

Universal coverage but unequal access? Experiences of health care in Northeast & South Thailand

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Abstract

Thailand's rapid economic growth has brought health challenges as well as benefits, namely a rise in life expectancy to 6.5 years above the global average, and an 'epidemiological transition' from infectious and deficiency diseases, to chronic non-communicable diseases such as diabetes. Previous research in Northeast and South Thailand by the Wellbeing in Developing Countries ESRC Research Group demonstrates the importance of health to people's subjective quality of life and wellbeing, and suggests that ill health is a significant problem - nearly a fifth of households in WeD sites experienced severe health-related 'shocks' during the past five years, and a third of household heads defined themselves as chronically ill.

In 2001 the Government of Thailand introduced the Universal Health Coverage scheme to offer near-universal health care coverage. However, while this has reduced 'out of pocket' expenditures for healthcare and impoverishment through 'catastrophic expenditures', the perceived quality of its services mean it is in danger of becoming little more than a safety net and failing to ameliorate existing inequalities. This proposition is explored using the results of large-scale qualitative health study carried out by WeD with 245 men and women from different age groups and socio-economic statuses in Northeast and South Thailand, supplemented by WeD household survey data.

The paper is divided into three parts; the first briefly introduces Thailand and the WeD sites, and describes the sampling and methodology. It also reviews current discourses about health and health issues in Thailand, and outlines the context to health and health services. The second presents data from the qualitative health research covering health risks, and the incidence and impacts of chronic illness and disability. The final section looks at the health seeking behaviour of people in the WeD sites (illustrated with case studies), focusing particularly on use of the UHC and traditional medicine.

Key words: Thailand; Health; Universal health insurance; Wellbeing

Universal coverage but unequal access? Factors affecting the use of health services in Northeast & South Thailand

Thailand's rapid economic growth has brought health challenges as well as benefits (Wibulpolprasert, 2005), namely the rise in life expectancy to 6.5 years above the global average (NESDB, 2002), and an 'epidemiological transition' from infectious and deficiency diseases, to chronic non-communicable diseases such as diabetes. Previous research in Northeast and South Thailand by the Wellbeing in Developing Countries ESRC Research Group (WeD)ⁱ demonstrated the importance of health to people's subjective quality of life and wellbeing (Jongudomkarn & Camfield, 2006). Data from WeD's Resources and Needs Questionnaire (RANQ) and qualitative interviews suggest that ill health is a significant problem - nearly a fifth of households experienced severe health-related 'shocks' during the past five years (rising to a quarter in two sites in the Northeast), and a third of household heads defined themselves chronically ill. In addition to the experiential dimension, health was seen as an important economic and social resource, and its absence often lead to financial and psychological stress.

In 2001 the Government of Thailand extended healthcare coverage to 18.5 million people who were previously uninsured. The Universal Health Coverage scheme or 'Golden Card' was a central plank of *Thai Rak Thai's* election manifestoⁱⁱ, and was designed to provide most curative and preventative health services for a fee of 30 THB per visit. The main reported benefit of UHC was the security it offered by covering healthcare costs for most chronic conditions, and reducing 'catastrophic health expenditures' (WeD Qualitative research, 2005). A recent report by EQUITAP confirmed this, demonstrating that UHC had succeeded in reducing the inequity of 'out of pocket' expenditures for healthcare and halved the incidence of impoverishment through 'catastrophic expenditures' (2006). Possibly for this reason chronic illness and disability appeared to have little effect on household resources or needs satisfaction for WeD respondents, although there were differences in asset holdings which are explored later. EQUITAP also observed that "better physical and cultural access, better perceived quality of care, and adequate financing of the scheme would potentiate the pro-poor nature of the scheme" (2006, p.13), and this proposition forms the main topic of the paper.

The paper presents the results of large-scale qualitative health study carried out by WeD with 245 men and women from different age groups and socio-economic statuses in Northeast and South Thailand. It is divided into three parts; the first briefly introduces Thailand and the WeD sites, and describes the sampling and methodology. It also reviews current discourses about health and health issues in Thailand, and outlines the context to health and health services, using data at national, regional, and local levelsⁱⁱⁱ. The second part presents data from the qualitative health research covering health risks, and the incidence and impacts of chronic illness and disability. The

final section looks at the health seeking behaviour of people in the WeD sites (illustrated with case studies), focusing particularly on use of the UHC and traditional medicine.

1. Context

Thailand is situated in the heart of the Southeast Asian Mainland; its total population is 64.2 million, at least six million of which live in the capital city of Bangkok, which is one of the busiest and most densely populated cities in Asia. The majority of people live in rural areas (68 percent), however, only 42 percent work in agriculture, and the annual per capita income (78,783 THB/ \$2,462) compares favourably to other countries in South East Asia. The national ethnic identity is Thai, but there is some regional identification and large ethnic groups in specific locations, which tend to have poorer access to healthcare (for example, Melayu speaking Muslims in the three Southernmost provinces) (NESDB, 2004). Thailand's rapid growth during the last 45 years led to substantial improvements in infrastructure, social development, and political reform. GDP per capita also rose, alongside employment opportunities in cities, factories, and the emerging service sector, and the incidence of poverty fell dramatically. However, the picture was not universally positive as emerging disparities were observed in key areas such as income, education and health, partially due to differential access to health services and educational institutions (Promphaking, 2006). For example, half the households in the Northeast are classified as living in slum conditions, compared to 27 percent nationwide, and maternal mortality per 100,000 births in the South is double the figure in other regions (UNDP, 2003). Annual per capita income in Bangkok is also three times that of the rest of the country and nearly ten times the figure in the Northeast (234,398 THB vs. 26,755 THB).

The Wellbeing in Developing Countries ESRC Research Group (WeD) is working in seven rural, peri-urban, and urban communities in the Northeast and South of Thailand, which illustrate some of the challenges presented by rapid and uneven development (see figure 1 for a map of Thailand and table 1.1 for a summary of the research sites). The complete WeD research methodology includes analysis of international and national policy regimes; community level profiles; the RANQ household level survey of resources and needs; in-depth qualitative and quantitative studies of particular households and themes; and the development and application of a measure of subjective quality of life (McGregor, 2007). This data provided a context for the qualitative health research, which involved in-depth semi-structured interviews with 24 people in each site. Respondents were sampled according to gender, age, wealth status, and religion (in the South). A further eight interviews were carried out with people with severe illness or disability, and up to five with workers at the local health centre, Village Health Volunteers, and traditional healers. The interviews explored 1) how respondents understand 'health' and relate it to wellbeing, 2) what they do to keep healthy, and 3) what they do when things go wrong (for example, 'self-care', and use of traditional and modern medicine).

Current discourses in Thailand about health

On an international level, health has been defined in increasingly all-encompassing terms, to the extent that it is almost indistinguishable from wellbeing (for example, the World Health Organisation's definition of health as a "state of complete physical, mental, and social well-being not merely the absence of disease" [WHO, 1946]). This criticism has also been made of measures of 'health-related quality of life', which by conflating the concepts make it difficult to measure the effect of health on quality of life, and may consequently underestimate the quality of life of people with chronic illnesses and disabilities (Michalos, 2004; Albrecht and Devlieger, 1999).

Health is so important in modern Western society that its pursuit has become the pursuit of moral personhood; "a healthy body has become a sign of individual achievement [...] the mark of distinction that differentiates those who deserve to succeed from those who fail" (Crawford, 1980). This is reflected in Thai public health discourses, where health appears to be equated with modernity, despite the prevalence of 'diseases of modernity'. The focus is on "unhealthy [consumption] behaviours" like over or under-eating, which increase people's vulnerability to costly chronic illnesses^{iv}. This focus risks overstating people's agency, and encapsulates the cultural and economic tension between "control" and "release" which Crawford argues is inherent in capitalist societies (1984). An example of this would be models of 'patient compliance' now being applied in developing countries, which ignore the "radical differences in the ability of different populations to comply with demanding therapies, [...for example] exhortations to take a year's worth of several drugs" (Farmer, 1997).

While these debates are not universally salient (despite the influence of global health discourses), 'healthism' and 'victim blaming' are already part of Thai health discourses, even in the concept of 'holistic health' (Wattanachai, 2005^v). Holistic health is translated in Thai as 'whole in one' (a concept with Buddhist resonances), and spans four levels: i) individual, which contains physical, mental (cognitive and emotional), social, and spiritual; ii) household; iii) community-country (reflecting a conception of Thailand as a giant *Baan* [village]), and iv) international (Jongudomkarn, 2006). It emphasises firstly, people's relationship to nature, which was a source of concern for many respondents (for example, use of chemicals in agriculture); and secondly, their use of self-care to maintain balance in their lives, and 'manage' thoughts and feelings. Holistic health fits with the Thai Buddhist emphasis on self-responsibility; for example, a traditional healer in the Northeast described how "when you are born you have both your happiness and your suffering with you", and likened building health to farming rice: "if you grow a lot of rice sprouts, you would get a lot of rice crops. It depends on each person's Karma". It also fits with traditional health beliefs in Northeast Thailand, which recognise three levels of causation: natural, preternatural (for example, use of

'black magic'), and supernatural, albeit that illness explanations usually operate on the first level (Nilmanat & Street, 2004).

The surprising consonance between core Thai values, and hegemonic Western health discourses, has led to their enthusiastic adoption by GoT. For example, the 9th NESDP^{vi} (2002-2006) aimed for a holistic and person-centred approach to health development, rather than a sectoral one, which combined the use of the whole of the health system with the encouragement of individual self-sufficiency. An explicit aim was that every person "should have access to resources to achieve good health, develop the abilities to adapt to change, and practice high moral standards and social responsibility" (<http://www.nesdb.go.th>, 5/07/2005). The plan focuses on 'health building' rather than 'health repairing' as a more efficient use of public funds, which would discourage dependency. Its aim was "absolute health management" to reduce the 'causal' factors of poverty; isolation; obesity; sexual promiscuity; addiction to alcohol, drugs, nicotine, and gambling; and other 'man-made illnesses' (for example, traffic accidents) (Wattanachai, 2005). Despite the discourse of holism, the majority of these focus on individual behaviours, have a moral tone, and are stripped of social context (for example, the current drive towards car ownership as a sign of prosperity and modernity). The focus on the individual has enabled what Jongudomkarn (2006) calls 'commercial holistic health' where people are persuaded to purchase the missing elements in their lives, rather than look for the root of the problem in the demands of their daily lives and environment.

1.2 Background to the provision and use of health services in Thailand

The 9th plan also promised an 'equitable and efficient' healthcare system, and in 2001 GoT established the Universal Health Coverage scheme to supplement the two employment related schemes, the Civil Service Medical Benefit Scheme (CSMBS), which covers government employees and their dependents (approximately seven million people, non-contributory), and the Social Security Scheme (SSS), which covers all employees in the formal sector (approximately 10 million people, costs shared between employee, employer, and government). The UHC replaced two existing risk protection schemes - the non-contributory Medical Welfare Scheme or Low Income card (people with low incomes, people under 12 or over sixty, people with disabilities, monks, and local government officials), and the contributory Voluntary Health Card Scheme or 500 THB card (farmers and informal sector workers), which cost 500 THB per year. It originally came in two forms: GC-exempt where treatment is free, and GC-co-payment where users are charged 30 THB per visit; however, the 30 THB fee has now been removed. The GC covers most curative and preventative health services, with the exception of road traffic accidents, which are covered by compulsory vehicle insurance paid on vehicle registration. Some high cost therapies such as chemotherapy are only partially covered.

Health insurance coverage has greatly increased since the introduction of the scheme; one national survey conducted in 2002 found only nine percent of respondents didn't have any health insurance (uninsured respondents were typically young and poor, with little or no education) (Suratdecha et al, 2005). The figure from the WeD qualitative health research was four percent, reflecting the time elapsed since Suratdecha's survey, and were usually older people who had been unable to register as they did not have a birth certificate. Five to six percent of people with a GC had previously had no health insurance and 73 percent of holders previously had Low Income cards, suggesting that the GC is effectively targeting the poor. Nonetheless, a survey shortly after its introduction suggested that those in the lowest income quintile were still spending 7.5 percent of their income on healthcare, compared with an average of 1.6 percent and 0.1 percent respectively for people in SSS and CSMBS (HSRI 2002, in Towse et al, 2004). Similarly, Mee-Udon's survey of two Northeastern villages (2006) found that in the more remote village six percent of respondents perceived their expenditure had increased, although this may be due to transport costs incurred by greater use of healthcare facilities. Another initial concern was that while 'compliance' figures from 2004 suggest that poor people are more likely to use the card than richer ones, indicating effective targeting, even in the lowest income quintile usage was not universal, as only 74 percent of cardholders use outpatient services, and 86 percent use inpatient. Usage figures then decline proportionate to salary so only 19 percent of those earning over 15,000 THB use outpatient services, and 40 percent inpatient, which suggests that the 'universal' health service is becoming a safety net rather than a choice.

The increase in coverage also necessitated changes in health care delivery; for example, GoT redirected funding from provincial and teaching hospitals (located in the main urban centres), towards district hospitals and local primary healthcare centres, in the expectation that this would increase the benefit derived by poorer people (Hanvoravongchai et al, 2003, in Towse et al, 2004). Prior to this primary healthcare was predominantly delivered by hospital outpatient departments, or government doctors working 'after-hours' in private clinics (Mills & Bennet, 2002), and consequently had a popular reputation for poor quality treatment and care. GC holders can now access healthcare through their 'contractor unit', which comprises a district hospital and related primary healthcare centres, and is funded through 'capitation'^{vii}. While it is possible to be referred to other services such as teaching hospitals, respondents described this as a time-consuming and bureaucratic process. People are reluctant to 'self-refer' as unless they hold a CSMBS or SSS card they are required to pay their costs. In contrast, SSS card holders can use any public and private service at 'registered hospitals' within their 'provider network', and CSMBS holders and their dependents can use any service, anywhere. In fact Pannarunothai (1993) estimated that a quarter of the income of private hospitals came from CSMBS.

The most recent information on the effects of the GC on health seeking behaviour comes from the 2002 survey conducted by Suratdecha et al (2005). This found that for non-hospitalised illness, self-care (traditional remedies or pharmaceuticals), or use of traditional healers was still the most common method of care for 42 percent of respondents, including those entitled to free care. This was also true in WeD sites where one poor villager spent 2,500 THB per month on Chinese medicine for his wife's diabetes. Only 33 percent of Suratdecha's respondents used government health services, while 18 percent used private clinics. The main reasons given for not using government services was that i) the illness was not serious, ii) purchasing drugs was easier, iii) the respondent didn't want to take leave from work, iv) the facility was too far away, v) the attitude or behaviour of the healthcare workers was unsatisfactory, or vi) the medicine or treatment was perceived as poor quality. The next section outlines the extent of formal healthcare provision at provincial and local levels. To simplify this, we have only reported figures for provinces containing WeD sites.

Government Health services at provincial and local levels

The impression given by local and migrant respondents of better health services in the South is supported by the ratios of population per doctor and per bed, which in Songkhla province were considerably better than the mean across the three WeD provinces: population per bed 424 (mean 643), and per doctor 3,301 (mean 6,204). While respondents from all sites have access to a range of facilities, there are some important differences between rural, peri-urban, and urban sites (see table 1.3). For example, Noreastville_far has access to a primary healthcare centre (PHC)^{viii} in the next village (nine km from the farthest end of the village), but for serious conditions villagers need to travel 38 km to the District hospital. They also have access to fewer private facilities (a private hospital and clinic in an adjacent district) although in 2005 a Public Health Officer at the PHC started an inexpensive private clinic in his home in the village. Currently Southville doesn't have a PHC, although the local government officer is campaigning for one as residents of the Muslim half of the village have to use the PHC in the district hospital (residents of the Buddhist half are in the catchment area of the PHC in the next village). Noreastville_peri has access to a PHC in the next village, and is relatively close to a modern Hospital that used to be private, which also provides an ambulance service. Southville_peri has a popular new Primary Care Unit (PCU), but is far away from the District Hospital, which also doesn't have provision for Muslim patients (for example, Halal food stalls). The city hospital is easier to access, but unfortunately isn't within the residents' catchment area. The two urban sites are the best provided for: the PHC in Noreasturban has closed, but residents have easy access to municipal health centres and hospitals in the city, while residents of Southurban can use a PHC, a PCU in the next community, an inexpensive private clinic, or nearly twenty other municipal health services. Southurban also has access to at least 173 private clinics and four private hospitals in the city. These often take patients from Malaysia, indicating that 'health tourism' isn't confined to Bangkok (MoPH, 2003).

Use of health services.

However, availability of government facilities is no guarantee of use: according to the RANQ a fifth of people who were sick in the two weeks preceding the survey had not sought treatment for this, and this was more common in the Northeast (28 percent) than the South (ten percent). Across all sites between 39 and 73 percent of respondents to the qualitative health research had never used government primary care services, and between 15 and 51 percent had never used a government hospital. The lowest usage for government primary care was in the South (a third of respondents, compared to a half in the Northeast)^{ix}, while only half the respondents in Noreastville_near and Noreastville_peri used government secondary care.

The main health service used in rural and urban sites was the hospital, and in nearly 90 percent of cases this was used under the 30 THB scheme. The remaining percentage had either used a private hospital, or used a government hospital but needed to pay because it was out of their catchment area, and/ or they hadn't obtained a referral from their district hospital (the head of the contractor network). Peri-urban sites were more frequent users of primary care: either a PHC or PCU under the Universal Health Coverage scheme (67 percent), or a private clinic (33 percent). The difference between site types may reflect either a different pattern of healthcare use where people in rural and urban sites self-treat unless the illness is serious, when they go straight to the hospital, or 'over-counting' arising from the location of many rural PHCs in hospitals. Formal traditional medicine use was minimal (less than two percent), but self-treatment with traditional remedies was relatively common among older adults, especially in Noreastville_far.

People in the South were more likely to have used a private service for a recent specified illness (28 percent, compared to 20 percent in the Northeast), and much less likely to use government health services in the past year (a third, compared to three quarters in the Northeast). Although the rate of satisfaction with government health services was slightly lower in the South, both regions recorded satisfaction rates of over 90 percent, which suggests relatively low expectations. Respondents from Southville reported the lowest level of satisfaction with government services, which may be due to the poor quality of services at the district hospital, which was also the nearest PHC for Muslim residents. Few people in Noreastville_far reported using a private service for a 'recent specified illness', possibly because until recently the nearest was a private hospital in the district town. Southurban presents an interesting contrast: because there was an inexpensive clinic within the community, people were more likely to use this than either of the two local health centres (45 percent private, compared to 39 percent government). NGO health service use was minimal as they only provide support in a few of the study sites.

Only a quarter of household heads in the South thought their family healthcare was inadequate, compared to a third in the Northeast. There were also marked differences between rural, peri-urban, and urban sites, as rural household heads were twice as likely to perceive their family's healthcare as inadequate as urban ones (38 percent rural, 27 percent peri-urban, 18 percent urban). Household heads in Noreastville_far were least satisfied, which is not surprising considering the distance to the nearest health service. In contrast, respondents in Noreasturban had a good choice of local providers, but were much less likely to use the health services (over a third of people with a recent illness didn't seek treatment). The main reason given was a preference for self-medication, possibly because attending government health services would cause them to lose a day's paid labour. Economic considerations, as well as more extensive choice, may explain why 90 percent of people sought treatment in the South, compared to only 72 percent in the Northeast.

Respondents to the qualitative health research perceived changes in people's attitudes to health, for example, an increased confidence about using government services, especially hospitals and vaccinations. The Southville_peri Public Health Officer described how

Previously when you were sick someone else brought you to the doctor, you were usually too afraid to come! People would only come when they were going to die, now they come as soon as they realise they're sick, they try to protect themselves

Paradoxically, some respondents felt doctors' knowledge had reduced, one attributing this to fewer 'foreign' doctors in hospitals, and another to the reduction in tertiary care funding. This suggests that the shift of focus to primary care may not have been universally popular.

Being economically poor was perceived as a big health risk, for example, i) people were unable to take time off to exercise or see the doctor, ii) took jobs that exposed them to health risks, iii) had a history of 'over-work', and iv) often did a 'double day' of work and child-care. Specific health risks were associated with different occupations; for example, i) making fishing nets at home (poisoning from the lead weights and chemicals on the net, pain in knees from sitting cross-legged for long periods), ii) rice growing (Weil's disease, leeches, chemicals from the rice), and iii) working in a factory (standing for long periods doing 'quality control', exposure to fumes, chemicals, and dust). However, these were often traded off against improved income and/or autonomy. For example, cutting rubber, while physically demanding, was as lucrative as factory work and enabled cutters to manage own time: "It isn't good for my health because I don't have enough time for sleep; however, it's worth it because to get money you have to spend health" (young Buddhist man, Southville_peri).

2. Outcomes

Contemporary health risks

Over the past thirty years Thailand has experienced a classic 'epidemiological transition' from infectious and deficiency diseases, to chronic non-communicable diseases. For example, in 2003 the combined mortality rate for three of the most common conditions in developing countries (malaria, dengue fever, and diarrhoea) was only 1 per 100,000 people (Wibulpolprasert, 2005). WeD data provided less support for an epidemiological transition, as the most common condition was for all age groups was pain in joints and muscles (14 percent of chronic illness overall, 23 percent for over 65s). In fact, WeD found higher than average incidences of both 'traditional' and 'modern' health problems, for example, the combined incidence of malaria, dengue fever, and diarrhoea was 4.8 per 1,000 people, compared to 1.7 per 1,000 nationwide, and the incidence rate for cancer was 2.4 per 1,000 people, compared to 0.9 percent nationwide. The main causes of lost Disability Adjusted Life Years^x nationwide were non-communicable diseases (twice as many as were lost to communicable), namely:

- i) Conditions affecting the circulatory system, particularly stroke (19 percent), which relate to smoking, drinking, and obesity,
- ii) Cancer, mainly liver and lung (16 percent), which relate to smoking, and drinking,
- iii) HIV and HIV-related tuberculosis (16 percent), and
- iv) Road traffic accidents (12 percent), especially among young men, three-fifths of which are alcohol-related

(Wibulpolprasert, 2005)

The causes highlight five public health risks that GoT is attempting to deal with (smoking, drinking, obesity, HIV/AIDS, and car use), despite their integration into Thai society, and even into what people understand as modernity. For example, 46 percent of men are classified as having 'drinking problems' and 10 percent of women (Kittirattanapaiboon, 2006), and a similar percentage are smokers (three percent of women). While GoT has not attempted to reduce car use (annual purchases of new cars are now approaching pre-economic crisis rates of 600,000), it has intervened to reduce drinking, smoking, and obesity, even including them as indicators in the annual Basic Minimum Needs household survey. Tobacco and alcohol advertising has been banned, cigarettes are no longer on public display, and licensing hours are limited. The government recently launched an anti-alcohol television campaign to suggest that by giving up drinking, a man could turn his family into a happy, healthy, and well-dressed one ('stop drinking for your economic health'), although ironically, the campaign's slogan 'poor, stressed, and drunk' has become a popular 'toast' while drinking!

Diet has proved an easier target: in 1995 forty percent of the population aged 40 to 49 was overweight, increasing their risk of coronary heart disease (CHD) and diabetes (Wibulpolprasert, 2005). Hospital admission rates for these conditions were 397 and 381 per 100,000 population respectively, and only half of those admitted with diabetes had been diagnosed (ibid). Obesity was found to be highest in Bangkok and other urban areas, and lowest in rural, due to its positive correlation with socio-economic status. 16 percent of children aged six to 12 were overweight in 2003 (14 times as many as in 1973) [WHO, 2003], and according to Sakamoto et al (2001) the figure was even higher among urban pre-schoolers (23 percent were clinically obese, compared to seven percent of rural). At the same time 12 percent of primary school children were underweight in 2001, and 11 percent of school children in the Northeast were malnourished; a striking illustration of uneven development in Thailand (UNDP, 2003).

Drugs control is also a national priority; however, due to the savagely punitive nature of recent campaigns^{xi}, it is difficult to get accurate figures of the number of users. In 2002 70,000 people were registered at drug treatment centres nationwide, half of who were new users. Estimates of intravenous drug use (IDU) range from 100,000 to 250,000; however, use of methamphetamines (*yaa baa* or 'crazy medicine') is estimated to be ten times higher, and concentrated among young people. Intravenous drug use is the main risk factor for HIV/AIDS in Thailand: HIV prevalence among IDUs is 50 percent, and they account for a quarter of new infections (UNDP, 2004).

The estimated number of HIV infections since the start of epidemic is less than one million, 460,000 people have died (53,000 in 2003), and the number of PLWHA in 2003 was 604,000, 12,000 of whom were under 15. Consequently, Thailand is considered an HIV/AIDS 'success story' as while the annual infection rate peaked at 143,000 in 1991, it fell to 19,000 in 2003, making it one of only a handful of countries to reverse a serious epidemic. The estimated adult prevalence rate is 1.5 percent; however, this conceals disparities between different groups and regions. For example, only seven to 12 percent of brothel-based commercial sex workers are infected due to the success of the "100 percent condom programme" (signs appeared over bar doors after the start of the campaign saying "No condom, no sex, no refund!" [Beyrer et al, 2006]). However, the rates for 'men who have sex with men' and intravenous drug users are much higher (15 and 50 percent, respectively), and high rates have also been recorded among pregnant women in the South (UNDP, 2004). Economic migrants (and their wives) and 'indirect' commercial sex workers are at risk, especially in border provinces such as Mukdaharn (Lyttleton & Amaripabal, 2002). Additionally, the concentration of AIDS deaths among people aged 20 to 49 years old has enormous socio-economic implications, for example, the effect on poor households of losing a working adult (Knodel & Im-Em, 2004), and caring for 'AIDS orphans' (Safman, 2004).

Participants in the WeD qualitative health research also identified environmental risks relating to climate (fever and respiratory problems from cold weather, exacerbated by poor quality housing), transport (pollution and accidents), and water quality. Urban environments were particularly unhealthy because of over crowding; rubbish; large, young families; and transient populations who didn't respect the environment. In Southurban the village health volunteer claimed that "in the past everywhere was cleaner" but now "people are drying fish, and there is goat shit and cow pats everywhere. These kinds of business belong to the gangsters so no one can complain about it, even if they don't feel happy about the smell!"

Chronic illness and disability

Incidence of disease

The incidence of disease in the four provinces where the WeD sites are located compares well to national averages as for all conditions, except cancer, the figures are significantly lower (see table 1.3)^{xii}. The wealthier provinces of Songkhla and Khon Kaen have high levels of heart disease, hypertension, and road traffic accidents (MoPH, 2003), and hypertension was the most common condition in Southern, and urban WeD sites. Unfortunately diabetes has not been recorded in Khon Kaen or Songkhla (anecdotal reports suggest it is endemic), however, nephritis and cerebrovascular conditions are common sequela to diabetes. The high rate of cancer in Khon Kaen and Roi Et is largely accounted for by alcohol-related liver cancer, as Khon Kaen has the highest international incidence, 90 percent of which is caused by liver fluke from eating raw fish and meat while drinking (Vanchai Vatanasapt et al, 2002).

The prevalence of 'pain in joints and muscles' in Northeastern and rural WeD sites suggests that chronic illness is strongly influenced by socio-economic status and occupation (for example, pain is presumably caused by prolonged physical activity in the fields, or as a daily labourer). The main problem in WeD peri-urban sites was respiratory disorders, which may also be occupational as a sixth of the population work in factories, or as motorcycle taxi drivers. Pain was the condition with the highest incidence overall, accounting for 14 percent of reported sickness, and experienced by three percent of the population. The next were 'other respiratory conditions', for example, coughs or asthma, diabetes, high blood pressure, and gastritis. These figures were supported by the WeD qualitative health study where the most common health problems were also 'pain in joints or muscles', diabetes, fatigue, hypertension, and respiratory conditions^{xiii}. During the previous year ten percent of households had members who were too sick to perform their usual activities and a quarter of these were sick for more than a month (30 percent in Noreasturban). The persistence of sickness in WeD sites may be explained by the fact that only 28 percent of people who were sick in the two weeks preceding the RANQ had sought treatment for this (the figure ranged from 12 to 44 percent in different sites), something which is explored further in the following sections.

Impacts of ill health

Scores from the RANQ Household Resources and Needs Deprivation Indices suggest that chronic illness and disability have little effect on household resources or needs satisfaction. However, there are some differences in asset holdings, with people with disabilities having the smallest mean score on the Asset Index^{xiv} (2.67, SD 1.4), followed by people with chronic illnesses (3.32, SD 1.4), and 'healthy' people (3.39, SD 1.4). The reason why the Asset Index is affected rather than the other indexes may be firstly that chronic illness is associated with age, which is positively associated with resources and need fulfilment, and secondly, that the index focuses on material resources, rather than say social or cultural, which are less affected by ill health. The exploratory quality of life research suggests that prolonged illness has a pronounced effect on household finances, for example, a middle-aged woman with renal failure described having to borrow from moneylenders to meet her medical bills ("I have spent more than 100,000 Baht over the years. I don't know how I will ever have the money to pay them back"). Another, who was being tested for cervical cancer, was worried because "my family would suffer a lot if I get sick - I don't have money for transportation to the hospital as I can barely feed my family" (Jongudomkarn & Camfield, 2006).

Many respondents talked about the effect of ill health on self respect; namely not being able to feel proud of themselves or look 'elegant', being 'gossiped' about, and being weak and dependent, rather than strong and self sufficient. A poor old man from Noreastville_far explained "if you're weak it doesn't matter how rich you are, if you have a million THB you can't do anything if you're sick, but if you're poor and healthy it's a treasure". In fact a common saying is 'you cannot buy good health, but have to practice it' (*Sukha-pap Dee Mai, Mee Khai Tha Yak Dai Tong Tam Eng*). Health was also discussed in terms of capability, being able to "do anything, go anywhere" and seemed to be a fungible resource that could be used for work and income generation, and to visit a sick friend, play football with friends, and "plan good things for your life" (rich middle-aged Muslim man from Southville). A wealthy Buddhist from Southville described what he saw as the connection between health and wellbeing:

If I am strong and have a rubber garden I can cut two to three rai per day, if I am weak I can only cut one rai. [...] When you are healthy you can work in your garden and earn lots of money, which gives you wellbeing

The alternative picture was of someone who had to stay at home, possibly even in bed, and was therefore in an unbalanced relationship to the rest of society and denied opportunities for social participation. Illness could cut people off from sources of self-esteem such as being able to help others, and do "good things" (for example, being the Vice President of your community – an example given by a middle-aged man with diabetes in Southurban). It also endangered people's moral and spiritual health ("if you are not healthy you will become lazy", young woman from Noreast_peri, employed in a garment factory). For example, ill health could mean that they didn't

have the strength to fast and pray during Ramadan, or money left to *tam bhun* (make merit^{xv}) after expenditure on healthcare.

Ill health was an important source of stress, people worried about the effect of everyday activities on their health, how their condition was affecting their family, and, ultimately, their own mortality (“Health makes you happy and able to go anywhere, sickness makes you afraid of death”, elderly woman from Noreast_near). It also placed a tangible financial burden on families as sick people couldn’t earn money, and needed to “waste” what money they had on medicine and travel to healthcare facilities. There was also the cost of food in hospital (for patient, family, and visitors), and extra expenses such as x-rays. Fear of physical and financial dependency was a persistent theme, for example, having to depend on external others (for care, agricultural labour, or money), or engage in relationships of dependency within the family, although paradoxically “mutual care” and receiving good care from others was also a signifier of a good family. Respondents talked about having freedom from the demands of an unhealthy body; for example, having to see the doctor regularly “without any sign of a cure” (something that was resented by respondents with diabetes), and their “dependency” on medicine, which was symbolised by “having to carry it around with them”.

3. Health Seeking

The section on health seeking begins with five case studies to draw out key themes. It then briefly explores experiences of using the 30 THB scheme, and traditional medicine, which expresses many of the contradictions of modernity Thai-style. The case studies were chosen to represent a range of experiences across key dimensions of location, socio-economic status and/or type of health insurance, age, and gender.

Salim is a relatively wealthy Muslim man in his thirties who lives in Southville, and has worked as a driver for a factory for ten years. He describes his health as 70 percent as he doesn’t have much time for exercise (playing football with his friends), and has chronic back pain from driving. He has numerous cards – SSS from the factory, a local government officer’s card^{xvi}, and GC, which he never uses. When he’s in pain he buys medicine from a general store, which only takes “three minutes” compared to a whole day to get equivalent medicine from the doctor. He prefers the shop to hospital, as although the latter is free (medicine from the shop costs 50 THB), you can spend a lot of time waiting and just get paracetamol. He sometimes uses the district or provincial hospitals, but they’re very busy and the ‘officials’ are often rude and abusive, and don’t seem motivated to serve people. He also uses a private clinic, because it’s faster than the hospital, buys traditional medicine in ‘modern’ capsule form, and has regular traditional massages. He feels that

Good health is very important to my life because if you have good health you can plan good things for your life, it’s easy to sleep. (...) You can work hard and aren’t easily tired (...)

you're not anxious, not serious. If you're sick you need to spend a lot of money to go to the doctor, and become anxious about spending this money, you're not happy

He looks after his health by taking care over what he eats, for example, growing organic vegetables or washing non-organic thoroughly to remove toxins, and drinking milk.

Mai is a relatively wealthy Buddhist woman in her twenties who lives with her parents in Southville_peri. She described her health as 90 percent, because she rarely goes to the doctor, however, she has worked at a factory making rubber gloves for eight years and worries that the chemicals might have affected her. She links good health to wellbeing because

If you have good health you can work for your family; I don't need to worry about anything because I work and earn money for my family so they don't need to borrow from other families

She explains that she keeps healthy by eating food from the "five food groups", but doesn't have time to exercise because she works late shifts. She also has fun with her friends, and gets good advice from her parents. When she feels ill, she usually takes paracetamol, and if she doesn't get better goes to the new PCU or a clinic where she can use her SSS card. She doesn't use the hospital (it's too far away and the queues are long), or traditional medicine.

Noi is a poor Buddhist woman, also in her twenties, who lives with her mother-in-law and young baby in Noreastville_far. She describes her health as 50 percent because she always has fevers, exacerbated by the leaky roof, and gets stomach pain because she doesn't eat regularly. Although she has a GC, she has to pay travel costs, which in Noreastville_far are fairly high. She regards sickness as normal ("it's natural; the Lord Buddha told us"), but feels that "if we are healthy we are strong, we have wellbeing". She keeps healthy by walking every day, praying, and trying to eat well, although their monthly household income is only 200 THB. She also boils fresh herbs to strengthen her body, which are collected for her by an old man who lives near the forest. If she is very sick, she goes to the PHC or hospital, but finds the staff uncommunicative ("he just gave us medicine, he didn't ask what happened"), although the treatment is usually effective. She has also been to a private hospital about her stomach pain, which cost 500 to 600 THB for medicine and 140 THB for travel. Although the medicine was effective, she felt pain when she ate chilli while taking it, which was a problem as their diet is primarily *nam prik* and *kao niaw* (fermented chilli paste and glutinous rice).

Mai Bhun is also from Noreastville_far, and is a medium-poor Buddhist woman in her late forties. She has low blood pressure, which she treats with herbs. This is her main form of healthcare; she boils them to drink, inhale, and bathe in. She massages herself with muscular balm when she feels tired, and has purchased Chinese medicine for her daughter from a mobile vendor. She also eats local and natural foods like bamboo shoots, fish, and vegetables, and takes *Newpharmavit* vitamin

B complex, which her son sends from Bangkok. Mai describes health as good because “you eat well, sleep well, and your food tastes better”. She had a GC (the staff at the PHC asked her to get it) but it expired, as she never used it. She doesn’t like the district hospital because it’s slow, the medicine is poor quality, and the doctor speaks rudely to her and isn’t interested in her sickness. Neighbours have also had bad experiences; “here they don’t call it the hospital but *Long Pan* [ruined place]”. Instead she uses *Inter* private hospital, paid for by her children. She used the PHC once, but wasn’t happy with the injection she was given, so afterwards got a healer to ‘blow’ on the area (this is a popular traditional treatment used for measles and herpes where the healer blows or sometimes spits betel nut juice over the affected areas and says a prayer).

Pi Pek^{xvii} is a medium-poor Buddhist man in fifties, who lives in Northurban and works as a sweeper. He gives himself 70 percent, as while his health is good, he gets very tired because he goes to work at four am and then takes care of his grandchildren. He has chronic leg pain, which he treats by buying painkillers every two days from the general store, and an itchy rash on his arms. He has a GCE and SSS but doesn’t use them for himself, and nurses from the local PHC visit his grandchildren every month. Last year he was knocked unconscious in an accident and was taken to Sringerind hospital, which isn’t covered by either of his cards. The mistake cost him 1,800 THB, which he is paying it off at 100 THB per month, and he’s not sure if he’ll be able to get it back in the end. He has never used private healthcare, although his SSS card would cover it, as he can’t afford unexpected expenditures. Health is important to him because “if our body isn’t good we can’t think; if we have good health we can think and stay in a good mood”. He keeps healthy by exercising, eating good food, and drinking filtered water (previously they purchased bottled). He also takes coffee as a supplement and *Red Bull* while he’s sweeping. He has never used traditional medicine or massage.

The five case studies suggest a number of themes, for example, mixing of traditional and modern (even within ‘traditional’ medicine), widespread use of non-prescription painkillers^{xviii}, and low opinions of 30 THB health services. They also demonstrate the linkage of health with occupational and environmental problems, for example, tiredness and working a ‘double day’, headaches and chemical inhalation, and fevers and leaky roofs. Health is clearly important to work and fulfill family responsibilities, but has an equally valuable experiential dimension. The next section looks at the 30 THB health scheme in more detail, beginning with a brief description of how health status, SES, and type of coverage affect the main source of people’s healthcare.

Responses from the qualitative health research were coded and analysed with SPSS to produce a more detailed picture of people’s health care use, which is reported below and in table 1.4 (unfortunately the sample was too small and unevenly distributed to allow more sophisticated statistical analysis). ‘Healthy’ people are mostly likely to use self-care as their main source of

healthcare, while people with disabilities are unlikely to use private services, probably due to the cost (they are also slightly more likely to use traditional medicine, which may be related to their age). Poor people are also most likely to use self-care, and less likely to use private, but the difference is not as large as might be expected. This may be because poor people often have access to children's health assurance; however, the differences in the main source of healthcare by health coverage are not large either. The small percentage of people without coverage are most likely to self-treat, and don't use private care. People with SSS and CSMBS are most likely to use private primary care, but almost no-one uses private secondary care as their main source of healthcare. A further analysis explored whether type of coverage affected simultaneous use of government and private health services. Type of coverage seemed to have little effect on simultaneous use (11 percent of people with a GC were simultaneous users, compared to 13 percent with CSMBS). However, people with SSS and CSMBS were more likely to only use private services than people with a GC (CSMBS 44 percent, SSS 31 percent, GC 24 percent). The percentages for private secondary care were too small to draw any conclusion; however, the experience of using government secondary care for someone with CSMBS is probably so different (respect from staff, private room, etc) that it isn't necessary to pay for a private provider.

Many respondents reported substantial benefits from the 30 THB scheme, despite the problems described in the case studies and below. For example, the cost of medicine was covered for most chronic conditions, which was a great saving for respondents with hypertension or diabetes. It also reduced large and unpredictable healthcare expenses, with the exception of road traffic accidents. It appeared to have led to increased use of healthcare services, especially preventative, and older people felt gratitude towards the government, which was expressed in spontaneous donations (one elderly villager explained "I know I use a lot of money, maybe 1,000 THB, so I wanted to donate something"). Nonetheless, the use of catchment areas, which are required by a capitation-based scheme, was perceived as a significant limitation. This was because it reduced choice (for example, if a hospital that was well-known for a particular service wasn't in the catchment area), and didn't always make sense geographically. Rigid enforcement of the areas created problems for emergency treatment, and being treated out-of-area involved substantial bureaucracy. None of this was a problem for SSS and CSMBS card holders who had almost complete choice over provider and location, and were able to self-refer. A wealthy Muslim woman from Southville_peri described how before she left her job she always used Siantong hospital because "it's clean and quick. [...] I was very satisfied because every time I went there I got much better. With the GC there are always very many people and a long queue, but at Siantong there aren't many people". She concluded philosophically "when I used the social assurance card [SSS] it was good, but now I have no choice, so use the GC instead. It's okay; I have no choice so I have to say it's good".

Other respondents had difficulties registering (especially if their births had not been registered), transferring their registration on marriage or migration, and renewing expired cards. There were also exemptions for certain conditions and treatments, which made it difficult to calculate exactly how much an intervention would cost. For example, a wealthy garage owner in Southurban described how

I would have been covered by the GC for the (eye) operation, but would have had to pay separately for the lens, and also for the medicine given during the treatment, which is imported and very expensive. The doctor said it depends on you which one you want to use but made it clear that I would be better off using my (daughter's) private insurance

The lack of clarity over coverage and cost (for example, whether it would cover cancer treatment for another respondent's wife), and whether the scheme would be continued if *Thai Rak Thai* left power, reduced the potential psychological benefits from a 'universal' scheme.

Other concerns related to the quality of the service, for example, the long queues (described in the case studies), the quality of care, and the quantity and quality of the medicine, compared to that offered by the other cards. A middle-aged truck driver in Noreasturban observed that while he would still go to the hospital if he had a GC "the service might not be as good as with my social security card because you get a lot of medicine with the social security card and with the GC you get less" (he also noted pragmatically that "it doesn't matter because for 30 THB you can afford to go back and get more!") This related to a general perception of inequity where services for rich and poor were 'segregated', for example, people with CSMBS would automatically have a private room. A concrete example of this is "private obstetric practice" in public hospitals (used in over a third of births), where for a fee of between three and five thousand THB, women could ensure continuity of care throughout their pregnancy (Riewpaiboon et al, 2005). This option was rarely taken up by poorer respondents, not just because of the cost, but because they felt their dissimilar backgrounds and relative position in the social hierarchy made it unlikely that they would ever have a 'special relationship' with their obstetrician, even if they paid for it. Respondents also mentioned the apparently arbitrary allocation of the two types of GC, which was a concern for people who had previously had a non-contributory Low Income card. One of the main cultural barriers to acceptance of the GC was a general suspicion of anything free; a typical comment from a Muslim respondent in Southville was that while he personally didn't have a problem with the GC "if you want good service you need to pay for it, if you get it free it won't be good".

Sequential and parallel use of different types of healthcare appears characteristic of Thai health seeking behaviour; for example, traditional medicine users described how they would get a diagnosis first, and then use both systems in parallel, or turn to traditional when conventional medicine had little to offer (e.g. after a stroke) (see also Nilmanat & Street, 2004). Traditional medicine has now entered the mainstream (for example, University centres of Thai Traditional

Medicine), and many healthcare workers are attempting to record and conserve traditional knowledge (Del Casino, 2004). Similarly, while there was less enthusiasm for 'traditional' traditional medicine among younger people due to the difficulty of preparation and associated food restrictions, there was increasing interest in traditional medicines packaged like pharmaceuticals, or from other cultures. Although a few people talked about their medicine use in the context of traditional beliefs, for example, the need to balance fire, wind, and water in the body, and get 32 completed organs, most people used medicines independently of the associated medical system, whether traditional or biomedical.

One benefit of traditional medicine, which is familiar from literature on TCM worldwide (e.g. Cant & Sharma, 1999), is improved communication. Many respondents described difficulty in communicating with healthcare workers because they were conscious of their low status, and lack of education, and felt *kreng jai*^{xix} to ask for more information, even though this is now a statutory right (see also Riewpaiboon et al, 2005, and Jongudomkarn et al, 2006). Doctors who had been educated within a Western influenced health system found it difficult to relate to the beliefs and experiences of their patients, for example, one Muslim man from Southville described how he went to a healer three years because he was "afraid of everything around me", and felt "anxious and very cold". He initially went to a hospital but "I think the doctor didn't understand my problem; he just gave me medicine to make me sleep, which I didn't take". Nonetheless, a few people felt that 'the world moves too fast for herbs', and that now there is a modern health system, people should use this instead, especially if they've moved to the city and adopted a 'modern' life style.

Conclusion

The discourse of holistic health extends the singular *sukha-pap* to a multiple *sukha-pawa*. While this transition could potentially aid our understanding of health as contextual and multiply determined, it could also have the reverse effect of individualising and disembedding our understanding of wellbeing. This is because contemporary health discourses are characterised by a focus on individual attitudes and behaviours (for example, raw fish consumption in the Northeast), which make little sense outside particular socio-cultural contexts. Redefining a social problem such as the high accident rate as a 'risk factor' effectively depoliticises it, and shifts the focus from the promotion of car ownership, to motorcyclists who fail to wear their helmets. It makes it possible to ignore the contradiction between on the one hand condemning drinking, and on the other promoting locally produced alcohol for export, and allowing an alcohol 'free market' to stimulate domestic demand (Thakhsapon Thamarangsi, 2006, p.783). Similarly, poor diets can be attributed to individuals making the wrong choices, without acknowledging that choices are limited (it isn't possible to 'choose' chemical-free vegetables), and constrained by lack of time and money.

To most respondents, however, health was not intrinsically interesting, and a marker of good health was its invisibility. This suggests that the best health seeking strategy is one that is quick and effective, even if it costs more. As material and 'time' poverty usually go together, poor people are likely to continue using over-the-counter and private medicine in preference to the 30 THB services. While the healthcare reforms have greatly increased coverage, there is as yet little evidence that they have changed patterns of use, substantially reduced household expenditure, or increased satisfaction. For example, there were marked differences between the availability and quality of facilities in the WeD sites, and also a lack of capacity and confidence in primary care, which suggested that the shift to a primary-led service might have been premature (Towse et al, 2004).

Further research on the meaning of health (not reported here) suggested that health also had multiple meanings for respondents – not only was it a basic capability and a resource that could be 'spent' to secure better economic outcomes, but it was also a precondition for community participation, and played an important role in attaining social, cultural, and spiritual wellbeing. Thailand is a country almost as well known for its inequality^{xx} as its remarkable economic growth, and these inequalities affect both exposure to risk and access to health facilities (for example, regional differences in the numbers of doctors and available beds). Currently the Universal Health Coverage scheme is in danger of entrenching these inequalities rather than reducing them, partly due to people's perceptions of the quality of its services. However, the international attention it has received suggests its future is relatively secure, and with a substantial increase in per capita funding (at least equivalent to that given to the CSMBS, which is likely to contain people with fewer health problems), it could begin to make a difference not only to people's physical and material health, but also to their wellbeing.

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Tables and Figures

Table 1.1: Description of the sites (summarised from the WeD Community Profiles)

Site	Noreastville far	Noreastville near	Southville	Noreastville peri	Southville_ peri	Noreasturb an	So
Distance to town	36 km	9 km	4 km	17 km	10 km	-	-
Landscape	Highland, in National Park	Forest & seasonal marshland, on flood plain	Lowland with small hills & forests	Mostly highland, some paddy	Plateau (forest) & lowland (paddy)	Slum on railway land	We res Ea on lan
Population (hh)	770 (173)	407 (67)	1,849 (369)	935 (175)	1,733 (479)	800 (163)	7, (1,
Pop. density (rai per head)	3.1	10.3	1.9	1.9	3.6	0.009	0.0
% aged 20-60	62.3	57	26.2	59.1	52.4	46	NK
Main employmt	Agriculture (cassava, some rice for household)	Rice farming, primarily for household	Agriculture, primarily rubber, some chillies	Agriculture, primarily rice	Agriculture (rubber, some rice for household)	Manual labour	Se inc
Other employmt	Gathering wild products, petty trading, labouring, cattle rearing, rubber tree cultivation ^{xxi}	Gathering wild products, home-work from clothing factory, cultivating fish, basket weaving, livestock	Factory work, civil service, state enterprises	Home work from fishing industry, labouring, trading, livestock	Factory work, labouring, trading, service sector	Selling prepared food, work in factories, shops, and on building sites	La dry ma tra
Annual household income*	107,240 THB (\$3,351)	388,513 THB (\$12,141)	492,983 THB (\$15,406)	348,865 THB (\$10,902)	1,317,125 THB (\$41,116)	159,747 THB (\$4,992)	50 TH (\$
% Muslim	-	-	70	-	50	-	30

*WeD-Thailand I&E data analysis, June 2007. The national average reported in UNDP 2003 was 143,856 THB (\$4,496)

Table 1.2: Facilities reported by respondents to the qualitative health research, WeD 2005
(percentage of respondents reporting use of these facilities)

Site	Government Health centre	Clinics	Government hospital	Private hospital
Noreastville_far	2 (next villages), (40%)	2 (in village & next district) (24%)	1 district, 1 provincial (74%)	1 in next district (24%)
Noreastville_near	2 (next village, Roi Et) (44%)	1 in Roi-Et (22%)	1 district, 1 provincial (50%)	1 in Roi-Et (25%)
Noreastville_peri	1 in next village (55%)	~ 10 (next villages) (61%)	2 district, 1 tertiary (49%)	2 in Khon Kaen (9%)
Noreasturban	4 nearby (61%)	~ 5 nearby (33%)	1 provincial, 1 tertiary (61%)	2 nearby (3%)
Southville	2 (next village & district town), (27%)	~ 4 (district town & Hat Yai) (58%)	1 district, 1 provincial, 1 tertiary in Hat Yai (85%)	2 in Hat Yai (9%)
Southville_peri	1 in village, 35%	~ 2 (Hat Yai) (50%)	1 district, 1 provincial, 1 tertiary (both Hat Yai) (74%)	2 in Hat Yai (15%)
Southurban	2 (own & next community) (30%)	~ 6 (1 local & nearby) (82%)	1 district, 1 provincial, 1 tertiary (61%)	3 nearby (12%)

Table 1.3: Incidence of Disease: National and Regional, MoPH 2003
(In: WeD Northeast and South Statistical Booklets, 2005)

National and regional – per 100,000 people	National	Khon Kaen	Mukdaharn	Roi Et	S
<i>Cancer</i>	101.7	125.9	17.4	109.3	
<i>Heart Disease</i>	451.5	58.0	28.2	16.1	
<i>Diabetes</i>	380.8	NA	4.1	16.6	
<i>High Blood Pressure & Cerebrovascular conditions</i>	389.8	47.8	2.4	2.3	
Rate of illness - overall	1,845.0	575.0	256.0	155.0	

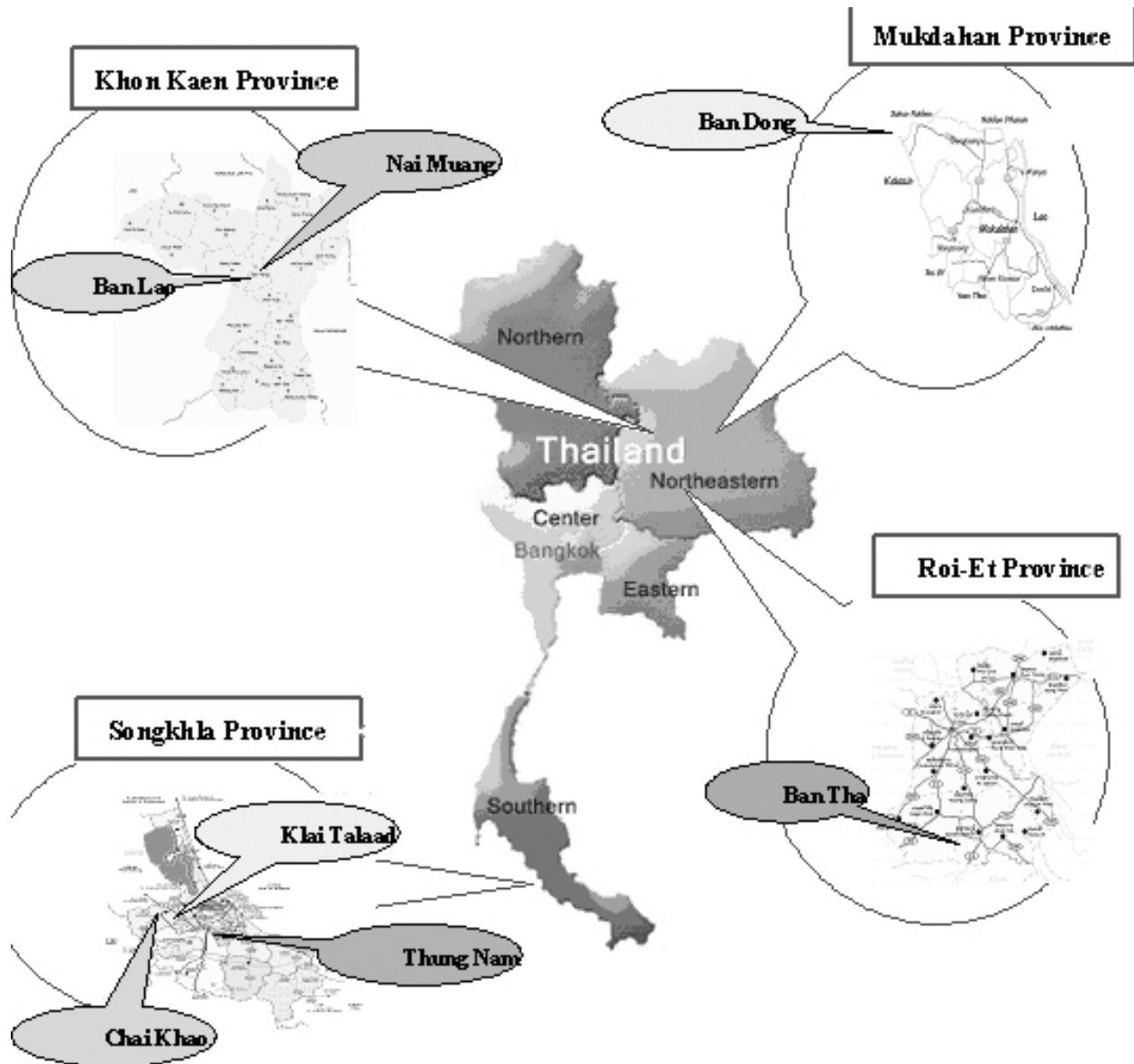
Bold = higher than national average

Table 1.4: Percentage of respondents describing this as their main source of healthcare

Main source of healthcare	Self-care	Trad. Med	Govt. Primary	Priv. Primary	Govt. Secondary	Priv. Secondary
'Healthy' (n=165)	54	3	16	18	9	1
Chronic Illness (n=47)	32	6	21	21	19	-
Disability (n=27)	58	8	19	8	8	-
Poor (n=99)	56	4	18	13	8	1
Medium (n=55)	42	7	11	18	18	-
Rich (n=85)	48	1	20	21	8	1
Nothing (n=8)	75	-	13	-	13	-
GC (n=181)	49	4	20	15	12	1
SS (n=16)	38	-	19	31	13	-
CSMBS (n=18)	56	-	11	28	6	-

WeD qualitative health research, 2005

Figure 1: Map of the sites



ⁱ The Wellbeing in Developing Countries ESRC Research Group (WeD) studies poverty, inequality and quality of life in developing countries - see www.wellddev.org.uk.

ⁱⁱ TRT was led by Thaksin Shinawatra, a wealthy telecommunications entrepreneur who capitalised on the growing antagonism between GoT and the rural electorate, and the frustration of small business owners.

ⁱⁱⁱ The quantitative primary data is predominantly from RANQ, supplemented with statistics from the qualitative study. Secondary data is drawn from recent reports on Human Development and the Millennium Development Goals, and a volume of provincial and regional statistics compiled by WeD.

^{iv} See, for example, the Thai Health Promotion Foundation at <http://www.thaihealth.or.th/>.

^v Prof. Wattanachai is a privy Councillor who was proposed as interim Public Health Minister (Bangkok Post, Sept. 2006).

^{vi} NESDPs are five-year development plans that are created, implemented, and monitored by the National Economic and Social Development Board.

^{vii} Capitation is a fixed prepayment, per patient covered, to deliver medical services to a particular population.

^{viii} A PHC is the lowest level of formal healthcare; usually staffed by Community Health Volunteers, it only gets weekly or monthly visits from a doctor. A PCU will have resident nurses, a doctor, and occasionally even a dentist.

^{ix} There can be some confusion between these categories as government primary care facilities are often sited in hospitals, for example, Southville, which may account for the fact that 85 percent of respondents in Southville said they used secondary care, but only 27 percent used primary. This may balance out as many younger respondents had never been sick enough to be hospitalised.

^x The DALY is calculated at the population level, and is the sum of years of life lost due to premature mortality, plus the 'healthy life years' 'lost' through disability.

^{xi} In February 2003, the Thaksin government instructed police and local officials that persons charged with drug offences should be considered "security threats" and dealt with in a "ruthless" and "severe" manner. The first three-months of this campaign resulted in 2,275 extra-judicial killings (Human Rights Watch, 2004).

^{xii} These have been recorded for the four conditions that the government considers to be current priorities

^{xiii} 63 percent of respondents to the health study reported health problems, from cancer to work-related stress. However, there was an inherent bias as a quarter of the sample had been selected because they were chronically ill or disabled.

^{xiv} See Clarke 2006 for a description of the Asset Index methodology.

^{xv} Merit enables Thai Buddhists to reduce the accumulated *karma*, or traces of previous existences, which can hold them back from enlightenment.

^{xvi} Elected local officials (for example, the village head) are not paid, but receive free govt. healthcare for themselves and their family.

^{xvii} In fact, Pip Pek could have used either card in this situation, however, the point of the story is that neither he nor the attending healthcare workers were aware of this, and this caused him much subsequent distress.

^{xviii} In 2002, drug consumption accounted for over a third of national health expenditure, compared to 10 to 20 percent in industrialized countries. A quarter of this was unsupervised consumption from general stores, as described above (Wibpolprasert, 2005).

^{xix} *Kreng jai* is a very Thai concept that merges courtesy and consideration, with reserve, respect, and fear of giving offence.

^{xx} For example, for example, its GINI coefficient increased from 41.4 in 1962, to 53.6 in 1992, although it had reduced to 43.2 by 2000 (a GINI coefficient of 0 represents perfect equality, and of 100 perfect inequality).

^{xxi} Rubber trees have only recently been introduced to Noreastville_far, but their cultivation is expanding rapidly.