Executive summary

Willingness-to-pay of Households Toward Health Promotion Programs of the Thai Health Promotion Foundation (ThaiHealth)

This study is the Assessment Results of Health Promotion Programs by way of evaluating the willingness-to-pay of households in relation to the health promotion programs being run by the Thai Health Promotion Foundation (ThaiHealth). It aims to assess the programs' value to the general public by quantifying the willingness-to-pay of households in six plans selected by the stakeholders and to analyze the factors related to the willingness-to-pay in each plan. This would show the characteristics of the population who recognize the value of the programs taken via the health promotion programs as well as to analyze the factors associated with health behaviors such as consumption of alcohol, tobacco, and physical exercise. This study is a cross-sectional survey on Thai households in Bangkok and 10 other regional provinces, consisting of Chiang Rai, Nakhon Sawan, Yasothon, Nong Khai, Nakhon Ratchasima, Phetchaburi, Chachoengsao, Phra Nakhon Si Ayutthaya, Phattalung and Chumphon. There were 7,311 individuals sampled using a questionnaire to collect data, ranging from socioeconomic status and the health of respondents and their family members, including pre-existing medical conditions, consumption of alcohol and tobacco, and physical exercise, through to awareness of operations of the ThaiHealth's programs and video media in disseminating information about the six plans. These plans consisted of Tobacco Consumption Control, Alcohol Consumption Control, Traffic Injuries and Disaster Prevention, Health Risk Factors Control (Nutrition), Physical activity and Sport for Health, and Social Marketing.

Fators related to health behaviors

1. Factors that increased the likelihood of becoming a drinker or smoker in the 12-month period are: males; people who have jobs; people with simultaneous drinking and smoking behaviors; and people who have family members with the same type of risk. Factors that

reduced the possibility of becoming a drinker or smoker in the 12-month period are pre-existing medical conditions, aging, and the tendency to quit drinking and/or smoking.

2. A correlation exists between abstaining from drinking and abstaining from smoking within the same 12-month period. It also exists between the reoccurrence of drinking and smoking after a period of abstinence. Once either drinking or smoking is resumed, the other habit will follow suit, with 65% of drinkers and 80% of smokers likely to resume their habits after a period of abstinence.

3. Factors which inhibited success in attempts to quit drinking and/or smoking were attributable to a lack of pre-existing medical conditions, youth, unwillingness to quit drinking or smoking simultaneously, and having a job.

4. People who engaged in regular exercise and sports activities comprised the likely drinkers since they are healthy and do not have any incentives to quit. Moreover, after playing sports, there may be social drinking sessions. However, these people had a lesser tendency to smoke than the non-exercising people while also having a greater probability to temporarily quit drinking and smoking in the 12-month period.

5. Drinkers and smokers who were aware of the operations of the ThaiHealth were those who succeeded in temporarily quitting drinking and smoking for at least a month through sheer effort. However, the majority of these people would resume their drinking or smoking habits. This may also be due to the fact that the operations of the two programs are still separated. This implies that the programs to control alcohol and tobacco consumption do not provide results which are effective in the long term yet. Most of the people who quit are those who are inflicted with pre-existing medical conditions or aging, which are considered to be personalized factors. Meanwhile, the research shows that the drinker and smoker is the same person and the drinking and smoking behaviors of these people coincide with each other as well as during the same periods.

The evaluation of willingness-to-pay of households on the ThaiHealth's programs has shown that the majority of the respondent (approximately 70%), both previously aware of and unaware of the programs, were willing to pay in order to support its continued

operations. The median value of the willingness-to-pay was found to be 20-100 baht per program since it was said to benefit society as a whole, and the total willingness-to-pay amount was found to be approximately 8 billion baht for the six plans. The factors associated with the willingness-to-pay (regardless of the amount willingly paid) were the level of secondary education or higher, high income, younger age, exercise, and awareness of the ThaiHealth's operations.

Factors associated with the willingness-to-pay amount between the six plans

When considering the group that is willing to pay and the analysis of factors associated with an increasing or decreasing willingness-to-pay for the six plans, the factors can be divided into four groups as follows:

1. Factors associated with an increase or decrease in willingness-to-pay for all six plans are: the set starting point of willingness-to-pay, where a higher starting point sets a higher willingness-to-pay amount; income, where the willingness-to-pay amount increases by income level; age, where 15-25 years old are more willing to pay than 26-65 years old; exercise, where those who exercise are more willing to pay than those who do not; and region, where people living in the North and Northeast are less willing to pay than people living in Bangkok.
2. Factors associated with an increase or decrease in willingness-to-pay for a majority of the plans show that: smokers have a higher willingness-to-pay than non-smokers in five plans, except for the Tobacco Consumption Control; people who have jobs in agriculture, manual labor, government officials/employees, and students/collegians were less willing to pay than people who do not have jobs.
3. Factors associated with an increase or decrease of willingness-to-pay in some plans show that: people with an education level of high school or higher were more willing to pay for the Health Risk Factors Control (Nutrition) and Physical activity and Sport for Health plan than people with an education level of high school or lower; people who are members of a

family with smokers or former smokers were more willing to pay for Tobacco Consumption Control and Alcohol Consumption Control plans; people who were aware of the ThaiHealth's operations were more willing to pay for the Alcohol Consumption Control plan than those who were not aware of the operations; and people who were involved in road accidents were less willing to pay for the plans involving Alcohol Consumption Control and Social Marketing.

4. Factors which had little or no association with an increase or decrease in willingness-to-pay (not significantly different from the reference group) include: people in the central and southern regions (reference group: Bangkok); people living in municipalities (reference group: people living outside of municipalities); males (reference group: females); manual labor/vendors/entrepreneurs (reference group: people without jobs); the spouse of the head of the household (reference group: relatives/household occupants); family history or pre-existing medical conditions (reference group: those without disease); people who were drinkers in the past 12-month period (reference group: non-drinkers); people who are members of a family of current or former drinkers (reference group: people without drinking family members); people who were involved in road accidents (reference group: those who have not been involved in road accidents); and people who were aware of the ThaiHealth's operations (reference group: people who were not aware of the operations).

The evaluation of the willingness-to-pay conducted was to assess the perceived value of the ThaiHealth to the general public. The method used to measure the willingness-to-pay is popularly used by economists to evaluate the value of products which are not available in the market. Therefore, the willingness-to-pay of 8 billion baht spread across the six plans cannot possibly be used to set the actual investment cost even though the general public is willing to pay since they are satisfied and appreciate the value of an organization working wholeheartedly to provide public benefits. Therefore, paying to support the continued operations is essentially the same as paying for the concept of health promotion. If the ThaiHealth were to use the results, they should be extremely careful since the public has paid 8 billion baht to the organization.

However, there are significant limitations to this study. One is that the survey may not have covered all of the factors related to health behaviors, such as: personal beliefs, which may be a factor associated with health behaviors but was not analyzed; queries which could have determined the amount of drinking and smoking; and exercise of the respondents 30 days prior to the interview in order to make it easier to answer, which may not reflect the actual health behavior. Another is that the willingness-to-pay of respondents, after taking income and actual expenditure into consideration, may have limited the amount willing to be paid. In the interviews, each respondent was given information via video media for two different plans and were given the option to pay or not pay for the programs/an additional program in order to reduce the survey time.

The hypotheses of this study are that the other plans for which respondents did not watch the video media and did not select as an additional plan were denoted as unwilling to pay, and the comparison between willingness-to-pay for each of the ThaiHealth's plans is the evaluation of the operations for the entire 10 years and the payment for an additional year of continued operations. Therefore, a comparison between willingness-to-pay and the continued operating costs for an additional year may not be the most appropriate.

Policy recommendations

1. The ThaiHealth and all of its networks should work together to reduce risky behaviors in a holistic approach, especially the consumption of tobacco and alcohol.
2. The ThaiHealth has not yet reached the grassroots of society (the less educated, farmers, low income), who have high risk behavior.

From both of the sub-studies, the research may be used as an example to evaluate organizations that work towards the benefit of the public in order to know the views and the value given by the public. The results of the study may also be incorporated with other data to plan the operations of the organization and to enhance the efficiency and support of the public.