

# Universal Health Care Coverage: Impacts of the 30-Baht Health-Care Scheme on the Poor in Thailand

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## I. BACKGROUND

In late 2000, the “Thai Rak Thai” (Thais love Thais) Party, hereafter, TRT, fueled the general election campaign by promising to carry out a set of new schemes. One of the most eye-catching ones was the “30-Baht Health-care Scheme,”<sup>1</sup> hereafter, the “30-Baht Scheme” (US\$1 = about 38-40 baht). During the election campaign, TRT indicated that the scheme would provide health care for everyone—regardless of the type or severity of the illness, at a cost of 30 baht, presumably per visit or per sickness. According to TRT’s website, a health insurance premium of 100 baht per month per person would be collected to provide additional funding for the scheme to supplement the regular government budget.

After TRT acquired the majority vote and led the coalition government, the government put forward this scheme very quickly. Following a workshop in February 2001, the first pilot project was announced for implementation in six provinces beginning on April 1. The second pilot project in another 15 provinces followed in June. In October, the scheme was implemented country-wide, except for some inner regions of Bangkok, which were deferred until January 1 or April 1, 2002. Under the pilot and full-scale implementation, the proposed insurance premium was eliminated and the project has become solely a tax-financed program.

As a universal health-care coverage scheme (“UC” for short), the 30-Baht Scheme covers everyone who is not covered by other government-sponsored forms of insurance, i.e., the Civil Servant (and public enterprise workers’) Medical Benefit Schemes (CSMBS), the Social Security Scheme (SSS), the Health Card Scheme, and the Health Welfare for the Poor and the Disadvantaged Scheme (HWPDS). In practice, the

latter two schemes were converted to the 30-Baht Scheme. In fact, the way these two schemes were implemented became the foundation of the 30-Baht Scheme.<sup>2</sup>

Besides providing health coverage to persons who were not in the CSMBS or SSS, during its first year of implementation the 30-Baht Scheme was an attempt to reform the health-care financing system; it was aimed at shifting the paradigm that governs the health-service system to place the main emphasis on health promotion and disease prevention.

This paper is an early attempt to assess the consequences and impacts of this new scheme on the poor. The results provided in this report draw from both desk and field research. The desk research focuses on the implementation and impacts of the previous programs, and attempts to estimate changes in the financial burden of the poor as well as the incidence of poverty. The field research comprises two rounds of fieldwork that attempts to explore health-seeking behaviors of the low-income group prior to and after the new scheme was implemented. The first round of fieldwork was undertaken by 10 researchers who stayed for two months in 10 villages/communities in late 2001.<sup>3</sup> However, the main fieldwork results presented in this paper are drawn from the fieldwork led by the authors in seven provinces in 2003.<sup>4</sup>

## II. IMPACTS ON THE USERS AND THE POOR

Although the 30-Baht Scheme preaches the concept of “universal coverage” and “entitlement/rights to health care”—as opposed to being a “welfare program”<sup>5</sup>—throughout the years that the TRT government has been in power, it has sent mixed messages to the public and health professionals. At

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times, the scheme was referred to as a “pro-poor program” where the high-income and middle class were persuaded to seek health services elsewhere so that they would not draw too much of the tight resources from the scheme. However, when a large faction in the Senate attempted to modify the National Health Insurance Act (which had been drafted to be the basis of the Scheme) to designate the Scheme as “for the poor/uninsured only,” the government turned to claim that the law was indeed intended for all Thai citizens. Nevertheless, the prime minister later asked the Thai people to be patient with the Scheme—which might still have been “unsatisfactory” for the middle class, claiming that it had successfully assisted the poor thus far.

The impacts of this Scheme on the users, with special reference to the poor, can be categorized in four aspects as follows:

#### a) Rights and Access to Care

Since 1975, the low income group was supposed to be eligible for free health care. Before the 30-Baht Scheme, all the poor were theoretically covered by the HWPDS, which provided the “Low-Income Card” (LIC) to a single person who earned less than 2,000 baht (\$50) per month or a family that earned less than 2,800 baht (\$70) per month.<sup>6</sup> However, many studies consistently found that most of the low-income families did not receive the LIC and the majority of the cards were distributed to people or families that earned more than permitted under the eligibility criteria. (See the authors’ review of these studies in Viroj and Anchana 2002a, which also indicates that the mis-targeted portions appear to have increased over time.)

Because of the mis-targeting problem, a significant number of the poor ended up buying the 500-baht (\$12) health insurance card designated to provide year-round insurance for a family of up to five. According to the Socio-economic Survey (SES) administered by the National Statistical Office (NSO) in 2000, almost one-half (47%) of the poor had the 500-baht health insurance card, more than twice the number of the poor that received the LIC (21%) (Viroj and Anchana 2002a). Although these figures may include mixed up or misidentified cases, the figures do indicate that mis-targeting had been wide-spread.

By its design and coupled with the publicity which makes its presence known to almost everyone, the 30-Baht Scheme effectively eliminates the major part of the mis-targeting problem—the quota allocation and the information problems—which were rampant before the Scheme was implemented. Under the Scheme, steps were taken to solve the eligibility problems of Thai-national migrant workers who in the past usually had been unable to pass many bureaucratic constraints. Currently, the number of non-eligible persons (who include those who do not have Thai nationality) is down from about 5 million (in 2001) to about 2 million.

It turns out, therefore, that a supposedly non-targeting scheme such as the 30-Baht Scheme has helped many low-income persons to gain access to low-cost health care that they were supposed to have gotten years ago but did not, or had to pay an extra premium for such access (i.e., by buying the health insurance card). It should also be noted that having an LIC would not necessarily ensure access to health care or coverage. Before the 30-Baht Scheme was implemented, some residents in an urban slum in a northeastern province of Thailand who had LIC cards reportedly avoided seeking health-care services from the hospital listed on the card, as they felt that they were not welcomed there. They were also unsure about the benefits that the cards would provide, or whether a particular service would be covered by the card or not. The name of the card, which could be literally translated “health welfare for people with a low-income and for people who should be assisted,” was rather ambiguous and not very informative. The LIC cardholders’ experiences from various provinces suggest that the manner in which these people were treated varied greatly, often on a case-by-case basis depending on the personnel who handled their case. Some patients felt that they were not welcome—or even verbally harassed—by certain hospital officials,<sup>7</sup> but were treated very nicely by others on different occasions. During the admission of one of her daughters in a regional hospital, an LIC cardholder, who was eligible for free care, in a province in central Thailand, was always asked by hospital personnel to pay for the prescribed medicine from the hospital pharmacy, even though the attending physician told her that she did not have to pay. Finally, a nurse persuaded the hospital welfare officials to give the woman an “exemption.” Under the new Scheme, uncertainties about rights and coverage appear to have diminished greatly, as the new scheme has been well advertised and thus is well known among the general public (and probably better known among the health-care providers as well).<sup>8</sup> In this connection, a large number of patients feel that they were treated better after the 30-Baht Scheme had been put in place.<sup>9</sup>

#### b) Health-seeking Behaviors

It is not uncommon to predict that, with a UC scheme in place, people would seek more of the free or low-cost health care since UC would remove the financial burden that is usually associated with seeking health care. Therefore, it had been expected that some people who had become eligible for this new scheme would visit health-care facilities more often than they had in the past. The figures released by the Ministry of Public Health (MoPH) indicated that, in fiscal year 2002, the number of outpatients who paid visits to its hospitals, which are supposed to look after more than 90 percent of the people in the 30-Baht Scheme, increased by about 54 percent over that of fiscal year 2001. The

number of inpatients has also increased, but at much smaller rates (about 7.5%), as they are partly constrained by the number of beds available in the hospitals.<sup>10</sup>

A large number of health-care providers in public hospitals claim that patients have flooded into their hospitals after the introduction of the 30-Baht Scheme. Some of the health-care providers observed that a number of people seek health services earlier than they had in the past. According to them, some people seek services for health concerns that could easily have been taken care of by themselves. Another claim, albeit less frequently voiced, by some providers is that people now take less care of themselves (i.e., a moral hazard problem has arisen as a result of the new health insurance scheme).

While it is agreeable that more patients now seek health services earlier than they had in the past, it is not clear whether such actions are appropriate or not. There has been no systematic study on this issue. However, a team of senior medical professors—headed by Prof. Charas Suwanwela, a former dean of the Faculty of Medicine, Chulalongkorn University—paid several visits to a number of hospitals in rural areas at the early stage of the Scheme's implementation, and found that almost all patients who sought health-care services did have reasonably alarming reasons to seek care from the providers.

Our findings from the field, which are based on information gathered from various focus group discussions and interviews with people from various income groups in several provinces in three regions of Thailand, include the following:

- Some patients agree that *some* hospitals have become more crowded after the 30-Baht Scheme was put in place;
- Most people indicate that their health-seeking behaviors have not changed. They usually assess their illness and take action accordingly. In an urban area where there are drugstores nearby, patients with a mild illness (based on their own assessment) would buy medicines from the drugstores (or grocery stores, for common drugs), as it would be cheaper and less time-consuming than going to a hospital or clinic. In rural areas where there are no nearby drugstores, many would go to a sub-district health center instead. Only when they believe that the illness is out of hand would they go to the hospital or go to see a doctor at a clinic. Choosing whether to go to a hospital or a clinic would depend on their income and time available (elderly people are more likely to use public services), how urgent the patient feels s/he needs to see a doctor (many rural dwellers would choose to go to a private clinic when they feel that their situation is urgent,<sup>11</sup> or when it is more difficult to assess

the situation, e.g., when a child is ill). In an emergency case, however, most would go to a hospital right away. People from a low-income family tend to go to their designated hospital,<sup>12</sup> and hope that the hospital would refer them to a larger hospital if needed. However, a better-off family in a peri-urban area would send the patient to the provincial hospital right away, or even to a private hospital, especially during nighttime or on the weekend when most public hospitals would be understaffed with doctors;

- Almost every patient indicated that, *when possible, they would stay away from hospitals as much as they could*. Many were amazed at the notion that someone would be willing to seek more or *unnecessary* care just because the 30-Baht Scheme had been put in place. According to them, the only difference after the introduction of the 30-Baht Scheme has been that, *some* patients would *occasionally* switch from going to a private clinic/hospital to use the public hospital instead. Even for these patients, at times they found that the hospital was too crowded and decided to waive their rights, so that they could get into a shorter waiting-line to see the doctor;<sup>13, 14</sup>
- In this connection, a number of dwellers in two low-income communities in Bangkok complained that they had several bad experiences with treatments received at a private hospital that participated in the 30-Baht Scheme. According to the villagers, they insisted that they would rather buy some medicine at a nearby drugstore than go to the hospital 4-5 kilometers away if they did not think that their illness was severe. However, when they eventually decided to go to the hospital, the screening doctors there did not take their illnesses seriously, and asked them to go home after giving them some common drugs (paracetamol and other such drugs). In one case, a patient urged her relatives to bring her to another private hospital and was told that she came too late; she died shortly after at the second hospital. Another case resulted in a ruptured appendix. Yet, another person from this community also had to pay multiple visits to this hospital before she was admitted to the ICU on the third visit, as her illness had become apparently severe. Only after that did she get fairly good treatment and follow-up service that satisfied both the patient and her relatives. Although some cases are in a gray area, such as appendicitis which a lot of even experienced doctors could misdiagnose, the three mishaps experienced by a small cluster

in the community suggest that, at least in some areas (and maybe because of some relationship with some of the private hospitals in the Scheme), the moral hazard from the hospital side might even be more problematic than the moral hazard from the patients;<sup>15</sup>

- However, even though most patients like to think that they would go to the hospital only as a last resort (after self-assessment and self-care by buying medicines from a nearby drugstore), people do have different attitudes or thresholds on the “severity” of an illness, which appear to vary from one person to another. (The most general conclusion that we could make out of several focus group discussions is that a male’s threshold is usually higher than that of a female’s.)<sup>16</sup> Therefore, even after self-assessment, there would still be a significant number of cases going to the hospital that would be regarded by the health-care providers as non-severe, or not urgent, or even not worth a visit to a doctor;
- When compared with the time before the implementation of the 30-Baht Scheme, the health-seeking behaviors of the low-income group had not changed very much (probably their behavioral changes are much less than those of other income groups). Part of the reasons are:
  - Limited alternatives. Most users are assigned to the same hospital to which they used to be assigned under the LIC or the 500-Baht Health Card Scheme. If they go to another hospital, they themselves would have to pay. In addition, transportation costs are still a barrier in many rural areas where public transportation is lacking. Therefore, even when they do not have much confidence in the designated hospitals, they usually go there and leave it to the hospital personnel to choose whether or not to refer them to a larger hospital;
  - Some poor people in remote areas still consider the 30-Baht co-payment expensive. To them this new Scheme does not come with a lower price tag, as commonly viewed by others.

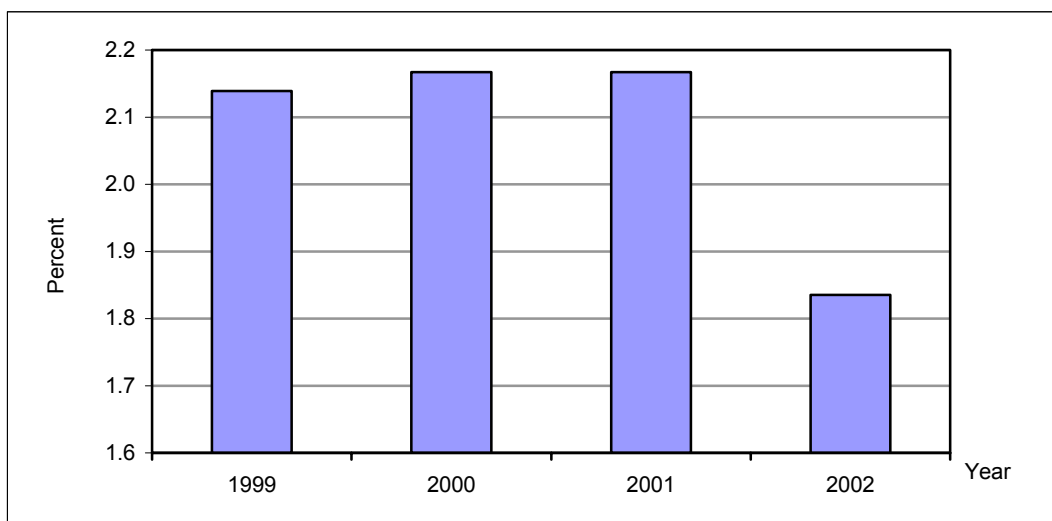
### c) Financial Burden

The 30-Baht Scheme was intended to remove financial burdens connected with health care, in that illness can be unanticipated and the cost concerned

might be unpredictable. This study provides preliminary estimates on the effects of the 30-Baht Scheme and the universal health coverage program on households’ cost savings and on poverty reduction. The estimates employed data mainly from the nationwide SES. Based on the stylized fact that the share of total health expenditure as a proportion of GDP in Thailand has been rather stable, we estimated the households’ cost savings, based on the decremental shares of the households’ health expenditure vis-à-vis total income and expenditures, and attributed them to government intervention (see Figure 1). The estimated implied cost savings of households in 2002 (relative to the shares of their health expenditure in the years 1999 and 2000) range from 7 billion to 8 billion baht, which is comparable to the incremental health budget the government added in fiscal year 2002, the first year that 30-Baht Scheme was implemented nationwide (except for inner Bangkok).<sup>17</sup>

In terms of poverty reduction, the study compares over time the percentage of people who were impoverished because of health-care expenses, using data from SES. The figures were drawn from the households that had a per capita income above the poverty line, but had after-health-care income (gross income after subtracting the household’s health expenditure) that fell below the poverty line. We found that the percentage of these impoverished groups declined from 2.15 percent of total households in 1992 to 1.84 percent and 1.53 percent in 1994 and 1996, to 1.1 percent and 1.3 percent in 1998 and 2000, respectively, and to 0.7 percent in 2002. The early declines could be attributed to the expansion of the Health Welfare Program for the Low-Income Group to cover elderly people and children in 1994, and its subsequent financing reform toward per capita budgeting that took place between 1998 and 2000. The decrease in 2002 is most likely the result of the 30-Baht Scheme (plus a small effect from the expansion of coverage of the Social Security System in mid-2002). Based on these figures, the households that were impoverished because of health-care burdens decreased by two-thirds as a result of the expansion of coverage toward universal coverage. The above finding is similar for all regions, but is more pronounced in rural areas.

We also measured the number of households that became impoverished because some members were hospitalized. We found, however, that the number of this type of household is rather small—ranging from one-seventh to one-fourth of those who were impoverished because of health expenses. This finding suggests that a comprehensive universal coverage scheme that also covers major outpatient expenses would still be crucial if poverty reduction is considered to be one of the main objectives of the universal health coverage program in Thailand.

**Figure 1 Percentage of Health Expenditure to Household Income**

Source: Viroj NaRanong et al. 2005a (processed from the NSO Socio-economic Survey).

On the qualitative side, our findings on this issue are as follows:

- For most people, including those in the low-income group, their financial costs for health care have not changed drastically after the implementation of the 30-Baht Scheme. Many families only had to change the method of payment from 500 baht per year (per family of five or fewer) to pay 30 baht per visit. This change could result in more or less financial costs, usually depending on whether or not that family had a member with a chronic disease. However, even when taking that into account, not many people regarded the financial burden to be the most important issue, as most of them felt that they could afford to pay 100-200 baht for a visit to a clinic when needed. The exception is the low-income group who clearly preferred to pay 30 baht per visit rather than a lump-sum advanced payment of 500 baht. They were the only group concerned when asked a hypothetical question about whether their health-seeking behavior would be changed if the government were to raise the co-payment from 30 to 50 baht. It is difficult for these people to pay a lump sum of 500 baht, which they considered a large amount. Some also complained that the subdistrict health centers had already raised their fee from a variable fee (most of which was in the range of 15-20 baht for common illness) to a flat fee of 30 baht.
- However, although many felt that the Scheme did not have a direct impact on the financial

burdens they faced, most people at all income levels preferred to retain this Scheme (or a similar scheme such as the 500-Baht Health Insurance Card) rather than returning to a targeting program like that of the LIC scheme. The main reason provided during our focus groups/interviews was that, while most of them could afford to pay 100-200 baht per visit occasionally, or could, at times, afford to be an inpatient in a private hospital, a time could come when they would need to be admitted to a hospital and they would be unable to pay on their own. When that time comes, this scheme would be the last resort, ensuring that they would still get some care without having their family impoverished. Interestingly, many who used to buy the 500-Baht Health Card also cited the same reason for buying such a card, even though they felt that every one in their families was rather healthy and would unlikely need to use the services covered by that scheme.

#### d) Quality of Service

One concern in implementing the 30-Baht Scheme is the quality of health care. However, it is rather difficult to assess the quality of the medical service—or even overall service. This section, therefore, gathers only the users' perception on quality issues.

- Unlike when the 500-Baht Insurance Card was implemented, when many interviewees perceived that some improvements had been made in the service they received, not many

interviewees attributed this element to be the outcome of the 30-Baht Scheme. Some patients who actually got the services—most of which were delivered in the outpatient department—felt that the hospitals tended to use more “common” medicines (such as paracetamol/acetaminophen) than in the past, which was a different situation compared with times when they went to see the same doctors at their clinics. However, virtually none of them perceived any clear deterioration in the services. While a significant number of patients did not like the system that required them to go to the designated hospital first, some patients perceived some improvements in the referral system.

- Most of the high-income group, who were accustomed to using services from large and private hospitals, were not very satisfied with the 30-Baht Scheme, partly because of the rationing of care. A number of interviewees experienced slower service when they used the 30-Baht card, especially in hospitals that have separate queues for the patients using the 30-Baht Scheme and those who self-pay.

### III. EXPECTATION OF THE USERS AND THE POOR

An indirect method we used in order to evaluate whether the 30-Baht Scheme has fulfilled the void or the needs of users and the poor was asking the interviewees and those who participated in our focus groups to rank the four most important things that they expected from the health-service system. The choices that were provided by the researchers are as follows: (a) a universal coverage scheme like the 30-Baht Scheme or other low-fee health-care schemes, (b) a health-service system with a sufficient number of hospitals and personnel, (c) the right to choose the health-care facilities, and (d) receiving good treatment (medically and verbally) from the health-care personnel. During the interviews/focus group discussions, the participants were also allowed to add their own suggestions to these four items.

In our interviews/focus groups, most participants ranked item (b) “a health-service system with a sufficient number of hospitals and personnel” as the most important thing that they would like to have, with some exceptions from some participants from the low-income group who chose item (a) “a universal coverage scheme like the 30-Baht Scheme or other low-fee health-care schemes” over item (b). Only a small proportion of the subjects chose (c) or (d) as their first priority.

The second choice showed more variation than the first one. Most respondents who chose item (b) as their first choice tended to choose item (a) as their second choice, and vice versa. However, some respon-

dents ranked item (d) “receiving good treatment (medically and verbally) from the health-care personnel” as their second priority. A smaller number of respondents chose item (c) “the right to choose the health-care facilities” as their second priority. Interestingly, many Village Health Volunteers who also act as intermediaries between the MoPH and the villagers and should have a better understand about the health-care service and referral systems tended to give a high priority to item (c) “the right to choose the health-care facilities.” This might reflect their awareness of the limitations of the existing health-care service and referral systems.

In light of these answers, we may conclude that people are more concerned about the inadequacies of hospitals and personnel (especially doctors) than the free or low-cost insurance program that the 30-Baht Scheme is intended to provide. A caveat to that conclusion is that these responses have been made after the 30-Baht Scheme has already been implemented and might have swayed many people’s opinion to another area that is lacking and that still has not been addressed as well as the health insurance issue.

### IV. CONCLUDING REMARKS

The 30-Baht Scheme is aimed at providing *universal health-care coverage/insurance* for everyone who is not currently covered by two other government-sponsored insurance programs (i.e., CSMBs and SSS).

While the 30-Baht Scheme preaches the concept of “universal coverage,” it has also advertised itself as a “pro-poor program” that is aimed at lifting the financial burdens arising from health-care costs, which could be detrimental, especially for the poor. According to the data from the national SES, the scheme appears to be successful in reducing poverty, probably much more than other targeted schemes in the past that often let the poor “fall through” the selection process (such as in the LIC Scheme). The more systematic and universal approach of the 30-Baht Scheme, which recognizes the “entitlement/right to health care” of everyone, makes the poor less vulnerable to being shut out from accessing the health-care system and makes them less subject to the whims of health providers in showing kindness.

Although the number of people who seek health care has increased substantially following the implementation of the 30-Baht Scheme, our fieldwork suggests that the health-seeking behaviors of the poor have not changed much after the Scheme started, as most of them have rather limited choices. For most people, including the low-income group, the financial costs for health care did not change drastically after the implementation of the 30-Baht Scheme.<sup>18</sup> However, most people feel more secure with this Scheme in place, as they now have an insurance against a drastic or catastrophic illness that they could suffer in the future.

While almost all beneficiaries—especially the poor—welcome this scheme, most people voiced concern about the inadequacies of hospitals and health personnel (especially doctors in small public hospitals), which is the main problem that the government needs to address should it really aim at providing universal and equal access to good quality health care for all, especially for the poor.

## ENDNOTES

<sup>1</sup> The exact translation would be the “30 baht for curing every disease” scheme. About a year ago, the official name of the scheme was changed to “30 baht [to] help Thai people stay away from diseases.”

<sup>2</sup> The payment mechanism of the 30-Baht Scheme was also influenced by SSS as well.

<sup>3</sup> These researchers work under the Poverty Reduction Partnership (Phase II) between the World Bank and Thailand Development Research Institute (TDRI 2003).

<sup>4</sup> See Anchana NaRanong (2005), which is part of TDRI’s Monitoring and Evaluation of Universal Health Care Coverage in Thailand, 2nd Phase, 2003-04.

<sup>5</sup> In the sense that is commonly used in the United States.

<sup>6</sup> These criteria were in effect since 1994. In 2001, the official poverty line was about 700-800 baht (\$175-200) per person per month.

<sup>7</sup> One LIC cardholder in the Central Region recalled an episode that, when she bought some food and brought it to eat in the hospital, she was questioned how come she had money to buy food while had no money to pay for her daughter’s medicine. Another LIC in the Northeastern Region told the researcher the reason why she also bought the 500-Baht Health Insurance Card: “I went to the hospital with a neighbor who had the 500-Baht Card, and I was told to sit on the floor while she got a seat. So I decided right then that I needed to save money to buy this card.”

<sup>8</sup> There are still some gray areas on the benefit package and these have occasionally caused problems, e.g., an exclusive clause which states that the scheme would not cover the cost of medicines that are not on the Essential Drug List. Some hospitals also try to cut their costs by cutting down on the number of drugs on their hospital drug list.

<sup>9</sup> However, part of such an improvement could be the result of more scrutiny from both the Ministry of Public Health (MoPH) and the public. This has forced the providers to be more conscious (or

careful) about their service. Yet, this does not come without a cost, as many health-care providers have complained about their work after the implementation of the Scheme and are less satisfied with their job. Many cited this as the reason that nudged them to decide to resign from public hospitals.

<sup>10</sup> Both figures are from Viroj NaRanong et al. 2005b. Although figures released by various sources may differ from the above, as there were also changes in the definition of outpatient visits (see also discussion of data inconsistencies in Viroj NaRanong et al. 2005b), there is a virtual consensus throughout the country that more patients than previously are using the health-care services in most of the MoPH hospitals.

<sup>11</sup> Although the patients realize that most clinics do not have facilities as good as hospitals, at a clinic they would be able to see a doctor right away, and, if needed, the doctor would be able to send or refer them to an appropriate medical channel without having to wait for a long time as would be the case when they go to the hospital on their own.

<sup>12</sup> Before the introduction of the 30-Baht Scheme, most people in this income group also had the LIC or 500-Baht Health-Insurance Card, both of which designated a gatekeeper hospital that each cardholder would be authorized to visit. Therefore, in this respect, their choices were not altered much after those two programs were replaced by the 30-Baht Scheme.

<sup>13</sup> Not every hospital applies different waiting lines for patients with different types of eligibility (or for paying versus non-paying patients).

<sup>14</sup> To cross-check the results of our study, which is mainly qualitative, the second author has supervised three graduate research projects that use similar questionnaires that focus on issues discussed in this paper in three provinces. One preliminary result from a province in the Central Region indicates that some patients (less than 5%) go to the health-care facilities to get medicines or vitamins while they were not sick. Some of these cases may happen when the people accompany the patients to the health-care facilities. Also, these incidents tend to take place at sub-district Health Care Centers, which usually have very short waiting lines.

<sup>15</sup> Some workers in the SSS also claim that many doctors would not listen to them or examine them seriously. They speculate that not only are financial issues involved, but also that the screening doctors are accustomed to frequent visits by healthy workers who just visit them to get a physician’s note that they could use to apply for sick-leave from their companies. Therefore, some of these doctors would presume that most patients were not ill. Some SSS

patients also indicated that, only after they get pass the “gatekeeper” to a specialist or are admitted as an inpatient, would they be treated normally like other patients.

- <sup>16</sup> Another pattern, although slightly less common, is that, when controlled by age group, the younger generation’s threshold tends to be lower than that of the older generation, many of whom are also less familiar with the hospitals and often try harder to avoid going there as well.
- <sup>17</sup> Based on the same approach, we find that the estimated cost savings of households in 2002 (relative to the years 1986 and 1988) range from 27 billion to 51 billion baht. These figures are considered lower estimates of household cost savings from the universal health coverage program, since the 1980s had already seen the implementation of CSMBS and the Health Welfare Program for the Low-Income Group.
- <sup>18</sup> Except, however, for some families that have a seriously ill member (or one with a chronic disease) who received a specific treatment/operation as the result of the 30-Baht Scheme.

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