

**การแนะนำระบบสนับสนุนอุปกรณ์เครื่องช่วยคนพิการ  
แบบที่มีการกำหนดราคารามาตรฐาน และระบบจ่ายร่วมในประเทศไทย**  
**Introducing the Fixed Standard Price System and Co-payment System  
into the Provision of Assistive Devices for Persons with Disability in Thailand**

ประกาย จิโรจน์กุล กาญจนา จันทรีไทย ชุตিকাญจน์ หฤทัย และกมลรัตน์ เทอร์เนอร์  
Pragai Jirojanakul\* Kanjana Chunthai\*\* Chutikarn Haruthai\*\*\* and Kamolrat Turner\*\*\*\*

### Abstract

This paper describes a part of a project on 'The Design and Development Systems on the Provision of Assistive Devices for Persons with Disability', conducted during the years 2005-2007. It aimed to develop a proper system to provide assistive devices to fit clients' needs with fast and convenient services. The fixed standard price system, in which the government subsidized a fixed amount of budget for each category of device, and co-payment system, in which the clients co-paid for the extra cost if they want to have more sophisticated or luxurious devices; were introduced to 11 pilot hospitals and clients as alternative means of payment.

Data were collected by in-depth interview and structured questionnaires from the providers and disabled persons/caregivers. The results showed that clients and officials involved were satisfied with the provision system. Most of the clients chose the device which was within the fixed standard price while only four cases chose co-payment. The findings support the government policy to use the fixed standard price as a payment system for the provision of assistive devices countrywide.

**Keywords:** fixed standard price, co-payment, provision of assistive devices, persons with disability

### บทคัดย่อ

รายงานนี้เป็นส่วนหนึ่งของงานวิจัยเรื่อง การออกแบบและพัฒนาระบบสนับสนุนอุปกรณ์เครื่องช่วยคนพิการในระบบหลักประกันสุขภาพแห่งชาติ ดำเนินการในปีพ.ศ. 2548-2550 โดยมีจุดมุ่งหมายเพื่อพัฒนาระบบการสนับสนุนอุปกรณ์เครื่องช่วยคนพิการที่สอดคล้องตรงกับความต้องการของคนพิการ ได้อย่างสะดวก และ รวดเร็ว รายงานนี้มุ่งเน้นในการนำเสนอผลเฉพาะส่วนของการนำระบบการสนับสนุนค่าใช้จ่ายค่าอุปกรณ์ 2 ระบบมาใช้ คือ ระบบแรกที่มีการกำหนดราคารามาตรฐานของอุปกรณ์ (Fixed standard price system) ซึ่งรัฐจะสนับสนุนค่าใช้จ่ายทั้งหมดของอุปกรณ์แต่ละชิ้นตามราคารามาตรฐานที่กำหนดไว้ และ ระบบที่สองคือระบบจ่ายร่วม (Co-payment system) ที่ผู้พิการสามารถเลือกซื้ออุปกรณ์ตามที่ต้องการได้โดยเสียค่าใช้จ่ายส่วนที่เกินจากราคารามาตรฐานที่กำหนดไว้เอง

\* Ph.D., Lecturer, Faculty of Nursing, Suan Dusit Rajabhat University, Bangkok, Thailand.

\*\* Ph.D., Director of Bureau of Nursing, Ministry of Public Health.

\*\*\* Bureau of Nursing, Ministry of Public Health.

\*\*\*\*Ph.D., Boromarajonani College of Nursing, Chang Wat Nonthaburi; Praboromarajchanok Institute.

การวิจัยดำเนินการในโรงพยาบาลนาร่อง 11 แห่ง เก็บรวบรวมข้อมูล โดยใช้แบบสอบถามแบบมีโครงสร้างจากคนพิการ หรือ ผู้ดูแล และการสัมภาษณ์เชิงลึกกับผู้บริหาร และ บุคลากรในทีมสุขภาพในโรงพยาบาลที่ให้บริการ รวมทั้ง คนพิการหรือผู้ดูแล ผลการศึกษาพบว่า คนพิการหรือ ผู้ดูแล และ บุคลากรที่เกี่ยวข้องมีความพึงพอใจในระบบการสนับสนุนอุปกรณ์เครื่องช่วยคนพิการที่นำมาใช้ ส่วนใหญ่เลือกรับอุปกรณ์ภายใต้ราคารามาตรฐานที่กำหนด มีเพียง 4 รายที่เลือกใช้ระบบจ่ายร่วม ผลการศึกษาสนับสนุนนโยบายของรัฐในการนำระบบที่มีการกำหนดราคารามาตรฐานของอุปกรณ์ มาใช้ในการสนับสนุนอุปกรณ์เครื่องช่วยคนพิการทั่วประเทศ

**คำสำคัญ:** ระบบที่มีการกำหนดราคารามาตรฐานของอุปกรณ์, ระบบจ่ายร่วม, ระบบการสนับสนุนอุปกรณ์เครื่องช่วยคนพิการ, คนพิการ

## Introduction

Thailand promulgated the Rehabilitation Act for Persons with Disability in the year 1991, giving the right for obtaining free health care to disabled persons (Department of Welfare, 1993). Assistive device is one among the list of 13 categories of health care provided. It was stated in the Ministry of Public Health Regulations, pursuant to the mentioned Act, that the health care facilities under the Ministry of Public Health, other ministries, state enterprises or local administration organizations shall provide assistive devices for any disabled person in need of medical rehabilitation. In cases where assistive device were not available, the hospital requested for support from the Sirindorn's National Center for Medical Rehabilitation (SNCMR).

During 1991-2002, the budget for providing the other 12 categories of health care was

supported by the Medical Welfare Scheme for the Indigent while that of assistive devices was paid from the SNCMR's budget through the Ministry of Public Health. After the enactment of the National Health Insurance Act in 2002, those expenditures were drawn from the National Health Insurance Program. In 2004, the National Health Insurance Committee decided to take a part of the medical emergency budget which was set at 4 baht per head of population, accounting for 188 million baht, for the medical rehabilitation of disabled persons. Eighty percent of this amount was for rehabilitation services, 15% assistive devices and another 5% for the provision of training for the disabled and their caregivers.

However, there was no clear principle or guideline in allocating this budget to responsible agencies and some of the disabled still have no access to the services. During the workshop on development of the disabled persons' quality of life on October 10<sup>th</sup>, 2004, when the prime minister met up with the disabled representatives, there were some suggestions to enhance the efficiency on the provision of assistive devices. In response to the plea of disabled persons to receive good quality devices which fit individual's needs, the Disabled Persons' Right Protection Sub-Committee agreed to introduce the fixed standard price system and co-payment system for the provision of assistive devices. The principles of the fixed standard price system and the co-payment system are that the disabled shall have a right to receive quality standard assistive devices appropriate to their needs free of charge within the standard fixed price set for each kind of device. If they want to have more sophisticated or luxurious

devices they must co-pay for the extra cost.

To introduce the fixed standard price system and co-payment system countrywide, it must be handled with care to ensure both equity and equality. Developing policy-relevant data that reflect the health needs of peoples with disability is crucial and can be achieved by well-designed studies (Walkup, 2000). There must be up-to-date databases on eligible users and previous usages to prevent the repetition or overlapping of services. The responsible officials involved in all levels of service must be prepared and enhanced in their capacities. Moreover, there must be the reference fixed price for each kind of device. These led to the design of this study, conducted from November 2005 to April 2007, in which 11 hospitals participated; 3 categories of assistive devices were selected to pilot; databases on eligible users and previous usages were updated; and an assistive device demonstration center at each participating hospital was set up. In the mean time, another study titled 'Standard Lists and Reference Prices of Assistive Device for Disabled People' was conducted to prepare the information for the National Health Security Office (NHSO) in case that the project needed to expand or launch into full scale.

The purposes of the research and development project on 'The Design and Development Systems on the Provision of Assistive Devices for Persons with Disability' were to design and develop systems on the provision of assistive devices for persons with disability. The project's activities are explained briefly in the methodology section. It aimed to provide assistive devices to fit their needs using fast and

convenient services; and to introduce the fixed standard price system and co-payment system as alternative means of payment. The fixed standard price system, which government subsidized a fixed amount of budget for each category of device, and co-payment system were introduced to hospitals and clients as alternative means of payment instead of the old system in which the budget was allocated to a certain institute.

The literature review found some papers relevant to co-payment or cost-sharing policies in health care e.g. Aslam et al. (2005) investigated the effect of prescription drug cost-sharing on overall health care utilization among elderly patients with rheumatoid arthritis in Canada. The study provided evidence that cost-sharing of prescription drugs results in fewer prescriptions being filled and more physician visits and hospital admissions. Hong, et al. (2005) assessed the impact of China's newly established community-based insurance (CBI), characterized as low premiums but high co-payments, on the equity of CBI enrolment, health service utilization and the net benefit distribution among enrollees and the overall population in the community. Huang & Tung (2006) reported their study on the effects of outpatient co-payment policy on health care usage by the elderly in Taiwan. Those three studies have shown that patient cost-sharing leads to a reduction in overall health resource utilization. In a predominantly publicly funded health care system, as in Canada, when cost sharing for prescription drugs increased, the demand for prescription drugs decreased and the demand for physician visits increased. The study in China indicated that a high co-payment rate imposed a deterrent on

health care utilization among the poor.

This paper is a part of the mentioned project focusing on how the disabled and officials involved responded to the introduction of the Fixed Standard Price Systems and Co-payment System. The rest of the paper will describe the methodology, results and discussion. Some conclusions and recommendations are also provided at the end of the paper.

## Methods

The system designed to provide assistive devices for persons with disability comprised many developmental activities as briefly described below:-

1. The databases on eligible users and previous usage were developed and updated by the Health Security Information Department, NHSO. Responsible officials at 11 hospitals and researchers were given passwords to access the database.

2. There were three categories of assistive devices selected to assess in this study, i.e. wheelchair, white walking stick and the training package on orientation and mobility (O&M), and hearing aids. The fixed standard price for each device was recommended by SNCMR and approved in a meeting between experts, representatives from the disabled persons' association, Disabled Persons' Right and Benefit Protection Sub-Committee, officials from the NHSO, administrators of participating hospitals and researchers. The fixed standard price for a wheelchair was set at 5,000 baht (about \$US 156 (the exchange rate at the end of the project was \$US 1 ~ 32 baht), adjustable wheelchair for a child

with cerebral palsy set at 8,000 baht (about \$US 250), white walking stick set at 450 baht (about \$US 14), O&M training package set at 9,000 baht (about \$US 281), Hearing aids-Analog type set at 3,000 baht (about \$US 94) and Digital type set at 8,000 baht (about \$US 250).

3. A handbook for participating hospitals and a handbook for clients on the usage and maintenance of assistive devices were developed by researchers and sent to each hospital.

4. The NHSO provided a budget of 500,000 baht (about \$US 15,625) to each participating hospital to set up its assistive device demonstration center. At the demonstration center, disabled persons and caregivers can look at and test the devices on display, which were usually within the fixed standard prices, under the supervision of responsible technicians. If they were satisfied with it and the device was available, then they could receive the device on that day, otherwise the hospital contacted the company to deliver it shortly. If they were not satisfied with the devices displayed, they could choose the co-payment system by buying it from elsewhere, and then show the receipt to reimburse from the hospital within the set fixed price.

5. The training for responsible officials at demonstration centers was held by SNCMR on April 24-28, 2006.

6. The administration system on the provision of assistive devices included two parts. The first part entailed the main activities the hospital had to perform, e.g. physical examination and diagnosis by specialists in that field, checking of eligible users and previous usage, displaying and giving advice on usage and maintenance of

assistive devices by technicians etc., was designed by the researchers. The second part involved the details on “how to do things” which hospitals could create on their own, e.g. appointment of an assistive devices provision committee, preparation of the location and personnel, managing supply of assistive devices for display and for clients, reimbursement for the client who purchases a device by co-payment, etc.

### Sample

The sample comprised 11 hospitals which were selected by purposive sampling using criteria of having specialists on visual, hearing and mobile impairment and willing to participate in the project supported by the NHSO. It included one university hospital, one specialized institute on rehabilitation medicine, six regional hospitals, and three general hospitals

### Research instruments

Three sets of research instruments were used, i.e. the question guide for the in-depth interview with the disabled/their caregivers, the question guide for the interview with healthcare providers and the satisfaction questionnaire. Semi-structured interview questions asked about opinions of the clients and the official involved in the project towards the provision systems, the quality of services, problems and obstacles found and their suggestions.

The satisfaction questionnaire used a 5-point rating scale and was composed of 20 items asking the disabled person or his/her carer about their satisfaction with the services received regarding convenience, coordination, courtesy, medical information, quality of care and out of pocket cost. It was developed by the researchers

based on Aday and Andersen's conceptual framework (Aday & Andersen, 1974, 1978); It was trialed with 20 persons giving a Cronbach's Alpha reliability index of 0.89 which was considered acceptable (Streiner & Norman, 1996).

### Data collection and analysis

Data were collected from six administrators; eight specialists on rehabilitation medicine; 13 technicians on assistive devices, hearing and visual aids; three supporting personnel who were involved in the project and three persons working in the demonstration center in five participating hospitals using in-dept interviews and focus group interviews. Data were also randomly collected from disabled persons and/or their caregivers who came to 11 participating hospitals, using questionnaires with 567 persons and in-depth interviews with 89 persons. Quantitative data were analyzed for distribution and central tendency using SPSS and qualitative data were analyzed by content analysis.

### Results and discussion

This paper focuses on how the disabled and officials involved in this project responded to the fixed standard price system and co-payment system. It was found that the assistive devices provided since the beginning of the project until April 30<sup>th</sup> 2007, as shown in Table 1, were mostly wheelchairs for adults and children while white walking sticks and hearing aids were given in some hospitals only. Most of the disabled chose the device displayed at the demonstration center which was within the standard fixed price. There were only four cases choosing co-payment.

**Table 1.** Number of assistive devices provided at each participating hospital in this project

Hospital	Wheelchair (adult)	Wheelchair (children)	Adjustable wheelchair for children with cerebral palsy	White walking stick	O&M training	Hearing aids (Analog)	Hearing aids (Digital)
No. 1	80	10	5	-	-	-	-
No. 2	28 (1)	-	-	3	-	-	-
No. 3	27	-	-	-	-	-	8
No. 4	28	8	(1)	52	-	-	15 (1)
No. 5	58	1	7	-	-	-	-
No. 6	145 (1)	2	19	-	-	-	-
No. 7	28	2	-	-	-	-	-
No. 8	29	8	1	-	-	-	-
No. 9	9	-	-	1	1	-	-
No. 10	2	-	-	-	-	-	67
No. 11	143	23	-	-	-	2	7
<b>Total</b>	<b>577 (2)</b>	<b>54</b>	<b>32 (1)</b>	<b>56</b>	<b>1</b>	<b>2</b>	<b>97 (1)</b>

Note: numbers in parenthesis represent cases that chose co-payment system

The information gained from the interviews with clients/relatives and the involved officials provided an explanation on the number of the devices given. At hospital No. 10 where only two wheelchairs were given because the hospital had received free wheelchairs from the Rotary Club and had just given them away to the disabled before this project started.

As for the walking sticks, only 56 pieces were given because it was not an expensive device and the hospitals could previously respond to the disable persons' needs. In addition, most of them were old-case clients, so they knew how to use the stick and did not need O&M training. Anyway, some officials commented that the public relation on this project was not done widely enough and some big hospitals were concerned

more about visually impaired clients than those with blindness.

The reasons that hospitals provided a small number of hearing aids were that the set fixed price of this device, especially the digital type (8,000 baht), was too low. The hospitals get no subsidy on the extra prices and the fixed price has to cover the cost of purchasing the items. The appropriate price suggested is about 13,500 baht each (about \$US 422 ). Apart from the price, there were some management problems in some hospitals which delayed the purchasing process of the hearing aids for the clients. There was an exception at hospital No. 10 where 67 sets of digital hearing aids were given because the hospital managed to subsidize the extra cost using other sources of budget (K-S2).



### The opinion of the disable persons/their caregivers towards the service received

This information was drawn from the in-depth interview with 89 disable persons/their caregivers. Eighty-eight of them said that it was convenient and quick to receive the assistive devices this time; it was good in particular because they had a chance to see and test various wheelchairs before they chose it. Only one person who came for a walking stick said, 'There is no difference, the device is the same. I just came to get the new one.' (P-18) This result was in concordance with the results from satisfaction questionnaire which participants rated highest on quality of care aspect ( $\bar{\chi} = 4.18$ , S.D. = 0.94) and high level on overall aspects ( $\bar{\chi} = 3.99$ , S.D. = 0.79) as shown in Table 2.

**Table 2.** Mean, standard deviation and level of satisfaction of disable persons/caregivers to the services received (N=567)

Aspects of Satisfaction	$\bar{\chi}$	S.D.	Level
Convenience	3.63	0.77	high
Coordination	4.17	0.96	high
Courtesy	3.99	0.84	high
Medical information	4.11	0.89	high
Quality of care	4.18	0.94	high
Out of pocket cost	3.74	1.16	high
<b>All aspects</b>	<b>3.99</b>	<b>0.79</b>	<b>high</b>

As for the 88 persons who had positive opinions towards the service received, the reasons they gave were that:

1) It gave them opportunities and enhanced their capacity to live their lives. An excerpt from the interview with a disabled person explained 'It is good since most of the disabled

have no income, it enhances my capacity; and it is best for someone who has never had a wheelchair before.' (M-1)

2) It made them happy and gave a better quality of life, as the relative of a 24-year-old disabled woman said,

'I feel that it is very good, one who receives this wheelchair will be proud of, like my relative. In the evening she would take a shower, dress up and ask me to take her out. She is tense to be at home all the time. When I take her out in a wheelchair, she will be happy and will talk to other people. I can see that she is getting better and becoming happy.' (L-2)

3) The disabled can see and choose the assistive device that fits their needs

'I got my previous wheelchair from charity. I had no choice so I had to use what I got. I am a small build woman and my arms are not strong. I couldn't wheel it myself, and have to ask my mom or brother to take me somewhere..... but sometimes I want to go by myself, so I want to get a lightweight one. At this demonstration center, there are several styles of wheelchair which I can sit and try out. It is usable since I can choose what I want.' (P-7)

4) It was quick and convenient. One participant who was a caregiver commented:

"This hearing aid is necessary for my grandma; without the device we couldn't communicate. We used to wait for up to two years to get it. It was so hard for us because we didn't understand what she wanted to do or where she wanted to go. The elderly need special care, we can't wait for so long. It is good that we can get the device very quick this time. I think we can wait for some time

but we shouldn't have to wait longer than two months." (P-10)

5) It was a comprehensive, one stop and immediate service.

A 52 year old grandma brought her 7-year old granddaughter who was disabled with congenital spastic extremities to ask for a wheelchair. During the in-dept interview she said,

'My granddaughter is growing up everyday; I can't carry her to go everywhere. I am living far away from the hospital and have not much money for traveling....I am going to choose what is available at this demonstration center, and I see that the wheelchairs on display look beautiful. I don't want to come back again....there is no direct bus to the hospital and I can't afford to pay for a taxi so I have to carry her and walk for a long way from the bus stop.... I don't want to come again and again.' (P-6)

The reasons given by the disabled and their relatives revealed that the main characteristics of the provision system which they wanted were that firstly, the device must fit their needs, so it is important that they could see and try out the device before receiving it. This would help to reduce uncertain costs associated with buying a product from a seller which may break within a short period of time or be otherwise unsatisfactory. The devices displayed in demonstration centers and the advice given by technicians can reduce Akerlof's lemons problem associated with asymmetric information since it is difficult for the disabled to know and choose the quality of such sophisticated devices from the market directly (Akerlof, 2003).

Secondly, the services should be comprehensive, one-stop, quick and convenient. This is consistent with Jutai (1999) who explained that the role of assistive devices was to enhance the quality of life of the disabled. However, the device must not annoy the users, but make them feel confident to use and have inspiration to live on according to their existing capacity. Another reason is that disability tends to be experienced by the individuals with low socio-economic status (Mwachofi & Broyles, 2008). Therefore, the disabled have to put in greater effort, in terms of physical, mental, emotional and financial to come to hospital each time than those who are more independent and wealthier.

Another interesting point is the concern of the disabled/caregivers on their travel arrangements to the hospitals. Transportation is a common structural barrier to access health care reported by the disabled (Drainoni et al., 2006) and health providers (Bachman et al. 2006). Going to hospitals in a big city causes much more burden to the poor than to the rich and it is even worse for the disabled. As Tancharoensathien (2003) found, middle income and poor families mainly get access at health centers and community hospitals, but some middle class and the rich gain more benefit from provincial hospitals. The middle and upper income group can have access to provincial hospitals more than the lower group because they are in the towns, and pay less for their transport. To enhance the accessibility to the service, it might be worth considering that the scheme subsidizes return transport for one visit for the disabled.



### The opinion of the officials involved towards the service provided

The interview with administrators, specialists on rehabilitation medicine, technicians, supporting personnel who were involved in the project and persons working in the demonstration center in five participating hospitals gave consistent information that the services provided under the systems designed for this project could respond to the needs of the disabled better than the previous one, in which the hospital had to ask for support from certain institutes. Participants commented:

'The problem we found in asking support from ..... is that it takes a long time to get the device - sometimes months or years...sometimes when we got the device and called the disabled, we were told that the patient was dead... but that usually happened with the wheelchair only...the other devices like walkers, we would ask for about 40 pieces each time and keep it for later use. Another problem we found is that... we have to use what we received; we cannot choose.' (M-S1)

'In the previous system, we used to receive the hearing aids from ..... since 1995 but the quality was not good, it was out of order after using for a few months and the disabled had to wait for a year. The hospital used to send back the whole batch of hearing aids because they didn't work.' (K-S4)

'In this system the hospital can purchase and manage the supply of devices by ourselves. It is good that the clients can get the device quicker and fit to their needs. The previous system had some good points, including that the price was cheap but the bad point was that we didn't get

enough devices for the clients. This new system facilitates the provision of assistive devices, especially wheelchairs, which I would give grade A+' (K-S3).

The results show that both the clients and providers found that services provided under the systems designed for this project could respond to the needs of persons with disabilities better than the previous one in which the hospital had to ask for support from certain institutes, which confirms that the provision system was effective. It is interesting to see when we compare between the number of devices provided under the fixed price system and co-payment system. Most of the clients chose devices shown at the demonstration center under the fixed standard price system because they found that it was convenient and they could receive the device within one day after a try-out. The results confirmed that the standard price set for wheelchairs given freely was appropriate so that most of the clients with physical and movement disability chose the available devices instead of waiting for the more luxurious ones with some extra costs. However the fixed standard price for hearing aids, particularly the digital type (8,000 baht/set), was too low as reported by audiologists. It is very important that the devices given must fit with the needs of the disabled since it will be useless if they have to compromise the cost with the lower quality of devices. The appropriate price suggested is about 13,500 baht each.

The reason that only a few clients chose the devices using co-payment system may due to the poor economic status of the disabled in general. Once the devices provided met their

needs, it was not necessary for them to pay for the extra cost. However, the expectation on the quality and utility of devices may increase so it is important that the cost-containment policy such as co-payment should be available as an alternative for the disabled who can afford to pay to accommodate continually rising costs of assistive devices. The co-payment system, or cost-sharing between patients and government, is common in developed countries like France, Germany and Switzerland (The Kaiser Family Foundation, 2009). Even in countries with universal healthcare policies where assistive devices are provided by public funds, some persons with disabilities have not yet received services and need to rely on private sectors or supplemental insurance plans in which they have to pay some part (Mencher, 2008; Wong & McPherson, 2008; Iorio & Costa, 2008; Davis, 2008). This financing mechanism is appealing because it supposedly reduces expenditures for medically unnecessary treatments by making patients pay for a proportion of all expenditures and thus making them more cost-conscious (Aslam et al., 2005).

When the fixed standard price and the co-payment systems are used countrywide, it is necessary to set the proper referred price for each assistive device. If the standard price is set too low, as of the digital hearing aids in this study, the disabled will not be able to get good quality devices. The lower fixed standard prices mean the higher the co-payment for the disabled and less likely they will use services. As shown in the literature, the poor have a more negative price elasticity than those with high incomes. This

implies that a high co-payment will have a greater negative impact on the utilization of services for the poor (Hong et al., 2005).

Introducing the fixed standard price and the co-payment systems benefits both the government and the disabled. The government can save the monetary cost when an appropriate price was set for each kind of device. As for the disabled, this initiative reduces search costs of finding different sellers and in allowing the potential to try the equipment out, together with the advice provided by experts at the hospital reduces uncertainty costs.

The research findings support the NHSO's policy to use the fixed standard price as a payment system on the provision of assistive devices for persons with disability countrywide. The reference price of each device should be developed further while the co-payment system should also be made available to give more choices for persons who can afford this service.

## Conclusions and Recommendations

It can be concluded that clients/caregivers were satisfied with the provision system. The effectiveness of the developed systems was affirmed by the quantity of devices provided and the quality of services perceived by disabled persons/caregivers. Moreover, the system introduced could also save search costs and uncertain costs to them. They preferred the fixed standard price to the co-payment because the devices given can basically respond to their needs and partly due to their poor economic status.

### The research findings suggest that

1. The NHSO should extend the systems on the provision of assistive devices for persons with disability countrywide using the fixed standard price as a payment system while the co-payment system should be also available as an alternative.

2. The reference price of each device should be developed further and reviewed regularly.

3. There should be an assistive device demonstration center attached to all provincial hospitals and some community hospitals so that the disabled could see and try out the devices before choosing the one that fits their needs and to lessen their burden of traveling to regional hospitals.

4. Regarding the concern of the disabled/caregivers on their traveling costs to the hospitals, it is recommended that the scheme subsidizes return transport for one visit.

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