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Exploring the Primary Healthcare Service Accessibilities of Patients with Chronic Illness in North Eastern Thailand

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Abstract— *The primary healthcare service is the key policy of caring for global population, as well as Thai people. However, the existing statistical data of health problems of people in Northeastern Thailand continues to dramatically increase. Thus, this focused ethnography research was initiative to explore the beliefs and perceptions of patients with chronic illness and their family members regarding primary health service accessibilities in the Isan region. Overall 30 participants were purposive sampling. Hence, 24 key informants were chronic illness, family members. In addition, six general informants were community leaders and health volunteers. The data were collected, during May 2018 to February 2019, by participatory observation, in-depth interviews, focus group discussions, document reviews, and field notetaking. Content with thematic analysis techniques of the data were employed. The five themes were revealed as follows: (1) a decision to access the health services, (2) seeking for a variety of health services, (3) providing access to health services, (4) non-access to the provided health services, (5) additional health service accessibility. The optimal primary healthcare services should be covering all dimensions of accessibilities to holistically healthcare services. The results of this study recommended the covered accessibility and holistic guideline for the primary healthcare service center, which placing the important of beliefs and perceptions of local to serve as comprehensive with covering all dimension services in the Isan socio-cultural context.*

Keywords— *The primary healthcare service accessibilities, Patients with chronic illness, Focused ethnography.*

I. INTRODUCTION

Access to healthcare services could promote equality in healthcare, increased quality of healthcare, reliability of the service receivers as well as reduce the unnecessary medical expenses (Starfield, 2012). Thailand has provided an effective health mechanisms and management in order to collaborate in providing the primary health services and public health through the active participation among the government sector, local government organizations and public sector. It is, eventually, anticipated that receivers could be provided with effective and equal health services according to the provision of section 55 of the Constitution of Kingdom of Thailand (Primary System Support institute and Primary Care Cluster, 2017). However, despite such actions, the number of patients with chronic diseases appears to increase; to illustrate, out of 21,861,423 inhabitants of Northeastern Thailand, 1,018,373 constitute in-patients with non-communicable diseases and cancer, accounting for4.658%.This phenomena is responsible for a considerable amount of economic loss in relation to YLL (years of life lost), cost of absenteeism of patients themselves and their families, travel expenses, and additional hospital expenses (Bureau of Non-Communicable disease, 2016). In other words, there remain a barrier of access to health services which deficiency the needs and remain discrepancy between receivers and providers in the healthcare service systems.

There is a consensus among previous studies that the conceptual framework of health determinants relies on the concept that individual factors, environment and public healthcare management determine individuals' health. The incidences leading to the illnesses of healthcare receivers are associated with determinants contributing to diseases. The intrinsic factors influencing individuals' health are as follows:1) genetic factors, including diabetics, hypertension and the approach of aging, 2) psychological factors, including perception, belief and attitude that shape individual behaviors influencing disease development and their health conditions, 3) behaviors directly affecting individual health and illnesses, including daily life behaviors such as unhealthy diet, poor physical activities and smoking (Sadana & Haper, 2011 Sadana R, Haper). To maintain good health of individuals, families and society are required to analyze and synthesize the dynamics of potential determinants influencing individual health.(Strategy and Planning Division Ministry of Public Health, 2015) In addition, certain cases develop health problems due to economic burdens and poverty; to illustrate, Thailand's Northeastern people are reported to have the average income of 21,094 baht per month/household, which is under the country's level at 26,915 baht per month/ household (National Economic and Social Development Plan Number 12, 2017). In other words, they work hard and have inadequate sleep or relaxation, contributing to some chronic occupational diseases or stress related chronic diseases, which is consistent with the report of stress contributing to physical illnesses (Muntaner et al., 2010). It is anticipated that in 2019 the causes of death found most among Thai males are road accidents, liver cancer and stroke, respectively; meanwhile, those found most among Thai females are diabetes, stroke and liver cancer, respectively. Thus, it suggests that non-communicable chronic

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diseases particularly cancer, diabetes and cardiovascular are the potential causes of death among Thai people.

The report of burden of disease and injury in Thailand, it suggests that the burden costs at a maximum of 15.3 million year, including YLL (years of life lost) 10 million and YLD (years lived with disability) 5.3 million (National Statistical Office, 2017). Once developing illnesses, patients themselves and their families tend to seek for own cure and family members based on their background of perceived knowledge, belief and family's spiritual anchor under social and cultural contexts in their community, which potentially influences healthcare behaviors and family's decision to access healthcare services available (Kleiman, 1980). There is case of the Northeastern region of Thailand, where its typical culture and belief determine the manner of healthcare as well as seek for treatments and health services (Jongudomkarn, 2015; Sodsuchart, 2010). Indeed, recently public health services, a health determinant, have been expose to service development to mitigate the perceived problems and respond the needs of healthcare receivers and their families in relation to social and cultural contexts for increased accessibility. Particularly, the primary healthcare service is essential systems having been operated in the closest relation with individuals, families and communities (Health Administration Division, 2014). The key attributes of the primary healthcare service are based on the principles of first care, easy accessibility, holistic care and co-ordination for the purpose of appropriate services with patient-centeredness. The countries realizing the importance and strengthened primary healthcare systems are reported better outcomes of health such as low mortality of children, low mortality of citizens, low rates of low birth weight, and low expenses on healthcare (Muldoon, Hogg & Levitt, 2006)

The phenomena and literature review have found that a decision on an access to health services relies essentially on experiences of individual family where their needs vary according to family's belief and perception shaped by social and cultural contexts, and their health status. These experiences influence their behavior patterns of seeking for health services and using the services, which could reflect the country's healthcare systems in respect of the accessibility and coverage of the system. However, few studies have focused on the beliefs and perceptions of healthcare receivers and their family members regarding primary healthcare service accessibilities. The findings might yield suggestions to develop a primary healthcare service guild line which placing the important of beliefs and perceptions of local to serve as comprehensive with covering all dimension services.

II. Objective

This focused ethnographic research aimed to explore the beliefs and perceptions of healthcare receivers regarding primary health service accessibilities in the sociocultural context of Northeastern Thailand.

III. Methodology

This study was conducted at a primary healthcare unit located in the Northeastern region of Thailand. This unit, designated as a primary care cluster, was purposely selected due to its availability of a multidisciplinary healthcare team providing the essential treatment, prevention, promotion and rehabilitation services.

Purposive sampling was used to selected two groups of subjects. The first group of patients included ten female and six male patients with chronic illness and 8 their family's members. Patients were aged 41-72 years on average; six suffered from diabetes; four suffered from hypertension; four suffered from hypertension coupled with diabetes; and two suffered from arthritis, respectively. Patients' family members were aged 30-66 years on average, constituted the subjects of the study as the key informants. The inclusion criteria were as follows: 1) those who originated in the Northeastern region of Thailand and previously received health services delivered by certain local primary health care unit under their chronic illness or health status, 2) those who had inhabited in the study area for a minimum of six months, and 3) those who did not severe fatigue and remained verbal communication, 4) those willing to participate and undertook in-dept interviews in the study. The general informants included a community leader and 5 public heath volunteers aged between 40-67 years.

Data were collected during May 2018- February 2019 through participant observation, in-depth interviews, field note recording and secondary data analysis. The informants were accessed by local gate keepers (register nurse and public health volunteer). The researcher investigated local essential characteristics through participating in community activities, interacting with the community leaders and public health volunteers and contacted them to observe their activities. Meanwhile, field notes were written for each observation to record what was heard and accomplished, include the key informants' belief, behaviors, the appearance of the environment, interaction with family members and healthcare team. In-dept interviews were conducted in their home at their convenience, asking questions like *What do you think about health services provide?*; *Why do you think that*?; *What did you practice during your illness?*;*Why did you do each action*?; and *What are the health services provide that you receive, neglected to receive, required to receive?*. These questions helped to achievement insight of the healthcare service accessibilities from the belief and perception of patients with chronic illness and their families. In-dep interviews were conducted during 45-60 minutes until data saturation.

The research tool comprised four compositions: 1) The researcher, who assumed a role as the principle tool and prepared with the approach of qualitative research by the advisor regarding the data collection, field note recording, data analysis and synthesis. 2) The in-depth interviews question of patients with chronic illness and their family members, which were adopted from the relevant literature review and verified by the co-author in respect to the appropriateness of language and essential contents. 3) Field note record form, which was subject to notetaking of relevant information. 4) The study framework from the relevant documents.

The researcher used four criteria of Lincoln and Guba to establish the trustworthiness of the study (Lincoln & Guba, 2000). Credibility was confirmed by prolonged engagement in study setting and member checking. Dependability was

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applied using an analysis audit trial to describe and record study processes thick description of transcriptions and field notes to establish certainty of interpretation. Confirmability was manipulation through audio recordings which immediately recorded after finishing the interviews, using method triangulation which include participant observation and in-dept interviews, rigorously content analysis and peer debriefing to establish data certainty. Transferability was achieved through dense description and could be replicated in similar informants or with similar contexts. For relevancy with data collection, the researcher conducted data analysis of content analysis. Transcriptions from informants were read and categories were reviewed several times in order to certify that the concepts related to the phenomena were allocated in an applicable theme. The themes and the content of the data completely the data collection and analysis processes were identified by the researcher for coding consistency, emergence of themes**,** and extirpation of announcements to support each theme. Coding, themes, and key findings were discussed by the co-authors until concurrence was reached **(**Miles, Huberman & Sandana**,** 2014**)**.

This study was approved by the human ethics, Khon Kaen University, HE 612009 and Khon Kean Hospital, KH 61046. The researcher followed three following ethical practices: 1) respect for person, where the researcher tentatively introduced herself, informed the research objectives, request their consent and kept their information confidential, 2) beneficence, where the researcher made a list of informants who had been notified the research contribution and implication and explained that no effects might arise owing to providing their accounts, and 3) justice, where the researcher intended not to group the subjects and treat them with equality so that they acquired the understanding before singing consent forms and participating in the research.

IV. Result

Sociocultural context of the setting

The primary healthcare unit as a study setting essentially provided the coverage of healthcare services, including common illness, chronic illness, emergency cases and referral to the network hospitals as well as disease prevention, health promotion and rehabilitation for bedridden patients or the disabled. The communities under responsible have variety populations but similar beliefs, perceptions and practice under local cultural of Northeastern. This article suggests findings discovered from the healthcare receivers with chronic diseases and their family's members. From content analysis, five main themes emerged: 1) a decision to access the health services, 2) seeking for a variety of health services, 3) the healthcare services must access, 4) the healthcare services intend not to access and 5) the healthcare services required to access.

Theme 1: A decision to access the health services: The decisions to used health services are based on the beliefs and perceptions and the major symptoms of the illness. These illustrate by the following accounts.

"Whenever I got headache, I went to a drug store to buy some medicine. Sometimes it worked; sometimes it didn't, but I could handle it. However, later despite taking drugs, the symptom remained, so I decided to go to the primary care cluster because I was frightened of being disabled. I was diagnosed as hypertension. So, I have undergone the treatment for ten years. And, now I am developing diabetics". (Patient, No 08)

"When I have fever, cough or leg pain, I take medicines in forms of pills, decoction bought from a drug store. If my symptom be bad, I will be to primary healthcare services." (Family member, No 05)

"There is a drug store located at the entrance of the alley, which is very convenient for me. I have developed chronic arthritis since 1995 and the symptoms remain unchanged. Until five years ago, I feel so painful that I can bear. I eventually decide to see a doctor at the primary car cluster because I am afraid that I can't walk. I am referred to have knee operation at the central hospital. After the operation, the pain had reduced, and I can depend on myself." (Patient, No 09)

These accounts could reflect the beliefs and perceptions of patients with chronic illness and their family members decision to access health services when one of family members suffers from chronic illness, they find their own way to cure themselves. They used medicines for the cure of minor symptoms such as muscle and joint pain, headache, fever and maintaining general health. Until the disease develops complications or disability, they eventually decide to access the healthcare services.

Theme2: Seeking for a variety of health services: Sociocultural context and the beliefs and perceptions of health service**s** access had important role in patients with chronic illness and their family members about seeking healthcare services. These illustrate by the following accounts.

"My knee is hurt. I am prescribed some drugs. When going to see a doctor, I underwent x-ray and was prescribed additional drugs. However, it seems unlikely to recover. So, I go to see a hot steel massager. He stepped on a piece of hot steel and massaged my body. He applied some oil and massaged tendon. Told that it works, I tried this treatment as I want to recover." (Patient, No 03)

"In addition to taking the drugs administered by the hospital, I go to see a folk healer to blow bones. I have been there four – five times. I think it works as I can walk swiftly. I also go to hot steel message. I always go to see any well-known folk healers." (Patient, No 09)

"I always take the drugs prescribed by the primary healthcare center. However, I also take herbal medicines such as Lingzi mushroom. When taking it, I feel more active. Unless the glucose level increases, I may ask the doctor to stop the drugs." (Patient, No 09)

These accounts could reflect the beliefs and perceptions of patients with chronic illness and their family members seeking health services, although they could access the health services available and they received treatments on the nature and symptoms of their illness, they remain their belief in alternative treatments and concurrently rely on additional treatments. Some patients used herbal medicine, used folk healer to blow bones, used a hot steel massager and used

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additional own purchase of drugs based on their belief and perception of the families.

Theme3: Providing access to health services: The patients with chronic illness and their family members used health services based on priority of health problems. They must access healthcare services that related their illness treatment. These illustrate by the following accounts.

"I keep the appointment strictly. I have never missed the appointments. When prescribed the drugs, I always finish them. I have the appointment every three months. I am always examined by a doctor. Unless having an appointment, I won't go." (Patient, No 02)

"I always go to see a doctor, physical checked and receive the drugs every time. I have blood checked twice a year. When I have a fever or cold or allergy, I' m taken to the medical center here." (Patient, No 03)

"When I have appointments to see a doctor, receive drugs, so far I have never missed. I go to the primary healthcare center ever three months. I get blood screening and eyes checked depending on their systems." (Patient, No 11)

These accounts could reflect the beliefs and perceptions of patients with chronic illness and their family members must access to healthcare services when experiencing any illness. They can see a physician specific to their illness treatment, and continuously obtained drugs, complication screening such as blood check, urinary check, eye check and other chronic disease check.

Theme4: Non-access to the provided health services: The patients and their family members realize the availability of health services but intend not to use the services. These illustrate by the following accounts.

"I have heard about flu vaccination and others. I am informed of the vaccination service, yet I, including all my family members, have never attended any health services such as breast cancer or cervical cancer screening." (Family member, No14)

"They know information about vaccination services and cancers screening, but they have never undergone the services because they can't manage to go". (Health volunteer, No 01)

"Frankly, unless I get sick, I won't go to the primary healthcare center. Once going to receiving drugs, I notice other services, but I don't access them. I only want them to treat me. It's all right. It is typical of Isan people not to be demanding. (Patient, No 11)

"I have gone through menopause for many years, but I have never had cervical cancer checked. The public health volunteer came to my home to tell me about this campaign, but I didn't go. I have an underling disease, but I am still fine, so I think it is not necessary to have it checked now." (Family member, No 12)

These accounts could reflect the beliefs and behaviors of patients with chronic illness and their families intend not to access health services, including health promotion services and health prevention services such as vaccination, cancer screening and other diseases screening. These behaviors like the informant said, "*It is typical of Isan people not to be demanding*". This indicates that the patients and their family members access the services only when they require to treat the current diseases because they are independent patients without complications and concentrate only their illness; they diminish the importance of additional access to health services.

Theme5: Additional health service accessibility: The patients with chronic illness and their family members were satisfied with health services and experienced problems accessing the services. However, the health services required were identified as barely or unlikely to use. These illustrate by the following accounts.

"I would like to have my health checked with some orthopedic doctors. It is all right if they come every month. I went to undergo physiotherapy, but it is not convenient for me to go the hospital." (Patient, No 08)

"At the primary healthcare service center, dental services dose not available every day. If I go to the hospital, I probably must wait for the queues a whole day. However, the center serves only teeth cleaning, meanwhile teeth filling and teeth pulling services are available only some days. In fact, I wanted to undergo root canal treatment, but it was difficult for me to go to the hospital, so I decided to get my tooth removed." (Patient, No 01)

"Whenever I have a dental disease, I have to go to a dental clinic even though it is quite expensive. This is because when I went to the medical center, I found inadequate facilities. If possible, it must be good if an after-hours clinic with some dentists is available at the center and dental services at the center were like at the hospital." (Family member, No 06)

"When I was recently sick, I was referred to the hospital for physical therapy. It made life difficult for those taking care of transportation. It must be good that a healthcare center could be established it because the elderly appears to increase and people suffering from bodily pain. (Patient, No 10)

"During a campaign for cancer screening, if the screening can be carried out in the community, it would be a good idea because there may be more people interested in attending the screening." (Health volunteer, No 03)

"We want providers home visit may be once or twice a year, which is probably good for us that they can check improving patients to follow up the given treatments as well as prevent potential complications." (Patient, No 11,14)

"I think there should be other services in addition to drug-related services such as smoking cessation, weight control, cooking for specific diseases." (Family member, No 09)

These accounts could reflect the beliefs and perceptions of patients with chronic illness and their famil**y** members required to access health services, as shown: 1) dental services, which is the critical issue that few patients could access. because the primary healthcare center provide the patients with limited types of services and restricted days; meanwhile, they fail to access certain essential services ; 2) specific treatment from orthopedic specialists, because the number of the elderly people in the community increase continuously; 3) physical therapy services; 4) progressive disease screening in the community; 5) home visit to independent patients in order

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to monitor and follow up the given treatments and complication prevention; and 6) health promotion services, such as smoking cessation, weight control, food preparation for specific diseases. In other words, providing that these services can be more accessed, these factors may increase the coverage of health service accessibilities.

V. DISSCUSSION

Results from the study showed that the patients and their family members develop certain ways of life and ways of self-care practices after experiencing chronic diseases. They cope with their diseases through the purchase of drugs specific to the developing symptoms. Even if the illnesses are unlikely to recover, the patients seem unwilling to access the available services. The finding supports previous studies that not until the onset of illnesses or the complication phrase of diseases or disability or critical periods, patients make their decision to access the health service systems (Benach et al., 2010). Almost of participants in this study also discover alternative traditional treatments. It is typical of individuals in the Northeastern Thailand context where conventional medicine and supernatural belief are currently used in combination (Sodsuchart, 2010). They carry out additional search for treatments of illness, which covers ritual therapies, the use of herbals, and additional own purchase of drugs (Depart of Thai Traditional and Alternative Medicine, 2013)

When experiencing a current disease or other illnesses, the patients could access the essential healthcare services and additional services, family members cooperated to seek for a treatment based on their paradigms of knowledge and belief under a community culture (Kleiman, 1980). Moreover, patients and their families have also separate belief and perceptions, which considerably influence healthcare behaviors and decisions to access healthcare services (Wright & Bell, 2009). In contrast , when they develop a chronic disease, the definition of illness is offered on the basis of their belief and individual perception that the illnesses can be controlled and treated (Horne et al., 2013) .The patients claim not to undergo disease screening, annual health check and essential vaccinations. This is maybe because they belong to the group who have not experienced any complications and no family members confront with any illnesses; they are, therefore, unlikely to realize the importance of other healthcare services as they rely on their experiences or feelings that their health is not threatened regardless of attending services (Meleis, 1990).

This study was found that healthcare services barely to access but highly required. These needs vary according to their belief and perceptions, health problems and seeking healthcare services. This finding extends previous qualitive study in Western country which found that access was an opportunity to identified healthcare needs, to seek healthcare services, to reached, to obtained or used healthcare services and to actually have the needs for services fulfilled (Levesque, Harris & Russell, 2013).Indeed, the access to healthcare services accounts for health insurance, the fundamental rights under the country's institutions. In addition, the health services accessibility is considered a key indicator of health systems in which healthcare service management, facilities, essential tools and devices are well equipped and fully utilized (Srivanichakorn, Petprasert & Chuengsatiensup, 2007). Furthermore, the essential requirements include the accessibility of the health systems with reliable, adequate, real-time and prompt services and appropriate proportion of service receivers to health service systems (Sandra & Marie, 2016). Nevertheless, the findings suggest that the healthcare management remain incomprehensive and unpractical in approbation of the dimension of service receivers and the primary healthcare services. However, the appropriateness of services as well as demand factors, such as the burden of disease, knowledge, belief and perceptions and individual experiences (Anderson, 1995)

VI. CONCLUSION

The research findings provide solutions to developing the primary healthcare services systems specific to patients with chronic illness and their families with full coverage and comprehensive management. 1) The authorities should provide essential dental services available at the primary healthcare unit where a dentist works on official days in either working hours or after-hours clinic. In addition, the primary healthcare unit should be equipped with the essential dental facilities enabling dental root treatments; in other words, healthcare receivers in communities can access dental services, which is one of the key determinants of having good health. 2) Home visit activities to independent patients should be intensified in order to follow up the given treatments as well as prevent potential complications. 3) A progressive screening center should be established in communities in order to stimulate the service receivers to access health promotion services and health prevention services with comprehensive coverage.

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