THAILAND
The development of primary health care
Acknowledgements

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Background

Thailand has had remarkable successes in its universal health coverage (UHC) policy and health development (1). Thailand has also eliminated maternal-to-child transmission of HIV, and is the first country with a generalized HIV epidemic to reach this milestone (2).

Since the Declaration of Alma-Ata in 1978, the design of primary health care (PHC) in Thailand has evolved significantly in response to the population’s evolving health needs. The capacity of successive governments to respond to health transitions and engage the community has shaped the design of Thailand’s PHC. This commentary reviews the historical evolution of PHC in Thailand, its contribution to securing the favourable outcomes of UHC, and the ongoing adjustments required to make it fit for the future.
Intervention

Selective child survival interventions were the cornerstone of PHC in the 1980s, when malnutrition, diarrhoea and vaccine-preventable diseases were major killers of children, and effective and affordable interventions were available but had low coverage. PHC in Thailand was heavily influenced by an initiative of the United Nations Children’s Fund (UNICEF) known as GOBI (growth monitoring, oral rehydration, breastfeeding and immunization) and, later, GOBI FFF (including female education, family spacing and food supplements for malnutrition). Eventually, PHC in Thailand evolved into a comprehensive system (3) at the district and subdistrict levels, and became the foundation for implementing UHC in the 2000s.

In parallel to the global PHC advocacy of the 1978 Declaration of Alma-Ata, successive governments have invested continuously in health infrastructure at the district and subdistrict levels since 1977, which was the start of the fourth 5-year National Economic and Social Development Plan (4). Since its inception in 1961, the 5-year planning system has guided Thailand’s comprehensive health, education, social welfare and economic development (5).

The development goal of Thailand’s PHC was to achieve full geographical coverage of health infrastructure at the district and subdistrict levels for catchment populations of 50 and 5000, respectively. Coverage of district hospitals in every district was achieved by 1990 (6), and this was followed by a decade of health centre development (1992–2001). By the 2000s, all subdistricts had at least one health centre. The district health system, comprising health centres and a district hospital, is the foundation of the close-to-client service (7), and this system provided a hub for implementing UHC in the 2000s.

Since 1975, financial access to care has been supported by government policies that provide free health care services for the poor through means testing. In addition, since 1991, private sector employees have been covered by Social Health Insurance, which is funded by a payroll tax. Historically, government employees were covered by the tax-financed Civil Servant Medical Benefit Scheme, and the informal sector by a voluntary public-subsidized insurance scheme operating since 1984 (8). Fig. 1 shows the evolution of PHC development within the context of the overall development of health systems and the expansion of financial risk protection. Table 1 shows key service coverage indicators, which are the outcomes of these reforms, between 1987 and 2016.
Fig. 1. Evolution of primary health care in Thailand

CBHI: community-based health insurance; CSMBS: Civil Servant Medical Benefit Scheme; SHI: Social Health Insurance; UCS: Universal Coverage Scheme.
Table 1. Service coverage indicators, selected years between 1987 and 2016

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<tr>
<td>Pregnant women receiving prenatal care (%)</td>
<td>80</td>
<td>85.9</td>
<td>91.8</td>
<td>94.3</td>
<td>97.8</td>
<td>99.1</td>
<td>98.1</td>
<td>98.1</td>
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<td>Births attended by skilled health staff (% of total)</td>
<td>65.9</td>
<td>–</td>
<td>99.3</td>
<td>–</td>
<td>96.9</td>
<td>99.4</td>
<td>99.6</td>
<td>99.1</td>
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<td>Third dose of diphtheria, pertussis and tetanus vaccinations (% of children aged 12–23 months)</td>
<td>75</td>
<td>94</td>
<td>97</td>
<td>98</td>
<td>98</td>
<td>99</td>
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<tr>
<td>Contraceptive prevalence, any method (% of women aged 15–49 years)</td>
<td>65.5</td>
<td>75.2</td>
<td>79.2</td>
<td>–</td>
<td>71.5</td>
<td>79.6</td>
<td>79.3</td>
<td>78.4</td>
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Source: World Bank’s World Development Indicators.

The district health system, as a qualified and trusted provider close to where people live, ensures the following: high use of contraception and coverage of maternal and child health services; surveillance and responses to avian influenza; detection and treatment of tuberculosis; prevention of maternal-to-child transmission of HIV; provision of, and good adherence to, antiretroviral treatment; management of diabetes and hypertension; home peritoneal dialysis and stroke rehabilitation; and home health care for those confined to their houses.

Health workforce: key to the functioning of PHC

An adequate number of qualified health workers is a prerequisite for a well-functioning PHC. Nurses are the “backbone” of the Thai health system; degree-educated nurses and midwives – together with other cadres such as physicians, dentists, pharmacists and public health officers – provide a wide range of services. These services include public health, disease surveillance, health promotion, and patient care and basic treatment in health centres and district hospitals. District hospitals also provide more comprehensive secondary-level curative services, whereas the provincial hospitals, located in all provinces, provide tertiary care and receive referral cases from district hospitals.

Thailand is self-sufficient in undergraduate and postgraduate training and education of all professional health cadres, and fully applies the rural retention policies recommended by the World Health Organization (WHO) (9). Recruitment of students from rural areas for professional training, hometown placement and 3-year mandatory service for all medical, nursing, dental and pharmacy graduates has encouraged professionals to stay longer in rural areas (10). Additional measures that are in place include financial incentives, social recognition and well-equipped workplaces.
Impact

The extensive geographical coverage of a well-functioning PHC – in particular, a network of health centres and district hospitals in all 878 districts countrywide – has provided contractor networks. Since 2002, this PHC has ensured service provision to all 47 million members of the Universal Coverage Scheme (UCS). Favourable outcomes of the UCS include improved level and equitable use, with low unmet health care needs on a par with the average for the Organisation for Economic Co-operation and Development (OECD) (11); pro-poor public services use and financial subsidies (12); reduced out-of-pocket payments (13); and low prevalence of catastrophic health expenditure and impoverishment (14). The district health system is the major hub (15) in translating the two goals of UHC – that is, improved and equitable access (16) and financial risk protection (17, 18) – into reality. The capacity to design and implement strategic purchasing (19, 20) contributes to efficiency in achieving the UHC goals of access and financial protection. Capacity development in health systems and policy research (21, 22), ability to monitor UHC progress (23), and improved information systems that facilitate equity monitoring (24) have contributed to evidence-informed UHC design and policy adjustments.

The UCS has survived eight rival governments, six elections, two coup d’états and 13 health ministers over the period 2001–2015. It continues to provide tangible results for the population. The pro-poor outcomes and contribution to health improvement have ensured that all governments, regardless of political parties, have continued to adequately finance the UCS (17, 25).
Way forward

Rapid demographic and epidemiological transitions will significantly shape the future functions of PHC, the skill and cadre mix of the health workforce, and other social welfare services and support. Developing countries are transitioning faster from an ageing to an aged society. China, Sri Lanka, Thailand and the Republic of Korea took 26, 24, 22 and 18 years, respectively, to reach an aged society; in contrast, France, Sweden and the United States of America took 115, 85 and 69 years, respectively, to reach an aged society. In the Asia-Pacific Region, the number of elderly over the age of 60 years is expected to increase from 12% in 2016 to 25% by 2050, and to more than 30% in the cases of China, Japan and Thailand (26).

Demographic and epidemiological transitions are reflected in the disability-adjusted life years lost between 1990 and 2010, as the share due to chronic conditions increases and that due to infectious diseases decreases (27). The elderly often have multiple morbidities and disabilities, and are limited in their ability to carry out normal activities of daily living (28,29). The widening gap between life expectancy and healthy life expectancy at 60 years means more years spent living with certain degrees of impairment, especially for women. This has major implications for health care, long-term care, financing of health systems, social protection and preparation for aged-friendly environments.

The increased aged dependency ratio (the ratio of people 65 years or older to those aged 20–64 years) places a fiscal constraint on the ability to support the ageing Thai population. Pension coverage is adequate but the payment rate is low, meaning that the elderly engage in income generation activities in the informal sector. Labour policy needs to increase incentives for decent work, as recommended by the OECD (30). The growth in nuclear families affects the traditional family support system for the elderly; thus, the demand for long-term care increases, in particular, among the elderly and frail who live without family support.

There are efforts to keep all pre-elderly and elderly healthy and living independently, through social mobilization and community engagement. Thailand is pursuing adjustment of PHC to cope, for example, with stroke management, home peritoneal dialysis and urinary catheter care. Examples of such adjustment are greater collaboration among PHC, the social welfare sector and local government, a greater reliance on the support of village health volunteers and communities. Other PHC adjustments needed in Thailand are the introduction of end-of-life care (31), improved access to pain management for end-stage cancer patients, social support for people facing death, and measures for ensuring a peaceful and dignified death.
References


COUNTRY CASE STUDIES ON PRIMARY HEALTH CARE