Chapter 7

Protection of Thailand's Health System

A good health system must be based on morality, righteousness and ethical conduct with respect for rights, values and dignity of human being, leading to equality. Besides, the system must have a complete structure and interrelated/coordinated working mechanisms in an integrated manner, with good quality, efficiency, cost-containment, accountability, and joint responsibility as well as unity, knowledge base, continued learning and development, in line with personal ways of life and social norms, self-reliance in a suitable and sustainable manner and participation of all sectors in society for promoting health of all the people, i.e. "all for health and health for all".

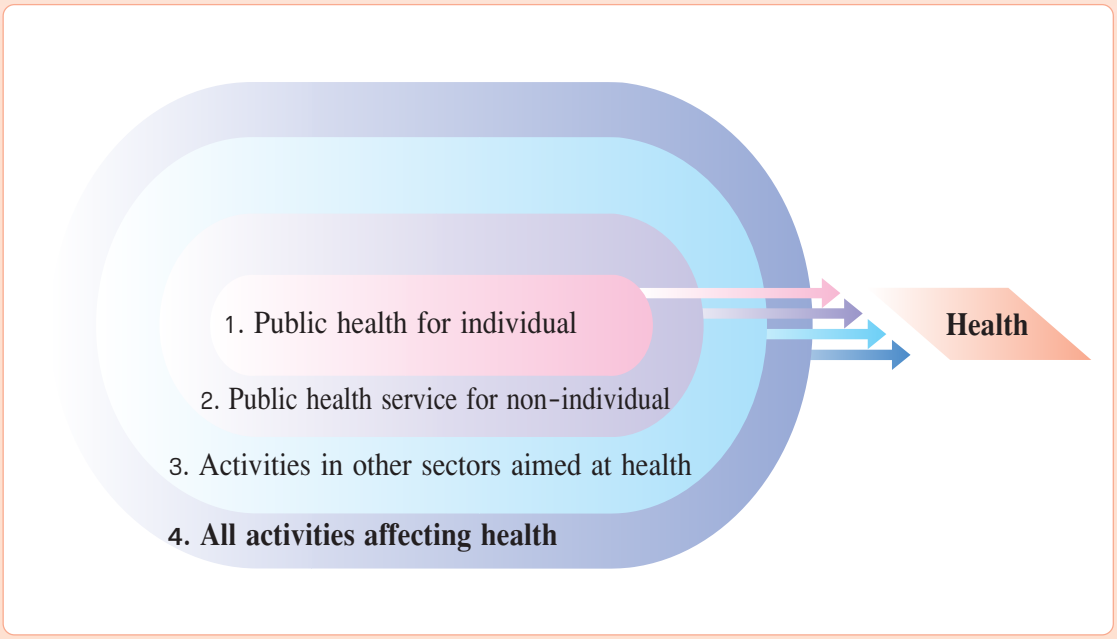
1. Scope of the National Health System

According to the National Health Act B.E. 2550 (2007) (Government Gazette, Vol. 124, Part 16Gor, 19 March B.E. 2550), **"health means the state of human being which is perfect in physical, mental, intellectual and social aspects, all of which are holistic in balance,"** and "health system means overall relations in connection with health."

"Public health system" means the management of activities related to disease prevention, curative care, health promotion and medical rehabilitation (Public Health Encyclopedia, 1988) and **"public health service"** means any service relating to health promotion, prevention and control of diseases and health hazards, diagnosis and treatment of illness and rehabilitation of person, family and community.

In summary, the "national health system" means various systems that cover the operations of health activities in all dimensions, while the public health system and the public service system are part of the national health system, as diagrammatically shown in the figure below.

Figure 7.1 Scope and meaning of health system



Source: National Health Act, B.E. 2550 (2007).

According to the figure above, the scope of health system can be described in four levels as follows:

Level 1: This is the narrowest level of health system which covers health services for individuals with respect to curative care, health promotion, disease prevention and rehabilitation.

Level 2: This level covers services outside the individuals such as disease prevention in the community, family and community health, but does not include other health-related activities such as water supply, sanitation, and legislation on reduction of lead content in fuels.

Level 3: This level covers activities of other sectors which are related to health such as solid waste disposal, water supply and road safety.

Level 4: This is the widest level that covers all activities that may have some effects on health, no matter whether they will have any health-related objectives or not, such as education, tourism, agriculture, city planning, justice, economy, etc.

The "Total health system" in the National Health Act covers all activities as described in "Level 4" above, while the public health system is a sub-system of the health system that covers activities in "Levels 1, 2 and 3", and "health care/service system" covers Level 1 activities and some activities of Level 2 such as family and community health.

2. Components of the National Health System

In drafting the National Health Bill, efforts were made to set up components of the health system in a comprehensive and coordinated fashion so as to obtain a desirable national health system. The components of the national health system are divided into 10 sub-systems as follows (Figure 7.2):

2.1 Health policy and strategy system

2.2 Health promotion system

2.3 Prevention and control of diseases and health hazards system

2.4 Public health services and quality control system

2.5 System for promotion, support, utilization and development of local health wisdom, Thai traditional medicine, indigenous medicine and alternative medicine

2.6 Health consumer protection system

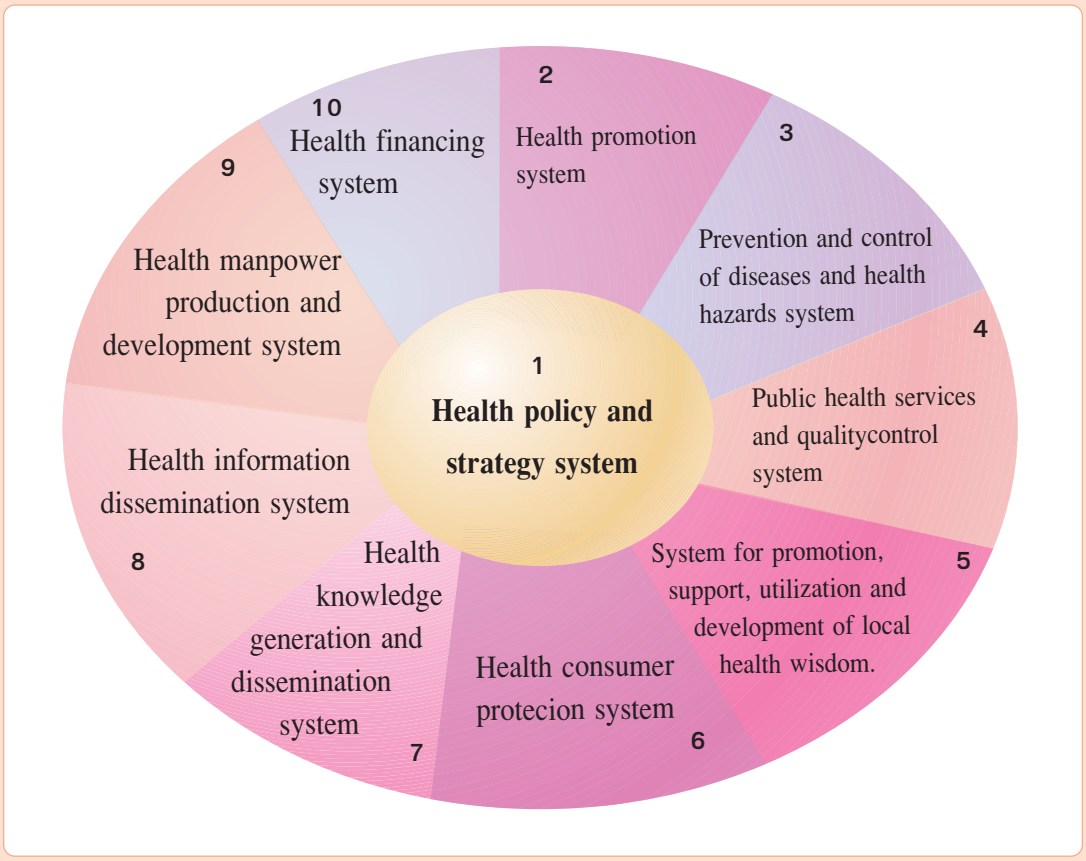
2.7 Health knowledge generation and dissemination

2.8 Health information dissemination system

2.9 Health manpower production and development system

2.10 Health financing system

Figure 7.2 Components of health system



Source: Modified from the National Health Act B.E. 2550 (2007).

2.1 Health Policy and Strategy System

Health policy and strategy include healthy public policy and public health policy. To formulate a good health policy and strategy system, emphasis should be placed on the participation of all sectors concerned to empower individuals, families, community and society, and to reduce social inequalities and injustice. The formulation process requires cooperation of all partners concerned and all sectors in society are to be encouraged to take responsibility for health, integrating interdisciplinary knowledge and technology. These policies and strategies have a broad scope such as policies on income distribution, wages, agriculture, industry, land use, city planning, energy management, environmental management, traffic accident prevention and control, alcohol and tobacco consumption control, all affecting health directly and indirectly. In addition, they include public health policies such as those on expansion and distribution of public health services, health security, prevention and control of diseases and health threats, HIV/AIDS prevention and control, consumer protection in food and drug, development of Thai traditional medicine and local wisdom, and primary health care.

Regarding the mechanism for developing health policies and strategies, the National Health Commission will coordinate with the government's policy and strategy formulation agency as well as other public and private health agencies. This is to create the process for developing health policies and strategies in a continuous manner with the participation of all concerned for the benefits of the majority of Thai people.

2.2 Health Promotion System

"Health promotion" means any act which is aimed at the fostering of a person's physical, mental and social conditions by means of supporting personal behaviors, social conditions and environments conducive to physical strength, a firm mental condition, a long life and a good quality of life (Health Promotion Foundation Act, 2001). It is a process of empowering personal and community's capacity to have a livelihood leading to good health, under supportive environments. And it is a process that enables the people to control the determinants of health resulting in better health, i.e. control their own behaviours so that they are prepared to modify the environments conducive to good health.

A health promotion system is thus a service rendered to the people by health personnel through health care delivery at various levels such as health-promoting hospitals which have concepts for hospital development and increase the role of hospitals as leaders of health promotion. Health promotion system in a broader context, according to the Ottawa Charter, views health promotion as a role of all sectors in society to develop healthy public policy, develop environments conducive to health, strengthen the community, develop personal skills, and reorient health service systems. As a result, there have been developments on several programmes such as healthy cities and healthy Thailand, healthy communities, and health-promoting schools. At present, the MoPH's Department of Health and the Thai Health Promotion Foundation (ThaiHealth) are the key supporting agencies.

2.3 System for Prevention and Control of Diseases and Health Threats

This system aims to decrease morbidity, mortality and disability, and to eliminate health threats, in an effective and timely manner, based on current knowledge and facts as well as the systematic approach of integrated technical and managerial operations. It does not mean the conventional system for disease prevention and control, but focuses on the prevention and control of health threats that cause illnesses and other problems. In the past, emphasis was normally placed on disease prevention and control, as well as project management in a vertical manner through the MoPH's mechanism with responsibilities distributed according to the nature of diseases such as communicable diseases, non-communicable diseases, environmental diseases, occupational diseases, and mental disorders. But currently, the system has been expanded to cover the prevention and control of factors affecting health including actions for minimizing health impacts from physical, biological and chemical factors (including infectious agents) and social systems. For example, in the case of avian influenza, which had an economic impact on the country through trade discrimination, there was a ban on imports of fresh chicken from Thailand; and several people lost their lives. Therefore, the prevention and control of diseases and health threats requires intersectional cooperation of all concerned. Central administration agencies, including the Ministry of Public Health, the Ministry of Agriculture and Cooperatives, the National Research Council, businesses, universities and others concerned, have to play a technical support role in keeping abreast of knowledge as well as local and international situations, and developing or seeking new knowledge for resolving the problem. Beside, efforts have to be made to monitor the mutation of avian flu virus and identify suitable measures for monitoring and evaluation of actions undertaken by various relevant agencies. Concurrently, regional/provincial and local administration authorities as well as the communities have to also coordinate with each other in mobilizing all resources for the prevention and control efforts. These include the setting up of public policies on sanitation, consumer protection, disease surveillance, and situation monitoring. Overall, this system in this context has a scope that is broader than that of medical and health system in the past.

2.4 System of Public Health Services and Quality Control

The system of public health services and quality control in Thailand has been developed from the concept of state health services for all the people in the form of social welfare. And until recently it has been transformed into the concept of universal coverage of health services under the responsibility of the government, or risk-sharing or self-reliance through personal savings. This is to create a tool that will lead to the goal of universal coverage, or access to, basic health services required for healthy living in an equitable manner. The new system has a clear separate role of services purchasers and service providers that equitably cover all localities and population groups so that the entire system is managed with efficiency, cost containment and quality assurance mechanisms.

Thus, a good public health service system means public services that are adequate,

equitable, accessible, of good quality, and efficient, not seeking unreasonable business profit. It also covers self-care at the individual, family and community levels, emergency services, primary care, secondary services and tertiary services, specialized services and emergency medical services. Moreover, there must be systems for development and accreditation of service standards and quality, and for assessment of health technologies that will be appropriately used in health services delivery.

2.5 System for Promotion, Support, Utilization and Development of Local Wisdom on Health, Thai Traditional Medicine, Indigenous Medicine and other Alternative Medicine

The system of local health wisdom means the body of knowledge, thoughts, beliefs and skills in health care that have been accumulated from life experiences and transmitted through culture of groups of people. The promotion, support, utilization and development of such local health wisdom have to be in accordance with local community's ways of life, traditions and culture, so as to respond to and support the principle of self-health-reliance and to provide several health services options.

In the past, local health wisdom was not systematically organized whereas present day's medical and health technologies have considerably advanced, resulting in local health wisdom being given less importance or missing. But when the health situation has changed, local health wisdom or non-mainstream medical care has been revised and become a new alternative. In 1993, the Institute of Thai Traditional Medicine was established under the Department of Medical Services; later it became the Department for Development of Thai Traditional and Alternative Medicine in 2002. That was the formal development of Thai traditional medicine since its abolishment from Siriraj Hospital in 1904 (Komatra Chuengsatiansup, 2004) and the movements towards new dynamics of medical diversity.

However, local health wisdom has to be further supported and developed as it has long been neglected. Dr. Komatra Chuengsatiansup (2004: 39-42), and Drs. Suwit Wibulpolprasert and Prapoj Petrakard and colleagues (2006) have made a number of strategic recommendations, namely: creation of mechanism for knowledge management by establishing an institute for research and development of Thai-style health care, establishment of a committee on local health wisdom policy to formulate policies and push for a national agenda on local health wisdom and to set up a Thai traditional medicine hospital, and to promote the development of networks for knowledge management and mapping for community health wisdom, and establishment of mechanisms for linking, communicating and networking with other world-class academic institutions related to medical and health derived from the new paradigm of science.

2.6 Consumer Protection System

Health consumer protection means any operation undertaken to provide protection for the people as consumers of health services/products in a safe and fair manner. So there must be

comprehensive systems for all relevant operations in this regard which include: health professional standard development, public health service standard development, health product standard development, information dissemination, counselling, complaint acceptance, inspection for justice provision, mediation, and remedies in case of damage. The designs of such systems must be based on people's rights so that they will live together in harmony which is a significant characteristic of Thai society.

In addition to the aforementioned systems, the promotion and support of people's system of consumer protection is essential through empowerment of non-governmental organizations working on health consumer protection in parallel with public sector's efforts. This is to supplement each other and set up a system of checks and balances.

2.7 Health Knowledge Generation and Dissemination

Over the past decade, Thailand has started to place importance on the generation and dissemination of knowledge about health. Several agencies have been established such as the Thailand Research Fund (TRF), the National Science and Technology Development Agency (NSTDA), and the Health Systems Research institute (HSRI). As a result, there has been a paradigm shift in health research in a systematic manner. More initiatives have been undertaken for health promotion; however, the utilization of research results and the management have not been carried out as expected. Therefore, in the future there should be a mechanism for setting directions and policies for management of research, administration of health resources, monitoring and evaluation of knowledge generation and dissemination system. In addition, all concerned have to promote, support and manage the establishment of a network or mechanism for health knowledge generation and dissemination. This is to ensure that research and knowledge management efforts are undertaken systematically and that the capacity of health system will be enhanced with decreased costs and more efficient results.

2.8 Health Information Dissemination System

A system for dissemination of health information is to be designed and developed in such a way that it is adequate and easily accessible to the people. Thus, the system has to be developed so that it is up to date and easily accessible to the public in a timely fashion. At present, the information can not reflect all dimensions of people's health and it is scattered in various agencies due to a lack of mechanism to collate, analyze and synthesize it so that it clearly shows the trends of rapidly changing situations. So mostly, the information is not accurate enough for actual utilization.

In the past, the dissemination of health information was done through the health education process by health personnel in healthcare facilities or by community health volunteers. So the information was rather limited, depending on the knowledge, understanding and beliefs of the informants. Sometime, the information was not up to date or not consistent with the advances in science

and technology as well as the rapidly evolving world. Some information did not correspond to the needs of the people who were facing specific health problems in various aspects. As the techniques of health information dissemination are now more modern, the people can seek the health information by themselves from various channels of media. If the information is managed in such a way that it is accurate, comprehensive, and relevant to the needs of people; the dissemination system to groups of professionals and the media, the modalities of health information dissemination will be revised and further extended from health personnel to the media and other groups of people, who have a more interesting technique of presentation. This can lead to the receipt of information of the people and society on a wider scale through various channels.

2.9 System for Production and Development of Public Health Personnel

This system covers subsystems of policy and production plan, production operations and development; the system requires specific knowledge and management. A good public health personnel system has to be a system that is efficient, of good quality, and able to create equity.

In the past, the system for production of health personnel was primarily linked to the public central administration system with the MoPH being the major agency deploying health personnel in the civil service system. But the production of personnel was under the national education system and the MoPH produced part of health personnel for its own deployment. Such systems had no specific mechanisms for policy and operational coordination at the national level. However, there were efforts for admitting students from provincial areas to study in certain health training programmes and, upon completion, go back to work in their own province of residence. This is to build up equity and resolve the problem of personnel shortages in rural areas. This mechanism is quite effective for nurses and health workers at the subdistrict health-centre level. But rural-urban brain drain is still a chronic problem for medical doctors. The problems are different in nature, depending on changing situations and factors. The system in the future has to adjust itself to cope with the changing situation in society, taking into consideration the participation of local administrative organizations, the private sector, and civil society, the reduction of dependence on state mechanisms. The new system has to be multifaceted; so it will be able to cope with the changing health system in a timely manner.

2.10 Health Financing System

Health financing means the financial management for health such as the use of tax measures to promote elderly care in the family, the promotion of private businesses to take care of their employees' health, the promotion of healthy environments, and the use of tax measures for tobacco and alcohol consumption control. It also includes the management of public finance for the provision of universal coverage of health services.

Financing of public health services means a financial system that creates a good service

system in all aspects, ensuring that all the people have equitable access to essential services without any financial barrier. In principle, health financing is to aim at building good health before repairing ill health with equity, transparency, accountability, efficiency, cost containment, and quality.

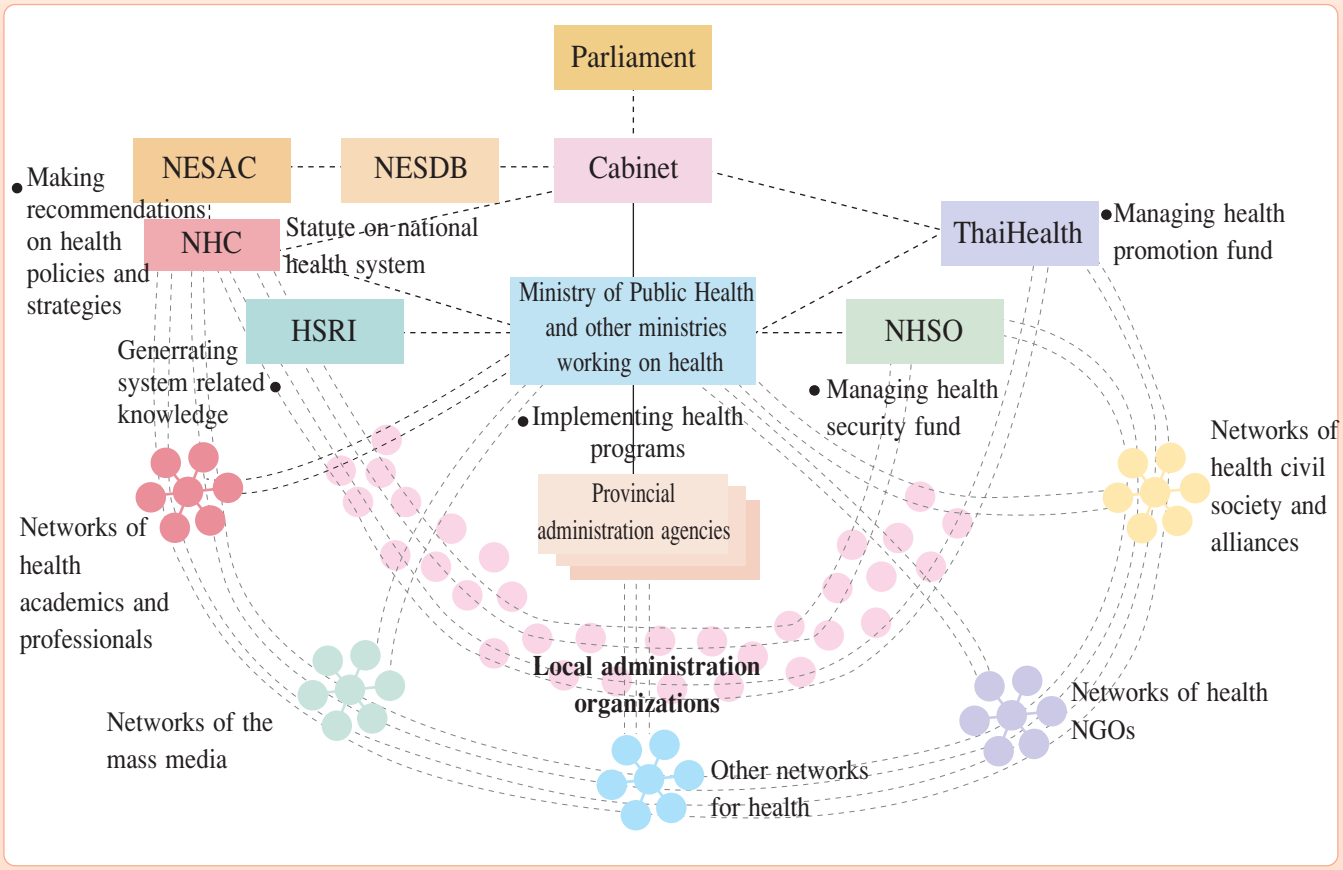
Thailand has had programmes on health financing for a long time such as the financial and tax measures (raising alcohol and tobacco taxes) and the enactment of the Health Promotion Foundation Act for collecting 2% tax on alcohol and tobacco for use in health promotion activities. Several other efforts have been made to build good health and protect or improve health conditions of the people and society. At present, developments in health financing for health services delivery are implemented in four major systems: universal healthcare system under the National Health Security Act of B.E. 2545 (2002), social security system, civil servants medical benefits system (for civil servants, state enterprise employees and family members), and private health insurance system.

The health financing system is regarded as one important system under the health system as it can be used as a tool in pushing forward the national health system in a desirable direction.

3. Mechanism for Protection of National Health System

In the past, when mentioning of mechanisms for the protection of the national health system, they were normally referred to mechanisms under the Ministry of Public Health, health facilities under other agencies, health educational institutions, health non-governmental organizations, for instance. But at present, the social context has changed considerably with new mechanisms taking part in health activities (Figure 7.3).

Figure 7.3 Linkages of protection mechanisms in the national health system



Notes: NESAC = National Economic and Social Advisory Council
NESDB = National Economic and Social Development Board
NHC = National Health Commission
NHSO = National Health Security Office
HSRI = Health Systems Research Institute
ThaiHealth = Thai Health Promotion Foundation

As shown in the figure, the MoPH is the principal mechanism of the national health system and, as the core agency of the government; it is responsible for the operations of health programmes through its administrative, service delivery and technical agencies located across the country. In all such efforts, other ministries also play a role in health-related activities in various dimensions in a coordinated fashion, including for example the National Economic and Social Development Board, the Ministry of Interior, the Ministry of Education, the Ministry of Social Development and Human Security, and the Ministry of Labour. In addition, there are other independent mechanisms, some under the supervision of the MoPH, some are not, including: the Office of the Thai Health Promotion Foundation (ThaiHealth), responsible for the management of the health promotion fund supporting all sectors in society to widely carry out health promotion activities in all dimensions; the National Health

Security Office (NHSO), responsible for the management of the health security or insurance fund for providing health services to the people; the Social Security Office of the Ministry of Labour, responsible for the management of healthcare funds for workers and their family members; the Health Systems Research Institute (HSRI), responsible for the management of funds for supporting the creation and management of knowledge for health; the Institute of Hospital Quality Improvement and Accreditation (HA), responsible for the promotion and support of health service quality development in hospitals and other kinds of health facilities; and the Office of the National Health Commission, responsible for making recommendations on health policies and strategies to the government and all sectors in society using the participatory approach involving all concerned in the process of policy and strategy formulation process.

Moreover, there are several other mechanisms involved in the movements for health such as the National Economic and Social Advisory Council, health educational institutions and technical agencies, health professionals councils, health NGOs, the mass media, health charity organizations, and health civil society networks, such as the National Health Foundation, the Folk Doctor Foundation (Mor Chao Ban), the Consumer Protection Foundation, health civil society networks working on AIDS, village health volunteers networks, networks for Thai traditional and alternative medicine, and health assembly networks.

Besides, at the local level there are local administrative organizations such as the Bangkok Metropolitan Administration, Pattaya City, provincial administration organizations, municipalities, and Tambon (subdistrict) administration organizations, totalling more than 7,000 nationwide in number, each responsible for a wide variety of health activities according to the intent of the 1997 constitution and other relevant laws.

It is obvious that mechanisms involving health are numerous and different in their missions and they are not under the supervision of the MoPH rather they have to work collaboratively in a pluralistic society. However, the MoPH has to play a key role in coordinating the efforts of all agencies to create synergy and move forward the actions of all subsystems towards the achievement of the common goal of health for all. In this connection, the MoPH has to readjust its role as an operator only for essential activities and promote as well as support other organizations and mechanisms to function as operators to the maximum extent possible.

4. Agencies Implementing Health Programmes

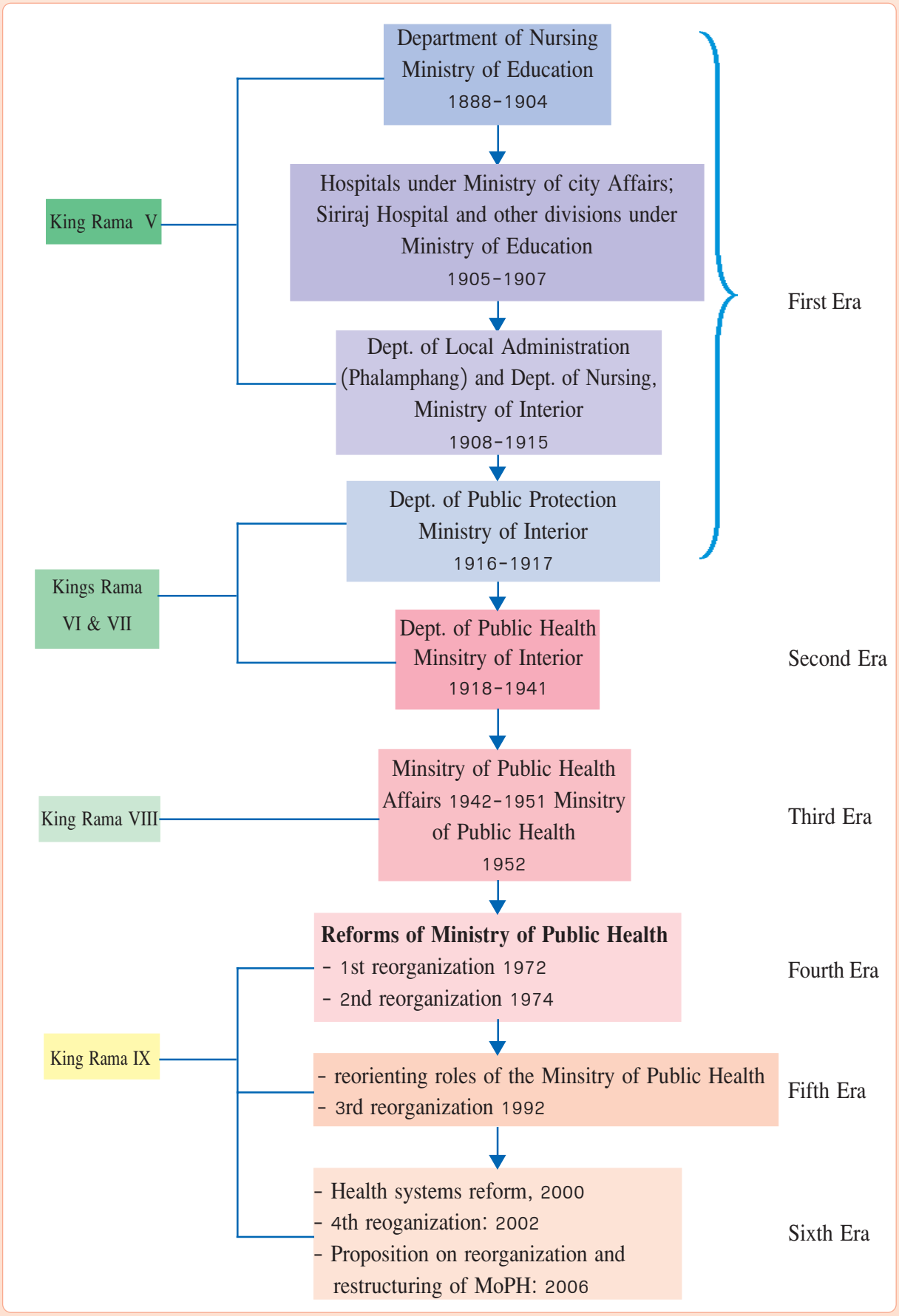
4.1 Ministry of Public Health

The MoPH is the core agency in the Thai public health system that implements health programmes with a budget share of more than 60%, almost all of which for rural health activities throughout the country. It takes the lead in healthcare delivery as well as setting public health policies for the country. Its major developments and administrative system are as follows:

4.1.1 Evaluation of the MoPH, 1888-present and Future Trends

The development of the MoPH began in 1888 when at that time it was the Department of Nursing under the Ministry of Education. It became the Public Health Department under the Department of Interior in 1918, until the establishment of the Ministry of Public Health on 10 March 1942, according to the Reorganization of Ministries, Sub-Ministries and Departments Act (No. 3) of B.E. 2485 (1942). Since then there have been several reorganizations, the first in 1972, the second in 1974, the third in 1992, and the fourth in 2002 with a major revision of roles, missions and structure. In 2006, the MoPH had a review of its roles, responsibilities and organization structure so as to lay down plans and restructure itself for keeping abreast of changing socioeconomic situations at the national and global levels. This is to efficiently improve the health status of Thai people and it is expected that the fifth reorganization/restructuring will be completed in the near future (Figure 7.4).

Figure 7.4 Evolution of the Ministry of Public Health, 1888-present



The Future Trends. The MoPH, especially agencies at the central administration level, will become smaller and serve as a mechanism in setting health policies and strategies, controlling, monitoring and setting standards, and coordinating with all other relevant sectors in society to jointly work on health in a systematic manner. Its roles as implementers will be decreased to perform only essential functions as almost all of the budget for health services delivery has been transferred to the National Health Security Office, which will make payments directly to healthcare facilities (without passing through the MoPH since May 2006). As for provincial administration agencies, provincial and district public health offices will become agencies under the jurisdiction of a provincial juristic person (provincial department) according to the provincial strategy-administration approach as well as the agreement to be developed in line with the national strategy. Regarding health facilities of all categories at all levels, they may be merged as a state juristic entity which is not a government agency, but under the supervision of the MoPH, responsible for providing health services to the people in their designated area, or they may be transferred to be under a local administration organization.

4.1.2 Authority and Administrative Structure of Ministry of Public Health

1) Authority and Mandate of MoPH

The Reorganization of Ministries, Sub-Ministries and Departments Act of B.E. 2545 (2002) provides that **"the Ministry of Public Health has powers and responsibilities related to the promotion of health, prevention/control and treatment of diseases, and rehabilitation of people's health, as well as other official functions as provided by laws which indicate that such functions are under the responsibility of the Ministry of Public Health".**

Its principal purpose is to make **all Thai citizens healthy, physically and mentally, with good quality of life, being able to live a happy life in society and being valuable resources of the country.**

2) Administrative Structure

The administrative structure of the MoPH is divided into two levels: central administration and provincial administration.

(1) **The Central Administration** (Figure 7.5) is composed of 10 agencies: (1) the Office of the Minister, (2) the Office of the Permanent Secretary for Public Health and (3) three clusters with eight departments as follows:

- **Cluster of Medical Services Development**, comprising three departments: Department of Medical Services, Department for Development of Thai Traditional and Alternative Medicine and Department of Mental Health.

- **Cluster of Public Health Development**, comprising two departments: Department of Disease Control and Department of Health.

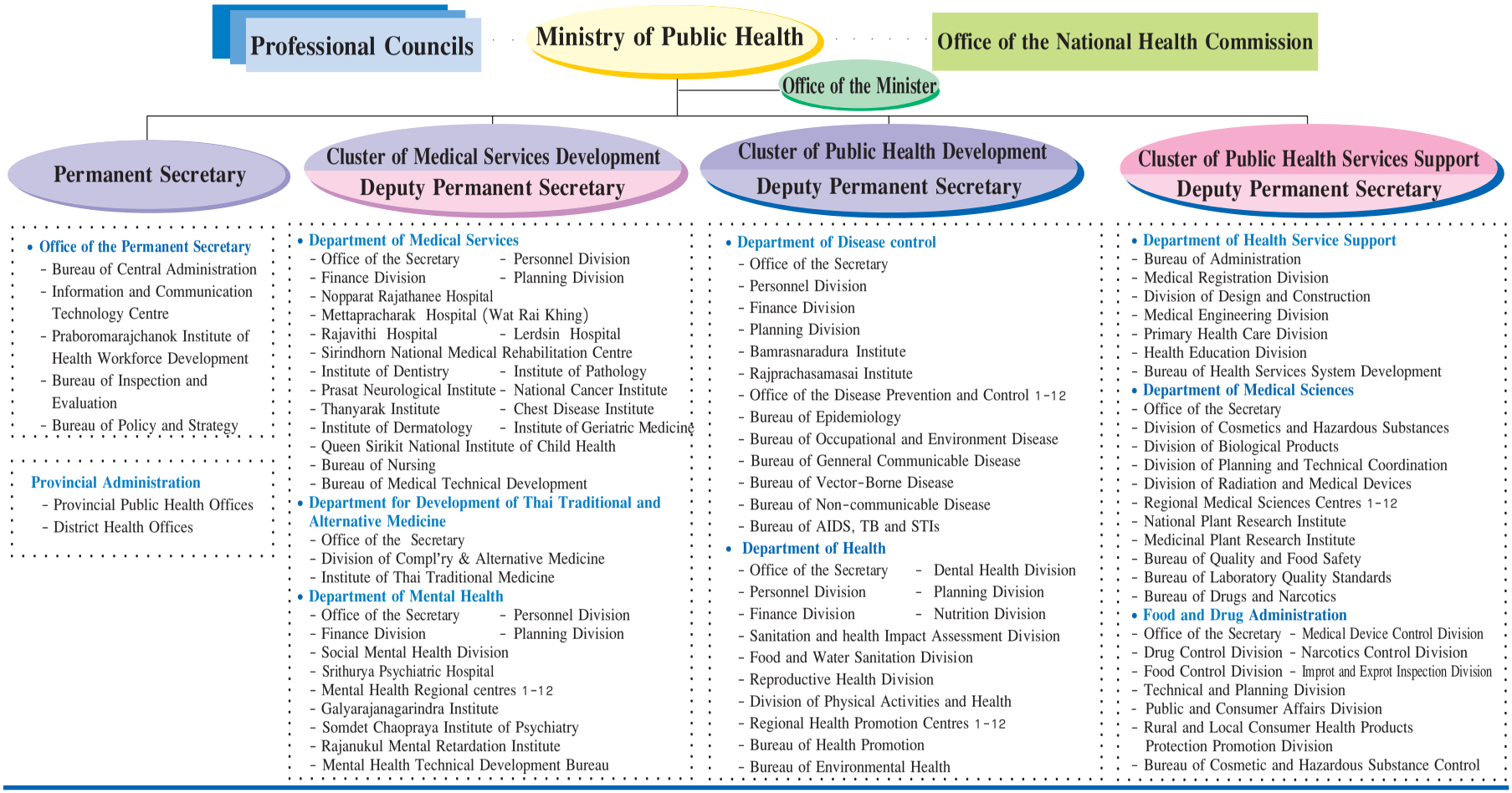
- **Cluster of Public Health Service Support**, comprising three departments: Department of Health Service Support, Department of Medical Sciences, and Food and Drug Administration.

Besides, the MoPH has some other agencies under its supervision, but are not under any of the aforementioned clusters, as follows:

- **Agencies under MoPH's supervision**, totalling six agencies; four of them are in the process of getting their legislations enacted, i.e. Prabromarajchanok Institute (under the Office of the Permanent Secretary), National Institute of Health (under the Department of Medical Sciences), Medical Emergency Services Development Institute, and Institute of Hospital Quality Improvement and Accreditation, and two other agencies that have had their own laws: Health Systems Research Institute and National Health Security Office.
- **State enterprise (1):** Government Pharmaceutical Organization.
- **Public organizations:** According the Public Organization Act of B.E. 2542 (1999), state health facilities (regional/general/community hospitals and health centres) are expected to be converted into public organizations whenever they are ready. At present there is only one hospital, Ban Phaeo Hospital in Samut Sakhon province, which has become a public organization; some more are in the process of getting established.

In 2007, the Office of the National Health Commission was established according to the National Health Act of B.E. 2550 (2007) as a juristic person under the Prime Minister's supervision. Its key role is to coordinate with other state agencies responsible for policy and strategy formulation as well as other health-related public and private agencies in carrying out efforts at the policy, strategy and programme level for health.

Figure 7.5 Organization of Ministry of Public Health



Agencies under the Supervision of MOPH :
- Health system Research Institute
- National Health Security Office
- Praboromarajchanok Institute of Health Workforce
- Development (Act required)
- National Institute of Health (Act required)
- Institute of Emergency Medical Services (Act required)
- Institute of Hospital Quality Improvement and Accreditation (Act required)

State Enterprise:
- Goverment Pharmaceutical organizations

Public organizations (Royal Decrees required)
- Health facilities (Royal Decree enacted for Ban Phaeo Hospital)

Source : *Ministerial Regulations of the Ministry of Public Health, 2002*

Note : *Public organizations and agencies under the supervision of the MOPH are not under any of the clusters.*

3) The Provincial Administration (Figure 7.6)

Public health agencies under the provincial administration are Provincial Public Health Offices, hospitals under the MoPH, District Health Offices, and health centres.

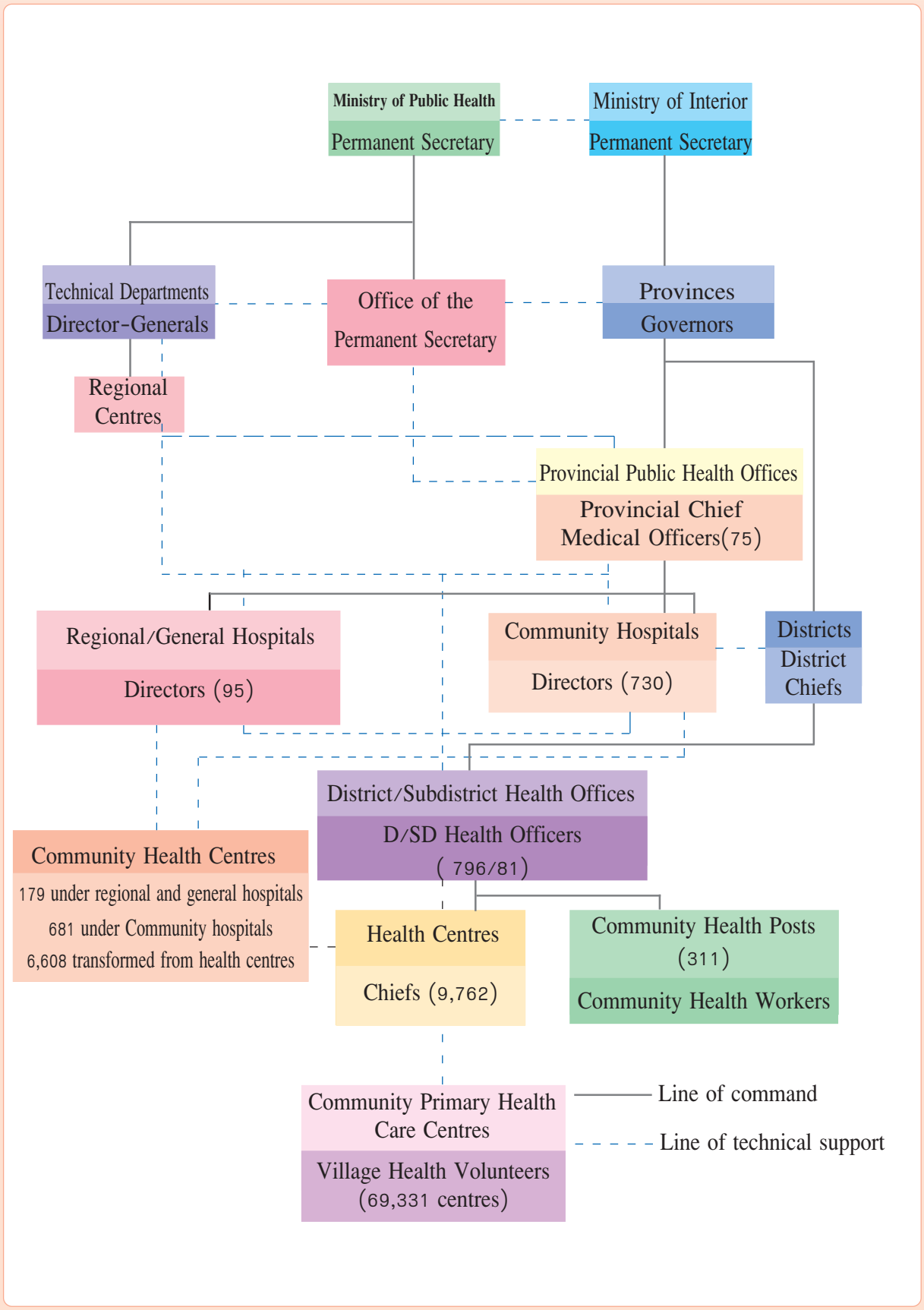
Since FY 2004, the government has changed the role of each provincial governor as chief executive officer (CEO) administering all activities within his/her jurisdiction on an integrated manner, aimed at achieving the state mission for the maximum benefit of the people. Thus, the Provincial Public Health Office in each province, which reports to the provincial governor, has to take part in resolving health problems at the local level, serving as one of the provincial administrators, with technical support from the MoPH.

In implementing the government's policy on universal health care, the MoPH has directed all hospitals and health centres to set up community health centres to take charge of health service delivery in a holistic and integrated manner. This is to continue providing health services to the people and community with the systems for home visits, counselling and referrals.

In 2006, there were 7,515 community (subdistrict) health centres across the country, of which 7,468 were under the MoPH including 179 under regional/general hospitals, 681 under community hospitals, and 6,608 transformed from health centres (67.7% of all 9,762 health centres), and 47 under private sector agencies.

Under the universal coverage of health care scheme, each of the provincial and community hospitals is a "contracting unit of primary care (CUP)" and health centres are supported by hospitals in terms of resources but are still under the supervision of the district health officer.

Figure 7.6 Organogram of Provincial Public Health Administration



4.1.3 Health-related Laws

There are a number of laws relating to health in the form of acts, ministerial regulations, orders and procedures as follows:

1) Acts under the responsibility of the MoPH (4 categories and 37 acts) are listed in Table 7.1.

Table 7.1 Acts under the direct responsibility of the Ministry of Public Health

No.	Act
1	Acts related to health service systems
	1.1 Medical Premises Act, 1998
	1.2 Health Systems Research Institution Act, 1992
	1.3 Thai Traditional Medicine Protection and Promotion Act, 1999
	1.4 Government Pharmaceutical Organization Act, 1966
	1.5 Health Promotion Foundation Act, 2001
	1.6 National Health Security Act, 2002
2	Acts related to disease prevention and control
	2.1 Public Health Act, 1992
	2.2 Communicable Diseases Act, 1980
	2.3 Zoonoses Act, 1982
3	Acts related to consumer protection in health
	3.1 Food Act, 1979
	3.2 Drugs Act, 1967; Amendment No. 2 (1975), No. 3 (1979), No. 4 (1985), and No. 5 (1987)
	3.3 Cosmetics Act, 1992
	3.4 Hazardous Substances Act, 1992
	3.5 Psychoactive Substances Act, 1975; Amendment No. 2 (1985), No. 3 (1992) and No. 4 (2000)
	3.6 Narcotics Act, 1979; Amendment No. 2 (1985), No.3 (1987) and No. 4 (2000)
	3.7 Medical Devices Act, 1988
	3.8 Royal Degree on Prevention of Volatile Substance Use, 1990; Amendment No. 2 (2000)
	3.9 Tobacco Product Control Act, 1992
	3.10 Non-smokers' Health Protection Act, 1992

Table 7.1 Acts under the direct responsibility of the Ministry of Public Health

No.	Act
4	Acts related to health professions 4.1 Medical Registration Act, 1999 4.2 Medical Profession Act, 1982 4.3 Nursing and Midwifery Profession Act, 1985; Amendment No. 2 (1997) 4.4 Pharmaceutical Profession Act, 1994 4.5 Dental Profession Act, 1994

2) Acts that the MoPH is not directly responsible for their implementation, but shares responsibilities with other ministries such as the Office of the Prime Minister and the Ministry of Interior

(1) Cemeteries and Crematoriums Act, 1985
(2) Drug Addicts Rehabilitation Act, 1991
(3) Rehabilitation of Disabled People Act, 1991
(4) Household and City Cleanliness and Orderliness Act, 1992
(5) Trade Secret Act, 2002
(6) The Act Establishing Youth and Family Courts and Trial Procedures for Youth and Family Cases, 1991
(7) National Health Act, 2007

3) Other health-related acts and announcements under other ministries' responsibilities.

(1) The Enhancement and Conservation of National Environmental Quality Act, 1992
(2) The Industrial Works Act, 1992
(3) Social Security Act (No. 2), 1990
(4) Vehicle Accident Victims Protection Act, 1992
(5) Workmen's Compensation Act, 1994
(6) Labour Protection Act, 1998
(7) Elderly People Act, 2003

4.1.4 Programmes/projects of the MoPH

The MoPH implements its programmes and projects under the National Economic and Social Development Plan and the Plan of Action (see details in chapter 3) in accordance with the

policies set by high-level health administrators, such as the Minister of Public Health and the Permanent Secretary for Public Health.

In implementing such programmes/projects, although in an integrated manner by provincial level health agencies, technical and resource support are still provided by central agencies in a vertical manner but with inadequate inter-agency coordination.

4.1.5 Human Resources of the MoPH

In the past 70% of MoPH personnel were civil servants and 30% were permanent employees. Since 1989 the proportion of permanent employees had declined to just 19.4% in 2006; and since 1999 the proportion of civil servants has steadily declined as there have been more and more "state employees". In 2004, the cabinet passed a resolution on 11 May 2004 to convert 27,385 state employees of the MoPH to civil servants, resulting in the increase in the proportion of civil servants to 80.1% in 2006 as shown in Figures 7.7 and 7.8.

In 2006, the MoPH had a staff of 211,891, of which 169,622 (80.1%) were civil servants, 41,074 (19.4%) were permanent employees, and 1,195 (0.5%) were state employees. The Office of the Permanent Secretary had the greatest proportion of personnel, i.e. 89.1% of all MoPH civil servants, 76.4% of all permanent employees, and 51.8% of all state employees; and the Department for Development of Thai Traditional and Alternative Medicine had the smallest (only 0.1% of all MoPH workforce). The Department of Disease Control had a lower proportion of civil servants compared with that of permanent employees (Table 7.2).

And in 2006, the MoPH recruited some state employees on contract so as to create flexibility in accordance with the modern state management procedures; so at present there are altogether 1,195 state employees, most of them are administrative and service support officials (Table 7.3).

Table 7.2 Numbers of civil servants, permanent employees, and state employees of MoPH, 2006

Department	Civil servants		Permanent employees		State employees		Total	
	No.	%	No.	%	No.	%	No.	%
Office of the Permanent Secretary	151,125	89.1 (82.5)	31,393	76.4 (17.1)	619	51.8 (0.3)	183,137	86.4
Department of Medical Services	7,572	4.5 (73.8)	2,582	6.3 (25.1)	112	9.4 (1.1)	10,266	4.8
Department of Health	2,009	1.2 (54.6)	1,621	3.9 (44.1)	48	4.0 (1.3)	3,678	1.7
Department of Disease Control	2,980	1.8 (47.7)	3,013	7.3 (48.2)	252	21.1 (4.0)	6,245	2.9
Department of Medical Sciences	973	0.6 (77.3)	263	0.6 (20.9)	23	1.9 (1.8)	1,259	0.6
Food and Drug Administration	602	0.4 (90.8)	60	0.1 (9.0)	1	0.1 (0.2)	663	0.3
Department of Health Service Support	3,265	1.9 (64.2)	1,712	4.2 (33.7)	109	9.9 (2.1)	5,086	2.4
Department for Development of Thai Traditional and Alternative Medicine	949	0.6 (69.0)	427	1.0 (31.0)	0	0.0 (0.0)	1,376	0.6
	147	0.1 (81.2)	3	0.01 (1.7)	31	2.6 (17.1)	181	0.1
Total	**169,622**	**100.0 (80.1)**	**41,074**	**100.0 (19.4)**	**1,195**	**100.0 (0.5)**	**211,891**	**100.0 (100.0)**

Sources: Personnel divisions/sections of all departments, MoPH, October 2006.

Notes: 1. Figures for civil servants and permanent employees of all departments are based on the numbers of actually filled positions in October 2006.

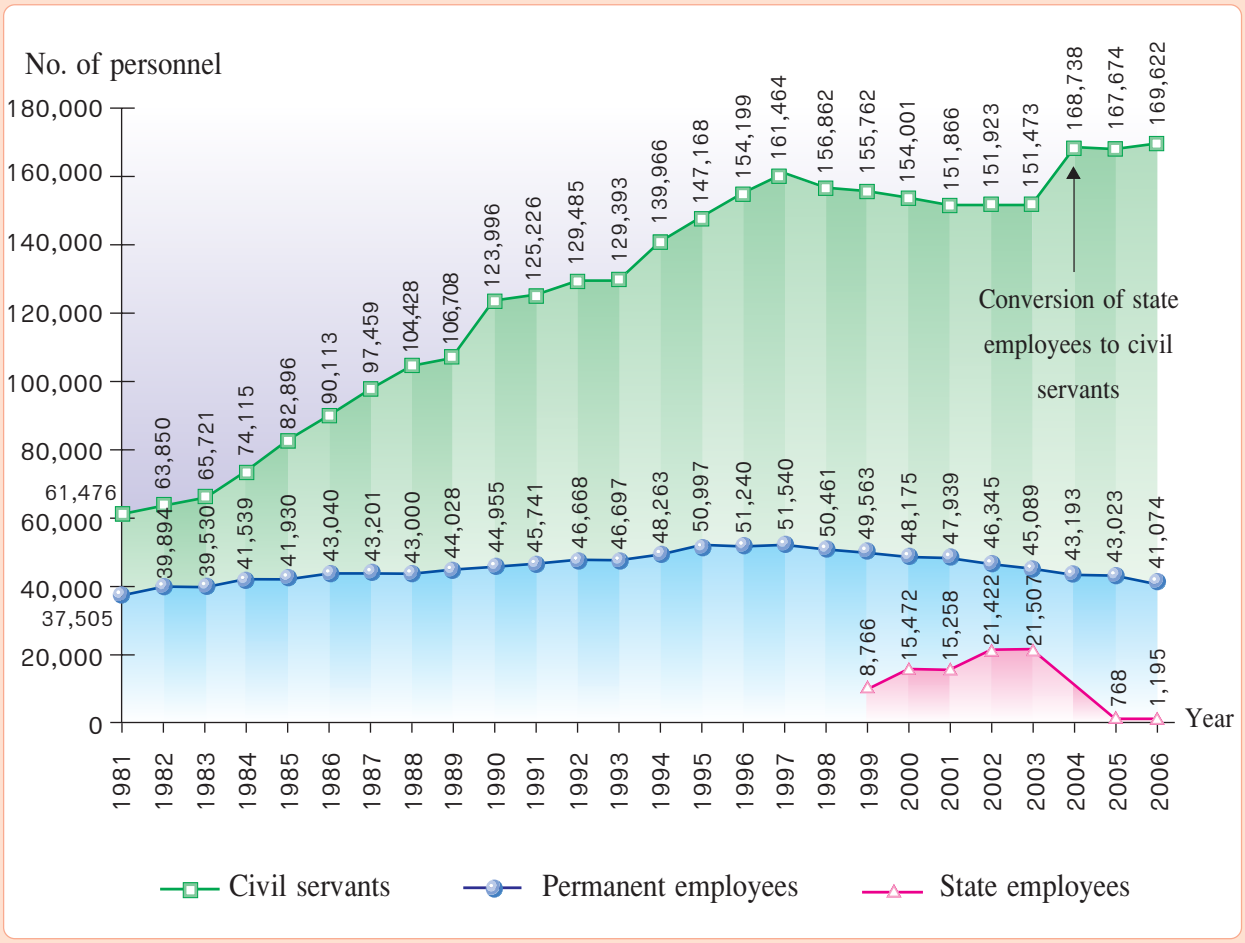
2. Figures in parentheses are percentages of their respective horizontal lines (of their own departmental totals).

Table 7.3 Number of state employees of MoPH by professional category, 2006

Professional category	Number of personnel
1. Financial and accounting specialists/procurement specialists	275
2. Diseases control officers/service support workers	199
3. Statisticians/computer specialists/computer system analysts	152
4. Professional nurses	104
5. Environmental specialists/health technical specialists	73
6. Administrative/financial/procurement/statistical/data recording officials	70
7. Occupational therapists/physical therapists	57
8. Medical technologists	51
9. Policy and plan analysts	43
10. Legal officers/specialists	29
11. Social welfare workers/psychologists	26
12. Personnel officers/human resources development specialists	21
13. Medical science officers	21
14. Foreign relations officers/public relations officers/ communication officers	18
15. General administration officers	17
16. Nutritionists	10
17. Technicians: civil engineering/mechanical/electrical/ electrical communication	10
18. Medical radiologists/medical radiology technicians/x-ray technicians	6
19. Researchers/research assistants	6
20. Librarians/library officials	3
21. Medical photographers/cardiology technologists	2
22. Pharmacists	2
Total	**1,195**

Source: Personnel divisions/sections of all departments, MoPH.

Figure 7.7 Numbers of civil servants, permanent employees, and state employees of MoPH, fiscal years 1981-2006

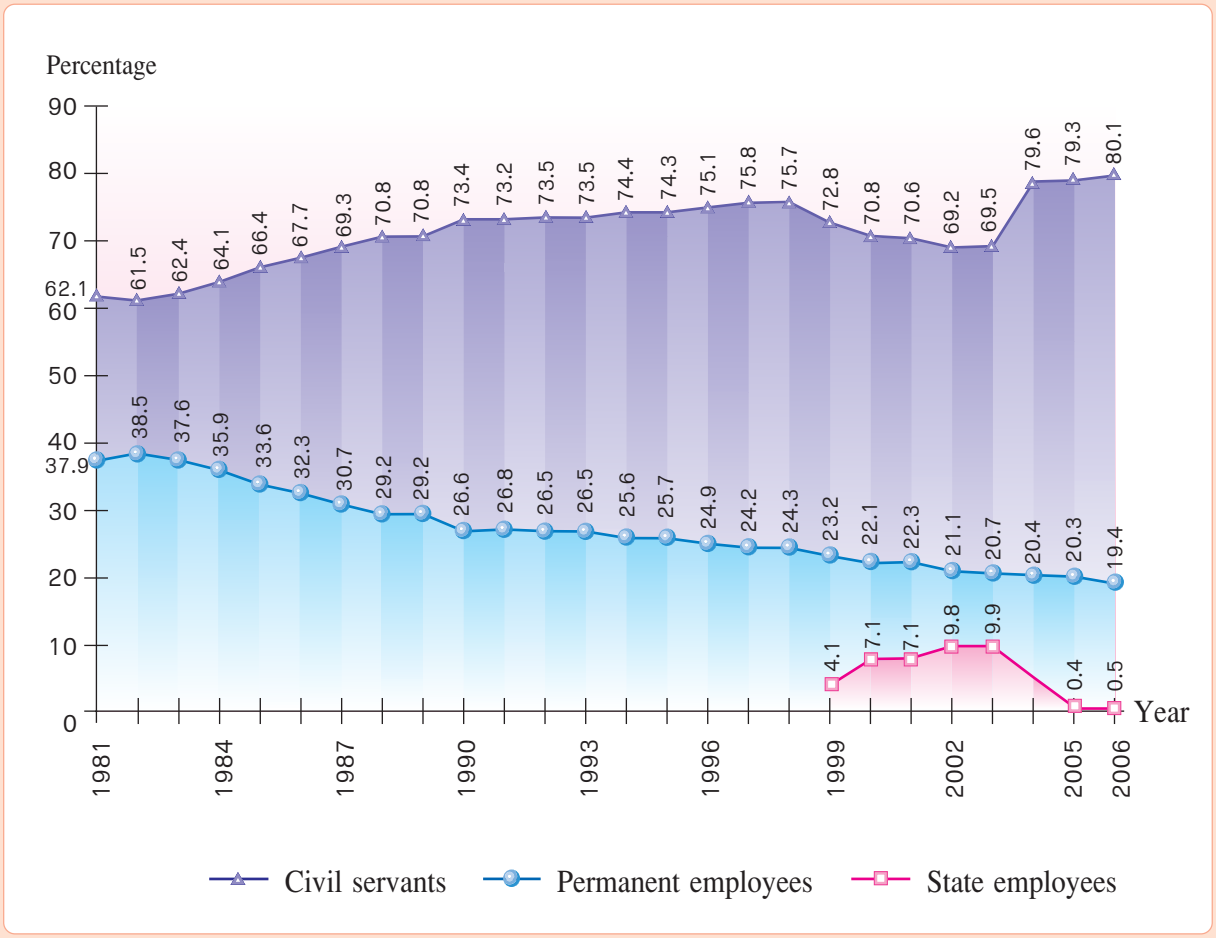


Sources: Data for 1981-1997 are derived from HEALTH DIARY of the National Health Association of Thailand.

Data for 1998-2006 are derived from personnel divisions/sections of all departments, MoPH.

Notes:
1. For 1998 onwards, the data represent actually filled positions.
2. Since 2004, MoPH has converted all state employees to civil servants.
3. Since 2005, MoPH has used a dual employment system, i.e. for state employees and civil servants.

Figure 7.8 Proportions of civil servants, permanent employees, and state employees of MoPH, fiscal years 1981-2006



Sources: Data for 1981-1997 are derived from HEALTH DIARY of the National Health Association of Thailand.

Data for 1998-2006 are derived from personnel divisions/sections of all departments, MoPH.

Notes:

1. For 1998 onwards, the data represent actually filled positions.
2. Since 2004, MoPH has asserted all state employees to civil servants.
3. Since 2005, MoPH has used a dual employment system, i.e. for state employees and civil servants.

The workforce of the MoPH classified by major group/profession includes 169,622 actually filled positions (2006) in 29 groups, excluding permanent employees and state employees (Table 7.4).

Table 7.4 Workforce of the MoPH (excluding permanent employees and state employees) by major group/profession: number and proportion of actually filled positions, 2006

Group/Professional category	Civil servants	
	No.	%
1. Professional nurses	69,142	40.8
2. Technical nurses	13,495	8.0
3. Community health officers	13,030	7.7
4. Health technical specialists	14,772	8.7
5. Health administration officers	9,555	5.6
6. Medical doctors	11,571	6.8
7. Correspondence, finance, logistics, statistics, data recording, computer, and typing officers	5,936	3.5
8. Pharmacists	5,767	3.4
9. Dental nurses, dental assistants, and dental health officers	4,311	2.5
10. Pharmaceutical assistants/officers	3,184	1.9
11. Medical science technicians	3,074	1.8
12. Dentists	2,884	1.7
13. X-ray/medical radiation officers	1,545	0.9
14. General administration officers	1,404	0.8
15. Medical technologists	1,148	0.7
16. Statisticians and computer specialists	1,067	0.6
17. Civil-works, electrical, and telecommunication engineers/technicians	831	0.5
18. Medical scientists and scientists	744	0.4
19. Policy and plan analysts	659	0.4
20. Physiotherapy and medical rehabilitation officers	596	0.3
21. Disease control officers	532	0.3
22. Social workers and psychologists	572	0.3
23. Personnel officers, training officers, professional registration officers, and human resource development specialists	465	0.3
24. Nutritionists	450	0.3
25. Public relations, information, audio-visual aid, communication, and library officers	425	0.3
26. Physiotherapists	429	0.3

Table 7.4

Group/Professional category	Civil servants	
	No.	%
27. Medical radiation specialists and medical physicists	289	0.2
28. Lecturers	190	0.1
29. Others	1,555	0.9
Total	**169,622**	**100.0**

Source: Personnel Divisions of all Departments of the Ministry of Public Health, October 2006.

Note: Major staffing patterns were re-designed and professionals re-categorized in 2002 according to the MoPH restructuring as part of the bureaucratic reforms, resulting in a decrease in the number of professional categories: the positions for health promotion specialists, disease control specialists, sanitation specialists and health education specialists were abolished, but the positions for health technical specialists have been established instead, for more flexibility in the process of transfer and assessment for taking such positions.

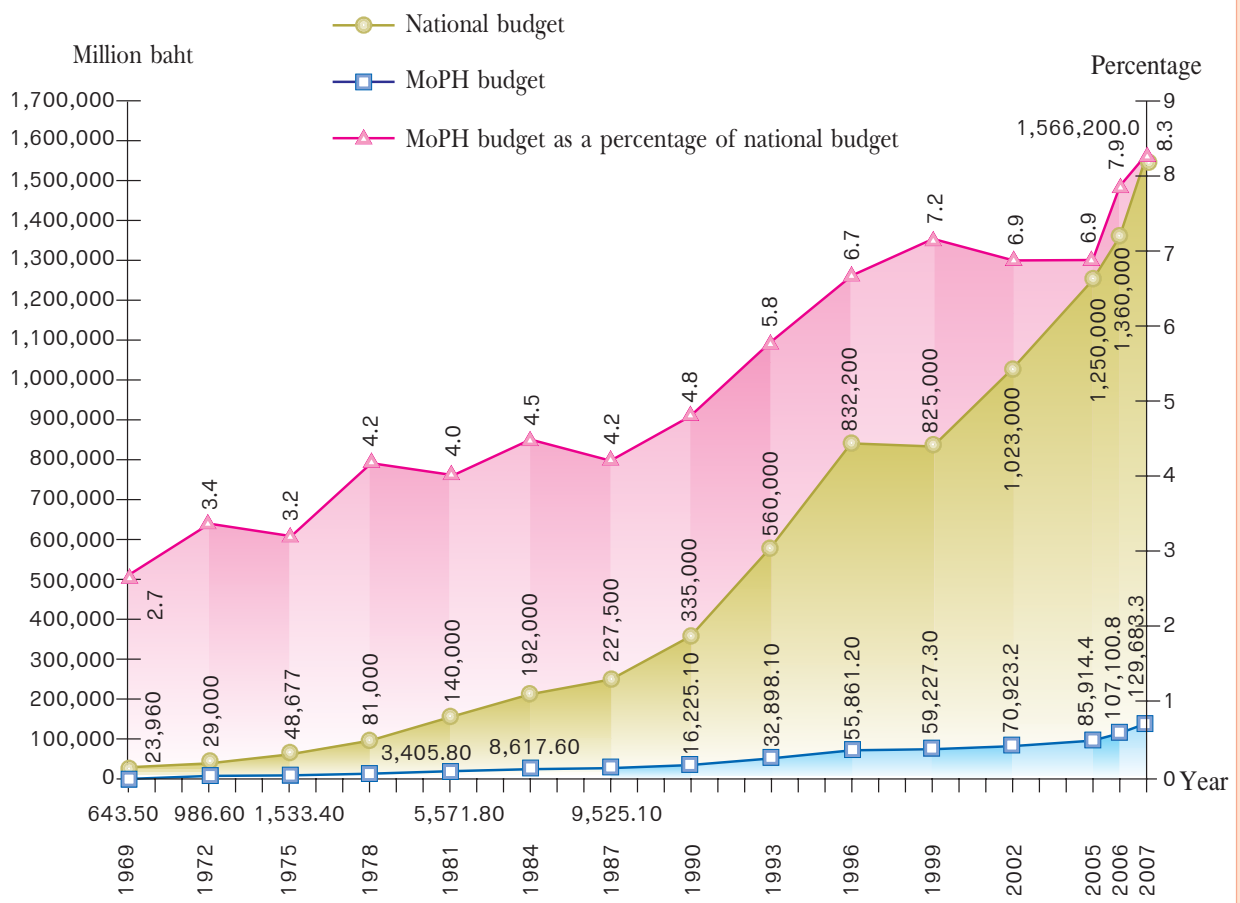
4.1.6 The Budget of the Ministry of Public Health

1) Proportion of the Budget

The proportion of annual budget allocated to the MoPH was 2.7-8.3% of the national budget during 1969-2007 (Figure 7.9) or approximately 0.4-1.4% of the gross domestic product (GDP). It can be noted that the MoPH's budget has increased significantly during the past decade, as the government has allocated more budget to the social service sector, due to a decrease in foreign debt repayments and security expenditure. Since the economic crisis in 1997, the foreign debts have increased from 5.0% in 1997 to 11.3% in 2007 (Figure 7.11). The proportion of MoPH's annual budget had declined until 2001. But since FY 2002, its annual budget has increased substantially as a result of the government policy on universal coverage of health care (Figure 7.10). In FY 2007, the budget is 62,319 million baht plus a health insurance revolving fund of 67,364 million baht, totalling 129,683.3 million baht, or 8.3% of the national budget (Figure 7.9).

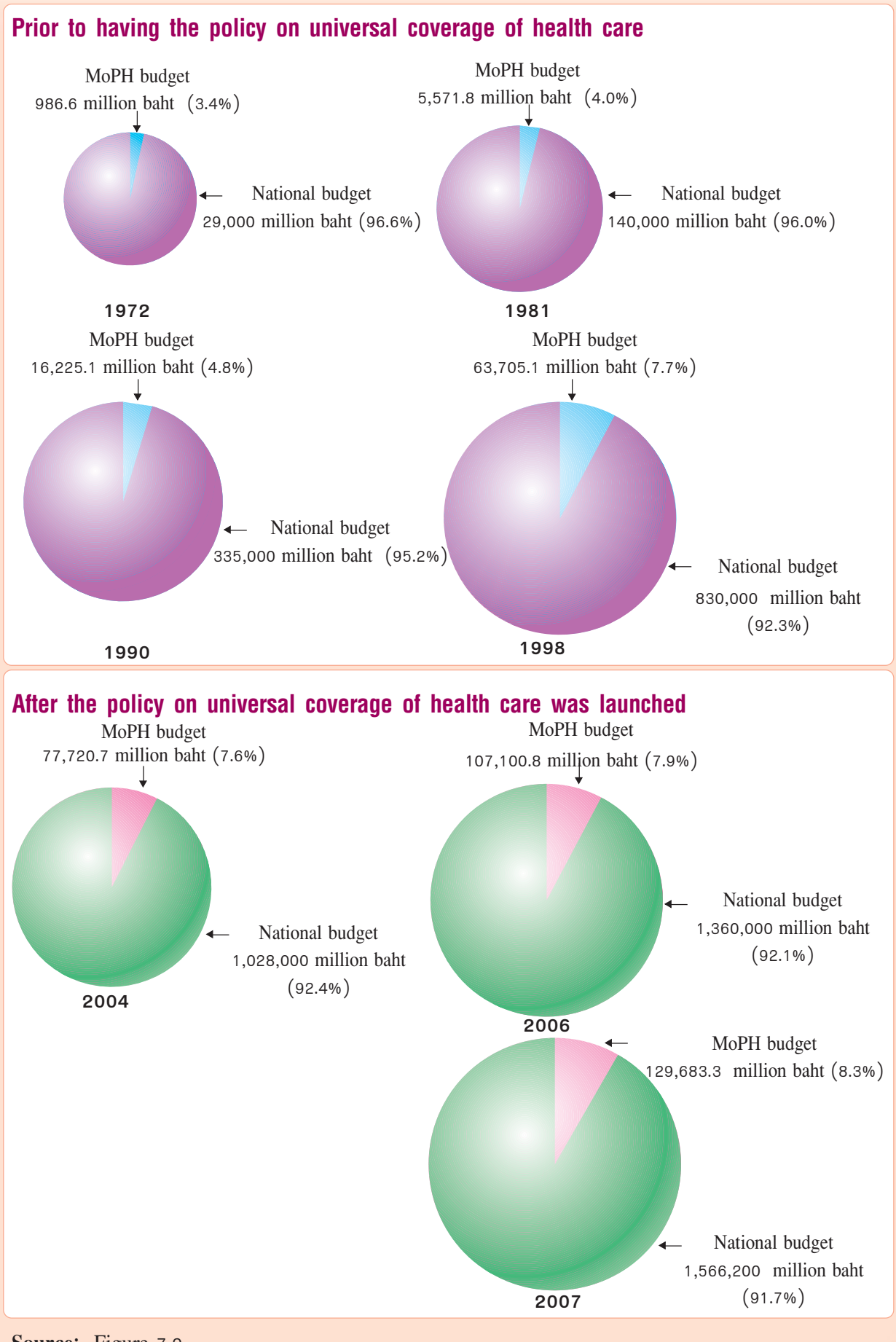
In real terms, the value of the budget for the post-economic crisis period (1998-2001) was less than that for 1996. It is noteworthy that there were large amounts of foreign loans during 1997-2001. But since the launching of the universal healthcare scheme in 2002, the value of the budget for 2002-2007 is 1.1-1.7 times higher than that for 1996 (Table 7.5).

Figure 7.9 Amounts and proportions of MoPH's budget compared with the national budget (present value), FYs 1969-2007



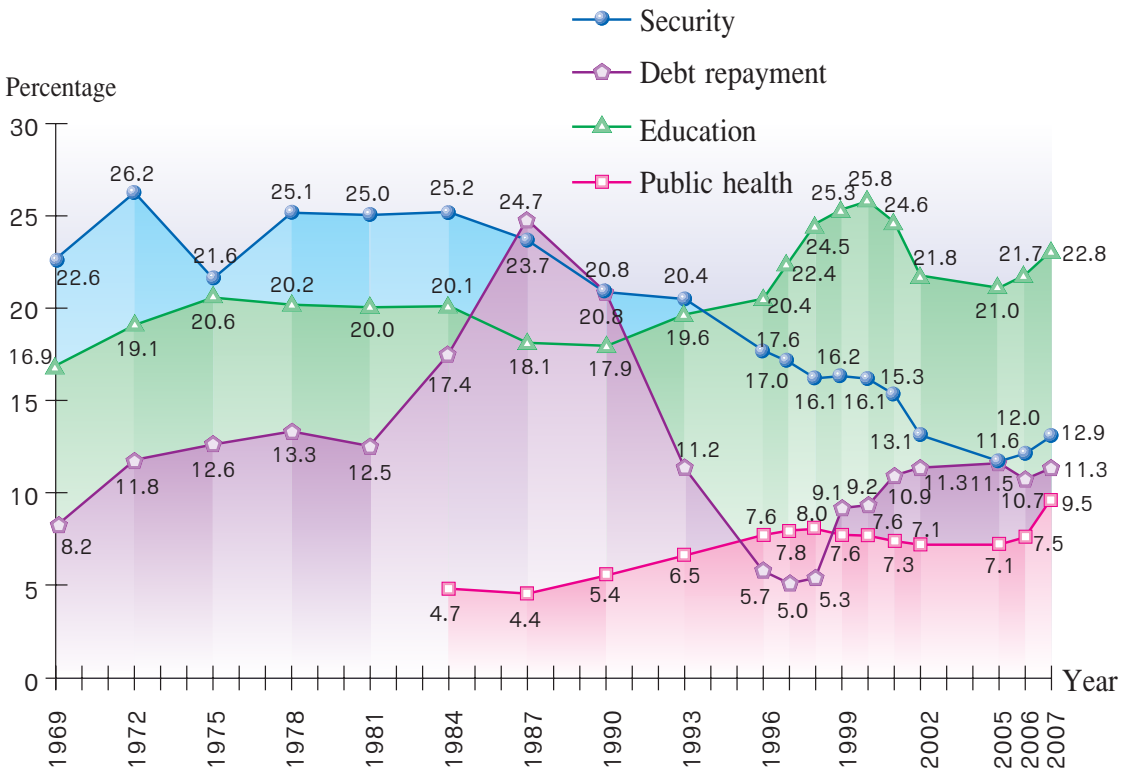
Sources: - Bureau of Policy and Strategy, Ministry of Public Health.
- Bureau of the Budget.

Figure 7.10 MoPH's budget compared with the national budget (baht)



Source: Figure 7.9

Figure 7.11 Proportions of security, debt repayment, education and public health budget, compared with the national budget, FYs 1969-2007



Source: Bureau of the Budget.

Note: There were no health budget data available for 1969-1981, as the health budget was included in the community social welfare service budget.

Table 7.5 MoPH's budget in present value and real terms (million baht)

Year	MoPH budget	Health insurance revolving fund	Total MoPH budget (present value)	Consumer price index (1994 = 100)	Budget at 2007 value	Increase/ decrease from previous year (2007 value)	As percentage of national budget
1992	24,640	-	24,640	92.1	40,960	-	-
1993	32,898	-	32,898	95.2	52,906	+29.2	5.8
1994	39,319	-	39,319	100.0	60,197	+13.8	6.3
1995	45,103	730	45,833	105.7	66,386	+10.3	6.4
1996	55,236	625	55,861	112.0	76,360	+15.0	6.7
1997	66,544	1,030	67,574	118.2	87,526	+14.6	7.3
			(68,934)		89,288	(+16.9)	(7.4)
1998	62,625	1,080	63,705	127.8	76,316	-12.8	7.7
			(65,065)		77,946	(-12.7)	(7.8)
1999	57,171	2,056	59,227	128.1	70,786	-7.2	7.2
			(62,787)		75,041	(-3.7)	(7.6)
2000	58,426	2,215	60,641	130.2	71,307	+0.7	7.1
			(63,001)		74,082	(-1.3)	(7.3)
2001	58,697	2,400	61,097	132.4	70,649	-0.9	6.7
			(61,563)		71,188	(-3.9)	(6.8)
2002	43,311	27,612	70,923	133.2	81,519	+15.4	6.9
2003	41,996	32,138	74,134	135.6	83,701	+2.7	7.4
2004	45,147	32,573	77,720	139.3	85,419	+2.1	7.6
2005	45,024	40,890	85,914	145.5	90,402	+5.8	6.9
2006	52,672	54,429	107,101	152.3	107,664	+19.1	7.9
2007	62,319	67,364	129,683	153.1[(1)]	129,683	+20.5	8.3

Source: Bureau of Policy and Strategy, Ministry of Public Health.

Notes:
1. MoPH's budget figures have included the budget of other agencies under MoPH's supervision, i.e. Health Systems Research Institute and National Health Security Office.
2. The numbers in ( ) include foreign loans for health programmes in 1997-2001: from Sweden, Denmark, OECF, The World Bank, Asian Development Bank and Japan (Miyazawa Plan) in 1997 for 1,360 million baht; in 1998 for 1,360 million baht; in 1999 for 3,560 million baht; in 2000 for 2,360 million baht; and in 2001 for 466 million baht.
3. For FYs 1995-2001, the MoPH received a supplementary budget for health insurance cards called "health insurance card revolving funds", which were previously included the MoPH's budget.
4. Since FY 2002, the MoPH has received a budget as "health insurance revolving fund" in stead of "health insurance card revolving fund"; the MOPH continued to administer the revolving fund of the National Health Security Office for the first three years after the National Health Security Act came into force.
5. [(1)]Consumer price index as of February 2007.
6. The health insurance revolving fund does not include personnel and operating costs.

2) Budget Allocation by Department

In considering the budget allocation for each department, it was found that in 2006 the National Health Security Office (including the health security revolving fund) received the largest amount of budget (52.5%), followed by the Office of the Permanent Secretary for Public Health (37.9%, including salaries for civil servants and employees, which are part of the universal healthcare budget), and the Department for Development of Thai Traditional and Alternative Medicine received the least (0.1%) (Table 7.6 and Figure 7.12).

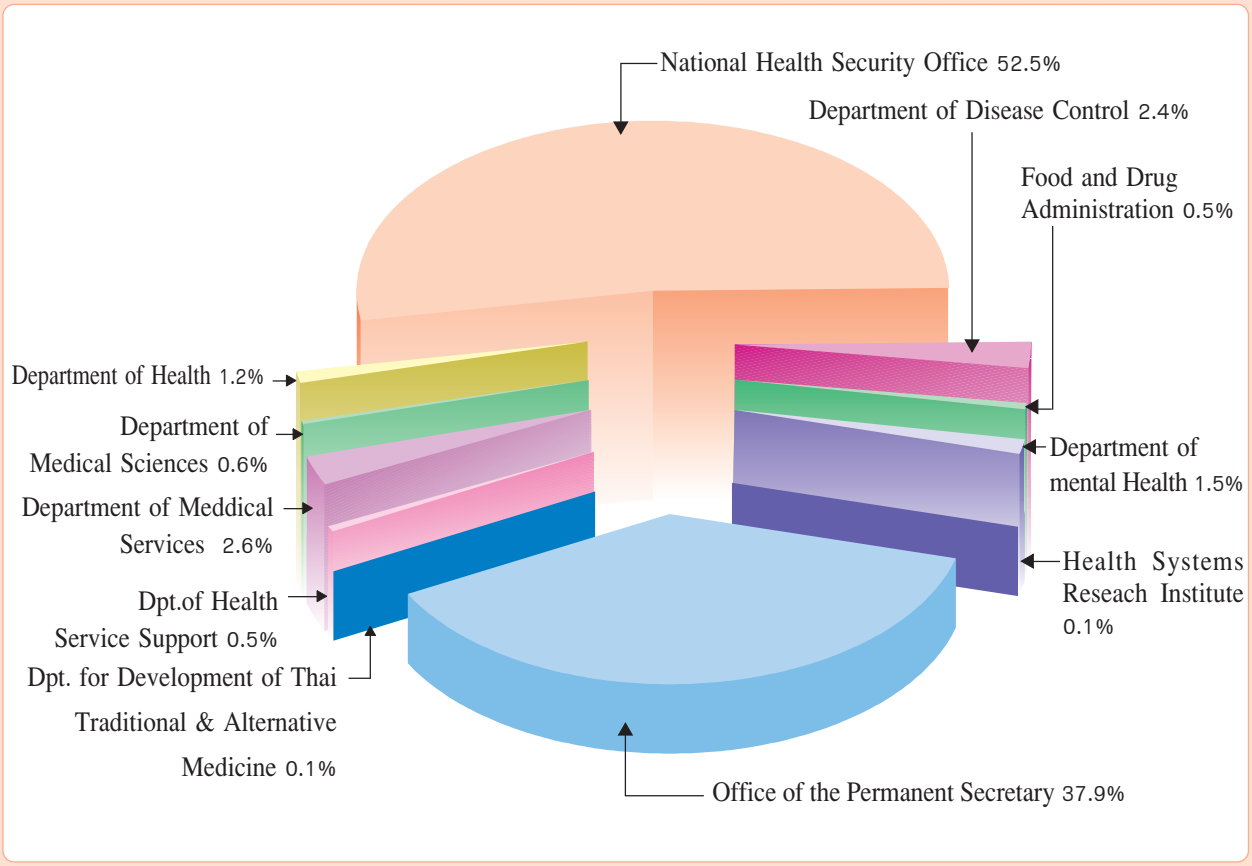
Table 7.6 The bubget of the Ministry of Public Health, 2000-2007

Department	Budget received (Million baht)															
	2000	2001		2002		2003		2004		2005		2006		2007		
	Amount	Amount	Increase/ Decrease from 2000(%)	Amount	Increase/ Decrease from 2001(%)	Amount	Increase/ Decrease from 2002(%)	Amount	Increase/ Decrease from 2003(%)	Amount	Increase/ Decrease from 2004(%)	Amount	Increase/ Decrease from 2005(%)	Amount	Increase/ Decrease from 2006(%)	Proportion (%)
- Whole country	**860,000.0**	**910,000.0**	**+5.8**	**1,023,000.0**	**+12.4**	**999,900.0**	**-2.3**	**1,028,000.0**	**+2.8**	**1,250,000.0**	**+21.6**	**1,360,000.0**	**+8.8**	**1,566,200.0**	**+15.2**	**-**
- MoPH	**60,640.9**	**61,097.2**	**+0.8**	**70,923.2**	**+16.1**	**74,133.9**	**+4.5**	**77,720.7**	**+4.8**	**85,914.4**	**+10.5**	**107,100.8**	**+24.8**	**129,683.3**	**+21.1**	**-**
- Office of the Permanent Secretary	46,487.4	46,691.6	+0.4	29,802.0	-36.2	28,978.7	-2.8	32,177.5	+11.0	32,096.6	-0.3	41,016.8	+27.8	49,115.0	+19.7	37.9
- Departmebt of Medical Services	3,083.7	3,189.3	+3.4	2,556.7	-19.8	2,490.4	-2.6	2,664.7	+7.0	2,721.6	+2.1	2,937.9	+7.9	3,421.8	+16.5	2.6
- Departmebt of Disease control	4,185.4	4,501.4	+7.6	3,670.1	-18.5	3,635.6	-0.9	4,081.5	+12.3	4,048.7	-0.8	2,736.3	-32.4	3,133.2	+14.5	2.4
- Departmebt of Health	4,073.8	3,755.2	-7.8	2,708.5	-27.9	1,185.6	-56.2	1,340.8	+13.1	1,361.2	+1.5	1,366.7	+0.4	1,559.5	+14.1	1.2
- Departmebt of Mental Health	1,478.5	1,628.3	+10.1	1,591.7	-2.2	1,553.2	-2.4	1,623.4	+4.5	1,721.7	+6.1	1,659.7	-3.6	1,888.6	+13.8	1.5
- Departmebt of Health Service Support	-	-	-	-	-	1,125.6	0.0	587.4	-47.8	597.8	+1.8	593.4	-0.7	651.3	+9.8	0.5
- Departmebt of Medical Sciences	815.9	804.5	-1.4	782.3	-2.8	747.3	-4.5	927.2	+24.1	973.1	+4.9	891.2	-8.4	838.2	-5.9	0.6
- Departmebt for Development of Thai Traditional and Alternative Medicine	-	-	-	-	-	73.7	0.0	120.1	+63.0	113.0	-5.9	113.1	+0.08	134.1	+18.6	0.1
- Food and Drug Administration	451.1	454.0	+0.6	464.0	+2.2	495.5	+6.8	507.1	+2.3	667.1	+31.6	613.1	-8.1	627.0	+2.3	0.5
- Health system Research Institute	65.1	72.9	+12.0	138.4	+89.8	109.9	-20.6	96.9	-11.8	88.7	-8.5	79.0	-10.9	99.4	+25.8	0.1
- National Health Security Office	-	-	-	1,597.4	-	1,600.0	+0.2	1,021.3	-36.2	625.0	-38.8	644.9	+3.2	810.9	+25.7	0.6
- Health Insurance Revolving Fund	-	-	-	27,612.0	-	32,138.5	+16.4	32,572.8	+1.4	40,889.9	+25.5	54,428.6	+33.4	67,364.1	+23.8	51.9
- Thai Traditional Medicine Wisdom Fund	-	-	-	-	-	-	-	-	-	10.0	0.0	20.00	+100.0	40.0	+100.0	0.03

Source: 1. Bureau of Policy and Strategy, Ministry of Public Health.
2. National Health Security Office.

Note: 1. For 1997-2001, the budget for the Office of the Permanent Secretary included the health insurance card subsidies.
2. For 2002-2006, the budget for the Office of the Permanent Secretary included salaries and wages were part of the universal health care budget.
3. The Department of Health Service Support and the Department for Development of Thai Traditional and Alternative Medicine, newly established agencies, according to the bureaucratic reform policy, have received their own budget since FY 2003.
4. The National Health Security Office, another newly established agency under the supervision of the MoPH, has received its own budget since FY 2002.

Figure 7.12 Proportion of MoPH's budget by agency, 2007



Source: Table 7.6.

Note: 1. The budget of the National Health Security Office includes the budget for the Health Insurance Revolving Fund.

2. For the Department for Development of Thai Traditional and Alternative Medicine, the budget has included that for the Thai Traditional Medicine Wisdom Fund.

3) Budget Allocation by Programme

MoPH's budget for 2002-2007 has been allocated for the implementation of nine major programmes (Table 7.7). It should be noted that the universal healthcare scheme is implemented in accordance with the policy of the present government. Thus, its budget has been increased in a much higher rate while those for other programmes tend to receive a smaller or constant budget (Figure 7.13).

Table 7.7 Health budget allocation by major programme, 2002-2007 (in million baht)

Type of programme	2002	2003		2004		2005		2006		2007		Proportion (%)
	Amount	Amount	Increase/ Decrease from 2002	Amount	Increase/ Decrease from 2003	Amount	Increase/ Decrease from 2004	Amount	Increase/ Decrease from 2005	Amount	Increase/ Decrease from 2006	
1. Universal health security	53,022.9	57,697.2	+8.8	60,431.2	+4.7	68,207.6	+12.9	78,535.7	+15.3	86,594.5	+10.3	66.8
2. Disease prevention/control and health promotion	7,619.9	6,292.0 [1]	NA	4,951.2 [2]	NA	2,968.4[3]	NA	2,944.0[3]	-0.7	3,584.7	+21.8	2.8
3. Health system development	1,519.6	1,674.0	+10.2	2,474.5	NA	3,292.2	+33.0	3,235.6	-1.7	4,026.5	+24.4	3.1
4. Support for the production and development of personnel	1,501.5	1,464.6	-2.4	1,495.9	+2.1	1,647.9	+10.2	1,919.3	+16.5	2,426.9	+26.4	1.9
5. Development of standards and quality health services and products	812.9	819.6	+0.8	1,085.0	+32.4	1,446.9	+33.3	1,513.1	+4.6	1,632.1	+7.9	1.3
6. AIDS prevention and control	698.7	885.1	+26.7	1,355.1	+53.1	1,321.5	-2.5	3,087.4[4]	+133.6	4,073.4	+31.9	3.1
7. Drug abuse prevention and resolution	524.7	538.2	+2.6	1,100.1	+104.4	842.1	-23.5	483.1	-42.6	526.5	+9.0	0.4
8. Thai traditional and alternative medicine	39.1	73.7	+88.5	120.1	+63.0	122.9	+2.3	126.9	+3.2	195.5	+54.1	0.2
9. Medicine rehabilitation services for patients and the disabled	65.7	79.5	+21.0	82.1	+3.3	87.1	+6.1	93.8	+7.7	120.4	+28.4	0.0001

Source : Bureau of Policy and Strategy, Ministry of Public Health.

Notes :

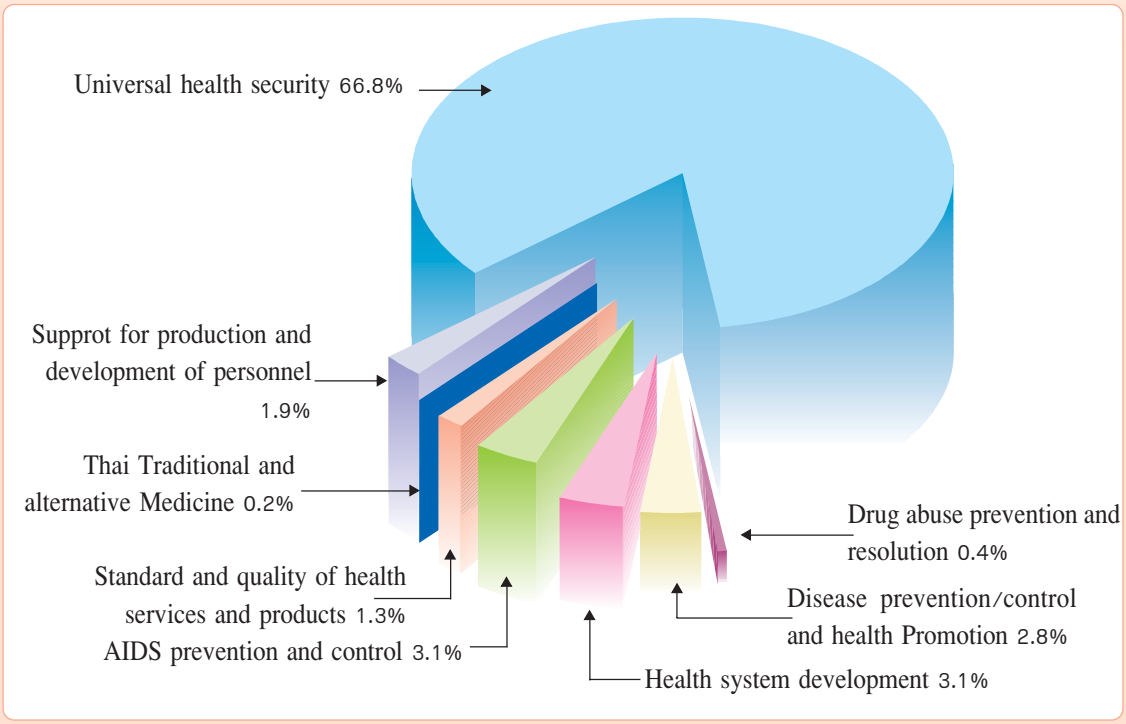
[1] For FY 2003, budget for the diesase prevention/control and health promotion was decreased as the Department of Health had transferred its programmes on environmental surveillance and analysis and water supply provision to the Ministry of Natural Resources and Environment, according to the bureaucratic reform policy

[2] Since FY 2004. budget for the disease prevention/control and health promotion has been decreased as the Department of Health has revised its role and thus the budget for such purpose has been shifted to the health system development programme.

[3] Since FY 2005, the budget for disease prevention/control of the Departments of Mental Health and Medical Services has been shifted to tertiary/specialty service programme; so their budget for such purpose has decreased.

[4] In 2006, the budget for antiretroviral drugs was 2,798 million baht and in 2007 it is 3,855.6 million baht; so the budget in HIV/AIDS programme has increased considerably.

Figure 7.13 Proportion of MoPH budget by major programme, 2007



Source: Bureau of Policy and Strategy, Ministry of Public Health.

4) Budget Allocation by Type of Expenditure

A large proportion of the budget of the Ministry of Public Health (31-53%) is used for staff salaries and wages and 28-50% for operating costs, which have been rising to more than 50% since 2002. The proportion of investment budget has changed considerably according to the economic conditions (by 11-39%; Table 7.8). And since 2002, despite the economic recovery, the government still maintains a low level of investment budget as it has implemented the universal healthcare scheme with a much higher budget for this purpose.

During the first economic crisis (1983-1986), the investment budget decreased from 22.1% in 1982 to 11.3% in 1987 (Figure 7.15). However, during the economic expansion in 1988-1996, the investment budget rose to 38.7% in 1997 but dropped again during the 1997 economic crisis to only 8.8% in 2001 and 6.8% in 2007. Consequently, new construction projects are almost none at present.

Notably, although the MoPH was allocated a much less budget during the economic crisis (Table 7.5), the MoPH still gives high priority to the budget allocation for helping the poor and underprivileged. The budget for such purposes has actually increased to the level higher than before (Table 7.9 and Figure 7.14). Between 2002 and 2007, the government continues to support such programmes, but in the form of health insurance revolving fund (capitation payment) covering a population of 46 million who have never had any other health insurance coverage. The annual capitation rates are 1,202.4 baht for 2002 and 2003, 1,308.5 baht for 2004, 1,396.30 baht for 2005, 1,659.2 baht for 2006, and 1,899.69 baht for 2007.

Table 7.8 Budget received by the Ministry of Public Health, FYs 1998-2007 (present value: amount in million baht)

Category of budget	1998		1999		2000		2001		2002		2003		2004		2005		2006		2007	
	Amount	(%)	Amount	(%)	Amount	(%)	Amount	(%)	Amount	(%)	Amount	(%)	Amount	(%)	Amount	(%)	Amount	(%)	Amount	(%)
1. Salaries and wages	**24,503.3**	**38.5**	**26,407.5**	**44.6**	**28,355.8**	**46.8**	**28,807.6**	**47.2**	**29,532.3**	**41.7**	**33,035.0**	**44.6**	**34,664.7**	**44.6**	**34,818.1**	**40.5**	**42,908.7**	**40.1**	**47,518.7**	**36.6**
1.1 Salaries and permanent wages	24,458.0	38.4	26,361.6	44.5	28,310.0	46.7	28,757.0	47.1	29,489.2	41.6	32,991.3	44.5	34,620.4	44.5	34,770.9	40.5	42,769.8	40.0	47,314.6	36.5
1.2 Temporary wages	45.3	0.1	45.9	0.1	45.8	0.1	50.6	0.1	43.1	0.1	43.7	0.1	44.3	0.1	47.2	0.1	138.9	0.1	204.1	0.1
2. Operating budget	**21,794.2**	**34.2**	**23,825.7**	**40.2**	**25,304.1**	**41.7**	**26,910.6**	**44.0**	**35,786.5**	**50.4**	**37,780.6**	**51.0**	**37,864.8**	**48.7**	**46,224.4**	**53.8**	**56,376.0**	**52.6**	**73,330.7**	**56.6**
2.1 Compensation supplies and miscellaneous	9,927.9	15.6	9,491.6	16.0	9,755.3	16.1	9,728.1	15.9	4,403.5	6.2	5,667.1	7.6	6,607.7	8.5	6,448.9	7.5	5,523.1	5.2	7,848.2	6.1
2.2 Public utilities	843.6	1.3	811.2	1.4	851.8	1.4	848.0	1.4	325.0	0.4	317.0	0.4	309.0	0.4	411.7	0.5	368.7	0.3	384.2	0.3
2.3 Subsidies	10,360.0	16.3	12,773.2	21.5	13,606.0	22.4	14,171.5	23.2	3,964..7	5.6	3,166.4	4.4	2,275.4	2.9	2,014.3	2.3	2,107.0	1.9	2,740.8	2.1
2.4 Other expenses	662.7	1.0	749.7	1.3	1,091.0	1.8	2,163.0	3.5	27,093.3	38.2	28,630.1	38.6	28,672.7	36.9	37,349.5	43.4	48,377.2	45.2	62,357.5	48.1
3. Investment budget																				
3.1 Equipment land and construction	17,407.6	27.3	8,994.1	15.2	6,981.0	11.5	5,379.0	8.8	5,604.3	7.9	3,318.3	4.4	5,191.2	6.7	4,871.8	5.6	7,816.1	7.3	8,833.8	6.8
Total	**63,705.1**	**100.0**	**59,227.3**	**100.0**	**60,640.9**	**100.0**	**61,097.2**	**100.0**	**70,923.2**	**100.0**	**74,133.9**	**100.0**	**77,720.7**	**100.0**	**85,914.3**	**100.0**	**107,100.8**	**100.0**	**129,683.2**	**100.0**

Source : Bureau of policy and Strategy, Ministry of Public Health.

Notes :

1. For FYs 1997-2001, subsidies include health insurance card counterpart funds: 1,030 million baht for 1997;1,080 million baht for 1998 2,056 million baht for 1999; 2,215 baht for 2000; and 2,400 million baht for 2001.
2. For FYs 2002-2006, other expenses include health insurance revolving funds less the investment budget for the National Health Security Office, which is 24,183.2 million baht for 2002; 28,608.8 million baht for 2003;28,652.4 million baht for 2004;37,286.3 million baht for 2005;48,296.4 million baht for 2006; and 60,717.8 million baht for 2007.
3. For FYs 2002-2007, MoPH's investment budget include the investment of the National Health Security Office, which is3,428.8 million baht for 2002; 1,929.6 million baht for 2003; 3,920.4 million baht for 2004; 3,603.7 million baht for 2005; 6,132.2 million baht for 2006; and 6,646.3 million baht for 2007.

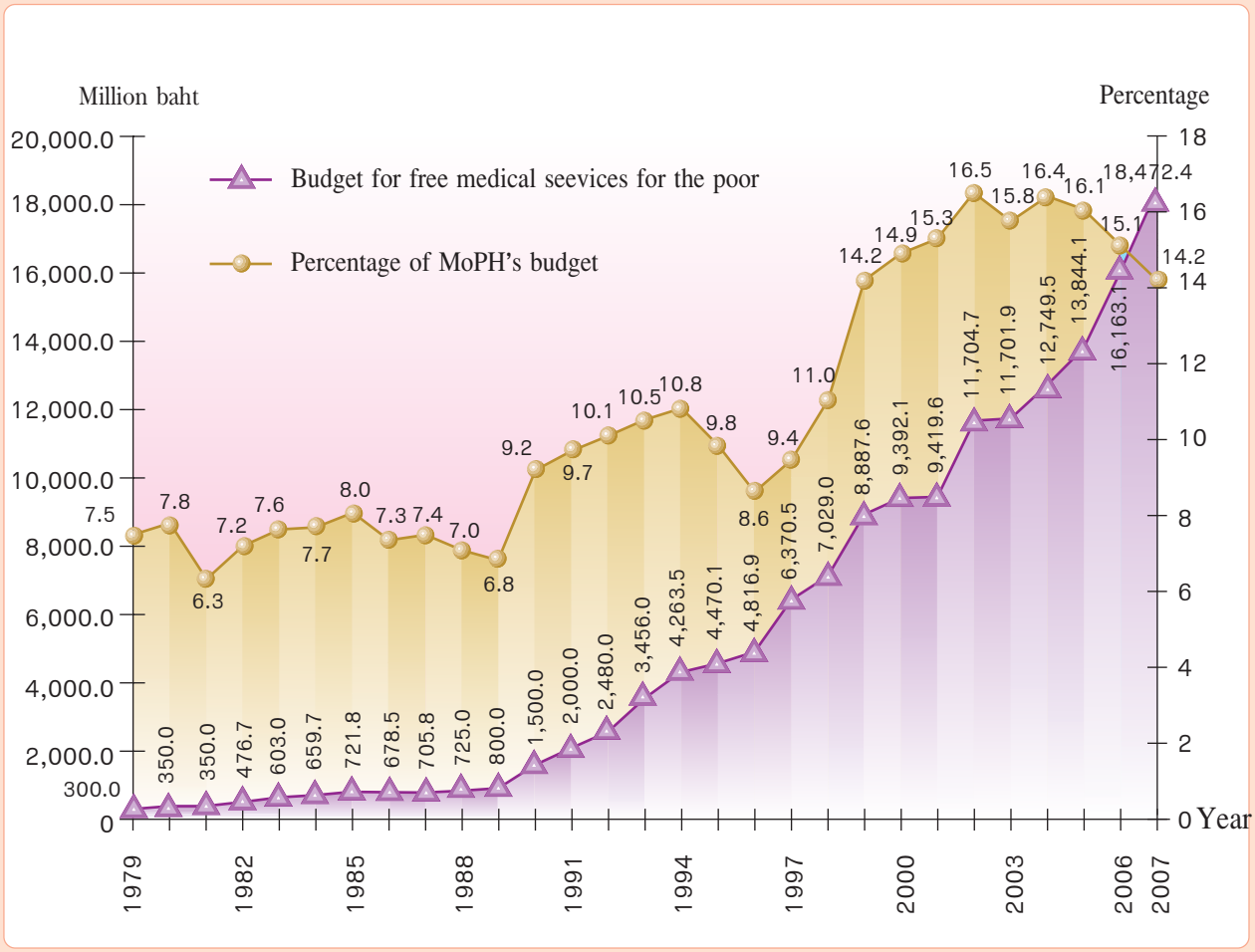
Table 7.9 Budget for free medical services for the poor and underprivileged,1979-2007

Year	MoPH's budget (million baht)	Budget for free medical services for the poor and underprivileged (million baht)			Percentage of MoPH's budget
		Present value	2007 value	Increase/decrease (real terms, %)	
1979	3,976.9	300.0	1,009.5	-	7.5
1980	4,494.5	350.0	983.2	-2.6	7.8
1981	5,571.8	350.0	872.7	-11.2	6.3
1982	6,652.3	476.7	1,129.8	+29.5	7.2
1983	7,902.4	603.0	1,377.9	+22.0	7.6
1984	8,617.6	659.7	1,494.1	+8.4	7.7
1985	9,044.3	721.8	1,596.9	+6.9	8.0
1986	9,274.7	678.5	1,475.5	-7.6	7.3
1987	9,525.1	705.8	1,496.6	+1.4	7.4
1988	10,372.5	725.0	1,480.0	-1.1	7.0
1989	11,733.1	800.0	1,548.4	+4.6	6.8
1990	16,225.1	1,500.0	2,747.0	+77.4	9.2
1991	20,568.6	2,000.0	3,463.8	+26.1	9.7
1992	24,640.4	2,480.0	4,122.6	+19.0	10.1
1993	32,898.1	3,456.0	5,557.9	+34.8	10.5
1994	39,318.7	4,263.5	6,527.4	+17.4	10.8
1995	45,832.6	4,470.1	6,474.7	-0.8	9.8
1996	55,861.2	4,816.9	6,584.5	+1.7	8.6
1997	67,574.3	6,370.5	8,251.5	+25.3	9.4
1998	63,705.1	7,029.0	8,420.5	+2.1	11.0
1999	59,227.3	8,405.6	10,046.0	+19.3	14.2
	(62,787)	(8,887.6)	(10,622.1)	(+26.0)	(14.2)
2000	60,640.9	8,910.1	10,477.2	+4.3	14.7
	(63,001)	(9,392.1)	(11,044.0)	(+4.0)	(14.9)
2001	61,097.2	8,966.3	10,368.1	-1.0	14.7
	(61,563)	(9,419.6)	(10,892.3)	(-1.4)	(15.3)
2002	70,923.2	11,704.7	13,453.4	+29.8	16.5
2003	74,133.9	11,701.9	13,212.1	-1.8	15.8
2004	77,720.7	12,749.5	14,012.6	+6.1	16.4
2005	85,914.3	13,844.1	14,567.2	+4.0	16.1
2006	107,100.8	16,163.1	16,248.0	+11.5	15.1
2007	129,683.3	18,472.4	18,472.4	+13.7	14.2

Sources: 1. Bureau of Policy and Strategy, Ministry of Public Health.
2. National Health Security Office.

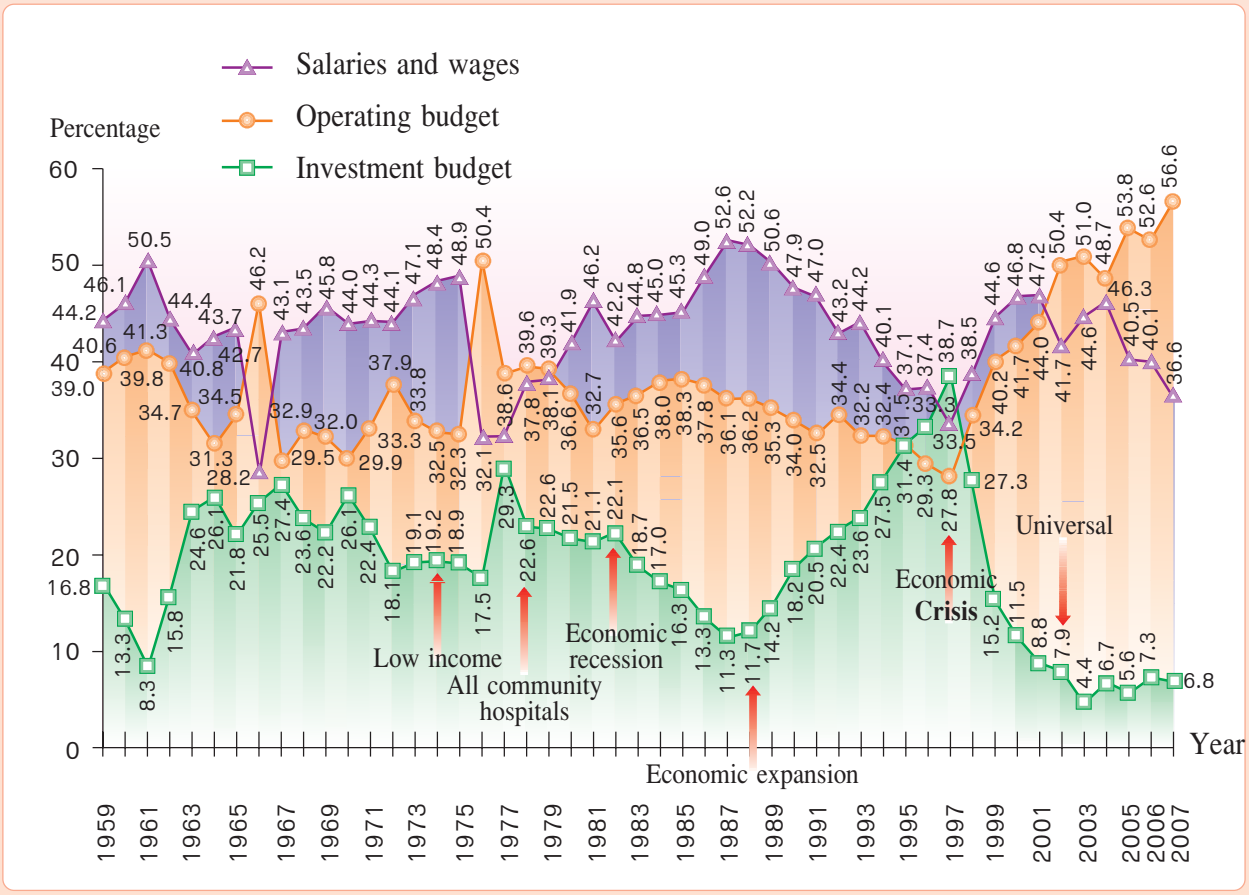
Notes: 1. Figures in ( ) include the loans from the Asian Development Bank and the World Bank, i.e. 482 million baht for 1999; 482 million baht for 2000; and 453.3 million baht for 2001.
2. Numbers of health insurance cards (non-30-baht co-payment): 24,336,250 cards for 2002; 24,330,386 cards for 2003; 24,359,065 cards for 2004; 24,787,262 cards for 2005; 24,353,691 cards for 2006; and 24,309,727 cards for 2007.

Figure 7.14 Budget for free medical services for the poor and underprivileged as percentage of MoPH's budget, 1979-2007



Source: Bureau of Policy and Strategy, Ministry of Public Health.

Figure 7.15 Percentage of MoPH budget by budget category, 1959-2007



Source: Bureau of Policy and Strategy, Ministry of Public Health.

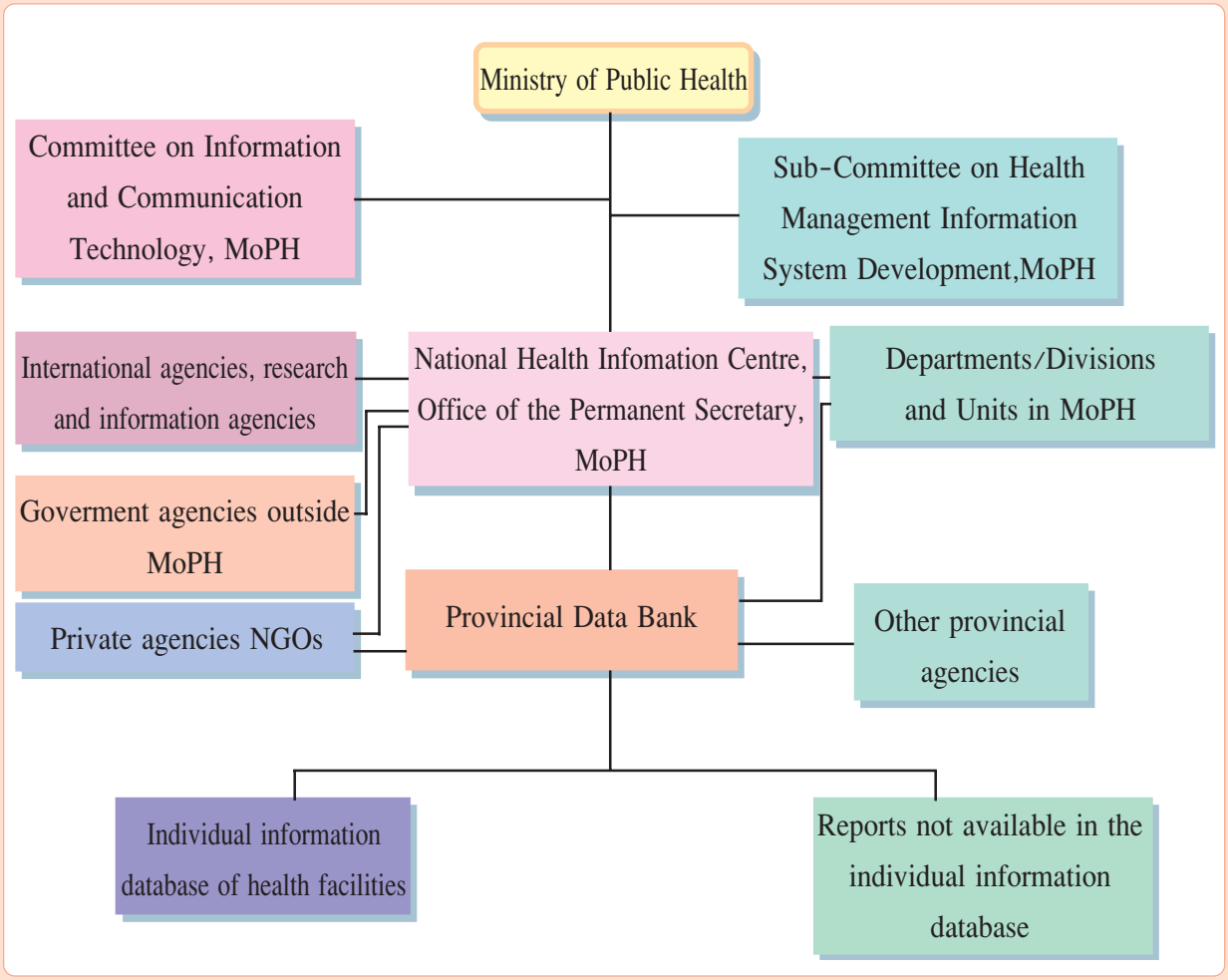
4.1.7 Health Information System (MoPH only)

Prior to the 4th National Development Plan period (1977-1981), the MoPH collected a lot of health information reports and statistics, but they were scattered in various agencies. As a result, it was rather hard for compiling them for proper use; and the analyses were incorrect resulting in the low levels of data quality and accuracy. Therefore, since the 4th plan period, the MoPH has implemented the Health Information System Development Project aimed at improving the quality of health information so that it is accurate and comprehensive. The modern technology has been introduced to the development of health information system and the capacity building, using computerized systems at the central and provincial levels. The Management Information System has also been established so that the administrators are able to use the information for decision-making at all management levels.

During the 7th-8th Plan periods, the MoPH abolished a number of unnecessary reporting systems, by supporting provincial health surveys and national health examination surveys. In 1997, the MoPH also started collecting information related to all health systems in Thailand as a report on a biennial basis called. "Thailand Health Profile".

During the 9th and 10th Plan periods (2002-2011), there is a reform of the MoPH health information system, using the modern management information system reform approach based on the electronic individual cards. Under the new system, the structure is of the same standard linking all agencies concerned together as well as the smart-card system in the future. This is in response to the performance achievement indicators such as KPI, E-inspection and the Ministry Operations Centre (MOC) (Figure 7.16).

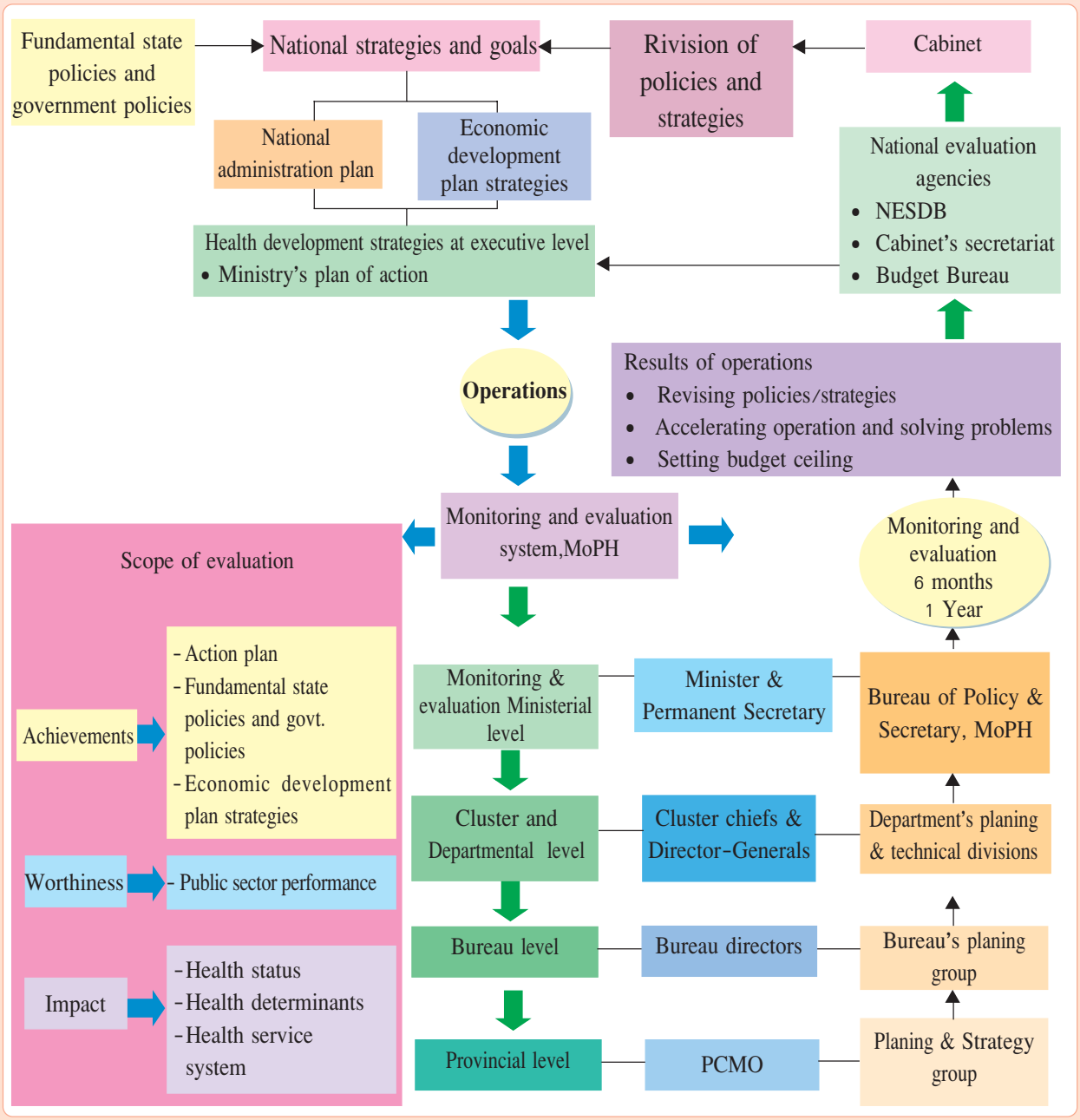
Figure 7.16 Linkages and network of the management information system, MoPH



4.1.8 Monitoring and Evaluation System

As the government has adopted the new public management principle, emphasizing the responsibility for results and outcomes that will affect the people, all government agencies have to lay down their goals and strategies to serve people's needs and use the results-based budget allocation mechanism, beginning in fiscal year 2003. The MoPH has also developed its monitoring and evaluation system as a key management mechanism to illustrate the achievements of program operations and impacts on the people by using key performance indicators (KPI) for the purpose of achieving the goal of Thai people's health development. However, that system is used only for program under the responsibility of the MoPH (Figure 7.17).

Figure 7.17 MoPH's monitoring and evaluation system



4.2 Agencies Supporting Health Programme Implementation

4.2.1 Public Sector Agencies Supporting and/or Implementing Health Activities

1) Public sector agencies providing health services and producing health personnel are the Bangkok Metropolitan Administration (BMA), the Ministry of Education (Office of the Higher Education Commission), the Ministry of Interior, and the Ministry of Defence.

2) Public sector agencies implementing health-related activities in connection with the environment, workers, children and women are the Ministry of Industry, the Ministry of Science and Technology, the Ministry of Agriculture and Cooperatives, the Ministry of Labour, the Ministry of Social Development and Human Security, the Ministry of Education, and the Ministry of Natural Resources and Environment.

3) Public sector agencies supporting the implementation of health programmes in an efficient and effective manner include the National Economic and Social Development Board (planning support), the Bureau of the Budget (budgetary support), the Civil Service Commission (health manpower support), Thailand International Development Cooperation Agency (international assistance), the National Statistical Office (information support), the Thailand Research Fund (TRF) and the Health Systems Research Institute (HSRI) (medical and health research support), the Thai Health Promotion Foundation (health promotion support), the National Health Security Office (standardized and equitable universal health insurance support), and in 2007, the National Health Commission Office is established (coordination support in health policy and strategy).

4) Public sector agencies responsible for health services for specific groups are the Social Security Office of the Ministry of Labour and the Insurance Department of the Ministry of Commerce.

4.2.2 Private For-Profit Health Organizations

In the past, most private health facilities were not-for-profit organizations. In addition to providing health services, after the period of rapid economic expansion period (1987-1997), the private sector has expanded considerably in the forms of private hospitals and clinics. Moreover, some private health facilities play a relatively little role in producing health personnel.

In privately-run for-profit medical facilities, 13 groups of investors have been formed and listed in the Stock Exchange of Thailand (2006). Such corporates and networks include Aekchon Hospital, Bangkok Dusit Vejakarn Hospital, Krung Thon Hospital. Mahachai Hospital, Chiang Mai Medical Business Co. Ltd., Wattana Hospital Group, Nonthavej Hospital, Ramkhamhaeng Hospital, Smitivej Hospital, Vibhavadi Hospital, Bamrungrad Hospital, Sikharin Hospital, and Bangkok Chain Hospital Public Limited Company

4.2.3 Health Non-governmental Organizations

There are some 300 to 500 not-for-profit private organizations working on health in Thailand; most of them are foundations or associations registered with the Ministry of Culture (Office of the National Cultural Commission and/or the Ministry of Interior). So a lot of them are juristic persons, but several other small NGOs are non-juristic-person agencies, such as the Rural Doctors Club and the Drug Studies Group.

Generally, these organizations receive financial support from international agencies, and from in-country donations, including government subsidies.

The MoPH allocated approximately 49.2 million baht each year during 1992-1997 and only 12-46 million baht each year during 1998-2007 for four major programmes of those NGOs: healthcare for the elderly, healthcare for the disabled and disadvantaged, healthcare for mothers, children and youths, and others. In 2007, a total budget of 12.0 million baht has been provided to 72 NGOs (82 projects) for their relevant health programmes (Table 7.10). Besides, another 36 million baht was provided to 672 NGOs working on HIV/AIDS in 2006 (Table 7.11) as they all would help the government in implementing health-related development programmes.

Besides, specialized agencies of the United Nations such as the World Health Organization has started to provide financial aids to several non-profit organizations: previously WHO provided such grants for public sector agencies only.

Table 7.10 Number of non-governmental organizations with funding support from MoPH, 1992-2007

Year	No. of organizations			No. of projects			Budget, baht		
	Requesting	Supported	%	Requesting	Supported	%	Requested	Allocated	%
1992	45	42	93.3	91	72	79.1	85,600,000	49,200,000	57.5
1993	142	119	83.8	264	185	70.1	160,844,928	49,200,000	30.6
1994	416	305	73.3	909	654	71.9	334,481,098	49,200,000	14.7
1995	362	103	28.5	615	287	46.7	205,348,213	49,200,000	23.9
1996	150	106	70.7	491	219	44.6	192,234,358	49,200,000	25.6
1997	142	78	54.9	420	180	42.8	230,287,800	49,200,000	21.4
1998	152	101	66.4	258	174	67.4	129,016,142	35,000,000	27.1
1999	177	114	64.4	541	223	41.2	241,270,797	35,760,000	14.8
2000	163	92	56.4	493	191	38.7	257,227,874	46,582,300	18.1
2001	152	66	43.4	411	166	40.4	160,768,084	33,557,800	20.9
2002	161	70	43.5	327	124	37.9	161,955,967	34,965,922	21.6
2003	235	128	54.5	411	251	61.1	160,813,010	34,831,160	21.7
2004	106	70	66.0	295	182	61.7	103,900,200	26,369,545	25.4
2005	104	76	73.1	210	156	74.3	91,655,450	26,454,000	28.9
2006	77	52	67.5	118	69	58.5	71,072,240	20,000,000	28.1
2007	91	72	79.1	127	82	64.6	89,877,311	12,000,000	13.3

Sources: - For 1992-2001, data were derived from the Medical Registration Division, Department of Health Service Support.
- For 2002-2007, data were derived from the Primary Health Care Division, Department of Health Service Support.
- Public and Consumer Affairs Division, Food and Drug Administration.

Note: The Food and Drug Administration provided financial support to consumer protection NGOs during1999-2003 only.

Table 7.11 Number of NGOs involved in HIV/AIDS programmes and the MoPH budgetary support, 1992-2006

Year	No. of organizations			No. of projects			Budget, baht		
	Requesting	Supported	%	Requesting	Supported	%	Requested	Allocated	%
1992	37	23	62.2	42	35	83.3	66,125,734	11,900,000	18.0
1993	38	36	94.7	61	56	91.8	33,123,818	15,000,000	45.3
1994	101	76	75.2	120	91	75.8	72,903,868	10,300,000	14.1
1995	115	94	81.7	209	153	73.2	350,765,292	75,000,000	21.4
1996	186	122	65.6	308	188	61.0	267,232,488	80,000,000	29.9
1997	268	184	68.7	385	247	64.1	309,015,357	90,000,000	29.1
1998	434	244	56.2	725	343	47.3	494,739,684	90,000,000	18.2
1999	596	371	62.2	931	458	49.2	450,972,885	87,262,350	19.3
2000	625	293	46.9	882	372	42.2	368,671,357	60,000,000	16.3
2001	497	371	74.6	730	457	62.6	403,438,189	70,000,000	17.4
2002	660	444	67.3	922	522	56.6	370,340,183	70,000,000	18.9
2003	712	519	72.9	987	605	61.3	337,938,984	70,000,000	20.7
2004	678	508	74.9	868	577	66.5	289,624,851	70,000,000	24.2
2005	795	637	80.1	935	657	70.3	277,646,531	70,000,000	25.2
2006	860	672	78.1	909	692	76.1	210,968,670	36,000,000	17.1

Source: Bureau of AIDS, Tuberculosis and Sexually Transmitted Infections. Department of Disease Control, MoPH.