

Reflective Piece on my Experiences at Banphaeo Hospital, Bangkok, for my Elective in February 2011

Background

Since 2001 it has been the stated aim of the Thai government to ensure that all Thai subjects had access to healthcare, this is being implemented through the creation and gradual expansion of a new health insurance programme available to all Thai's known as "Universal Coverage" (UC) which provides a baseline minimum level of healthcare funding which is being gradually raised year-on-year.

Figure 1 outlines the most recent National Health and Security Office (NHSO) data on the coverage of the population by all 3 of the public health insurance programmes in operation today: the Civil Servant scheme is reimbursed generously according to the fee charged by the healthcare provider that the patient selects, the Social Security scheme is funded by government subsidised payroll contribution and is paid through a slightly more restrictive reimbursement-based approach; the UC programme requires no copayment by the individual and the healthcare provider is paid directly according to flat tariffs according to Disease Related Groupings (DRGs); the estimated 1% who remain uninsured generally comprise the refugee population in Thailand.

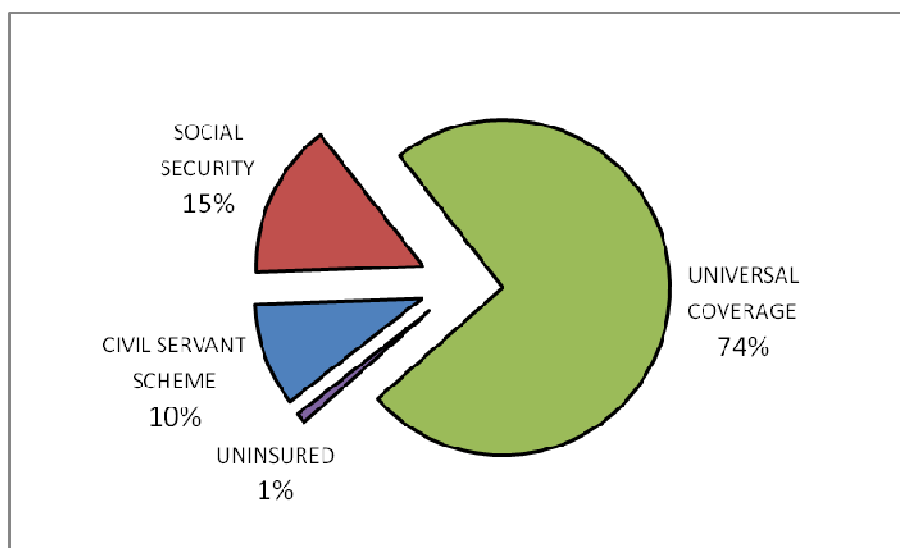


Figure 2: Breakdown of the Public Healthcare Insurance Programmes According to Proportion of the Population Eligible as of October 2010¹

In 2008 the government expanded the Universal Coverage scheme to include End Stage Renal Disease (ESRD) treatment, which at the time was delivered predominantly by Centre-based Haemodialysis (CHD) in Thailand. The logistics of having patients brought to the hospital 3 times a week as well as cost of providing this CHD, was deemed unworkable within the UC programme so the National Health and Security Office (NHSO) announced that ESRD treatment would be funded as a "PD-First" therapy

- * Blindness of the patient and no carer able to perform exchanges.
- *Skin lesions which prevented the use of a Tenchoff catheter (eg psoriasis),
- *Extensive adhesions within the abdominal cavity or poor peritoneal membrane function sufficient to prohibit CAPD

Figure 1: Exceptions from the "PD First" policy

¹ Source NHSO Powerpoint Presentation

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whereby a cheaper, home-based alternative dialysis therapy (Continuous Ambulatory Peritoneal Dialysis - CAPD), would be the only dialysis modality funded for patients under the Universal Coverage programme, except in circumstances where CAPD could be considered impossible which need to each be approved by the NHSO, (see figure 2).

I arranged to use my elective to spend time with the department of Dr Piyatida Jeungsmarn who is the NHSO medical consultant for their dialysis policy and is also the Director of the Renal Department of Thailand's only publicly-funded private hospital: given this status by the Prime Minister Abhisit Vejjajiva, while he was still Minister for Health, (and his father was a Professor of Neurology there).

Aims of my Elective Experience

The stated aims for my elective were:

1. To immerse myself in and learn about the work of a Nephrologist in Thailand, (including but not limited to Peritoneal Dialysis), and to explore how cultural and economic differences influence on the way health care is provided in Thailand.
2. To contribute wherever possible to the provision of care for patients at Banphaeo Hospital, (whilst acknowledging the limitations of my own competence).
3. To gain an insight into the impact that national political policy has on clinical practices, decision making and patient care at a local level.
4. To share with Dr Piyatida's team my perspective as a student who has experienced the provision of care in the NHS and has spent time with Professor Wang Tao in Beijing.
5. To contribute to any ongoing academic or clinical governance work or to design and implement a small project for myself to complete during my time in Bangkok.

I was fortunate to have been awarded a bursary by the British Renal Association to help fund my Elective experience. What follows is a reflective piece of my experiences during my elective.

My Impressions on the Work of Doctors in Thailand,

Having previously spent more than a year in a hospital in the Peoples' Republic of China (PRC), I feel that I had anticipated and was emotionally prepared to see the massive differences in wealth which is so conspicuous in developing countries, and indeed my impression of Bangkok was that the level of absolute poverty and individual abandonment was not as stark compared to that which I noted in the PRC: I feel that this may be a reflection of the difference in priority placed by the government on social rather than economic development goals.

I spent most of my clinical time with a young Consultant called Dr Apishat who was a humble, yet clearly intelligent man. He was originally from a poor family in a poor North Eastern province and at a young age he was identified by his local education authority as being a very high achiever: they sponsored for him to travel to Bangkok at the age of 12 to sit an exam for a scholarship to attend a prestigious school, which he won and then continued the rest of his education away from home.

Reflective Piece on my Experiences at Banphaeo Hospital, Bangkok, for my Elective in February 2011



Figure 3: A Chinese New Year Lunch with (from left to right) Dr Apishat, (Consultant Nephrologist); Wipada, (CAPD Nurse); Kanda, (Renal Head Nurse) and myself

Dr Apishat's day started at 0730 when he would conduct a general medical ward-round (there are no junior doctors at the hospital branch where we were based therefore he usually conducted this alone, usually seeing around 15 patients before 0900. This contrasts starkly with the 'monster' ward rounds conducted by NHS hospital Physicians. In my view the main reason for this was because he saw them all daily and the average stay of patients in Banphaeo appeared greater than patients in the UK so he knew most very well. I think that this longer inpatient stay could be explained by a number of differences between our countries:

- Most of the patients in the wards were UC patients and from rather impoverished backgrounds, and the general impression was that many patients would be discharged into unhygienic, chaotic poorly nourished environments and so were kept in to avoid the possibility of more severe re-admission.
- There was no emphasis on early discharge as there is in the UK or the Kaiser Permanente, therefore discharge planning was not something ingrained in the culture through admission, rather something to do at the end.
- I felt there were no clear pathways for treatment of any condition, and things were handled in a case-by-case basis, which I think resulted in a delay in treatment completion.
- Whilst Thailand did have 'GP-analogues' known as "Family Physicians" in the community, (I spent a day with them), and also some social service network growing I got the impression that primary health care was still rather sparse and not treated as the foundations of the healthcare system as it is here. As a result:
 - There was no outside professional to liaise with regarding ongoing management

Reflective Piece on my Experiences at Banphaeo Hospital, Bangkok, for my Elective in February 2011

- Often more work had to be done at a hospital level to initiate treatments, for example all of the counselling and education.
- discharge had to be delayed until it was felt that patients were relatively stronger than in the UK

Another notable difference was that there were no ward based pharmacists to check prescriptions so there was less margin for error for Dr Apishat (who didn't have a BNF, and relied on MIMS instead). Other notable omissions included the lack of Oxygen Sats being used routinely and the ICU made little use of ABGs (when I visited).



Figure 4: This Banphaeo Patient Had what Appeared to be Ichthyosis (with Total Body Coverage as in the Photograph) but was Not Exempted from the PD First Policy, highlighting the Routine Inconsistencies in the NHSO

Perhaps the greatest frustration for Dr Apishat, was the constant consideration of finance that he had to make, if there was any patient that he considered unsuitable for CAPD he had to deal directly with the beurocracy of the NHSO to obtain funding, which often made variable decisions, furthermore the NHSO would only fund Bampaeo hospital for "tertiary ESRD services", which comprised CAPD fluid, renal-related admissions and (more recently) erythropoietin injections. Any other treatment the patient required (officially) had to be provided by the patients "primary" hospital rather than Bampheao, (the patients "tertiary" hospital). In practice this meant that Dr Apishat was not funded to prescribe antihypertensive or diabetic medication, (two forms of

medication which possibly 95% of ESRD patients require), but the primary hospital often was unable or unwilling to obtain funding and provide this treatment – it was routine in the department to use second hand medication (for example medication donated after a patient died), in order to provide poor patients with something, if not a sufficient amount. At first

I was shocked by this, (particularly as the patient received perhaps only enough for 6 days, which I felt gave them the false impression that it was curative), however over time I realised that it was better than nothing. Out of date medication was never dispensed, and a great amount of work went into sorting out these donated medications.

I enjoyed discussing patients with Dr Apishat, and I do feel that my experience from a healthcare system that is much more 'proforma driven' benefitted him somewhat also – I was astounded to note how little use was made of local guidelines – for example he was very surprised to hear that each hospital would have a different guideline for which antibiotics to prescribe for common problems and that it was emphasised that this must be followed at all times. Figure 5 describes two brief case reports which exemplify the challenges for Dr Apishat to be an effective doctor in the Thai system.

Reflective Piece on my Experiences at Banphaeo Hospital, Bangkok, for my Elective in February 2011

Patient A

38 year old woman with disseminated Varicella infection, sent to Banphaeo by her Primary Hospital to receive rescue haemodialysis, however whilst she was at Banphaeo she experienced a new onset of confusion requiring a CT head, which would only be funded by the NHSO if it was performed in her Primary Hospital.

After a day or so discussion between the 3 organisations Banphaeo agreed to waive the fee for the CT scan and made a loss treating this patient.

Unfortunately, after this delay the CT was unremarkable.

She died a few days later on 20-2-2011 – autopsy revealed chronic meningitic damage

Patient B

Patient referred to Banphaeo hospital for dialysis after 30 years poorly controlled hypertension which had led to causing blindness and chronic glomerulonephritis. This was prior to the NHSO ESRD policy so he chose to use his Social Security Insurance to co-pay (his 500 Baht to 1500 Baht from the government to fund thrice weekly CHD), after 3 years of this, the patient could no longer to fund it and wished to switch to the NHSO policy which he was also eligible for and who would fund CHD due to his blindness.

The NHSO refused to accept his claim, and said that they would only fund CHD if he was first trialed (as a blind man) on CAPD, undergoing a Tenchoff incision operation.

Figure 5: Two Brief Cases to Demonstrate the Frustrations of a Doctor in Thailand

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Figure 6: Buddhist Monks Were Invited to Bless the Department on the 3rd Anniversary of the Opening of the CAPD Centre on February 11th 2011

Managing the Explosion in Patient Numbers

The other great challenge for hospitals with the new NHSO ESRD policy was the avalanche of patients who would wish to use the services newly available to them. In the space of 3 years the number of CAPD patients at Banphaeo hospital increased from less than 30 to more than 600. Not only has there been a challenge to employ enough adequately qualified staff, but the challenges that these new patients present are different in nature than the wealthier population that existed before. The CAPD department continues to employ the same 2 doctors that existed in the beginning and the growth in the workforce has come from bringing in and training up 9 nurses, 3 dieticians, one two district health nurses, one social worker, 4 support staff, 5 patient-volunteers and 2 full time drivers.



Figure 7: Providing Patient Education whilst Patients Are Waiting to be seen in the Outpatient Clinic, with Dr Piyathida Writing on the Whiteboard

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All patients are seen in clinic at least monthly (as before) and as the time with the doctor is more sparse the waiting time that patients spend has been used as an effective way to promote patient education with a programme of talks from the dieticians, doctors, nurses and guest speakers. It is also a chance for patients to meet other patients and receive peer support.



Figure 8: The Home Visit Team Helping a Patient to Improve the Cleanliness of the Area he used to Carry Out his Exchanges

To augment clinic visits, there are 2 home visit teams, consisting (variably) of a social worker, nurse, public health nurse and PD nurse. All patients are visited at home at least once every 3 months to inspect the area where they carry out their exchanges and to counsel them one-on-one: this is hugely popular with the patients. The second team was brought in to focus on giving a higher intensity of support to patients who are at high risk, identified through careful paper record taking.

385	A17	A49	A81	513	545	577	609	641	67
386	A18	A50	A82	514	546	578	610	642	67
387	A19	A51	A83	515	547	579	611	643	67
388	A20	A52	A84	516	548	580	612	644	67
389	A21	A53	A85	517	549	581	613	645	67
390	A22	A54	A86	518	550	582	614	646	67
391	A23	A55	A87	519	551	583	615	647	67
392	A24	A56	A88	520	552	584	616	648	67
393	A25	A57	A89	521	553	585	617	649	67
394	A26	A58	A90	522	554	586	618	650	67
395	A27	A59	A91	523	555	587	619	651	67
396	A28	A60	A92	524	556	588	620	652	67
397	A29	A61	A93	525	557	589	621	653	67
398	A30	A62	A94	526	558	590	622	654	67
399	A31	A63	A95	527	559	591	623	655	67
400	A32	A64	A96	528	560	592	624	656	67
401	A33	A65	A97	529	561	593	625	657	67
						594	626	658	67

Figure 9: The Board Used to Triage CAPD Patients According to Intensity of Health Input Required

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Final Reflections

I was overwhelmed with the hospitality of the department, and considering it was a place to help people who suffered from a severe condition it was a remarkably happy, low stress environment.



Figure 10: A Young, Enthusiastic Staff is Crucial to Manage the Recent Explosion in Patient Numbers

I would like to end this reflective piece by telling you about a patient story that happened before I arrived at the unit. There was a patient who attended the Peritoneal Dialysis clinic who lived in such poor conditions home visit team were concerned that it would fall down imminently, (figure 11). A few members of the department were so concerned about this that they posted the plight of this patient online, publicised it and managed to raise enough money to repair the house.

The patient actually lived with her daughter and son in law, so once collected it was given to the son-in-law to repair the roof of his house amongst other things.

Unfortunately as time passed the home visit team did not notice any change in the home whatsoever, and even now, more than a year later no alterations have been made to the house. Nobody at the centre



Figure 11: The Shared Family Home of one of the Poorer CAPD Patients

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knows what happened to the money that they raised, the son-in-law won't say. Whilst the team who raised the money are sad, they don't appear to bear any lasting malice about it, indeed now the same patient is invited to the department to have a free every day, they said to me the reason for this is because they realise that perhaps they cant change the home she lives in, but at least by giving her an incentive to come in daily they can control the place she does at least one of her exchanges. For me, this story represents to me a very characteristically Thai psychology.

The patient remains in relatively good health.