The Third Wave of Health Care Reform in Thailand

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Abstract Health care reform movements in Thailand have occurred during three main overlapping periods. The first wave of health care reform focused on increasing the geographical coverage of the health care infrastructure, while the second wave focused on reforming health care financing mechanisms. The third wave shifted its focus to strengthening primary care. This paper is aimed at exploring the third wave of health care reform in Thailand using literature and document review. It was found that, among five areas of reform initiatives to strengthen primary care, there was an imbalance of investment in the primary care infrastructure and capacity building of health staff. An insufficient number of health centre staff, along with their limited capacity, is a major constraint affecting the ability to improve health centre performance. The development of a referral system has been neglected and could reduce confidence of the people in primary care. Although health care financing reform has improved financial status of the health centres, it still needs continuous development in order to promote the responsibility and productivity of health centre staff toward its registered population. Finally, there is a need to develop and adapt the concept and practice of family medicine to fit with the country-specific context and to promote it to be well recognized by the general public as well as by physicians. New challenges for the development of primary care in Thailand include its governance system, in the context of health care devolution, and the provision of health services for chronically ill patients and the elderly.

Key words: *health care reform, primary care*

บทคัดย่อ **คลื่นลูกที่สามของการปฏิรูประบบบริการสุขภาพในประเทศไทย**

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การปฏิรูประบบบริการสุขภาพของประเทศไทยได้ก้าวสู่ระยะที่สาม หลังจากประสบความสำเร็จในการขยายความครอบคลุมสถานพยาบาลไปทั่วประเทศในระยะที่หนึ่ง และการปฏิรูประบบการเงินการคลังจนมีระบบหลักประกันสุขภาพถ้วนหน้าในระยะที่สอง โดยจุดเน้นหนักของการปฏิรูประบบบริการสุขภาพในระยะที่สามคือ การสร้างความเข้มแข็งให้กับระบบบริการสุขภาพปฐมภูมิ ซึ่งมีการดำเนินการอย่างมากในช่วงสองทศวรรษที่ผ่านมา การทบทวนสถานการณ์การปฏิรูประบบบริการสุขภาพในระยะที่สามจากเอกสารและงานวิจัยต่างๆ พบว่า มีการดำเนินการเน้นหนักใน ๕ ด้านประกอบด้วย ๑) การพัฒนาโครงสร้างพื้นฐาน ๒) การพัฒนาศักยภาพบุคลากร ๓) การปฏิรูประบบการเงินการคลัง ๔) การพัฒนาระบบส่งต่อ และ ๕) การประยุกต์แนวคิดและแนวปฏิบัติของเวชศาสตร์ครอบครัวให้สอดคล้องกับบริบทสังคมไทย โดยมีการลงทุนพัฒนาด้านโครงสร้างค่อนข้างมากและไม่สมดุลกับการลงทุนพัฒนาบุคลากร สถานีอนามัยซึ่งเป็นสถานพยาบาลปฐมภูมิหลักของประเทศ มีจำนวนบุคลากรเฉลี่ย 2.8 คนต่อแห่ง และเพิ่มขึ้นน้อยมากขณะที่จำนวนประชากรที่รับผิดชอบเพิ่มมากขึ้น ผลการปฏิรูประบบการเงินการคลังทำให้สถานะทางการเงินของสถานีอนามัยดีขึ้น แต่ยังต้องมีการปฏิรูปอย่างต่อเนื่อง เพื่อส่งเสริมประสิทธิภาพการปฏิบัติงานและความรับผิดชอบของบุคลากรต่อประชาชนที่รับผิดชอบ การพัฒนาระบบส่งต่อมีการดำเนินการค่อนข้างน้อยและผู้บริหารมักจะไม่ให้ความสำคัญ ขณะที่แนวคิดและแนวปฏิบัติตามหลักเวชศาสตร์ครอบครัวยังไม่ได้รับการยอมรับกันอย่างกว้างขวาง ปัญหาเรื่องการขาดแคลนกำลังคนที่มีศักยภาพเป็นอุปสรรคที่สำคัญที่สุดของการพัฒนาระบบริการสุขภาพปฐมภูมิในระยะต่อไป และการเสริมสร้างศักยภาพบุคลากรผ่านรูปแบบ "การเรียนรู้โดยใช้บริบทเป็นฐาน (context based learning)" ที่ศูนย์การเรียนรู้ (learning centre) ต่างๆ ที่ได้พัฒนาขึ้นในช่วงทศวรรษที่ผ่านมา น่าจะเป็นทางเลือกที่ดีอันหนึ่ง การพัฒนาระยะต่อไปต้องให้ความสำคัญกับการพัฒนารูปแบบการจัดบริการ สำหรับผู้ป่วยโรคเรื้อรังและผู้สูงอายุซึ่งมีจำนวนมากขึ้น รวมทั้งการพัฒนาทางเลือกรูปแบบการบริหารจัดการ ในกรณีที่จะมีการกระจายอำนาจให้แก่องค์กรปกครองส่วนท้องถิ่นด้วย

คำสำคัญ: *การปฏิรูประบบบริการสุขภาพ, บริการสุขภาพปฐมภูมิ*

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Introduction

Among developing countries, Thailand's health care system has attained impressive performance in terms of health outcomes and equity improvement.[1,2] This success was made possible through continuous reforms of the country's health care system, especially during the last three decades. In fact, health care reform movements in Thailand occurred during three main overlapping periods. The first wave of health care reform started in the First National Economic Development Plan (1958-1961) when there was a national plan to increase the coverage of the health care infrastructure until every administrative area of the country could be covered by the Sixth National Economic and Social Development Plan (1987-1991). The second wave focused on reforms of health care financing mechanisms and started in the mid-1970s when the Low Income Scheme was implemented. Other health care financing initiatives, including medical benefits for civil servants and their dependents, the Health Card Project, and Social Security Scheme (SSS) for formal sector employees were implemented subsequently in 1980, 1983 and 1990 respectively. The second wave of health care reform ended up with the implementation of the Universal Coverage (UC) Scheme in 2002.[3]

The focus of health care reform was shifted to strengthening primary care in the third wave. This reform was aimed at improving not only the efficiency of the health care system but also the quality of health services. In addition, it is also proved that effective primary care could reduce disparities in health across population groups and thus improve equity.[4] Several reform initiatives to strengthen primary care started in the 1990s using a variety of approaches. However, its success is still limited. This paper is aimed at exploring all reform initiatives to strengthen primary care during the last two decades, using literature and document reviews, and assessing the lessons learned from their implementation.

Five health care reform initiatives

Reform initiatives to strengthen primary care could be categorized into five areas according to their objectives. These include the following: (1) improving primary care infrastructure by making additional capital investment; (2) capacity building of primary care staff; (3) financing reform to allocate sufficient resources for primary care and for enhancing the per-

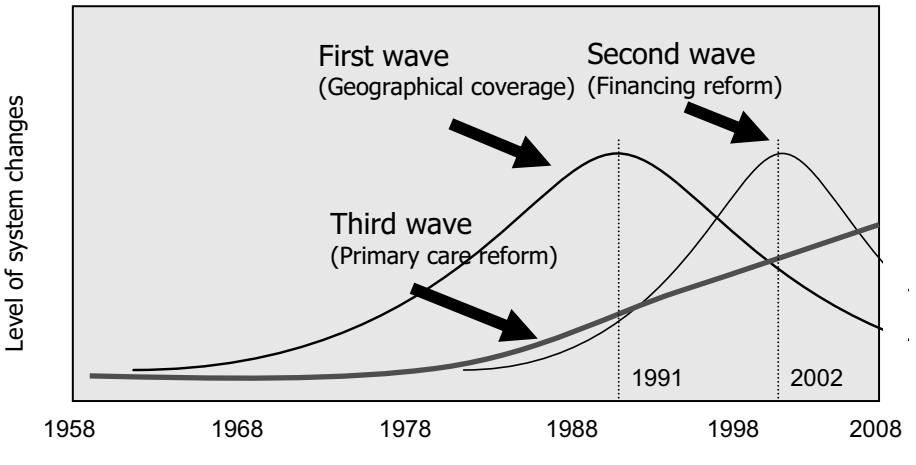


Figure 1 Health care reform movements in Thailand

formance of primary care staff; (4) strengthening the referral system; and (5) development of the family medicine concept and practice, which fits the context of Thailand.

1. Improving primary care infrastructure

Significant additional investment to improve the primary care infrastructure was first started in 1992 under the "Decade of Health Centre Development Plan, 1992-2001." The total budget for this development plan was about 30 billion baht; it was spent mainly on improving infrastructure and purchasing equipment. Some of the budget was spent to produce 2,000 additional health centre staff, while little was spent for training existing staff.[5] The National Health Security Office (NHSO), which is responsible for implementing the UC scheme, has also allocated 18 percent of capital replacement budget for investing in primary care since 2006 and its cost was about 1 billion baht but decreased annually.[6] However, only half of this budget has been spent on primary care infrastructure and the rest has been spent for capacity building and other initiatives. At the beginning of 2009, the government allocated an additional 1 billion baht for improving 2,609 health centres nationwide. Recently, the cabinet approved the Economic Development Plan 2010-2012 (Stimulus Package 2: SP2) to respond to the ongoing global economic crisis. The total budget for investing in health is 86.7 billion baht, of which 14.8 billion baht is earmarked for improving

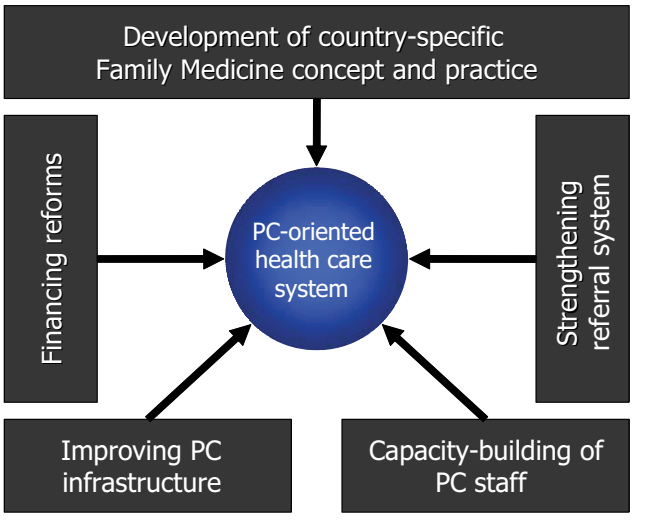
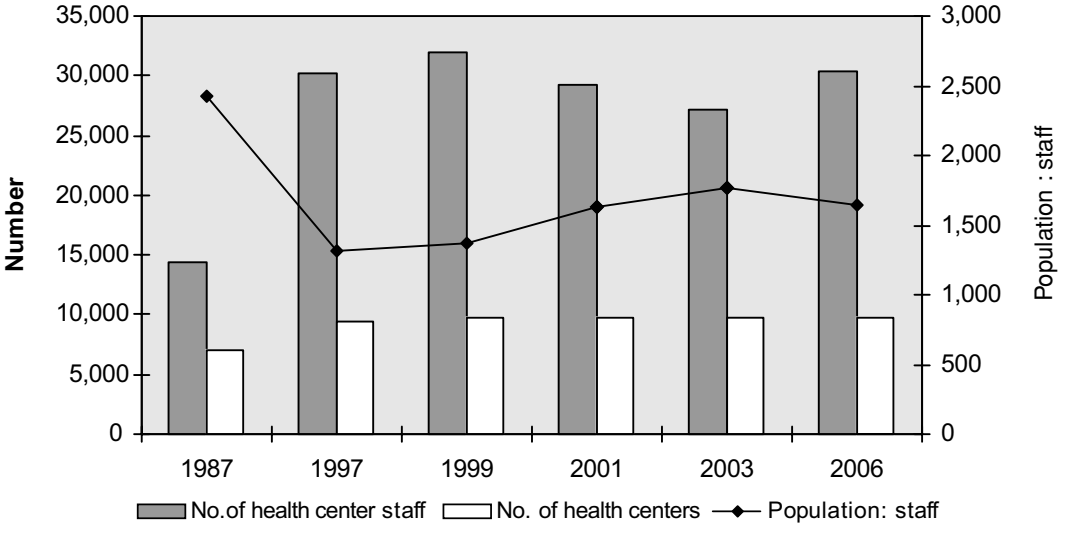


Figure 2 Five main areas of primary care (PC) reforms in Thailand



Source: Srithamrongsawat, 2009.

Figure 3 Number of health centres, health centre staff and population per health centre staff during 1987-2006

health centres.[7] In summary, during the last two decades (1992-2012) an additional 47.8 billion baht was made available for investing in health centre infrastructure.

2. Capacity building of primary care health staff

Although the quality of health services is mainly determined by the capacity of health staff, policy makers pay little attention to the capacity building of health staff and invest only a small budget on this. There have been many attempts to fill this gap but they have been implemented on a small scale as pilot development models. Various approaches have been developed not only in universities but also in public health units and health facilities. These include short course training programs on family medicine and the community approach, context-based learning,[8] and learning networks.

The number of staff, including the staff mix, also affects the quality of health services. The average number of staff at a health centre is 2.80, which has remained the same for a long time while the number of the catchment population has increased. Among 9,762 health centres, only 50 percent have registered nurses. Regarding the new government policy to upgrade health centres to become "Sub-district Health Promotion Hospital," each health centre requires at least 5 staff, one of whom should be a registered nurse.[9] According to this policy, at least 21,476 additional staff are needed, among whom 4,881 should be registered nurses.

3. Financing reform

Previously, health centres were financed through the line-budget system. The UC scheme has reformed the financing mechanism of primary care starting in 2002 by accepting the primary care unit as its main contractor : the Contracted Unit for Primary Care (CUP). CUP needs to have a full-time physician and will get capitation payment for providing health services to its registered population. Based on this requirement, the health centres which operate without a physician can be only a sub-contractor of CUP and receive payments based on negotiation. However, it was found that during the period by 2005-2009, the net revenue of health centres as well as all related expenses increased about 16 percent.[10] A criticism has been made that financing health centres in this way will not promote responsibility and proactive activities of health centre staff toward their registered population. Continuous development of this financing mechanism is in process.

4. Strengthening the referral system and referral hospital

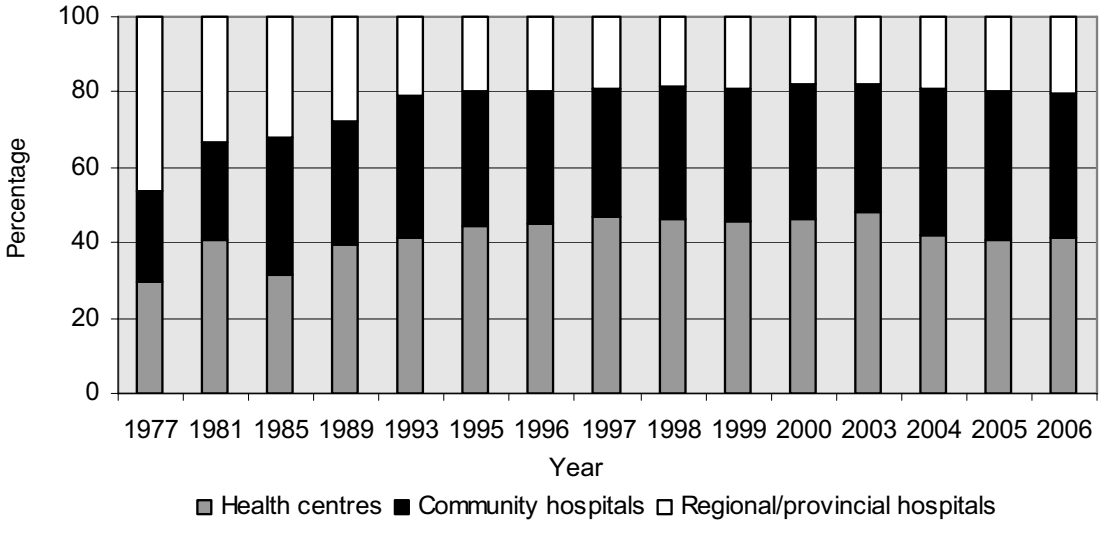
The referral system has rarely been identified as a key development issue although it is crucial for the continuity of health service provision. Beneficiaries of the UC scheme and SSS need a referral system if they would like to use health services outside the main contractor's health facilities; this has been enforced by implementing cost-sharing and "money follows the patient" strategies. The latter intends to rationalize referral cases by providers but creates negative consequence of delaying referrals. Referral notes have been used mainly for administrative purposes instead of service provision. The NHSO has established a referral coordinating centre and a special financial incentive for hospitals with reserved beds for referral cases. This model could improve access to hospital care of some patients.[11] Recently, the Minister of Health initiated a new policy to allow UC beneficiaries to obtain health services from any health facility in a province. This was to respond to the complaints of beneficiaries about the poor quality of services of registered health facilities and delays in getting referrals, but it could downgrade the referral system. Fortunately, this policy has not yet been fully implemented.

5. Development of the family medicine concept and practice

Before the concept of family medicine becomes familiar in Thailand, there was an initiative to demonstrate an effective primary care model in Ayutthaya Province in 1989, using the action research approach.[12] This model has spread nationwide and has created many learning centres for primary care staff. In addition, the knowledge and experience learned from local model development as well as that of developed countries have been formulated into a country-specific concept and practice of family medicine. This also led to a change of medical specialty from general practitioner to family physician in 2001. However, this medical specialty has not been well accepted by physicians and the number of training applications each year is very small as compared with other medical specialties. There is still a need to develop and promote the concept of family medicine so that it will be recognized by the general public as well as by physicians.

Some evidence of success

There is some evidence which could indicate the success of primary care development in Thailand. First, there has been a substantial shift of ambulatory service utilization toward primary care; it was found that the proportion of ambulatory services at the primary care level increased from 29.4% in 1977 to 41.1% in 2006. The highest number of health centres compared with other health facilities could be a possible explanation for this since the ratio of health centre: district hospital: general/regional hospital was 98.6:7.4:1 in 2007.[13] In addition, the waiting time of patients at health centres is shorter when compared with that of other health facilities. The average waiting time at health centres was only 35 minutes, while the average waiting time at district hospitals and general/regional hospitals was 77 and 89 minutes respectively.[14] In summary, this evidence could reflect better access to health services for people at the primary care level.



Source: Ministry of Public Health, 2007.

Figure 4 Proportion of ambulatory service utilization at different levels of health facilities during 1997-2006

Second, benefit incidence analysis comparing pre- and post-UC implementation found that the pro-poor subsidy was very pronounced at health centres and district hospitals and the concentration index was -0.3326 and -0.2921 respectively.[15] This indirectly indicated that the poor utilize health services at health centres more than the rich.

Lessons learned and conclusion

During the last two decades, there have been several efforts to strengthen primary care in Thailand, using various approaches and interventions both at the national and local levels. The development of reform initiatives links closely with knowledge and evidence obtained from research studies. Knowledge generation to support primary care development started from projects, such as the Ayutthaya Project, but has developed later into a research program and a research institute: the Institute of Community based Health Care Research and Development under the joint investment of the Health Systems Research Institute (HSRI) and Mahidol University. The Primary Care Forum was established by the National Health Foundation (NHF) in 2008, with the support of many funding agencies; it acts as a new mechanism to gather additional evidence, to synthesize, and to develop policy packages to support primary care. Development of policy could be aimed at strengthening primary care with that as its main objective, or it could serve as a means for the development of other policies, such as the universal health coverage policy. Concerning the five areas of reform initiatives to strengthen primary health care, it was found that there was relatively less budget spent on capacity building of health staff than for primary care infrastructure. Capacity of health centre staff, including average staff number in each health centre, improved slowly, producing only limited performance improvement of health centres. The limited number and competency of health staff at health centres also limit the effective utilization of additional resources obtained from financing reform in order to improve the quality of health services. Development of the referral system has been a neglected development area and could reduce the confidence of people in the primary health care system.

In summary, the third wave of health care reform in Thailand, which focus on strengthening primary care, has created some system changes especially increased access to primary care but it is still inadequate to move the existing health care system to be primary care oriented. An inadequate number of primary care staff with limited competency has become the major constraint; it cannot be easily overcome because of the shortage of staff and limited training capacity. The context-based learning approach and learning centres which have been established during the last decade by many research and development projects could help in strengthening existing primary care staff; they need continuous support to expand their capacities. A new challenge for the reform initiatives concerning primary care would be the governance system, especially when, according to the Thai Constitution of 2007, responsibility for health service provision should be devolved to the local authorities. In addition, because of the substantial increase in demand for chronic care and long-term care[16], primary providers need to develop new approaches by working closely with the community to respond to this demand.

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