# CHAPTER 1

## INTRODUCTION

Thailand is one of the fastest growing economy in Asia and recently has been classified by the United Nations as a newly industrialized country. The economic miracle of Thailand that began in early 1970s continued almost unabated. In the early stage, Thailand utilized its vast agricultural products for trade and the economy. But very quickly it got into tourism and entertainment business which in the late eighties was its main source of foreign exchange earning. In the 1980s, Thailand opened and quickly expanded its industrial sector for foreign and private investments which in recent years have become an important component of the national GDP along with the agriculture and service sector. As a whole, Thailand, like its East and Southeast Asian neighbors is going through quick succession of socio-economic transitions. Some of the important changes are discussed in the following sections.

### 1.1 Socio-economic Transition:

Because of the rapid economic growth in the past twenty years there have been several important changes involving economic, demographic, epidemiological, socio-cultural and general livelihood of the people. Much of the economic development centered in and around the large urban areas and concerned mostly the industrial and service sectors. But the overall impact of economic development - positive and negative - has touched every sectors including the rural poor. The following are some of the important changes that bears impact on the performance of the health service system of the country:

#### 1.1.1 Economic changes:

Past rural agricultural based economy is gradually shifting to the industrial and service sectors. The price of agricultural products remain virtually unchanged in real terms for more that twelve years. As

a result, the rural farmers have become relatively poorer. They are becoming indebted because of heavy borrowing they have made to purchase modern agricultural tools as well as to cope with the life style of increased consumerism. Many young farmers have moved from the rural areas to the cities and industrial centers for hard cash jobs. These transient migrants are faced with the new patterns of health problems in their adopted workplaces. At the same time, the provisions and cost of health care have also significantly changed. Those without a permanent job usually do not have the means to access formal health services.

The economic gap between the high and low income groups are also creating a serious gap for the provisions for health care in the country. It is very obvious that while the minority high income people are enjoying high quality expensive private health care, the majority low income are left to be cared by the resource starved public health sector. As a result the public health sector is suffering from serious challenges from all sides, notably its financing for the services.

### 1.1.2 Demographic Changes:

Because of prevailing situations, infant mortality rate (IMR) has markedly decreased and life expectancy of the population increased. Crude birth and fertility rates have significantly been reduced and therefore, the population growth rate slowed down. Number of children under 15 years has actually dropped over past years. There has been an increase in the proportion of population over the age of 15 and elderly people in the society. Another important change has been the relative increase in the number of urban population over its rural counterparts. These demographic changes are demanding reorientation towards more adult and elderly type of care while gradually reducing obstetric and pediatric services.

### 1.1.3 Epidemiological Changes:

The health problems are undergoing transition from its past communicable diseases like diarrhea and respiratory infections to that of non-communicable diseases e.g. accidents, heart problems and cancer. Meanwhile, childhood morbidity is overtaken by the increasing number of adult and elderly problems. Disease patterns have also been changing as manifested by the AIDS epidemic and resurgence of tuberculosis. Mental health problems, drug addiction and alcoholism, although existed in the past are becoming an important health issues

nowadays. Whereby malnutrition is well under control in most parts of the country, the problem of over-weighing is becoming a serious concern for the urban people. As a result of these changes, there is a need for surgery, orthopedics, heart problems, geriatric problems and AIDS care facilities are needed in the hospital.

### 1.1.4 Social and Cultural Changes:

Increased level of education, combined with improved communications have facilitated contacts within and outside the country. This has contributed to the significant changes in the health care seeking behavior of the population as more people are becoming interested in the formal health care services against the former traditional, self-medication and quackery treatment. A growing number of population are becoming accustomed to the consumer friendly private health care facilities. This is inevitably going to put pressure on the public health sector to come up with the better health care facilities or they will be labeled as the low class among the health care industry.

## 1.2 Emerging Health Sector Problems:

Coupled with the above socio-economic changes several areas of concerns have emerged involving Thai health care industry. While they differ in the nature and magnitude, each of them pose a threat to the equitable health care in the country. Four of the key issues are discussed below:

### 1.2.1 Private Health Sector:

First, there has been rapid growth of private health sector in the country during the last two decades. In 1987, 5.7% of the GNP was used for the health care as compared to the 3.4% in 1978. The share of GNP is projected to grow up to 8.1% by the year 2000 if the present trend is allowed to continue. In 1987, a total of 68 billion Baht was spent on health care nationwide of which 24.2% was managed by the public sectors including 14.1% by the MOPH. Of the remaining 75.8%, 73.2% was spent by the private households. In 1984, the public health sector share was 27.9% (MOPH 17.4%). This trend continues to grow and the share public health sector financing is less and less when compared to the rapidly developing private health sector. The private household spending is usually made on two categories - first, buy drugs in the stores and the second, take medical services in the public and private hospitals. The national socio-

economic surveys show that private household spending on health care is rapidly shifting towards private sector e.g. in 1986, 50% spending was made in the public hospitals compared to 46% in 1988. The balance is spent in the private hospitals, clinics, drug stores and other health services.

### 1.2.2 Cost Escalation:

Second, there has been significant cost escalation in the health care industry especially in the private sector. The main causes of cost escalation are attributed to the overuse of highly expensive medical equipment, over-prescription of drugs and introduction of many expensive but consumer friendly services in the health facilities. This trend is more prevalent in the urban and peri-urban areas where most of the rich patients go to the private clinics and hospitals. This over-subscription of high technologies are also affecting public hospitals because they feel the pressure of having to be competitive with their private counterparts. As a result there has been marked increase in the cost for health care in the public sector hospitals. The public sector is expected to provide health care for the vast majority of rural and low income people despite its ever diminishing resources.

### 1.2.3 Shifting Health Manpower:

Third, there has been significant loss of health personnel to the private sector. During 1960s and 1970s, many of them went to work in the developed countries. In the 1980s, situation got a bit better. Then in the late eighties onwards, most of them remained in the country but opted to work in the private clinics and hospitals. This is true to almost all types of health personnel especially those of the specialist doctors and senior nurses. In a report Chunharas (1995) shows that during 1986 to 1990, out of 689 specialist doctors trained by the public health sector in the country, 354 or 51.38% dropped out of public services. The reasons for this 'brain drain' has been due to lower level of income, poor working conditions, remote duty stations and administrative bureaucracy. This trend is expected to continue until such time that the private sector become saturated and/or the public sector comes up with innovating new ideas to attract the health personnel to continue to work in the government sector.

### 1.2.4 Equity of Health Care:

Fourth and the most crucial one is the concern for equity of health care. While the country is steadily achieving higher economic

status, about 10 millions people (one-sixth of the population), most of them from the rural areas continue to live in very poor conditions. Although high level health care is growing very fast for the high income pepole, the low income groups are not able to reap the benefit of those development. It should be noted here that almost all low income people are the beneficiaries in the public hospitals, not the private and are, therefore, recipient of the relatively poor health care there. This is clearly evident from the available health statistics. Infant mortality in the northeastern region of the country is almost double than that of the Bangkok and its vicinity. 34.8% of the population live in the northeastern region but it has only 19.5% of available hospital beds or only 13.9% of doctors. This region produces only 10.6% of the national GDP. Even within the region or provinces, remote districts have much poorer facilities when compared with its urban counterparts.

### 1.3. Health Care Reform in Thailand

#### 1.3.1 PHC in the Rural Area - Declining?

To address this situation, the Thai government has been developing several health schemes. In 1960s and 1970s, Thailand pioneered in the primary health care (PHC) throughout the country highlighted by series of activities from the rural drug funds to community cooperatives and village health volunteers. This approach vastly expanded health care to the rural areas and the gap with their urban counterparts narrowed down. But this success story has come under serious threat because of the fast economic development and its associated factors. While the urban health care has very quickly moved ahead, the PHC projects in the rural areas remained static or declined in some instances. In fact, many of the rural health care services are experiencing difficulties for its survival due to shifting socio-economic conditions. In another words, quality of care provided by the PHC approach has relatively declined when compared with the rapid development of the urban and private health care system.

#### 1.3.2: Public-Private mix in the Health Sector

Thailand has long history of conventional public-private mix in the health care system. It has been actively promoting users' fee in all hospitals, provision for private beds in the provincial, regional and national level hospitals, community financing in the primary health care etc. In recent years it has introduced contracting out of public

services to the private sector and competing in an open market on private and state organized insurance schemes. While all of these are in the positive direction, they are not yet sufficient to remain competitive in the face of the growing private sector.

### 1.3.3 Health Care Insurance Schemes in Thailand

Over years, the government has launched various health security schemes (see Table 1.1) in the country. The first and most notable one is the CSMBS designed for the public and state enterprise employees. It provides comprehensive health care coverage for the civil servants, state enterprise employees and their family members, approximately 11% of the total population. The next important one is the Social Security Scheme (SSS). This scheme provide coverage for the industrial workers and currently includes about 7.3% of the population. The government has also made commitment for free health care of the poor, elderly, children under 12 of age and other vulnerable groups (LIC/EP/SHP). This group covers a population of 33.1% nationwide, although some of them may already benefit from the better care from CSMBS or SSS. In addition, the MOPH has launched a voluntary health card scheme (HCS) for the rural people at a low cost of 500 Baht per family of five for which the government pays a matching amount. The success of this project is unclear that currently covers about 8.4% of the population. It should be noted here that the LIC/EP/SHP and HCS receive care in the public hospitals only. Unlike the SSS and CSMBS they have no access to the better quality facilities in the private hospitals.

The equity and efficiency of these schemes are questioned in and outside the system. Because none of these schemes have the capacity to develop into a universal coverage of health care for all citizens. In summary, present financing is inadequate for the running of the public hospitals and their acceptance among population is rather very low. The growing number of private hospitals are not in effect provide care for the vast majority of the population who remain dependent on the public hospitals.

**Table 1.1: Schemativ Comparison of Health Care Schemes in Thailand: Coverage, Benefits, Amount and Mode of Finance**

| | CSMBS | SSS | WCS | LIC/EP | HCS | SHP | P.INS | UNCOVER |
|---|---|---|---|---|---|---|---|---|
| **Responsible Agency** | Ministry of Finance | Social Sec Organization | Social Sec Organization | MOPH | MOPH | Education Ministry | Commerce Ministry | ?????? MOPH |
| **% of Pop covered** | 11.0 | 7.3 | 3.2 | 24.0 | 8.4 | 9.1 | 1.8 | 35.2 |
| **Choice of Providers** | Free | Contract | Free | Referral - Public | Referral - Public | Referral - Public | Free | Free |
| **OPD care** | Public only | Public and Private | Public and Private | Public only | Public only | Public only | Public and Private | Public and Private |
| **IPD care** | Public and Private | -ditto- | -ditto- | -ditto- | -ditto- | -ditto- | -ditto- | -ditto- |
| **Preventive & Promotive** | Yes | Limited | No | Limited | Possible | Yes | Vary, not so keen | Vary |
| **Maternity care** | Yes | yes | No | Yes | Yes | No | Vary | Vary |
| **Annual Check-up** | Yes | No | No | No | Possible | Possible | Vary | No |
| **Source of Finance** | Tax | Tax + Employers | Employers | Tax | Tax + Premium | Tax | Premium | Out-of-pocket |
| **Baht/Pers/Yr** | 916 | 805 | 418 | 317 | 141 | 27 | 933 | ???? |

***Source: Situation Analysis of Health Insurance and Future Development, Anuwat S. 1995 (modified).***
CSMBS = Civil Servant Medical Benefits Scheme; SSS = Social Secrity Scheme; WCS = Workmen's Compensation Scheme; LIC/EP = Low Income Card/Elderly Programme; HCS = Health Card Scheme; SHP = School Health Program; P. INS = Private Insurance; Uncovered = Not covered by any pre-paid health care scheme.

## 1.4 A Case Study of Ban Paew Community Hospital

Ban Paew is a district with 93,057 population in the central region province of Samut Sakhon. Population growth rate for the province has been reported to be 1.28% and GNP per capita as 113,726 Baht (National average of 54,082 Baht) in 1992. It has wide agricultural base e.g. orchards, fruit gardens, paddy field and other cash crops. In recent years a number of industries have grown in the district bringing in large number of migrant labors. The province is well connected by roads to Bangkok and neighboring provinces. Because of the busy traffic on these roads, traffic accident has become a serious health problem in the province including Ban Paew district. Other health problems are similar to rest of the central region of Thailand.

Until 1887, Ban Paew like many other district level hospitals in Thailand used to be a sleepy district hospital with low quality health care facility, few health staff and importantly, few resources. As a result, few patients used to visit hospital but instead they would go to the drug stores or private healers. The hospital was expected to raise local revenues to supplement the budgetary shortfall but without much success. With the arrival of new hospital director in 1987, there has been increasing focus on the management restructuring and modified functions to adapt to the changing situation. The main aim of the management restructuring is to become competitive with the growing private health sector but maintaining the basic strengths of the public hospital i.e. equity, comprehensive care and low cost services. Several adjustments have been made in the hospital management with strong emphasis on the community participation and community financing as well as incorporation of the private sector concept in parts of its services. It must be emphasized here that Ban Paew has strong community organizations who are actively involved in their health care matters and contribute in every possible way for its improvement.

Geographically the district is off route from the provincial hospital but is closer to the near by Nakhon Phathom province. As a result patients from the district are usually referred to Nakhon Phathom hospital which is also the regional hospital for all nearby provinces. In many ways, Ban Paew community hospital is a special case when compared with other district hospital in Thailand. Because of these considerations, the hospital receives broader administrative and political interest for its work.

## 1.5 Research Questions

Research questions of the study are divided into two groups - primary and secondary as enumerated below:

### 1.5.1 Primary Questions

a. What are the characteristics of the public/private mix management system in Ban Paew community hospital?

b. What are the specific effects on the hospital utilization and the economic conditions of the hospital due to the public/private mix management?

### 1.5.2 Secondary Questions

a. What are the responses from the patients, community leaders, hospital staff and the Ministry of Public Health concerning the effects of the management?

b. What lessons can be learned about Ban Paew community hospital management that may be useful elsewhere in the country or abroad?

## 1.6 Research Objectives

The objectives of the research is divided into two broad groups - general and specific - as described below:

### 1.6.1 General Objectives

To study the nature of the public/private mix management system and its effects on the hospital utilization and economic conditions in the Ban Paew community hospital.

### 1.6.2 Specific Objectives

a. To study the characteristics of the public/private mix management system of Ban Paew community hospital.

b. To study the pattern of hospital utilization following implementation of the P/P mix management.

c. To provide an economic evaluation especially cost-recovery of the hospital following the changes in the management system.

d. To study the responses from the patients, hospital staff, community leaders and the Ministry of Public Health concerning the changed management in the hospital.

e. To extract potential applications of the public/private mix management in Ban Paew community hospital that may be used in other community hospitals in the country or elsewhere.

## 1.7 Scopes of the Study

The study analyzes Ban Paew community hospital data for a definite period i.e. 1987 to 1995 during which time a rapid succession of P/P mix activities have been implemented. Year to year hospital data are compared to show the improvement of hospital utilization and cost-recovery. The trend of these outcomes are used in the interpretation of the apparent success or failure of the hospital. Because of unavailability of data, it has not been possible to analyze and compare situation prior to implementation of the P/P mix activities in question.

The study has focused on the macro-situations of the hospital in relation to the P/P mix activities. It has not been intended to provide full micro-analysis of one or other specific activity. Because some studies have already been undertaken elsewhere to measure the impact of some of these individual activities. It is anticipated that the study will provide the combined effects of these activities on the hospital performance. This is especially important in relation to the hospital staff motivation and work performance which otherwise will be difficult to quantify in any case.

Because of the limited time available for the study, it has not been possible to provide analysis of some of the exogenous factors that might have influenced the functioning of the hospital vis-à-vis results of the study. Such factors include the changes in the socio-economic conditions, transport and communication, information and education, employment and health care schemes etc. While acknowledging the importance of the role of these of the variables, it may be very difficult to find their impact within the context of the present study.

## 1.8 Benefits of the Study

The study is expected to assist the hospital management to document the steps undertaken so far and the resultant effects on the functioning of hospital. This may lead to some modification or readjustment in the management of activities.

Assist the MOPH to examine the nature and impact of the public-private mix management in a community hospital. The MOPH may use this for the policy formulation and the possible development of similar models that can be applied to other community hospitals in the country.

This may be the first study of its kind that provide a framework of a public/private mix system in the country. Based on this initial study, additional research may be generated to fine tune the concept, application, monitoring and evaluation of the public-private mix management.

Finally, although the study is limited to a Thai community hospital, its principles and mode of implementation may be applicable to hospitals of similar socio-economic situations in other countries in the region. Similarly, it may also facilitate growth of future research of the kind or comparative studies that can be made with the existing ones, if available in those countries.

## 1.9 Limitations of the Study

There are certain limitations of the study. The first is the interdependence of the P/P mix activities initiated over a period of nine years and many of them producing the similar outcomes. It is not, therefore, possible to adequately quantify the outcome against any single activity. Nonetheless, the objective of the study the is not to measure effects of a single activity as such but to measure the overall effects of the combined P/P mix activities. It might be possible to measure the impact of some of the activities individually in the expanded studies e.g. economic benefits of contracting out of services to the private sector and so on.

Second, there are some problems concerning quality of economic data of the hospital. The hospital uses community financing for certain activities especially those for the capital investments. Many

of those come in the form of in-kind donations to the hospital for which no proper valuation is made. It will take quite some time to document hundreds of these items and may not be suitable within time constraints of the present study. As a result, emphasis has been given on the operational accounting cost for the analysis of economic conditions of the hospital.

Finally, there are some difficulties in finding out a suitable comparison for the Ban Paew community hospital. The location, community structure and socio-economic conditions of Ban Paew may not be similar to other community hospitals in the country. In consideration of these factors, another district community hospital (Krathum Baen) in the same province is chosen for the comparison of hospital utilization. However, it has not been possible to analyze comparable economic data of Krathum Baen for the study.