Changes in Health Care Utilization in Thailand

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ABSTRACT

The health care system in Thailand is pluralistic. Thais are generally involved with both modern and traditional health treatments and seek health care from many sources of government and private practices when they are ill. However, during a single illness episode, patients are more likely to change sources of health care, ranging from lay treatment to highly professional health care. Riley and Sermsri (1974) identified Thai behavior in seeking health care as a "switching health care pattern." In the 1970s, government health services affiliated with modern medicine, were grossly under-utilized, while traditional health care was private and favored. By the end of the 1990s, government health care became preferable, particularly for the majority of the poor in rural areas and the use of traditional medicine faded. This paper overviews 30 years of health care utilization patterns in Thailand (1970-2000) with the findings that change in health utilization is clearly observed, shifting from a gross under-utilization to a preference for government health care services. This paper holds that the shift lies with the emphasis of health authorities within the domain of the Thai medical care system. The implications of this change are now assessed for further research and policy planning.

MODERN AND TRADITIONAL MEDICINE

In Thailand when one has an illness, he/she can obtain health treatment from several sources and forms of medical care including government health services, private practices and modern and traditional health treatment. It has been documented that during 26 years of modern health care utilization era in Thailand (1970-1996) the predominant source of health care was self-treatment and the use of drugstores (Table 1). The most common practice among Thais was to buy medicine from drugstores where both traditional and modern medicine are available without the requirement of a physician's prescription. However, when Thais were asked to express their preferred mode of treatment, modern medical care was the most preferred. This modern health care is available within government health practices. Modern medicine is considered to provide more effective outcomes and to be superior to traditional health treatment. Riley and Sermsri (1974) had identified the superiority of modern medicine as due to three components of the health care system, namely, medicine, personnel and techniques of treatment. A recent study (Sawangdee et al., 2000) confirms that the expertise of modern health care providers and medical equipment in big hospitals attract many patients even though their illness is not severe. Good quality care is then dependent upon the availability of health specialists and technologies.

Table 1. Percentage of health care utilization in Thailand for the years 1970, 1979, 1985, 1991, 1996 and 2000

Source of Health Care	1970	1979*	1985**	1991***	1996***	2000****
Take no medicine	2.7	4.2	6.3	15.9	7.8	2.0
Traditional practitioners	7.7	6.2	2.4	2.6	2.3	0.9
Self-Treatment and drug- stores	51.4	42.4	24.4	38.3	31.6	10.1
Government health centers	4.4	16.8	13.3	15.7	17.1	25.8
Government hospitals	11.1	10.0	32.8	12.9	21.2	38.4
Private hospitals and clinics	22.7	20.4	20.8	12.4	18.2	20.4
Other lay-referrals	-	-	-	1.7	1.0	2.0
Don't know	-	-	-	0.4	0.8	0.4
Total percent	100.0	100.0	100.0	100.0	100.0	100.0

Sources : * Ministry of Public Health. 1982
** Ministry of Public Health and Institute for Population and Social Research. 1987
*** National Statistical Office. 1991 and 1996
**** Kamnuansilpa et al., 2001

Modern medicine came to Thailand from the more developed countries of Europe and America and is regarded as effective and efficient. Based on the author's interviews, Thais view that modern medicine provides quick results. "You may feel something running in your vein when you have modern medicine" many Thais responded. Modern health technologies, particularly the techniques of treatment, consist of several advanced approaches including surgery, vaccination and x-ray. Many doctors have often experienced a request from patients to have an injection as part of the consultation and treatment. Patients would feel dissatisfied with the treatment if doctors did not give any injection. Computerization of modern medical care has also advanced both diagnosis and treatment. This advancement is also increasing both monetary and social costs to modern health care. In contrast, traditional practitioners who give herbal medicine and sometimes involve magic and superstition as well as religious practices, are more rural-based. In fact, when illness is concerned with life and death; i.e., a dangerous snake bite or a severe injury or car accident, patients hurry to modern medical care. Modern doctors look more charming and attractive with clean, white clothes and a stethoscope around their necks. Importantly, modern doctors are government officials and they enjoy more privileges and higher prestige.

Sermsri (1989) discussed the social roles of modern doctors working in provincial hospitals in Thailand and found that these doctors were called **mor Yai** 'a big doctor' and **jao nai** 'a boss' as compared to **mor lek** meaning 'a lower status doctor' in a health center at the village level. Modern doctors attend university for many years with legally prescribed courses in medical treatment while other health care practitioners receive no legal support from the government authorities. Modern doctors are also attached to large buildings and advanced technologies. Government health care services offer mainly modern medical care whereas traditional health practitioners are unauthorized to operate in government health care services. Traditional practitioners who adopt modern medical treatment are more likely to be termed "quacks" as part of the monopolization of the modern medical profession.

UNDER – UTILIZATION OF GOVERNMENT HEALTH SERVICES

In the 1960s, although the preference for modern medicine among Thais was prevailing, the use of government health care was grossly under-utilized (Sermsri, 1989). When compared to traditional treatments, health centers of the government were found to be less used. The percentage of health care utilization at government health centers in 1970 was 4.4 percent against 7.7 percent for traditional healers (Table 1). The under-utilization refers to a balance of government efforts concerning health centers and the output of patient use. The Thai government put a lot of investment in building health centers and training health personnel to provide decent care to the majority of Thais in rural areas, but only a few local villagers came to use the services offered by these health centers. A significant problem in using government health care was that the cost of the services, including economic and social costs, was higher than that of traditional practitioners.

Concerning social costs, government health care was bound up with red-tape, making a patient pass through several steps before seeing doctors for only two or three minutes. The long waiting time was also a big problem. It was often seen that in many government health care service centers patients came to the government hospitals at dawn and were only able to see a doctor at nearly noon. Also, communication between modern doctors and patients was problematic. It was quite easy to encounter misunderstandings by the patients in following the doctor's consultation. Patients were reluctant raise questions although doubts were evident. A story is often cited regarding the miscommunication between doctors who provided family planning advice and young couples who failed to use condoms. A couple came to see a doctor with a pregnant wife after receiving an unclear message. As Cohen (1989) pointed out, the Thai modern medical system in the past failed to develop the proper mindset for serving the poor majority. Doctors were employed in a bureaucracy. Doctors worked in private clinics in addition to serving in government health centers and hospitals. Modern doctors wear two hats. Doctors needed to work in private clinics and government hospitals in order to earn an income commensurate with their high social status.

In addition, the economic costs of modern health care at government health service centers are high. These costs include medication, doctor consultation, x-ray, laboratory tests and the cost of travel and lodging for relatives and family. This monetary expense of modern health care is always higher than that of traditional health treatments. The cost of traditional healers is related to a "guru" donation which is very small when compared to the cost of modern health treatment. It is well documented that modern doctors are, as is well documented, less willing to go to rural areas and prefer to treat urban and educated Thais. Modern health care, with enterpreneurial medicine, is then flourishing in the large cities and urban areas. As Lyttleton (1996) pointed out in the study of the Northeastern Thai health system, the Thai medical system failed to develop into a vehicle for serving the health needs of the mass population in rural areas. Modern doctors prefer to work with urban patients.

PREFERENCE FOR GOVERNMENT HEALTH CARE SERVICES

In 1978, the World Health Organization called for a revolutionary approach to health care in the Alma Alta Declaration. The practice of primary health care emerged then in Thailand. From the 1980s, bottom-up planning was encouraged. This was done by several national

planning groups in order to attack not only poverty but also the wide gap in modern health care services for the urban minority and rural majority. Inshort, this strategy was adopted to guide multi-sectoral village level activities. It was therefore an attemped integration of the health care system of the government and other main forces of human development. The strategies to increase the accessibility of both government health care and primary health care services for the majority of Thais were then implemented as follow:

- *Increased coverage of basic health care services;*
- *Training for primary health care workers;*
- *Securing of resources to assist primary health care activities so as to strengthen government capabilities in management;*
- *Decentralization of decision making; and*
- *Promotion of community organization and participation at every stage of health service delivery.*

Along with the implementation of the primary health care approach carried out by senior health authorities, the active work of the young modern rural doctors the so-called "Phaet Chon Bot" Forum, has shaped government health care services relevant to the culture and rural ways of life. District and community hospitals, as well as health centers, where rural Thais are easily accessed, were staffed with "Phaet Chon Bot" doctors. These young active doctors played an important role in helping the majority of Thais come to use the government health care services. Many young doctors were eventually interested in community organizations and turned out to be well-respected persons and leaders in many community development activities. A growing number of active doctors eventually wore two hats; i.e., working as a government health provider and as a socially-minded public person. A referral system of health care, for example, was redefined and supported. These efforts allowed district and community hospitals to coordinate with the services of health centers.Co-operative drug stores at the village level were established and many health welfare programs were introduced through the efforts of the movements of these young doctors. In other words, the activities of both primary health care and movements of the Phaet Chon Bot Forum, have reduced both the economic and social costs of government health care services for the rural majority. Accordingly, the percentage of using government health centers increased to 16.8, 15.7 and 17.1 in 1979, 1991 and 1996, respectively. The use of government hospitals was also the highest at 32.8 percent in 1985 during the peak active year of the Phaet Chon Bot Forum and government rural hospitals (Table 1).

Since 1979, the utilization of government health care services has been increasing and has become the preferred choice of health care. The percentage for the use of government hospitals jumped from 11.1 in 1970 to 12.9 and 21.2 in 1991 and 1996, respectively (Table 1). Overall, a growing utilization of the government health sectors, the use of drug stores and self-treatment remain preferred activities among Thais when they get ill. Reports of the Health and Welfare Survey (1993 and 1996) indicated that private hospitals and clinics are more predominant in urban areas (Table 2). In other words, government health care is only one of the resources available for treatment among the rural population. The reasons given for using the government health care services are mainly related to living nearby and the inexpensive treatment (Table 3). At government health centers, 85.3 percent cited the prime reason as

living near the center as the main stimulus to use the government health care services. For those using government hospitals, 33.3 percent indicated "living near" and 21.2 percent indicated to "inexpensive treatment" as a good reason to come to government hospitals. Rural Thais therefore use modern health care services because they live near the facilities and the treatment is inexpensive. The reputation and image of modern health care providers is also acknowledged. Both government and private hospitals, which are totally westernized and modernized, are cited as places with proficient health care personnel (Table 4). It is from this conclusion that the government health care service is now located where the majority of poor and rural Thais have access to it and the quality of services is recognized.

Table 2. Percentage of health care utilization in Thailand, classified by urban and rural areas, for the years., 1991 and 1996

Source of Health Care	1991		1996	
	Urban	Rural	Urban	Rural
Take no medicine	17.7	15.6	7.5	7.8
Traditional practitioners	2.0	2.8	1.2	2.5
Self-treatment and drug-stores	37.0	38.5	31.2	31.7
Government health centers	2.8	18.1	2.4	19.8
Government hospitals	13.2	12.8	19.9	21.4
Private hospital and clinic	24.7	10.2	33.9	15.3
Other lay-referrals	2.2	1.6	1.5	0.9
Don't know	0.4	0.4	2.4	0.6
Total percent	100.0	100.0	100.0	100.0
Number	5,880	16,860	5,904	17,523

Source: National Statistical Office. 1991 and 1996

Table 3. Percentage of persons reported ill or not feeling well during 2 weeks prior to the survey by type of treatment and reasons for choosing the treatment on the first day of illness, Thailand, 1996

Reasons for choosing	Self-treatment & Drug stores	Traditional healers	Health centers	Gov. hospitals	Private hospitals
Poor	38.8	37.6	5.1	4.4	0.2
Living near health care	21.7	19.5	85.3	33.3	19.4
Quick services	22.8	9.8	2.1	1.6	51.9
Inexpensive	13.3	25.2	5.6	21.2	1.2
Having proficient physicians	3.4	7.9	1.9	39.5	27.2
Total percent	100.	100.	100.	100.	100.
Number	391.3	68.3	1405.0	1881.2	1600.4

Source: National Statistical Office. 1996

Note: Number refers to the population per thousand (000).

Two reasons: having little illness, living far from health care, and three sources of health care, i.e., take no medicine, others and unknown cases were excluded from the table.

Table 4. Percentage of persons reported ill or not feeling well during 2 weeks prior to the survey by type of treatement and reasons for choosing the treatment on the first day of illness, urban and rural Thailand, 1996

Reasons for choosing	Urban					Rural				
	Self-treat ment & drug store	Tradi tional healers & drug store	Health Center ment	Gov. Hospital healers	Private Hospital	Self-treat	Tradi tional	Health Center	Gov. hospitals	Private hospitals
Poor	41.9	30	15.2	5.0	0.1	38.4	38.0	4.9	4.3	0.2
Living near health care	9.7	-	72.9	19.7	21.9	23.4	20.4	85.5	35.6	18.4
Quick services	17.5	30	3.8	1.0	50.4	23.5	8.9	2.0	1.7	52.5
Inexpensive	28.7	10	5.5	25.9	1.9	11.2	25.8	5.7	20.4	0.9
Having proficient physicians	2.1	30	2.6	48.4	25.7	3.5	6.9	1.9	38.0	27.8
Total%	100	100	100	100	100	100	100	100	100	100
Number	47.4	3	31	271.4	463.9	344	65.3	1374.2	1609.8	1136.5

Source: National Statistical Office. 1996
Note: Number refers to the popualtion per thousands (000).
Two reasons: having little illness, living far from health care, and three Sources of health care, i.e., take no medicine, others And unknown cases were excluded from the table.

IMPLICATIONS FOR THE CHANGING PARADIGM OF FUTURE HEALTH CARE

In 1997-1998, the so-called ASEAN economic crisis affected Thailand. It is argued that this economic recession compelled Thais not to seek health care if the illness was not serious, severe, or related to an accident. With the implementation of the International Monetary Fund (IMF) policies and regulations, an economically liberalized health care policy was introduced to run the government health care services, particularly in district and provincial hospitals. Some government hospitals have started to embark on the new paradigm of hospital management but many government hospitals are moving quite slowly in adjusting the structure of their hospital services. This is possibly due to the uncertainty of this new paradigm. It is anticipated that the structural adjustments will impose strict limits on government spending. Many hospitals are less likely to make a profit and must reduce spending by cutting several social and welfare programs.

Alternatively, a rise in cost of services seems to be the choice in practice in order to balance hospital expenses and revenues. It has been politically easier for the hospital to cut spending on medical supplies and facilities rather than salaries. It is then presumed that health personnel may be working in an health service inadequate particularly for the poor since the high cost of health and medical care is beyond the reach of poor patients. In the African (Ghana and Zimbabwae) experience, the structural adjustment to a health care system was adopted but the cut-backs of health care led to an erosion of the government's ability to

implement decent health care for the poor and underprivileged classes. The poor could only use health care services with great financial sacrifice. When Africa experienced the economic crisis in the 1980s, health care in African countries became problematic. As the governments of African countries turned to the programs of structural adjustment to overcome the economic crisis, the effects on health care was to exacerbate rather than fix the problems created by the economic crisis. In other words, the health systems of Africa depended on imported and Western medicine, including medical technologies, supplies and modes of treatments. This resulted in an increase in the number of babies with low birth weights, a high death rate among young children and an increase in the incidence of infectious and poverty-related diseases and deaths (ICCAF, 1995).

In China, the health care system in the form of the so-called bare foot doctor program which had served the country so well during the previous quarter century, has now fallen apart (Gwatkin, 1999). China's rapid economic advance can be attributed to a series of economic reforms initiated in the late 1970s. The reforms featured increased reliance on market incentives in place of government direction. The reforms responsible for the accelerated economic progress undermined the rural health system for which China had become world famous for decent health care for the majority poor. China moved rapidly from socialized to private and fee-for-service medicine. Soon, evidence began to emerge to suggest that the poor are now suffering. A research report on the structural adjustment in China (Gwatkin, 1999) revealed that people in poor areas fell ill and died more frequently than did people in other areas. The infant mortality rate had increased from 50 per 1000 births in the late 1970s to 72 a decade later in many areas. This is evidently because low income or insufficient assets have prevented people from using health services as frequently as they should have. In the areas studied, more than 40 percent of those reporting that they had been ill said they had not sought medical assistance for financial reasons. Moreover, nearly 60 percent of those recommended for hospitalization did not apply for admission because they said they could not afford it.

Wongmanovisuit (1999) examined patient satisfaction in a Thai government district hospital, Ban Paeo Hospital, where a new paradigm of structural adjustment had been introduced and found overall patient satisfaction. An average score of satisfaction was given for 4 of the total 5 points. However, aspects of the social cost of health care; i.e., the behavior and actions of health personnel, were found to be prevalent. Doctors giving too little time to patients (3.35 points) and the long waiting time to see a doctor (3.52 points) were cited as the dissatisfactions with the government hospital (Table 5). Sawangdee et al., (2000) recently examined the experience of Thai patients in obtaining services from government and private health care facilities and found that the patients face a difficulty in using the services. Causes of the shortcomings include mainly health personnel and the management systems of government services. A lack of health personnel resulting in long waiting time, limited time for meeting with doctors and no communication between health personnel and patients were cited as the causes of dissatisfaction with government health care services. Importantly, most of the problems affected patients of low socio-economic status. Patients with health insurance, including health cards and welfare systems, perceived that they had received poor services and lower quality medicine than patients who paid cash. When asked about needs, patients responded with having health care facilities which are equipped with experienced medical

doctors and modern medical equipment. The poor are also worried that the services of government health care have to be upgraded like that of private facilities and are afraid that the cost of health care services will thus be increased.

Table 5. Average Scores (X) and Standard Deviations (SD) of Satisfaction Scale Items, District Hospital of Ban Paeo, Samutsakhon Province,1999

Items	X	SD
Nurses' facial expressions unhappy	4.46*	1.06
Nurses exhibited impolite gestures	4.45*	1.09
Hospital medicine can cure illness	4.53	0.71
Medication was provided with clear instructions	4.84	0.41
Doctors gave too little time to patients	3.35*	1.44
Doctors examined /diagnosed in detail	4.52	0.77
Doctors did not explain the cause of illness	4.20*	1.25
Doctors did not pay attention to patients	4.45*	1.00
Doctor's explanation was easy to understand	4.75	0.65
Doctors told patient how to care for illness if it recurs	4.61	0.41
Doctors provided better services to the rich rather than the poor	4.11	1.16
Patient queue was very confusing	4.51*	0.97
Waiting time to see doctor too long	3.52*	1.44
Satisfied with waiting time	4.63	0.62
Announcement for picking up medicine not clear	3.29*	1.49
Hospital has competent doctors	4.32	0.85
Inconvenient to obtain services from the hospital	4.44*	1.10
Registration section /OPD provided quick/efficient services	4.66	0.68
Satisfied with the general environment of the hospital	4.63	0.75
If need to again, I will come to this hospital	4.64	0.74
Will tell friends to come to this hospital	4.74	0.59
If there is a choice, I would choose this hospital first	4.19	1.01

Source: Wongmanovisuit. 1999.
Note: *The item scores have been adjusted in a positive direction

CONCLUSIONS AND RECOMMENDATIONS

From the reviews, it can be argued that the structural adjustment of health care in Thailand will definitely impact the poor in the same way as it did in China and African countries. When the implementation is put into action, health care utilization by the poor is anticipated to be difficult. That is, as discussed, because the adjustment will raise the cost of the services. The change in health care utilization in Thailand has important implications for the demands and the needs of the poor. Aside from the lessons learned, these implications should raise awareness on the part of health care authorities. Challenges for research in areas of health care utilization by the poor will be, therefore, essential to monitoring health policies and planning health care systems in the 21st century with national and international agencies, including the World Bank, the World Health Organization and the United Nations, whose attempt is to bridge the gap between the life of the rich and the poor.

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