Fairness[1] in Access to Health Services[2] by the Disabled[3]

Background and current situation

1. The World Health Organization (WHO) stated that 10% of the world's population are disabled people[4], and 80% of these people are in developing countries, and that they comprise the poorest of the poor[5]. Important causes of disabilities are: war related injuries, from violent situations, natural disasters, accidents, illnesses from HIV/AIDs, and chronic diseases.

2. In Thailand, the tendency is for the number of disabled and dependent people to increase. This is due to a change in the way of life and social context to that of a more modernized society, which in turn results in a change in the nature of illnesses. The point is substantiated by statistics of people injured in accidents, on cancer incidence, and on illnesses from chronic diseases such as diabetes, high blood pressure, heart diseases, cerebrovascular diseases, all which has shown a continuing increase to become important diseases of Thai people in the current era. Other factors working to increase the incidence of disability are the increasing use of narcotics, hyper or over nutrition, obesity, lack of exercise and transition to an aging society. These result in more opportunities for people to become disabled and dependent on others[6 7 8]

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[1] Fairness means receiving healthcare services in an appropriate manner befitting the individual's needs, and without obstacles in the provision of the service, in the budget, in terms of area where the service is provided, in terms of limits to the type of disability and its degree of severity (we are talking here about sufficiency and a just situation)

[2] Health services means "public health services" as stated in Section 3 of the National Health Act B.E. 2550 (2007). The meaning of these terms is the same as in the words "health system" and "health" contained in other sections of this Act.

[3] According to the Promotion and Development of the Quality of Life of Disabled Persons Act B.E. 2550 (2007), Section 4, disabled persons are individuals who face limitations in the conduct of their daily routine or in social participation, due to impairments or to various obstacles. The Act divides disability into 6 types: 1.sight handicap, 2.disability in hearing or communication of meaning, 3. mobility or physical handicap, 4. mental or behavioral disability or being autistic, 5. disability in intelligence, 6. learning handicap. That is, the Act sees many types of disability occurring and with different degrees of severity which leads to different types of problems and different health needs.

[4] 58th World Health Assembly Document A58/17, 17 April 2005

[5] *Disability, Poverty and Development*, Department for International Development (DFID), February 2000.; E. Helander, *Prejudice and Dignity; an introduction to community based rehabilitation*, UNDP, 1992.; Ann Elwan, *Poverty and Disability; a background paper for the World Development Report,* World Bank, October 1999.

[6] http://bps.ops.moph.go.th/index.php?mod=bps&doc=5 ,

3. A survey by the Thai National Statistical Area Office in 2002 found that Thailand's population of disabled people was 1.7% of the total population, and this increased to 2.9% (or to 1.9 million people) in 2009. Out of this latter number, it was found that 2% clearly had either abnormalities or impairments in physical, mental, or intelligence aspects. Six percent found it difficult to help themselves, especially in performing daily routines. Some have more than one type of disability. Note that the survey did not include he population aged 0-7 years old. It is believed that considering this exclusion, plus the factor of definition of disability, the survey methodology, and the general trend in disability, the survey results are an understatement of the magnitude of the phenomena.

4. The survey also found that 3.4% of the people living outside of municipal areas were disabled, whereas inside the municipal areas, the percentage was1.6. The Northern part of the country is home to the highest number of disabled persons (4.4%), followed by the Northeast, South, and Central, in that order (3.5%, 2.2%, and 1.7%)

5. From the same survey, it was found that out of the disabled persons in school age (meaning aged 5-30 years old), 81.7% were not students or have never studied. And 46.8% of the disabled who were of working age (15 years old upwards) were not working. Also, in general, it was found that only a small proportion of disabled people received assistance or welfare from the state. Most also lacked the opportunity to develop their quality of life especially with regards to education, occupation, and the chance to receive appropriate disability assistive devices. Most were left to live with family and to fend for themselves as best as they could.

6. In order to build social awareness of the human rights of the disabled, an international day of disabled persons was declared by the United Nations on 3 December 1981, to be held every year. This was followed by an action plan aimed at creating equal opportunity for the disabled to participate in the wider society. A United Nations Resolution was also issued on 4 March 1994 laying down 22 standard operating principles, in order to achieve the action plan[9]. The resolution specified some conditions that must be present first if equal opportunities were to be realized. These are: a realization that disabled people have a right to human dignity and additional rights specific to a disabled person; that they have access to medical and rehabilitation services; that they are given support in assistive devices and the required social services, as well as other facilities to access such devices so that they can really use them.

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[7] Working group to study incidence of disease and injuries, Ministry of Public Health, *The Ranking of Health Problems of the Thai population in 1999 Using Disease Incidence indicators*, Journal of Public Health, year 13, 2nd issue (March-April 2004)

[8] Institute of Research and Development of the Thai Elderly Foundation, *Report on the Situation of the Thai Elderly in 2008.*

[9] UN-General Assembly Resolution on "Standard Rules on the Equalization of Opportunities for Persons with Disabilities", Document [A/RES/48/96]

7. The global trend of sympathy towards the disabled has led to an international acceptance that helping the disabled to achieve quality of life equal to that of the non-disabled, and assuring that they are not discriminated against, is a problem of human rights at the international level. The U.N. recognizes this point and issued a convention on the Rights of Persons with Disabilities (CRPD) on 3 December 1997, which is in effect an international legal instrument to protect human rights of the disabled in practical terms. The convention specifies basic concepts for the state to pursue in its policy and action towards the disabled. It is an approach that changes from one deriving from the idea of compassion and assistance, to one of affirming their rights and freedom and the protection of such. Thailand is a signatory of this convention and ratified it on 29 July 2008.

8. At the national level, the 2007 Thai constitution did make a reference to the need to protect the dignity of human beings and promote equality among individuals, as well as forbidding unjust discrimination for reasons of disability, of physical condition or health of the person (Section 30). The constitution also provided for the right of the disabled to access and utilize welfare services, facilities, state assistance (Section 54), and arrange assistance and welfare for the handicapped (Section 80(1). In addition, it stated that the state must act in accordance with human rights treaties that Thailand signed, this to include other commitments made with various countries and international organizations (Section 82).

9. The Promotion and Development of the Quality of Life of Disabled Persons B.E. 2550 (2007) defined a disabled person as someone with limitations in performing daily routines of living or in participating socially, due to certain deficiencies and obstacles.
The Act grouped disability into six categories: (1) disability in vision, (2) disability in hearing or communication of messages, (3) disability in physical movement, (4) emotional and behavioural disability or autism, (5) disability in intelligence, and (6) disability in learning. All this means there are many types of disabilities and different degrees of severity, which result in differences in problems and health needs.

10. Section 20 of the above mentioned Act spells out the basic rights of the disabled in concrete terms, which would open the way to achieving the goal of equal opportunity. Section 20 (1) refers to the right of the disabled to be rehabilitated by medical processes, to be covered in terms of medical expenses, of expenses for disability, assistive devices and communications aids to support development of the disabled. The aim being to enable the appropriate physical, mental, emotional, social behavioral and learning adjustments. In other words, to improve their capabilities. All in all, 26 items concerning disabled persons' rights are specified, and contained in the Ministry of Public Health Announcement on "Rehabilitating Disabled Persons' Capability through Medical Processes and Expenses for Treatment, for Disability Assistive Devices and for Media to Support their Development", announced on 30 September 2009.

11. As for basic laws on health, i.e., National Health Act B.E. 2550 (2007) and the Statute on Health System B.E. 2552 (2009) also placed importance on the idea of justice and social equality, their content indicating pursuance of the goal of developing a systematic approach to meet the needs disabled persons.

12. On the aspect of health security, the National Health Security Act B.E. 2545 (2002) and the Social Security and Compensation Fund Act B.E. 2534 (1991) contains principles that clearly cover disability and rehabilitation of capability to a certain extent. But in practice, the servicing of rights and benefits, and the management of mechanism of disbursements in accordance with such rights still suffer from stark differences and inequalities. For example, the right to claim financial assistance for hearing aids can differ between individuals by a hundred percent; or, there is a case where for the cost of treatment and rehabilitation of capability one assistance fund has a maximum of 2000 Baht per month to give out, whereas another fund gives the hospital or clinic the right to claim for actual expenses incurred; also, one assistance fund has a disbursement procedure where the disabled has to pay out of his or her pocket first for the treatment, then claim reimbursement later, which results in many disabled unable to access high price needed services or equipment such as above-the- knee prosthesis, wheel chair for the handicapped; while another fund allows the patient to get such services free of expenses. Thus, the result is the disabled are unable to access services with fairness. In many cases, needs are not serviced at all, or for some needs not enough services are there to meet them.

13. However, the Royal Decree on welfare funds for medical treatment of civil servants does contain the idea of medical treatment and cure, which could be taken to include providing for rehabilitation of capacity and of assistive devices to aid the disabled. However, because of the prevailing goal is generally to achieve an outcome of curing or limiting the extent of disability, the time span of service is thus limited. The thinking is not extended to that of achieving an outcome of increasing the capacity of the disabled by means of rehabilitation. Or in some cases, money and resources are wasted without achieving the end result of actually increasing the capacity of the disabled. So there is a difference in detail for each of the health insurance provisions, and the consequence is the disabled faces acute problems of fairness when accessing health services compared to non-disabled patients, especially when there is a change in the situation on rights.

14. It is found that the rehabilitation services provided by the 3 health security schemes in Thailand are different and not supportive for the disabled.

15. There is an integrated national mechanism called the National Commission for Development of Health Financing System responsible for providing advices to the Cabinet regarding the development of health financing system, policy, and structure in the country, including the amendments of laws and regulations related to health financing to be sustainable, updated and complying with current situation.

Facts concerning problems arising from gaps in accessing health services by the disabled

16. Up to 31 March 2010, it had been 15 years since the government started the process of registering disabled persons for the purpose of according them basic rights, and 1,081,938 had registered to receive what is legally due to them. But this amounts to only about half of the total number of disabled, as recorded by the National Statistical Office survey. Out of the people registered as above, only 695,470 disabled people further registered with the health insurance for all scheme (as of 31

March 2010), which is a clear indication of the existence of an inefficient mechanism in place in terms of access to rights and services. This can further be substantiated by the graphic pictures and description in the media of the disabled being abandoned to live in suffering.

17. Out of the total number of disabled as defined by Thai law, 53% are handicapped in their physical body and in their movement. Those who are disabled in their hearing and in communications ability comprise 15%, while those disabled in seeing 11%, those handicapped in intelligence comprise 14%, those in psychological and behavioral terms comprising 7%. More than 70,000 of the disabled have more than one type of handicap. The fact of many types of disability, result in different problems generated and different health support needs. And if one considers such variations with other complicating factors such as age, economic condition of the individual, religion, and place of residence, the end result is that we have a health system that currently can not cover all needs and cover them on an equitable basis.

18. The Office of National Health Security, started to allocate a budget for providing rehabilitation services for the disabled in 2004. A fund for medical rehabilitation was subsequently set up, and in the budget year 2009, it received a budget of about 5 Baht per person who qualified for assistance under the national health security scheme. This amount was increased in the budget year 2010 to 9 Baht per head, which translates to a total amount of 380 million Baht. But from the annual report of the Fund for the year 2009, it was found that only 54,840 disabled persons[10], which amounts to less than 10% of the disabled people registered with the national health insurance scheme, actually came to receive services. As for provision of assistive devices, only 9,421 disabled persons used such service, which is in line with the general picture we have of the disabled not being able to access health services even though they are covered by the national health insurance scheme.

19. From this same report, it was also found that out of the 382,409 times the services were provided, 70% had to do with rehabilitation of physical and mobility handicaps where most of the work done consisted of physical therapy, occupational therapy, and home visits of at least 1 visit per person. For other kinds of services performed: 4% were rehabilitation of those with hearing and communication skills disability; 0.4% were cases of rehabilitating those with sight handicap; and 25% involved mental and behavioral rehabilitation. As for disability assistive devices that were provided, as reported in the paper, they all were for helping in movement or mobility, namely, artificial legs, wheelchairs, and crutches, which indicates that the services provided are still lagging behind needs. They are not managed equitably in terms of meeting needs that are varied as befits the varied nature of disability.

20. The system for medical restoration of capability is one basic component in the necessary health services for the disabled. At present, such medical services are not sufficient and are not well developed to solve the health problems of the impaired population. This point can be seen in a study done by Orathai Kiewcharoen et al.

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[10] A report on the situation of care and rehabilitation of disabled persons under the national health security scheme, presented at a Fund for Medical Rehabilitation seminar, *“ Fund for Medical Rehabilitation in the New Era: Cooperation, Merging of Minds, Progress towards Universal Standards”*, 29-30 July 2010, Mae Nam Ramada Hotel, Bangkok

titled, “The Situation on Activities to Medically Rehabilitate the Handicapped in Thailand and its Assessment in terms of the Outcome”[11]. The study found that rehabilitation services were provided to only 2.8% of all out-patients, and to only 4% of all in-patients. Just 287 beds for disability patients were available in 14 center hospitals, in specialist hospitals, and medical schools. Moreover, the system can muster the necessary staff such as physical therapists and occupational therapists only at the proportion of 3.3% and 0.7% respectively per hospital (including community hospitals), while rehabilitation medical specialists and orthotic technicians can be found only at the level of provincial hospitals at the proportion of, respectively, 0.8% and 1.3% per hospital. In addition, virtually all the rehabilitation services are for caring of physical and mobility handicap only. At the same time, medical practitioners, family physicians, and nurses that are the core human resource of the health system, especially at the primary healthcare level still lack the additional knowledge and skills required to service the handicapped. Lack of personnel is an important factor in causing such inadequacies, and planning for development and investment must be done systematically.

21. The study by Orathai Kiewcharoen et al. give a picture of a situation of insufficiency and unfairness in the health system in responding to the health needs of various types of disabled people. Similar conclusions come from a study done by Suwit Wibulpolprasert et al.[12] 12 years ago. That is, as far back as 1992, Thailand did set a target of 17 rehabilitation wards to be established, and this was put in the 8th National Public Health Development Plan. But up to now, there has been no progress. More than that, more limitations on the provision of services to the disabled have resulted from the adoption of the Diagnostic Related Group or DRG [13] [14]system. This underlines the fact that the Ministry of Public Health lacks planning to develop a system of rehabilitation services and overall heath care for the disabled, as well as not having indicators to use for continuing supervision, monitoring, and evaluation.

22. The slow development of the health system as mentioned above resulted in unfairness for the people, especially for families of the disabled, in the sense that they have to look after the handicapped themselves at home. This is substantiated by a study done by Samrit Srithamrongsawasdi et al.[15] which found that most patients who suffered paralysis from cerebrovascular disease spent only 5.2 days in the hospital bed. Seventy-two percent of them suffered from hemiplegia but only 45% had the

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[11] Orathai Kiewcharoen et al., “*The Situation on Activities to Medically Rehabilitate the Handicapped in Thailand and its Assessment in terms of the Outcome*”, Journal of Public Health, yr.18, issue 4, July-August 2009, p.475-488.

[12] Suwit Wibulpolprasert et al., *The Medical Service System for Rehabilitating the Disabled*, Nonthaburi: Institute for Research on Public Health.

[13] Orathai Kiewcharoen et al., *Diagnostic Related Group and Payment Options for Servicing Patients both Semi-Acute and Acute,* Journal of Public Health,yr.16,issue2, March-April 2007

[14] Orathai Kiewcharoen et al., *Diagnostic Related Group in Semi-Acute and Non-Acute Syndromes and determination of Treatment Expenses for Thailand*, J Med Assoc Thai vol 93, 2010,p.849-859

[15] Samrit Srithamrongsawasdi et al., *Report of a Study on the Provision of Services and Real Costs for the Medical Rehabilitation of Intermediate care Patients Under the National Health Security Scheme,* presented to the Office of National Health Security Scheme 2010

opportunity to receive continuing physical therapy. And 30% had a problem in swallowing but only 7% received guidance practice on how to swallow, before they returned home. Forty-five percent had a problem in speaking and communicating, but did not have the opportunity to receive guidance services on how to speak in a handicapped condition. Also, when these patients went home, only 64% had the opportunity to do further physical therapy on a continuing basis. And those that did, more than half were conducted by relatives. These facts are in accord with the study done by Arthon Riewpaiboon et al.[16] which pointed out that the families of the handicapped had to bear the cost of looking after their disabled to the amount of 4,600 Baht per month, or translated into time spent in looking after them, amounted to an average of 94.6 hours a month.

23. For those with mental impairments or disabilities, Vijj Kasemsap et al. have found that although the Civil Service Health Security and the Universal Coverage Schemes have covered medical services for psychiatric in-patients without a limitation on number of days admitted to a hospital, the Social Security Scheme does have a limitation of length of stay in a hospital for not exceed 15 days per one admission. This condition offered by the Social Security Scheme which is limited for only not more than 15 days is considered not enough for the treatment and rehabilitation.

24. The development of well being of the handicapped cannot be achieved merely by developing the public health system. There has to be joint concurrent development of the welfare system and of appropriate social services at the community level, so that the disabled can access and really make use and benefit from them. At present, the rights and welfare accorded by the state to disabled people consist of: a disability allowance of 500 Baht per month for all those defined in the law as disabled; the right to borrow money at 20,000-40,000 Baht per person interest-free for 5 years for investing in a self-employed enterprise; and the right to receive family assistance money at the rate of 2,000 Baht a time, but not more than 3 times a year.

25. Other rights and welfare assistance in which some principles and regulations have been drawn up are, for example: help services in the case of severe handicap in which the patient cannot help him or herself, services to make adjustments to the house to facilitate the handicapped, services in the form of group home or home care in the case where no one is helping the disabled, subsidy to the family on a monthly basis in the case where it has to support the severely disabled all his life, and hand-sign language interpretation services for the deaf when accessing necessary services. But there has not been implementation on a comprehensive or on an equitable basis.

26. It can be seen that to solve the problem of access to necessary services for the disabled, it is essential to use a very pro-active strategy and to engage the community where the disabled resides, to assist in operations. In addition, cooperation among all the concerned agencies in the public and private sector, the community, the family, and the disability-help organizations, must be encouraged to help develop a sound system. Only then will efforts in rehabilitation lead to the outcome desired, that is,

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[16] A. Riewpaiboon, et al. *Economic valuation of informal care in Asia: A case study of care for disabled stroke survivors in Thailand*. Social Science & Medicine 69 (2009) 648–653

that is that the disabled are able to live a life of meaningful participation in the society.

Opportunities in mitigating the problem of unfairness faced by disabled people in accessing health services.

27. It has been five years that the fund for Medical Rehabilitation of the Office of Health Security has had a policy of ,one, stimulating the development of a system of medical rehabilitation for the service agencies to use, and two, a policy of developing the capability of disability-help organizations to do their work better. These two policies have been given continuing support, resulting in success in concrete terms. That is, integrated health services for the handicapped are now offered by more than 24 community hospitals. Examples of where these are offered are: Kuchinaray Hospital in Kalasin Province, Dan Sai and Phu Kradueng Hospitals in Loei province, Selaphum Hospital in Roi Et, Hospitals Hua Sai, Sichon,Tha Sala in Nakorn Si Thammarat, Kuan Khanun and Takli Hospitals in Nakon Sawan, Bang Mun Nak Hospital in Phichit , Khun Tan Hospital in Lampang, and Nong Muang Khai Hospital in Phrae Province. In every area that disabled persons were found and registered, assessment of health problems and needs were done; rehabilitation services were offered and equipment to assist the handicap provided; some centres have embarked on developing units to produce artificial legs, and provide repair services. All the services are offered pro-actively, in the form of a network of cooperation among primary health care units, public health volunteers, disabled people organizations, family, Buddhist temples, and local administrative organizations.

28. In addition, there has been established a form of health care management of the disabled, that is, by the organizations of the disabled themselves. For example, a network offering independent life skills development services to the severely handicapped exists in 10 places. The services involve seeking out to find the disabled, give them consultation as friends, train them on social participation skills, and offer personalized individual help services some of the time. Then, there is the network of disabled children's family and network of the blind offer training on orientation and mobility skills to the blind in the communities.

29. Moreover, the Subdistrict Health Fund, under the auspices of the National Health Insurance Fund, and in cooperation with the local administrative organizations, has a clear policy of engaging the community to look after the health of the handicapped within their local communities. This has resulted in many volunteer activities at the community level to look after the disabled, rehabilitate them, and build up other aspects of health.

30. As for the part played by the Ministry of Public Health, two policies have had a positive impact. One is the paying of health volunteers at 600 Baht a month, the other is the supporting of subdistrict hospitals to engage in health promotion in which the specific task of looking after and rehabilitating the disabled is included in their brief. An evaluation was done after a year of implementation, and it was found that both policies were instrumental in increasing health care for the disabled, especially for the

disabled who cannot help themselves and are unable to access services for various reasons.[17]

31. Another important mechanism is the establishment of provincial subcommittees on promotion and development of the quality of life of disabled persons, set up under the auspices of the National Committee to Promote and Develop Quality of Life of Disabled Persons, in accordance with the Promotion and Development of the Quality of Life of Disabled Persons Act B.E. 2540 (1997), and this sub-committee has been established in every province. Furthermore, in every province a 3-year integrated plan to promote and develop the quality of life of the disabled, with participation from all parts of society, has also been drafted. In addition, a preliminary budget allocation was made from the Promotion and Development of Quality of Life of the Disabled Fund at the rate of 0.50 Baht per registered disabled person. What is still lacking is the efficient linkage among the databases of various agencies such as those of social, public health, education, labour and local agencies, so as to facilitate the appropriate service delivery to the disabled. Another problem is the lack of joint investment to enable development to move forward in a systematic way. What are also lacking are indicators and mechanisms to efficiently and continually monitor and evaluate.[18]

32. The above mechanisms will be even more effective in development if Section 21 of the Promotion and Development of the Quality of Life of Disabled Persons Act is implemented more in a concrete manner. The section states "For the benefit of promotion and development of the quality of life of the disabled, the local governmental organizations are to issue local ordinances, municipal laws, provisions, regulations, or notices, depending on the specific context, so as to facilitate implementation of this Act". And if one looks at the results of a sample survey of 170 local government organizations [19], it was found that in only 18 areas had there been issuance of a mere total of 26 such regulations, notices, etc. Half of such instruments were on the topic of living allowance and fund for the disabled. One-third of the instruments were about the annual budget, whereas 11% dealt with services for the disabled, for example, with regards to travel assistance. And 5% of the instruments were issued on actions to facilitate the handicapped persons' social engagement. Also to be noted is that 90 of the 170 local organizations have been drawing up work plans on the disabled. Thus, it is appropriate to have a mechanism of cooperation to further stimulate the utilization of this section of the Act.

33. In addition, there is a trend in the policy of the Office of National Health Security, that emphasizes cooperation with the provincial administrative organizations in order to scale up the development framework, like what has happened in the cooperative

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[17] *Preliminary Report on the Policy of Paying 600 Baht per month to Health Volunteers*, presented to the 3/2553 meeting of the Committee of the Public Health Research Institute on 21 June 2010; Preliminary *Report on the Policy of Developing Subdistrict Hospitals to Promote Health*, presented to the 4th/2553 meeting of the Committee of the Public Health Research Institute on 16 August 2010.

[18] Tipaporn Potithawil et al. (2010), *Final Report on the Project to Monitor and Evaluate the Third National Plan to Develop Quality of Life of Disabled Persons 2007-2011 (covering first half of the plan i.e. 2007-2009).*

[19] Ibid, point 18

efforts to set up a provincial fund for rehabilitation in Nong Bua Lamphu, Amnaj Charoen, and Ubol Ratchathani provinces. The examples there enables one to see an opportunity for development of a system --as distinct from piecemeal efforts—to look after the health and to develop the quality of life of disabled persons in a wider dimension. Moreover, the policy is in harmony with the direction and mechanism of welfare and social services for the disabled drawn up by the Office to Promote and Develop the Quality of Life of Disabled Persons.

34. Thus, proposals to increase fairness for the disabled in accessing health services consists in the main the following: creating mechanisms to translate policy into practice; creating mechanisms on academic level work, and on monitoring and evaluation at the national level that works in tandem with the local level; building mechanisms for cooperation in budgeting, so as to arrange for a sufficient budget for investment in systemic development, and also to encourage substantive measures , measures that stimulate participation by all parts of the society, especially by disabled people's organizations.

Issues for consideration by the National Health Assembly

The Assembly is requested to consider the document NHA3/Draft Resolution 3.