2. Health System Management

2.1 Health Policies and Plans

The Thai health system (particularly in the public sector) has been developed in accordance with the Health Development Plan, which is part of the National Economic and Social Development Plan.

During the past three decades, Health Development Plans have been implemented continuously in the following phases:

(1) The 1st - 7th Plan period (1961-1996)

During the 1st-7th Health Development Plans (1961-1996), numerous efforts were mainly made for making people healthy and for enhancing national capacity in economic development. During the first period of the 1st-3rd Plans, there were investments in infrastructure development. The 4th-6th Plans were the transitional phase of adopting a more systematic national health development planning process by using the Country Health Programming technique and Managerial Process for National Health Development (MPNHD) - the systematic process, including problem analysis, policy and strategy identification, as well as the Planning Programming and Budgeting System (PPBS) technique. The primary health care concept was applied, aimed at encouraging people to realize the problem and causes of problem as well as to allow them to learn and apply new knowledge to solve the problems. Consequently, the **"Health for All by the Year 2000"** goal was established as a long-term target emphasizing people and community participation in health development.

As a result, health development programmes were expanded extensively during the 7th Plan, and efforts were made on quality assurance, resulting in health facilities' quality development at all levels, effective management system, new technology application, health manpower training and development of health centres to serve as the coordinating centre for health for all. Thus, the 10-year project on health centre development (1992-2001) was initiated and expanded to provide services covering two-thirds of the population.

(2) The 8th Plan period (1997-2001)

During this period, the emphasis on economic development was shifted to people-centred development focus, as people were regarded as the key to successful development. As a result, health development plans was aimed at holistic development. However, in the beginning of this Plan's implementation, the economic crisis occurred, which led to a requirement for the plan adjustment so as to reduce investment budget and maintain basic health services provided for the poor.

During 2000-2001, the movement of health care reform was initiated, resulting in the issuance of the Prime Minister's Office's regulation pertaining to health care reform, the establishment of the health care reform committee and the establishment of the National Health System Reform Office (HSRO). At that time, it was expected that within the following three years, a National Health Act will be enacted (by 31July 2003). However, the timeframe was extended for two years, with an expectation that the law will be proclaimed by 8 August 2005.

Moreover, the government laid down a policy on univeral coverage of healthcare scheme

in February 2001, which has been implemented and covered the entire country since 2002.

(3) The 9th Health Development Plan (2002-2006)

During this period, the emphasis is still placed on people-centred development approach, as well as the "self-sufficient economy" principles directed by His Majesty the King. Such phylosophy has been used to guide the formulation of the **national health development** plan aimed at improving the public health and the overall health system. The strategies adopted include the creation of balances in the individual, social, economic, and environmental systems, based on active participation of all sectors concerned.

Moreover, the government has placed emphasis on other health programmes such as food safety, exercise for health, and road safety management.

2.2 Laws

Laws related to health include acts, ministerial regulations, orders and procedures as follows:

1) Acts under the responsibility of the MoPH (four categories, 37 acts) are listed in Table 6.43.

Table 6.43 Acts under the Direct Responsibility of the Ministry of Public Health

No.	Act
1	Acts related to health service systems
	1.1 Medical Facilities 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 Thai 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
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 (six with 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

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

(1) The Environment 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

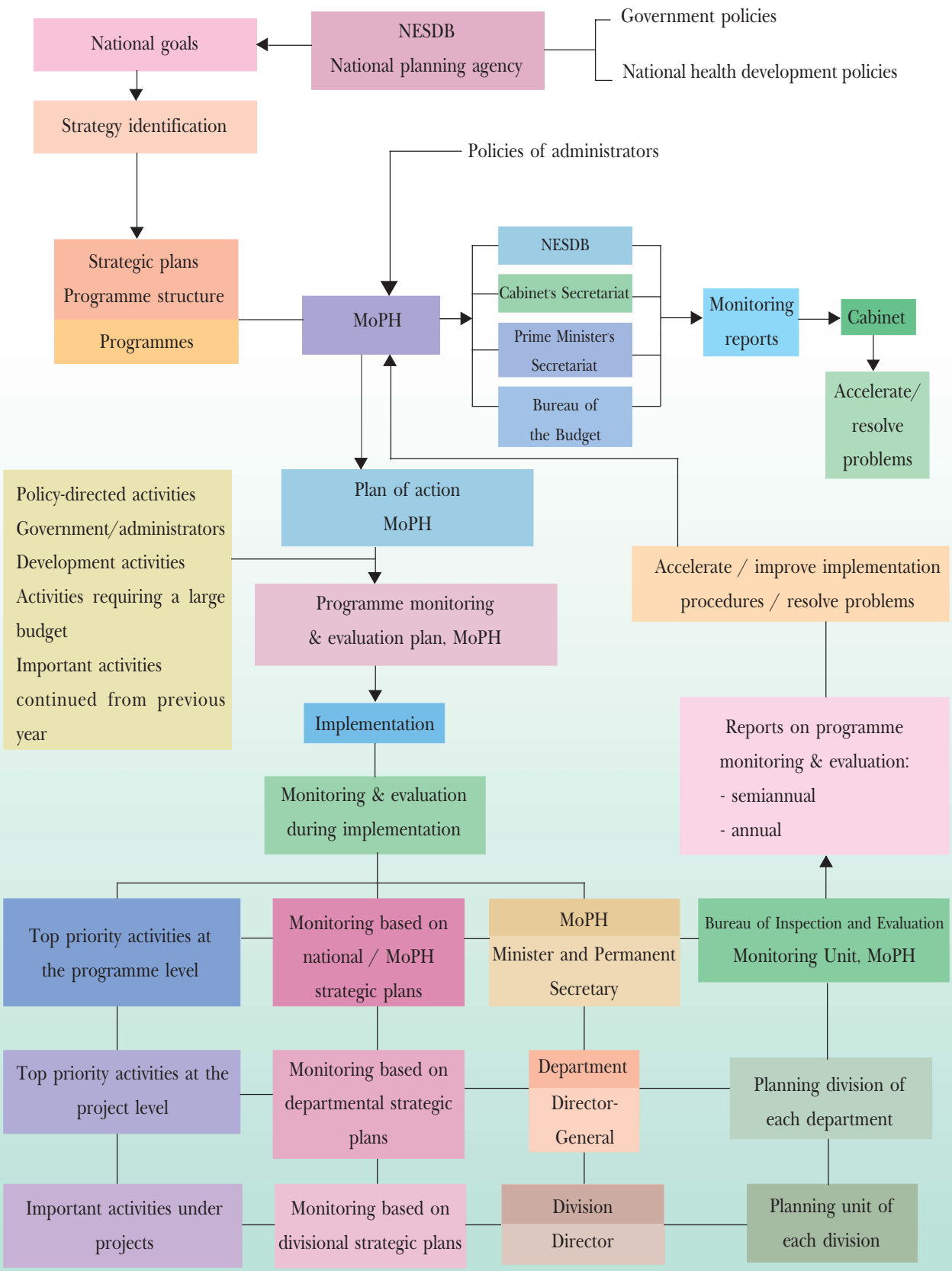
Besides, the National Health System Reform Office has been established, according to the regulation of the Prime Minister's Office, aimed at formulating processes leading to the passage of a National Health Act, which will be regarded as a "health constitution" of Thai people.

2.3 Monitoring and Evaluation System

According to the government's public sector management policy, which emphasizes the results-based management system, goals, targets and strategies of all government agencies are to be set up in response to the needs of people. As a result, the results-based budgeting system has been adopted since fiscal year 2003. And the MoPH has to revise its major programmes according to MoPH's strategic plans, using key performance indicators (KPI) in the monitoring and evaluation of health development programmes so as to meet the national development goals (Figure 6.31).

In order that MoPH's monitoring and evaluation system is undertaken systematically in a unified manner, agencies relevant to programme inspection and evaluation have been merged as the Bureau of Inspection and Evaluation under the MoPH's Office of the Inspector-Gernerals. The Bureau is assigned to be responsible for monitoring, inspection and evaluation of health programmes according to the mandate of the MoPH.

Figure 6.31 The System for Monitoring and Evaluation of MoPH programmes



2.4 Health Information

Health information is available at various agencies; the core agency being the Bureau of Policy and Strategy of the Ministry of Public Health. The evolution of Thailand's health information system can be categorized into four phases as follows:

(1) Prior to the 4th Plan

During that period, the MoPH collected a number of health statistics on births, deaths, population, and morbidity. Health activity reports were prepared and conducted by health officials at Tambon (subdistrict) and district levels, then submitted to various divisions concerned at the central level for processing as national health statistics. When the decision-makers requested information and data, they had to ask for them directly from such responsible agencies. This led to problems of scattered health statistical data in various agencies and inefficiency of data utilization. The lack of clear understanding about data requirement and use, coupled with inappropriate data processing and reporting, resulted in considerably poor quality and inaccuracy of data.

(2) The 4th to 6th Plans (1977-1991)

During this period, MoPH decided to establish the Health Information Centre at the central, provincial and district levels under the Planning Management Information System Development Project (PMIS). The developed system and formats were aimed at obtaining quality and complete health data and information at a single unit at the same administrative level. Moreover, the computer technology was introduced for the improvement of the health information system. The capacity of the computerized systems was expanded to all MoPH agencies at both central and provincial levels. Besides, the Management Information System was set up to serve health administrator's decision-making at all levels.

(3) The 7th to 8th Plans (1992-2001)

During the 7th Plan, a new concept of health information system was adopted. The MoPH lessened the reporting of unnecessary activity items and promoted a data collection system based on provincial health surveys and national health examination surveys, including surveys on the underprivileged such as the hilltribes. For use as a guide in future surveys for health planning purposes, the MoPH coordinated with public educational institutions (under the then Ministry of University Affairs) and the Thailand Development Research Institute in developing the methodology and health survey patterns in four underprivileged groups: the urban and rural poor, child and female commercial sex workers, the disabled, and the elderly who had no relatives or caretakers.

During 1999-2001, the MoPH also conducted a study on the causes of death in 16 provinces, based on the assumption that the mortality information derived from the population registration system of the Ministry of Interior was markedly inaccurate. The study aimed to explore and improve the information system so as to obtain standardized mortality information on causes of death, which would be used for making decisions on investment in effective health service programmes.

In 1997, the MoPH initiated the compilation of all information about health systems of the country as a biennial report entitled “Thailand Health Profile”.

(4) The 9th Plans (2002-2006)

The health information system of the MoPH has been reformed during this period, in line with the government's public sector reform policy and the restructuring of the MoPH. New guidelines for developing the health information system or MIS reform have been laid down. The new system aims to develop electronic individual cards, which can be linked between the central and local levels. The information in this format can be used for integrated provincial administration purposes. At the operational level, the information systems have been revised at all health centres, community health posts, hospitals and provincial public health offices. The standardized system and structure has been able to link with all agencies concerned; and it is expected to link to the "smart card" system in the future. This system will be able to respond to the need for measuring programme achievement indicators such as KPI, e-inspection, and providing the information to the Ministry Operations Centre (MOC), according to the roles and functions of each agency in an efficient manner (Figure 6.32).

Figure 6.32 Flowchart of the Network of Health Information System, Thailand