INEQUITY IN ACCESSING HEALTH CARE SERVICE IN THAILAND IN 2015: A CASE STUDY OF THE HILL TRIBE PEOPLE IN MAE FAH LUANG DISTRICT, CHIANG RAI, THAILAND

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ABSTRACT:

Background: Getting equity of access to health care in any individuals is a basic rights as a human being. The quality of given care from health care professionals should be constant for all races and tribes.

Methods: Data included a systematic literature review based on secondary information from various sources together with information obtained from group discussions in November 2014 aimed to investigate the equity of accessing to health care service among the hill tribe people who lived in Mae Fah Luang district, Chiang Rai province, Thailand.

Results: The main findings revealed that the hill tribe people who lived in Thailand had faced many barriers to access health care service such as language, the right to access, distance from health care center, difficulty of transportation, and stigmatization from the health care providers.

Conclusion: The best solution is to encourage and train local people to be health professionals, and to return to provide care for this particular population group.

Keywords: Equity, Access to care, Hill tribe, Rights to access, Thailand

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BACKGROUND

In the globalization climate there may have been a misled belief that everyone has ready access to most things that man may desire for a decent living. In human rights term “equity” is used to represent equality with fairness [1]. This is synonymous with the notion of distributive justice, or fair distribution of good things within a society, whether they be material possessions, access to health care, or simply survival. However, some population do not have the same opportunity to gain benefits from resource allocations or services even though they are living in a modern democratic political system country as Thailand. The hill tribes in Thailand are a good example for this matter.

The hill tribes in Thailand are classified into six main groups [2]: Lahu, Akha, Lisu, Karen, Yao, and Hmong. They have migrated from the south of China to Thailand over the last several decades. Approximately 800,000 were living in Thailand in the year 2012 [3]. Each group has their own language, culture and beliefs which are different from those of Thai indigenous people. Most of them live in the mountainous border areas in 16 Northern provinces of Thailand. In 2012, there were 180,214 hill tribe people who lived in 652 villages in Chiang Rai Province [2]. Their villages are in remote areas far from the city and health service facilities, with poor road access and public transport. Many of them do not qualify for, or have failed to obtain, a Thai ID card regarding Thai’s law and regulation [4] which generally is required for free or subsidized government medical and educational services. Most hill tribe people work in low pay manual jobs with limited opportunity to earn money, receive health information, or have access to affordable healthcare. They have become a vulnerable population to many infectious diseases including HIV and TB [5]. They also lack some basic rights such as the rights of land use, readily access to the justice system, education and health care services including curative and

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preventive programs without charging.

Thailand has an excellent computerized population database as all Thais are required by law to register for an ID card by the age of 7 [5]. A Thai ID card with ID number is essential for most legal or formal transactions in Thailand including claiming access to government free or subsidized health services. Hill tribe people have been migrating to and formed settlements along the Thai border areas for many decades [3]. Their settlements are gradually becoming more permanent with later generations but there is still a tradition of hill tribe people crisscrossing the border according to their economic, cultural or political necessity from time to time. Their villages are often in very remote areas making applying for a house registration or address either difficult or unnecessary. Their status is rather like one of alien refugees even well into a second or third generation of immigrants. Successive Thai governments, being concerned about border security, have taken a cautious approach toward conferring Thai citizenship to hill tribe people by granting different types and stages of internal passport and citizenship. Many still have not obtained documentation which entitles them to travel legally within an allowed area, due to lack of information, language barrier, fear of arrest etc., which considerably restrict their movement including seeking employment, education for children, and medical treatment. Also traditional belief and medical system is still strong in their villages and which many may choose to manage their health and illnesses [6].

In time of having health problems the hill tribe people have their own steps of taking care of themselves and their families. The first step, the hill tribe people try to seek and use their local traditional remedies [6]. This is very common because the modern health care setting that could be used in the area is usually very far from the village. A decision to get access to modern health care is not limited only by their traditional belief but also by the distance and difficulty in travelling, especially in the raining season which calls for reasonably good road and vehicles. A two hours journey to the nearest health center is not uncommon, which in many emergency cases is too long. Such obstacles do not have adverse impact only on therapeutic care but also make delivery of prevention programs such as mother and child health, immunization program, health education, etc. difficult to reach their targets [7].

The annual report of Mae Fah Luang District Office in 2014 shows that totally 73,507 people (35,440 males, and 38,067 females) lived in 4 sub-districts, which break down into 76 villages, 146 small communities, and 11,354 families [8]. Ninety nine percent were hill tribe people; 34% were Ahka, 18% were Lahu, 17% were Yunnan Chinese, 16% were Shan, 9% were Lisu, 3% were Yao, 2% were Hmong, 1% were others. Most people worked in agriculture with a low income status. A total of 65,980 persons (89%) have the right of access to health care under the Thai Universal Coverage System [8]. These people have been given Thai ID card since 2000. However, this number would be an over estimation because 25% of the people are Shan and Yunnan Chinese who are not allowed to have Thai ID card [4].

Under the Thai Universal Coverage System Mae Fah Luang district is divided into two Contracting Units for Primary Care (CUP): Mae Fah Luang Hospital and Mae Chan Hospital. The average distance from a village to a hospital is 15 kilometers while the farthest is 35 km. [8]. The allocation for which village belongs to which hospital was done geographically with the result that 58% of people came under Mae Fah Luang Hospital, while 42% under Mae Chan Hospital. A closer look shows that Mae Chan Hospital is a 120-bedded hospital [9] with a full range of health specialists whereas Mae Fah Laung Hospital is only a 30-bedded hospital [10], much more remote than Mae Chan, with very limited number of working health professionals particularly very few doctors. The proportion between health professionals and population in Mae Fah Laung Hospital in 2014 was 1:21,295 for medical doctor, 1:14,197 for dentist and pharmacist, and 1:1,374 for nurse. This indicates that people who live in a similar environment or location may not necessarily have access to the same opportunity or equality of care [11].

In terms of health status it was found that the top five infectious diseases were diarrhea (3,400/100,000 pop), hemorrhagic conjunctivitis (450/100,000 pop.), pneumonia (270/100,000 pop.), scrub typhus (250/100,000 pop.), and hand, foot and mouth disease (230/100,000 pop) [8]. Mae Chan Hospital reported in the same year that 1,700/100,000 pop. for diarrhea, 900/100,000 pop. for hemorrhagic conjunctivitis, 850/100,000 pop. for pneumonia, 120/100,000 pop. for scrub typhus, and 150/100,000 pop. for hand, foot and mouth disease [12]. These were a significantly greater rate than those reported from the whole of Chiang Rai Province which were 180/100,000 pop. for diarrhea, 23/100,000 pop. for hemorrhagic conjunctivitis, 35/100,000 pop. for pneumonia, 7/100,000 pop. for scrub typhus, and 4/100,000 for hand, foot and

mouth disease. Mae Fah Luang has also been the highest area for diarrhea and fever of unspecified causes in Chiang Rai Province since 2012 [13]. This statistics strongly indicates that personal hygiene and sanitary systems are the basic needs of these people [14-16].

Pa Ya Prai Health Promoting and Terd Tai Health Promoting Hospitals are the sub-district hospitals in Mae Fah Luang district. Pa Ya Prai Health Promoting Hospital reported that in 2014 approximately 500,000 baht was the budget received from the Thai National Health Security for the improvement of both therapeutic and health promotion programs for the 7,200 population in the whole year [17]. The annual report of Terd Thai Hospital in 2014 found that most of the patients who visited the sub-district hospital needed the service of a translator for better and clearer understanding of the conversation with health providers [18]. Non-communicable diseases such as hypertension and diabetes mellitus are becoming a major problem for these groups of population due to heavy consumption of salty and fatty food [18]. Half of the patients of hospitals in this area are foreigners who cross the land border to seek health care on the Thai soil which adds a burden to the hospital resources both in medical equipment and manpower [17]. An average of 50-70 cases per day of patients come to get a service at these small hospitals. The major health problems among young children are upper respiratory tract infection (URI), and diarrhea [17]. Family planning program is the most ineffective because people still want a large family and favour sons to daughters [17]. The turnover rate among the health professionals who are working in these areas is very high [18].

Most of the health professionals who work in the sub-district hospital and local hospitals in Mae Fah Luang district are Thai language users while 75-80% of the people who live in these areas cannot speak Thai [6]. Difficulty in communication and misunderstanding between health care providers and clients are very common. There is a risk of poor compliance with instruction for treatment and also of misdiagnosis. The study of Nunn et al. [19] reported that education was fundamental to achieve the equity in health care services. Nunn et al. [19] also reported that recruiting staff from minority groups or encouraging graduates to work in areas where minority population live in low income countries in project similar to what is known as social capital program would address the problems of communication and discrimination between health care providers and their clients. Jang et al. also reported that factors effecting the health care access and utilization in developing countries were composed of education, income, language, and citizenship [20]. Simkhada et al. in their meta-analysis [21] reported that education of clients was the most important factor that affects the utilization of health care systems particularly among the minority populations. Seng et al. [22] reported that being marginalized population associated with mental health.

Stigmatization is an important issue which makes minority people often feel uncomfortable or anxious when seeking assistance from healthcare staff.

METHODS

This was a conclusion from three separate group discussions in November 2014, to identify barriers to accessing healthcare by hill tribe people. These had been held at Pa Ya Prai Health Promoting Hospital in 2014: 12 females in the first group, 12 males in the second group, and 5 males and 6 females in the last group. Participants were public health volunteers and community leaders who were able to speak Thai language from Pa Ya Prai and Ter Tai Sub-district hospitals, and used purposive selecting method and invited them into forums in different days. There was approximately 3 hours lasted in each forum. The discussions were focused on the barriers of accessing health care systems in different needs of the people who lived in Mae Fah Luang District, Chiang Rai Province, Thailand. The process was done by 3 facilitators, starting by providing some basic information on the rights to access to health care systems, and followed by obtaining the thoughts from the participants by using 6 main lead questions which had been tested before use: a) What is the basic human right? b) Do we need to be treated as the general Thai people when we access health care settings? c) What are the main problems do you face while access to health care system? d) Do you get all things that your expectation after getting access to care from the health professionals? e) What did you do when you did not get equally services from the health care professionals? and f) What is the best solution to solve this problem as your opinion?. The discussions had been highly interactive among the participants. Finally, the researchers come up with content analysis and make conclusion. In the discussions mentioned a point for solving the problem of stigmatization by allowing children from the village to be trained in health care professionals in recognized universities. This preliminary finding coincide with various studies [23-26] reported that supporting vulnerable people to access education

particularly in health professional could increase health care unitization among the marginalized populations.

CONCLUSION

It doesn't matter that we are now well into in the 21st century or how long the hill tribes have lived in Thailand or how much they themselves feel that they are Thai, getting a good access to health care service in Thailand remains a significant problem which has not been fully resolved. Improving access to education is one of the urgent and key elements for achieving a better health care among these groups of population.

Another possible solution is training the local people by selecting the high school children who meet basic qualifications to be trained in different health care professionals such as medical doctor, dentist, nurse, and public health professional in the standard programs in the universities, aftermost, to become health professionals to serve in their own communities. This will enhance effective communication, empathy and trust, at the same time reduce the sense of discrimination and alienation. These missions should be contributing together with the local administration office.

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