STUDY ON FAMILY'S ABILITY TO PAY AND FINANCIALLY CATASTROPHIC ILLNESS AMONG INPATIENTS IN SONGKHLA PROVINCE

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ABSTRACT

Rising health care costs, poor insurance coverage, inequalities in income distribution, and inequities in health resource distribution and health care consumption are important health care problems in Thailand. The underprivileged group, the poor who are not covered by any existing insurance and welfare schemes tend to be faced with payment difficulty for health care cost and are vulnerable to financially catastrophic illness.

The objectives of this thesis are to document family's ability to pay, coping strategies in dealing with the costs of illness, and

the situation of financially catastrophic illness among out-of-pocket in-patients in Songkhla Province.

This research consists of three studies using both quantitative and qualitative methods. First, the financially catastrophic illness-1 study ("FCI-1 study") comprises a hospital-based survey and a time-series data collection. Second, the financially catastrophic illness-2 study ("FCI-2 study") is a hospital-based survey, Lastly, the coping study ("Coping study") is a qualitative in-depth interviewing. FCI-1 hospital-based study focused on socio-demographic characteristics and family's ATP for hospital bills. A sub-sample of these subjects was used to collect data in a time-series pattern to observe financial coping strategies during current admission. FCI-2 hospital-based study intended to filter more FCI patients thus allow better understanding about FCI cases and their socio-demographic characteristics. For the coping study, in-depth qualitative method was employed to gather insight information about coping strategies.

Out-of-pocket in-patients in our sample were a mixture of upper, middle, and lower socio-economic status. Most of the subjects were in the working age group and admitted in a variety of wards.

Ability to pay (ATP), defined as the degree of payment affordability for hospital charges, was measured and classified into 3 categories: pay all the bill, pay some parts of bills, and pay nothing.

ATP was analysed using two statistical methods, namely dichotomous analysis and survival analysis. To measure family ATP, the

survival method has advantages over the dichotomous analysis. Hospital charges and severity of disease, which have a strong influence on ATP, are controlled. Moreover, this method is potentially useful in comparing ATP in different hospital settings. Both methods consistently show that the low socio-economic patients are more vulnerable to ATP problems. Education and income classes are highly associated with family ATP.

With regard to financial coping strategies, most families used any available cash or savings as the primary source of finance to pay for the bills. Taking loans and family networks were the common response if cash or savings were not sufficient. Financial consequences ensuing from the illness were more severe if the patient was the head of the families or principal income earner.

Our data on disease profiles suggested that severity of disease had only a slight impact on the patient's ATP compared to the effect of family income. Resource-intensive DRGs and long hospital stay influenced ATP and frequently led to financial catastrophe. However, there was no striking common DRGs that resulted in FCI and unable-to-pay cases.

Incidence of FCI depends on the definition. The computation is based on the data in FCI-1 study. We proposed three definitions of FCI in this research. The proportion of inability-to-pay among out-of-pocket in-patients in Songkhla Province was 20.7 percent (first definition). FCI events were 0.36 and 5.02 per cent if school dropout or indebtedness is considered as an indicator of financial catastrophe respectively (second definition). The in-

patients who incurred catastrophic medical expenditures in our sample were 9.6 percent (third definition). FCI by any definition was associated with low socio-economic groups.

This research was confined to ATP and FCI problems among out-of-pocket in-patients in a single admission. It might not be a complete picture of ATP and FCI in the whole population. Any out-patient care, chronic illness, repeated admissions, or patient transferred from private hospital due to affordability problem, were not included in this study. Problems of ATP and FCI incidence might be over-estimated because the studies were conducted during an economic crisis. It is hoped that the crisis would shape the patients towards a reasonable health care utilization. The estimated magnitude of the problems may not deviate from the true situation. Thus, generalizability is still acceptable to the target population in the setting like Songkhla Province.

There is a need to strengthen a safety net for protecting the poor and the uninsured from FCI events. Similar studies should be carried out in other representative provinces of Thailand in order to gain more information on FCI throughout the country. It is necessary to check whether currently insured people are also faced with FCI events.