in a good outcome and high satisfaction by the people. He subsequently implemented the Insurance Card Project throughout Thailand, and refined the concepts of Primary Health Care to the Mooban Self – Help in Primary Health Care by developing funds, human resources, and administration skills to implement the Health Insurance Scheme in 2536 (Ministry of Public Health and Khonkaen University, 2001).

The Insurance Card Project was initiated to help people participate with the government. This scheme was a fore-runner of the Universal Health Coverage Scheme (30 Baht Policy).

In Thailand it is necessary to use both concepts, because it is a developing country, and thus the government should provide free services for people that cannot afford to purchase Health Insurance.

Concepts of Health Insurance

Health Insurance is the financial mechanism that society creates to disperse the cost of health services for its members. It guarantees that if a member becomes ill he should not hesitate to receive health services because of financial or social problems. It also guarantees to the provider, or the hospital, that it will really receive funds for the services rendered. In brief this system guarantees that all Thai people have access to standard health care.

The health insurance has 2 types:

1. Voluntary Health Insurance
2. Compulsory Health Insurance

Voluntary Health Insurance

England is the first country that started Voluntary Health Insurance. After the Industrial Revolution the labor supply was large, but social welfare or security was low. The Mutual Benefit Society, Sick Fund, Friends Society was created. These funds were donated by their members to help members by providing cash or services. These associations/funds were employed to pay doctors to serve their members. The doctors were employees of the association/fund. Gradually these doctors were not happy having to serve as employees. Thus they organized the Medical Association to improve their situation and free themselves from this employee status.

In the economic sense the health services has two distinct poles. The patients were consumers, while the doctors were providers. Voluntary Health Insurance can be divided into 2 types e.g.

1. Consumer Sponsored Health Insurance is the consolidation of consumers for health insurance and employs doctors to serve them.
2. Doctor Sponsored Health Insurance is the consolidation of doctors providing health insurance under this system; which in fact is a "doctor's monopoly", with the consumers being at a disadvantage.

Compulsory Health Insurance

Under this form of health insurance, the government passes legislation requiring all people to obtain health insurance. Germany was the first country to establish a Compulsory Health Insurance System. It began among government Civil Servants and then expanded to the general population in 1883. The government used the law to require the population and this program became the first National Health Insurance System. England eventually established its own National Health Service which provided free health services from the government, paid by personal income taxes.

In Thailand the Compulsory Health Insurance started in 2495 BE. (1952) through the passage of a social insurance law. But when the people disputed this law, it was aborted. In 2501 B.E. (1958) this law was revised, but the government was shortly overthrown. In 2510 B.E.(1967) the government established the Social Committee under the Fourth National Socio – Economic Development Plan, but the policy was not

specific nor serious. In 2518 B.E. (1975) hospital directors were authorized to consider providing free services for some categories of patients. In the Fifth National Socio – Economic Development Plan (2524 – 2529 B.E.) (1981-1986), the government made this a national policy "To assist low income persons and the elderly with curative care expenses".

The assistance provided for low - income persons by the Office of the Prime Minister's Law 2524 B.E. (1981) and amended Law/second Law 2525 B.E. (1982) created the Tambon Council Committee enabling the "Kamnan"(i.e. the chairman of village headmen) to identify low – income families (those with inocmes < 1,500 Baht/month) to be eligible for free health care. This list was submitted to the "Nai Amphur"(District Officer) enabling all such family members to receive free health care services. The card expired after 3 years. It could be used for services at the sub-district health center, district hospital, provincial hospital, or other government hospitals. But this welfare scheme created over- utilization in all hospitals, not in sub-district health centers, so it was terminated on September 30,1983. The government passed other welfare regulations for low – income persons in 2527 B.E. (1984) and adjusted the process to be expedient, consistent with the approved budget.

This regulation stimulated the following:

1. Monks, teachers, elderly persons selected by their community and the village health volunteer were eligible to become committee members.
2. Eligible recipients had to follow the prescribed channel to obtain health services (i.e. the first service center is near their home, and if necessary

the health center can refer the patient to a more sophisticated hospital). This process hoped to promote appropriate service delivery in the most economical manner (MOPH, 1974)

Development of Health Insurance and Universal Coverage in Thailand

After the WHO Policy of "Health For All By The Year 2000" was implemented in Thailand, Health For All became a human right, and the concept of Universal Coverage became part of the national social security network. Universal Coverage is a way to promote equity in society with respect to equal access for health services.

In the past health services in Thailand was managed by the government and provided by the government, with the population as customers. This situation resulted in many people not receiving any, or receiving incomplete, health services. This was especially the case when it came to new medical and health technologies for the poor. This has led to an attempt to change the nature of health service delivery by promoting greater participation by the population, while the government promotes, coordinates and supports the material and technical know-how to provide health services. In addition to changing the relation between medical officers and the local population, the population has became the initiator and manager of health, while health personnel are the facilitators and service providers of high technology. The important factors are committees, human resources and funds created from the community. Some actions taken at the community level are the creation of the Drug Fund, Nutrition Fund; including the Health Card Fund.

The Health Insurance Card Project is an initiative that mobilizes the resources in the community. (Taweetong Hongviwat et al. 1986)

The first stage

The Thai Universal Coverage Project began in June, 1983. The Ministry of Public Health experimented in 7 provinces: Khonkaen, Lampoon, Roi et, Nakorn Sawan, Petchaburi, Ratchaburi and Songkhla. The name of the project was "The Maternal and Child Health Development Fund". This project used the principles of Primary Health Care. First it created the Maternal and Child Health Development Fund, including Primary Health Care and the curative sector; because people need curative care when they are ill. Interested persons wanting to use this card, could buy it from the community fund, and divide some income for deposit in the nutritional fund.

It was a way to train the community about financial management and to improve the quality of the service provider.

There were three types of Health Cards

1. For curative care and MCH promotion, a Red card/price 200 Baht
2. For curative care, a Yellow card/ price 100 Baht
3. For MCH promotion and vaccination, a Blue card/price 100 Baht

This type of health insurance was Voluntary Health Insurance (Prepaid medical care) The conditions for use were as follows:

Type 1 : For the family, and children under 12 years old and pregnant women. The card was valid for 1 year. If the card was not used, it could be extended two times.

Type 2 : For the family with no pregnant women and no children under 1 year old. The card was valid for 1 year. If the card was not used it could be extended for two times.

Type 3 : For the same type of family same as Type 2 card, and for a mother who became pregnant during the card's valid period. One needed to buy Type 3 for MCH promotion.

The rights are:

Type 1 :

1. ANC 4 times/year/card
2. Delivery
3. Post natal examination within 6 weeks of delivery
4. BCG, DPT 3 times, OPV 3 times
5. Curative services 8 times
6. 10% discount if patient buys medicine from the drug fund, Sub-District Health Center or the hospital
7. Card holder can borrow money from the fund
8. Free health examination and receipt of 3% from profits of the fund.

Type 2 : Same as Type 1 from No 5 to No 8

Type 3 : Same as Type 1 from No 1 to No 4

This project was evaluated after 8 months. Due to the positive findings, the project was expanded and replicated in October 1983 to at least one Tambol in every province.

The second stage

Initiated between in 1984 to 1985 under the name "Insurance Card Project ". The goal was 1 Tambon in every province. In 1985 the goal was 1 Tambon in every district. There were 2 type of Health Cards.

Type 1: Red card for curative care, price 200 Baht (It was later changed to green in 2528 B.E., price 300 Baht).

Type 2: Blue card for MCH promotion and prevention, price 100 Baht (It was later changed to red, price 200 Baht). Free curative services 8 times/year (then changed to 6 and 4 times per year)

"One curative service" meant the continuity of care for an illness until the patient recovers. If the patient wants to pay for treetment, he can receive a 10 %t discount and not be "debited" for the visit. The registered service center is specified on the card, and patient must only use that service center. The doctor, however, can refer the patient to other services centers if necessary. The type of illness was originally limited to cover specific diseases, but was later changed to cover all illnesses. The cost per care could not, however, exceed 2000 Baht. If over 2000 Baht the patient had to pay a 10% service charge. The validity of the card was 1 year. The Type 2 card provided ANC, Delivery, Post Partum services, vaccinization and curative services to mothers and infants under 1 year of age.

The third stage

It was implemented from 2528 to 2530 B.E. (1985-1987). Its goal was every Tambon in every district. There are 3 types of cards

Type 1: "Curative Card" (300 Baht price) or "Family Card" comprises of Father, Mother, 2 sons or daughter aged under 15 years. The card was valid for 1 year.

Type 2: "Personal Curative Card"(200 Baht price) or "MCH Card" for pregnant Woman. In third stage, the Type 1 allows for 6 curative care visits and 4 visits for Type 2. There was no limitation on the type of illness except plastic surg ery, spectacles and dentistry. The expense could not exceed 2,000 Baht per visit.

The goal of the third stage stressed quality of services more than the geographic extension of the service area.

2530-2534 B.E. (1987-1991). The Sixth National Socio-Economic Development Plan extended coverage to 70% of all Moobans (Villages).

2534-2536 B.E (1991-1993) The German Agency for Technical Cooperation (GTZ) provided assistance to develop a model for voluntary health insurance in rural areas. The pilot project was implemented in 5 provinces (i.e. Chiengmai, Lampang, Mahasarakam, Rayong and Suratthani).

2536-2537 B.E. (1993-1994) Health insurance coverage was extended to community leaders (Phu Yai Ban, Kamnan, Phaet Prajam Tambon - District Doctor, Sarawat Kamnan, Phu Chuay Phu Yai Ban and Village Health Volunteers), and in

2536 B.E (1993) the government endorsed the "Voluntary Health Insurance Plan" allocating a budget of about 50 million Baht to create the fund. The card price was 1,000 Baht; with an indivudal paying 500 Bahtand the government supplementing another 500 Baht for a family for 1 year. In 2537 B.E. (1994) the government endorsed the creation of the "Health Insurance Card Revolving Fund"

2538 B.E. (1995) the Ministry of Public Health changed its model to match financial conditions and to improve efficiency and coverage to the target population (i.e. the farmers in rural areas, laborers in cities or urban areas or in SME factory, seasonal labor that migrated to the city, and independent small-scale practitioners). The card price was 1,000 Baht; with the person paying 500 baht and the government paying a supplement of 500 Baht for a family for 1 year. It could be used by everyone in the family. The supplement budget is the Health Insurance Card Revolving Fund. The goal was to increase the target population's accessibility to health care; that is the rural population and the medium income or uncertain income that did not have other welfare benefits or access to other Health Insurance Programs. The target population was about 1 million families or about 5 million persons.

There are 5 rights provided by the card :

1. The card price was 1,000 Baht; with the person paying 500 Baht and the government supplementing the remaining 500 Baht. The government supplement is the family card
2. The person usually received the card within 15 days, not longer than 30 days after applying for it.
3. The life of the card was valid for 1 year from the date of registration.
4. If the person is not living with his family (i.e. for working or studying in other geographic area), he can use an "added card"
5. The family member refers to:
   - 5.1 the head of family, his wife or her husband
   - 5.2 if the head of the family has no wife or husband, he/she can include his/her father and mother if they are under 60 years of age.
   - 5.2 If there areother persons who live in his house, he can include them, but the card cannot exceed 5 persons.

In 2541 B.E. (1998) the government increased the price of a card from 1,000 to 1,500 Baht, but the individual still paided only 500 Baht.

In 2542 B.E. (1999) the government endorsed "The Students Health Insurance Project" covering Primary and Early Secondary School, which included children aged 0-12 years.

However some inequities still remained for certain population groups, which was not the goal of section 52 of the Thai Constitution (2540). Approximately 27.5% of the population still did not have any Health Insurance (Perasit Kumnomsil et al., 2000)

Universal Coverage 30 Baht Scheme

In 2544 B.E. (2001) the government, under Prime Minister Dr. Taksin Shinawatra, stated its policy to provide health insurance for the entire population by making health services accessibility to everybody; emphasizing health promotion and prevention. In the first period the government created the Universal Coverage 30 Baht Scheme to enable Thai people to have the same kind of health insurance. In the long term the government endorsed a "National Health Law".

The purpose of the Universal Coverage 30 Baht Scheme is to ensure that people have Health Insurance, and at the same time reduce people's health-related expenses. This project targets people who have no rights under other laws, acts or commandments (i.e. the officer, the government labor, the social insurance, the people that have Ministry of Public Health's health card or the other government welfare (low-income, children under 12 years old, persons over 60 years old, the physically handicapped, monks or religion leaders, community leaders, war veterans/ soldiers). The people not mentioned above must be registered Thai citizens in order to be eligible for health services under the new health policy. The new policy began as follows:

April, 1, 2001 covering 6 provinces : Payao, Nakorn Sawan, Yasothorn, Patum Thani, Samut Sakorn, and Yala.

June, 1, 2001 covering 2 new provinces : Chiengmai and Nakorn Ratchasima

After October1, 2002, covering the remaining provinces in the country (MOPH, 2001.)

Persons eligible by the project had to register at a nearby health center or district hospital. They should use their identity cards or census records; which will eventually allow them to receive a Universal Coverage 30 Baht Scheme Card. The Universal Coverage 30 Baht Scheme Card consists of 2 types

1. Non Co-payment Card
2. Co-payment Card

Non Co-payment Card

The people entitled to this card are the following:

1. Community leaders (i.e. Phu Yai Ban, Kamnan, Phaet Prajam Tambon-District Doctor, Sarawat Kamnan, Phu Chuay Phu Yai Ban, and Village Health Volunteer, including their immediate family members).
   - 1.1 Husband, wife and legal child who are below legal age
   - 1.2 Father, mother and children who are single (must be ncluded in the same census records).

2. Low-income persons consistent with welfare regulations for the low-income person (i.e. income lower than 2,000 Baht per month per person).
3. The person who the society is required to assist according to the Ministry of Finance (i.e. persons 60 years of age old or over)
   - 3.1 Children under 12 years of age
   - 3.2 The physically handicapped covered under law passed in 2534 B.E.(1990).It is, however, unnecessary for the physically handicapped to have a card.
   - 3.3 Buddhist monks with certificates, or members of a religious fraternity other than Buddhist or Muslim leaders that have certificates; including their family members. (Musjid's Committee, Provincial Muslim's Committee, Thailand Muslim's Committee, "Imam", "Kortep Bilan").
   - 3.4 War veterans/ soldiers every class (1 – 4); including their spouses and children under legal age.
   - 3.5 Middle grade students.
4. Low-income persons as defined by law and regulations of the Ministry of Finance; indicating that the individual had a Welfare Card in the past.
5. Persons who have the right according to regulations passed by the Ministry of Public Health in 2003. This includes:
   - 5.1 Holder and holder's family; legal child under legal age, or dependent child, his or her spouse, his or her father and mother.
     - 5.1.1 European War Medal Recipient

5.1.2 Korean or Vietnam War Veterans

5.1.3 Malarial volunteer

5.1.4 Mooban lavatory technician

5.1.5 The director and teacher in Muslim schools in Pattani,Yala,Narathiwat, Satun, Songkhla, Patthalung, Nakon Si Thammarat, Ranong, Krabi, Pangnga and Phuket

5.1.6 Donator of land or other asset not lower than 2,000,000 Baht

5.2 Special individuals,

5.2.1 Those who received the King Service Medal

5.2.2 Those who received the Free Thai Movement Medal

5.2.3 Soldier or officers injured during Communist insurgency

5.2.4 Persons injured while helping the officer against criminal uprisings.

5.2.5 Persons injured by a criminal

5.2.6 Members of the Thai Red Cross that have donated blood at least 18 times.

5.2.7 Mooban Doctor Volunteers in Ministry of Defense Project.

5.2.8 Donators of land or other asset not lower than 1,000,000 Baht for Ministry of Public Health.

5.2.9 Behavior Control Volunteers of Ministry of Justice

5.2.10 Soldier students and conscript soldiers

Co-payment Card

For general people not included in non co- payment card group

Note :

1. Non co- payment card for health volunteer and social leader (with his or her family), which expired in 1 year (from October 1 until September 30).
2. Non co- payment card for low-income person consistent with regulations issued by Office of the Prime Minister 1995, which expired in 3 years (This includes cards that will expire on September 30, 2003).
3. Non co- payment card, which expired, dependent upon specific date by holder characteristic.

Regarding the success of this policy, if we are concerned only with quantity (i.e. the number of people covered by the Universal Coverage 30 Baht Scheme Card), one can say it has succeeded. But the key to the creation of the Universal Coverage is the quality of services and satisfaction of the population. This is the topic of my interest.

2. THEORY OF HEALTH SERVICES BEHAVIOR

Theory of health service seeking behavior.

Health seeking behavior means a person ' s self-practice to counter unusual physical developments he experiences by seeking opinions and advice from a health specialist; and express behavior of seeking treatment, retreating from society or doing

nothing regarding recovery by non – treatment. Each person behaves differently according to his knowledge about the cause of disease, symptoms of the ailment, perception of the degree of illness, the method of treatment, belief, value, tradition, self-health care, and location of health care unit. So when they are ill or encounter some unusual symptoms to their bodies, they react differently; stay idle until recovery, go to the drugstore or health care unit, hospital, clinic or even a shaman or quack doctor. So health care seeking behavior will take place when unusual symptoms happen to a person (Mechanic, 1968).

When a person interprets his sickness from the symptoms according to severity, chronic or acute, depending on social and culture perception, they will change their roles by seeking advice from others or seeking treatment, and during this process relatives, friends, or parents will be involved with the sickness (Christina and Klieman, 1983). The step of health care seeking behavior begins with self diagnoses; then choosing the medical unit and the most efficient practice of treatment. If this initial treatment fails, the patient will evaluate the method and re-diagnosis the symptoms, and move on to other other forms of treatment (Igum, 1979).

Behavior related to choosing a specific health care unit, out of various units and alternative treatments, is called " The Health Care Choice Making Model" (Young, 1981). This model is dependent upon 4 important factors: (1) the degree of sickness perceived by the a person when they are sick and the type of illness or symptoms will be considered in choosing a spcific health care unit and manner of treatment. It will also take into consideration the views of the patient's relatives and friends, (2)

Knowledge on treatment and self-care, (3) Confidence in the outcome of treatment and (4) Accessbility to the health care unit; the kind of the health care unit, and the time of services. Consumer satisfaction is the feeling consumers experience from each health service (Aday & Anderson 1975).

Thomas and Penchansky refer to 5 related factors concerning access to services: (1) Availability of services, (2) Accessibility: easy to go to health care service by imagining the location of the place, distance and the traveling time, (3) Accommodation: the comfort received in the preparation of health care services at the health care unit, (4) Affordability: the patient can afford to pay for treatment or afford to purchase insurance to provide health services, and (5) Acceptability of high quality services; including the manners of the services providers.

From the concept of service accessibility, there are many factors related to obtaining services, the health unit, and the availability of health services unit, as well as the qualitative aspects of the health care unit. From the study, the related factors should be the accessibility; means of transportation, distance, time spent traveling, traveling related expenses, and the satisfaction to the contracting partner hospital which depends on the professional and personal characteristics of the services givers, hospitality, service preparation, images of the services providers and confidence in the quality of health services.

Health service satisfaction depends on many factors; the convenient accessibility, co-ordination, hospitality/friendliness of service providers, information received and service quality.

Utilizer's satisfaction depends on the quality of services. If they have a low opinion of the quality of services from the health units where they are registered, they will stop using those units and switch to others. So high satisfaction should be a main concern of the contracting partner hospital where patients are registered.

3. FACTORS RELATED HEALTH SERVICE SEEKING BEHAVIOR AT HEALTH CARE UNITS

The manner in which people made decisions to seek health care in Phatthalung, as well as factors related to the utilization of Gold Cards at health care units and government hospitals in the province were studied by selecting demographic factors concerning gender, age, occupation, income, level of education, religion, type of illness or sickness recognition and knowledge on the privileges offered under the 30 Baht treatment scheme. Factors concerning quality of service accessibility included mode of transportation, distance, time spent traveling and expense. The factors of satisfaction on quality of services are studied concerning the need and manner of choosing health care services by utilizers themselves.

3.1 Demographic Factors

3.1.1 Gender: The study on health care seeking behavior in Suphanburi province found that one of the factors that effect service in the provincial hospital and community hospitals is gender; the rate of male and female health seekers being nearly the same (Saisamphan Rapkhwan, 1986). From the Development of District Health Services by researching Model of Khunharn found that the percentage of out-patients who were female was 68% (Nittayarumphong et al., 1990).

The factor of gender of the health care seekers is unsummarizable. So that gender of utilizers is an interesting variable for studying, but it is presumed that difference in gender should probably relate to health service seeking behavior at health unit in main contracting partner hospital and at health facilities not designated on the Gold Card.

The difference in utilizers' gender tends to effect different kinds of services offered in health units. For one reason, the role of patients, are different between male and female patients. This is related to society-culture that allows females to be sick more easily than males. Males are supposed to be the stronger gender who have to endure more severe illness before they are accepted as being sick (Saisamphan Rapkhwan, 1986 refers to Nathanson, 1997) . This characteristic influences males to utilize a more complex and higher level of health care than females, and if one compares hospital and health centers, men prefer to go to a hospital than a health center, while women may visit all types of health care units for uncomplicated illness.

All of these points are only hypotheses. Other factors, such as, physical reasons may effect symptoms and condition of illness as well.

3.1.2 Age: is a individual characteristic which causes different behavior. The study of health service seeking and non-seeking behaviors, at district health units, found that the different ages of patients are related to the rate of health services seeking and non- seeking behavior. For example the average age of health service seekers are a little older than the non-seekers, that is : 39.2 years compared to 33.5 years old, respectively.

The most active health service seeker group is 30-39 years old, and the least active seekers are between the age of 15-19 (Chanin Charoenkoon, 1979). A study at the out-patient department of Khunharn hospital found that 30 % of the patients were between the age of 26-35 years because theses ages can travel for health care services by themselves (Sahon Nithayarumpong et al., 1990).

The study on factors influencing health seeking behavior at the hospital show that more elderly people directly visit the hospital after being ill for longer periods of time than children. They decide to go to the hospital because they accept the illness, so their sickness becomes more complex. On the other hand children apparently express their sickness immediately and urge their parents to take them for treatment as quickly as possible. So children with simple ailments recive treatment at the local health care unit more often than other groups. (Saisamphan Rapkhan, 1986).

Reviewing documents show that age is still a factor related to the conduct of choosing services from different health units and hospitals. People of different ages seek different places of treatment. This is because people of different ages sense their illness differently. For instance, adults feel worried, concerned about their family, and they worry very much and are concerned if their children become ill. This will cause them to seek more effective health services at a hospital. Duration of illness may probably be another factor encouraging adults to go to the hospital instead of other health care units. Adults can go to the hospital by themselves but children and young people have to depend on other stronger persons. However, it is expected that age may be related to seeking services from the contracting unit, or from outside the contracting hospital.

3.1.3 Level of education: education means seeking knowledge to support or increase a person's ability; enabling him to grow and mature more intelligently. Education is another factor related to making decisions on health care seeking behavior from each health care unit. The study of patients in Muang Nakon Ratchasima Municipality area, and outside area, found that people with higher education levels choose to get services from higher level of health care unit (Chuthamas Siriwongpanit, 1990); Tapanee Phrompat, 1991.The study on Khunharn Project found that most out-patients (79.0%) finished primary school (Sahon Nithayarumpong et al.,B.E. 1990).

The study shows that education level is still a factor influencing different services. People with higher education, understand symptoms or cause of illness, how to take treatment, and which is the appropriate unit of treatment better than less

educated people. It is expected that different educational levels of utilisers may cause them to obtain treatment at out of contracting hospital without patient's referral form. This study expected that if more educated people understand the 30 baht scheme (Universal Coverage Scheme), it will have an impact on the systematic provision of health care services; and influence the way people seek health care from the main contracting hospital as well as outside of designated hospital.

3.1.4 Occupation: occupation is a determining factor for income. Different occupations effect different income levels. The study of format of health services practice in Thailand local health care unit found that the group of people who are not farmers seek health care in town in higher numbers. Farmers seek health care at local health care units in large numbers (Day and Leoprapai, 1977), and most of health care seekers at government hospitals are farmers (Weeraphan Suphanchaiyamart et al.,1999; Sa- nguan Nittayarampong et al., 1990 ; Suphattra Sriwanithakorn,1996).

Reviewing the above studies demonstrates that different occupations choose different services units.

3.1.5 Income: It is an influential factor for a living. The study of format of public health care services using in Thailand found that economic status, or income of patients, results in different health service seeking behavior. Those with higher incomes seek more efficient service delivery sites because of their ability to pay all expenses or spend more time than the not well-to-do people (Day and Leoprapai, 1977). The family income of utilizers of health centers in Bangkok shows that if people have higher income they will not seek care at a health center.

From reviewing related literature, it was found that patient's income is a factor influencing different service seeking behaviors. High-income earners have more chances to seek better and more efficient services because they have greater ability to pay, and when comparing local health units and hospitals; the hospitals have higher service delivery potential than local health units. Although the hospital services cost is free, expenses are incurred for traveling, and time spent away from the work place. So income variation should probably be related to service seeking behavior in the main contracting partners hospital and outside the main contracting, or designated, hospital.

3.2 Illness Factor

Factors relating to illness symptoms and severity of disease: from studying format of health services in Thailand' s rural areas found that local people always evaluate their illness with the way in which to seek treatment. For example if they have a common ailment, they will go to drugstore because it is very convenient. When the symptoms become more serious, or when an illness becomes more severe, they need to get treatment from a more efficient health care unit because they feel confident that they will surely recover there. Patients like to choose treatment from the provincial hospital more than a local health center (Day and leoprapai, 1977), But there is some contradictions with factor study on the relationship between illness perception and services taking at local health unit in Lampang province (Saisamphan Rapkhwan, 1986).

From the study on the perception of illness severity and health care seeking behavior it was found that when the patients perceive different illness severity, manner

of taking services is also different. When a patient knows that his illness is serious, he will prefer to seek treatment from the hospital rather then the local health center. And so on. If the illness is acute they prefer the hospital to the local health unit. But on the contrary, when they know that the illness is chronic, they will choose treatment at the local health unit. The study of Day and Leoprapai, 1977, shows that the reason people did not seek treatment at local health center is because the unit cannot treat severe illnesses, but the hospital can. Apparently those who perceive different levels of illness and severity, will probably exhibit different services seeking behavior.

3.3 Service Access Factor

Convenience of traveling-the study of treatment service of consumers before arriving at Khunharn hospital found that paitients go to a health care unit because it is convenient and close to their homes (Nittayarapong et al.1990). This finding is in agreement with the study on health and health care needs of local people of Khonkhaen province and the development model for a patient referral system in local health units.

In summary the most important factor influencing the selection of a treatment unit or treatment methodology is the perception of the severity of illness. If a person knows that his illness is very severe, he and his family will choose the health care unit they consider the most efficient;with good doctors and without considering the expense. But if they know that the ailment is not serious, they will try to cure it by themselves or choose somebody whom they know that can treat such an illness.

Opinions on health service seeking behavior in developing countries point to the method of treatment and personal factors of the consumers and non-consumers, of doctor's services and traditional doctor's services by dividing them into 3 variables (Kroeger, 1983). They are as follows: 1) predisposing factors concern demograhic characteristics, characteristics of the family; the attitude, education and condition of health, 2) enabling factors concern service access, health insurance and stability of income and 3) health service system concern the infra-structure of the service delivery system which in turn is linked to the country's political system.

These ideas indicate health service-seeking behaviors of the privilege Gold Card holders in Phatthalung is probably related to many factors: demographic factors; gender, age, income, level of education, occupation and religion. Illness perception factors; degree of illness, symptoms from the patient's perception. Factors related to knowledge on the rights and privileges of the 30 Baht Scheme to provide treatment for all illness

4. THEORY OF MEDICAL ACCESSIBILITY

The following four issues influence accessibility and directly or indirectly affect health care service: 1) The nation's health, 2) Characteristics of the health care delivery system; including the service system of each health care unit, sufficiency and distribution of health care unit and coverage of service, 3) Characteristics of population; such as age, gender, race, religion, value of health and illness.; supporting factors, income, health insurance, community health care units and distance; health perception,

illness evaluation. These factors will affect health service satisfaction, and 4) Utilization of health care services, including convenience of traveling to the health care unit or community hospitals will be relevant factors in choosing an appropriate health care unit (Tatsanee Sinlapabutr, 1993), Somsong Na Nakhon,et al,1993).

4.1 Distance from home to health care services

The study of Saisampahan Rapkhan ,1986, found that patients who live near health centers will not leap to other health units. But those living further away from health centers or hospitals will change their designated health care units to non-contracting units. This is in agreement with Saengthong Haem-ngarm , 1990 ,who found that utilizers who live less than 2 km. from the local health service unit will increasingly prefer to receive health services at this health unit. The study contradicts the study of Somsong na Nakhon et al. (1993) which found that the distance from village to health units is not a determinant in deciding to seek or not to seek health care services.

The above study shows that distance is still an interesting factor to be studied concerning health service seeking behavior. But generally it was found that health care consumers choose to seek services from nearby health units, because illness is a serious matter for them. The fastest health care seeking behavior is for those people who are ill. But some studies found that distance from home is not a determining factor for seeking health care, but convenience of traveling is. For example, if there is no car or bus passing the health care station or it is inconvenient for driving, especially during the

rainy season, people may choose to seek health care from a more convenient site (Somsong Na Nakhon et al., 1993). So distance of health unit is still a problem to be studied in greater detail.

4.2 Time of traveling

It was found that patients, or people, feel convenient traveling about 5.1 minutes and if travel time is greater than 10 minutes, health consumers will decrease their practice (Tatsawalai Jaronsri, 1993). People tend to use the drug–store or quack remedies because they spend less time going there, and also it is easy and quicker to obtain this type of health care (Rauyajin et al., 1981).

Most patients choose to visit providers who live nearby and take less time traveling from health station, and if comparing the local health center and hospital, the health center is usually closer involves less traveling time.

4.3 Satisfaction (Qualitative Service Factor)

Satisfaction of service consumers is an important indicator, by evaluating people's perception because most people cannot assess quality in terms of treatment, so that service quality in the eyes of people is very important with their overall satisfaction of the service. Prompt servicing, a presentable facility, and information provided about illness from doctors after the service, including manners of the service providers are important factors in determining the quality of services (Supattra Sriwanithakorn,

1996). Most people are satisfied with the treatment and quality of the services of the health care unit. When consumers feel pleased with convenience, hospitality, care taking of service providers and information from the health unit, (Somsong na Nakhon et al., 1993) they will choose the health care unit with knowledge and confidence, as well as also recommend it to other people they know (Rauyajin et al., 1981) . This present paper aims to study the satisfaction of consumers in using the Gold Card at health care services units in Phatthalung. So by random sampling, we selected the privileged Gold Card [co-payment] holders who decided to obtaini health care under the new health policy.

A literature review and related documents found that important factors influencing health service behavior are as follows: 1) Demographic factors such as; gender, age, education level, income, 2) Illness factors such as characteristics of illness and severity of illness, 3) Health service access; communication, distance, and time spent traveling from home to the health care unit, and 4) Quality of services including satisfaction of services from the government health care units designated on the Gold Cards; which selects health care units by administrative area and not by distance or time spent traveling. This is another interesting factor to be studied in- depth. Thus if Gold Card holders go to non-designated health units where they have to pay for services, it probably means that they are satisfied at these government health care units.

5. RELATED STUDY

Concerning people's opinion regarding the health services card (Between 1985 and 2002).

With regard to researching utilizers' opinions about the 30 Baht Universal Coverage Scheme (30 Baht Scheme), the researcher reviewed a number of the following related studies:

Supot Denduang et al., 1994 : Study of Development and Evaluation of the Voluntary Health Insurance in Social Insurance Concepts at Taklee District, Nakornsawan. The satisfaction of the patient to Taklee Hospital is not good especially regarding hospital facility and the convenience of obtaining services there.

Taweekieat Bunyapaisancharoen, 1995: Study on an appropriate model of Health Insurance, Ayutthaya Province. A large amount of patients were satisfied in obtaining services in health centers.

Surank Pilasakool, 1996 : Study of the opinion of the population about the Ministry of Public Health's regulations. The target group want to adapt conditions to use the card (53.1%), that it influences the service system, and the customers (patients) were not impressed with the service delivery system. The majority (90%) feel there is a lack of continued public relations, and a lack of quality control over the service delivery system.

Wirat Promdee and Tongsert Chaito ,1996: Study of the predictive factor to buy the Health Insurance Card in the next year for persons who used this card in Mukdaharn Province. The population was satisfied with the health center worker more than with district hospital or provincial hospital personnel.

Wirat Saitong, 1996: Study of the Health Insurance and customers' opinion in Kampangpet province. The majority of the customers were satisfied with health center services (82.%). But an obstacle was that services were not available in all health centers, because some service centers were not opened.

Surachet Narkprasertkool, 1996: Study of the officer's problems and obstacles to the work of Voluntary Health Insurance Project. Job satisfaction of health workers influenced the their work (90%).

Nuchanart Boonchoo, 1996: Study of opinion of customers using the Health Insurance in Krabi province. The most important factors influencing health service seeking behavior was the closeness of the health care unit to their home (90%).

Urai Samakkarn, 2002: studied the establishment of the Universal Coverage of Health Insurance in Puket Province : According to local perspectives it was found that the insurance must be compulsory Health Insurance, and the target group must be the group who lack health insurance. The population need additional information to understand about the Health Insurance (52%) and they think that the co-payment fee should be 50 Baht (41.5%).

Frederick A. and Boonlert Leoprapai, 1977: Study of an appropriated model of the Health Insurance for the rural Thai population. Gender, age, level of the education, income, place of residence, waiting time, and travel time were factors influencing satisfaction. Male, elderly, low-income groups were satisfied more than the young, high income, or groups who spent a long time traveling for services.

Wannasri Sasen, 2000: has studied factors related to health services card obtained through the Health Welfare, and health insurance cardholders registered at Phon destrict, Khoneaen province. She found that factors related to utilization were occupation, ailment perception, communication routes, convenience and time of traveling from home to hospital which had the important statistic significance of 0.05. And the variables of gender, age, level of education, income, perception to degree of ailment, distance of traveling from home to hospital, convenience, time of traveling from home to local health unit, satisfaction to the health unit and factors of health care development program in the district level were not related to service utilization.

Wirot Tangcaroensatian et al, 1992, had studied health seeking behavior of the insured workers in Samut Prakarn province in 1992; finding that the first cause that hindered service seeking at the contracted partner hospitals were the inconvenience of traveling and the dissatisfaction with the hospital services, and the reasons of seeking health services from the contracted party.

Piroon Rattanavanit and Suvadee Chusuwan, 2001 , had studied the clients' opinion toward the hospital services in Trang province, under Ministry of Public Health, and found that the most important reasons for choosing services at the ministry hospitals were the convenience of traveling, the doctor-specialists and previous experience with obtaining care at the hospital.

Yothin Swangdee et al, B.E. 2000, had studied about Problems and Sufferings Experienced by Patients Obtaining Services at Health Care Facilities. Most out-patients wanted doctors to spend more time examining them, as well as taking the time to ask more questions about their illness before writing a prescription. They wanted doctors to clearly explain about their sickness and how it can be cured.

6. CONCEPTUAL FRAMEWORK

From the theoretical belief, the literature review illustrated the relationship of factors I intend to insert in the conceptual framework. The conceptual framework of The Utilization of Health Care Servicess Under Universal Coverage Scheme (30 Baht), Phatthalung Province, during 2003. (in Figure 1) is illustrated below.

Figure 1: The Conceptual Framework of The Utilization of Health Care Services Under Universal Coverage Scheme (30 Baht), Phatthalung Province, during 2003.