Management of care following hospital discharge of elderly patients to home in Thai communities:
A grounded theory study explaining how Thai community health practitioners prioritise practice decisions in community health services

By

Thaworn Lorga

April 2003

Small grant, Round 2 (2001)
Alliance for Health Policy and Systems Research, WHO
Summary

Discharge from a hospital does not necessarily mean that a patient no longer requires care at home. In fact, many patients continue to have needs for support and care to be met by themselves and their families. This study investigated the management of care following hospital discharge of elderly patients to home in Thai communities. The researcher interviewed patients, family caregivers, and hospital and community health staff about their involvements in the care of elderly people following hospital discharge to home. In times of weakened family support, emphasis was placed on community health practitioners whose roles in assisting families during this phase of care are theoretically important, yet under-researched.

This report highlights how community health practitioners prioritise their existing resources in a way that ensures satisfaction of service users and therefore defends their practice—a practice called defensive prioritising. Authoritativeness of service coverage has emerged as a framework that guides these practitioners’ prioritising practice. This theory explains why continuity of care services receives a lower priority status than others and how this leads to gaps in such services.

The main problems encountered by community health practitioners are the issues of increasing demands amidst under-resourcing and conditions of understaffing. These structural conditions force the practitioners to assume versatile roles and responsibilities, which are more often competing rather than complementing. It is clear that the demands, when compared with available resources, are overwhelming, and it is impossible for the practitioners to respond to every demand with this given capacity—hence the need to prioritise existing resources.

Adding to the issues of resource scarcity is the need to ensure satisfaction of end-users on the services they receive. The issues of end-users’ satisfaction are taken into considerations in the prioritising of resources. This practice of prioritising is called defensive prioritising.
Authoritativeness of service coverage is employed by community health practitioners as a framework to assist them with defensive prioritising decisions. Service coverage concerns the allocation of existing resources that can be controlled by community health centres, that is, their personnel and their time. It refers to a pattern of decisions on what service, when and how the personnel and their time will be allocated. The three varying degrees of authoritativeness of service coverage have been identified. They are authoritative, benevolent and optional coverage. They vary the constancy and warranty of service coverage, explaining how community health centres spend their time and staff in the practice.

Authoritative coverage refers to the allocation of personnel and their time that is considered necessary and compulsory. This type of coverage is required by the service of authoritative status. The service is demanded and therefore expected by patients and the community in general. As a consequence it is monitored and evaluated by the community. Services in this category receive a priority status and therefore their coverage is warranted. Such services are, for example, curative care.

Benevolent coverage refers to the allocation of the personnel and their time, which is considered benevolently necessary but not compulsory. It is associated with home-based services given by community health practitioners, which are driven by their sense of benevolence and compassion, and seen by patients and families as an expression of benevolence on behalf of the practitioners who extramurally engage in the care of the elderly—care that is perceived as a moral quality of a family.

Optional coverage refers to a type of coverage that is considered important but optional. It is associated with health services that deem to have potential benefits for the community; however, it possesses less ability to compete for limited resources than other services. Services in this category, for example, health promotion are conceived by health professionals for the interest of the community. Services can be planned but their coverage is not necessarily warranted.
This defensive prioritising framework, i.e. authoritativeness of service coverage, helps explain that gaps in post-discharge continuity of care occur because many of its essential service components possess only a benevolent or optional status making them less capable of competing with more authoritative services for limited resources and are consequently subject of negligence.
Acknowledgement

The researcher wishes to thank the following persons who have been helping to make this report possible.

Professor Rhonda Nay and Dr Bill Koch, the researcher’s supervisors at School of Nursing and Midwifery, La Trobe University, Australia, for their continuous support and feedbacks.

The Alliance for Health Policy and Systems Research, WHO for providing a small grant for this study.

The Royal Thai Government for funding a scholarship for the PhD study from which this project is conceived.

Mr Apichat Thongma, Miss Saiyud Moolphate, and Miss Chuttipan Lorga who assisted the researcher with transportation, data entry and transcribing during the data collection period.

Mr Bradley East for editing this report.

All the participants who spent time sharing the information with the researcher.
Table of Contents

Summary 2

Acknowledgement 5

Part I: Backgrounds and methodology

Chapter 1: Lapse in attention: Continuity of care for the sick in prophylactic health care environments 8

Chapter 2: Methodology 19

Part II: Demands in community health services and the authoritativeness of their coverage

Chapter 3: Defensive prioritising: scarcity management in satisfaction-oriented services 26

Chapter 4: Authoritative services and their authoritative coverage 34

Chapter 5: Non-authoritative coverage: A case of benevolent care and optional benefits 47

Chapter 6: Gaps in continuity of care services: Theoretical explanations and practical implications 64

References 76
Part I

Backgrounds and Methodology
Chapter 1

Lapse in Attention: Continuity of Care for the Sick in Prophylactic Health Care Environments

On the first of May 2000, an article appeared in the online English newspaper, *Bangkok Post*, addressed a contemporary issue of health care in Thailand. Titled, *Health Care Crisis*, it suggested that:

Thailand’s health care system is based on cure rather than prevention, and public policy is more concerned with economic growth than people’s well being. That could be why health care costs are skyrocketing and more people are sicker than ever.

The main theme of this article portrayed Thailand’s health care system as “inefficient” and described it as placing an overemphasis of curative measures and a negligence towards promotive and preventive ones.

On the same day, another online Thai newspaper, *Dailynews*, dedicated its front page’s special scoop to an article “*Easy and costly death: Thailand’s bubble medical care wasting three billion Baht a year*”. The report highlighted the crisis of the health care system that emphasised repairing the sickness rather than building overall health, and that despite a dramatic rise in health care expenditures, the system had failed to create a healthy society—a phenomenon described in the article as “the sufferings of Thai people and the nation”.

The shortfalls of curative health care and the emphasis on a “health-repairing or sick health approach” not only provided one of the major forces for health care reform starting in 1996 (Wasi, undated) but have also created a discourse of “health-building health care” to counteract it. This makes the prophylactic-curative dichotomy a dominant lens to view health and health care, and subsequently spawned many
prophylactic health activities. One good example was a “National Health Building Event” day held on the 23rd of November 2002. This event attracted 46,824 people, including the Prime Minister, his cabinet, socialites and celebrities, to join a 61-minute aerobic exercise session in Bangkok in an attempt to make a new world record. An unknown number of participants also celebrated this event in other cities throughout the nation. During the media interview, the Minister of Public Health told reporters that:

If Thai people exercise regularly and maintain their health, they will help reduce the likeliness of getting sick as well as the cost of healthcare for chronic diseases. At the present, there are approximately 6.8 million Thais who have chronic diseases that require treatments, for example, diabetes, hypertension and heart diseases. These diseases cost the government fourteen thousand million Baht a year…. If Thai people exercise regularly and actively engage in health promotion activities, costs for healthcare will be markedly reduced and our population will become a quality population (The Thairath Daily, 2002a, online).

It is unquestionable that the so-called health-building approach, in contrast to the health repairing approach, does offer a positive and optimistic insight into health and healthcare. Despite this, there is reason to believe that the prophylactic-curative dichotomy, as a lens to view health and healthcare, offers an incomplete picture of health, illness and healthcare. A report from the Thairath Daily (2002b, online) illustrates a case of a 34-year old father of one who two years ago broke his cervical vertebrae, which unfortunately resulted in him becoming a quadriplegic. The report reads:

There was nothing much that the doctor could do to help him. He was quadriplegic and unable to move himself. His wife later took him back home. But being immobile caused him gangrenous pressure sores from the thighs to the buttocks. His wife took him back to the hospital. The surgeon
amputated his legs because they were seriously infected. He was later discharged home waiting for his pending death.

During the interview with the reporter, he said:

While I was expecting my death, I felt so sorry for my wife that she had to shoulder the care by herself. At that time I had a dearest friend and I decided to give my wife to him. I asked them to take care of me in return until I die because I knew that my time was so short. Both of them agreed and they did look after me well. But it was me who could not stand seeing both of them living together happily. And the fact that I didn’t want to burden them anymore, I decided to tell them that I wanted to go back to my hometown and die here. …

At the time his story was on the newspaper, he was living in his dilapidated hut built next to his brother’s house. He was cared for by his brother who himself, with financial hardships, had to take care of his own family—without any formal support. This case was picked up by a member of parliament, who was requested to intervene the case by the man’s family in hoping that they would receive some assistance. This case scenario is not something new in our society—similar stories of men and women, regardless of age, who have persevered the consequences of their illnesses and the lack of formal or informal support, have been heard over and over in the various medias and everyday conversations. There is no doubt that there will be many more repeated stories that continue to test our compassion and generosity. Despite being able to move the public compassion, not all of these stories receive instrumental intervention—leaving the entire responsibility to the family to shoulder.

Previous researched studies, in fact, reveal that families are willing to take on this responsibility to care for their loved ones at home (Caffrey, 1992, Sasat, 1998). Despite this willingness, caregiving-related stresses have been persistently reported in these studies. The researchers insist that formal support be put in place to help reduce
stresses and the care burden on families. It is not known, however, to what extent, if at all, these recommendations have been taken up. Williams et al (1996), for example, conducted a qualitative study of terminal care of cancer patients at home in northeast Thailand. Their participants included family caregivers, traditional and conventional practitioners. They found that the community health practitioners in their study believed that caring for dying patients was not their role. Reflected by the article title “They just go home and die: Health care and terminal illness in rural northeast Thailand”, the researchers commented that:

Very little advice was given by biomedical staff to patients and their families on coping with difficulties they would experience when caring for a dying person at home. Community members shared previous experiences and supported each other in this situation, but there was no input from health services… (p.105)

In the worst-case scenario, where family caregiving does not exist, the responsibility of care is left to the patients themselves—a situation that can cause enormous distress to the patient who hardly manages to meet basic needs, let alone health needs. A multiple case study on “The suffering of Thai people within the health system” by Boonmongkol et al (2002) found that negligence from family is one of the main sources of psychological distress for elderly people. In many cases, the elderly, who at their age would expect a filial repayment for care, have to resume a role of caregiving for other family members despite their own declining health (Boonmongkol et al 20002, Nilmanat 2001).

So far, where do these stories fit, if at all, in the prophylactic-curative health debates? Up to this point, it is clear that the prophylactic and curative dichotomy is inadequate as a frame to accommodate health and illness. It is inadequate because it fails to acknowledge the fact that there are individuals whose illness stories or trajectories, fall beyond the preventable and the curable. It is well understood that different illnesses may have different trajectories and that these illness trajectories vary the
types of healthcare services required by the patient. Some illnesses are medically or surgically curable and transient. Some are chronic or terminal. For those whose illnesses are chronic and irreversible in nature, neither prophylactic nor curative services alone or a combination of both may be adequate to maintain their health and independence. Often, these individuals will require some forms of assistance with their activities of daily living, for example, cooking, eating, bathing or managing medications. Many, whose health is irreversibly deteriorating or whose illnesses are terminal and do not respond favourably to prophylactic and curative measures, require supportive or palliative services to comfort their physical and psychological wellbeing.

The prophylactic-curative dichotomy precludes the dialogue about these services in today’s healthcare debates—firstly by leaving no room for a debate on ongoing care required following the illness, and secondly by portraying illness as well as its services as subservient to prophylaxis and prophylactic services. This raises a concern that there will be a lapse in discussions about continuity of care beyond prophylaxis and cure and those who are in need of this type of care. In fact, the anecdotal and researched evidence presented above already suggest that there has been a long-standing lack of these services in Thai communities. If the health system wishes to accommodate the stories of the quadriplegic man and other vulnerable individuals and families, dialogues that allow a possibility to see health and illness as a continuum of trajectory should be encouraged. These dialogues will allow further dialogues leading to the organising of healthcare that continually corresponds to the trajectory of health and illness—a system of organised services known as continuum of care. This is because, according to Evashwick (1996):

A continuum of care is a comprehensive, coordinated system of care designed to meet the needs of patients with complex and/or ongoing problems efficiently and effectively. A continuum is more than a collection of fragmented services. It includes mechanisms for organizing those services and operating them as an integrated system. … the
continuum guides and tracks over time, through spells of illness and wellness. The continuum of care does not imply that a person must be sick to be part of a continuum. Rather, should a person become ill, they would have easy access to the services needed. In the interim, they might participate in wellness activities…. The continuum incorporates both acute and long-term services, intertwining the two with common integrating mechanisms, rather than creating two separate systems of care (p. 6-7, original emphasis).

**Post-discharge care of elderly patients: a study focus**

This study was conceived in response to the foregoing arguments, which suggest that there is a lack of continuum of care dialogues in contemporary healthcare debates in Thailand and that this could impede the development of continuity of care services to support ongoing needs of ill people. The study investigated how the care following hospital discharge of elderly patients was managed at home and in the community. Discharge from a hospital does not necessarily mean that care is no longer required by a patient. This phase of care marks a critical transition of any individual patient wherein certain kinds of care are to be continued at home. It is usually a time when family has to learn new skills to deal with the disabilities of the patient following hospitalisation (Congdon, 1994). Families can experience stresses due to difficulties in managing care (Bull, 1992, Bull & Jervis, 1997). It is also a time when input from health services may be helpful for the family. As a result, the post-discharge period provides an ideal snapshot for a study that aims at identifying the extent to which the ideal continuum of care exists in practice.

Care of the discharged elderly patients was a chosen focus for this study. The elderly (aged 60 or over) represents the rapidly growing population group in Thailand (Chayovan & Knodel, 1997). In number, the total population of Thai elderly increased from 1.7 million in 1970 to 5.2 million in 2000. In 2010, 2020 and 2030, the number is projected to reach 6.9, 10.2 and 14.9 million respectively (Knodel et al
2000). The relative increase of the elderly population changed from 4.8 to 8.7 percent of the overall population between 1970-2000. The figure is predicted to be 10.8, 15.1 and 21.1 percent respectively in 2010, 2020 and 2030. These increases have resulted from the increase in life expectancy of the Thai population and a decrease in the fertility rate. In 1970s, Thai men and women lived to an average age of 58 and 63.8 years respectively, whereas in 1996, men and women could live up to 70 and 75 years (National Statistical Office, 1998).

The increased longevity is likely to be accompanied with an increase in the chronicity of health conditions. Jitapunkul et al (1999) report that one in four Thai elderly people acquires a disabling condition that limits their ability to perform activities of daily living. Furthermore, 19 out of every 1000 elderly population suffer from severe to very severe disabilities that require maximum support for daily living. The elderly population are more likely than other age groups to experience illnesses (Jongvatana, 1998). Disorders of musculoskeletal, cardiovascular, respiratory and gastrointestinal systems were common illnesses reported by the elderly. Cardiovascular, gastrointestinal, respiratory and urinary tract disorders correspond to 25.6, 25.3, 20.2, and 15.3 percent of hospital admissions among the elderly population respectively (Jongvatana, 1998).

In Thailand, families have long been the prime source of direct and material support for the elderly (Knodel et al, 2000). While the reliance of family caregiving has been emphasised (Ministry of Public Health—MOPH, 1997, Knodel et al, 2000), the continuation of this tradition has been questioned by changes in family support. A success from past family planning programmes and a consequential decline in fertility rates in Thailand have resulted in a decrease in the number of prospect family caregivers available for elderly at home (Pardthaisong, 1996). The decrease in number of family caregivers as well as the increase in chronicity causes a disproportion between demand and supply for support within the family. Previous research has documented caregiving-related stresses within the family as a result of this (Choowattananpakorn, 2001, Sasat, 1998, Caffrey, 1992). Besides, family direct
support and care is increasingly replaced by financial support (Knodel et al, 1995).

As issues related to the ageing phenomenon have gradually manifested themselves, the Thai governments’ responses to this have been increasingly salient. The first ‘Home for the Aged’ was established by the Department of Public Welfare (DPW) in Bangkok in 1953. Another eighteen homes were later built to cover other areas of the country (Jongsathitmun et al, 2000). These homes accommodate mostly the elderly who are poor, homeless and deserted (Knodel et al, 2000). In 1993, the DPW initiated a monthly allowance for the poor elderly. This scheme provides a monthly allowance to selected elderly with an amount of 200 Baht (approximately $US 4). By the end of 1997, approximately 318,000 elderly people were under this scheme. The amount of the allowance has recently been increased to 300 Baht per month.

In terms of health care, aged care is superimposed over and organised in accordance with the existing health care services. These services can be classified into five levels, namely, self-care, primary health care, primary care, secondary care and tertiary care (MOPH, 1997). The self-care level takes place within the family where an individual and family look after themselves and make decisions related to health and illness. The primary health care level involves health volunteers who provide a very basic health service to the community and communicate with health professionals. The primary care level is performed by trained health professionals or community health practitioners at community health centres at a subdistrict level. These practitioners include professional nurses, technical nurses, public health practitioners and dental auxiliary. These practitioners have undergone formal education ranging from 2 to 4 years in a public health or nursing college. Services at this level include health promotion, disease prevention and curative activities.

The secondary care level can take place in a community (district-level), general (province-level) or regional (region-level) hospital. Services provided at this level generally involve medical general practitioners and therefore emphasise curative care. The tertiary care level provides specialised services, which take place in general,
regional or university teaching hospitals. The higher care level hospitals serve as a referral resort when care cannot be managed at lower-level care hospitals. However, all of these hospitals provide primary care services through their outpatient departments.

Government responses to the health care needs of elderly people have so far emphasised medical coverage. A free medical care programme was initiated in 1989 by the MOPH to cover indigent elderly and subsequently made to include all elderly who do not have other types of medical coverage (Knodel et al, 2000). The scheme subsidises the cost of inpatient and outpatient services provided at public health facilities. This scheme mandates a stepwise service utilisation, that is, a patient is required to make a first contact at the designated health facility, which functions as a gatekeeper. Choices of designated gatekeeper are made according to the proximity between the patient’s residence and existing health care facilities within the community. For those who reside in an urban area, the first contact can be made at an outpatient department of a general or regional hospital, which is classed as a tertiary care hospital. Those who live in a suburban area may have an outpatient department at a community hospital as a first contact. Rural or some semi-urban counterparts are required to be seen first at a community health centre located within the community. Referrals to higher-level care facilities can be made upon permission from practitioners.

The MOPH’s measures aiming at improving referral systems during the past three decades have concentrated mainly on the referral from lower-level care facilities to the higher ones, that is, from community health centres to hospitals (Chunharas, 1998). This is primarily due to the attempt to ensure stepwise service utilisation and reduce bypassing rates at lower-level care facilities such as community health centres. Referrals from hospital to the community have appeared to be lacking. These scenarios highlight the overemphasis of medical services and the negligence of continuity of care in the community.
Given the issues of weakening family support and ongoing needs of the elderly patients following discharge from the hospital, formal support should be put in place to facilitate family caregiving of the elderly at home. In theory, community health centres located within the community are responsible for providing support for the family when they require (MOPH, 1996). Much of the previous research on community health services has concerned primary care services, i.e., health promotion, disease prevention and curative care with no known research studies specifically focussed on care following hospital discharge. This study therefore explored the nature of community health practitioners’ involvement in the management of this phase of care of elderly patients. It was envisaged to improve the understanding of community health practice in general, and continuity of post-discharge care in particular. This understanding can be utilised to guide practice and research in the future.

Summary

This chapter has argued that there has been a lapse in the continuity of care attention due to the dichotomising of prophylactic-curative approaches to healthcare. The focus of this study was on the management of care of elderly patients following discharge from hospital to home in Thai communities. Following hospital discharge, many patients continue to have needs that are to be met by themselves and their families at home. During this period, families can experience difficulties and stresses related to caregiving. It is envisaged that community health practitioners’ involvement in this phase of care is essential to facilitate a smooth movement of elderly patients from hospital to home.

The rest of this report is organised as follows:

- Chapter 2 describes the methodologies employed in this study.
- Chapters 3, 4 and 5—being the core presentation—present a theory
“authoritiveness of service coverage”—a framework that assists community health practitioners in their prioritising practice.

• Chapter 6 focuses on continuity of care. Authoritiveness of service coverage theory is used to explain gaps in continuity of care services. Practical implications are offered.
Chapter 2

Methodology

This chapter describes briefly the methodology that guided the data collection and analysis as well as the development of the main findings to be presented in the second part of this report.

Aim

The main aim of this study was to identify opportunities to efficiently utilise existing health and social systems to better manage care of elderly patients following discharge from hospital to home. This was achieved by analysing strengths and weaknesses of the current management of this phase of care as performed by family caregivers and community health practitioners.

Study design and methodologies

The study design was exploratory in nature. It was organised into two phases. The first phase utilising mailed survey was to identify participants for in-depth study in the second phase. The second phase, which constituted the main component of this study utilised grounded theory methodology (Glaser & Strauss, 1967, Glaser, 1978, 1992, 1998 & 2001) to explore current practice in relation to the management of care of elderly patients following hospital discharge.

During the first phase of the study, questionnaires were sent to elderly people who had been discharged from the regional hospital in a province six months prior to the study. In the final section of the questionnaire, elderly patients were asked whether they wished to participate in the second phase of the study. Thirty-five patients agreed to participate in an in-depth interview at home. However, 21 families out of these were finally interviewed. Health professionals involved in the management of post-
discharge care of the elderly were identified. These included mainly community health practitioners currently working in seven community health centres located within the community that these elderly patients resided as well as those from a division of health promotion of two community hospitals. Other participants included social workers and nurses who were working in acute care wards and a home health care unit of a regional hospital. A monk who established the shelter for homeless elderly was also interviewed. Altogether, 41 interviews were conducted.

**In-depth interview and constant comparative analysis**

Methods of data collection and analysis in the second phase were informed by grounded theory methodology. In-depth interview was the main method of data collection. Patients were asked an open-ended question: How have you been doing since you left the hospital? For family caregivers or relatives, a similar question was asked: How have you and the patient been doing since he/she left the hospital? Health professionals were requested to tell of their experiences in the management of care of elderly patients after hospital discharge. For community health practitioners, the following request was used: Please tell me about your experiences in providing care or support to elderly patients and their families after they return home from the hospital. For the hospital staff, the following request was used: Please tell me about your experiences in the discharge of elderly patients to home. Subsequent questions were guided by the participant’s answers.

Most interviews were tape-recorded and last between 30-60 minutes. Each record was transcribed immediately after the interview and the analysis began before the next interview. The analysis utilised constant comparative analysis method to generate categories and their properties. General steps of constant comparative analysis are described as follows.

1. Open coding: This stage of analysis concerns the naming and abstracting of empirical incidents provided by the participants. The researcher looks at
incidents in the interview transcripts that might indicate concepts. These incidents are constantly compared with one another to generate abstract concepts that encapsulate the pattern between these incidents. Names are given to these abstracted concepts. Open coding ceases when a core category is identified.

2. Identification of core category: Central to grounded theory methodology is the focus on the participants’ problem. Grounded theory advocates that the study should be dictated by the problem that concerns the participants and how they resolve it. During open coding, the researcher is forced to ask what problem or issue (of the participants) he/she is actually studying. The problem is identified by constantly comparing incidents to incidents. Upon the identification of the problem, the researcher should be able to identify how the participants resolve the problem that concerns them, again by constant comparison. This resolving category is called a core category.

3. Selective coding: This stage of analysis aims to saturate the core category. The researcher begins coding data selectively to generate concepts in relation to the core category and its properties. This is to saturate the core category. The researcher also saturates other categories and their properties that are relevant to the core category. This is done by theoretical sampling, where the researcher collects data from different or similar units. Other categories that are not relevant to the core category can be omitted. Data collection ceases when no new concepts are discovered—a situation called theoretical saturation.

4. Theoretical coding: At this stage, the categories are put back together to build a theory. A theory is generated around a core category. In other words, a theory of a core category is developed by integrating all relevant categories into a theoretical model that fits best.

In this study, the researcher started by interviewing elderly patients and their families. After a number of interviews, it was discovered that the caregiving was considered as “a moral quality of Thai families”. It followed that the families’ main concern was
related to this belief, that is, they desire and, in some cases, feel pressured by the society to maintain this moral quality despite difficulties. In response to their desire and the perceived social pressure, families stretched to the limit to continue family caregiving as long as they could. Three categories were then identified: (1) Care as a moral quality of Thai families, (2) Familial desire and social pressure to maintain caregiving, and (3), being a core category, Stretching to the limit. Stretching to the limits has three interrelated stages—doing well, persevering, and giving in or giving up.

After several interviews with community health practitioners, it was discovered that the main issues faced by them were understaffing and open-ended demands, which forced them to prioritise existing resources. Further comparisons with more incidents indicated that these practitioners were also concerned about the community expectations on their performance, and that they had to take this issue into prioritising considerations. The ultimate aim of their prioritising practice was therefore to be able to manage scarce resources and at the same time to ensure end-users’ satisfaction. This pattern of behaviours was conceptualised as “defensive prioritising”, which was identified as their main concern. The data collection was subsequently made to focus on how community health practitioners went about prioritising resources in defensive ways. Following this, “authoritativeness of service coverage” was identified as a core category. This core category was employed by the practitioners as a framework for defensive prioritising practice. Care as a moral quality of Thai families also emerged in the interviews with community health practitioners.

As may have already been noted, there were two core categories that emerged from the data. That is, “Stretching to the limits” from family participants and “Authoritativeness of service coverage” from community health practitioner participants. One core category had to be demoted, and a theory was to develop from another core category. This was to improve the scope and parsimony of the theory (Glaser, 1998). Finally, “authoritativeness of service coverage” was chosen as a core category to generate a theory. The selection of this category was consistent with the
original emphasis of this study that advocated the involvement of community health practitioners in post-discharge care management. Data collection and analysis therefore proceeded to saturate this core category and its properties and other relevant categories by means of theoretical sampling. For example, the researcher interviewed nurses from a home health care unit, which was better staffed, to compare whether there were any differences in the prioritising practice. Theoretical saturation was achieved after 41 interviews and data collection then ceased. A theory of authoritativeness of service coverage was finally integrated utilising continuum theoretical code—that is, degree of authoritativeness. Three varying degree of authoritativeness of service coverage were identified—namely, authoritative, benevolent and optional coverage. The development and integration of a core category and its properties and other categories will be presented in the next three chapters.

*The logics of rigour of a grounded theory study*

Glaser (1998) proposed four criteria for judging the quality of a grounded theory study—fit, workability, relevance and modifiability. Fit is equated with validity—the ability of the concept to explain the underlying pattern the incidents that generate it. Workability refers to the ability of the concept, once integrated into a theory, to explain how the participants resolve their main concern. By relevance, it means, once the theory is brought back to the area under study, it is capable of providing relevant explanations of what is going on in the area. And finally, modifiability refers to the ability of the theory to be modified by constantly comparing new data to achieve best fit and explanations of the area being studied.

*Ethical considerations*

Prior to each phase of the study, ethical approvals were granted by the La Trobe University ethics committee and all the organisations involved. Participants were fully informed about the research project and their rights to refuse participation or, once
participated, to withdraw from the study. Participants were required to consent their participation in the study at all stages. The participants were provided with the opportunity to consent verbally or in writing. Permission to record the interview was obtained from the participant prior to the interview. Their rights to refuse taped interview were respected by the researcher. In this case, notes were taken during and after the interview. The recorded interview data, once transcribed were erased. The hired transcriber was instructed to adhere to the project ethical protocols. Data were stored safely in a locked filing cabinet. Anonymity of the participants is assured in any presentations and publications resulting from this study.

The next part of this report focuses on the prioritising practice of community health practitioners and its relation to the management of care of elderly people following hospital discharge.
Part II

Demands in Community Health Services
And the Authoritativeness of Their Coverage
Chapter 3

Defensive Prioritising: Scarcity Management in
Satisfaction-Oriented Services

This chapter identifies the main concern of community health practitioners in their
day-to-day practice. This concern is the prime mover of their actions in dealing with
service provision to the community. It directs these practitioners towards finding a
solution to solve the concern and maintain the control in their practice. Here the
concern is conceptualised as “defensive prioritising”—a situation where community
health practitioners need to manage scarce resources and at the same time ensure end-
users’ satisfaction with their services.

Role versatility: a case of multi-purposed community health practitioners

The roles and responsibility of community health practitioners are conceived around
four core functions, namely health promotion, disease prevention, curative care and
rehabilitation, which are directed to individuals, families and the community. The
Division of Nursing, Thailand (1996), for example, identifies seven roles of
community nurse practitioners and lists them as:

- Direct care provider—provide health services to individuals who are in good
  health, at risk of developing illness, or already ill.
- Educator—educate individuals, families and the community on health
  promotion, disease prevention, self-care and rehabilitation.
- Advocate—inform the community about choices in health services, develop
  services that meet the community needs, advocate for underprivileged groups
  and voice their concerns about community health problems.
- Manager—assess problems, identify needs, develop health plans according to
  the needs, implement the plans, supervise the implementation, evaluate the
  outcomes as well as administer the organisation.
- Collaborator—collaborate with other organisations, for example, social work, education, agriculture and community development teams to integrate health services into these organisations.
- Leader—act as a change agent to improve health of the population, and
- Researcher—research health care problems systematically in order to provide resolutions to the problems.

The above description reflects the everyday work reality of community health practitioners in the studied community health centres. In fact their roles are designed to be multi-purposed to deal with complex community problems and needs. During interviewing, such comments as “we do everything” or “we do many things” were frequently heard. One practitioner reflected on their practice:

Our general work involves health promotion, disease prevention and rehabilitation. But in reality, the majority of our work is curative care. … We spend the morning for curative care, which is really not our core function. … We were trained (in a public health college) to do health promotion, disease prevention and rehabilitation. But in practice, we have to do everything by ourselves.

The following provides a non-exhaustive list of what these practitioners are involved in during their day-to-day practice.

- Antenatal care
- Maternal and child health
- School health and immunisation
- Curative care
- Consumer protection
- Sanitation and environmental health
- Home health care
- Home visit
- AIDS campaigns
• Anti Drugs campaigns
• Special clinics such as diabetes and hypertension clinic
• Health promotion activities
• Surveillance of epidemic or seasonal diseases and outbreak
• Health screening for at-risk groups such as aged people
• Meeting with the community to disseminate health and healthcare information
• Dental care
• Other urgencies
• Administrative work
• Meetings and workshops, and
• Social relation with the community

Open-ended demands in a changing health environment

In addition to their diverse responsibility, the multi-purposed design of a practitioner’s roles implies that there is always the possibility of adding new roles into their job description. This is especially true in ever-changing health and healthcare situations. For example, when directly observed treatment, short-course (DOTS) have been introduced to battle non-compliance with medical regimen in tuberculosis patients in a time of endemic resistance to drug therapies, community health practitioners are required to visit these patients at their homes to make sure that they take tuberculosis medications in front of them. Alternatively, they can ask the patients to come to the health centre to take the medications there. If any patient does not turn up, however, the practitioner has to visit them at home to ensure that the medications are taken. As one practitioner commented:

We have TB patients who have to take DOTS medications everyday that we have to make sure that they actually take them. By rules, they have to come to the health centre to take their medications in front of us everyday. But in reality, they cannot do it, perhaps they have other things to do or there is no transportation available. If this is the case, then we have to see
them at home. Make sure that they take the medications and show them that we are concerned. Hopefully this gives them a bit of motivation to continue the course of the treatment.

Another example of a professional’s diverse responsibilities is highlighted by their involvement in anti-drug campaigns. Drugs, especially amphetamines, have become an increasing and overwhelming problem in Thailand that successive governments have continuously combated. Many anti-drugs campaigns target school students and youths to prevent their future involvement in drugs. Community health practitioners, as part of the community are requested to take part in these collaborative campaigns. When the government first introduced a universal health coverage programme—a so-called 30-Baht scheme, these practitioners were required to meet with community leaders and residents to disseminate information and create a better understanding about this new system of health insurance. In response to national policies on ageing and aged care, aged people have been made a new target that deserves close attention in the community. Roles and responsibility in relation to aged care in the community have been prescribed for the practitioners to follow—whereas other groups that have long been targeted as at-risk groups such as mothers and children continue to hold this status (MOPH, 1996). More relevant to this study, recent initiatives to provide continuous care for patients following hospital discharge have made post-acute care services, including home health care and home visit, their new role to fulfil.

Changes often necessitate responses to contain or control undesired events and to meet the changing needs of the community. The new roles and responsibility created to respond to the changing environment in health and healthcare literally mean that there are more demands placed on community health services. These demands seem to be open-ended and are growing steadily in a time of cost-conscious health care and where active professional involvement is required to monitor health of the individual, family and the community. The practitioners are increasingly required to engage in activities once solely the responsibility of individual and family (for example, exercise and self-care) and more efforts will be needed to work with other health
organisations to coordinate the care of individuals to maximise their health and
minimise the use of expensive acute care services. These scenarios beg a question
whether community health practitioners will be able to cope with this increase in
demands.

Practitioners’ ability to respond and available resources

Resource reality is one important factor determining whether the community health
practitioners are capable of meeting all the demands they face in their practice. Two
resources that can be controlled by the practitioners are personnel and their time. They
shall be discussed further here.

Each community health centre is generally staffed with 3-4 practitioners. The staffing
comprises of one public health administrator, one public health educator, one public
health practitioner and, in some health centres, one dental auxiliary—all of them are
regarded as community health practitioners. The health centre caters for a population
of about 4,000-5,000 in its catchment area. This population, as mentioned above,
represents a diversity of health needs and problems that can occur from time to time.

The adequacy of staffing levels cannot be judged without taking the issues of
demands into considerations. To many practitioners, the staffing level is sufficient if
their only role is curative care. Many agree that the current staffing level is considered
adequate if they focus only on preventive and promotive care, which are their core
functions. With the increase in demands and their versatile responsibility, most
practitioners agreed that staffing is well below the satisfactory standard—they believe
a unit that consists of 6-7 practitioners is a good standard. A head of one health centre
commented:

The number of patients that come to our health centre has always been
high because we cover a population of over 7000 from 7 different villages.
This is considered high, given the fact that there are only three of us here.
By a standard, there should be one practitioner per every 1250 population. But we have only three. Basically, we are overloaded. Admittedly, proactive (health promotion and prevention) services are lacking because of this. In fact, it is already too much for us to cope with reactive (curative care) services.

When the resource, namely staffing level, does not match the demands, the practitioners need to design how to spend their working hours with the various demands presenting to them. Fixed and scarce resources, that is personnel and time, amidst open demands, forces these practitioners to allocate these resources to these demands in a way that ensures the availability and continuation of overall community health services. This practice of managing scarce resources is conceptualised as “prioritising” (Klein et al, 1996). One administrator commented on why prioritising was important to her practice:

I told the management that we don’t have enough staff here considering what we have to do. They said, “You can do it”. Well, they said we can do it then we have to manage and survive.

Another community health centre head also expressed a concern about understaffing issues and the need for prioritising resources.

If there is something that is more urgent, then we have to see to it first. For example, today one of us has to be in the workshop, I myself have to be in the meeting. So there are only two left— one is the public health practitioner and another one is dental auxiliary. We have to cancel our plan to visit the community (which is proactive health service). This is because we are short of staff.

**Defensive prioritising: scarcity management in satisfaction-oriented services**

Recently Thai people have become increasingly aware about their rights to health care
and are encouraged to voice their concerns and complaints about health services they receive. Sometimes they exercise their rights to complain when the service they receive is not to their expectations. The complaints and allegations may take place when the service they require is not readily available when it is required or when a community health practitioner misdiagnoses their illness and thus fails to control the course of the illness. The complaints can be made by the patient directly to the senior management, which will lead back to the practitioners at a later stage as a form of blame and performance appraisal. Allegations can travel across the community causing great damage to the reputation of the health centre and the practitioner. All of these make customer satisfaction a key component of service delivery in community health practice. Previous experiences with complaints and allegations make practitioners become aware that the services they deliver must satisfy the patient and their family. The ultimate goal of this is to maintain a good relationship with the community they are working with. In doing so, the practitioners guard against the blame from their senior management as well. Another administrator commented on the situation:

Things are different now. Before they (community residents) had to bow to us. But now we have to bow to them if we want to work with them.

The under-resourcing and open-ended demands have already created overwhelming conditions for community health practitioners to prioritise their resources. The situation is further complicated by fear of complaints and allegations against their practice. It is therefore necessary that they get their priorities right. By right, it means the priorities that will satisfy service users and defend, or safeguard themselves against blames and complaints. This practice of prioritising is conceptualised as “defensive prioritising”.

Summary

This chapter has highlighted the main concern of community health practitioners in
their day-to-day practice—the defensive prioritising. Several contributing factors to this concern are role versatility, resource scarcity, open-ended demands, the ability to respond to the demands, and the pressure to ensure customer satisfaction. All of these make prioritising inevitable in their practice and that it should be done in a way that defends the practitioners and their practice in general. The next chapter presents a framework that assists the practitioners in prioritising their resources—the personnel and their time.
Chapter 4

Authoritative Services and
Their Authoritative Coverage

With limited resources, community health practitioners cannot respond to every demand in the same way—or more precisely, with the same priority. In other words, different demands deserve a different priority status. The previous chapter has identified “defensive prioritising” as the main concern of community health practitioners that forces them to prioritise their personnel and time in a way that guards against complaints and allegations. This chapter follows how community health practitioners resolve this concern. To be able to do this, the practitioners create a framework called “authoritateness of service coverage” to assist them with the allocation of resources in a defensive way.

Service coverage: the use of personnel and their time

Existing literature on prioritising or rationing usually refers to resources as healthcare monies. Therefore, prioritising is accordingly discussed in terms of the allocation of the healthcare budget. Klein, Day and Redmayne (1996), for example, state that prioritising at the service delivery level—in their preferred term “rationing”, occurs when

…those responsible for providing services or making payments decide on who is to get what within the budgetary limits that they have been set. It is at this point in the hierarchy of decision-making that doctors decide on which patients to treat, social workers decide on the eligibility of clients for residential care and housing officers decide to whom to allocate homes (p. 10).

Unlike the above vignette, community health practitioners commonly talk about
prioritising in terms of the use of themselves and their time. To community health practitioners, personnel and time are probably the only resources that they have control of, hence being the focus of their prioritising practice. As already indicated, demands in community health services often compete with each other for limited resources. The decision on how to allocate the avail personnel and their time is therefore not easy or straightforward. The use of personnel and time concerns when, where, and what services they will be involved, whether and how they should spend their time for a particular service—a pattern of incidents conceptualised as “Service Coverage”. Here the word “service”, in the strict sense, refers to direct health services provided to individuals, families and the community. It may also refer to administrative work involved in community health practice as otherwise stated.

Service coverage is an essential aspect for prioritising considerations. To help with decisions on what services will require coverage and how time should be spent, community health practitioners must have a clear understanding of the many demands and that only some appear to require authoritative coverage. Other services signal a lesser degree of coverage or no coverage at all. Three differing degrees of authoritativeness of service coverage are identified as a framework that guides the prioritising practice of these practitioners. They are: (1) authoritative coverage, (2) reactive benevolence and (3) optional benefits. In this chapter, the discussions will concern service coverage that receives the highest degree of authoritativeness—authoritative coverage.

4.1 Demanded and Appraised Coverage: Its Authoritative Status

Services that acquire the authoritative status—the status that in effect makes the coverage authoritative, share at least two common and intertwining characteristics. Firstly, these services are generally demanded directly from those who are in need of them. Secondly, they necessitate performance appraisals of the practitioners in relation to the service they provide. The following discussions concern factors that give rise to the authoritative status of certain services.
Role image and role publicity: a case of curative care

The community perception of the community health practitioners’ roles is one important factor that contributes to the authoritativeness of coverage for the service associated with that particular role. In the community health context, curative role is seen as an image of the practitioner. Comments referring to the practitioners such as “when we are sick we go to see them” or “cure is their job” were often heard from family and patients interviewee. According to the Ministry of Public Health regulations, these practitioners are able to provide basic medical care for minor illnesses such as fever, cough, headache, back pain, abdominal pain, constipation, diarrhoea and anaemia (Division of Nursing, 1996). They are also able to perform minor surgical procedures such as excision, minor wound suture and wound dressing.

Whittaker (1996), who studied primary health services in rural Thailand, wrote about the curative role image of nurses in community health services.

A basic dilemma is entailed in the roles of nurses in the primary health care station. Although official discourse decrees their primary task is that of health promotion, in actuality they perform as curative practitioners and villagers expect them to provide curative services (p. 75, emphasis added).

Other authors such as Sawanpanyalert (1998, p. 45), while advocating comprehensive healthcare, has observed that in reality, curative services are overly emphasised because “they are valued most by the providers and the people”. The curative image of community health practitioners, and in fact most health professionals, makes this role above all others the most publicly recognised by the community—perhaps, the only role publicly concerned. It functions as a determiner of what the practitioners should do—in other words, what their responsibility is.
Curative rights

Despite being referred to as a responsibility of practitioners, curative care can be conveyed implicitly as a right of patients. In a practical sense, this right is entitled by a health insurance card they hold. One practitioner stated, “Curative care is their right because they have a low-income health insurance card. So they don’t have to pay for it”. Another practitioner expressed similar comments about the community residents’ uses of curative services.

When they come to see us at the health centre, it does not necessarily mean that they are sick. Sometimes they come here simply because they want some medicines to stock their supply. Like paracetamol, CPM (anti-histamine), or vitamins. Sometimes I ask them “what can I do for you today, grandma?” or “what brings you here today, grandpa?” They say, “Nothing, I just want to have some paracetamol and anti-allergic drugs because my supply has almost runs out”. … Sometimes they want vitamins, especially the elderly. I tell them “Look, you look very healthy to me, and I don’t think you need vitamin supplements, what you need is just good food”. But they insist that I give them vitamins. I just couldn’t say “No”, could I? Otherwise they would complain that I didn’t want to give away medicines. What I can do though is to give them a smaller amount and tell them to be careful about taking the medicines. I talk about side effects of these medicines if they use them for a long period. But whatever I say I can still expect them to come back for more medicines in a couple of weeks.

Similar comments from one practitioner:

Sometimes when I see that they don’t really need medicines, I’ll tell them “Look, I don’t think that you’ll need any medications today. One-day rest
should make you feel better”. I would spend time educating them on how they can look after themselves. I tell them “Whenever you come here, I’ll always spend time talking to you about your health so you can learn how to look after yourself”. Some of them will start whinging “When I go to the clinics, the doctors don’t have to talk about this stuff. They just prescribe. But why are we wasting time here?” I responded to them “You can think about it. With the same illness, here you spend more time and get free self-care education and don’t have to take any medication to get better. At the clinics, it’s quick but you have to pay for your medications”. Then they will understand. Changing people’s behaviours takes time.

Some practitioners expressed concern that after the introduction of universal health coverage, people will use more curative services. This is because, they believed, the rights to free curative services under the new insurance scheme will encourage people to be less concerned about getting ill because health services are free. They are afraid that people will enjoy their rights so much that however minor their illness, they will seek help from health professionals without trying to manage it themselves.

Curative rights also concern the referral from the community health centres to a higher level of care such as the community hospital and regional hospital. According to the rules of stepwise service utilisation, the community health centre within the community functions as a gatekeeper where patients are seen first before any referral can be made. Some patients insist they be referred to the hospital because they are more confident in hospital services where they can see a doctor—despite the fact that their illness can be managed at the health centre level. Some even bypass the centres and go directly to the hospital without any consultation with the practitioners and later have their relative ask for a referral letter from the centre. This usually frustrates the practitioners but at the end they must concede—a referral is permitted and written. In the latter case where the bypassing patient is not seen at the centre, signs and symptoms are reported in a referral letter according to the relative’s words. These reports sometimes are found to be inconsistent with what the hospital discovered—
usually signs and symptoms are exaggerated—leading to the hospital’s criticisms on the assessment skills of the practitioner and unnecessary referral of the patient who could be treated at the centre.

**Expectation, appraisal and risk of complaints and allegations**

Curative care as a professional responsibility and patients’ right create community expectations on this service. These expectations concern the at-all-times availability, convenience and quality of services.

The health centres are open from 8 am to 4 pm or until 7 pm in some centres that recently extended their service hours under the new policies of Ministry of Public Health. During these hours, patients will expect a service, which is readily available when they come to the centre. It is therefore the administrator’s responsibility to ensure that, despite other demands, the centre is to be staffed with at least one practitioner at any given time during opening hours. Because most visits for treatment are unscheduled and unknown in advance, the curative services are therefore organised in accordance with this. This is to ensure the convenience for the community residents as service users. As one practitioner commented:

> We have to choose whether we will close the centre for a few hours to visit the community then get complaints from people because they cannot find us when they come here. Or we make sure that at least one person is on stand by at the centre just in case we have a patient coming in.

One practitioner believed that the perceived convenience is associated with creating a mutual understanding. She stated:

> We need to communicate with them frankly. Try to get them to understand our situations. If I am here at the centre by myself and there are many patients waiting, I will talk to someone who seems to be understanding
and domineering. Tells him that I am busy and they may have to wait a bit longer today. He will tell the others “Hey, guys. She is by herself so be patient”. Then there is no problem if they understand that I am seeing other patients. Next time, I won’t have to tell them again. Someone will do it for me. But in any circumstance, there must be at least one staff here when they come.

The availability of curative services—in fact, the presence of the practitioner, is subjected to scrutiny of the community. The absence of the practitioner at the time a patient visits the centre may risk several adverse consequences. The practitioners can be accused of negligence. Complaints can be made by the patients to the senior management. The subject of negligence can be the talk of the town topic and a gossip in the wider community. All of these can greatly damage the reputation and image of the centre and cause a rift in the relationship between the centre and the community. Further, the complaints and allegations can cause them a great deal of blame from the senior management when they concern the reputation of the senior management as well.

In terms of quality of curative services, there are two aspects that concern the patients; firstly, the quality of medications used and secondly, the curative ability of the practitioner. Due to their previous experiences with health services at different levels of healthcare, for example the community health centre, community hospital, clinics, and regional hospital, patients are aware that the medicines dispensed at the health centre are of lower quality than those of hospitals and clinics. Generally there are no problems regarding this issue in community health practice as patients understand that the centres are supplied with basic drugs—the drugs that are used for a treatment of minor illnesses. This supply system is bound to the legal ability of the practitioners to prescribe. However, problem can occur when there are discrepancies in the prescribing practice between different healthcare centres as outlined in the interview extract below.
... patients have visited other community health centres, which are staffed with a doctor and were prescribed with better and more potent drugs, sometimes brand-name drugs. Here we have Penicillin V, but over there they have Ampicillin or Amoxycillin. We prescribe CPM here but there they do Sulidine (*brand-name anti-allergic drug*). When I gave them local antacid tablets, some patients ask for Antacil Gel (*brand-name antacid drug*) because they used to get it from other health centres. They said “I used to get it from other health centre, why can’t I get it here?” You have to explain why there are such discrepancies. They will understand but if they are still not happy with our prescriptions they can always go to the centre that give them what they want. We can’t control or stop them.

Quality of medications, however, is not of much of a concern to the practitioners because there are reasonable explanations on the part of their legal ability to prescribe and the availability of the supply. Their responsibility is to make sure that patients understand their limits in prescribing and why discrepancies in prescribing occur. The more important issue in relation to the quality of curative service is the ability to manage the illnesses. The illness management ability not only includes the ability to diagnose and treat the illness but also the ability to prevent avoidable complications as well as the ability to recognise the need for referral. The latter two pose a major concern on the practitioners’ behalf. One practitioner who failed to acquire the diabetic history of a patient upon attending to and treating her punctured wound on her foot, found out later that the small wound developed into a complicated wound. She also discovered that:

> Gossip about the incident spread through the community. It doesn’t matter how many good things you have done in the past, just one failure can rid them all.

This same practitioner also commented on the issues of referral:
When they are sick and we can’t handle it we have to refer them to the hospital. And when their family insist we refer a patient, then we have to do it too, even if we believe that we can handle the case. The family sometimes say “If you don’t refer him and there is something wrong with him later, you are responsible for it”. If they insist, we do it because we don’t know what will go wrong.

Complaints and allegations are not part of a practitioner’s everyday practice, but once it happens it continuously serves as reinforcement for appropriate approaches that will guard against the practitioners and their practice from future complaints.

**Inter-organisational collaboration, meeting and workshops: a required presence**

Other roles of the community health practitioners involve the collaboration with other organisations. Health-related collaborative projects such as the anti-drug and AIDS campaigns require active participation of the community health practitioners as representatives of health services in the community. Their contribution is essentially compulsory as part of their professional responsibility, which is well known among their peers. Their absence in inter-organisational collaborative activities would lead others to question their competency on their roles and responsibility in the activities.

Work of community health practitioners not only includes the provision of services to the community residents, but also involves administrative and development matters. Two good examples are meetings and workshops. Their main purpose is to keep the practitioners updated on emerging issues relevant to their practice such as changes in policies and disease outbreaks. Workshops are normally scheduled in advance. Besides scheduled and routine meetings, additional ones can be arranged when urgency is necessary. Meetings and workshops represent administrative demands that require a cooperative response from the health centre. The head of one health centre stated:
We have to juggle the demands within and outside the centre. But there have been much more demands from outside that I am hardly in. I am always out for meeting after meeting. Especially now that we have new provincial management policies and the head of health centre has been made part of the team. I have to attend every meeting. I mean ‘every meeting’. It doesn’t have to concern the public health issues but I have to be there. Agriculture, development matters, health, I have to be there.

**Routines and their percentage of achievement**

There are activities that are performed by the practitioners because they are “routines”. These routines are often written in policies and job descriptions along with a statement for desired achievement. For example, all pregnant women receive antenatal care, or every mother and child is visited at home following the delivery. Percentage of achievement serves as a tool for performance appraisal of the health centre.

**Deadline: a scheduled appraisal**

A deadline controls the pace of the work of the practitioners because it is scheduled. It signals what they must achieve by when. In community health services, most deadlines concern administrative work or financial accounts such as weekly, monthly and half-yearly reports on certain activities. There is usually a pressure associated with deadlines that forces the practitioners to dedicate their time to fulfil them. The following are some examples of the deadlines, which can be routine or situational.

- At least one food shop per one community health centre acquires a standard of operation according to the agreed sanitation criteria within three months (from the meeting date)
- Within six months (from the meeting date), eighty percent of computerised patient records will be complete and,
- Submit Report 0110 RNG 5 before the fifth working day of the month.
4.2 The use of personnel and their time for authoritative coverage

The discussions so far have demonstrated that services of authoritative status will reinforce an authoritative coverage because they are demanded and appraised. These characteristics have implications for prioritising practice in relation to the services of this kind. As already stated, the prioritising in the studied community health centres concerns the use of their personnel and their time, believed to be the only two resources that they have control over and therefore can exploit in a way that serves their purpose—defensive prioritising. In most cases, authoritative coverage concerns the warranty of coverage, and in one case, namely curative services, it dictates the constancy of the coverage.

Warranty of coverage

Authoritative services warrant the allocation of personnel and their time. This is to ensure the coverage for those services and in turn to reduce risks of complaints and allegations related to dissatisfaction as well as to demonstrate cooperation. One practitioner talked about how she and her other two colleagues coped with three authoritative demands in one day.

It just so happens today that the head of the centre has to be in a meeting in the province; one practitioner is in the workshop. There is only person left, which is me. So I have to standby here to cover the centre, because we may expect some patients.

Another practitioner commented:

Initially I had a plan to visit the community today, but there is an anti-drugs campaign at the primary school and we were asked to join. So I have been with them for the whole day today…. The visit to the community will probably be put off until I have time.
On paper work:

As you can see, I have lots of reports to do. They’re all due at the end of this month. I haven’t had time to do it. I really have to fix the time to do it.

**Constancy of coverage**

Besides acquiring a warranted coverage and unlike other services, curative services are the type of service that requires a constant just-in-case coverage. This is because the demand for this type of service is not normally known beforehand. It is out of the scope of this study to state how much time the practitioners spend on the actual provision of curative services, however what can be said is that most working hours of at least one practitioner at a given health centre are spent on constant coverage for curative services—in their words, standby mode.

**Attention to best possible quality: the importance of qualification and experience in allocating the personnel**

Because of its association with the community expectations, this type of service, curative care in particular, requires the allocation of appropriate resources that will best do the job. For example, nurse practitioners, believed to have better knowledge in medical treatment than practitioners with other training backgrounds, will be placed to look after curative services if necessary. Experiences related to the service area also count in the placement of the practitioner in the service they are involved. The nurse who was on standby at the centre explained how her and her colleagues went about deciding the placement.

At first it was me who would attend the workshop, but the head happened to have an urgent meeting. Then there were only two left—my junior colleague and me. She is a technical nurse with two years of training,
compared to me as a professional nurse (*four-year training*) with many more years of experience. So we decided that I am staying and my junior would be in the workshop. Just in case, there are complicated cases and I can handle them better than she does when she is by herself.

**Summary**

This chapter has discussed what makes certain services and their coverage authoritative. Services that are demanded and appraised earn the authoritative status and therefore warrant the coverage. The practitioners’ role image and publicity and the perceived rights in services such as curative care play a major part in creating the community expectations on the services associated with this role. In terms of direct health services, curative care is considered authoritative and as such it deserves warranted and usually constant coverage. The organisation of resource allocation for authoritative coverage represents the least flexible structure of resource allocation compared to other types of coverage. This relatively fixed structure has an enormous impact on the allocation of resources for other community health services, which will be covered in the next chapter.
Chapter 5

Non-Authoritative Coverage:
A Case of Benevolent Care and Optional Benefits

In this chapter, two other types of service coverage, namely benevolent care and optional benefits will be explored and discussed in a hope to gain more comprehensive understanding of service coverage in community health services in Thailand. The chapter begins with what gives rise to the benevolent and optional status of the coverage for these services and ends with how this affects the allocation of the community health centres’ personnel and their time.

5.1 Benevolent Care

It is clear from the discussions in the previous chapter that curative services are the responsibility of the community health practitioners. This section, on the other hand, discusses what families and health professionals in general believe the family should do in relation to the care of the elderly. The discussions on care as a moral quality of the Thai family and the illustrations to follow are imperative to understand the benevolent status of many a continuity of care service. The care of the elderly mentioned in this chapter refers to home-based care or care outside health facility unless otherwise stated.

Care: a moral quality of Thai families

It is well documented that family caregiving in Thailand and in fact elsewhere around the globe is perceived as a moral responsibility of the family. In Thailand, in particular, this perception is believed to have strong intertwining social and religious influences.
From the Buddhist perspective, the discussions on family caregiving have been associated with the concepts of karma, *Bunkhun* and merit and sin (for example, Choowattanapakorn, 2000, Subgranon & Lund, 2000). The karmic belief states that the present life has been influenced by the past deeds and will influence the future or the next life. While merit making will cultivate good deeds for the future, committing sin will lead to a life of misery. The *Bunkhun* system dictates that those who are favoured should return the gratefulness to those who favour them. According to these concepts, parents who have nurtured their children should be returned the care when they are in need. The filial negligence to provide care for aged parents will cause misadventure to those who commit this sin. On the other hand, those who fulfil their duty of care will thrive. These beliefs have imprinted the way of life and beliefs in Thai society and reinforce appropriate social conducts in relation to care.

**Stretching to the limit: families’ responses to the familial desire and social pressure to maintain a moral responsibility to care**

A patient can be discharged from the hospital for many reasons—being that the health problem has been solved, a patient is recovering at home or nothing more can be done by the hospital. The latter can apply to a patient who was sick and discharged from the hospital and has recovered to a point yet left with disability that medication or surgery can do very little to help. It can be a patient who is terminally ill and that any treatment is considered futile. A recovering patient can be someone whose physicality is good enough to leave the hospital and that care at home can be managed by himself and a family. It may be someone who can hardly manage but staying in the hospital does not make any difference because he does not have acute medical needs. In this case, the family is expected to cope with other needs at home.

**Care at home should not be demanded from community health practitioners: family perspectives**

Apart from curative care, the rest of the care of the elderly following hospital
discharge takes place at home. In all cases caring for the elderly at home suddenly falls on family hands. It concerns not only the management of medical and physical conditions but also social and financial matters as well. The care required ranges from basic management of daily activities of daily living to the management of chronic and terminal conditions. Some of them can be fulfilled comfortably by the patients themself or the family caregiver. Some of them require learned technical skills or are physically demanding.

It should be noted here that while facility-based care is associated with the professional domain, the home-based care belongs to the family domain. For families, this can have at least two implications. Firstly, home-based care is ultimately their responsibility. Secondly, they have control over the decisions involved in the course of care at home and that their decisions should be respected. The following extract illustrates the latter point.

Both the patient and the family should cooperate with our care plan to improve the care and the conditions of the patient. Sometimes we try our best to help but if the relatives don’t care and don’t want to do it, we can’t do anything more. We can’t go further than that. There have been quite a number of cases like this.

The following account from one elderly person illustrates the point that care at home is the responsibility of the family.

It’s not right to have the community health practitioners to come and see us at home. They have already finished their job. If we are sick then we go see them at the centre, and their job is finished there. Should we need a referral to the hospital, we go and ask them for the documents. And it’s done. When we get home from the hospital, it’s the family’s responsibility to take on the care. Given that there are only three practitioners (in the community) and that they have so many other things to do, we should not
demand the home care or follow-up from them. I don’t know whether other people will have the same idea, but for me it’s a family’s responsibility.

**From doing well to persevering**

Central to the family caregivers’ concern is how to maintain the expected moral duty of care whatever situation they are in. Most families can manage quite comfortably—physically and financially. Many families, however, find it hard to cope with needs for physical care. These families find themselves frustrated by a fine line between their desire and social pressure to maintain care of their elderly members. This is especially frustrating when social and financial situations are not in favour of the full-time caregiving. Some families find it hard to make ends meet. When illness happens in the family and care is required at home, a family member is to be secured for a full-time caring job. This makes a family with a small number of capable carers more vulnerable since they have to juggle between work and caring for their elderly parent. One woman had to quit her job to look after her parents who were both ill—one with unstable diabetes and another with a psychiatric problem.

**Calling upon existing resources**

With a desire and pressure to maintain their moral duty of care, however, families stretch to the limit to make sure that the care is always available for their family member or their ageing parents. When needed, they call upon existing resources such as asking their siblings for help with care—be it financial or physical. Being out of work and having no money at the time of their parent’s illness, they may borrow money from their neighbours and return it when they resume working after the recovery of their parent.

**Making do and persevering**

Families make do with what they have and do their best to care for their parents. They
do whatever they can despite difficulties to maintain the care at home—in fact to maintain the moral quality of being sons or daughters. In one family situation it was observed that a 2.5 by 2.5-square metre temporary hut was built to accommodate the changing needs of the elderly patient after discharge as he could not walk or climb flights of stairs to the toilet outside the original house. The floor of the hut was cut through to make a small rectangular vent with a receptive tin under it to accommodate his toileting needs. The tin was cleaned by his son and daughter in-law every time after his use. A pair of cracked and stained spectacles found in the rubbish bin were still of good use to help improve his sight. This elderly person persevered the heat in his low, tiled roofed hut during the hottest summer months in Thailand with intermittent cool relief from a few showers given by his son and daughter in-law. The slow progress on his physical and medical conditions were worrying and stressing the family. They were all desperate to see the doctor at the community hospital located 7 kilometres away from home; however, the cost of transportation was unaffordable. Before this illness, he had been able to be on the back of his son’s motorcycle to the health centre and the hospital. But after returning home from the hospital, he could not even travel on the pickup truck shared by other passengers—the only type of public transport. The only possible means was then a hired car.

Better-off families do not generally experience the persevering state of caregiving. These families normally have secure incomes and/or comprise of enough capable caregivers. A woman with spinal vertebrae injury was cared for by four caregivers who took turns at the caregiving. A single man who suffered from stroke was sent to the private nursing home because his sister who also had diabetes and hypertension could not manage the care by herself. The cost of the nursing home placement of around $US 150 per month was paid for by his sister’s son who had a secure job in the bank. While there were caregiving-related stresses in these families, their limits to cope were more than a family with a single caregiver who had multiple care recipients and no regular income.

For poor families, resources, which are already scarce, can become exhausted.
Poverty among siblings denies the possibility to accumulate funds for the care of their ageing parents. Community support may be helpful but some forms of support have the limitations. While knowing that her neighbours continuously praised and encouraged her to provide care for her frail parents, a woman was disinclined to trouble them with more financial loan requests. She was on her conscience that she should no longer take her father to the hospital on a free ride offered by her neighbours and that she started paying them when she had to do so. Despite financial hardships, the poor persevere the course of care at home. A home health care nurse reported a story of a daughter who locked her frail mother who was on tube feeding inside the house while she was at work. She, however, fed her mother before she went to work in the morning, and came back for another feeding during her lunchtime. To maintain this moral duty of care is to continue to be a good son and good daughter.

**Giving in: seeking professional care**

Families will normally do everything they can to keep the patient at home unless the demands for care exceed their limits to cope. This is usually the case of deteriorating medical conditions where families believe the patient could benefit from medical intervention at hospital. Otherwise they will try their best to maintain care at home. A daughter told the researcher about her decision to take her father back to the hospital after a few days following discharge from the regional hospital.

The doctor discharged him because there was nothing more to do, and he would not get better. We took him home thinking that he would finally die at home. But it was too much for me to cope with. He was crawling around the house moaning and groaning in pain and agony. It was so distressing to see him like that. I couldn’t stand it. My mother *(with a psychiatric problem)* almost stabbed him with a knife because she did not recognise him. I took him back to the community hospital and he is now in the hospital. In fact, he has been readmitted to the community hospital a few times after leaving the regional hospital.
Giving up: the negligence and breakdown of the moral duty of care

While most families try their best to provide the care for their elderly parents, some choose to give up the duty of care. Financial hardships and lack of direct family were the main causes of negligence. This is especially true when the reason for maintaining care is one based on social pressure rather than a filial desire. Children who co-reside with their parents have to maintain the duty of care for the elderly despite facing considerable strains from the demands of caregiving. The maintaining of care in this situation is not often free from physical or verbal abuse.

Upon returning home from the hospital, a frail and elderly woman was told by her neighbour that her only living daughter and her family had moved out to somewhere else. She searched desperately wanting to know where they were or whether they were still alive. She had not had contact with them since. She was, at the time living in the shelter for homeless elderly in a temple.

When becoming frail, those with no direct family member, i.e., spouse or children, are distanced from people they used to have close relationships with in the past. Their sisters, brothers or ex-employers become acquaintances, neighbours or even worse total strangers. Their diminished productivity and the increased dependency explain many of the distancing relationships and negligence. The same elderly woman at the temple shelter recalled her experiences about her neglected friend who died at the temple.

About thirty people attended her funeral organised at the temple. Most of them were from her hometown. Her sisters were here too, but they told me that they were neighbours. But other people from the same town told me they were actually her sisters.

And about her other friend
He has no immediate family at all. He used to work for a man in the fruit orchard and lived there. But when he became frail and senile, the guy he used to work for refused to look after him. He simply said he (her friend) didn’t work for him. He let him live in a hut in his orchard because he had no relative.

Sometimes negligence occurs because the elderly have no asset left—known colloquially in Thai as “a dead log with no mushroom”. A diabetic woman was found dead in her own house by her neighbour after she had gone unnoticed for two days. Before she died she was persuaded by her only son and daughter-in-law to transfer all her properties to them. Her son shortly died of AIDS and his wife took all the properties and moved in with her parents in another town leaving her at home alone. Her other relatives were infuriated about her decision to transfer all the properties to her son and therefore cared less to look after her. This probably further agonised the poor woman until her death.

**Professional descriptions of ‘good’ and ‘bad’ families**

The foregoing discussions have demonstrated that the strong belief in care as a moral quality of the family makes most families pursue the care of the elderly at all cost. This proposition renders two questions concerning health professionals and their belief in moral duty of care. Will this belief influence health professionals who have been raised and grown up in the same society? Will this influence how they see family caregiving?

The responses to the two questions are positive. Health professionals refer to families who attempt to maintain the care for their sick members as “good” or “responsible” families, whereas those who fail to do so are considered “bad” or “irresponsible”. Their descriptions of “good” and “bad” families are identical with those of lay people. These moral descriptions—whether applicable to families or professionals—reinforce the
idea that families should remain in the act of caregiving. The message clearly conveys that, ultimately, the responsibility to care for the elderly remains with the family.

**A benevolent status of professional involvement in family caregiving**

*Professional benevolence: the making of extramural efforts*

Having prescribed that family caregiving is the entire responsibility of the family, families and community health practitioners give a less authoritative status of professional involvement to it. The involvement of community health practitioners in the care of the patient at home is seen as having made extra efforts—hence professional benevolence. Professional involvement is associated with generosity, kindness, compassion or worry. One practitioner responded to the question whether home health care is considered as a right of the patient. She said:

Let’s not talk about rights. For me it is humanity. If I know that a family is not managing, I will visit them without them having to ask me. Whenever we go there we will have a gift set for them—like a dozen eggs or some milk. We just want to see how they are doing and see if there is anything we can help. Our visits support them mentally and encourage them to continue the care. The gift sets normally come from our pockets. There is no budget for this. Sometimes we can’t do much. We just feel compassionate for them.

There was a patient who broke his leg and was put on external fixator. He needed wound dressing changed daily at his place. He couldn’t come here at all. We had to go there everyday and that made him feel sorry that he was troubling us. However busy we were we had to have someone go see him. One of us had to sneak out to see him, and ask the others to look after the centre while she was away.
Another practitioner responded in the same way.

I don’t look at rights. I’ll see to which case needs a home visit. There was one case that I happened to find out by chance. I felt that I didn’t help him much. He came here to buy alcohol and cotton balls. I was surprised that I had been working here for many years but never met him. And here he was asking for alcohol and cotton balls. I found out that he wanted them for insulin injection. He had diabetes. I had not seen him before because he went directly to the hospital. I gave him alcohol and cotton for free. I was worried that he might not cope well with the injection and whether he knew how to store insulin. I planned to visit him at home sometime during the week. Unfortunately, he died of pneumonia before I made a visit. He was only forty-two.

In many circumstances where operating hours are overwhelmed by other demands, the practitioners even use their after-hour time to visit patients. Trips to patient homes are done at the expense of the practitioners to cover the cost of petrol and maintenance of their own vehicle used for public service. Should a patient need a referral and transport is not affordable by the family, the practitioner’s car can be used for this purpose. Work colleagues donate their extra-duty living allowances to an informally organised benevolent fund to allow them to purchase gift sets for patients they visit. This is an obvious case where the practitioners have invested their own resources into the care of the sick at home—making their extramural service a case of professional benevolence.

The publicity and scrutiny of the benevolent roles

The benevolent nature of professional involvement in the care generally accepted as the responsibility of the family makes the roles associated with these services less visible than that of curative care. The community in general may have experienced such services directly or indirectly, however, the provision of the services by the
community health practitioners is not seen as prescriptive, but benevolent. The practitioners and the family engage in a benevolent relationship where the practitioners exercise their generosity and kindness to assist the family who is in need of help. It follows that there is no such scrutiny from the community as that of curative services—the scrutiny that concerns expectations and satisfaction. If there is one, such evaluation is done on the ground of relative benevolence. For example, nurses working under the present management policies that do not have a home health care programme are not seen to be as kind as nurses under the previous management that provided home health care services for the patient.

_The initiation and maintenance of the benevolent relationship_

Despite feeling or having the needs associated with care, families hardly express these needs to the practitioners. Because of this the practitioners may not be aware of vulnerable families in the community who are in need of help. Practitioners can somehow find out that there are families in the community who are not managing well in the community. Several means of finding out about the vulnerable family are as follows: (1) intentional referral by the family and community networks and their advocacy group such as friends, neighbours, members of senior citizen club as well as health volunteers, (2) unintentional disclosure of the case—namely, by words of mouth heard by the practitioners, and (3) active case finding by the practitioners. The former two are the most common means of making the case known to the practitioners, the latter is quite rare, given the fact that the practitioners’ constrained time is dedicated to other services with more authoritative status. The practitioners’ awareness of vulnerable families induces their compassion and benevolence towards the family and the patient. Professional benevolence helps initiate the engagement of the community health practitioners in assisting the family with the care of the patient. The benevolence can keep the practitioners in this helping relationship until the situation improves.

_The compatibility between professional capacity and the demands, and the nature_
of professional involvement

Despite having versatile roles, it is evident that the community health practitioners do not have all the qualifications that match all services, especially those that require specialised skill training. The most common case is rehabilitation where there is no physiotherapist working in any of these community health centres. The practitioners rely on their limited rehabilitation knowledge to help the patient, for example, by encouraging them to move around and do simple range-of-motion exercises. Other sophisticated procedures normally performed by a physiotherapist are unachievable. Sometimes, the needs such as financial matters fall outside their responsibility and capacity. These needs normally warrant no intervention from the practitioners.

Professional involvement in the care is instrumental in certain cases where the practitioners provide direct intervention for the patient such as wound dressing, injection, and urinary catheterisation. In other cases their involvement is more a supervising, educating and encouraging in nature. This type of involvement usually takes place in a context where the practitioners attempts to assist the family to deal with and as such retain them in the care of their family members. This type of care, while not instrumental, is helpful to encourage families with social and financial concerns to continue their duty of care.

5.2 Optional Benefits

This section focuses on services that are believed to have beneficial effects on health, however, are considered optional—optional benefits. In line with foregoing discussions on authoritative coverage and benevolent care, the discussion on optional benefits will begin with what makes them “optional benefits” and how they impact on the overall prioritising practice of community health practitioners. Health promotion will be used as a case example to provide an understanding of any service of optional benefits.
Health promotion: professional interest and effort for the interest of the community

While the community express an interest to acquire curative services from community health practitioners, they hardly do so in relation to health promotion services. In fact, it is the practitioners who believe that health promotion is organised in the best interest of individuals, families and the community. Despite the enthusiasm in health promotion as discussed in Chapter 1, health promotion is described by the practitioners as optional benefits—an activity, which is potential for health benefits on the condition that the practitioners have time to do it.

The fact that health promotion services normally target healthy people makes their status less authoritative than other services of authoritativeness and benevolence in nature. Axiomatically, the lack of health promotion services poses a lot less immediate threat to individual health than the lack of curative and other restorative services. Despite the need for collaborative efforts from both sides for any service to succeed, the efforts in organising health promotion activities seem to be dominantly appreciated by community health practitioners. These professional efforts are sometimes futile because there are minimal reciprocal efforts from the people they are working with. The problems in obtaining reciprocal efforts can be experienced through the course of health promotion services from recruiting participants, maintaining their interest to retaining them in the activities. In comparison with curative services, performance appraisal for health promotion, from the community at least, is minimal or even nil. Amidst limited resources and other competing demands, health promotion and other health services that share the above-mentioned characteristics are given optional status. The following interview excerpts provide the illustrations of the foregoing discussions.

Last year we organised a programme to promote exercise among elderly people. We wanted to engage them in health promotion activities and to raise their awareness about this. It might not be successful. Let’s say, if we
have twenty participants, probably only five of them continue to do it after the programme finish. But I am happy about that because changing people’s behaviours takes time.

We do have a problem with inadequate staffing. Like this year we plan to apply for funding from the local government for exercise projects…. But we are not anywhere near to what we have planned yet. There have been a lot of other things to do. There are always other priorities.

There is a monthly plan that we’ll follow and tell us what we have to do. But it doesn’t mean that the plan will be followed exactly. If there is something that is more urgent, then we have to see to it first. For example, today one of us has to be in the workshop, I myself have to be in the meeting. So there are only two left—one is the public health practitioner and another one is dental auxiliary. We have to cancel our plan to visit the community (which is proactive health service).

5.3 The benevolent and optional service coverage

The discussions so far concern community health services under the ‘benevolent care’ and ‘optional benefits’ categories. The discussions have highlighted factors that give these services the so-called benevolent and optional status respectively. With this in mind, the discussion to follow will concern how these status impact the nature of service coverage for these services.

Benevolent coverage

Reactive coverage

As in authoritative services, benevolent care takes place in response to needs of people. Despite this similarity, there are differences between these ‘reactive’
responses—the differences that lie in their requirements for professional involvement. While the practitioners’ involvement in services under authoritative services is necessary and compulsory, their involvement in benevolent care services is believed to be non-compulsory but necessary—a so-called benevolent coverage. This type of coverage is reactive to professional awareness of vulnerable individuals and families who are in need of help.

Because of its benevolent status, home-based care services are sacrificed for services of more authoritative status such as curative care. Personnel and their time are allocated first to cover authoritative services, which are the priority in community health practice. As a result, home-based care services have to utilise the remaining and perhaps minimal resources. These minimal resources can be further exploited by authoritative services. This was illustrated by the cancellation of home visits due to other urgent demands.

Finding time: a case of strategic flexibility of resource utilisation

Being equipped with minimal resources, the utilisation of these resources for this type of service requires a considerable degree of flexibility for them to function within a relatively fixed structure of resource allocation for authoritative coverage that dominates overall community health practice. Community health practitioners will exploit opportunities, whenever they become available, to maximise service coverage. For example, the practitioners sometimes “sneak out” from routine but compulsory work to visit a patient in the community. They may “drop in” at a patient’s home on the way back from a meeting. One practitioner commented:

The work (home visit) that we are doing does have a plan. But in reality, this plan is hardly followed. We really have to find time when we don’t have anything else to do to visit patients in the community.

Investing personal resources
Sometimes formal resources are not adequate to deal with existing demands, the practitioners have to invest their own resources in the delivery of services. For example, they may use their after-hour’s times to visit a patient in the community on their way home. Some practitioners who also reside in that community may utilise personal relationships to gain knowledge about the community and families. These personal relationships generally cannot exist without professional relationships where the practitioners provide advices or assistance concerning health for families.

**Social and financial needs: a case of no intervention**

Social and financial needs do not warrant an intervention from community health practitioners because these needs lie outside their capacity to manage. Furthermore, there is no well-established system of referral should these needs arise. Despite expressing their compassion over the situation of patients and families, they could do nothing to improve the situation. This often distresses the practitioner who is involved in the case. One practitioner said:

> I go out in the morning a happy person, but come back a distressed one in the afternoon after meeting families who cannot manage their social and financial needs. I just feel sorry for them, but there is nothing much that I can do to help them.

**Optional coverage**

The optional coverage can be described as the coverage that is considered important but optional, e.g., health promotion. Because of its optional status, its planned coverage can be traded off for services of higher priority or may not even take place.

**Role specificity and versatility: their impact on service coverage**
The specificity or versatility of professional roles has demonstrated an impact on the service coverage. The more specific the role is, the better coverage of services associated with that role is achieved. For example, the home health care unit whose only focus is on home-based care services performs better, in terms of the amount of service coverage at least, than community health services whose roles are versatile. This can be explained by the fact that the role of the home health care unit is authoritative in terms of compulsory performance evaluation from the hospital it is associated with. Being versatile and under-resourced, on the other hand, forces community health centres to be selective of their service coverage—namely, by focussing on roles that are associated with public expectations and consequently paying less attention to other roles with less expectations from the wider community.

Summary

This chapter has concerned services that hold lower priorities than authoritative services—namely, benevolent care and optional benefits. The benevolent status of home-based care services is associated with the mutually held belief that family caregiving is a moral quality of the family. The optional status of health promotion and other services alike is due to the lack of community interest and active participation in these services. Given the existing conditions of limited resources and competing demands, services of benevolent and optional status are sacrificed for services of authoritative status. The next chapter will attempt to explain gaps in continuity of care services by utilising the theory of authoritativeness of service coverage presented in chapters 5, 6 and this chapter.
Chapter 6

Gaps in Continuity of Care Services:
Theoretical Explanations and Practical Implications

This final chapter utilises the theory of authoritativeness of service coverage to analyse and explain gaps in continuity of care services in the study communities. Recommendations for practice will be proposed based on this theory.

Conceptualising gaps in continuity of care services

For practical purposes and to facilitate the analysis, gaps in continuity of care services are conceptualised here as unmet needs of the patients due to lack of appropriate responses that match the changing conditions of a patient. Examples of gaps can be presented below.

- An elderly diabetic woman who had no family caregiver was found dead in her house after having gone missing for two days.
- A daughter had to quit her job to become a full-time caregiver for her parents. She experienced financial hardships and stresses throughout her caregiving period. There was no formal support for her caregiving role and she believed it was entirely her responsibility to care for her parents.
- A family could not take a patient to the community health centre or hospital because they could not afford the cost of transportation.
- A woman with broken vertebrae did not receive rehabilitation service because there was no such service in the community.
- A stroke patient was visited at home by a practitioner, but due to the lack of rehabilitative training of the practitioner, he did not receive any rehabilitative service.
- A patient failed to take tuberculosis drugs and the practitioner did not have time to check on him.
• An elderly woman was locked in the house while her daughter was at work.
• An elderly woman discovered that she no longer had a family caregiver after her daughter ran away. She did not know how to cope with the situation.
• Many more hypertensive patients could have been found had there been more health screening programmes.
• Chronically ill patients who could have benefited from home health care or home visit services did not receive such services because community health practitioners had no knowledge of their existence.
• Families persevered financial hardships and community health practitioners could do little to help because it was outside their capacity.

Classifying gaps

The preceding list has presented various types of gaps. These gaps can be understood as consequences of certain causes and therefore classified in terms of these causes. The cause-related classification of gaps can be achieved in various possible ways. The first possible classification, for example, states that these gaps exist because: (1) the required service does not exist in the health system, (2) families and patients fail to continue the care at home, and (3) health professionals fail to intervene in the care of the patient who is in need of professional support. The second classification, on the other hand, states that gaps may occur because (1) the service required is outside the practitioners’ responsibility, or (2) the service required is within the practitioners’ responsibility but they fail to intervene. While the former classification focuses on who is at fault of the gaps, the latter classification focuses on the realm of responsibility of community health practitioners. These two classifications however are overlapped.

Taking the context of resources into considerations gaps may occur because resources are limited. The third classification then states that gaps occur (1) as a result of defensive prioritising of resources and (2) because the required services do not exist in the system to be utilised. The first statement is based on the knowledge that the
defensive prioritising of resources results in the differing status of service coverage. The making of these coverage status, namely authoritative, benevolent and optional status is where gaps occur. Gaps that occur as a result of defensive prioritising are associated with the community health practitioner’ responsibility. Unlike the first statement, the latter conveys that gaps are outside the practitioner’ responsibility and ability to manage. The third classification is situated within the context of the study and is therefore relevant to the discussion about gaps to follow.

**Gaps as a result of the defensive prioritising**

From “Authoritativeness of service coverage” theory perspectives, it can be concluded that gaps in continuity of care occur because community health practitioners fail to provide sufficient coverage for some services. The non-priority status of such services is a result of the defensive prioritising of limited existing resources. The following summarises the course of defensive prioritising and its consequences on service coverage. This will lead to the understanding on how gaps in continuity of care services may occur as a result of this.

- **Personnel and their time as resources:** Community health practitioners themselves and their time are believed to be the only two types of resources that the community health centres have control of. They play a major role in prioritising practice in community health services.

- **Demands:** Demands in community health services are open-ended. Within changing social and health environments, demands are on the increase. Community health practitioners are required to resume new roles and responsibility in response to changing health needs of individuals, families, and the community. Administrative and managerial demands represent a considerable portion of the overall demands.

- **Resource scarcity:** Relative staffing level and demands ratio is considered inadequate. Understaffing is prevalent among community health services. Community health practitioners must take on versatile roles and responsibility
to accommodate a diversity of services required within the community.

- **Pressure to prioritise scarce resources:** To be able to continue the overall services, community health centres must prioritise existing resources—namely community health practitioners and their time.

- **Community expectations and defensive prioritising:** The prioritising of existing resources must take the issues of community expectations and consumer satisfaction into consideration. This is to safeguard them and their practice from complaints related to dissatisfaction, which may damage the reputation of the centre and practitioners.

- **Authoritative demands:** Facility-based services such as curative care receive a priority status because they are associated with health professionals’ identity and therefore belong to the professional responsibility domain. They are evaluated and appraised by the community. Other collaborative services such as anti-drug campaigns as well as administrative and managerial demands are considered authoritative. This type of services is generally demanded directly by those who want it.

- **Authoritative coverage:** Coverage for authoritative demands is compulsory and therefore warranted. Personnel and their time are allocated first to these services. Curative services require constant coverage to ensure readily available service and patient’s satisfaction. Authoritative coverage, which is relatively fixed in structure, dictates overall community care practice and other types of service coverage.

- **Care as a moral quality of Thai families:** Family caregiving is culturally believed to be a moral quality of the family. This belief is mutually held by both families and health professionals. It leads to the construction of a moral role of the family in providing care to their sick or elderly member.

- **Families stretch to the limit:** Most families try their best to maintain their moral responsibility to care for their sick or elderly members. Not all families manage comfortably—physically or financially. Many families persevere the course of caregiving and the stresses related to it, believing that this should be contained within the family. They believe professional care should not be
demanded at home, because it is outside the practitioner’s responsibility. Some families choose to neglect the moral duty of care.

- **Benevolent relationship in home-based care:** Community health practitioners’ involvement in home-based family caregiving is seen as the making of extramural efforts by community health practitioners and therefore perceived as professional benevolence. The benevolence initiates and maintains the helping relationships.

- **Benevolent coverage:** Service coverage in benevolent relationships is considered necessary but not compulsory. Community health practitioners respond to family caregiving situations on the grounds of humanity and benevolence. For the helping relationship to take place, it requires the practitioner to aware of such situations. The allocation of resources for this type of coverage is subservient to that of authoritative coverage. Its planned services can be sacrificed should personnel and their time are required by authoritative services. Community health practitioners must find time to perform services under the benevolent coverage category. They may even invest their own resources to compensate the coverage.

- **Optional benefits:** Services of this kind are thought to be potentially important but optional. They are initiatives originated from professional interest for the best interest of the community. This type of services such as health promotion demands considerable effort from community health practitioners to recruit and retain people in the programme.

- **Optional coverage:** Despite potential benefits, the lack of services such as health promotion appears to pose a considerably less threat to people compared to that of curative or restorative care. Therefore, they can be postponed or traded off when minimal resources are needed for services of higher priority.

As the picture of defensive prioritising practice and its consequences on service coverage is complete, gaps in continuity of care services can be now identified. The discussion will begin with the identification of three major factors that give rise to
authoritative, benevolent and optional status of service coverage. These factors comprise structural, psychological and socio-cultural factors and will be discussed below.

- **Structural factor**: Structural factor here concerns staffing levels. As already indicated, the staffing level in community health services is insufficient compared to the existing demands. The understaffing condition necessitates the prioritising of existing resources.

- **Psychological factor**: This factor concerns community health practitioners’ fears of allegations and complaints of negligence, and therefore the need to ensure service users’ satisfaction.

- **Socio-Cultural factor**: Socio-cultural factor concerns the belief that family caregiving is a moral quality of the family and health professional identity is associated with curative care. These identities reinforce the roles and responsibility of the family and community health practitioners that are associated with them.

**Gaps associated with benevolent and optional status of service coverage**

While structural factors necessitate the need to prioritise resources, it is the psychological and socio-cultural factors that determine how the prioritising should be approached. These intertwining factors produce three differing priority statuses of service coverage, namely authoritative, benevolent and optional coverage, as a guiding framework for prioritising resources. It is this framework that causes gaps in continuity of care coverage. These gaps are attributed to the benevolent and optional status of continuity of care services. Contributing factors of gaps associated with benevolent and optional status are considered below.

- **The dominance of authoritative services in resource allocation**: Authoritative services dominate the resource allocation in community health services. The resources will be allocated first to cover authoritative services, and the remaining allocated to other services. Curative care service, which are
one component of continuity of care services takes up a considerable portion of existing resources because they require constant coverage.

- **Lack of competing ability for limited resources:** The most important factor that contributes to gaps in services under “benevolent care” and “optional benefits” categories is their lack of the ability to compete for limited resources with authoritative services. The allocation of resources for these services is subservient to and controlled by that of authoritative services. In the worse case, the already planned resources may be sacrificed for authoritative services when additional resources are required.

- **Cultural impediment to professional involvement:** The cultural belief that family caregiving is a moral responsibility of the family forms a major barrier that barricades community health practitioners from assisting families with caregiving at home. This cultural barrier may impede the development of services to assist families to cope with caregiving of their elderly member.

- **Cultural impediment to the seeking of health services of the family:** By the same token, the cultural belief that family caregiving is a moral responsibility of the family can delay or stop families from seeking and getting help from health professionals. Families persevere and contain the course of caregiving and stresses related to it by and within themselves. This can prevent a patient from getting health services that can improve his health. The lack of this seeking may cause worsening of preventable ailments.

- **Reactive approach for case intervention:** Community health practitioners’ reliance on the community networks to refer patients is not sufficient to identify patients that are in need of help in the community. Many families do not necessarily refer a patient if they lack the knowledge about patient’ conditions and the course of the illness. Many families stretch their limits to cope with the caregiving for a prolonged period that may delay necessary interventions for a patient.

- **Lack of community awareness about existing services:** The lack of community awareness about existing services is associated with their lack of expectations on such services. While the lack of awareness impedes the
possibility for service utilisation, the lack of community expectations maintains the benevolent and optional status of these services. This lack of awareness and expectations can delay or stop families making use of such services.

**Gaps outside professional responsibility and ability to manage**

To complete the discussion about gaps, this section turns to gaps outside the responsibility and ability of community health practitioners to manage. Gaps in this category concern the lack of services or skills that lie outside the capacity of the practitioners, and, if existed, will facilitate the work of community health practitioners. The following factors contribute to gaps in continuity of care services.

- **Lack of rehabilitative skills and rehabilitative health professionals:**
  Rehabilitative service is one of the most common services required for the care of chronically ill patients, however, this type of service is lacking in the community. At the time of the study, there were no rehabilitative health professionals such as physiotherapists working in any of the community health centres. This service is only available in the acute care hospital. Furthermore, community health practitioners lack specialised training in rehabilitative care. Community health practitioners rely on their limited knowledge to teach the family to continue rehabilitation at home.

- **Problems with transport and access to services:** Even though the service required exists, access to it has proved to be difficult in many cases. Hospital-based rehabilitative service, for example, requires travelling from home to the hospital. Many families cannot afford the cost associated with transport and choose not to use the service. Transport problems also delay or prevent a patient from getting timely health services.

- **Lack of referral agency for social and financial problems:** There is a lack of active coordinated systems between formal health and social services that allows community health practitioners to refer families with social and financial problems to. The lack of social and financial support for vulnerable
families compromises quality of life of both caregivers and patients.

- **Lack of support services for family caregivers:** There is no established support service, such as respite care, available for family caregivers. The lack of this service forces family caregivers to leave jobs to provide full-time caregiving. In some cases, caregivers juggle between their jobs and caregiving causing stresses on the caregivers and compromising the health of the patients whose care may be inadequate as result of the juggling.

**Utilisation of “Authoritateness of Service Coverage” theory**

Having identified the problems associated with community care practice, how they were resolved, and resulting gaps in continuity of care services, this section now attempts to make recommendations on how to reduce these gaps and improve existing services in general.

Besides being a theoretical framework that explains defensive prioritising, a grounded theory of “Authoritateness of Service Coverage” gives practitioners, service users, the senior management, and policy makers control by providing a framework for actions. As a framework for actions, the theory serves two main purposes. Firstly, it provides policy makers with an opportunity to identify why gaps in services exist and introduce interventions to improve the services. Secondly, it can be exploited as a framework to manipulate other stakeholders to remain in control over the situation.

The theory can be exploited by all stakeholders. For example, it can be used by community health practitioners to retain the control over their practice by focussing on services with authoritative status to protect their reputation. Other services with less authoritative status can be neglected without criticisms from the community. The senior management, on the other hand, may apply measures and pressures such as publicising non-authoritative roles of the practitioners to the community and demanding intense performance appraisal to raise the status of services related to
these roles. The community may apply more appraisal pressure to services they require. Nonetheless, there is a danger associated with these exploitations. As in the case of professional exploitations, gaps will remain and vulnerable families continue to persevere hardships. Attempts to raise the status of all service coverage to authoritative status without improving staffing conditions can overwhelm community health practitioners with unrealistic workloads. Therefore the utilisation of this framework deserves a serious ethical consideration. With this in mind, the recommendations are as follows.

**To improve practice**

- **Improving staffing level:** As persistently indicated throughout the report, staffing levels are the major problem that leads to gaps in continuity of care services. We have learned that the allocation of personnel and their time is dictated by services of authoritative status. Given the exhausting nature of authoritative coverage, namely the warranted and often constant coverage for curative care, minimal personnel time will be left to be allocated to other services of lower status. The new staffing characteristics should ensure that a reasonably fixed portion of the personnel time is dedicated to these services. This means more personnel are required to contribute their time to these services. While the extension of service hours without increasing staffing level may improve the use of primary health services, it does not necessarily improve the coverage of non-authoritative services, as these extended hours will still be used for constant coverage of curative care. Unless the staffing level is improved, gaps will remain and the following recommendations may cause further adverse effects on the practitioners and their practice.

- **Publicising the services:** The service should be publicised to improve the use of it. This can be done by educating the community about what services are available from the community health centre and by encouraging people to use it when necessary. Families should be informed about health services available both *at* and *from* community health centres. This is to dispel the belief that
health services are only facility-based and that professional home-based care is not possible.

- **Establishing and strengthening advocate networks:** Because of the reactive nature of case finding in existing community care practice, the availability of advocate groups will improve utilisation by initiating referral of their members for health services when necessary. The affiliation with a status group improves the status of service coverage. That is, the service requested will warrant the coverage.

- **Establishing a coordinated system for social and financial referral:** Considerations should be given to the establishment of a coordinated system for social and financial referral or strengthening the existing ones. This system will facilitate the continuity of family caregiving at home by providing assistance with transport, respite and other social and financial matters.

- **Providing rehabilitative training for community health practitioners:** Training on rehabilitation should be provided to community health practitioners to improve the quality of care of those who require rehabilitative services.

- **Breaking the cultural barrier to help:** Importantly, health professionals in general should be encouraged to examine their attitude towards family caregiving. It is suspected that the strongly held belief about “care as a moral quality of the family” impedes health professionals from freely assisting families in caregiving. The researcher personally suspects that this cultural belief has made health professionals who have grown up with it reluctant in developing necessary services to support family caregiving. While benevolence is essential in bringing and maintaining health professionals in the helping relationship, it does have limitations. In many circumstances, professional benevolence does not lead to instrumental actions.

**Theoretical use**

This study does not claim the representativeness of its findings to other community
health centres. Rather, it encourages readers who have experiences in this area of practice to use their experiences and other forms of data to modify and expand the theory to explain their prioritising practice. Researchers may wish to utilise the concepts from this theory to study resource management in other areas of practice where demands are open but resources are limited.

**Future research**

Future research concerning continuity of care services in Thailand should aim at the development of a coordinated system of referral between health, social and financial care. This system will allow community health practitioners to refer families with social and financial problems, which have been found to compromise family caregiving, to appropriate agency. Future studies should also identify the possibility and opportunity to develop services such as respite care to support family caregivers within the community.

**Finally**

This report has highlighted a problem experienced by community health practitioners in community health centres, Thailand. It has shown that limitations of resources and open-ended demands lead the community health centres to prioritise their personnel and their time in a defensive way to safeguard themselves from complaints and allegations. As a result of this, existing services are not given the same priority status. Whereas curative services secure an authoritative status, other services such as home-based care and health promotion receive a low benevolent and optional status. It is concluded that gaps in continuity of care exist because many of its services are of benevolent and optional status and therefore have the least ability to compete for limited resources with services of authoritative status.
References

   http://bangkokpost.co.th/today/010500_Outlook01.html
    http://www.dailynews.co.th/news/ne_scoop.htm (in Thai)
11. Division of Nursing. (1996). Roles and responsibility of nursing personnel
who practice in the community. Bangkok: Thammasart University Press. (in Thai)


Public Health, Thailand, Bangkok. (in Thai)


   http://www.thairath.co.th/today/ntoday/page2/p2_1.html (in Thai)


36. Williams, A. et al. (1996). “They just go home and die”: health care and