ผลกระทบของโครงการ 30 บาทรักษาทุกโรคต่อคนจนในประเทศไทย
Impacts of the 30 Baht Health Care Scheme on the Poor in Thailand

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บทความนี้ศึกษาผลกระทบของโครงการ "30 บาทรักษาทุกโรค" ต่อผู้ใช้และกลุ่มคนยากจน การประเมินผลกระทบใช้ข้อมูลการเปลี่ยนแปลงพฤติกรรมในการรักษาพยาบาลของประชาชนหลังจากมีโครงการ และความคาดหวังของประชาชนต่อการบริการรักษาพยาบาล

โครงการ "30 บาทรักษาทุกโรค" เป็นส่วนหนึ่งของความพยายามด้านหลักประกันสุขภาพถ้วนหน้า โครงการนี้จึงไม่ได้เจาะจงเฉพาะคนยากจน หากแต่ครอบคลุมประชาชนทุกคนที่ไม่ได้อยู่ภายใต้โครงการหลักประกันสุขภาพอื่น ๆ ของรัฐ แต่ผลการศึกษาพบว่าที่ผ่านมาโครงการนี้มีผลกระทบต่อกลุ่มคนยากจนมากกว่ากลุ่มอื่น เนื่องจากโครงการช่วยให้คนจนสามารถเข้าถึงการบริการด้านการรักษาพยาบาลมากขึ้น ซึ่งในอดีตนั้น คนจนเหล่านี้ควรได้รับสิทธิในการรักษาพยาบาลฟรี แต่บางส่วนกลับไม่ได้รับบัตรรายได้น้อย ทำให้หลายคนต้องเสียค่าใช้จ่ายซื้อบัตรสุขภาพแทน อย่างไรก็ตาม หลังจากที่มีโครงการนี้ พฤติกรรมการรักษาพยาบาลของคนจนไม่ได้เปลี่ยนแปลงไปจากเดิมมากนัก เนื่องจากว่าคนจนส่วนใหญ่มีทางเลือกค่อนข้างจำกัด สำหรับประชาชนส่วนใหญ่ (รวมทั้งกลุ่มที่มีรายได้น้อย) ค่าใช้จ่ายในการรักษาพยาบาลก็ไม่ได้เปลี่ยนแปลงไปมากเช่นเดียวกัน

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ประชากรกลุ่มตัวอย่างให้ข้อมูลว่าได้เห็นการบริการที่ดีขึ้น แต่ความคิดเห็นของประชาชนแต่ละกลุ่มเกี่ยวกับคุณภาพการรักษาพยาบาลภายใต้โครงการ "30 บาทรักษาทุกโรค" แตกต่างกัน

การศึกษาความคาดหวังของประชาชนต่อระบบบริการสุขภาพของรัฐนั้น พบว่าประชาชนกลุ่มที่ผู้มีรายได้น้อยให้ความสำคัญกับการมีหลักประกันสุขภาพ (เช่นโครงการ 30 บาทฯ) มากที่สุด ขณะที่ประชาชนส่วนใหญ่ให้ความสำคัญกับการมีโรงพยาบาลและบุคลากรทางการแพทย์โดยเฉพาะแพทย์ที่เพียงพอมากกว่า อย่างไรก็ตาม ประชาชนทุกระดับรายได้ยังต้องการให้โครงการ 30 บาทคงอยู่ต่อไป เพื่อเป็นหลักประกันในยามที่เกิดการเจ็บป่วยรุนแรงที่มีค่าใช้จ่ายในการรักษาพยาบาลสูง

Abstract

This paper assesses the impact of the 30 Baht Health Care Scheme on its users, with special references to the poor in Thailand. Part of the assessment came from our study concerning changes in health seeking behaviors after the scheme was introduced and people's expectations on the public health provision.

The 30 Baht Health Care Scheme was launched by the current government as a part of the universal health coverage program. It is a non-targeting scheme, covering everyone who is not under another government-sponsored health insurance program. Thus far, however, the scheme has had a greater impact on the low-income populace, many of whom had in the past been missed by the selection process for gaining access to free health care. This study found that the health seeking behaviors of the poor did not change drastically after the scheme had been implemented, as most of them had rather limited choices. For most people, including the low-income group, the financial cost for health care did not change drastically as a result of the scheme. Most subjects saw improvements in service, but their perceptions on the quality of health care under the scheme varied.

Peoples' expectations of the public health provisions varie. The poor tended to place the highest emphasis on having a low-fee insurance program (like the 30 Baht Scheme). Others were concerned more with the adequacy of hospitals and personnel (especially doctors). People from all income groups, however, preferred to retain this scheme to guard against catastrophic illnesses.

1. Background

In the late 2000, the Thai Rak Thai Party (hereafter, TRT) fueled the general election campaign by promising to carry out a new set of programs. One of the most eye-catching was the "30 Baht Health Care Scheme[1]" (hereafter, the "30 Baht Scheme"). During the campaign, TRT specified that the scheme would provide health care for everyone—regardless of the illness being treated, at a cost of 30 Baht, presumably per visit or per sickness. According to the TRT website at the time, a health insurance premium of 100 Baht/month per person (approx $2.5) would be collected to provide additional funding for the scheme to the regular government budget.

After TRT acquired the majority vote and became the leader of the coalition government, the government initiated this scheme very quickly. Following a workshop in February 2001, the first pilot project was announced for implementation in six provinces on April 1. The second pilot in another 15 provinces followed in June. In October, the nationwide scheme was implemented, covering all areas save some inner regions of Bangkok, which were deferred until January 1 or April 1 of 2002. During the pilot and full-scale implementations, the proposed insurance premium was taken off and the project has since been financed solely by taxes.

As a *Universal Health Care Coverage scheme* ("UC" for short), the 30 Baht scheme applies to everyone who is not covered by other government-sponsored insurance, i.e., the Civil Servant (and public enterprise) Medical Benefit Schemes (CSMBS), the Social Security Scheme (SSS), the Health Card Scheme, or the Health Welfare for the Poor and the Disadvantage (HWPD). The latter two schemes were merged with the 30 Baht Scheme, although those

covered under HWPD are not required to pay the 30 Baht fee. The implementation of these two has, in fact, become the foundation of the 30 Baht Scheme.

Aside from providing health coverage to people who were not in the CSMBS or SSS, during its first year of implementation, the 30 Baht Scheme attempted to reform the health care financing system. It also aimed to shift the paradigm that governs the health service system—moving the main emphasis from health care service to health promotion and disease prevention.

This report is aimed at describing the consequences and impact of this new scheme on the users and particularly the poor. The results provided in this report came from both desk and field research. The desk research focused on the implementation and impact of previous programs. The field research was comprised of two rounds of fieldwork that attempted to explore health-seeking behaviors of the low-income group prior to and after the implementation of the new scheme. The first round of the fieldwork was undertaken during a TDRI poverty study project in the late 2001, when ten researchers stayed for two months in ten villages/communities. However, the main fieldwork data present in this paper were drawn from an ongoing project[2] led by the authors.

II. Impact on the Users and the Poor

Although the 30 Baht scheme preaches the concept of "universal coverage" and "rights to health care,"—as opposed to being a "welfare program",[3] throughout the two years that this government has been in power, it has provided mixed messages to the public and the health professionals. At times, the scheme was referred to

as a "pro-poor program,"--the high-income and middle class being persuaded to seek health services elsewhere so that they would not consume too many of the tight resources for the scheme. However, when a large faction in the senate attempted to modify the National Health Insurance Act (drafted to be the basis of the scheme) to cover only the poor or the uninsured, the government turned to the claim that the law was indeed intended for all Thai citizens. Nevertheless, the prime minister recently asked the Thai people to be patient with the scheme—which might still have been "unsatisfactory" for the middle class—claiming that it has successfully assisted the poor thus far.

The impact of this scheme on the users, with special references to the poor, could be summarized in four aspects:

a) Rights and Access to Care

Since 1975, the low-income group has been eligible for free health care services supposedly covered by the HWPD scheme, which provides the "Low Income Card" (LIC) to a single person earning less than 2,000 Baht ($50) per month or a family earning less than 2,800 Baht ($70) per month.[4] However, studies consistently found that most low-income families did not receive the Low Income Card and that the majority of the cards were distributed to people or families that earned more than the eligible criteria. (See the authors' review of these studies in Viroj and Anchana 2002). The mis-targeted portions moreover appeared to increase over time.

Because of this problem, a significant number of the poor ended up purchasing the 500-baht ($12) health insurance card designated to provide insurance for a family of up to five persons. According to the Socio-economic Survey administered by the National Statistics Office in 2000, almost one-half (47%) of the poor

held the 500-baht health insurance card, more than twice the number that had received the low income card (21%) (Viroj and Anchana, 2002). Although these figures may include misidentified cases, the figures do indicate that the mis-targeting had been widespread.

It turns out, therefore, that a supposedly non-targeting scheme like the 30 Baht Scheme has helped many low-income persons gain access to low cost health care, for which they have been eligible. At present, the poor do not--as was the case under the HWPD, have to pay an extra premium to gain such access. It should also be noted that having a card does not necessarily ensure access or coverage. Before the 30 Baht scheme, certain LIC-holders of an urban slum in a province in northeastern Thailand reportedly avoided seeking service from the hospital listed in the card, feeling that they were not welcomed. They were also unsure of the benefits the card would provide, or if a particular service would be covered by the card. The name of the card, which could be literally translated to "Health welfare for people with low-income and for people who should be assisted," was rather ambiguous and uninformative. The cardholders' experiences in various provinces suggest that the manner in which these people were treated varied greatly, often on case-by-case basis depending on the personnel who handled the case. Some patients who felt that they were not welcome–or were even verbally harassed—by certain officials,[5] were treated very nicely by others or on different occasions. During her daughter's admissions in a regional hospital, an LIC cardholder in a province of central Thailand was asked repeatedly by hospital personnel to buy the medicine from the hospital pharmacy, even though the attending physician told her that she did not have to pay. Finally, another

nurse persuaded the hospital's welfare officials to give her an exemption. Under the new scheme, uncertainties on rights and coverage appear to diminish greatly as it has been well advertised and thus well known among the general public (and possibly the health care providers as well). Most patients also feel that they were treated better, at least verbally and mannerly, after the 30 Baht Scheme was put in place.[6]

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 the UC would remove the financial burden that is usually associated with seeking health care. Therefore, it had been expected that people would pay more visits to the health care facilities that participated in this scheme. The figures released by MoPH indicated that, in FY 2002, the number of patients who visited its hospitals, which were supposed to look after more than 90 percent of people in the 30 baht scheme, increased by about 60 percent from FY 2001. Although the actual number may differ from this because of changes in the definition of outpatient visits, it has become almost a consensus that more patients come to use services in at least some of the MoPH's hospitals.

A number of health care providers in public hospitals claim that patients have flooded into their hospitals after the initiation of the 30 Baht scheme. One of these providers' observations is that people seek health services earlier than in the past. Some people, according to them, come to seek services that could easily be taken care of on their own. Another less common claim by some

providers is that people take less care of themselves (i.e., moral hazard problems have arisen from the new health insurance scheme).

While it is agreeable that a number of patients seek health services earlier, it is not clear whether such an action is appropriate or not. There has been no systematic study on this issue. However, a team of senior medical professors—headed by Prof. Charas Sawanwela, a former dean of the Faculty of Medicine in Chulalongkorn University—paid several visits to a number of hospitals in rural areas during the early stage of the scheme's implementation. They reached the conclusion that almost all patients who sought health care did have reasonably alarming causes to do so.

Our findings from fieldwork, which involved gathering information from various focus groups, and interviews of people of various income groups in several provinces in three regions of Thailand, revealed that:

- Some patients agree that *some* hospitals have been more crowded since the 30 Baht scheme was in place.

- Most people indicate that their health seeking behaviors have not changed. They usually assess the situations of their illnesses and take action accordingly. In an urban area where there are drug stores nearby, patients with mild illnesses (based on their own assessments) would buy medicines from drug stores (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 an illness is out of their own hands would they go to the hospital or to see a doctor at a clinic. Whether they choose to go to a hospital or a

clinic would depend on their income and time available (e.g., the elderly are more likely to use public services), how urgent the patient feels s/he needs to see a doctor (going to clinic if the need is urgent[7] or when it is more difficult to assess the situation, e.g., when a child is ill). In an emergency case, most would go to a hospital. People from low-income families tend to go the designated hospital[8], and hope that it would refer them to a larger hospital if needed. However, a better-off family in peri-urban area would send the patient to the provincial hospital right away, or even to a private hospital, especially during the nighttime or weekend, when most public hospitals would be understaffed by doctors.

- Almost all patients indicated that, when possible, they would stay away from hospitals as much as they could. They were amazed of the idea that some would be willing to seek increased or unnecessary care after the 30 Baht Scheme had been in place. The only difference after the 30 Baht Scheme is that *some* patients *occasionally* switched from going to a private clinic/hospital to use the public hospital instead. Even these patients found at times that the hospital was too crowded, and sometimes decided to waive their rights so that they could get into a shorter waiting-line to see the doctor.[9]

- In this connection, a number of dwellers in two low-income communities in Bangkok complained that they had several bad experiences with treatments received by a private hospital participated in the 30 Baht scheme. According to the villagers, they insist that they would rather buy some medicine from a nearby drugstore than go to the hospital 4-5 kilometers away if they did not think that their illnesses were 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 with some common drugs (Paracetamol and other drugs of that ilk). In one of these cases, the patient urged her relatives to bring her to another private hospital and was told that she came too late, dying shortly at the second hospital. Another case resulted in a ruptured appendicitis. Another person from this community also had to pay three visits to the hospital before she was admitted in the third visit to the ICU, as her illness having become apparently severe. Only after that did she get fairly decent treatment and follow-ups that satisfied both the patient and her relatives. Although some cases were in the gray area, such as appendicitis which a lot of experienced doctor could still misdiagnose, these three cases experienced by a small cluster of the community suggest that, at least in some areas (with some possible connections with private hospital) the moral hazard from the hospital side might even be problematic than that of the patients.[10]

- However, even though most patients believe that they only go to the hospital at the last resort (after self-assessments and self-care through medicines from a nearby drugstore), people do have varying attitudes or thresholds on the "severity" of an illness. (The most general conclusion that could be made out of several focus groups is that a male's severity threshold is usually higher than that of a female counterpart).[11] Therefore, even after self-assessments, there would still be a significant number of cases going to the hospitals that are regarded by the providers as non-severe or not urgent or even as unneeded of a doctor's help.

- When compared with those before the implementation of the 30 Baht scheme, health-seeking behaviors of the low-income group have not changed very much (probably their behavioral changes are much less than those of other income groups). Some of the reasons are:

- Limited alternatives. Most users are assigned to the same hospital that they used to be assigned under the HWPD or the 500 Baht Health Card Scheme. If they go to another hospital, they will have to pay by themselves. In addition, transportation cost is 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 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 has been intended to remove financial burdens rising from health care, for which an event could be unanticipated and the cost might be unpredictable. Our findings on this issue are as follows:

- For most people, including the low-income group, the financial cost of health care has not changed drastically after the 30 Baht scheme. Many families only had to change their payment routines from 500 Baht per year (per family of five or less) to 30 Baht per visit. This change could result in a smaller or greater financial cost, usually depending on whether that family has a member with a chronic disease. But even accounting for that, not many people

regard the financial burden a big issue, as most of them feel they could afford to pay 100-200 baht for a visit to a clinic when needed. The exception is the low-income group, which clearly prefers to pay 30 Baht per visit over a lump-sum of 500 Baht in advance. This was the only group that was concerned when asked a hypothetical question: whether their health seeking behavior would be changed if the government raised the copayment from 30 to 50 Baht. It is difficult for these people to pay a lump sum of 500 Baht, which is considered a large amount. Some also complained that the subdistrict health centers had already raised their fees from a variable fee (most of which were in the range of 15-20 Baht for common illnesses) to a flat fee of 30 Baht.

- However, although the scheme has not had a direct impact on their financial burden (and a large number of the eligible seek their service from their designated health facilities), most people (from all income levels) prefer retaining this scheme (or a similar scheme, such as the 500 Baht Health Insurance Card) rather than returning to a targeting program like the LID scheme. The main reason provided during our focus groups/interviews was that while most of them could afford paying 200 baht per visit occasionally, or could at times afford to be an inpatient at a private hospital, there could be a time to come when they need to be admitted to a hospital and would be unable to pay on their own. When that time comes, this scheme would be the last resort to ensure that they would still get some care without having their family go broke. Interestingly, many who used to buy the 500 Baht Health Card also cite the same reason for buying such a card, even though they had

felt that all their family members were rather healthy and would not likely need to use the service covered by that scheme.

d) Quality of Service

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

- Unlike the implementation of the 500 Baht Insurance Card, which many interviewees felt brought improvements in the services they received, not many interviewees attribute such an improve as an outcome of the 30 Baht scheme. Some patients receiving the services, most of whom at the outpatient department, feel that the hospitals tended to use an increased amount of "common" medicines (such as paracetamol) than in the past, unlike the same doctors at their clinics. However, almost none perceived any clear deterioration of service. And while a significant number of patients did not like the system that required them to go first to the designated hospital, some also perceived some improvements in the referral system.

- Most of the high-income group, who are accustomed to receiving services from large and private hospitals, are not very satisfied with the 30 Baht scheme, partly because of rationed care. A number of interviewees experienced slower service when using the 30 baht card, especially in hospitals that have separate queues for the 30 Baht and self-paid patients.

III. Expectations of the Users and the Poor

An indirect method to evaluate whether the 30 Baht Scheme has fulfilled the needs of the users and the poor is asking the interviewees and those who participated in our focus group to rank the four most important things that they expect from the health service system. The choices that are provided by the researchers were 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 sufficient numbers of hospitals and personnel, (c) The right to choose the health care facilities, and (d) Receiving good treatments (medically and verbally) from the health care personnel. During the interviews/focus groups, the participants were also allowed to add their own suggestions to these four items.

In our interviews/focus groups, most participants ranked "(b) A health service system with sufficient numbers of hospitals and personnel" as the most important quality, with some exceptions from some low-income participants, who chose "(a) A universal coverage scheme like the 30 Baht scheme or other low fee health care schemes" over (b). Only a small proportion of the subjects chose (c) or (d) as their first priority.

The second choice had more variations than the first one. Most respondents who chose (b) as their first choice tend to choose (a) as their second choice, and vice versa. However, some respondents ranked "(d) Receiving good treatments (medically and verbally) from the health care personnel" as their second priority. A smaller number of respondents chose "(c) 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 on the health care service and referral systems—tended to give a higher priority to "(c) Right to choose the health care facilities." This might reflect their awareness of limitations in the existing health care service and referral systems.

In light of these answers, we may conclude that people are more concerned of the inadequacy of hospitals and personnel (especially doctors) than the free or low cost insurance program intended by the 30 Baht Scheme. A caveat to this conclusion is that these responses have been made after the implementation of the 30 Baht Scheme, which might have swayed many people's opinions to another lacking area that still has not been addressed as much as the health insurance issue.

IV. Concluding Remarks

The 30 Baht Scheme aims to provide ***Universal Health Care Coverage*** by providing health insurance for everyone who is not currently covered by two other government-sponsored insurances (i.e., the Civil Servant/public enterprise Medical Benefit Schemes and the Social Security Scheme).

While the 30 Baht Scheme preaches the concept of "universal coverage," it has also advertised that it is a "pro-poor program" that aims at removing financial burdens arisen from health care, which could be detrimental especially for the poor. Interestingly, an untargeted scheme like this one has benefited many of the poor who used to fall through the selection process in the HWPD Scheme. The more systematic and universal approach of the 30 Baht Scheme, which recognizes the "right to health care" of everyone, makes the

poor less vulnerable from being shut out from accessing the care and lessens their dependence on the health providers' kindness.

Health seeking behaviors of the poor have not considerably changed after the scheme, as most still have limited health-care choices. For most people, including the low-income group, financial costs for health care have not changed drastically after the 30 Baht Scheme. However, most people like to have this scheme in place as an insurance against drastic or catastrophic illnesses that could come in the future.

While almost all beneficiaries—especially the poor—welcome this scheme, most people voice their concerns on the inadequacy of hospitals and personnel (especially doctors in small public hospitals). This is the main problem that the government needs to address if it really aims to provide universal and equal access to quality health care for all and especially for the poor.

Footnote

[1]The exact translation would be the "30 Baht curing any disease" scheme.

[2]Namely, the Monitoring and Evaluation of Universal Health Care Coverage in Thailand, 2nd Phase, 2003-04.

[3]In the sense that is commonly used in the U.S.

[4]This criteria were effective since 1994. In 2001, the poverty line was about 700-800 Baht per person per month. The US dollar equivalence is based on the current exchange rate.

[5]One LIC cardholder in the Central Region recalled an episode that she was questioned after buying some food and brought it into the hospital, of how she had money to buy food while none to pay for her daughter's medicine. Another cardholder in the Northeastern region told the researcher the reason why she also bought the 500 Baht Health Insurance Card that, "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."

[6]However, part of this improvement could also have resulted from more scrutiny by both the MoPH and the public, forcing the providers to be more conscious (or careful) in their service. This does not come without a cost, as many health care providers have complained about their work after the scheme and are less satisfied with their job.

[7]Although the patients realize that most clinics do not have as good facilities as the hospital, 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 channel without having to wait for a long time, unlike when they go to the hospital on their own.

[8]Before the 30 Baht Scheme, most people in this income group also had LICs or 500 Baht Health Cards, both of which also specified the designated hospital that would be the gatekeeper. Therefore, in this respect, their choices have not changed after those two programs were replaced by the 30 Baht Scheme.

[9]To cross check results of our study, which is mainly qualitative, the second author has supervised three graduate research projects that use similar questionnaires focusing on issues discussed in this paper, in three provinces. One preliminary result from a province in the Central Region indicates that less than 5 percent of all patients go to the health care facilities to get medicines or vitamins when they were not sick. Part of these cases may occur when they accompany the patients to the health care facilities. These incidences are also more likely to take place in the subdistrict health centers or district hospitals, which usually have short waiting lines.

[10]Some workers in the SSS also claim that many doctors would not listen to or examine their cases seriously. They speculate that it was not only the financial issue that was involved, but that the screening doctors are accustomed to frequent visits by healthy workers who simply want a physician note that they could use to apply for a sick leave from their companies. Some of these doctors would therefore presume that most patients were not ill. Some SSS patients also indicated that it was only after they passed the "gatekeeper" to a specialist or were admitted as an inpatient that they would be treated normally like other patients.

[11]Another pattern, although slightly-less common is that, when controlled by the age group, the younger generation's threshold tend to be lower than that of the older ones—many of whom are also less familiar with the hospitals and often try harder to avoid making visits there as well.

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