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Qualitative Assessment of Health Equity among the Elderly People in Thailand: Utilization and Financial Protection

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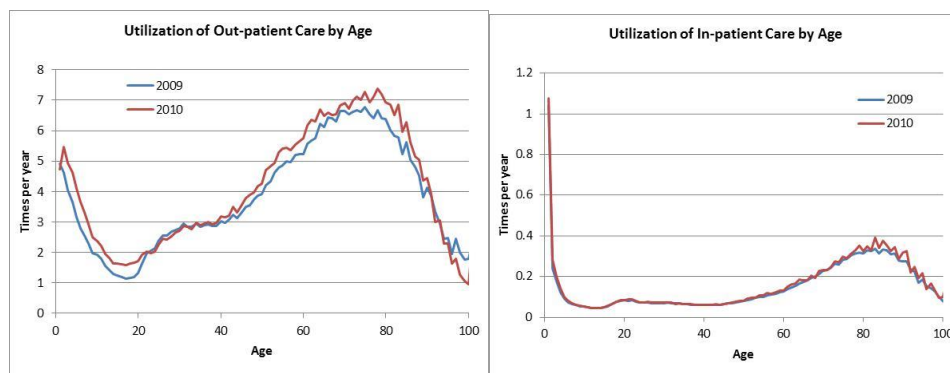
Qualitative Assessment of Health Equity among the Elderly People in Thailand: Utilization and Financial Protection¹

Background and rationale

Thailand has succeeded in expanding coverage of publicly-funded and publicly-managed health insurance schemes, following the introduction of universal health coverage policy in 2001. Today, 100% of Thai citizens are statistically covered by one of the publicly-managed health insurance schemes, mainly the Universal Health Coverage scheme (UC), Social Security Scheme (SSS), Civil Servant Medical Benefits Scheme (CSMBS), and medical benefits for state enterprise employees. These arrangements have broadened access to health services, contributed to higher and more equitable patterns of utilization, and helped reduce the financial burden and risk of impoverishment associated with health care expenses.

While Thailand's achievement of universal health coverage is well noted, recent researches and studies have indicated that there are still gaps in health utilization and financial protection. A recent study by Thailand's Health Insurance System Research Office (HISRO) shows that utilization of health services by patients of three main health insurance schemes combined increased markedly after age 45 for both out-patient care and in-patient care but later dropped during an advanced age.² Utilization of out-patient care services decreases among patients who are over 75 years of age while that of in-patient care services decreases after 85 years of age, as per the graphs below.

Figure 1: Utilization of out-patient and in-patient care data of UC, SSS, and CSMBS by Age



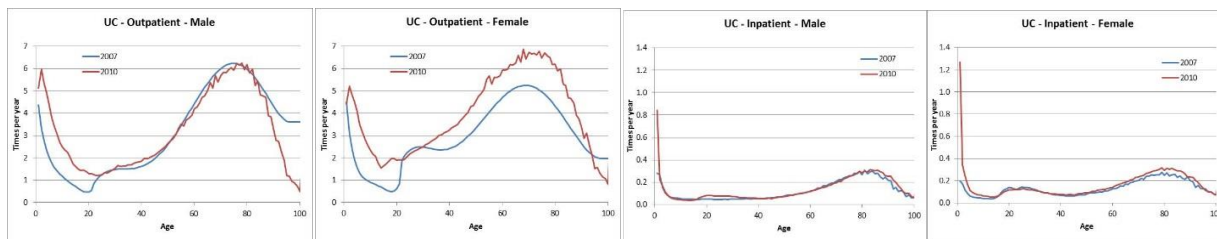
Source: Utilization of out-patient and in-patient care data of UC, SSS, and CSMBS (provided by HISRO)

¹ This study was prepared and led by Sutayut Osornprasop. Research assistance was provided by Noppakwan Inthapan, Sakulrat Sirikul, Theepakorn Jitthitikulchai, Sukanya Kulkaew, Jarmmaree Sornboot, Nateerai Jandprook, Thitinan Tanyuwattana, Apisit Kullanit. The team appreciated Emily Sinnott, Toomas Palu, Lars Sondergaard, Philip O'Keefe, Aparnaa Somanathan, and Yang Huang for reviewing and providing valuable contribution that helped improve the quality of this study. The team appreciated valuable inputs from Dr. Thaworn Sakulphanit and Orawan Prasitsiriphon of the Health Insurance System Research Office and Dr. Chanvit Tharathep of Ministry of Public Health. Most importantly, the team are grateful to all elderly participants, Ministry of Public Health officials, dedicated health providers at university, regional, provincial, community, and health promotion hospitals, as well as village health volunteers who participated and provided much valuable inputs during the qualitative study.

² Performance of Health Care for Elderly and Impact on Public Health Care Financing during 2011-2022, HISRO, 2011, p.33.

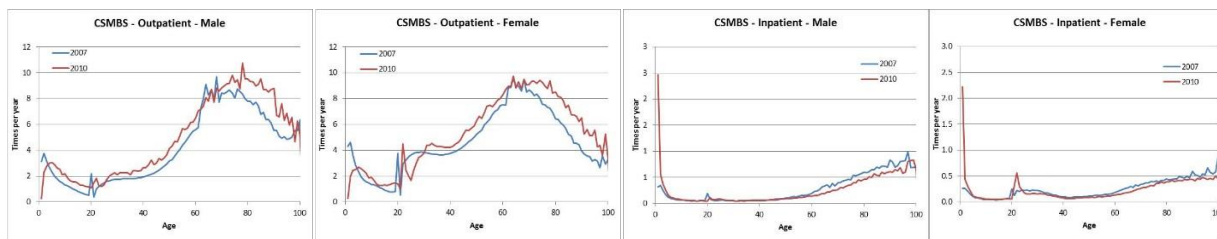
Breakdowns of utilization by schemes indicate major disparity in utilization of in-patient care by schemes. While utilization of in-patient care services by CSMBS patients rises with age, utilization by UC patients starts to decrease after the age of 82. As for out-patient care, utilization by both UC and CSMBS patients rises sharply after the age of 50. However, the decline of utilization by UC patients started from around the age of 75 and the rates went down very sharply. The decline in utilization by CSMBS patients started at around the age of 80, but the rates did not go down as sharply as UC patients.

Figure 2: Utilization of out-patient and in-patient care data of UC by gender



Source: Utilization of out-patient care data of UC by gender (provided by HISRO)

Figure 3: Utilization of out-patient and in-patient care data of CSMBS by gender



Source: Utilization of in-patient care data of CSMBS by gender (provided by HISRO)

These findings raise several important questions: Why did the utilization of out-patient care by UC members drop after the age of 75, while the elderly people are more likely to have higher health care needs when they are older? Why did utilization of in-patient care services by UC patients drop after the age of 82 while that of CSMBS patients continue to rise? Were there problems with access to health care among the eldest old group? Given that the UC members generally comprise population with lower socio-economic status (compared with CSMBS and SSS), it is important to raise a question whether there were problems with financial protection in utilizing health services among the elderly members of the UC scheme, particularly among the elderly poor?

Objective

The objective of the study is to identify the gaps of accessing universal health coverage scheme's care system by the elderly population, focusing on utilization and financial protection aspects.

Methodology

The team conducted small-scale area-based qualitative case studies, focusing on elderly UC members who live in selected urban and rural areas in four different geographical regions of Thailand – Central, North, Northeastern, and South. The case studies are not designed to generate quantitative results and are not nationally representative, but served the purpose of this small study in providing preliminary information on key utilization and financial protection issues that elderly UC members could have encountered in accessing health care services.

Key research questions are:

1. Why does out-patient utilization drop after the age of 75 for all health care schemes in Thailand?
2. Why does in-patient utilization of patients on the Universal Healthcare Coverage drop after age of 82 while it continues to rise for patients with the Civil Servant's Scheme?
3. What are the causes of high out-of-pocket among the poor elderly?
4. What is the level of transportation cost paid by poor elderly to access health services?
5. To what extent have the transportation costs posed burdens to poor elderly to access health services? Is transportation a barrier to access health services by elderly patients?
6. What are key diseases that are not adequately covered by the current UC coverage, that require out-of-pocket expenditures?

The study followed standard qualitative research methods, including focus-group discussions (FGDs) and in-depth interviews (IDIs) with elderly people who are members of the universal health coverage scheme. Families of the elderly were also interviewed when the elderly people had difficulties in communication. Relevant health providers and local government units were also interviewed. Below were the study sites:-

1. An urban and a rural district in Nontaburi province (Central Thailand)
2. An urban and a rural district in Lopburi province (Central Thailand)
3. An urban and a rural district in Nakorn Sawan province (Northern Thailand)
4. An urban and a rural district in Chiang Mai province (Northern Thailand)
5. An urban and a rural district in Kalasin province (Northeastern Thailand - poorest province in Thailand), with referral hospitals in Khon Kaen province
6. An urban and a rural district in Songkhla province (Southern Thailand)
7. An urban and a rural district in Surat Thani province (Southern Thailand)
8. Chulalongkorn University Hospital in Bangkok

In each district, separate FGDs focusing on two different issues were conducted. One FGD focused on utilization and access to health care services, in which general elderly people aged 75 and above were participants (to understand why utilization drops after age 75). The other FGD focused on financial protection, in which the elderly (60 years and over) who were admitted (being in-patient) in a hospital during the past one year were invited as participants. The number of participants in each FGD is between 20 and 30. Following each FGD, around 5-10 elderly individuals were selected to participate in IDIs. In each district, the team also conducted IDIs with approximately 5 bed-ridden patients at their respective homes to understand utilization and access to health care issues. Additional IDIs were also conducted with health facility staff, village health volunteers, and representatives of local administrative organizations. Summary of research instruments and number of elderly participants (with overlaps in participants between FGDs and IDIs of the same issue) is outlined in the table below.

Table 1: Summary of research instruments (FGDs and IDIs) and number of elderly participants

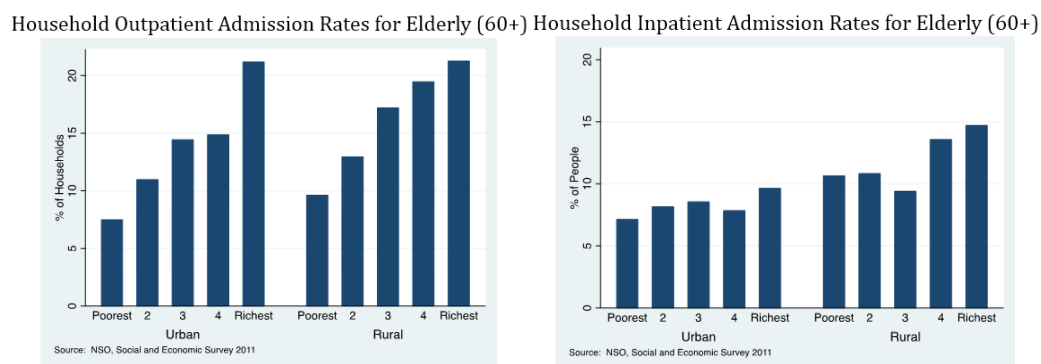
Research instruments	Central	North	Northeast	South	Total
FGD utilization and access	76	86	54	56	272
FGD financial protection	62	105	42	66	275
IDI utilization and access	33	33	7	19	92
IDI financial protection	30	20	27	17	94
IDI bed-ridden	19	19	9	17	64
Total	220	263	139	175	797

Key Findings on utilization of health services

- To provide a big picture on utilization of health care services at the national level, the team analyzed Socio-Economic Survey (SES) 2011, which is the national household survey in Thailand that collected information on household income as well as health expenditures. However, it must be cautioned that there is no direct health care utilization information available at the individual level in SES, and hence the analysis indicates the health utilization based on the health expenditures on in-patient or out-patient services of households with elderly members (aged 60 years and over), and not exactly health utilization of elderly individuals. In other words, the information presented here is the share of the elderly who are living in a household with any health service utilization.

According to SES 2011, there are gaps in utilization of out-patient and in-patient care services among households with elderly members from the poorer and richer quintiles in both urban and rural areas. The gap is largest in utilization of out-patient care services, with the utilization rates of the richest households doubled that of the poorest households in both urban and rural areas, as indicated in Figure 4.

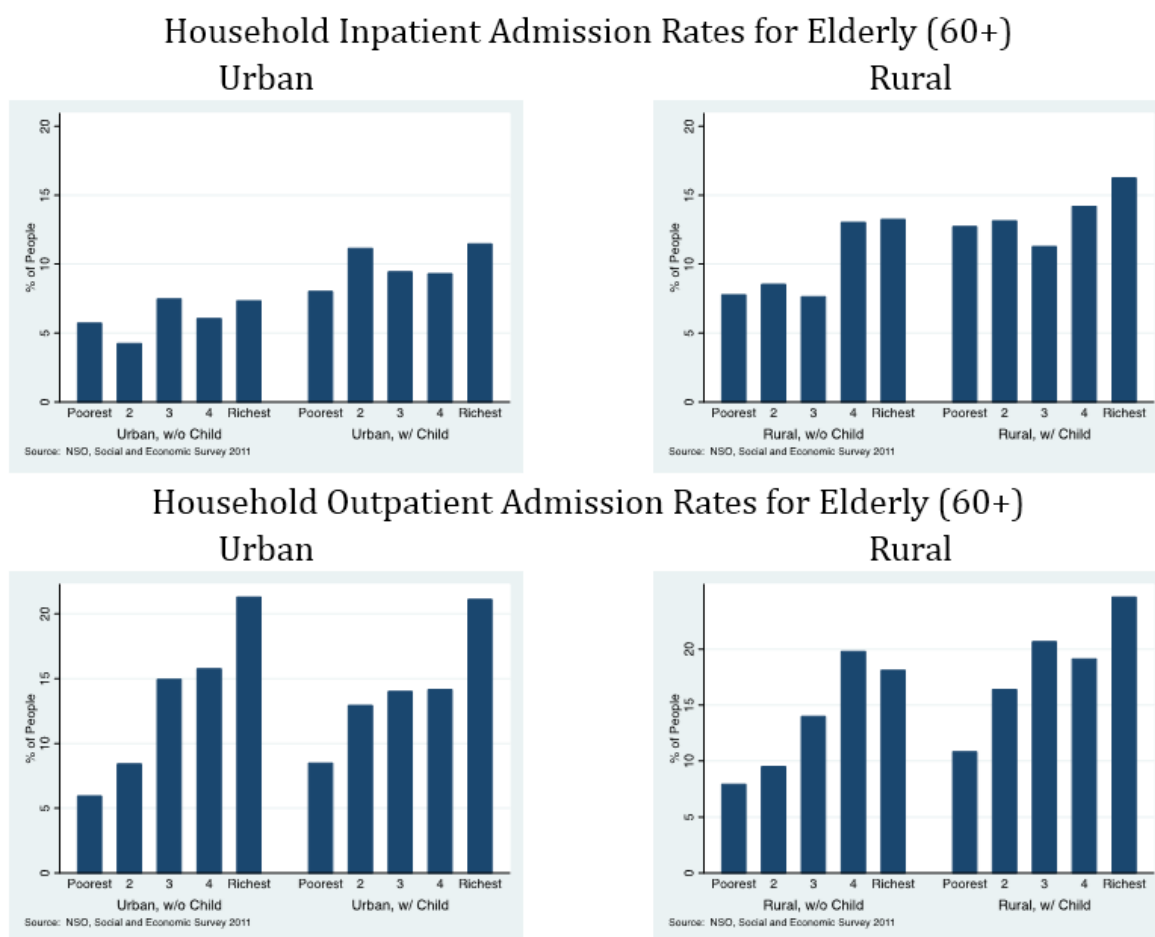
Figure 4: Household Out-patient and in-patient utilization rates for elderly³



³ This figure was prepared by Yang Huang. For SES, there is no health care utilization information at individual level, which means the team could not disaggregate the figures by gender. The team plotted household inpatient admission rates and household outpatient visit rates against household expenditure per capita quintiles for people aged 60 and above. In other words, the team shows here the share of the elderly who are living in a household with any health service utilization. The team ranked expenditure per capita at household level to define quintiles.

SES 2011 also indicates that co-residence with adult children played a significant factor in the level of utilization of out-patient and in-patient care services among poorer households with elderly members (two bottom poorest quintiles) in both urban and rural areas. This could partly be attributed to the lack of caretakers to help bring poor elderly that do not live with adult children to receive health services when needed. Co-residence with adult children does not appear to influence significantly the utilization of health care services among the elderly with higher incomes (top two quintiles), as illustrated in Figure 5. This might partly be attributed to the ability of the richer elderly who do not live with adult children being able to hire caretakers to bring them to receive health care services when needed. In summary, this indicates that the poor elderly who do not live with adult children are most vulnerable and have more probability to not being able to access health care services when needed.

Figure 5: Household out-patient and in-patient utilization rates among households with elderly members, disaggregated by co-residence and non co-residence with adult children⁴



2. According to the qualitative assessment, 43% of elderly interviewees are fully satisfied with the services provided by health facilities under the universal health coverage scheme, and do not encounter any key barriers to utilizing health care services. Of those who have identified barriers

⁴ This figure was prepared by Yang Huang.

to utilizing health care services, “long waiting time” is the top barrier among elderly interviewees in urban areas, while “long distance to a health facility” is the top barrier to accessing services in rural areas.

3. Among frail and bed-ridden elderly interviewees, the key barrier to accessing health services is the unavailability of caretakers/relatives and transportation to bring them to health facilities, and that this barrier tends to have greater effects on elderly interviewees who do not live with adult children, who live in rural areas, and who are females, particularly widows.
4. There is a trend that utilization of out-patient services increases as people grow older, particularly after age 55-60, but then utilization frequency decreases after age 75-80. A key reason that contributes to the drop in utilization of out-patient care services after the age of 75 appears to be the dependence on availability of caretakers and relatives to bring the elderly patients to a health facility. At age 55-65, most of the elderly interviewees were able to travel independently to utilize out-patient care services at different level of health facilities. However, as they grow older, they become frail and start to have health conditions that prevent them from travelling to health facilities independently. Once the elderly people become dependent and need others to bring them to health facilities, frequency of their utilizing services at health facilities generally drops. This tends to affect more elderly people who live in rural areas, particularly those that need to visit higher-level health facilities which are located in bigger cities further away from their homes.

Cataracts appears to be the most common disease that affects mobility of the elderly people and make them dependent of relatives and caretakers to bring them to health facilities. As cataracts progress with age, it disproportionately affects the eldest old group.

Several elderly interviewees also shared that they started to be diagnosed with non-communicable diseases (NCDs) in their mid-50s and 60s, that they were worried at the time, and that this led to frequent visits to health facilities to treat these emerging NCDs. But after they have lived with the diseases and received treatments for 10-15 years, they feel that this has become part of their normal lives and are not enthusiastic to visit health facilities as often as before.

5. The main factors that most likely contribute to the differing trends in in-patient utilization rates of UC and CSMBS scheme members are the differences in living location and wealth of the UC and CSMBS scheme members. On average, CSMBS members and their families tend to have higher incomes than UC members, and tend to live in cities and urban areas. Having higher incomes allow CSMBS members more opportunities to own private cars and hire caretakers, making it easier to bring elderly patients to health facilities when it is needed. This is further complemented by the fact that most CSMBS members live in cities and urban areas, giving them easy access to higher-level hospitals where in-patient services are needed.

Another reason which contributes to the continuing rise in utilization of in-patient services among CSMBS members is that due to the relatively more generous CSMBS benefits package and fee-for-service provider payment method, it is practically possible for CSMBS members to utilize in-patient services for long-term care purposes. This is not possible for UC members.

6. Lack of public and affordable transportation is the most important barrier to accessing health services among the elderly interviewees who live in rural areas and far from major highways and

roads where public buses and taxis operate. This is a major problem even in such area that is adjacent to Bangkok as Sai Noi district in Nontaburi province. Elderly farmers working in orchards in Sai Noi district who do not have private cars have experienced enormous difficulties in getting taxis to pick elderly passengers up from their homes during health emergencies, particularly during night times.

Elderly people without private cars who reside outside of Greater Bangkok and major cities most likely do not have access to taxis and need to rely on public buses or renting private cars. Use of public buses is a cheap and affordable option for many elderly interviewees who live next to major roads and highways. However, the routes and frequency of public bus services are limited, and hence it may serve those who need out-patient services, but not in health emergency circumstances.

It is also important to note that public buses mainly benefit the elderly who live near the major highways and roads where public buses are operated. A large number of elderly interviewees who do not have access to public buses identify that the cost of renting private vehicles is a major impediment for their accessing health services, and this point will be discussed in more details in the financial protection section below.

7. Village Health Volunteers (VHVs) have played a crucial role in supporting the health and utilization of health services by the elderly, particularly in rural communities. They serve as a strong linkage between the elderly in communities and health care professionals at health promotion hospitals and high-level health facilities, particularly through home visits, organizing health education sessions as well as physical exercise sessions for the elderly in the communities.

There are good practices in several communities whereby health promotion hospitals and elderly members prioritize elderly population for their services, including conducting mapping of elderly in the communities into three groups: (i) *Tid Sangkom*, which refers to the elderly who are physically fit enough to go out and socialize regularly with friends; (ii) *Tid Ban*, which refers to the elderly who are frail and that their physical conditions do not allow them to go out of their homes to socialize with friends regularly; (iii) *Tid Tieng*, which refers to bed-ridden elderly who are very frail and spend most of their times on the bed. VHVs then prioritize their services to these different groups accordingly. For *Tid Sangkom* group, the elderly are usually invited to participate in physical exercise and health education sessions. For *Tid Ban* group, the VHVs make plan for home visits occasionally to check on their health and other needs. For *Tid Tieng* group, the VHVs make plan for home visits regularly, provide physical therapy sessions, as well as perform health check-ups along with staff from health promotion hospitals.

In Kalasin province, the Provincial Health Office (PHO) has provided unique and extra support for the elderly in the community. First, they set up *Suksala*, which is a small health center (a unit under the health promotion hospital) manned by VHVs in every village in the province. Each *Suksala* is equipped with basic medical supplies, and VHVs are trained to dispense them at no cost to the villagers. There are approximately 8-10 VHVs in each village, and they take turn to man the center. Each *Suksala* usually operates early in the morning and later in the evening, outside the operating hours of health promotion hospitals, providing the elderly and village residents more options to utilize health services. Second, VHVs are given the opportunity to receive specialized training on geriatric care (among other few areas of specialized training). This

not only help create community health cadres with relevant knowledge on how to support health care for the elderly, but it also empowers the cadres to be confident and proud in what they do.

Overall, the performance of VHVs in Thailand varies from communities to communities, but the key success factors are regular supervision by health promotion hospitals as well as collaboration with local administration organizations, which can provide additional resources for the activities conducted by VHVs to support the elderly population in local communities.

Key findings on financial protection

1. The UC scheme has provided a high level of financial protection against catastrophic health care costs for its members, which account for over 75% of Thai population; specifically the UC scheme covers all Thai citizens who are not covered by SSS (formal sector workers), CSMBS (civil servants and their immediate family members), and other medical benefits provided by state enterprises for their employees and immediate family members. This level of financial protection is rarely achieved by other countries with similar development and income level as Thailand. With only very limited exceptions, all out-patient care and in-patient care services provided by lower-level health facilities, including health promotion hospitals (formerly health centers) and district hospitals, are free for elderly UC members.⁵ Out-of-pocket medical expenses for UC members do sometimes take place at higher-level health facilities such as provincial, regional, and university hospitals, and yet a large number of UC patients do not experience catastrophic health expenditures nor do they become impoverished due to health expenditures.

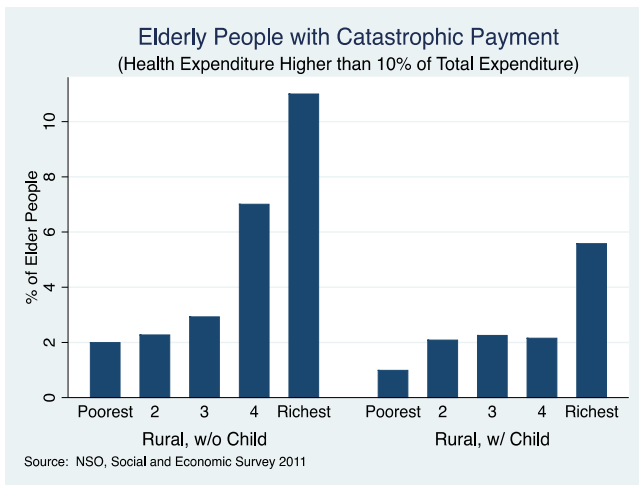
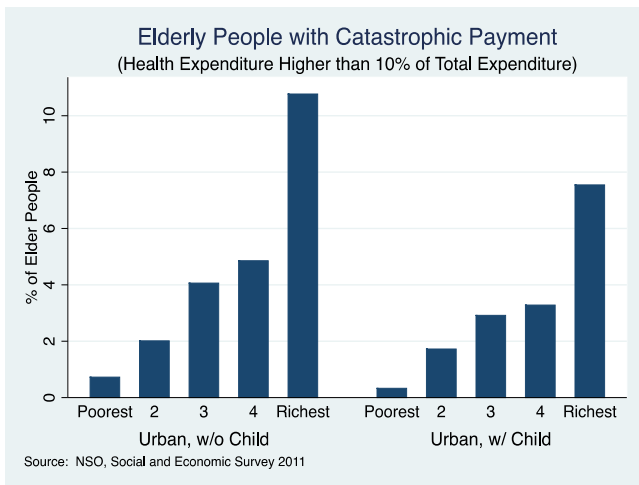
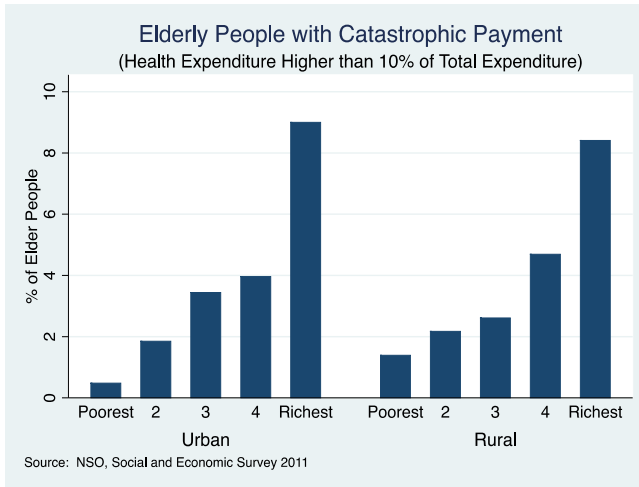
Nevertheless, the UC system is not without any gaps on financial protection, and catastrophic health expenditures do incur among the small minority of elderly UC members. To provide a big picture on financial protection at the national level, the team analyzed SES 2011. As per Figure 6 below, the incidence of catastrophic health expenditures among the two poorest quintiles of elderly people is about 1% and 2% respectively.⁶ Among these bottom 40%, it is important to note that there is a higher incidence of catastrophic health expenditure among the elderly people who live in rural areas compared with those who live in urban areas.

We have also noticed a relationship between co-residence with adult children and catastrophic health expenditures. Elderly individuals who live with adult children across all wealth quintiles have lower catastrophic health expenditures compared with their peers who do not live with adult children. It is important to note that the incidence of catastrophic health expenditures of elderly individuals living in rural areas without co-residence with adult children doubled that of the elderly individuals in rural areas who live with adult children. This problem is likely to grow in the future, as the proportion of Thai elderly living with adult children is on the decline, from nearly 80% in 1990 to less than 60% in 2011 (shown in Figure 7), while more and more Thai elderly do not live with their adult children.

⁵ Non-elderly UC members are expected to contribute THB 30 per each visit to a health facility, but they have an option to sign a declaration that they are not willing/able to contribute THB 30 per each visit at the health facility.

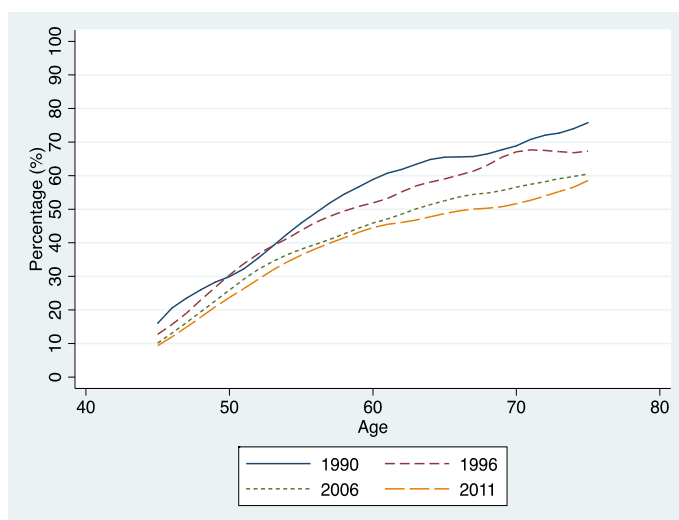
⁶ Catastrophic health expenditures in the study are defined as having health expenditures higher than 10% of total expenditures.

Figure 6: Incidence of catastrophic health expenditure among elderly people⁷



⁷ This figure was prepared by Yang Huang.

Figure 7: Share of elderly in Thailand with co-residence with adult children (SES 1990, 1996, 2006 and 2011)⁸



Note: Adult child here is defined as child aged 24+

Sources: Thailand Socio-economic Survey (SES) 1990, 1996, 2006 and 2011

- While the low incidence of catastrophic health expenditures among the elderly people in poorest income quintiles can partly be attributed to the effectiveness of the UC scheme in providing financial protection to the poor, it may also be attributed to “foregone” care – that some poor elderly individuals may not access health care services when needed, contributing to low catastrophic health expenditures. The factor “foregone” care is partly supported by SES 2011 analysis (more information is provided in the utilization section above), which indicates that there are gaps in utilization of out-patient and in-patient care services among households with elderly members from the poorer and richer quintiles in both urban and rural areas, and that the gap is largest in out-patient care services utilization, with the utilization rates of the poorest households (bottom two income quintiles) lower than half of that of the richest households (top two income quintiles) in both urban and rural areas. SES 2011 also indicates that co-residence with adult children played a significant factor in the level of utilization of out-patient and in-patient care services among poorer households with elderly members (two bottom poorest quintiles) in both urban and rural areas.⁹ This could partly be attributed to the lack of caretakers to help bring poor elderly to receive health services when needed.

⁸ This figure was prepared by Yang Huang.

⁹ The team analyzed Socio-Economic Survey (SES) 2011, which is the only national household survey in Thailand that collected information on household income as well as health expenditures. However, it must be cautioned that there is no direct health care utilization information available at the individual level in SES, and hence the analysis indicates the health utilization based on the health expenditures on in-patient or out-patient services of households with elderly members (aged 60 years and over), and not exactly health utilization of the elderly individuals. In other words, the information presented here is the share of the elderly who are living in a household with any health service utilization. Hence, the information on health utilization of elderly individuals will be provided in the qualitative assessment results presented below.

3. It is important to note that less than half of those surveyed under SES 2011 paid out-of-pocket health expenditures. Hence, the team has analyzed average out-of-pocket health expenditures, as shown in Table 2. The analysis confirms that there are poor elderly people who still need to pay for the costs of out-patient and in-patient care services at publicly run health facilities. It is to note that SES does not provide information on transportation costs to health facilities, so this information is not part of the table.

Table 2: Average of health and medical expenditures among those elderly who paid out-of-pocket health expenditures per year

Average of health and medical expenditure: SES 2011							
Medical and supplies							
	Modern medicine	Traditional/herbal medicine	Contraceptives and condom	Vitamins	First-aid kits/medical equipments		TOTAL
Poorest 1	49.4	59.2	51.7	317.6	18.3		62.6
2	73.4	99.7	72.7	336.4	21.1		96.6
3	99.6	183.4	88.8	635.5	35.2		146.6
4	170.8	210.5	110.3	762.6	105.4		212.3
Richest 5	294.9	302.0	147.5	1,566.9	1,121.0		637.5
All	111.3	151.0	82.4	1,005.1	175.9		172.8
Medical services (outpatients)							
	Public health centre/hospital	Private clinic/hospital	Traditional healer/ medical services	Private dental clinic	Optometry services & equipment	Other health services	TOTAL
Poorest 1	375.1	381.6	396.2	356.8			380.6
2	465.7	477.6	293.4	210.9	353.9	760.5	493.3
3	887.0	614.3	378.1	462.2	1,943.0	404.5	703.2
4	2,621.9	1,052.6	730.7	910.9	1,433.7	3,373.6	1,465.0
Richest 5	4,586.0	2,751.5	544.7	4,056.3	3,544.0	10,000.0	3,961.5
All	1,655.6	1,021.9	434.3	1,953.6	2,197.0	4,461.4	1,402.6
Medical services (inpatients)							
	Public health centre/hospital	Private clinic/hospital	Other expense				TOTAL
Poorest 1	213.2	185.6	155.5				188.7
2	162.7	381.4	335.4				351.0
3	468.1	603.4	200.1				424.9
4	825.0	1,129.7	246.2				845.9
Richest 5	1,346.6	3,245.3	519.9				2,183.1
All	555.2	1,295.7	260.2				643.4

4. Through interviews with elderly patients and health facilities, while the UC's coverage of drugs and treatment is relatively comprehensive, there are key cost items that are not covered by the UC scheme which are likely to be paid for by elderly patients such as drugs that are not on the essential drug list, selected medical equipment for knee/hip replacement, hemodialysis for severe chronic renal disease patients (except for those who cannot receive peritoneal dialysis), cost of setting up home-based non-medical accessories for peritoneal dialysis patients, and all cancer therapies that are outside of UC scheme's cancer treatment protocol, e.g. targeted therapy and selected drugs for chemotherapy. It is important to note that key drugs that are not covered by the UC scheme include all drugs that treat (or slow down the progress of) dementia group of diseases that include Alzheimer. Dementia is the group of diseases that affect a significant number of

elderly in Thailand – from about 7.1% of elderly in the 60-69 age group to one-third of the elderly in the 80 and over age group.¹⁰

In summary, while treatment of most diseases are fully covered by the UC scheme, there are specific diseases that are not adequately covered by the current UC coverage and patients of these diseases are required to pay out-of-pocket expenditures. These include severe chronic renal disease, certain types of cancer that require treatment and drugs that are outside of the UC scheme's cancer treatment protocol (though it is to be noted that the UC scheme covers the cost of radiotherapy, surgery, and several types of chemotherapy for cancer patients), and dementia.

A recent quantitative study led by Dr. Vich Kasemsap also shows that UC patients with chronic renal diseases still need to pay out-of-pocket, even for peritoneal dialysis which is covered by the UC scheme.¹¹ This amount can impoverish poor elderly who need such treatment, as illustrated in Table 3, 4, and 5.¹²

Table 3: Out-of-pocket payment per each visit to a health facility paid by patients who need dialysis services

Cost	Transportation	Fees paid to hospital	Food/Accommodation	Total (per time)	Total (per year)
Hemodialysis (335)	226	223	99	548	56,992-85,488
Peritoneal dialysis (1125)	327	140	124	591	7,092
Kidney transplant (16)	674	3056	174	3904	23,424

Table 4: Patients' opinion whether the related healthcare cost affect their families economically

Assessment	Have economic impact on families (%)	Have no economic impacts on families (%)
Hemodialysis (335)	53.7	46.3
Peritoneal dialysis (1125)	44.9	54.9
Kidney transplant (16)	31.5	68.8

¹⁰ It should also be noted that dementia affects more female elderly than male elderly. Among the elderly that are in the 80 and over age group, the dementia prevalence in males is 22%, while that of female is 40%. Suwit Wibulpolprasert et al, Thailand Health Profile 2008-2010, Ministry of Public Health, April 2011, p. 234.

¹¹ Vich Kasemsap et al, Assessment of Access and Service Delivery of Renal Replacement Therapy under the Universal Health Coverage Scheme, HISRO, 30 September 2013.

¹² Ibid.

Table 5: Patients' opinion whether the related healthcare cost affect their families economically, by health insurance schemes

Assessment	Have economic impact on families (%)	Have no economic impacts on families (%)
UC (1275)	47.5	52.4
CSMBS (68)	26.5	73.5
SSO (35)	45.7	54.3

5. Transportation is a major cost for elderly rural residents to utilize health services. From the qualitative study sample (which is not nationally representative), the average transportation cost incurred by elderly rural residents is more than 10 times that of elderly urban residents, as per Table 3. The UC scheme does not provide support for transportation costs, making it the major gap.

Transportation costs were identified as the most important impediment to accessing health services by elderly rural residents. These affect particularly the elderly poor, and the elderly who do not live nearby major highways and roads on which public buses operate. The cost of renting private cars to take them to hospitals is simply not affordable by many elderly households, even those who live above the poverty line. The elderly poor who live on allowances from universal pension alone is the most vulnerable, as they need to use all of the monthly allowance to pay for room rent and food, and these people do not have extra resources to travel to health facilities in time of sickness.

The qualitative study identified several elderly poor patients from remote districts who undergo cancer radiotherapy and chemotherapy at regional and university hospitals, far away from their hometowns. Depending on the course of the therapy, they need to travel from remote districts to a regional or a university hospital in another province every other day or every week for a period of up to several months. Even though the cost of these cancer treatments are covered by the UC scheme, the cost of transportation was not, and there are several elderly interviewees that suffered catastrophic health care expenditures as a result of related transportation costs, and needed to borrow money from neighbors to pay for such high transportation costs.

Food is also a significant cost item for elderly patients who need to travel from rural areas to receive care at higher-level health facilities in large towns and cities. Also, elderly patients from rural areas generally need to bring caretaker(s) along to support them, and this also adds up the total cost of accessing care, as the caretaker(s) also need to spend on transportation, food, and residence if overnight stay is required.

Table 6: Average health-related expenditures per year by urban and rural residents (from qualitative study)

Expenditure type	Transportation	Food	Medicines	Carer's expenses
Urban	474	343	1,331	256
Rural	6,004	1,891	1,393	393

6. Affordable accommodation options for elderly patients and their caretakers at referral hospitals are too limited. Regional and university hospitals in Bangkok and major regional cities like Chiang Mai, Khon Kaen, Surat Thani, and Songkhla are tertiary hospitals that are responsible for treating patients from several provinces in its network. Oftentimes, elderly patients and their caretakers need to travel for 6-7 hours from their respective home districts to reach the regional referral hospital. In these cases, even an out-patient care visit requires overnight stay. Elderly patients from remote districts who require continuous out-patient care visits for such treatments as hemodialysis, radiotherapy, or chemotherapy (these specialist services are not available at lower-level hospitals) also need overnight stays. Unfortunately, most of the tertiary referral hospitals are located in big cities in which accommodation tends to be much more expensive than in rural areas. Hence, accommodation in referral hospitals has been cited by elderly rural residents as one of the major factors for their decisions whether or not to access out-patient specialist care services at higher-level hospitals.

7. Poor elderly respondents indicated they do not have the means to travel to health facilities, as their only income is universal social pension, and that the current level of monthly allowance from the universal social pension is not sufficient to sustain their minimum living expenses – they do not have any money left after spending on food and accommodation, and do not have any savings (the level of universal social pension is illustrated in Table 7). Out of 547 elderly participants of FGDs, 38% indicated that their monthly incomes are insufficient to sustain their living standard. This group of elderly people tend to be those that depend on universal social pension as the main source of their incomes, and that they do not have other financial support from relatives, from work, and do not have savings. The situation is worse among the oldest old: of the 272 elderly participants aged 75 and over, as many as 101 or 37% indicated that the universal social pension is their only income source. It is important to note geographical disparity in terms of elderly incomes, as the elderly in the North and the Northeast tend to be poorer and dependent on universal social pension and support from relatives, while the elderly from the South and central Thailand on average tend to have higher incomes from continued employment or work in the agriculture sector in addition to the allowances from the universal social pension.

Table 7: Universal Social Pension by Age

Age range	Amount (THB) per month
60-69	600
70-79	700
80-89	800
90 and older	1,000

8. Some of the local administrative organizations (LAOs) visited during the qualitative study have played an instrumental role in promoting access to health services for the elderly in rural communities. Several LAOs make available health emergency vans for people in the community free of charge. There are best practices from smaller LAOs (e.g. Tambon administrative organizations) with small amount of budget that do not have sufficient resources to purchase a proper health emergency van, but were able to turn an old pick-up truck into a well-equipped health emergency van at small costs, and using the fees that they receive from Emergency Medical Institute of Thailand (with each valid health emergency delivery to a health facility) to finance the operating costs of health emergency vans for both emergency and non-emergency

cases (i.e. to bring poor elderly to hospitals in non-emergency cases). Several LAOs also arrange annual health check-up (in coordination with health promotion hospitals) for the elderly in the community so that the elderly residents do not need to travel to health facilities for annual health check-ups.

Nevertheless, the health-related support for the elderly vary significantly from one LAO to another, depending on the interests and priorities set by LAOs' chief executives and mayors. Some LAOs do not provide any health-related support for the elderly and focus more on building infrastructures for the communities, while some LAOs focus very much on health to the point of establishing health clinics and hiring medical doctors with LAO resources to serve the local population.

All the elderly participants in this qualitative study were asked what they would like LAOs to support them, and three most popular answers by far are (i) for the health emergency van initiative to be expanded into more LAOs, (ii) for LAOs to provide free transportation for the poor to travel to health facilities when sick, and (ii) for LAOs to consider providing vehicles to bring elderly people from rural areas to receive out-patient care services at hospitals once a week on a regular basis, as this will help boost health utilization.

9. It should be noted that several large public hospitals set up social welfare schemes, drawing resources from donation and hospital's own funds. These social welfare schemes are expected to provide financial support to the poor who do not have the means to pay for extra healthcare costs that are not covered by the UC scheme, and also support transportation costs for the poor to return home. The implementation of these social welfare schemes varies, but many large hospitals that have such schemes do not promote them actively on the ground that the resources are limited, and leave it to relevant medical doctors and nurses to inform the patients about the schemes. Several elderly poor patients whom the team interviewed at these large hospitals were not aware that such social welfare schemes exist.

The fact that several hospitals have social welfare schemes but do not promote them actively lead to inequity in access to information. As medical doctors and nurses in large public hospitals need to attend to so many patients each day, it is very possible that they may not be able to detect all poor patients and inform them about the social welfare schemes. This is particularly true for patients whose treatment was fully covered by the UC scheme but needed to pay large amount of money for transportation, as these health professionals do not have information about the transportation costs that the patients needed to pay.

Another gap in these social welfare schemes is that they support transportation costs for the poor once the patients already arrive at the hospital, and hence there is a challenge of how the poor elderly can finance transportation costs to get to such hospitals in the first place.

Recommendations

1. Poor elderly individuals who do not live with adult children are more likely to have lower utilization of health services but incur higher catastrophic health expenditures, compared with

their peers who live with adult children. Poor elderly individuals in rural areas who do not live with adult children (particularly females and widows) are the most vulnerable and are exposed to the highest risks of inadequate health utilization and deepening impoverishment due to healthcare costs. Special attention to help improve health utilization and reduce catastrophic health expenditures needs to be provided to this group of vulnerable population.

2. Transportation costs to health facilities is the most important obstacle that prevents elderly poor in rural areas to access health care services. It is interesting to note that health protection programs in countries that are much less developed than Thailand, e.g. Health Equity Funds in Lao PDR and Cambodia, often include support for both health care costs and transportation costs as part of the benefit package for the poor. While Thailand is able to support free health care costs for all of its citizens, there is no national program that supports transportation costs for the Thai poor to travel to health facilities. It is important for the government to consider options to support transportation costs to health facilities for the elderly poor living in rural areas.
3. The health care coverage supported by the UC scheme is relatively comprehensive. While there are still some diseases that may lead to high out-of-pocket and catastrophic expenditures (e.g. some types of cancer, chronic renal diseases), extending the coverage universally to cover the costs of these high-cost treatments, hi-tech medical equipment, and brand name drugs that are outside the essential drug list may add up too much cost pressure to the already steadily rising cost of the UC scheme. For treatments and medical equipment that are not covered by the UC scheme, it is fair for the hospitals to ask for financial contribution from patients who are able to afford to pay. Nevertheless, the government should consider arrangements for these excess health care costs to be covered for the poor, and hence identification of the poor to receive these benefits are worth considering.
4. The issue of identification and targeting of the poor for benefits that address unmet health-related needs should be revisited, given the gaps in transportation costs and other health care costs that are not covered by the UC scheme. Since Thailand has successfully launched the universal health coverage in 2001, the formal system of targeting the poor has been dismissed from the policy agenda of successive governments. Nevertheless, the health-related support from the universal health coverage does not cover such key item as transportation to health facilities, and this lack of support has negatively affected the access to utilization of health services by poor elderly Thailand, which account for around 10% of total elderly population.¹³ Once the identification and targeting of the poor has been conducted, the list of the poor could be used by the National Health Security Office (that manages the UC scheme) and a number of social welfares schemes operated by large hospitals to provide needed health-related benefits for the poor in their coverage areas.
5. To supplement the benefits provided by the universal health coverage, social welfare schemes currently operated by large hospitals with the aim to provide necessary support on health care and transportation costs for the poor need to be expanded to all tertiary hospitals. Furthermore, these social welfares schemes run by hospitals need to be promoted actively, and the hospitals should ensure that the information about their support for the poor is accessible to all poor patients. Several university hospitals, including the Prince of Songkhla University Hospital, managed the

¹³ Reducing Elderly Poverty in Thailand: The Role of Thailand's Pension and Social Assistance Programs, World Bank, 2012.

social welfare scheme to support health care costs for the poor in a transparent and equitable way, with clear guidelines and criteria. This kind of good practices and lessons should be promoted and shared with other hospitals.

6. Special attention and support should be given to bed-ridden elderly who are poor. These elderly poor tend to suffer from chronic diseases that need intensive care and support but often they are not able to travel to health facilities frequently due to difficulties to move, dependence on availability of caretakers to take them to health facilities, and transportation costs. Hence, regular home visits by health promotion hospital staff and village health volunteers targeting these bed-ridden and poor elderly should be promoted, and support for transportation from health centers or from LAOs should be provided to this group of the elderly as needed.
7. LAOs can play an instrumental role in promoting access to health services for the elderly in rural communities. Several best practices from selected LAOs under the qualitative study include making available health emergency vans for the community and arranging annual health check-up (in coordination with health promotion hospitals) for the elderly in the community so that the elderly residents do not need to travel to health facilities for annual health check-ups. These practices by LAOs should be promoted.
8. The VHVs are instrumental to the provision of health-related support to the elderly in communities, particularly through home visits as well as organizing physical exercise and health education sessions. The experience from Kalasin's Provincial Health Office, which established *Suksala* in every village, as well as providing options to VHVs to receive specialized training on geriatric care are good lessons and are worth exploring if it is worthwhile to expand such initiatives beyond the province. In any case, the performance of VHVs in Thailand varies from communities to communities, but the key success factors are regular supervision by health promotion hospitals as well as collaboration with local administration organizations, which can provide additional resources for the activities conducted by VHVs to support the elderly population in local communities.