

CICRED'S SEMINAR

**Reproductive Health Behavior and Quality of
Care among Thai Women**

Malinee Wongsith

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A study of reproductive health is a positive, health-oriented concept. Reproductive health includes the health of the women in pre-reproductive age, reproductive age and post-reproductive age, as well as the health of their spouses with potentials of socially transmitted diseases. In addition, there are a number of health-related problems in Thailand, particularly health problems of the women in reproductive age, owing to the fact that the understanding and awareness of female reproductive problems receive less care than they deserve,¹ despite the fact that reproductive health is most crucial for women as it is fundamental in female health care and women are usually the primary caretaker of their family health and well-being. Hence, female health care needs to receive proper and due attention.

This report aims at providing fundamental data on reproductive health behavior and quality of care, starting from women health assessment. Good health, apart from taking good care of oneself in good health, requires self-preventive measures from potential diseases. One means is to pay regular visits to the doctor for physical examination, which should be considered as extremely important for personal health care. Hence, this paper proposes three aspects of women health care, namely physical health examination, pelvic examination and AIDS test. AIDS, being one among the ten areas in reproductive health care in Thailand, poses an important health-related issue, with particular concern on AIDS in pregnancy. Although this is the least found segment of the AIDS infected patients, compared with those HIV positive from homosexuality, prostitution and blood transfusion, the seriousness of AIDS in pregnancy should receive attention because it is potentially transmittable to the new-born, and thus the next generation in the population.² AIDS test is therefore herewith included, together with the factors influencing AIDS test.

Besides appropriate reproductive medicine, positive inclinations of reproductive health of a population also depend on appropriate reproductive health service delivery

systems.³ The paper thus delineates health service resources, indicators of service quality and assessment of service quality.

Sources of Data

The sources of data for the study came from the information provided in “The Economic Crisis and Reproductive Health Care Provision and Use in Thailand” under the responsibility of the College of Population Studies, Chulalongkorn University.

The quantitative fieldwork was conducted from April 20 – May 10, 1999. Sample provinces were purposively selected: Bangkok, Sri Saket in the Northeast region and Ang thong in the Central region. A total of 625 currently married women aged 15-39 years were interviewed, with the exception of the five 40-year-old women who were included in the analysis.

The questionnaire used in the project was divided into four sections:

1. Background of the respondent and her husband, primarily focusing on their economic situation
2. Maternal and child health with a focus on last birth and current pregnancy
3. Reproductive health status and behavior
4. Knowledge, experience and attitude toward the economic crisis.

For more detail, see Napaporn Chayovan et al., *Thailand's Economic Crisis and Reproductive Health: A Case Study of Bangkok, Ang Thong and Sri Saket*. College of Population Studies, Chulalongkorn University, CPS Publication No. 279, February 2000.

Limitation of Date

1. The sample provinces were purposively selected and the sample size is very small. It is not national represent.
2. This project targeted low income communities. These data miss effect based on class differences. The samples are representative of low income area. Therefore I did not relate the reproductive health behavior with poverty.
3. With the sample limited to married women, I am not able to examine the health status and reproductive health behavior of unmarried women.

4. Many questions in the questionnaire are retrospective questions including questions on use of reproductive health care services, respondent's understanding of their physical and mental health status etc. These questions are subject to recall bias. However, these data are useful as they provide understanding of current perceptions of health care provision and care.

Assessment of Physical and Mental Health

Health comprises personal care and individual concern, and depends largely on genetics, environment, personal hygiene and sanitation. Individual health thus means different things, subjectively, and varies from one person to another, so much so that it is generally hard to objectively judge the level of health on individuals, except by physical examination and diagnosis.⁴ Another means of assessment is by self-assessment according to one's own perceptions. The physical assessment in this study is through the respondents' own assessment based on the question "On a scale of 0 –10, 0 meaning the worst and 10 the best, how do you assess your own current physical health?" The question is the same for the assessment of physical health three years ago. The mental assessment is also based on a similar question asked of the respondents.

Table 1 shows the comparative physical and health assessments of eligible women based on the current status (1999) and that of three years ago (1997, before the economic crisis). It is found that more than half of the female samples reported good physical health in comparison between the present and the past. Overall, the percentage of the women reporting better physical health three years ago amounts to 72.2 percent, compared with the currently reported 55.2 percent. Part of the reasons may be due to the deteriorating health over time. However, given the fact that the respondents in question are all in their youthful years, it is unlikely that they should have remarkably worse physical health. In all likelihood, the falling percentage in the responses may be owing to other factors such as their economic status. This last factor is further confirmed by the mental assessment as it was found that the comparison of the current physical and mental health indicates that the female samples suffer markedly from worse mental health than from physical health. The percentage of those reported being in good mental health is lower than that in good physical health and the percentage of those reported being in bad

mental health is lower than that in bad physical health. In comparison, the current and last three years' mental health falls into the same tendency in physical health, I.e. the percentage of those reporting in good mental health drops somewhat significantly, as compared to the past, a decrease from 69.9 percent to 37.6 percent. The reason being possible stress caused by the economic downturn.

Physical Examination, Pelvic Examination and AIDS Test

General physical examination is a very effective way of health care and promotion. People should have physical examination in order to be aware of their own health condition and follow up closely on their health problems⁵ (if any). As reproductive health care covers a large area from reproductive organs to AIDS, the study is presenting percentages of those who have had physical examination, pelvic examination and AIDS test, altogether.

Table 2 shows the percentage of the women who have had annual physical examination, pelvic examination and AIDS test by background variables. It is found that, overall, the percentage of those having had annual physical examination is lower than that of those having had other types of examinations. Specifically, 39.2 percent of those having had annual physical examination, 79.5 percent of pelvic examination and 42.9 percent of AIDS test. The fact that the percentage of the female samples having had annual physical examination is lower than that of other examinations may be because the results of annual physical examination rarely show disorders or diseases, except in babies and the elderly.⁵ People at large thus pay little attention to annual physical examination. As for the female samples having had the highest rate of pelvic examination, it may be due to the fact that these women are married. Notwithstanding with or without birth control, with or without children---when they have reproductive problems, they invariably seek pelvic examination.

Age is another factor affecting the three types of examination. Older women tend to undergo more of physical and pelvic examinations than younger women. Conversely, younger women tend to undergo more of AIDS test than their older counterparts. Specifically, the 18-24, the 25-34 and the 35+ have had AIDS test by 49.2, 46.5 and 31.9 percent, respectively. The reason why age may conversely affect the types of

examination may be because older women are usually more aware of the importance of physical examination and pelvic examination than their younger counterparts. As for AIDS test, most younger women, who may have just embarked on married lives and may be facing higher risks of infection, opt more for this kind of test, as compared to their older counterparts.

Education and ethnicity play better parts in the differences in AIDS test and other types of examination. The percentage of those receiving AIDS test rises in accordance with the higher levels of education. Those with lower than Primary School education receive AIDS test by 26.3 percent and the percentages rise to 38.7 and 59.7 percent in Primary School and High School and Over, respectively. The reason being that education provides better information and awareness of AIDS and its pertaining danger and repercussions. Thus, higher educated women opt more for AIDS test. As for ethnicity, Other ethnics have higher percentage in AIDS test, compared with Thai ethnics.

Occupation appears to be an important factor in the differences of the three types of examination. Those in the agricultural sector have markedly lower percentages of physical examination, pelvic examination and AIDS test, compared with their Non-agriculture counterparts. The reasons may be owing to the fact that those in Agriculture are poorer and less educated, etc. so that they are less aware of the implications of the different types of examination. Also, they may not be able to afford the costs of the examinations in question, or may be too busy to go for such examinations as they live from hand to mouth. In addition, some types of examination, such as annual physical health examination, can only be obtained at hospitals, rather than at health centers.

Residential zone is also another influential factor in the different types of examination. Regardless of their occupation, rural women have lower percentages of obtaining any type of examination, as compared with female urban residents.

As above stated, various factors are influential in types of examination, either in more or less the same way. However, one critical health problem in Thailand and throughout the world at large is AIDS infection, especially AIDS in pregnancy. It is estimated that, in 1998, approximately 2.4 million pregnant women all over the world are HIV positive, with the result that the babies born of these mothers are faced with serious

mortality rates. In Thailand, without proper care in HIV-infected pregnant women, it is found that there are approximately 5000-6000 newborns each year getting the AIDS infection from their mothers.⁶ Better care and promotion for AIDS test in women may provide preventive measures for such serious health problems. Thus, this study presents the various factors that are most likely to influence women to seek AIDS test.

Table 3 presents a multiple classification analysis of AIDS test by selected variables, namely age, education, ethnicity, occupation and residence. The adjusted results show net influences of each attribute after control of all other variables, as seen in R^2 . Variation of variables could be explained by about 9 percent.

The relationship between independent variables and AIDS test drops somewhat after adjusting the multiple classification analysis, as can be seen by the comparison of Eta and Beta. In conclusion, the comparison shows that, for each variable, education is highly influential to AIDS test in women. The higher the education the higher rate in AIDS test. The next most influential factor is occupation. More of non-agriculture sector seeks AIDS test, compared with their Agriculture counterparts.

Regarding age, pre-adjusted values indicate that older women receive less AIDS test than younger women. The pattern persists even after adjusting the values. However, the relationship between age and AIDS test carries no statistical significance.

Regarding the influences of ethnicity and residence, pre-adjusted values show that Thai and Other ethnics and urban residents receive more AIDS test than Thai ethnics and rural residents. However, after adjusting, the relationship is undetectable.

Sources of Service

Sources of reproductive health care service are important to health care, as they not only represent access to medical service but also the differences in service providers and service users.

Table 4 shows the data on family-planning service centers and health service providers. The health-service data presented here are based on the question “Within the past year, when you or your family members are ill or sick, where or how do you or your family members go for advice or cure?”

With regard to receiving family-planning service, it is found that about one third of women seek advice at health centers and government hospitals. These two most visited resources are followed by purchase at Pharmacy/Self care. Only 10.2 percent said they went to have service at private hospitals or clinics. The reason being that family planning service is a popular government service in every health center in villages and all government hospitals. Access to the public is made available at low charges or no charge at all for certain contraceptive methods, making more women seeking family planning advice and service at health centers and government hospitals. Considering health care and cure, it is found that 6.1 percent of women choose not to seek direct medical service but rather use self-care methods by purchasing medicine at pharmacies. The percentages of those using self-care in this study are lower than those in other studies.⁷ However, almost half of the female samples reported that when they or their family members fall ill, they go to government hospitals. This percentage is followed by medical visits at private hospitals or clinics and at health centers, by 25.6 and 18.2 percent, respectively. The reasons may be because of nearness to their residence and convenience in traveling to seek service or that the illnesses are in the initial states as health centers only provide services for preliminary illnesses. With more serious illnesses, most women would rather go to government or private hospital.

Considering the various factors that are likely to affect selection of health service sources (Table 5), it is found that there are variations between age and service sources, i.e. as high as 71 percent of the younger women reported using service at government hospitals. The percentages decrease with advancing ages while the percentages of using service at private sources increase with older ages. Specifically, the 15-24, the 25-34 and the 35+ use services at private sources by 23.4, 25.2 and 27.8, respectively. The reasons may be because service at private sources requires higher medical fees than using service at government hospitals. Hence, those who can afford services at private sources are usually well-to-do or have enough income earning, which falls under the category of those with secure and sizable income-earning occupation. The 30+ age group are those who are better equipped with work security and income brackets, as compare to their younger counterparts.

Education is also another factor affecting the selection of health service sources. Less educated people make up the largest percentage in using government sources. The percentages of those using government sources decrease with advancing education. Not unlike the use of private sources, the percentages of the women reporting the use of private sources in sickness increase according to the higher levels of education. The reasons may be because education corresponds with income earning. Higher educated women can better afford the costs of services at private medical resources than lower educated women.

In so far as occupation is concerned, it is found that those in Agriculture sector receive health care service at government sources more than their non-agriculture counterparts. Meanwhile, higher percentages of those in Non-agriculture use private health care sources. It is noteworthy that the percentages of those in Agriculture who buy medicines from pharmacies or use self-care methods are lower than those in Non-agriculture. The results in this study do not correspond with those in Veerapan Supanchaiyamat et al, which found that most family members in the Agriculture sectors who fall ill tend to buy medicines for self-care.⁸

Given work status in view, it is found that those in government or state enterprises make less use of services at government sources than those in other work status. Specifically, 60 percent use government sources, while those in Other work status use the service at government source by higher percentages. As for the use of services at private hospitals or clinics, government or state enterprise officers use more of these services than Other category. Meanwhile, the percentages of those in Private business who buy medicines for self care are slightly higher than those in Other work status. The reasons may be because these people have no time to seek medical service at health care sources.

The number of household members is likely to influence the use of health care service source. Women residing in a household of 6+ members tend to seek medical service at government sources by the highest percentage of 74.6. The percentages decrease with the decrease in the number of household members. Approximately 35.3 of the women in 2-3 member households go to private hospitals or clinics. The percentages drop as the households get larger. The possible reason being that living in a large

household means sharing household resources by more members and private hospitals or clinics may pose burdens of costs for larger households.

Nonetheless, the differences in residential areas carry implications in the selection of health service sources. It is found that urban residents have higher percentages of pharmacy purchase or self-care and using service at private hospitals or clinics, compared with rural residents. Possible explanation: the urban areas have a large number of pharmacies, as well as private clinics or hospitals. Therefore, urban residents have more access to private sources, as compared to their rural counterparts.

However, all in all, government sources are still the key sources in providing health care to patients, followed by private hospitals or clinics and pharmacy/self-care at diminishing percentages.

Service Quality

Health care service or reproductive health service should include technical provision and medical service. The service should take into consideration benefits to users and society at large, while regarding moral and ethical standards.⁹ Quality of service, must have easy access to users and service should be satisfactorily provided. This study has not developed fully-functional tools in measuring service quality. Instead, it made use of a number of questions designed to make medical service quality assessment. The questions help to reflect interactions between service providers and patients. The questions are based on the time of waiting, privacy of examination, attentiveness of medical staff in listening to their patients, and being informed of the patients' medical condition and diseases. Table 6 shows that about a quarter (27.2 percent) of the respondents reported having to wait for a long time to get examination. The figure is quite low, compared with the result in other studies, which specified that 70 percent had to wait for examination from a long to very long time.¹⁰ The patients' major anxiety waiting to be examined is a long wait to see the doctor. However, 1 in 5 women stated they did not have privacy of examination. Regarding the medical staff's treatment to the patients, 13.6 percent of the respondents said that health service providers did not tell them of their ailments. The results here are in line with those in other studies,^{7, 11} which found that doctors had no time to talk and discuss the patients' illnesses and that

most patients' anxiety were caused by their worries after seeing the doctors because the doctors never told them of their diseases and their medical conditions. Regarding attentiveness in listening to the patients' report of their illnesses or health problems, 6.1 percent stated that service providers were not attentive to them. The results are in accordance with the findings in the focus groups conducted by Yothin Sawangdee et al,⁷ which reported that the doctors were very fast in examining patients and did not give enough time for the patients to tell of their ailments. However, when classified by residential areas (Table not shown), it is found that urban residents reported having to wait long, not getting privacy of examination, inattentiveness from service providers and being uninformed of their medical conditions by larger percentages than their rural counterparts. This may imply partially that rural service quality is of higher standards and partially that urban residents' expectation is higher than that of rural residents.

Considering overall assessment of service quality (Table 6) from the questions asking "Overall, how do you rate the quality of service you get? Very good, Good, Moderate, or Not good?", the results show that more than half of the respondents rated it Good to Very good. Only 5 percent rated it Not good and about a quarter of the women asked evaluated the service quality to be moderate. The results that turned out to be from Good to Very good should not be rushed into a conclusion that service quality is truly what was stated. High satisfaction reflected in the results may simply mean that Thais tend not to voice their negative responses to strangers. Being asked directly by unfamiliar interviewers, the respondents may give answers they think would satisfy the interviewers. Hence, they may tend to give positive evaluation. Qualitative methods for this sort of data collection may reveal quite a different result.

Based on such a data assessment, the results will be divided into 2 classifications—one being Good to Very good; and the other Moderate to Not good. The results should be considered in conjunction with the background of the female samples. Table 7 indicates that the assessment varies according to age, i.e. higher percentages of older women gave more positive responses than their younger counterparts. The fact that the younger respondents in the 15-24 bracket gave Moderate to Not good responses by higher percentages than other age groups may be because younger women are more expressive than their older counterparts. Education seems to play very little parts in the differences of assessment.

Other factors influencing the results of the overall assessment of service quality include ethnicity, occupation and residence. Thai and Other ethnics show lower percentages of negative assessment, Moderate to Not good, as compared to Thai ethnics. Meanwhile, about a third of those in Agriculture gave a Moderate to Not good assessment by higher percentages than those in Non-agriculture. The reasons may be because most Agriculturists (Table 3) use health care service from government sources and it is believed that government sources provide inferior quality of service while charging lower than private sources. More users of government sources means more chance of negative experiences.

Assessment by residential areas shows the same results as those obtained from the question on the interaction between service providers and service users. Specifically, urban residents gave Moderate to Not good assessment by slightly higher percentages than rural residents.

Conclusion

Almost half of the female samples reported having good physical health, albeit having worse mental health than physical. In so far as health examination is concerned, the highest percentage goes to the women having had pelvic examination, followed by AIDS test and physical examination. A number of factors, such as age, education, occupation, etc. do affect different types of examination, with education and occupation as the far-leading factors in AIDS test in women. Hence, education for women should provide the first and foremost basis in preventive measures against AIDS transmission.

As for the health service delivery sources, government sectors remain the major source in providing family-planning service and health care. Despite the service indicators reflecting more of positive rather than negative attitudes, there is no denial in service delivery problems, such as long wait before getting serviced for physical examination, and lack of privacy of examination. In the overall assessment, most of the respondents rated their evaluation on Good to Very Good, which should be viewed as even better in reality. Nevertheless, urban and rural respondents show varying degrees of differences in the evaluation.

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Table 1 Physical and mental health assessment, comparison between present health status with health status 3 years ago

Assessment	Physical health	
	Present status	3 years ago
Poor	6.9	7.2
Moderate	37.9	20.6
Good	55.2	72.2
	Mental health	
	Present status	3 years ago
Poor	12.2	6.7
Moderate	30.2	23.4
Good	37.6	69.9
Total	100(625)	100(625)

Table 2 Percentage of women who have had physical examination, pelvic examination and AIDS test by background variables

Background variables	Physical health examination	Pelvic Examination	AIDS Test
Age group			
15-24	33.6	64.0	49.2
25-34	39.1	82.5	46.5
35-39	43.4	85.0	31.5
Education			
Less than primary	33.7	81.0	26.3
Primary	28.8	79.9	38.7
Secondary	46.4	75.5	57.8
High school and over	59.5	80.2	59.7
Ethnicity			
Thai	39.2	79.3	42.5
Thai and others	39.1	80.9	47.7
Occupation			
Non-agriculture	42.0	81.8	49.1
Agriculture	32.3	73.8	25.2
Work status			
Self employed	35.0	82.3	35.9
Family business	25.0	72.8	31.1
Private business	45.4	78.0	52.2
State or gov't officess	66.7	84.4	60.5
No of household member			
2-3	39.8	80.5	44.2
4-5	38.7	80.8	39.8
6+	39.4	76.7	46.8
Residence			
Urban	39.1	77.5	48.8
Rural	39.2	81.4	37.2
Total	39.2	79.5	42.9

Table 3 Multiple classification analysis of AIDS Test by selected variable

	N 625	AIDS Test	
		Unadjusted	Adjusted for independent
Grand mean	1.57		
Women's Age			
15-24	113	5.10	.38
25-34	306	3.72	2.99
35+	162	-10.59	-5.92
Eta/Beta		.13	.08
Education			
Less than primary	151	-16.86	-13.19
Primary	215	-4.08	-2.75
Secondary	99	14.89	11.65
High school and higher	116	16.80	12.31
Eta/Beta		.27	.20
Ethnicity			
Thai	538	-.31	.13
Thai and others	43	3.83	-1.68
Eta/Beta		.02	.01
Women's Occupation			
Agriculture	426	6.38	4.81
Non agriculture	155	-17.52	-13.21
Eta/Beta		.21	.16
Residence			
Urban	286	5.92	-.28
Rural	295	-5.74	.28
Eta/Beta		.12	.01
R Squared			.09

Table 4 Percentage of women by source of family planning services and health care

Sources of service	Family planning	Health care
Health center	34.8	18.2
Gov't hospital	33.9	49.8
Private	10.2	25.6
Pharmacy/self care	18.6	6.3
Others	2.5	-
	100(590)	100(624)

Table 5 Percentage of women according to sources of health care by background variables

Background variables	Sources of health care			
	Pharmacy/ self care	Gov't facility	Private facility	
Age group				
15-24	5.6	71.0	23.4	100(124)
25-34	6.4	68.4	25.2	100(326)
35+	6.3	65.5	28.2	100(174)
Education				
Less than primary	7.9	73.9	18.2	100(165)
Primary	6.1	74.7	19.2	100(229)
Secondary	7.3	60.9	31.8	100(110)
High school and over	3.3	54.2	42.5	100(120)
Ethnicity				
Thai	6.1	68.3	25.6	100(577)
Thai and others	8.5	66.0	25.5	100(47)
Occupation				
Non agriculture	6.6	62.7	30.7	100(440)
Agriculture	5.5	83.6	10.9	100(165)
Work status				
Self employed	5.4	70.1	24.5	100(261)
Family business	5.4	78.3	16.3	100(92)
Private business	7.8	63.4	28.8	100(205)
State or gov't	6.7	60.0	33.3	100(45)
No of household member				
2-3	16.5	48.1	35.3	100(133)
4-5	3.7	72.8	23.5	100(298)
6+	3.1	74.6	22.3	100(193)
Residence				
Urban	9.5	56.5	39.0	100(306)
Rural	3.1	79.2	17.6	100(318)
Total	6.3	68.1	25.6	100(625)

Table 6 Quality of care indicators and assessment of the overall service

Indicators	Yes	No	
Having to wait long for treatment	27.2	72.8	100(625)
Receiving treatment privately	78.1	21.9	100(625)
Was told about illness	84.6	13.6	100(625)
Listen attentively about health problem	93.8	6.2	100(625)
Assessment of the overall service			
Very good		21.8	
Good		48.8	
Moderate		24.5	
Poor		5.0	
		100(625)	

Table 7 Percentage of women according to their assessment on the overall service by background variables

Background variables	Good-very good	Moderate not good	
Age group			
15-24	61.6	38.4	100(125)
25-34	69.9	30.1	100(326)
35+	78.2	21.8	100(174)
Education			
Less than primary	73.9	26.1	100(165)
Primary	67.2	32.8	100(326)
Secondary	70.0	30.0	100(110)
High school and over	72.7	27.3	100(121)
Ethnicity			
Thai	70.2	29.8	100(578)
Thai and others	74.5	25.5	100(47)
Occupation			
Non agriculture	71.9	28.1	100(441)
Agriculture	66.1	33.9	100(165)
Work status			
Self employed	73.9	26.1	100(261)
Family business	62.0	38.0	100(92)
Private business	69.4	30.6	100(206)
State or gov't	71.1	28.9	100(45)
No of household member			
2-3	64.9	35.1	100(134)
4-5	73.2	26.8	100(298)
6+	76.5	29.5	100(193)
Residence			
Urban	69.7	30.3	100(307)
Rural	71.4	28.6	100(318)
Total	70.6	29.4	100(625)