The future of primary care in Thailand in the context of a global financial crisis

Robert E. Dedmon

Department of Population Health, Medical College of Wisconsin, Milwaukee 53226, USA

Background: Primary care physicians are in short supply worldwide, and Thailand is no exception. The current economic crisis contributes further to this situation. Thailand does not yet have a formally defined and certifying family practice board. In addition, there are two opposing trends in Thailand which stress an adequate supply of providers: 1) Inadequate formal training for primary care doctors; and 2) The ‘brain drain’ caused by the higher salaries in the private sector and the effort to make Thailand a key hub for ‘Medical Tourism’. From one perspective of primary care, Thailand is a developing or transitional country rooted in hospital/specialist care, yet seeking ways to improve overall quality and cost-effectiveness for its people.

Objectives: To ascertain the current and future potential for increasing the number of primary care providers in Thailand, and to encourage further research on this question in the context of economic reality and the cultural background of medical care in Thailand.

Methods: Literature search of Thai and other international medical journals for ‘Primary care Thailand’; Google Scholar search for ‘Primary care Thailand’; Pubmed search using MeSH terms ‘Primary care’ AND ‘Thailand’. In addition, physicians and administrative staff in Bangkok from private general-travel medicine practice, an academic medical center, two non-profit facilities, and four investor-owned institutions were interviewed. The literature review was completed 13 March 2009, and the interviews were conducted in person during the author’s visit to Bangkok in January 2009.

Results: Although there is some interest in promoting primary care more effectively, the majority of medical practice is still hospital-specialist oriented, at least in Bangkok. One exception was in one of the smaller private hospitals, where several well-trained primary care physicians practiced. In addition, some of the larger hospitals noted for medical tourism are developing sections for local Thai patients, and this may encourage recruitment of fully trained family doctors or specialists in general internal medicine.

Conclusions: The future of primary care in Thailand remains in question. It needs the change by the political establishment and medical leadership to define formally primary care or a recognized and certified medical specialty. Furthermore, careful research of both national and regional health needs and practices is a critical factor for success.

Keywords: Family practice, health economics, health policy, primary care, universal coverage.

The global financial crisis and the evolution of health care and disease prevalence in Thailand

The financial news seems to get worse daily. One only has to scan the news on the internet. One recent report indicates another 100,000 jobs lost worldwide in less than 2 weeks. If people cannot work, they cannot eat properly. Health budgets are also strained. This implies inertia in making major health reforms, such as expanding and improving primary care where this is most needed [1, 2]. WHO Director-General Margaret Chan has expressed concern that countries will cut health programs affecting the neediest [3]. In the same commentary, the World Bank was quoted as being quite blunt: ‘Focus… on specific, essential services for vulnerable populations’. This requires ‘better science, better data, and better monitoring…’. The risk of pursuing hi-tech expensive approaches without basic essentials is fraught with potential
economic disaster [4-6]. Health reform introducing universal coverage with the 30 baht scheme in Thailand was a great step forward [7]. Authors of this article raised some key issues, discussed as below: 1) Staff need to be redeployed to primary care units, which are still underdeveloped, 2) Patients are used to accessing their care from hospitals and choosing their provider; 3) Confidence in primary care needs building, and 4) The scheme may have to be modified to permit more choice and raise more funding (difficult in this 2009 financial environment).

Thailand has made significant achievements in public health and these are detailed in the WHO Country Health System Profile [8]. For example, infant mortality has declined from 40.7 per 1000 live births in 1985-86 to 16.3 per 1000 live births in 2007. Ninety-nine percent of infants were immunized against TB by their first birthday (2005). Ninety-three percent of the people had access to safe drinking water (2000). Seventy-five percent of women had been immunized with tetanus toxoid during pregnancy (2002). Another significant achievement is the marked reduction in rabies deaths from about 400 annually in the 1980’s to less than 20 in 2008 [9]. However, this was achieved by widespread post-exposure treatment, not dog control. There are still a lot of unvaccinated dogs in Thailand.

Overall mortality in Thailand has shifted from infectious/communicable disease to chronic diseases and those related to lifestyle/behavior. For example, diabetes-related deaths increased from 7.5/100,000 in 1997 to 13.2/100,000 in 2001. This is a disturbing trend, and requires attention of policy makers, public health educators, and health providers. These trends have yet to be widely acknowledged [10]. Psychiatric disease is a growing concern [11]. Due to the universal coverage rules for payment, patients usually go to their GP/primary provider before going to a mental/psychiatric hospital. Problems were: 1) Most of the drugs available through primary care were those available 30 years prior to the survey, and 2) About 40% of GP’s reported seeing more than 70 patients per day-not enough time for a psychiatric patient, or anyone else!

The many varieties of primary care practice

When discussing primary care, it is important to understand that ‘one-size-doesn’t-fit-all’. Cultural differences and varying social determinants require understanding before implementing programs [12, 13]. In addition, large differences exist among practices in various countries. One study [14] of primary care practices in the USA, Australia, Canada, Germany, New Zealand, the Netherlands, and the United Kingdom found wide variations in use of health information technology, availability of data on outcomes, use of a documented process for analyzing adverse events, and pay-for-performance incentives.

Primary care infrastructure, safe water and sanitation, immunization, universal health coverage/access, health policy based on careful research, public support and participation, and political will are all essential pillars in protecting a nation’s health. Relying on expensive, hospital/specialist-oriented care risks bankrupting both the health care system and the public treasury of any country [1-7]. In addition, health care providers must acquire new knowledge and skills to meet the demands of the 21st century. We are all players in the ‘Global Village’ [15, 16]. A recent report by four family physicians from four continents underscores the challenges facing primary care implementation in different geographical and cultural contexts [17]. The rapidly aging population requires more providers for continuity of care for people with one or more chronic medical problems [18]. Concepts such as general, comprehensive, accessible, continuous, family-oriented, integrated, and coordinated may sound like outmoded mantras or pipe dreams in our ‘real-time’ world. However, the world needs leadership in redefining health priorities based on evidence and an economically-sustainable approach.

In the commentary on primary care in Thailand, Pongsupap Y et al. [17] describes some of the challenges to primary care as follows:

1. Weak stewardship and regulatory functions,
2. Inadequate benchmark indicators and how to monitor them.
3. Modest support from high-level policy makers.

There is a shortage of primary care doctors, and much of the primary care is done by nurses [19] and volunteer health workers (Village Health Volunteers-VHV’s [20]).

WHO, WONCA, and family practice training in Southeast Asia

All this may sound discouraging, but there is cause for some degree of optimism. First, the World Health Organization’s (WHO) 2008 World Health Report [21, 22] devotes the entire issue to the need for strengthening primary care in a global context, and
this puts the issue on center-stage. Second, the global consortium of family practice organizations (WONCA) [23], headquartered in Singapore, is actively involved in primary care development. Both Hong Kong and Singapore have active Family Practice training programs. At present, Thailand has none. Searches for family practice training in Thailand, including Mahidol University, and its affiliated hospitals/medical schools gave no results. Another interesting finding is that the American Board of Family Practice (ABFM) lists five ABFM-certified physicians in Thailand.

However, Mahidol does have a very active research and training program in Tropical Medicine endorsed by the International Society of Travel Medicine (ISTM) and the American Society of Tropical Medicine and Hygiene (ASTMH). It is one of the eight schools globally where a student can qualify for the Diploma in Tropical Medicine and Hygiene (DTM&H), a six-month course [24].

**Current practice in providing primary care doctors to rural areas needs revision**

One way the Thai authorities have supplied primary care doctors to rural areas is a mandatory 3-year internship upon medical school graduation. This is in return for their medical education at government expense. However, this has come under fire in the Thai press, and young doctors can opt out early by paying a fine of 400,000 baht [25]. This contributes to the internal ‘brain drain’ in Thailand. Both doctors and nurses migrate from the public system to private hospitals and from rural to metropolitan for economic and other reasons [26]. Another study on physician mobility in Thailand [27] found that the older cohorts stayed in rural areas longer than younger ones and that females stayed for shorter times than males. The 1973 cohort stayed an average of 6.1 years. The 1993 cohort stayed only an average of two and a half years. Further analysis estimated that about 50% of doctors returned to urban areas after their three years of compulsory internship. Graduates of regional medical schools, such as Chiang Mai, were less likely to migrate to urban areas than Chulalongkorn graduates.

**The need for more careful research:**

Outcomes research is also badly needed in order to allocate scarce resources and provide meaningful feedback. Two recent Thai studies underscore this. The first was a retrospective study published in 2007 on diabetes management and complications [28]. It was conducted in 37 randomly selected primary care settings. The researchers found poor compliance with recommended assessments and a high rate of neuropathy and foot ulcers. The second study [29], a prospective/control study on hypertension conducted in Patumthani Province, was more encouraging. Its purpose was to develop a model using health personnel, village health volunteers (VHV’s), and family health leaders (FHL’s). The interventions were deemed cost-effective, sustainable, and with a high prospect of transferability to other areas.

**The technology beast needs taming** [4]

Health technology assessment (HTA) has been explored [30], but requires further study and resources. The authors of this study define three steps in the HTA process as follows:

1. Identification of technologies needing assessment,
2. Assessment procedures,
3. Technology appraisal.

The Health Intervention and Technology Assessment Group (HITA) serves as a technical advisor to groups at national level responsible for technology planning and evaluation. HITA is funded jointly by four public groups: Thai Health Foundation, Health System Research Institute, National Health Security Office, and Ministry of Public Health (MOPH).

This area is of critical importance. As has been stated previously, poorly evaluated and regulated technology will soon overshadow cost concerns in other health delivery areas and bankrupt the system [4]. A good example is MRI and PET-CT scanning equipment.

**Over-testing and over-prescribing:**

A study using simulated patients to ascertain diagnostic procedure use and prescribing patterns in Bangkok evaluated provider behavior in public versus private and hospital versus primary care environments [31]. Excessive use of pharmaceuticals was observed in both public and private settings, but was greatest in private hospitals. In addition, physicians in private hospitals employed more expensive, often not necessary and potentially harmful investigations. The author opined that if patients in Bangkok want to receive optimal care, they should avoid both public
and private hospitals and specialists for initial care. Rather, they should seek initial consultation with a trusted general practitioner in primary facilities. This has its own risks, because Family Practice is not yet a defined/certifying specialty in Thailand. It is also well-known that seeking help in a large facility without proper referral can produce disastrous results. This applies not only in Thailand, but in the USA and other locations as well. An adequate number of well-trained primary care providers are badly needed. In Thailand, the nursing profession is training Advanced Practice Nurses who are moving to fill the void [4, 20]. It is time for the Thai medical establishment to review and revise their policies on primary care and family practice. They should formulate and implement a more effective primary care health policy suitable for the 21st century. This must be done in consultation with the front line HCW’s, the doctors and nurses who do the work [4].

**Epidemiology an important contributor to services and facilities planning**

Planning type, scope, and location of primary care facilities based on disease burden, demographics, environment, and geography [32] are all necessary steps in cost-effective health care planning. As an example, distance-decay has been shown to affect outcomes in studies on malaria morbidity in Kenya. In this case, malaria hospitalization more than doubled as travel time to the nearest primary care facility increased from 10 minutes to two hours [33]. In 1980, the Thailand Ministry of Public Health, in collaboration with WHO and US Centers for Disease Control and Prevention (CDC), established the first Field Epidemiology Training Program (FETP) in Southeast Asia. This program, using satellite mapping (GIS), has had significant impact on HIV-AIDS control in the region [34]. While this does not involve primary providers directly, it does impact planning for what services they need to provide in a given area.

**Population aging and HIV-AIDS both contribute to increased demand**

As the population ages, the demand for skilled primary care providers will increase. The ongoing struggle with HIV-AIDS and TB will continue. The 2006 WHO World Health Report summarized health worker shortage (HCW) and maldistribution. In Africa, there were 2.3 HCW’s per 1000 population, in Southeast Asia 4.3 per 1000, and in the Americas, 24.8 per 1000 population [35]. In Thailand, international organizations such as WHO and Medicine Sans Frontiers (Doctors without Borders) (MSF) have provided help. MSF has been especially active with HIV-AIDS antiretroviral (ART) treatment [36]. Again, this underscores the pressing need in Thailand for training more primary care physicians and nurses, along with other HCW’s. The proposal to provide patients and families with a primary care ‘Medical Home’ is gaining acceptance. Several studies document improved quality, reduced errors, and improved patient satisfaction [37]. The bottom line in all this is improving and protecting the nation’s health.

**The other side of the mountain, still a long climb:**

Discussing the prospects for universal health care in 2001, Wilde et al. [38] issued a plea for more evidence-based practice and more careful health care planning for an infrastructure with enough doctors and nurses in primary care. The results have been mixed as follows:

1. Universal health care with the 30-baht scheme discussed above,
2. No formally-defined family practice specialty or effective residency training,
3. Self-styled family practice without the benefit of formal training [39],
4. An internal brain drain related to medical tourism and the increasing demand of affluent urban Thais for hi-tech services [40],
5. Incoherent policies related to universal health insurance coverage and the promotion of international trade or medical tourism [41].

In 2002, Williams et al. [42] raised a key question: ‘Family Practice in Thailand: Will It Work?’ Answer: ‘The jury is still out!’

**Conclusions**

Thailand has made significant strides in improving the nation’s health. However, until better focus on primary/outpatient, continuous/coordinate/patient-centered, and measured health care occurs, necessary objectives will not be achieved. Continuing hospital/specialist/over-prescribed care as the predominant mode of care will bankrupt the health system and runs the risk of losing what has been accomplished. There is an urgent need to promote primary care by increasing training of practitioners and by educating the public to the advantages of having a “medical
home” rather than shopping from one specialist to another.

References
9. Wilde H. Personal Communication. 02FEB2009;
10. Madur G. World needs fresh research priorities and new policies to tackle changing patterns of chronic disease. BMJ. 2004; 331:596;
24. Bangkok School of Tropical Medicine. www.tmmahidol.ac.th/eng/academic/aca_index.htm Accessed 01FEB 2009;


