Stages of Seeking Medical Care: Empiric to Quantity

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ABSTRACT

This paper discusses the stages of medical-seeking behavior of Thais in a context of pluralistic health care system. Thais are generally involved with both modern and traditional health treatment and seek medical care from various sources of government and private practices when they are ill. Within a single illness episode, Thai patients are more likely to change sources of medical care, ranging from lay treatment to highly-professional medical care. Interestingly, this so-called "switching medical care pattern" seems to be more focused and narrowly involved around highly-professional care, i.e., government hospitals and health centers, as the illness prolongs. This is clearly predominant among rural and poor patients. It is suggested that with a main stream of privatization and structural adjustment of health care, health care should be excepted from the globalization drive, and that health policies of Thailand should be relevant to the poor and rural majority. The information of this paper is based on the results of a research project entitled "Utilization of Government Health Care Services in Thailand, 2003" which was financially supported by Thai government funds. Methods of the investigation of the research include a structured questionnaire and in-depth interview.

PLURALISTIC HEALTH CARE SYSTEM

In Thailand, health care system is pluralistic, ranging from government to private practices, traditional to modern/western medicine and lay to medical professionals. When a person has an illness, he/she can obtain health care and treatment from several sources of medical care, including self-treatment/self-care, consulting lay professional and significant others, drug-store, traditional practitioner, health center, clinic, community and provincial hospital as well as polyclinic and university hospital. In fact, the predominant source of health care among Thais has been self-treatment and the use of drug-stores in which these sources are associated with lay professionals and tradition.

HEALTH PROFESSIONALISATION

Professionalization in health care here refers to the classification of health practitioners, including professionals and non-professionals. The sources of health care are arranged from low to high levels of medical treatments, regarding to the body of knowledge and outcomes of the treatment. Degree of this classification is based mainly on both the qualification of health providers and level of social relationships between the providers and clients. The sources of health care services indicated above are therefore ranked in terms of professionalization. That is, the lowest level is self-care/self treatment, and then increasing up to higher levels, i.e., drug-store, traditional healers, health center, private clinic, community/ district hospital, private hospital, regional and university hospital, respectively (Figure 1). It

is well accepted that university hospital, where advanced medical technologies are equipped, is the highest level of the qualified treatment but more socially-distant to clients. Specifically, health professionals who are affiliated with government health system and obtain modern medical practices, are given a special status while lay professionals and self-care being considered as lower statuses. In sum, a physician is the highest and drug-stores are lower. Among the physicians, those working with university hospitals are higher than doctors working in provincial hospitals and clinics. The basic distinction between lay professionals and medical professions is that the latter makes physical examination whereas the former only asks about the symptoms.

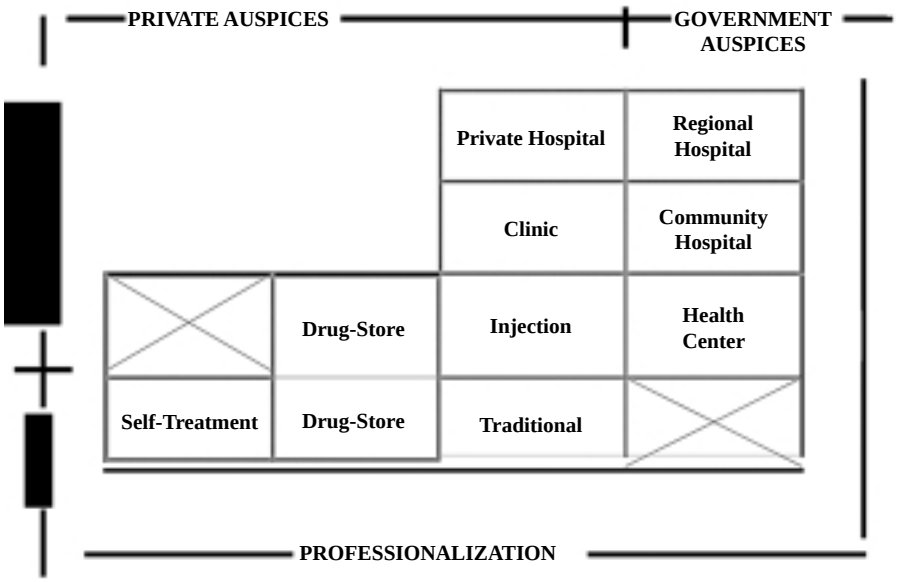

Figure 1. Levels of Health Professionalization.

MODERN AND TRADITIONAL MEDICINE

The institution of traditional medicine was esteemed in the past and traditional healers were respected. The role of traditional healers was integrated into community, religion and culture. Today, traditional healers are disappearing. In a village where traditional healers once performed the medical treatments for rural folks, many stopped providing the practices. When these traditional healers die, it is hard to locate a single traditional practitioner or their children to look after the practices. Although the government has recently attempted to support the benefit of the traditional medicine by establishing Traditional Medical Department under the Ministry of Public Health, only a few traditional healers practise due to the rank-and-file status of these traditional practitioners in modern Thai health care system. Modern medicine, in contrast, came about 100 years ago from the more-developed societies of America and Europe and then became believed to be more effective and efficient. Technologies and equipment of modern medicine, including antibiotics, surgery, vaccination, x-ray, blood test or urine test as well as computerized and digital medical machines, have helped further the favor, preference and also superiority of modern medicine. In contrast, traditional medicine lies to religious practices, magic and superstition as well as herbal mixed medication. Modern medicine and treatment are therefore requested and patients would feel dissatisfied with the treatment if they are not given. Modern health personnel are regarded and respected as they utilize modern medical technologies and their treatments are more justified. All of the government health care services are therefore staffed by modern medical and health workers,

i.e., medical doctors, nurses, midwives and sanitation workers.

The dichotomy between traditional and modern medicine is clear. When people are asked, modern medicine and treatment are preferred. The belief in modern medicine, as discussed, comes from three main components; (1) medication, (2) treatment tools and (3) personnel. With respect to the latter, modern health providers have been trained in a formal training, i.e., 4 to 6 years in medical and health schools and also granted by the government the right to perform health care treatment. For traditional healers, the health care practice is still restricted by scientific arguments and therefore abstinence from the public. Interestingly, the expense of traditional treatment is economically small while that of the modern medical care is high and expensive. Traditional healers begin the treatment with a brief traditional ritual to their Guru. The expense of the treatment is therefore made for the Guru cost. The offering cost is low and sometimes there is no need for patients to pay more than this initial amount. On the other hand, the expense of modern medical service includes more than one item. It is generally made based on medical fees, treatment fees, x-ray cost, blood test and other medication and technological costs. These do not include traveling cost and cost of absence from work (Figure 2).

Modern vs. Traditional Costs of Treatment

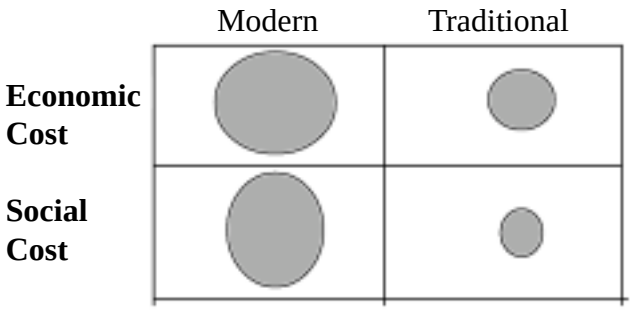

Figure 2. Costs of Health Treatment.

GOVERNMENT AND PRIVATE PRACTICES

The status of a government and a private position had different advantages and privilege. The benefits of the government position come from the special social status associated with bureaucrat rankings, work security and social power. While private position has relatively more subordinated roles, the practices of private health care are therefore more community-oriented and public-serving minded. In opposite, government duties tend to be more restricted by rules and regulations, bound up with red-tape. The patients may spend all day in passing the bureaucratic channels, hurdling ten desks of interviews at dawn before coming to see government physicians for only three to five minutes at noon. In contrast, a service of the private health care is more accessible and provides quick services. Workers of the private services are efficient in serving the clients but the same person could be difficult to deal with if he were in the government post. However, the role of the private practice has its notoriety in terms of money business. Since modern medicine has been integrated into the government system, the social communication between modern health care professionals and the patients is a one-way traffic, i.e., top-down hierarchy. It is difficult to see patients asking some questions about doubts, or making an argument with government health personnel. During a clinical interview, passive patients is good patients and those who dare to ask questions are labeled as talkative “red buster” patients. The verbal communication between government health professionals and patients is sometimes problematic. It is quite common

to encounter mis-understanding by the patients following the consultation with the physician.

In traditional health care, social relations between these two parties are two-way communications. Patients feel more free to ask many questions and traditional practitioners are called in kinship term, connoting close family relationship, e.g., auntie or uncle. As a result, a government health care is therefore tied with social-distance problems (Figure 3). These problems include waiting time, discomfort feeling and government health care providers do not give enough time to the patients. Different language between government health care providers and patients create more negative attitudes towards bias in the treatments. It is well stated that government doctors, for example, prefer to treat urban and educated persons (Cohen, 1989). Patients who have no economic resource and education are those with poor health condition due to in- accessibility to government and modern health care services.

In the first decade of modern health care development in the country in 1960, government health service was very burdensome with bureaucratic environments and official personnel mind-set. The performance of the government health care to provide services of high quality was in-obtainable. Statistics of health care utilization in 1970 indicated that the use of government health care was grossly underutilized (Sermsri, 1989). When compared to traditional treatment, government health centers were found to be less-used, although as mentioned earlier, the preference to modern medicine was prevailing. The economic and social costs of government health care are therefore high. In 1978, a year of primary health care implementation, government health care was revitalized, reducing both economic and social barriers, allowing the rural and poor majority access to government health treatments. The utilization of government health care has been then increasing.

Social Relationship

Types	**Health Care System**	**Government System**
Old Thai	**Health Practitioners** ↕ **Patients**	**Government Officials** ↓ **Ordinary People**
Modern Thai	**Traditional Health Practitioners** ↕ **Patients**	**Modern Health Care Providers/Physicians** ↓ **Patients**

Figure 3. Social Relationship between Government Health Care Providers and Patients.

In 1997, an economically-liberalized health care was introduced to run the government health care services. This new paradigm of health management and structural changes are moving the quality of the government services. It is anticipated that the structural adjustment will again impose the use of the poor and rural majority folks. Government personnel may be working in health care inadequate for the poor. As such, a health insurance coverage, especially for the poor and rural majority, has been operated in order to reduce the difficulties of the poor in accessing decent health care services. The aim of this universal insurance coverage, a so-called “30 Baht program” is therefore to remove the economic barriers to government health care services. This popular 30 Baht program or gold card program has

been on-going and become most-preferred means to access government health care services since then.

METHODOLOGY

The research is a community-based study. Two research methods are employed to collect the information, including constructed questionnaires and in-depth interviews. Two districts and one sub-district in neighboring provinces of Bangkok were selected according to the research objectives on how poor people in rural areas choose health care services. The studied communities chosen have various sources of health care available, ranging from self-treatment, drug-store, health center, private clinic and private hospital and government hospital as well as university hospital. A total of 86 questions of the survey tool were constructed and employed. An in-depth interview technique was utilized to probe the details of seeking health care services. An interview was conducted to ask both women and men available from January to March 2002. The interview took 45 minutes on average per respondent. With the research aim, one person in each family was interviewed by trained interviewers. The interview started with a few screening questions. Was any one in this family ill during the past three months? If yes, the interview continued. But if no, a member from a new family would be sought out. The meaning of illness was also clarified and conveyed to the respondents. Illness was based on a so-called health-status-perceived concept. The illness causes a person to take a leave of absence from work one or two days. A total of 743 interviews in the studied communities were completed. Afterward, in-depth interview techniques took place in the whole month of June 2002. Two field research assistants went to the studied communities twice a week to conduct the details of illness experience and the use of the government health care services.

ILLNESS BEHAVIOR

Patients in Thailand are more concerned with symptom of illness than the causes. Illness is named according to the symptom appearance and medication is called as medicine for treating the actual symptom. Explicitly, a flu is “hot body and cold” fever and medicine used is to reduce hot and treat a cold. In order to understand the choice of medical care when illness appears, three main discussions above will exemplify the following narrative on stages of seeking medical care services. It should be noted here that a medical-seeking behavior is an illness behavior, not health behavior (Cockerham, 1998). It is the purpose of this paper to explain how people select among the alternative sources of health care. In Thailand, patients can choose freely variegated alternative. They can switch from health care practitioners including non-professional to medical professionals and they may patronage several medical care services until they are satisfied with the results of the treatment (Figure 4).

Health Seeking Behavioral Pattern

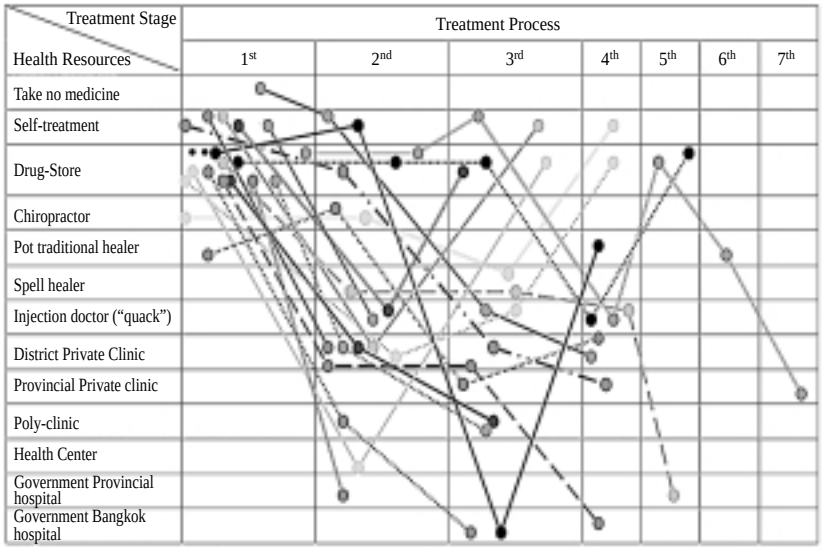

Figure 4. Health -Seeking Behavioral Pattern.

Selection of medical care services definitely depends on interpersonal network. As symptomatic condition is so concerned, the desire for quick symptomatic relief provides a motivation for seeking the best-likely source to cure the illness and also a cheap expense in terms of money and time spent. If a given source does not produce symptomatic relief with as short a time as one or two days, it is usual for a patient to seek help from another, with or without dropping the first one. In choosing the best-likely source of medical care, a patient will consider a place where economic and social costs are less. In other words, people will think how much money and time they have. The following cases come from the earlier observation work of the author (Riley and Sermsri, 1974) which show how people seek medical care in rural villages. Mr. A got illness. He started buying a medicine from a drug-store and used it in the first day. In the second day, the symptom had not gone and some body suggested another kind of medicine. He then went to obtain another medication from the drug-store. Only a day , his illness was still prevailing and he was given another kind of medication from his wife. He then was in "a stage of self-treatment". He decided to go to an injection doctor when he knew a reputation of the para-medic person who offered a treatment nearby. Two days later, he went back to buy another medicine from the drug-store and it was a short time he received a treatment from a traditional healer in his village. Finally, he went to clinic in town as the symptom was still critical and finally the symptom had gone. He therefore recovered. Mr. B was a young farmer and got ill. He used his family medicine which was left over from previous illness. A day later, he bought drug from a drug-store and used it only for two days before deciding to go to clinic in a district town. The symptom had not gone after the first clinic treatment for only a day and a half. He then went further to the second private clinic in a city. This time, the symptom was gone and he then stopped using the medication. Probably, credit of the treatment generally goes to the last source/last provider. With respect to a dot, when illness is perceived, one gets drug from a drug-store. Subsequently, he/she recoveres and stops using the medicine, meaning the symptom is gone with a single act of the treatment.

From the discussion above, the behavior is called "a pattern of switching medical care". In a single simple illness episode, it is to conclude that one source of medical care is not one illness. In order to understand this concretely, the researcher should not ask question about seeking medical care that implies a single visit to health care service for a single illness

treatment. The information on seeking medical care therefore becomes quite complicated, covering a wide range of stages of seeking care. Question should include more than a single activity/stage. It should ask “When illness occurs to you, what do you do at first in treatment?” Then , the interviewer continues about what is next act and the third and so on in a single illness episode. In addition, other kinds/types of illness, i.e., chronic, accident or injuries and labor, should be excluded from this simple illness episode. This research has set up this guideline. The interviewer of this research started with a first question “Within the past 3 months, did you yourself have an illness that hindered you from working or taking an absence from regular activities (or from going to school) in one-two days?” Then, what did you do? Where did you go or get the care and who was your healer? And, what is next if the illness is still prevailing? This question has been repeated up to four or five times. Table 1 provides a result of this interview on seeking medical care.

Table 1. Percent on Stages of Medical-Seeking Behavior, 2002.

Types of Health Care	Stage 1	Stage 2	Stage 3
No treatment	25.6	0.3	2.0
Drug-store and self-treatment	29.8	5.4	0.0
Traditional practitioners	0.2	0.3	0.0
Health center	12.0	20.9	11.7
Government hospitals	23.3	59.7	72.5
Private clinic and hospitals	9.1	13.3	13.7
Total Number of Studied Cases	519	315	51

As expected, self-treatment and drug-store get a large share of the medical care services among the studied poor patients. Both sources are the least professionalized where the economic and social costs are lowest. A large proportion of the patients, 29.8 percent, visit drug-store and do some self-treatment. Since the studied patients are generally poor persons, several factors concerning accessibility of medical care could explain why many take no-treatment when illness appears. Interestingly, the use of government health care services, including health center and community and provincial hospitals, is large. About 35.3 percent of the patients visited government health care as needed. The need factor is a function of the amount of illness or the severity of illness. Also, the availability of the health insurance coverage “30 Baht program” plays an important role in increasing the number of patients in government health care services. As mentioned above, the government health care services have been improved through more effective management and the provision of insurance coverage, especially for the poor in recent years. Both red-tape of the government health care has been solved and economic cost of the treatment has been reduced to a small threat to accessing. These make the government health care preferable. For traditional practitioners, a very small number of the patients make a visit to this traditional health care although this traditional care is less expensive. But to-day it is difficult to locate a type of traditional health practitioners in villages of the country. As government health care for the poor is presently more accessible, private clinic and private hospital get only a small share of the medical use. In other words, government health care becomes a main focus among the poor and rural villagers, and this predominance of government care gets clearer when the illness takes longer (column 2, stage 2 and 3). That is, a majority of the patients, around 80 percent make a visit to government health centers and hospitals in the second and third stage

of seeking medical care. From this, it suggests that with a main stream of globalization along with privatization, national health care, particularly the government health and medical care system, should be made relevant to the poor and rural majority.

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