CHAPTER I
INTRODUCTION

1.1 Rational and Background

Many countries have continuously developed their healthcare systems for their citizens because their governments are obliged to do so. These countries believe that healthcare should be a basic right for everyone, accessible regardless of socioeconomic status. This principle is widely accepted by many countries and the World Health Organization (WHO) wanted to incorporate it into the Health For All by 2000 campaign (WHO, 1978). According to a 1993 World Bank report, the number of people who are covered by health insurance is proportionate to the development level of the country. People who live in a wealthy countries have better healthcare than those living in poor ones. The report suggested that developing countries increase the number of insured people (The World Bank, 1993).

Thailand's healthcare insurance system have been developed in order toestablish healthcare security for its citizens. Currently, there are three public insurance schemes: The first is the non-contributory Civil Servant Medical Benefit Scheme (CS - for government employees, pensioners and their dependants); the second is the Social Security Scheme (SS - for private sector employees, financed by tripartite contributions); the third is the Universal Health Coverage (UC - for the rest of population, financed by general tax revenue). In addition, people can also opt to purchase private healthcare insurance. However, approximately 35% of total health expenditures are from direct payments made by households (National Statistical Office, 2007). This implies that the health insurance has not yet fully utilized by some groups of the population. The National Survey of Health and Welfare (2007) showed that among Thais suffering from an illness during a month, 24.7% did not seek care from health facilities, but chose self-medication instead. The self-medication was shared mostly by the UC beneficiaries (75.4%). Self-medication was most common for the illness on respiratory tract (53.8%), musculoskeletal tract (11.8%), and gastrointestinal tract (8.5%) (National Statistical Office, 2007). Almost

half (45%) of drug consumption nationwide is channeled through community pharmacies (Viboonponprasert et al., 1994). In Thailand, community pharmacies are the frontline of health care because they are easily accessible, especially for care of minor sickness (Kapon et al., 2001) and widely available than hospitals (The Education and Analytical Thai Drug System Committee, 2002; Kunotai et al., 2001). The public insurance schemes in Thailand do not cover community pharmacy services. As a result, self-medication must be paid for directly by households. This economic burden can be large for the poor households (Naranong et al., 2007).

Virtually no drug utilization studies conducted in community pharmacies have focused on the poor subgroup (Chalongsuk et al., 2008; Chaisong et al., 2005; Kanchanakitsakul 2006; Satayawongtip et al., 2003; Saengcharoen, 2007). This study aimed to determine economic impacts of the community pharmacy visits by the poor, Since financial risk to the poor from visiting the community pharmacies is foreseeable, a key policy question is *"should community pharmacy visits by the poor be reimbursable by health insurance?*

1.2 Scope of the Study

This aim of this research was to study socioeconomic and health care utilization profiles in term of drug expenditure, illness experience, and economic impacts of community pharmacy visits by poor households. The study sample consisted of individuals from poor households exhibiting one of the six groups of commonly complaint symptoms classified anatomically: urinary tract, fever/headache, throat/nose, skin, joint/back/musculoskeletal pains, and gastrointestinal tract symptoms. The individuals visiting a community pharmacy during the period from May to July 2009 formed the study samples. This research specifically covered an officially certified community pharmacy with licensed pharmacists located in the urban area of Mahasarakham Province.

1.3 Objectives of the Study

1.3.1 To identify the socioeconomic and health profiles of the poor visiting a community pharmacy.

1.3.2 To determine the expense paid by the poor for drugs treating each symptom group.

1.3.3 To determine ability to pay of the poor for the standard treatment of each symptom group.

1.3.4 To assess the effects of out-of-pocket payment on the daily economic activities of the poor.

Studied symptom group included illness related to (1) urinary tract, (2) fever/headache, (3) throat/nose, (4) skin, (5) joint/back/musculoskeletal pain, and (6) gastrointestinal tract.

1.4 Definition of Term Use

The definitions of terms used in this study are provided below.

1.4.1 Household is defined as the household member who lived in the same house and also shared living expense.

1.4.2 Poor household is defined as a household that met three out of eight poverty indicators compiled by interviewing a yes/no question format. The following indicators are used to classify as a poor household: 1) insufficient income for family; 2) too few family members with income; 3) increasing debt; 4) inability to borrow money from other people; 5) no asset; 6) living from "hand to mouth"; 7) lack of working knowledge and skill, and 8) bearing burden of family dependents.

1.4.3 Impacts of out-of-pocket payment for visits to the community pharmacies is defined as:

1) Those affecting the daily consumption and living, including decreased consumption, school drop out, and meal skipping;

2) Those affecting saving, including decreased savings, and inability to save;

3) Coping strategies, including taking loans with interest, got loans from relatives or other interest-free, selling household possessions, and selling property.

1.5 Potential Benefit of the Study

The findings from this study can provide information to policy makers to help poor households reduce financial risk and increase access to services, as well as to help make this the goal of the national insurance system.