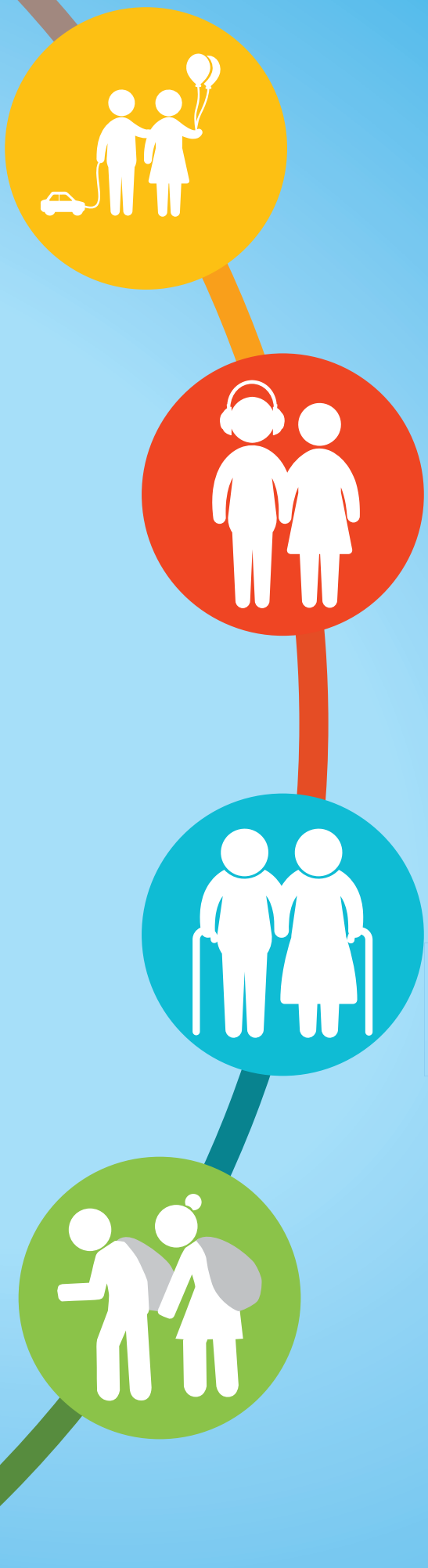
The Prince Mahidol Award
Side Meeting 2017

The Last Mile of UHC in Thailand,

"Do We Reach the Vulnerable?"



สถาบันวิจัยระบบสาธารณสุข

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Social Stratification Social Inequality and the Explanation for being Vulnerable People in Society

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Abstract

This article aims to apply the concept of social stratification to explain social inequality. This will help understand who is vulnerable population in the society. The authors have reviewed the literature of concepts and theories in social sciences that can explain and rank the social stratification. Moreover, this first phase of the big research project "Social Stratification in the Context of Thai Society and Health Status" applied in-depth interviews and meetings with experts from March 2015 to March 2016 to select indicators of social stratification measurement appropriate to the context of Thai society. The research finding explains that social stratification and social inequality are conceived from the life chances concept as the beginning point of differences of human being. Life chance either by nature, by culture, or by social situation, leads to social differentiation, social stratification and eventually social inequality. Social stratification measures can be used to rank people by two approaches: 1. Objective measures of social stratification cover five indicators; 1) Birth origins 2) Standard of living in household 3) Economy 4) Education and 5) Health, and 2. Subjective measures of social stratification also cover five indicators; 1) Social status 2) Freedom and liberty 3) Fraternity 4) Consumption and lifestyle and 5) Class awareness. All of the above indicators of social stratification will be utilized to find populations who are the most disadvantaged, or the "vulnerable populations." This finding has contributed to help build life chance guarantees, social equality and social equity for the vulnerable in Thai society in the future.

Concepts and Practices of Community-Based Health Interventions for Vulnerable Populations in Thailand: a Qualitative Study

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Abstract

Objective: To synthesize lessons learned from the existing community-based health interventions for vulnerable populations in Thai contexts in order to create policy recommendations for further health systems development and response to health needs of vulnerable populations.

Methods: This study utilized qualitative study design to investigate and compare community-based health interventions for vulnerable populations in eight district health systems (DHS) of Thailand, including Umphang, Ubolratana, Dan Sai, Khon Buri, Kuchinarai, Lam Sonthi, Kong Rha, and Khlong Khlung. Qualitative data were collected from the local practitioners by semi-structured interviews, focus-group interviews, and non-participant observations, and were synthesized by thematic content analysis.

Results: Content analysis reveals four emerging themes. First, sense-making of the vulnerable population concept was challenging for practitioners in Thai contexts. Second, effective community interventions for vulnerable populations were initiated by local practitioners, not from policy and planning at the national level. Third, effectiveness of community interventions for vulnerable populations depends on services design being customized to the nature of vulnerability. Lastly, traits of local leadership, not authority, are necessary for creating and implementing sustainable community-based health interventions for vulnerable populations.

Discussions: Despite no mutual understanding of the vulnerable population concept in Thai contexts, we found strong evidence of innovative community-based health interventions in Thailand. To scale up such programs, policymakers should create criteria to help practitioners identify vulnerable populations in their contexts, allow for contextualizing health needs of different vulnerable populations, and put more emphasis on developing information systems at both the national and the local level, so there will be more systematic monitoring and evaluation of community-based health interventions for vulnerable populations in Thailand.

Comparative cross-case analysis of service models for patients with chronic kidney conditions in Klong Klung and Kong Rha Districts, Thailand

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The expansion of benefit package covering patients with chronic kidney diseases (CKD) since 2007 resulted in increased access to care and minimized disparity of access to renal replacement therapy (RRT) across public health insurance schemes. Nonetheless, growing concerns of financial burden to the public health programs ensued. This poses a challenge for policy makers in terms of inventing preventive or mitigation measures for CKD. Recently (2016) Ministry of Public Health promulgated upscaling of Klong Klung Model (KKM) as a prototype for such measures after the findings of effectiveness of the model. Given complexity of the health care systems, the upscaling might not be straightforward. There is still need for clarification of what and how building blocks of the model were developed under specific circumstance of Klong Klung District in Khampang Phet Province, a lower northern province. Using comparative cross-case analysis, this report gathered data from focus-group discussions, direct observation and documentary review relevant to development of CKD care models in Klong Klung District and its comparator in Kong Rha District, Phattalung Province in the South. It was found that KKM, with a focus on prevention and mitigation of CKD, was developed based on randomized controlled trial to test a standardized protocol jointly determined by Klong Klung Hospital and the Kidney Disease Institute of Thailand. To the contrary, the care model at Kong Rha District covered a spectrum

of care ranging from prevention to RRT. Kong Rha adopted a trial and error approach in applying existing knowledge acquired by the local team in close collaboration with a multidisciplinary team of Phattalung Hospital (the referral center of the province) led by an internist with training in kidney dialysis. Given such differences, both models shared a common feature of leadership: sustained leading role of a senior nurse head for Kong Rha and of the hospital director for Klong Klung. Both leaders was found to perform in a remarkably autonomous status based on patient-centric principle. Under this leadership style, multidisciplinary team members interacted on an equal ground rendering ongoing learning and adaptation. In term of generating knowledge on the effectiveness, KKM was found to be much more systematic in data management and analysis reflecting a significant technical contribution from academic experts of the institute. In contrast, Kong Rha faced with limited capacity in terms of manpower and technical expertise in making use of the data. This resulted as expected in more ambiguous findings to prove the effectiveness of the model. In effect, the limitations of Kong Rha reflect widespread phenomenon of sluggish development of the capacity to make use of existing health information systems in the country despite substantial investment in the hardware. Finally, we did not find "vulnerable population" as a common language among the study areas. This does not mean that the health professionals play down the importance of ensuring access to care of the poor or the disadvantaged. To the opposite, they have made substantial attempts to do so. For instance, community resources were mobilized to reconstruct a sufficient hygienic space for home-based peritoneal dialysis in Kong Rha. Under KKM frequent home visits to all the patients especially the poor enabled better understanding of limited food choices contributing to difficulty in sodium reduction. This led to modification of dietary education to be more suitable to the poor patients' situation.

Screening of Children with Learning Disabilities and Emotional Behavior Disorders

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Introduction: Primary school students with learning disabilities (LD) are defined as one of the main vulnerable populations who are at risk for lacking access to essential services. Current social and economic condition and attitude of parents toward education systems are likely to leave their children's health and education to be primarily under both health organizations and schools.

The situation of accessing to the service needs is getting worse when the government agencies, especially schools and hospitals, perform basically on Key Performance Indicators (KPI) which may not meet local needs of particular groups e.g. children with learning disabilities. In fact, they need integrated programs between health and education. Due to the silo based design of public programs, there is little system structure of facilitating integrative approach to provide more effective programs for children with learning disabilities. It is then unfortunate to Thailand to leave these children to be fallen in the gap of the systems although they should have been fully developed and become healthy and competent people.

The inspiration of this project was that many children of our health personnel suffered from LD. In general, the education system identifies children with learning disabilities as a "Special Child" group. They will be sent to attend a class at a special school. Health care professionals

could do only diagnosis for them to indicate that they have LD so that they are able to be entitled to get proper services, which are still difficult to access especially a number of special services mostly available in cities.

Methods: The approach to deal with this problem began with the meeting between parents, school managers, and the hospital. The meeting aimed to provide and enhance understanding about LD in children and to indicate that this is a significant problem which requires an urgent solution. In terms of preparedness, the hospital started by sending health personnel, physicians, and nurses to attend a "Child and Adolescent Psychiatry and Child Development" course. Moreover, the hospital had prepared the place for LD screening and treatment, and coordinated with Loei Primary Educational Service Area Office to arrange a training program in which teachers will be able to screen learning, behavioral, and emotional problems in their students by using an adapted instrument.

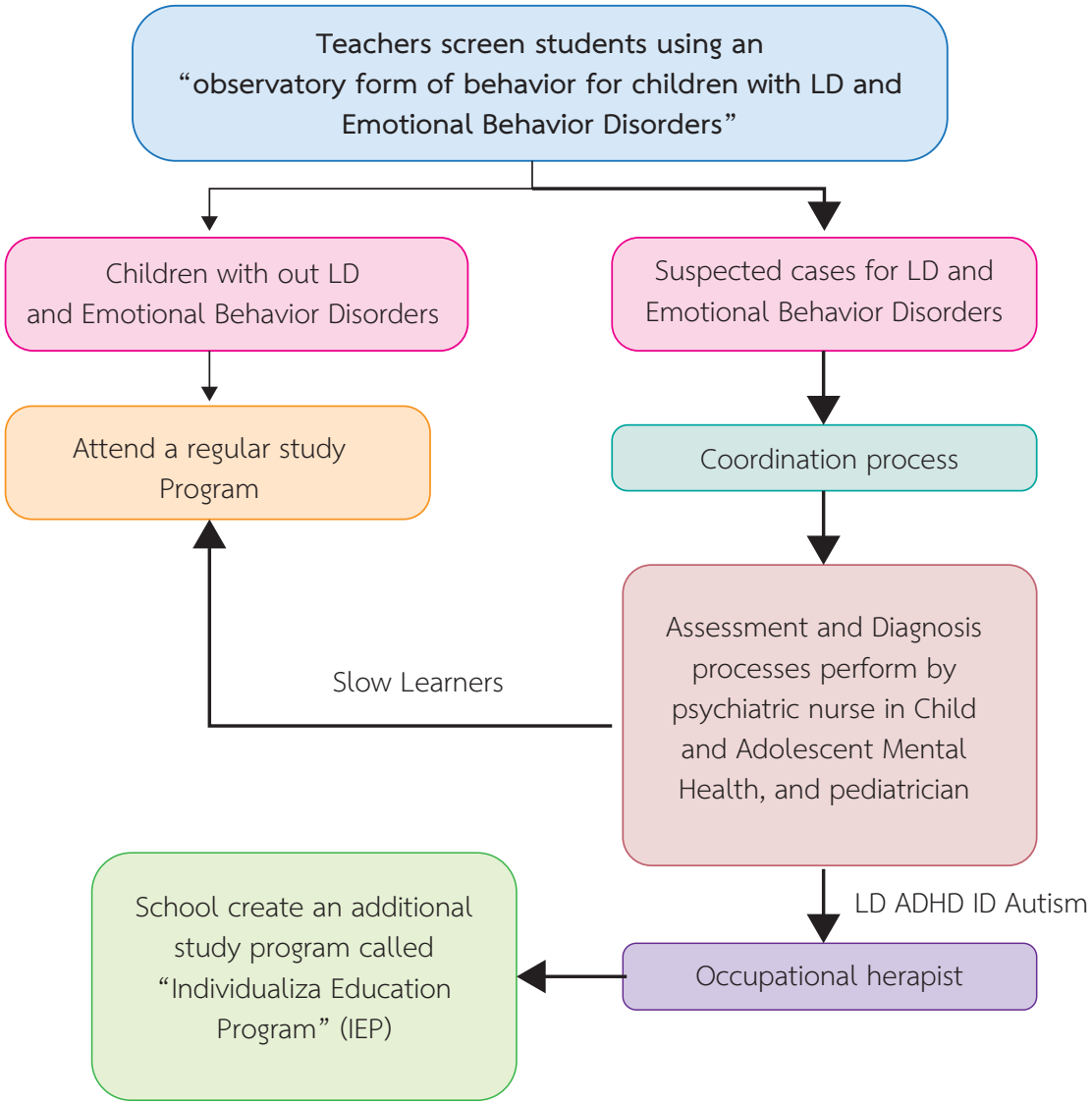
There was an appointment system to reach access from both schools and hospital. Teachers brought students who had been primarily screened for LD to the multidisciplinary team at the hospital for repeated screening, designing treatment process, and referring and monitoring cases. Students with LD were provided additional classes such as music and sports. Home visit approach was performed to follow specific cases such as children with LD and low social economic status. Moreover, the informal Special Child's Parents Association was established which aimed to encourage others and share experience and perspective toward the issues of learning of primary school students.

Results: The school number of participation increased from 9 schools in 2014 to 16 schools in 2015. In 2016, there were 46 schools participating in this project, accounted for 41% of all schools under the administration of Loei Primary Educational Service Area Office covering 3 districts. The screening covered 2,009 students, accounted for 35.7% of all students in this educational service area. The primary screening results indicated 243 students with learning problems, representing 12.1%. After the multidisciplinary team did the repeated screening it found that 0.1% was normal, 3.0% was LD, 1.8% was Intellectual Disorder (ID), 0.2% was Attention Deficit Hyperactive Disorder (ADHD), and the rest of them which accounted for 6.9% were Slow Learners. The guideline for screening and diagnosis LD and Emotional Behavior Disorders was developed and used presently in our area (see flow chart).

Success factors: Success factors are an effective coordination between school managers and hospital, simple and effective screening instrument, multidisciplinary team with skills and knowledge in providing services to students with LD. Moreover, the cooperation and trust from parents and teachers are significantly played an important role.

Recommendation: Government should set up a development center networks to exchange knowledge about services for children with LD based on area context.

Screening of Children with Learning Disabilities and Emotional Behavior Disorders
By Loei Primary Educational Service Area Office and Dansai Crown Prince Hospital



Phetchabun Hospital Management Program of Substance Abuse for Youth

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The management program of substance abuse for youth was initially set up in Phetchabun Hospital according to the order of the National Council for Peace and Order (NCPO) "NCPO 108/2557". This order indicated that "Substance abuser" is "Patient". Moreover, according to this order, the Substance Screening Center was established and focused on both reactive and proactive work in community. The statistics showed a significant increase in the number of substance abusers among youth and the age of first-time substance users became younger. The youngest one was 11 years old. The situation of substance abuse was getting worse in schools.

To tackle this problem, Muang Phetchabun district's Government Office, Office of the Narcotics Control of Phetchabun province, Office of the Narcotics Control Board Region 6, Police Station, and Military were collaborated in order to screen and assess substance abusers which were 800 students who came late to their schools in the morning. Of that, 224 students reported they had used illegal substances within 3 months. Drug testing results indicated that 80 students had substances in their urine requiring further treatment process. However, at that time, there were no suitable treatment programs or models for youth under 18 years old. Therefore, our team decided to develop a "Model of Behavior Change" to provide appropriate treatment to the teenagers under 18.

The Model of Behavior Change was developed by applying the theory of Cognitive Behavior Therapy (CBT) into the program (Figure 1).

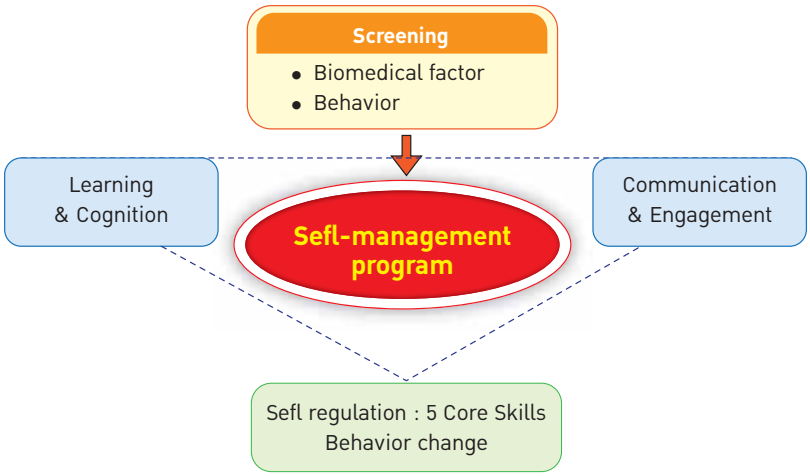

Figure 1: The Model of Behavior Change by Phetchabun Hospital

This model was to design the activities under three technical measures which were prevention measure, remedial measure, and therapy and rehabilitation measure. The main objectives of this model are learning and cognition. This refers to students with substance abuse able to identify whether activities have positive or negative effects by themselves. This can lead to their ability to control themselves and change behaviors as the final outcome. There are five core skills they have to learn in order to change their behaviors, namely problem solving, decision making, resource utilization, healthcare partnership, and action taking.

On the other hand, providers must have good communication and engagement skills and be friendly with substance abuse teenagers. Phetchabun Hospital's healthcare team plays a vital role in screening and prevention measure. For therapy and rehabilitation measure, the team acts as the facilitators to provide knowledge, make them understand and support them to change behaviors. In addition, the team is a supervisor for substance abusers in the remedial measure.

An important task of this project is to classify students into groups based on secretive or suspicious behavior levels. There are five criteria: violent behavior, premature sexual problems, drinking alcohol and substances use, late school coming or class skipping, and the last criterion which is "not specified". The results of running this program showed positive effects. The number of substance abusers dramatically decreased from 20% to 5.71%. Surprisingly, many students in our cohort have grown up strong and happy. Some of them are engineers, soldiers or police men and have a warm and happy family.

It can be indicated that this support system for substance abuse teenagers is an integrated model of internal school management and clinical practice. This is an example of School-based care. Currently, 12 schools in Muang Phetchabun district have adopted this model to use in their area and have adjusted some points based on their local context. For example some schools have additional creative activities for the youth. This resulted in improving in self-awareness and self-esteem which also contribute to behavior change. The changing behaviors of substance abusers also have positive externalities for example reduced inappropriate behaviors when they are at schools and reduced cases of unwanted pregnancy and violence.

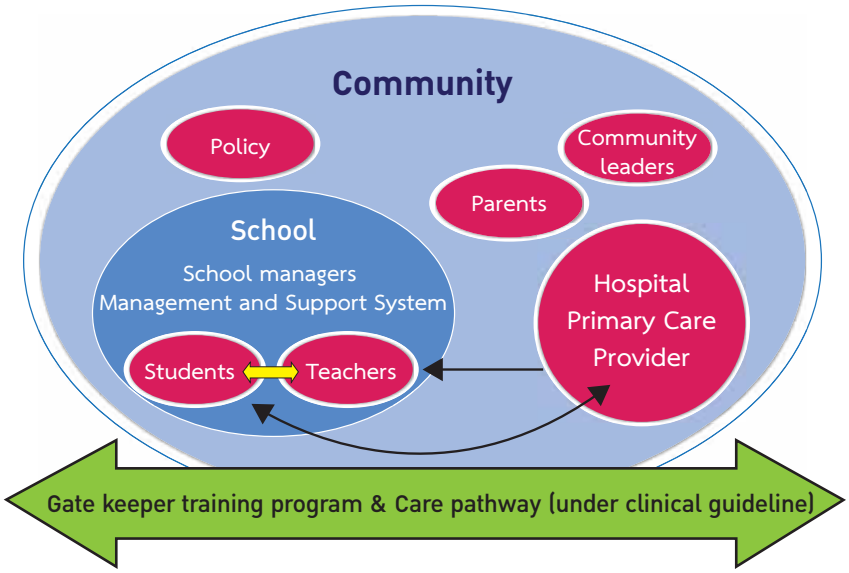

Figure 2: School-based Integrated Pathway to Care Model

Principles of School-based Integrated Pathway to Care Model:

1. Love, relationship and forgiveness from family

2. Attention from teacher and healthcare team

3. Learning of basic discipline, self-awareness of the consequences of actions on social norms and school measures.

Key success factors of this project are the support from school executive committees, collaboration and action from relevant stakeholders. Providing that giving a chance to substance abuse teenagers is the way to help them to overcome the problems they face. From that, those teenagers who used to be substance abusers are able to grow up strong both in mind and body. So, we have to take care of our teenagers expected to be responsible for our country development in the future. The lesson learned from this project is that we should pay considerable attention for early childhood cognitive development and children with learning disabilities. This is to prevent the development of inappropriate behaviors in the future.

An Emerging Demand for Long-Term Care (LTC): Lam Sonthi Model

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Long-term Care: A Challenge of Elderly Society

The long-term care has become a public concern in Thailand as well as the growing of ageing society. Among South-East Asia countries, Thailand has moved up to be the second most aged country in the region (next to Singapore). The National Statistic Office reported in 2013 that Thailand has become aging society already since the population aged over 60 is now 13.2 percent accounting for 9 million of total population following the United Nation's criteria. This aging of the population has accompanied an epidemiological transition from 'disease of poverty' to 'disease of wealth' that has shifted the major health burden to a more chronic nature, indicating increased needs for long-term care. Taking care of dependent elderly becomes a challenge for the family and society.

Starting Point of Lam Sonthi Model of Long-Term Care for Elderly

The initiative LTC has established by Dr. Santi Lapbenjakul, Director of Lam Sonthi hospital since 1996. He did a home visit and found abandoned disabled and elderly. He totally understood that the family doesn't mean to leave the elderly alone, but they need to earn money for supporting the family. With many dependent cases that he found, he realized that such problem would be increased because Lam Sonthi is a completed aging society with 13.6% of older population. To solve this problem, roles of health care providers need to be changed. They cannot be passive and wait for patients coming to the hospital. The active strategies and LTC system in community is needed for the district. Therefore, Dr. Santi has developed the community oriented service to serve the needs of LTC with community participation.

Since Dr. Santi and his staffs have worked closely with both health sectors and non-health sectors, including all local authorities in Lam Sonthi, his idea is totally supported by all sectors, and they have involved in this model following the motto of "Lam Sonthi People will never leave others behind." LTC in Lam Sonthi has started since then with fully community involvement of all sectors based on the mutual main goals as following: to reduce number of elderly who are dependent; to decelerate death of elderly that are partially or totally dependent; and to promote healthy elderly to be able to care themselves and maintain their healthy status.

Coordinating Processes for Integrating All Parties of LTC's Lam Sonthi Model

There are two channels to accept and register dependent elderly into LTC system: via hospitals or communities. LTC coordinating committee will be informed and formulate care plan. Patients' houses will be examined by a hospital's technician and health care team. Some parts of house are modified as needed by cooperation between the technician, family members, and neighbors with funding support from the Sub-district Administrative Organization (SAO).

After registration, LTC coordinating committee will examine health in all aspects and plans for caring patients using holistic approach. The data will send to case manager in district level. The case manager will set a meeting with community LTC team to formulate individual LTC program, assign a formal community caregiver, and assign each involved sector to integrate care for the clients.

Community LTC team will perform care for the dependent person following care plan. A family community caregiver will provide care using family medicine approach. If there is any problem, they will report to the case manager for solving the problem. Case manager will set the meeting for reviewing the cases, analyzing the problems, and developing the LTC processes. All data will send to LTC coordinating committee once a week.

LTC Approach of LTC's Lam Sonthi Model

The LTC approach focuses on design care at clients' houses with in-depth understanding Thai culture that although when they are sick, they would like to stay at their homes.

Main services of LTC include health and social care. Health services are responsible by Lam Sonthi Hospital, provincial public health offices, and health promoting hospitals (primary care centres) in Lam Sonthi. Holistic care approach is used to provide continuum care focusing on three BBB (Brain, Bone, Body) approaches that are suitable for elderly condition. Care and activities are also adjusted to be appropriate for each person's functional ability and dependent level. Frequency of home visit will be set following health needs of each case.

Social services are responsible by all SAOs of Lam Sonthi focusing on social welfare services and others such as cost of living, necessary factors for living, budget for housing and environmental modification, and career building.

There are also synergized between family, health, and social care. LTC plan incorporates family members and provide respite care. All aspects of life, including suffering and happy factors, are included.

Formal Community Caregivers: Initiative model of LTC

Usually, for custom of Thai society, family members play main roles to look after their parents or relatives who are old. Due to limitation of their time and work, they have faced with difficulty to provide care, especially for elderly who are partially and totally dependent. Therefore, formal community caregivers have been developed at Lam Sonthi as initiative model in order to provide daily care for dependent patients and respite care for family members,

Currently, there are 25 formal community caregivers in all six SAOs of Lam Sonthi. Inclusion criteria are volunteers who have service mind and are trained by Lam Sonthi hospital about hygiene care, basic physical examination, and how to examine blood pressure, fingertip blood sugar. Their knowledge is reviewed after each home visit. They will receive cases from the case manager and provide care following care plan with compensation from SAOs about 5,000 – 6,000 baht per month. Indeed, the amount of this compensation is a few comparing with transportation and other expenses.

Outcomes of LTC's of Lam Sonthi

With the effort to conduct the LTC model since 2011, all 2,270 dependent elderly in Lam Sonthi has received LTC under participation of all involved sectors. All sectors in Lam Sonthi incorporate to solve this health issue and others in the district because they realize the importance of health and people's quality of life. Therefore, local authorities confirm to support budget to sustain LTC in community.

Based on the Bathel Index of activities of daily living, the number of dependent elderly who cannot perform their daily activities is decreased as shown in the figure 1. Importantly, quality of life of either dependent patients or their family members increases.

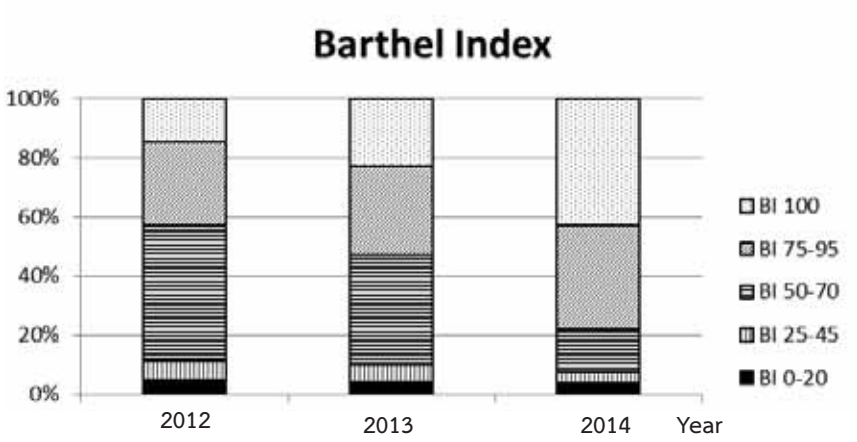

Figure 1 Bathel Index of dependent patients of Lam Sonthi from 2012 – 2014

Key Success Factors

The participation and involvement of both health and non-health sectors are the main key success of LTC model in Lam Sonthi. Sharing experience of each part is also important to develop this model and cultivate team.

District health system (DHS) applied to use appropriately with the context of the Lam Sonthi and its culture is also important as Dr. Santi said "This LTC model may not be the best model, but it is the most effective model under the limited budget and context of Lam Sonthi."

The formal community caregivers are important persons to integrate care and information between elderly and their families, multidisciplinary health team, and local authorities. This initiative of formal community caregivers is becoming the model for other rural communities and districts in Thailand.

Challenges of Lam Sonthi LTC

The design of the model focusing on community participation is unclear and overlapped in nature. Therefore, clear roles and responsibilities of each sector is a challenge that is needed to be clarified. Because family member is part of care of this model, it is not suitable for a dependent elderly who lives alone or no relatives. Fortunately, there are only a few cases and hospital can provide care for them. However, the system for this kind of patients is needed to be further developed.

Lessoned Learn

Participation in all levels of organization and people in communities is important to resolve complex health issues such as LTC. However, “which sector should start this collaboration in community for providing LTC and how to sustain this collaboration?” are important questions that need to be considered since the starting point. New ways of systematic thinking to overcome the issues is also needed, with the ultimate goal of population’s health and equity.

“Legal Clinic” a proactive approach to ensure health of vulnerable populations in the borderland

Dr. Worawit Tantiwattanasup

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Umphang Hospital is a sixty-bed community hospital of the Thai Ministry of Public Health. It locates in Umphang, one of the five districts of Tak province that form the western border between Thailand and the Karen State of Myanmar. Umphang being, among all districts in the country, the largest and the farthest from the provincial center; most of its area is conservative forest. The “only” route to enter Umphang is the 164-kilometers mountainous road that takes four hours from Mae Sot, the closest urban city. Seeing from the scope of the nation, therefore, Umphang seemed to be a “closed city” at the border.

Nevertheless, if we take a broader perspective, Umphang is an ancient outpost. The name “Umphang” comes from a Karen word means showing the travel documents. And it was the site of “Mae Klong Outpost” of Ayutthaya Kingdom. It thus a significant route for transportation for hundreds of years. People in this area live together before the line was drawn to separate Thailand and Myanmar. Moreover, the long-lasting civil wars between the Burmese government and Karen minority have forced people to flee their home to seek for safe shelter, and some cross the border to seek for better health services in Thailand. As a porous borderland, Umphang has been Thailand’s buffer that protect the inner part from epidemics from Myanmar, such as the deadly outbreak of meningococcal in 2003 or cholera in 2015.

Therefore, Umphang Hospital cannot selectively provide care only for the patients who have Thai nationality. We have to care for everybody seeking help without discrimination. .

From a broad perspective, the establishment of the Thailand Universal Coverage Scheme (UCS) in 2002 helped to expand the coverage of public health insurance to almost all people living in the country. In Umphang context, however, using citizenship as the prerequisite for coverage the UCS excluded a large number of people who immediately categorized as uninsured. The new health financing that allocates resources by the number of registered citizens, has put the hospital's finance to suffer with liquidity problems. Although in 2010 the Ministry of Public Health set up a fund to support people with legal status and rights problems, it covered only 6,000 more people in Umphang. From 2015 statistic, 42 percent of Umphang residences (32,000 of 68,000 people) were uninsured. In the past three years, Umphang Hospital had the expenses of providing free care around 30 million baht per year.

Regardless of the problems in financial perspective that access effectiveness with the ideas of profit, lost, and debt, Umphang Hospital has committed to work with humanitarian and public health ambitions. We aim to create a local health care system that everyone can access essential cares without any barrier. One example of our effort is the "white card" system, established in 2002, provided substitution of insurance card to reassure the patient that he or she is welcome to come back in the next visit. Now there are approximately 32,000 people registered in this system.

The Umphang Hospital's "legal clinic" established in 2010. It was an outcome of the social movement of the network of border hospitals that help to increase public health concern about the relationship between legal person status and health. The problems of legal person status are the barriers to access not only the essential health services, but also many other social welfares and basic rights substantive for healthy living. Therefore, they should be considered as "illnesses" that need remedying. Umphang Hospital thus set up a special clinic that has two lawyers and a social worker working as the "doctors." This legal clinic provides care for individual cases and seeks to control the "epidemic" of these illnesses in the borderland.

Remedy: Investigation into individual cases and Thailand's complex nationality laws, the legal clinic found that the uninsured people who have problems of legal person status can be classified into six groups: 1) People who lack of proof of personal identity. Some of them were born on Thai soil, but never get birth registration because lack of access to the registration system or lack of concern about its significance. 2) People who have the rights for Thai nationality by birth, but identified as foreigners in the Thai registration system. 3) Foreigners born in Thailand (since February 26, 1992) and registered as non-Thai. 4) Foreigners born abroad who have lived for a long time in Thailand until granted the permanent rights for housing. 5) Foreigners present as immigrant workers from Myanmar and get registration of that status. 6) Foreigners live in Nupo Refugee Camp in Mae Chun Sub-district.

From this finding, the legal clinic set up the three steps remedial processes. Beginning with "examination" of the narrative and evidence of each case, the clinic, then analyzes the information and current laws to "define the status and rights" of each individual. In the final step, the clinic facilitates the case through legal procedure to "develop status and rights." Since its establishment, the clinic has served almost 300 people.

Prevention: As the lack of birth registration is the first and foremost cause of the legal person problems, the legal clinic worked with the legal clinics of three other border hospitals in Tak (Pophra Hospital, Mae Ra Mard Hospital, and Ta Song Yang Hospital) to eliminate this cause by the project entitled "zero-state-less-children zone." Beginning in October 2014, the project developed the system to facilitate birth registration for all children born in the hospitals. Recently, around 84 percent of babies born in Umphang Hospital got their birth registration, while before the project only a half of the newborns got theirs.

Case finding: As people lack of understanding and concern about their right and legal person problems, the clinic has tried to conduct community surveys to identify cases and provide help. However, the key barrier is the difficult transportation to remote villages, especially in the rainy season.

One of the major obstacles is people's attitude that the problems of legal person status are beyond the scope of hospital's responsibility. Therefore, the clinic has to encounter with misunderstanding, resistance, and lack of support or collaboration. Regardless of this obstacle, the hospital administrators and the clinic's staff have continued working and building the understanding that this area of work is public health and significant to the security of national health security.

From the experiences of Umphang Hospital, I would like to suggest that achieving Universal Health Coverage required understanding of and responding to the specific needs of the vulnerable populations live in each particular area. For the borderland, like Umphang, these require thinking outside the limited common sense of financial calculations, bureaucratic division of labor, and nationality-based discrimination. By this way, I believe, we would truly create a healthy, inclusive society for all of us and the future generations.