6. Problems of the Thai Health Systems

Major problems of Thailand's health systems are divided into 5 groups as follows:

6.1 Inequities of Medical and Health Services

6.1.1 Inequities in Resources Allocation

Although the overall proportions of health resource per capita tend to be higher and achieve the target of health accessibility indicator in the 8th Plan, there is disparity between regions in terms of human resource, number of beds and health facilities, particularly between BMA and the Northeast. This clearly reflects the inequities in resources allocation as shown in Table 6.42. In Bangkok, the bed / population ratio is 1: 202 and the doctor / population ratio is 1 : 793, compared with the Northeast, of which the bed / population ratio is 1 : 766 and the doctor / population ratio is 1 : 8,311. The differences between regions particularly the health professional / population ratio, such as doctors, dentists and pharmacists, reveal that between BMA and the Northeast the ratio is 8 to 11-fold disparate. Nevertheless, the inequities in all regions in the past tended to improve. After the economic boom period, in 1989, there was a rapid expansion of private health facilities in Bangkok Metropolitan Areas and other large cities, immigrating resources from the rural / regional areas. Since then, urban-rural disparities have been stabilized and increased. After the 1997 economic crisis, a number of private hospitals have cut down on their number of beds, and discontinued recruitment of doctors and other types of personnel. Thus, the bed / manpower proportion in the public sector has risen. It is expected that the urban-rural disparities will improve, awaiting results of the 1998 and 2000 health resources surveys. (see the health resources in chapter 6)

Table 6.42 Distribution of Health Resources (Resource to Population Ratio) by Region, 2000

Type / Region	Bangkok	Central (outside BKK)	The North	The South	The Northeast	Nationwide
Beds	1: 202	1: 369	1: 493	1: 494	1: 766	1: 454
Health centers [1]	1: 39,660[2]	1: 3,631	1: 4,132	1: 3,896	1: 4,930	1: 4,247
Doctors	1: 793	1: 3,576	1: 4,501	1: 5,194	1: 8,311	1: 3,427
Dentists	1: 3,529	1: 16,813	1: 17,037	1: 22,549	1: 35,476	1: 14,917
Pharmacists	1: 2,551	1: 11,058	1: 11,012	1: 10,575	1: 21,740	1: 9,676
Nurses (all categories)	1: 271	1: 539	1: 632	1: 571	1: 1,109	1: 615
Nurses: professional	1: 309	1: 825	1: 908	1: 884	1: 1,702	1: 870
Nurses: technical	1: 2,208	1: 1,555	1: 2,078	1: 1,612	1: 3,183	1: 2,096
Health center staff	-	1: 1,059	1: 1,292	1: 1,141	1: 1,666	1: 1,324
Pharmacies: modern[1]	1: 1,872	1: 8,365	1: 19,136	1: 11,309	1: 39,356	1: 9,546
Pharmacies: traditional[1]	1:13,944	1: 26,528	1: 37,735	1: 28,352	1: 43,244	1: 31,203
Pharmacies: modern, readily-packed[1]	1: 9,199	1: 9,975	1: 11,783	1: 10,160	1: 19,376	1: 12,896

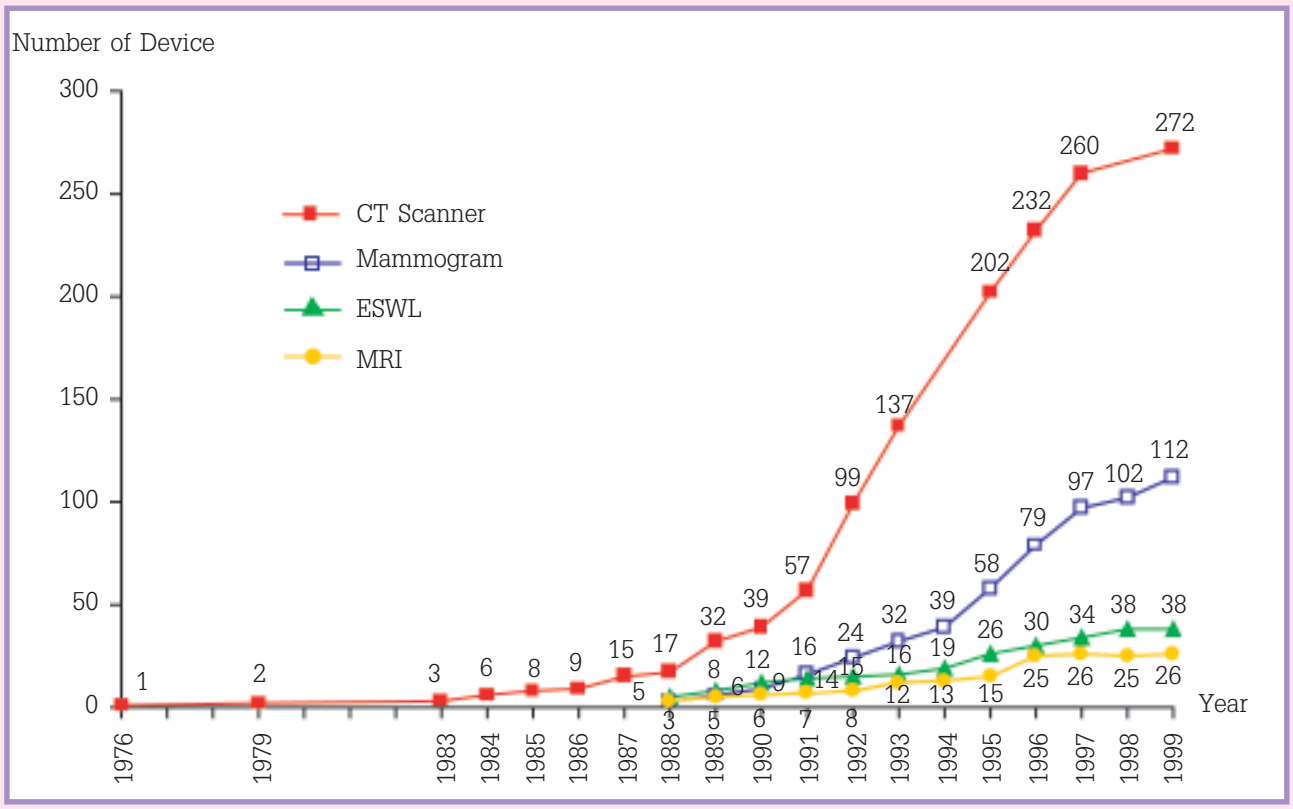
Sources: 1. Report on Health Resources, Bureau of Health Policy and Plan, MOPH.
2. Food and Drug Administration, MOPH.
3. Rural Health Division, MOPH.

Note: [1] Data in 2001
[2] BMA health centers (and branches).

In addition, the inequities in health care are also found in terms of the diffusion of medical and health technologies, for instance, CT scanner, MRI, ESWL and Mammogram. Although medical technologies tend to rapidly increase (Figure 6.39), leading to a higher proportion of Thailand's medical technologies to people, the inequity diffusion problem in the regional areas remains unresolved. (Table 6.43).

Regarding to discrepancy index comparison, the index of 4 types of medical appliances equipped in BMA ranging from 3.6 to 7.9. While the index of medical appliances used in the regional areas stands at 0.4-0.7, compared to that of the national overall figures. (Table 6.43). For CT Scanner, the disparity gap between regions tends to improve. (Table 6.44).

Figure 6.39 Numbers of Thailand Costly Medical Technology in 1976-1999



Source : Wongdeuan Jindawattana et al., High-cost Medical Devices in Thailand: Utilization Distribution and Accessibility , 1999.

Table 6.43 Ratio of Costly Medical Technology and Discrepancy Index by Region, 1999

Region	No. of medical appliances (per million population)				Discrepancy index			
	ESWL	CT	MRI	Mammo	ESWL	CT	MRI	Mammo
Bangkok Metropolis	3.4	15.9	3.2	10.9	5.5	3.6	7.9	5.9
Regional areas	0.3	3.3	0.1	0.9	0.6	0.7	0.4	0.5
The Central	0.2	5.2	0.1	1.5	0.3	1.2	0.3	0.8
The North	0.4	3.4	0.2	0.6	0.7	0.8	0.4	0.3
The Northeast	0.4	2.2	0.1	0.7	0.7	0.5	0.2	0.4
The South	0.3	2.8	0.3	1.1	0.4	0.6	0.6	0.6
Nationwide	0.6	4.5	0.4	1.8	1.0	1.0	1.0	1.0

Source: Wongdeuan Jindawattana et al., High Cost Medical Devices in Thailand : Utilization and Distribution and Accessibility, 1999.

Table 6.44 Ratio of CT Scanners and Discrepancy Index by Region, 1994 and 1998-1999

Region	No. of CT scan			Population (millions)			Ratio of CT scanners (per 1 million population)			Discrepancy Index		
	1994	1998	1999	1994	1998	1999	1994	1998	1999	1994	1998	1999
Bangkok Metropolis	88	83	89	5.6	5.6	5.6	15.7	14.8	15.9	12.1	8.6	7.2
Regional areas	117	156	183	53.1	55.5	55.5	2.2	2.8	3.3	1.7	1.6	1.5
The Central	45	66	74	13.4	14.2	14.2	3.3	4.6	5.2	2.7	2.7	2.4
The North	31	37	41	11.9	12.1	12.1	2.6	3.1	3.4	2.0	1.8	1.5
The Northeast	26	36	46	20.3	21.2	21.2	1.3	1.8	2.2	1.0	1.0	1.0
The South	15	17	22	7.5	8.0	8.0	2.0	2.1	2.8	1.5	1.2	1.3
Nationwide	205	239	272	58.7	61.1	61.1	3.5	3.9	4.5	2.7	2.3	2.0

Sources: Data for 1994 from Viroj Tangcharoensathien et al., Diffusion of Medical Equipment in Thailand, 1995.
Data for 1998 from the Radiation Protection Division, Department of Medical Sciences.
Data for 1999 from Wongdeuan Jindawattana et al., High-Cost Medical Devices in Thailand: Utilization Distribution and Accessibility, 1999.

Inequity in health is also found in terms of the diffusion of health care budget. Regarding to allocation and diffusion of health care budget per capita, (Table 6.45) the overall budget allocation mostly tends to distribute to the wealthy regions. Specifically, the Northeast is annually allotted with health budget per capita lower than other regions, while the Central region and ministerial level agencies catch the highest. Such allocation has reflected inequities of health care service in those regions, which include the problem of centralization of the public sector management system.

Table 6.45 Allocation of Health Budget per Capita by Region (Constant Price in 1999)

Unit : baht

Region	1992	1993	1994	1995	1996	1997	1998	1999
The Central	338	389	489	517	603	654	411	768
The East	277	349	444	519	641	639	549	396
The West	332	363	429	480	580	638	673	454
The North	315	440	497	567	584	574	462	367
The Northeast	252	338	396	441	474	386	321	328
The South	390	416	519	596	579	575	412	409
The central agencies & Ministry	2,474	3,207	3,490	3,773	3,871	3,608	4,878	3,831
Nationwide	661	845	969	1,068	1,210	1,065	1,297	1,008

Source: Bureau of Budget.

6.1.2 Inequity in Accessibility to Health Care

The people in the urban and rural areas have unequal opportunities in accessing health services. The urban people have greater chances in gaining health services from health facilities due to more availability of physicians. After the economic crisis, urban people are greater likely to seek self-prescribed drugs. (Table 6.46)

In 1998, Supasit Pannarunothai conducted a study on the equity to access health services by using the diffusion index and the concept of service provision according to health needs. The findings revealed that the acute illnesses were higher found in the poor than the rich when applying the adjusted or non-adjusted standard value methods (by age group and sex). In aspects of the overall service utilization (including self-prescribed medication and institutionalization), it highly implied greater use of the rich, as well (CI value is positive). In other words, there was greater service utilization of the wealthy from health facilities whereas less actual sicknesses. (Table 6.47). In 1991, accessibility to health services of the poor, however, was inclined to improve. (CI value is negative).

Table 6.46 Service Utilization Behaviour of People in Community, 1988, 1999

Type of service	Total		Urban		Rural		The North		The Northeast		The Central		The South		Bangkok Metropolis	
	1988	1999	1988	1999	1988	1999	1988	1999	1988	1999	1988	1999	1988	1999	1988	1999
Health facilities with doctors	54.3	54.3	81.0	67.3	47.3	52.1	61.9	52.2	46.3	52.4	47.0	53.1	43.4	59.2	81.3	62.5
Health facilities without doctors	4.7	NA	1.1	NA	18.2	NA	15.2	NA	15.2	NA	21.0	NA	17.1	NA	0.5	NA
Traditional care	2.4	1.6	1.0	0.8	2.8	1.7	1.9	1.3	1.3	1.2	3.8	1.9	4.1	2.9	1.0	0.8
Self-medication/self-care	28.6	24.1	17.0	31.0	31.7	22.3	21.0	20.2	37.2	23.6	28.2	26.8	35.4	17.8	17.1	32.7

Sources: Data for 1988 from IPSR, MMD, 1988.
(IPSR = Institute for Population and Social Research
MMD = Morbidity Mortality Differentials)
Data for 1999 from Report on Sickness and Health Welfare 1999, National Statistical Office.

Table 6.47 Non-adapted and Adapted Standard Value of Diffusion Index in 1986 and 1991

	Year	Concentration Index (CI)	Standardized
Acute illness	1986	- 0.0573	- 0.0069
	1991	- 0.1504	- 0.0148
Service accessibility	1986	0.0822	- 0.0027
	1991	- 0.1572	- 0.0260

Source: Supasit Pannarunothai and Clas Renburge (1998).

6.1.3 Inequity in Health Status

The infant mortality rate (IMR) is a good indicator in identifying health status differences in various population groups. For instance, the IMR in non-municipal areas accounts for 1.85 times higher than that in the municipal areas. Although the IMR has dropped by half in the past 20 years, the urban-rural difference is widening (Table 6.48).

Table 6.48 Infant Mortality Rates (per 1,000 Live Births) in Municipal and Non- municipal Areas, 1964-1996

	National average	Municipal areas	Non-municipal areas	Non-mun. / Mun. difference
SPC 1 (1964 - 1965)	84.3	67.6	85.5	1.26
SPC 2 (1974 - 1976)	51.8	39.6	58.7	1.48
SPC 3 (1985 - 1986)	40.7	27.6	42.6	1.54
SPC 4 (1989)	38.8	23.6	41.4	1.75
SPC 5 (1991)	34.5	21.0	37.0	1.76
SPC 6 (1995 - 1996)	26.05	15.24	28.23	1.85

Source: Survey of Population Changes (SPC), National Statistical Office.

In addition, World Health Organization employed the diffusion of infant mortality rate of ages under 5 in different income groups in each country as a equity indicator of health facilities distribution. Although Thailand stays at the first rank of WHO/SEAR member countries, when comparing with Asian countries, Thailands rank is still lower, particularly Singapore, Brunei and Malaysia. (Table 6.49)

Table 6.49 Health Facilities Diffusion for Children Aged under 5 in Each Countries, 1997

WHO/SEAR country member	Index	Rank		ASEAN country member	Index	Rank		World top ten	Index	Actual rank
		Actual	In-group			Actual	In-group			
Thailand	0.845	74	1	Singapore	0.971	29	1	Chile	0.999	1
Sri-lanka	0.833	80	2	Brunei	0.936	42	2	U.K.	0.999	2
Bangladesh	0.692	125	3	Thailand	0.845	74	5	Japan	0.999	3
Maldives	0.671	134	4	Malaysia	0.901	49	3	Norway	0.999	4
North Korea	0.631	145	5	Philippines	0.892	50	4	Poland	0.999	5
India	0.601	153	6	Indonesia	0.599	156	9	Greece	0.979	6
Indonesia	0.599	156	7	Vietnam	0.779	104	6	Israel	0.979	7
Bhutan	0.598	158	8	Lao	0.624	147	7	Austria	0.978	8
Nepal	0.586	161	9	Cambodia	0.606	150	8	San Mario	0.978	9
Myanmar	0.579	162	10	Myanmar	0.579	162	10	Switzerland	0.978	10

Source: The World Health Report 2000, Health Systems : Improving Performance.

Note: Nearly 1means the highest equity; nearly 0 means the lowest equity

6.1.4 Inequity in Health Expenditure Burden Undertaking

The burden of health expenditure does not rely on the ability to pay of people. For example, the comparison of health expenditure proportion in each income group reveals that the poor have had a greater burden of health expenditure in proportion to income than the rich. (Figure 4.10 in Chapter 4) This is in consistence with the result derived from Kakwani's index application that the Thailand's overall health financing is receding, in spite that fact that during the 1996 period the recession declined.(Table 6.50)

When compared with other countries, Thailand's equity in health expenditure burden undertaking is behind the WHO/SEAR member countries and other Asian nations (Table 6.51)

Siriwan Pittayarangsarit and Suwit Wibulpolprasert conducted the study on the equity trends in health expenditure burden bearing during 1991-1999. The results showed the improving tendency, as seen from inequity index (Fairness in Financing Contribution index: FFC), which declined from 0.023 in 1994 to 0.011 in 1998. The equities of FFC, thus, have risen from 0.908 in 1994 to 0.958 in 1998.

Table 6.50 Income Diffusion Index and Health Financing in Thailand 1986 - 1996

Year	Gini's income distribution index	Kakwani's tax progressivity index	Kakwani's health expense index	Total Health Financing
1986	0.4850	- 0.1322	- 0.3176	- 0.2620
1988	0.4930	- 0.1019	- 0.2327	- 0.1935
1990	0.5143	- 0.0640	- 0.2317	- 0.1814
1992	0.5360	- 0.0362	- 0.2380	- 0.1472
1994	0.5317	- 0.0667	- 0.2227	- 0.1525
1996	0.5186	- 0.0972	- 0.1507	- 0.1218

Source: Supasit Pannarunothai, et al. Equities in Health System, 2000.

Table 6.51 Equities in Bearing Health Expenditure of countries, 1997

WHO/SEAR country member	Index	Rank		ASEAN country member	Index	Rank		World top ten	Index	Actual rank
		Actual	In-group			Actual	In-group			
Thailand	0.913	128	7	Singapore	0.929	101	3	Columbia	0.992	1
Sri-lanka	0.940	76	5	Brunei	0.934	89	2	Luxambourg	0.981	2
Bangladesh	0.956	51	2	Thailand	0.913	128	5	Belgium	0.979	3
Indonesia	0.942	73	4	Malaysia	0.917	122	4	Dibuti	0.979	4
India	0.962	42	1	Philippines	0.913	128	5	Denmark	0.979	5
Bhutan	0.934	89	6	Indonesia	0.942	73	1	Ireland	0.978	6
Maldives	0.956	51	2	Vietnam	0.643	187	9	Germany	0.978	7
Nepal	0.714	186	9	Lao	0.885	159	7	Norway	0.977	8
North Korea	0.829	179	8	Cambodia	0.814	183	8	Japan	0.977	9
Myanmar	0.582	190	10	Myanmar	0.582	190	10	Finland	0.977	10

Source: World Health Report, 2000, Health Systems : Improving Performance.

Note: Nearly 1 means the highest equity; nearly 0 means the lowest equity

6.2 Problems of Health Services System Efficiency

6.2.1 Problems of Health Service Efficiency

Curative care is much less efficient with regard to its capacity in making people healthy, compared to promotive and preventive care (see the section on health care financing in Charter 6). Besides, for the curative service system itself, inefficiency is found in terms of, for example, drug over-utilization (from the community level up to medical specialist level)

6.2.2 Problems of Investment in Hospital Beds

According to the 1995-2000 reports on health resource surveys conducted by the Bureau of Health Policy and Plan, the MOPH hospitals have had the bed-occupancy rate of 80 percent, followed by those of Ministry of Interior and other Ministries. Whereas the bed-occupancy rate is less than 50 percent in for-profit private hospitals. Especially, after the economic crisis the trend has been declining to 40.5 percent in 2000. This clearly indicates an oversupply of beds in the private sector (Table 6.52)

Table 6.52 Numbers of Beds and Bed-occupancy Rates in Health Facilities Nationwide, 1995- 2000

Agency	Bed						Length of stay (day)						Patients / bed ratio						Bed-occupancy rate (percent)					
	1995	1996	1997	1998	1999	2000	1995	1996	1997	1998	1999	2000	1995	1996	1997	1998	1999	2000	1995	1996	1997	1998	1999	2000
MOPH	73,191	76,379	79,818	81,035	82,085	87,752	4.8	4.6	4.6	4.3	4.3	4.6	62.6	67.5	66.6	72.4	70.1	66.2	83.6	85.9	83.5	84.3	82.8	82.7
Other Ministries	14,236	17,143	16,880	15,948	15,879	13,216	5.5	8.2	6.4	7.6	6.7	7.8	18.3	19.9	24.9	31.0	30.5	30.2	27.6	44.7	43.6	64.7	55.6	64.4
Ministry of Interior	3,359	3,417	3,402	3,457	3,591	3,433	9.7	8.5	8.1	4.3	4.6	6.9	23.0	31.5	32.6	60.5	58.0	41.9	61.2	73.5	72.5	71.7	73.7	79.0
State enterprise	365	365	365	385	385	332	10.9	9.1	9.3	12.9	6.4	9.8	14.3	19.0	18.6	23.8	15.6	30.4	43.2	47.3	47.3	84.7	27.3	81.9
For-profit	25,298	29,611	29,945	31,123	31,207	29,361	4.0	4.8	3.1	3.0	3.1	2.9	38.3	54.9	52.8	52.1	47.4	50.7	42.3	46.2	44.3	42.9	39.9	40.5
Non-profit	1,968	2,004	1,995	2,156	2,156	2,107	7.3	6.9	6.6	6.8	6.0	5.8	34.6	34.7	36.5	34.9	35.2	38.9	69.4	66.1	66.1	65.3	57.7	62.1
	118,417	128,919	132,405	134,104	135,303	136,201	4.8	4.9	4.4	4.2	4.3	4.5	50.4	50.7	56.7	61.7	59.2	58.2	67.1	70.6	68.9	71.7	68.9	71.4

Source: Report on Health Resources, Bureau of Health Policy and Plan, MOPH.

Notes: 1. Data of length of stay of the state enterprise's health facilities in 1998 were much greater than those in 1997 due to high inpatient's length of stay of the Metropolitan Electricity Authority Hospital. While in 1999, the rate was considerably lower due to effect of the length of stay restriction measure

2. Data of length of stay of other Ministries' health facilities during 1998-1999 were higher due to the rate derived from hospitals under the Faculty of Medicine, Chiang Mai University.

Table 6.53 Ratios of Beds to Doctor, Beds to Nurse, Inpatients to Doctor, Inpatients to Nurse and Outpatients to Doctor, 1996 - 2000

Agency	Bed : MD					Bed : N					Adm : Md : yr					IP : Md : d					IP : N : d					OPD : Md : yr				
	1996	1997	1998	1999	2000	1996	1997	1998	1999	2000	1996	1997	1998	1999	2000	1996	1997	1998	1999	2000	1996	1997	1998	1999	2000	1996	1997	1998	1999	2000
MOPH	9.9	9.9	8.4	8.4	9.4	1.2	1.2	1.1	1.1	1.2	666.7	662.2	608.4	587.2	619.9	8.5	8.3	7.1	6.9	7.7	1.1	1.0	1.0	0.9	1.0	2,451.6	2,520.1	2,159.9	2,211.6	2,442.9
Other ministries	4.8	4.7	4.8	4.6	4.2	1.7	1.7	1.6	1.5	1.2	93.1	111.4	168.5	159.0	126.1	2.2	2.1	3.1	2.6	2.8	0.7	0.7	1.0	0.9	0.8	1,046.1	981.5	607.4	564.1	669.8
State enterprise	5.5	4.4	3.4	3.3	2.9	3.9	2.4	1.3	1.3	1.1	104.9	81.9	80.4	51.6	88.7	2.6	2.1	2.9	0.9	2.4	1.9	1.1	1.1	0.3	0.9	273.7	217.7	152.7	156.7	125.1
Municipalities	4.6	4.5	4.5	4.4	4.0	0.9	0.9	0.7	0.7	0.6	201.9	205.5	215.2	200.9	198.5	3.7	3.6	3.4	3.3	3.0	0.8	0.8	0.5	0.6	0.5	938.7	928.7	795.5	795.0	817.2
Private sector	8.9	9.2	8.7	9.2	7.5	4.7	4.6	3.5	3.5	3.1	489.5	487.7	454.8	434.5	379.4	6.5	4.1	3.7	3.7	3.0	3.5	2.1	1.5	1.4	1.2	1,488.3	1,370.6	1,451.7	1,348.6	1,057.4
Independent agencies	2.4	2.4	3.6	3.6	3.2	1.1	1.1	0.6	0.6	0.9	83.9	85.7	126.2	125.5	125.3	1.6	1.5	2.6	2.1	2.0	0.7	0.7	0.4	0.4	0.6	348.9	343.1	426.3	420.0	511.0
Total	7.9	8.0	7.5	7.6	7.6	1.6	1.5	1.4	1.4	1.4	450.9	453.2	460.8	441.4	439.8	6.1	5.5	5.4	5.1	5.4	1.2	1.1	1.0	0.9	1.0	1,765.3	1,764.8	1,604.7	1,600.6	1,670.6

Source: Report on Health Resources, Bureau of Health Policy and Plan.

Note:
Bed : MD = No. of beds per doctor
Bed : N = No. of beds per nurse
Adm : Md : yr = No. of admissions (inpatients) per doctor per day
IP : Md : d = No. of inpatients per doctor per day
IP : N : d = No. of inpatients per nurse per day
OPD : Md : yr = No. of Outpatients per doctor per day

6.2.3 Problems of the Quality of Service System

With regard to the level of consumers' perception, the public and private sectors' problems are different. The specific problems of the public sector include patient's interest and service convenience, especially in the higher-level health facilities the score of patient satisfaction is declining, while the problem in private sectors usually is related to service prices (Table 6.54, 6.55)

However, it is necessary to analyze more deeply into the quality assurance aspect, resulting in satisfied health outcomes. At present, Thailand has put numerous efforts in this matter by establishing Hospital Accreditation Institute under the Health Systems Research Institute to set the quality assurance standard for both public and private health facilities. Besides, the effects of health system reform that has raised the issue of health service quality development in National Health Act, as well as an issuance of Health Facilities Act and new ministerial regulations will drive for a sustainability of health facility quality assurance and hospital accreditation system.

The 30 baht scheme policy of the current government has considerably taken part in expediting quality assurance system development of hospitals and primary care centers.

Table 6.54 Opinions towards Health Facilities' Services by Issues Related to Service Quality, Type of Facility and Opinion Level

Sector	Opinion Level		
	Good	Satisfied	Poor
1. All Levels of Health facilities			
All aspects	74.3	24.3	1.4
Convenience from getting service	52.0	41.9	6.1
Personality of service provider	53.4	40.4	6.2
Information from service	81.8	14.3	3.9
Service quality	70.7	26.1	3.1
2. Regional Hospital			
All aspects	69.3	29.5	1.2
Convenience from getting service	45.8	45.4	8.8
Personality of service provider	47.6	43.5	8.8
Information from service	78.9	17.3	3.8
Service quality	72.3	25.7	2.0
3. General Hospital			
All aspects	77.5	20.8	1.7
Convenience from getting service	54.3	42.1	3.6
Personality of service provider	55.1	40.3	4.6
Information from service	84.1	11.0	4.9
Service quality	68.5	27.7	3.8
4. Community Hospital			
All aspects	81.2	17.2	1.6
Convenience from getting service	62.3	34.6	3.1
Personality of service provider	63.1	34.3	2.5
Information from service	85.5	11.4	3.1
Service quality	69.6	25.5	5.0

Source: Panbaudee Ekachampaka and Suthisarn Wattanamano, Assessment of Clients' Satisfaction towards Service Delivery of Health Facilities during the Economic Crisis, 1999.

Table 6.55 Opinions towards Service Quality of Private Health Facilities Compared with that of Public Health Facilities by Issues Related to Service Quality, Type of Health Facility and Opinion Level

Sector	Opinion Level				
	Poor	Satisfied	Moderate	Good	Very good
Public Health Facilities					
Reception	16.3	35.3	38.5	7.5	0.5
Waiting for service	33.4	37.9	24.9	2.2	-
Convenience	17.4	39.3	36.1	5.0	0.5
Doctor's skill	1.6	8.2	15.0	35.3	38.1
Nurse's service	12.8	35.9	40.4	8.4	0.9
Attention to Patient	15.7	37.2	37.9	6.7	0.9
Treatment instrument	2.1	9.1	19.9	33.1	34.1
Quality of medical products	1.8	8.8	19.4	34.8	33.4
Service price	1.0	6.2	18.0	27.0	45.0
Service place	4.0	17.2	34.8	29.9	12.2
Private Health Facilities					
Reception	0.1	2.1	32.4	54.5	8.6
Waiting for service	0.3	3.7	41.7	46.6	5.4
Convenience	0.4	4.0	40.0	45.6	7.6
Doctor's skill	0.3	1.9	20.7	48.1	26.6
Nurse's service	0.4	2.8	37.7	49.9	6.9
Attention to Patient	0.3	2.9	35.4	51.2	8.0
Treatment instrument	0.1	1.8	24.6	54.8	16.3
Quality of medical products	0.5	1.7	20.6	52.0	22.5
Service price	11.0	26.1	37.7	20.6	3.6
Service place	0.3	2.7	33.8	49.6	10.9

Source: Kusol Soonthorntada and Worachai Thongthai, Type of Service Users and Determinants of Health Services in the Private Health Facilities, 1996.

6.6.4 Problems of Accessibility to Emergency Service

Despite the expansion of health services in both public and private sector, a number of people continue encountering the problem of medical emergency services from the site of accident to the hospital-due to no systematic management and no direct responsible agency. It is found that some hospitals in Bangkok refuse to admit an accident victim because they claim to no available bed. For some cases, doctors give an inadequate attention to patients on a timely basis, or some private hospitals insufficiently provide basic care for the patients who cannot afford to pay for services. These problems need to be resolved and efforts are being made to set up an emergency services system outside hospitals in Bangkok by the Medical Services Department and at Khon Kaen Regional Hospital in Khon Kaen Province as well as in several other private hospitals. Yet, there still are the problems in service and administrative management, standard quality development, information system and the cooperation among responsible agencies. The MOPH has, therefore, established the master plan of the National Medical Emergency Services System in order to create the efficient and quality medical emergency services system within 2006.

After the effect of the 1995 Third Party Insurance Law, the problems of emergency cases have been minimized, as there is a definite party responsible for medical expenses (within the 50,000-baht limit). But it has been found that most private hospitals tend to send the patient who has exhausted the 50,000 baht to a public hospital to take the extra burden, as well as the burdens from insurance company and people, which are pushed to health insurance card.

6.6.5 Coverage of Health Insurance

The trends of health insurance coverage in Thailand are expanding to all the people under such schemes as the revolving fund for medical services, voluntary health insurance, social security, students health insurance, workmen's compensation fund, and insurance for road traffic accident victims. As of 2001, approximately 71.0 per cent of the Thai people have been covered by any of health insurance schemes, (Table 6.56) specifically greater coverage for the Thai people in the rural areas. (Table 6.57) Nonetheless, the problem of macro health-financing policy to health insurance system is not clear and unified, leading to a variety of health insurance schemes in Thailand, coupled with the differences of each scheme's financing management and minimum basic benefits. The consequences of initiatives in developing standard and equity of health insurance system are the impacts on health system in terms of effectiveness and fairness as shown in Table 6.58. The civil servants' medical benefit scheme covering 12 percent of population is allocated with the highest budget about 2,106 per capita per annum, with a wide range of coverage and benefits. While medical welfare for the low-income group and health card that cover most of the population around 58 percent are least subsidized with budget about 273 baht per person per year and with a rather limited benefit. In addition, a study on health insurance of 2,516 surveyed people showed that 29.2 percent of households never claimed to their health benefits. Such a group that could claim to gain benefits from

health card, medical welfare for the low-income group and the deprived, included the elderly, the disabled, and the uninsured, which mostly were those residing outside the municipal areas and with the household income of less than 5,000 baht per month. While the group that claimed the health benefits from medical service for civil servants and state enterprise employees, social security fund and workmen's compensation fund, private enterprise health insurance, mostly was the group in municipal areas and with a household income of higher than 20,000 baht per month. This reflected the disparity and inequity in health. (Table 6.59)

The 30 baht scheme policy of the current goverment provides an invaluable chance to develop efficient and fair health financing by stressing on the universal health insurance coverage. As such, the complementary system that promotes the equality and efficiency of health resource allocation and proper arrangement of resource utilization is necessarily needed.

Table 6.56 Percentage of Health Insurance Coverage by Scheme, 1991, 1996 and 2001.

Health insurance scheme	1991	1996	2001
1. Medical welfare for the low income group (So. Po. Ro.)	12.7	12.6	31.5
2. Medical welfare for civil servants and state enterprises	**15.3**	**10.2**	**8.5**
- Civil servants	13.2	9.0	7.5
- State enterprise officials	2.1	1.2	1.0
3. Social security and Workmen's compensation fund	-	5.6	7.2
4. Voluntary health insurance	**4.5**	**16.1**	**22.1**
- Health insurance by MOPH	1.4	15.3	20.8
- Private health insurance	3.1	0.8	1.3
5. Others	0.9	1.0	0.8
6. Gold cards (30 baht payment required)	-	-	0.9
Total: People with health insurance	33.5	45.5	71.0
Total: People without health insurance	66.5	54.5	29.0

Source: Report on Health and Welfare Survey, 1991, 1996 and 2001, National Statistical Office.

Table 6.57 Percentage of Health Insurance Holders Residing in and outside the Municipalities by Scheme, 1991, 1996 and 2001.

Insurance possession	In the municipality*			Outside the municipality		
	1991	1996	2001	1991	1996	2001
No insurance	65	58	42	68	53	22
Civil servants and state enterprise officials	22	17	15	6	7	5
Health insurance by MOPH	-	11	13	-	3	4
Medical welfare for the low-income group	7	5	15	21	16	39
Health card	1	6	10	2	20	27
Private health insurance	5	2	3	1	1	1
Others	1	1	1	1	1	1

Source: Report on Health and Welfare Survey, 1991, 1996 and 2001, National Statistical Office.
*Including data of sanitary district in 1991 and 1996 in order to be able to compare with those in 2001.

Table 6.58 Privileges of Health Insurance System and Health Welfare

Health Insurance System and Health Welfare	Expenses(Baht) /person/year*	Health Benefits and Coverage			
		Health facility selection	Cash	Pregnancy/ Birth delivery	Disease prevention/ Health promotion
Welfare for the low income and the deprived	273[1]	Referral system	no	available	limited
Civil servant's medical benefit scheme	2,106	public(private)	no	available	available
Compulsory health insurance					
* social security	1,284	Mutual contract	available	available	some
* compensation fund	n.a.	Mutual contract	available	no	no
Voluntary health insurance					
* health insurance card	249[1]	Referral system	no	possible	possible
* private health insurance	1,667	independent	on condition	on condition	on condition

Source: Supachtikul 1996 : Tangcharoensathien, et, al. 1998 (quoted in Jirut Sriattanaban)

Note: *Data for 1999 are quoted in Supasit Pannarunothai 2000.

[1] only drug and operational expenses, excluding labour and investment costs,

Table 6.59 Sources of Fund for Health Disbursements by Residential Area and Monthly Total Family Income

Sources of Fund for Health Disbursements	Percent	Residential area		Monthly Total Family Income				
		In municipal area	outside municipal area	<5,000 baht	5,001-10,000 baht	10,001-15,000 baht	15,001-20,000 baht	>20,000 baht
1. Civil servants and State enterprise welfare	23.3	28.9	19.9	10.0	25.6	34.2	44.0	49.7
2. Social security fund and Workmen's compensation fund	15.4	20.2	12.4	6.7	22.7	22.1	27.8	23.3
3. Health card	39.8	25.3	48.8	55.9	35.7	27.8	22.7	12.3
4. Low income people welfare for health care	5.5	3.9	6.5	9.3	3.9	1.9	1.4	2.3
5. Private health insurance	5.3	6.0	4.8	2.0	4.2	11.5	7.0	15.4
6. Company welfare and agency	7.2	9.0	6.1	3.0	6.2	15.8	15.2	14.0
7. Other elderly identified card /Rehabilitation card of Social Work Department (the disabled) School health card	8.2	6.2	9.4	9.6	5.3	5.0	2.3	8.1
8. No health privilege	29.2	35.3	25.4	30.8	29.2	30.4	21.0	21.5

Source: Coverage health insurance in people's viewpoint, ABAC Research Institute-KSC Internet polls, 2000.

Note: More than 1 answer can be applied.