CHAPTER II

DAYNAMIC OF THANDLAND AND HUP POLICY

Medical tourism is a large and growing sector within Thailand's extensive tourism and healthcare industries. The country is attractive to potential medical tourists and international patients for a number of important reasons: Thailand was the first country in Asian to achieve Joint Commission International (JCI) accreditation in 2002.

A. The Overview of the Political system in Thailand

Thailand has a different history with other states in Southeast Asia because Thailand never been colonized by other country. Because the location from geography is central in Southeast Asia, they become a protectorate state to colonize each country in Southeast Asia.

Thailand is a Buddhist society, and has many cultures including language, dress, and many more. Therefore, Thailand's society is varied. Thailand, population is around 67,010,502 million people. The population growth rate was estimated in 2010-2015 at 0.5 percent. Around 32 percent in urban areas and 68 percent of the population lived in rural areas (including people that live near river). Official government estimates show that people of Thai ethnicity make up 75 percent of the population. Another 14 percent are ethnic Chinese, and 4 percent are Malay. Regarding the religion, the predominant religion is Theravada Buddhism, representing about 94 percent of the practicing population and about 90 percent of all Thai people. Muslims represent 4.6 percent, Christians 0.7 percent, Hindus 0.1

percent, and Sikhs, Baha'i Faith, and others, 0.6 percent. Section 73 of the constitution of states will protect all religion.[15]

The government system uses constitutional monarchy. The head of state is the King and the head of government and control politic in country is the Prime Minister. Regarding executive branch, the constitutional monarch and head of state is King Bhumibol Adulyadej the Privy Consul, which is still provided by constitution. It is a member of constitutional body that advises the king on matters of legislation, government affairs, clemency, awards, and other matters requiring the king's signature. The Privy Consul, whose members are appointed by and served at the pleasure of the king, also recommends the name of a suitable person to hold the position of regent when the king is absent from Thailand or unable to perform his duties. Under the interim constitution, executive governmental power is exercised through a cabinet headed by a prime minister appointed by the king (with the concurrence of the Consul for National Security (CNS) chairperson) and the members of the Consul of Ministers who head major ministries.

a. Economy

Thailand has a mixed economic system in which there is a variety of private freedom, combined with centralized economic planning and government regulation. Thailand's currency is the baht. One U.S. dollar is equivalent to 32.456 Thai baht. Imports include raw material, fuel, and electrical appliances, and vehicle

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15 Akira Suehiro and Natenapha Wailerdsak, *Family Business in Thailand its management, governance and future challenges,* ASEAN Economic Bulletia Vol, 21, No. 1 (2004). pp.81-93,Family business in the Thai economic

parts. Meanwhile the exports include mechanical appliances, electrical apparatus, Refined Petroleum.

b. Geography

Regarding the climate, as a tropical country, Thailand has three seasons. The first is hot and dry season starting from February to May, with temperature around 34E C and 75 percent relative humidity. Second season is followed by a rainy, cooler season bring by the southwest monsoon from June to September, temperature around 29E C and 87 percent relative humidity. A cooler, dry season, caused by the northeast monsoon, lasts from November to January, with temperatures ranging from 32E C to less than 20E C and lower relative humidity. The Isthmus of Kra is always hot and humid and has the heaviest rainfall. The lightest rainfall is in the northeast. Temperatures in Bangkok range from 20E C and 35E C

In regarding with natural resources, Thailand's most natural resources are fluorite, gypsum, lead, lignite, natural gas, rubber, tantalum, tin, and tungsten. Renewable resources include fish and timber.[16]

16 Ibid

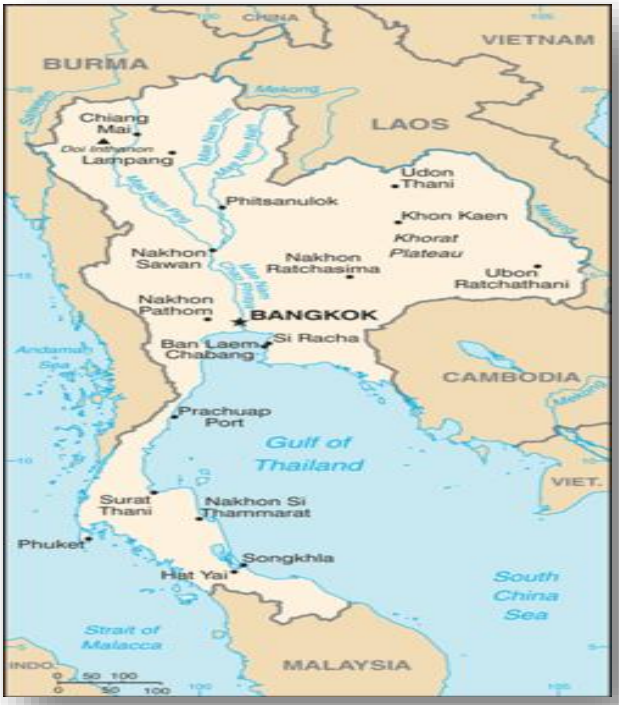

Figure 2.1. Map of Thailand

B. Thailand Health Profile

Health policy and strategy in Thailand are based on a "health for all, and all for health" approach. Rights and obligations of individuals, the community, and the local1 this section is mostly from Supakankunti & Huerberholz (2011), but updated as indicated150 and central government in promoting and protecting health are spelled out in the National Health Act of B.E. 2550. Five-year National Health Development Plans are designed and linked to health plans for action, national development plans as well as Thailand' s Millennium Declaration. The objectives of the Tenth National Health Development Plan 2007-2011 are

(1) To promote good health as a lifestyle for all age groups, emphasizing health sufficiency at the family and community levels,

(2) To create a good healthcare system, based on the human being principle, with quality and friendly care, paying attention to the suffering of patients and the delicacy of human being,

(3) To build a good society with wellness and health security for the people to feel warm and secure in normal, illness and critical situations

(4) To create a sufficient and sustainable livelihood that is peaceful with a culture that facilitates healthy lifestyle and leads to the attainment of the highest level of human potential.[17]

The overall health status of Thai people has improved over the past decades. Maternal mortality as well as infant and under 5 mortality rates have decreased, while life expectancy has increased, with female life expectancy outpacing male life expectancy. The fertility rate was 1.6 in 2009 which is below the replacement level. This together with increased life expectancy has triggered significant demographic changes and results in Thailand facing problems of an ageing society. Thailand experienced a transition from communicable diseases to non-communicable diseases and the major causes of death as well as disease burden are

[17] Janjaroen, W.S., Pinitpuvadol, S., Pongpanich, S., Samrongthong, R., Sitthi-amorn, C.,Supakankunti, S., *et al*. (1999). *Preliminary Study on Trade Liberalization in Health Services Sector: Its consequences on Social and Health Care System in Thailand.* Research Report submitted to the Thai Research Fund, Bangkok, Thailand.

non-communicable diseases, accidents and HIV/AIDS. In 2008, total expenditures on health (in % of GDP) were 4.05 percent.

This percentage has remained rather stable since 2002, but increased in 2007 and 2008. While the Ministry of Public Health (MoPH) is the principal agency responsible for promoting, supporting, controlling and coordinating all health service activities, other agencies such as the Ministry of Education, the Ministry of Interior, the Ministry of Defense, the Bangkok Metropolitan Administration, state enterprises and private sector enterprises also play an important role since they operate health facilities. Hospitals are major health service providers and in 2008 the number of hospitals reached 1,239, of which 78.05 percent were government hospitals and 21.95 percent private hospitals. [18]

Seventy eight percent of private clinics and 70 percent of private hospitals, most of which are medium-sized with 51 to 100 beds, are located in provincial areas, while 21 out of 31 large private hospitals, with more than 200 beds, were located in Bangkok. However, most hospitals beds in Bangkok are in private hospitals while most hospitals beds in the provinces are under the MoPH, with MoPHM hospitals having the highest bed-occupancy rate and hospitals under the Ministry of Defense and private hospitals the lowest. As reported in Sakunphanit, private clinics in urban areas are mostly run by physicians from the public after work.

[18] MoPH. (2008). *Thailand Health Profile 2005-2007.* (W. S., Ed.) Bangkok: Ministry of Public Health, Bureau of Policy and Strategy.

The number of private hospitals increased rapidly between 1994 and 1997, concomitantly with financial liberalization as well as due to tax incentives, some of which experienced financial difficulties in the wake of the 1997 crisis and had to be closed. Most private hospitals are for-profit and 13 private hospitals were listed on the Stock Exchange of Thailand as of June 2011. The distribution of health personnel, however, still is a major problem in Thailand due to significant differences between Bangkok and other provinces and internal brain drain has remained a debated issue. Most doctors in Bangkok are under ministries other than the MoPH (42.5 percent), followed by the private sector (33.8 percent) and the MoPH (12.4 percent). In the provinces, most doctors are under the MoPH (64 percent in the North, 66 percent in the Central region, 71 percent in the South and 82 percent in the Northeast, Thailand's poorest region).

Thailand has continuously expanded health insurance under various schemes such as civil servants medical benefit worker compensation (for work-related illnesses and injuries), social security (SSS), medical services for the poor and society supported groups, voluntary health insurance project, private health insurance, vehicle accident victim protection and eventually the universal coverage scheme (UCS). As of 2007, the CSMBS covered 5.1 million beneficiaries (MoPH, 2009), mostly civil servants, and is entirely paid from the general tax revenue. Payments are made based on fee-for-service and retrospective reimbursement for outpatient services and diagnosis related groups (DRG) for inpatient services. Public facilities are the main providers, but patients have a choice of public and private (subject to co-payments) 152 providers.

The SSS is a contributory scheme that covered 9.6 million employees as of 2007 based on tripartite contributions made by employees, employers and the government. Payments for inpatient and outpatient services are made based on capitation. In 2009, the Social Security Office contracted with public and private hospitals and of the main contracted hospitals, 152 were public hospitals, 98 were private hospitals and 2,313 were network hospitals. The UCS was launched in 2001 and its population coverage has risen to 46.7 million people or 75 percent in 2007.

The UCS is also entirely financed through the general tax. Providers register with the governing agency, the National Health Security Office (NHSO) and as of 2010, registered providers included 831 hospitals of the MoPH (including more than 10,000 health centres), 75 other public hospitals, 49 private hospitals, 19 public primary care units and 169 private clinics. Provider payments are made based on capitation for outpatient services and DRG with global budget for inpatient services. The low participation by private facilities may partially reflect that capitation levels are inadequate to cover unit cost.

Rapid implementation of UCS has raised serious questions of financial sustainability, especially in light of limited human health resources and funding, that need to be addressed urgently to ensure equitable access to quality health care. Since the introduction of the UCS, many public hospitals have faced very high occupancy rates and workloads, inter alia due to failures at the primary care level and resulting over-referrals while around half of private hospital beds have remained vacant. In addition, the quality of medical services has remained a matter of concern. With the introduction of UCS, some smaller and medium-sized private

hospitals repositioned themselves towards social insurance, while large private hospitals continued to focus an affluent Thai and foreign patients.[19]

The number of foreign patients that entered Thailand in 2007 was 1,373,807, of which 17% from Japan, 12% from the Middle East, 62% from South Asia. (Department of Export Promotion, Ministry of Commerce, in MoPH)

C. Thailand medical hub policy

The vision that "*Thailand will be a world class "Medical Hub.*"" is explicitly stated in MoPH (ministry of public health) and includes the wellness sector and Thai herbal products, which entails collaboration with a number of agencies such as the Tourism Authority of Thailand, the Ministry of Education, the Ministry of Foreign Affairs, the Ministry of Commerce and the Ministry of Labor. The medical hub strategy in general is aimed at developing Thailand into a first-class destination for medical tourists. To provide world-class services, standards for hospital accreditation in Thailand were set and international standards such as ISO and Joint Commission International (JCI) introduced.[20]

In addition, a controversial medical malpractice law is being discussed to strengthen the rights of patients. The literature identifies several pull and push

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[19] MoPH. (2008). *Thailand Health Profile 2005-2007.* (W. S., Ed.) Bangkok: Ministry of Public Health, Bureau of Policy and Strategy

[20] Drager, N., & Fidler, D.P. (n.d.). *GATS and Health-related Services: Managing Liberalization of Trade in Services From a Health Policy Perspective.* Retrieved from WHO Trade and Health Notes:
http: //www.searo.who. int/LinkFile s/Global_Trade_and_Health_GTH_No6.pdf

factors that are conducive to international trade in health-related services. Most commonly cited push factors include, high cost of obtaining services in the home country, limited insurance coverage and long waiting queues. Pull factors discussed in the Thai context are low cost of obtaining services of similar/acceptable quality, price certainty through fixed package prices offered by medical facilities, well developed tourism-industry and other supporting industries (e.g. low cost of traveling, accommodation and food for a companion as well as other tourism activities, attractions and entertainment), excellent hospitality and low entry barriers. Thailand originally focused on tourism related areas such as spas, traditional massages, herbal treatments and other kinds of alternative medicine. In recent years, however, private hospitals have discovered niche markets in elective medical procedures such as plastic surgery.[21]

[21] Imison, M. and S. Schweinsberg, Australian news media framing of medical tourism in low- and middle-income countries: a content review. BMC Public Health, 2013. **13**(109): p. 109.