UNCTAD-WHO Joint Publication
International Trade in Health Services
A Development Perspective
Geneva, 1998

[Doc. symbol: UNCTAD/ITCD/TSB/5 - WHO/TFHE/98.1]

14. THE CASE OF THAILAND

Songphan Singkaew and **Songyot Chaichana**

I THE HEALTH SECTOR IN THAILAND: AN OVERVIEW

The Thai health-care system is characterized by two main features: traditional medicine and Western medicine. The role of traditional medicine, however, is now declining.

In keeping with its economy, Thailand has a market-oriented health-care system. The patient has free choice to visit a doctor or health-care facility and this choice is exercised fully. Fee-for-service is the main method of paying service providers. Although public providers play the major role in providing health-care services, private hospitals, mainly owned by groups of doctors, are sprouting up in the big cities.

Health care providers

Health facilities. Public health-care facilities such as regional hospitals, provincial hospitals, medical-school hospitals and specialized hospitals cover all the provinces of Thailand. In addition, at district level, there are 708 community hospitals which, in 1996, covered 94.5 per cent of the total number of districts. In urban areas, moreover, there are 278 municipal health-service centres in the Bangkok Metropolitan Area and around the country. At *tambon* level, there are 9,239 health centres, which amounts to about 100 per cent coverage. Additionally, there are 521 community-health centres located in remote village areas. In addition, there are 61,432 primary health-care (PHC) centres established in rural areas and 808 PHC centres in urban areas.

With regard to private health-care facilities, there are private hospitals, private clinics and drug stores scattered around the country. The government has also provided equal opportunities for both private and public facilities based on market competition. However, when attention is focused on the locations of health-care

facilities, it is found that private health-care facilities are more concentrated in Bangkok and its suburbs and large cities.

Health personnel. There is a considerable shortage of health personnel countrywide, in both quality and distribution, despite past efforts to increase production in order to meet demand. Added to the already inadequate supply of health personnel, the outflow of public health personnel to the private sectors during the past five years has worsened the situation in the government sector. For example, the Ministry of Public Health can fill only 48.3 per cent of the total available posts of 53,371 professional nurses. Similarly, the Office of University Affairs can fill only 40 per cent of professional nurses' jobs. Other government agencies and the private sector have also faced similar situations. For the private sector, the shortage of professional nurses proves to be considerably more serious than that of medical doctors. This is reflected by the high rate of turnover in nursing posts. The salary of a new graduate nurse working in the private sector, however, is two and a half times that in the public sector. In conclusion, the ratio of nurses per population in Thailand is extremely low (1:1,150 in 1993), especially when compared to Japan (1:156), or our neighbouring ASEAN countries, such as Malaysia (1:470).

There is also unbalanced distribution of health personnel such as doctors, dentists, pharmacists and nurses between Bangkok and the other provinces. In Bangkok, there is one doctor per 940 of the population, while in other regions the ratio is less than one to 5,000. Particularly in the north-eastern region, the proportion is as low as 1:10,885. A similar pattern of unequal distribution is found for other health personnel.

In addition, there are a number of supportive health personnel and other personnel whose work is related to health such as *tambon* health personnel, village health volunteers and nursing sisters in local nutrition, child development and other centres.

Health expenditure

Between 1978 and 1992, health expenditure as a percentage of GDP increased from 3.4 per cent to 5.9 per cent. Total health expenditure rose, in real terms, from 853 Baht per person in 1978 to 2,689 Baht in 1992. Direct private payments accounted for as much as 73.7 per cent of total health expenditure in 1992. However, 57.7 per cent of this was for curative care.

Health financing originated from the four main sources described below.

Public expenditure was channelled mainly through the annual budget of the Ministry of Public Health which, in 1992, accounted for 16.78 per cent of overall health expenditure. In the same year, other governmental agencies' expenditure accounted for 3.2 per cent. The governmental budget allocated to public health in

the past five years has risen moderately. For the years from 1992 to 1997 respectively, health expenditure accounted for 5.4 per cent, 5.8 per cent, 6.3 per cent, 6.5 per cent, 6.7 per cent and 7 per cent of the total governmental budget.

Health schemes expenditure still played a minor role, despite considerable development in the health insurance system. Total health insurance expenditure was 4 per cent in 1978, with an increase to 4.8 per cent of total health expenditure in 1992. A noncontributory scheme for civil servants, financed from general taxation and controlled by the Ministry of Finance, provides medical benefits to civil servants and state pensioners. This scheme has shown a trend towards rapidly increasing medical expenditure. In 1978, the expenditure of the civil servants' scheme was 2 per cent of the total compared with 4.2 per cent in 1990 and 3.5 per cent in 1992. State enterprise employees also receive noncontributory medical benefits from their employers: expenditure on this scheme was around 0.4 per cent in 1978, with some increases reaching 0.9 per cent in 1986 and dropping back to 0.4 per cent in 1992. The cost of the workmen's compensation fund remained at between 0.4 and 0.5 per cent of overall health expenditure throughout the period. Private insurance reduced its share from 1.2 per cent of the total in 1978 to 0.4 per cent in 1992.

Foreign aid in health played a decreasing role, both in real terms and as a percentage of total foreign assistance. Foreign grants in the health sector declined from 1 per cent in 1978 to 0.2 per cent in 1992. The Department of Technical and Economic Cooperation is responsible for the assistance received by coordinating general loans or grants, part of which go to the health sector. Foreign aid may, however, be channelled directly to ministries or operating agencies.

Direct private payment is the major component of health sector expenditure. In 1978 it constituted 66.7 per cent and had increased to 73.7 per cent by 1992. In Thailand, direct private payments by households are made for health services received from traditional healers, drug stores, private and public clinics, health centres and hospitals.

Health care coverage

Health schemes in Thailand cover about 70 per cent of all Thai citizens. There are several health insurance schemes, each protecting specific groups of the population: low-income households are covered by free medical care funded from the Ministry of Health budget; the elderly of 60 years of age and above are entitled to free care subsidized by the same budget; school children are covered by school health insurance; civil servants and state enterprise employees, including their dependants, are entitled to medical fringe benefits under a non-contributory system; a compulsory social security scheme covers formal sector employees for

non-work-related medical benefits, maternity benefit, death and disability compensation. The government, employers and employees also pay contributions at 1.5 per cent of payroll value to the social security fund. There is also a workmen's compensation fund covering work-related illness and injury.

Private sector collaboration

Private sector activity falls into two categories: non-profit-making organizations such as hospitals under the patronage of religious institutions or foundations, and profit-making organizations such as private hospitals or clinics. Since 1992, the Ministry of Public Health has provided funding to the private non-profit-making organizations for community and health development activities to the amount of 47 million Baht annually. It also provides about 80 million Baht annually to private organizations for AIDS relief. In total, in 1997, the Ministry provided direct funding to private organizations to the amount of 619.6 million Baht, or around 0.87 per cent of the total Ministry budget. In fact, the majority of the public health funding projects in the private sector are in the area of health-care prevention and promotion such as family planning, AIDS prevention, nutrition, etc. and accounted for 83.41 per cent of the total.

International collaboration

Total external assistance to Thailand in the health sector decreased from US$ 12.65 million in 1992 to US$ 5.17 million in 1996. Forms of external assistance for health vary, although they can be classed as so-called "technical cooperation". The activities involved training, fellowships, experts, equipment, missions (such as consultancy, joint-venture), volunteers and grants.

Recently, the Government of Thailand has provided health assistance to neighbouring countries for a total amount of US$ 5 million in 1995 and US$ 4.25 million in 1996. In 1997, health projects were financed for Cambodia, Lao People's Democratic Republic, Myanmar and Viet Nam to the value of US$ 1.2, US$ 1.5, US$ 0.8 and US$ 1.2 million respectively. The main assistance activities are hospital construction and repair, provision of essential equipment, training, drugs and medical supplies.

Legislation and regulations

There is a passive regulatory system for health care. Although some mechanisms for health-care supervision and monitoring in public facilities are implemented, there is a lack of continuous, formal appraisal of the quality and appropriateness of care in public and private hospitals as well as private clinics. Regulations on health and health-related services include:

• law on setting up government organizations. A government department is allowed to establish its own health-care facility in accordance with budgetary and resource availability. The department can provide medical services and public health with autonomy in planning, personnel recruitment and so on;

• law on professional standards and ethics. The professionals (doctors, nurses, pharmacists, dentists and traditional healers) must have basic knowledge in their profession prior to their registration with the Ministry of Public Health;

• the Act on Medical Care Institutions B.E. 2504. It concerns the registration procedure and quality control of private hospitals and clinics. Some safety and quality of care standards for consumer protection are enforced. According to this law, information on the professional qualifications of health personnel must be provided before setting up a new hospital or clinic in Thailand.

Consumer preference for health services

One of the strengths of the health system in Thailand is the diversity of its services. The consumer's choice of provider is maintained. Government household surveys show that there is an increased demand for treatment, accompanied by a significant decrease in the demand for traditional medicine/healers and self-prescribed drugs, although primary health care visits are grouped under the heading of self-prescribed drugs. A decline in the number of private clinics/hospitals was found in the 1995 survey due to the high charges to users. Public hospital use rose from 11.1 per cent to 32.5 per cent over the period from 1970 to 1985 but fell sharply to 17.79 per cent in 1995. The availability of health centres with their improved quality proved its value by attracting back local visitors whose number more than doubled from 14.7 per cent in 1985 to 39.34 per cent in 1995. A screening mechanism for outpatient visits with an effective referral system is now in operation, after continuing efforts for more than three decades to establish it.

II HOW TRADE IN HEALTH SERVICES IS BEING CARRIED OUT

Owing to rapid industrialization and urbanization, the health sector has had to cope with an increase in environmental health and occupational health hazards. There is a rise in the number of formal sector workers who are protected by the 1990 Social Security Act. Since 1991, there has been a rapid increase in the number of hospitals due to changes in the method of paying providers. Thus the potential is obvious for the domestic health trade but less clear for international trade. This is due to prohibition by Thai legislative measures, especially the Public Health Act

B.E. 2535, the Act on Medical Care Institutions B.E. 2504 and the Act on the Art of Healing, B.E. 2479.

Movement of suppliers

In the case of Thailand, owing to a shortage of medical professionals working in remote rural areas, the government and the medical council have lifted the barriers to the medical profession for those who graduated abroad and for foreign doctors. At present, a Thai doctor who received training abroad must apply for and take a professional examination to obtain a medical licence to practise. Between 1969 and the present, 164 out of 1,096, or 14.96 per cent of all applicants, failed the professional examination. During that period, those who failed the examination could take an intensive course provided by some medical schools, and sit for a comprehensive examination, along with local medical students in training. Under a new regulation, however, Thai medical specialists who have graduated from developed countries, especially the United Kingdom and the United States, are entitled to receive a temporary licence to practise in government hospitals for two years, after which they receive a special permanent licence. Foreign doctors from developed countries may also apply to practise in public hospitals under the supervision of Thai doctors. For foreign doctors, it is still difficult to apply for a medical licence in Thailand because the examination is conducted entirely in the Thai language.

Nevertheless, some types of medical facility, such as fitness centres, clinics and health promotion centres, are run without professional supervision. Their licenses are granted directly and they are controlled by the local administration, the Ministry of Public Health or the Ministry of Trade. Some health and health-related services such as Chinese healers, chiropractic, etc. are also outside the control of a professional council or a national committee. For this reason, they are not free to trade in health and health-related services but they continue to practise illegally.

Movement of consumers

Although there is no specific data available in Thailand, people from neighbouring countries arrange inpatient visits, especially to teaching hospitals and private hospitals in Bangkok. Those who go to prominent hospitals in Bangkok are foreigners who work in international organizations and some better-off business people. On the other hand, hospitals located near border areas such as Had-Yai, Khon Kaen, Nong Kai, Ranong and Chieng Rai are also busy with poor immigrant patients. Overall, the Thai Government has had to allocate large subsidies to care for them.

Apart from this, about three million people a year who visit Thailand as tourists and businessmen may fall sick during their journeys and have access to all health-care facilities. Some private hospitals also provide dental care and cosmetic

surgery to foreign clients, especially Japanese, who find that services rendered in Thailand cost much less and are better than those provided in their own countries.

Many hospitals are endeavouring to obtain accreditation with the standard-setting agencies such as the International Standards Organization in order to be accepted by international insurance firms which are seeking suitable hospitals to satisfy their customers' needs.

Recently, there has been clear evidence of the popularity of Thai massage, health clubs, spas and traditional medicine services. In the future, health promotion and rehabilitation services are expected to generate foreign exchange. This results from the government policy of providing incentives to promote service investors and measures to control quality of care, as well as to accommodate foreign clients.

Commercial presence

The private health insurance business in Thailand began in 1978. Its growth rate has been very low in comparison with other types of insurance business. It has not had great success in terms of its market share, and business has been unstable and fluctuating. Only six companies writing solely health insurance policies share approximately 65 per cent of total direct premiums paid. Total expenditure on private insurance has decreased from 1.2 per cent of total health expenditure in 1978 to 0.4 per cent in 1992. However, 1.6 per cent of the population was covered by private health insurance in 1992 and figures projected for the year 2001 are 4.02 per cent.

Foreign-owned private hospitals or clinics are not permitted in Thailand unless the foreigners have established a joint venture with Thai partners. It is a requirement of the Ministry of Trade that their maximum share is 49 per cent of total investment. However, all foreign doctors working in a joint-venture private hospital are also required to pass the examination for a Thai professional licence.

Cross-border trade

A four-year telemedicine project has recently been set up at a total cost of 346 million Baht. It aims at providing health care in remote areas as well as continuing education for medical doctors. At present, there is a network of three teaching hospitals, 14 regional hospitals, seven provincial hospitals and 20 community hospitals. To date, there is no specific plan to cooperate with universities abroad in the provision of telemedicine. In the future, however, there is room for further international development in this field.

III PROBLEMS ENCOUNTERED

A number of obstacles to development of trade in health services in Thailand are identified below.

• Investment for hospital services must be licensed in accordance with Thai regulations which restrict this to Thai citizens only.

• Licences to practise professionally in Thailand are issued on a permanent or temporary basis. Those who wish to apply for a permanent licence must pass the professional examination set by professional councils or the national committee in each area of the profession. Eligible persons must have at least the basic qualifications issued by the committee, such as relevant education or an appropriate qualification granted by the approved professional institution abroad.

Those who wish to obtain a temporary licence must apply directly to the health minister who issues a temporary licence permitting the holder to work in the public service only.

• Imported pharmaceutical products and medical equipment for domestic use must be approved by the Food and Drugs Administration of the Ministry of Public Health. Imported products should pass through normal customs clearance procedures. However, there is also a patent law to control the licensing of pharmaceutical products and medical equipment.

• Persons not of Thai nationality wishing to work in Thailand must receive a work permit as required by Thai regulations.

• Setting up a new health insurance company is difficult. Application must be made through the Ministry of Trade. There is a limited quota for establishing new firms, as well as additional restrictions.

• The setting up of hospital consultancy services and the construction of hospitals and similar establishments are also controlled by the Ministry of Trade.

• To set up an educational institution or training centre in the health profession, application must be made to the Ministry of Education. Moreover, the curriculum must be approved by the professional council or the national committee for the particular profession.

• Health service research and development and technological development are protected by patent law.

IV STRATEGY TO INCREASE PARTICIPATION IN TRADE IN HEALTH SERVICES

A strategic plan to increase participation in health services has been drawn up. Its objectives are:

- to increase capability in producing the raw materials needed for domestic manufacturing of modern and traditional medicines by revising the structure of import taxes for raw materials and by promoting cross-licensing or joint ventures in drug manufacturing;
- to promote research and development of health products by both the public and private systems;
- to revise laws and regulations which hamper the growth of the health industry, for both domestic consumption and export;
- to promote the participation of consumer organizations and manufacturers' organizations in monitoring and controlling the standard, efficiency and quality of health products;
- to strengthen the government's monitoring and control systems to ensure the quality, safety and reasonable pricing of consumer products;
- to develop mechanisms and autonomous bodies for quality control of public and private hospitals and to promote the dissemination of information on quality, standards and pricing of hospital services in order to stimulate market competition for consumer protection;
- to promote the participation of the private sector in health system research, laboratory analysis, information dissemination and campaigns for consumer protection by providing budgetary support, information and technical documents, while reducing unnecessary control by government regulations;
- to decentralize authority for managing health resources to provincial, municipal and community levels and to nongovernmental organizations;
- to reform the health-care financing mechanism by emphasizing efficiency and equity in health-resource allocation and utilization;
- to reduce unnecessary procedures and regulations which hamper development, while accelerating the enforcement of essential laws and regulations, i.e. Royal Decree on Drugs, Royal Decree on Public Health. Furthermore, to promote the use of new technology and business management techniques to improve public health management;
- to promote networking of health development at all levels involving cooperation by all concerned parties including the government, nongovernmental organizations, the business sector, technical professions, people's organizations and the mass media; and
- to encourage nongovernmental organizations to become involved directly or as a joint venture with the government in various forms of health-care provision, with emphasis placed on quality and appropriate prices.