CHAPTER II

ORGANIZATION OF PUBLIC HEALTH ADMINISTRATION

Before we discuss the present organization and functioning of the Ministry of Public Health in Thailand, it is desirable to trace its history. A study of the past development would give us a clear understanding of the analysis of the issues relevant to the present public health administration.

When the Thai Kingdom was re-established at Sukhothai in 1238 there was no systematic departmentalization in the administration. The King combined all the functions of government in his own person. A system of specialization of functions was introduced by King Ramathibodi I, who was the first King of the Ayutthaya period and reigned between 1350 and 1369. The King set up the system of Chatu Sadom whereby four ministries or departments were instituted to administer the affairs of the Kingdom. These ministries and their responsibilities were:

1. The Wiang or Huang Ministry which was responsible for the maintenance of public order;

2. The Wang Ministry which took charge of palace affairs and the administration

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of justice;

3. The Khlang Ministry which collected the country's revenues and supervised the royal property; and

4. The Na Ministry which supervised farming operations, distribution of food supplies, and matters connected with the tenure of land.

A further attempt at functionalization was made in 1454 by King Boromtrailokanat who brought about a dichotomy between the civil and the military aspects of administration which had previously been closely interwoven. Two new top level ministers holding the rank of chief ministers were appointed, one called Samuhansyok was responsible for all civil affairs, while the other with the title of Samuhaphrakalahom was in charge of all military affairs. The four ministries were brought under the direction of the civil chief minister. Later in the Ayutthaya period, the functions and responsibilities of these ministries or departments underwent substantial changes, during the course of which several minor departments were added to the four major ones.

The system of administration adopted during the Ayutthaya period remained in use during the early Chakri Dynasty and prevailed until the reign of
King Chulalongkorn (1868-1910). It was King Chulalongkorn who in the 1890's launched a sweeping movement for reorganization of the entire administration. Steps were taken to replace the traditional government departments by western-style functional ministries. These new ministries were Interior, Defence, Foreign Affairs, Justice, Finance, Public Works, Education, Agriculture, Local Government, Royal Household and Privy Seal, whose respective heads constituted a Cabinet.

The change from the absolute monarchy to the constitutional monarchy in 1932 was not followed by any major change in the basic structure of administration. Although a few new ministries have been created, their scale of operations have expanded considerably and their organizational pattern has grown much more complex, the basic ministerial structure remains unaltered. In other words, the foundation of the present-day system of Thai Public Administration was laid in the course of development of absolute monarchy and particularly during the reign of King Chulalongkorn.

The Act of 1952 sets the basic pattern of the organizational structure of the present government. It stipulates that the central administration shall consist of (1) the Office of the Prime Minister;
(2) Ministries; and (3) Departments or agencies of departmental status.

The government set-up is strongly centralized (Refer Chart 1). Most of the executive power rests in the office of the Prime Minister, Ministries, Bureaux, and Departments. The National Socio-economic Development Board (NESDB), the Budget Bureau(BOE), the Civil Service Commission(CSC), and the Department of Technical and Economic Co-operation (DTEC), hold most of the authority for policy-planning, budgeting and personal administration.

NESDB is the National Planning Commission which supervises the coordinated planning for all the socio-economic sectors of the country. NESDB is directly involved in developmental planning and has the responsibility of approving the sectoral plans in accordance with the policy of the Government. DTEC exercises control over all sources of support at all governmental sectors, including UN and bilateral agencies—the department is responsible for planning and scrutinizing the programme of assistance of all sources in relation to national priorities and policy and for proposing the most appropriate nature, quantum and sources of assistance.

Other important government agencies in the Office of the Prime Minister in relation to the health
sector are:

(1) The National Statistical Office (NSO)
(2) The National Environmental Board (NEB)

The National Statistical Office conducts household surveys which elicit, among other things, information on health expenditures by families. It also has final responsibility for assembling information on births, deaths and net changes in the whole population of Thailand. The National Environmental Board exercises surveillance over major projects which may modify the environment in ways that create hazards to health.

Besides, the Bureau of State Universities (BSU) and the National Research Council of Thailand (NRCT) help in education, training and research in Public Health.

Thus, the Ministry of Public Health has to ensure complete integration with the overall national policy. The Ministry of Public Health has to plan under the overall direction from cabinet, NESDB, Bureau of Budget. It has also to ensure balance among different activities and areas (Refer to Chart II for Planning and Budgetary Process).

This leads to inconsistency among the systems
of planning, budgeting and manpower allocation. The National Economic and Social Development Board, the Bureau of the Budget and the Civil Service Commission have their own statutory authority and operate independently from each other, making it difficult for the integration of planning, budgeting and personnel allocation. In addition, the budgetary and financial processes still serve principally as regulatory mechanisms. The budget is prepared on an annual basis only and classified by live items of expenditure rather than by programmes in line with national plan objectives and strategies. At present, the Civil Service Commission has already undertaken a crucial step in setting up ceilings for posts to be allocated to various Government agencies during a certain period of time. However, the extent to which the posts allocated can be filled depends very much on the budget allocation by the Bureau of Budget. Hence, in the past, various programmes and projects had often not been allocated financial resources and manpower which are consistent with one another. This impedes, to a considerable extent, the translation of development plans into actual implementation.¹

The country's administrative structure consists of Bangkok Metropolis area, 73 provinces and 163 municipalities. The Bangkok Metropolis is headed by a governor and his four deputies. Each province is headed by a governor who is appointed by the Ministry of Interior. Each Municipality is headed by a mayor who is elected by Municipal Council.\(^1\)

The typical province has a population of about 500,000 and the smallest well over 100,000. Each province is composed of about 3-20 districts (amphoes) depending on population and area.

There are 628 district (amphoes) and 82 smaller districts (ging amphoes). Each district is administered by a district officer (Nai Amphoe), a civil servant appointed by the Interior Ministry who is responsible to the Provincial Governor. Each sub-district is under the supervision of a deputy district officer responsible to the district officer.

There are 5,608 communes (tambons) and 56,286 villages (mubans). Majority of the communes and villages are not legally recognized as part of the administrative system of the country. A commune consists of a group of villages. The tambon head official acts as registrar.

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1. Members are elected by people.
and as intermediary between the district officer and the village headman. The village is the smallest unit consisting of a cluster of 50 households, having about 200 inhabitants, and is headed by a village headman (puyaiban) elected by the inhabitants of the village.

The functions of the various Ministries in Thailand are very similar to those of the major subdivision of the executive branch of any modern government. The general pattern of organization at the ministry level is relatively standardized and long established. The head of each Ministry is its political chief—the Minister—who is responsible to the Cabinet for the proper functionings of his Ministry and its subordinate Departments. The Minister may be assisted by one deputy or assistant Minister or more holding a political appointment. Each Minister has attached to him one political secretary or more whose appointment and removal is effected by the Cabinet. In each Ministry, the secretary, his assistants and staff, form the Office of the Secretary to the Minister.

In each Ministry, there are the Office of the Under-Secretary and a number of Departments. The Under-Secretary is the non-political head of the Ministry who remains in office irrespective of any change in the governments. In addition to serving as
as the administrative chief over the various Departments, the Under-Secretary is also responsible for the functions of the Ministry, which do not specifically belong to any Department in the Ministry. He may be aided by one deputy Under-Secretary or more. The Office of the Under-Secretary contains a group of divisions. Standard components include a central division, responsible for handling paper work including correspondence and records, and a finance division preparing budget estimates for the Office of the Under-Secretary and Controller Accounts and Disbursement. In addition, there are other divisions performing line-type functions in some cases, and in others rendering auxiliary technical services, research and staff functions.

Below the Office of the Under-Secretary are the various departments. The number of Departments in each Ministry depends on the volume of work and the fields of specialization for which the Ministry is responsible. While there are 6 Departments in the Ministry of Public Health, there are only 4 Departments in the Ministry of Industry.

The Department is headed by a Director-General who may be assisted by one Deputy Director-General or more. The Director-General and his deputies are permanent civil servants. In each Department, there
is an Office of the Secretary which has the status of a division and is in charge of records, correspondence, and some other auxiliary technical staff activities. In large Departments are also found Finance Divisions performing financial activities and Supplies Divisions responsible for purchasing, storing, and providing supplies for the Departments. In addition to these divisions, there are a number of line divisions, each of which is responsible for a specialized function or a group of functions of the Ministry.

A division is subdivided into several sections. The section is the lowest administrative unit of a Ministry.¹

There is lack of planning system at ministerial level. At present, the role of various ministries in planning and budgeting is still very limited. Various ministers and ministerial under secretaries have not yet taken an active part in setting up priorities of development programmes and projects as well as allocating the budget of their ministries. Hence, the departments play the major roles in the decision-making process. In order to rectify this shortcoming, the effectiveness of ministerial planning units must be improved so that they can take active parts in

appraising and setting priorities of development projects of each ministry in accordance with the National Economic and Social Development Plans.\footnote{1}

Besides, lack of decentralization and delegation of power to field officers. Since development programmes and projects are at present determined by the central government, field officers who are responsible for the implementation at the provincial and local levels have a minor part in the whole development management process. This kinders the effectiveness of project implementation and calls for a need for decentralization.\footnote{2}

In addition to the Office of the Prime Minister, which has ministerial status, there are 13 Ministries as follows:

1. Interior
2. Defence
3. Finance
4. Foreign Affairs
5. Agriculture and Co-operatives
6. Communications
7. Science, Technology and Energy
8. Justice
9. Education

\footnote{1}{The Fifth National Economic And Social Development Plan (1982-1986): Government of Thailand, p. 321.}
\footnote{2}{Ibid., p. 322.}
Since we are concerned with the administration of public health, we deal with the Ministry of Public Health. This Ministry is in charge of public health programmes. It works to safeguard and improve the health of the people. Before we discuss its functions and structure, let us trace its history.

A. First Phase up to 1908

As in other countries, the first incentive to the public health work in Thailand was the desire to struggle against epidemic diseases. From various accounts, it may be gathered that the early efforts were directed towards relief rather than prevention. In 1888, the Department of Medical Care, which may be regarded as the first institution dealing with the health of Thai people, was established. Its main functions were the management and supervision of hospitals in Bangkok, the management of the Medical School (established in 1889) and the control of smallpox epidemic by vaccination (introduced into Thailand in 1839 by the American missionaries). This Department, believed to be under the direct supervision of the King at first, was subsequently placed under
Ministry of Public Health
Devavesm Palace
Bangkok
the jurisdiction of the Ministry of Education.

In 1897, the first public health law was promulgated requiring the appointment of a medical officer of health and a city engineer whose duties were to take charge of environmental sanitation and disease prevention in Bangkok. This was the Local Sanitation Enactment of 1897. To guard against the imposition of dangerous infectious diseases from foreign countries, maritime quarantine was instituted from time to time by Royal Decree between 1901 and 1905 when a permanent quarantine station was established on the Island of Phra.

From 1888 to 1905, the Department of Medical Care had taken many important steps towards the improvement of the health of the people. The midwifery School financed by Her Majesty Queen Saovabha was opened in 1897 as an affiliate to the Medical School. The Government Medical Depot and the Vaccine Laboratory were started in 1901. The Provincial Medical Officers, recruited from amongst the Medical School Graduates, were appointed to take charge of health matters in some of the provinces. Dispensaries were set up in many towns to provide medical care for the people. A Division of Infectious Diseases Control was created in the Department to deal with epidemic diseases and to carry out mass vaccination. The
Department also prepared and supplied eight simple remedies for the use of the people in rural areas. The Department of Medical Care was dissolved in 1905 and its functioning units were consequently taken over by the Ministry of Interior and the Ministry of Local Government. The Medical School and Siriraj Hospital remained with the Ministry of Education.

B. Second Phase up to 1942

In 1909, the Provincial Sanitary Organization Law was gazetted following an experimental sanitation project at Thachalom District of Samut Sakhon province. This effected the creation of Sanitary Boards for towns and communities whose duties were: (1) the maintenance of cleanliness, (2) the prevention and treatment of diseases and (3) the upkeep of the roads. In 1911, the supervision of these Sanitary Boards was entrusted to the Medical Department, a newly formed organization under the Ministry of Interior. This marked the inception of the national public health work of today. The Medical Department had made considerable progress during its six years of existence. The Pasteur Institute was established as the first public health laboratory. Many important public health laws were enacted: Small-pox Prevention Act, Infectious Diseases Act, Local Administration Act, etc. Vaccination was
gradually expanded to cover all provinces in the Kingdom. A provincial health officer was assigned to each province. Many more health centres were set up both in towns and rural districts to render medical and health services to the population.

Despite the progress that had been made, it has to be admitted that the national health organization at that time was in rudimentary stage and was far from ideal. It was obvious that since the beginning, the public health activities in Thailand had been carried on by many independent agencies without coordination among them. As a result, the progress of the public health work had been rather slow. The reorganization of the whole structure thus appeared inevitable. On 27th November, 1918, the Department of Public Health was instituted to supervise all the medical and public health services, both of the capital and of the provinces by Royal Decree. This Department was placed under the jurisdiction of the Ministry of Interior. It envisaged the organization of a unified and centralized public health service. Certain national health activities which theretofore had been carried on by the Ministry of Local Government, were assigned to the Department which gradually assumed other functions of this nature.
From 1918 to 1942 some big strides had been taken by the Department of Public Health. Among the most important achievements were the Sanitary Campaign (assisted by the International Health Board and the Rockefeller Foundation) for the relief and control of intestinal diseases, the expansion of rural health services, the development of extensive health education programme, the control of infectious diseases (including malaria, yaws and leprosy), the initiation and subsequent expansion of maternal and child health services and the implementation of narcotics control. Since 1920, the Department had been made responsible for vital and health statistics hitherto handled by the Administration Department of the Ministry of Interior. It is worth mentioning that the Department was also responsible for medical services and had a number of hospitals under its direct control including the Hospital for Mental Diseases.

The Department of Public Health in the Ministry of Interior was subsequently transferred to the newly founded Ministry of Public Health in 1942. All matters concerning health of the nation, whether preventive or curative, are thus put under one control and under the sole responsibility of the Ministry of Public Health. Now, let us examine critically the structure and functions of this Ministry.
C. Ministry of Public Health

(Refer to Chart III)

The principal governmental agency (but by no means the only one) responsible for health services is the Ministry of Public Health. The Ministry of Public Health (MOPH) has undergone several re-organizations since its founding and at present (1982) its responsibilities at the central level are divided among six departments or offices:

1. Office of the Under-Secretary of State for Public Health
2. Department of Medical Services
3. Department of Communicable Disease Control
4. Department of Health
5. Department of Medical Sciences
6. Office of Food and Drugs Committees

The six Departments or Offices of the Central MOPH are each further organized into 'divisions' with a wide variety of functions.

1. Office of the Under-Secretary of State for Public Health:

The office of the Under-Secretary of State, besides its administrative functions and correlation of the work of the various departments, exercises its

# OBTAINED OF THE MINISTRY OF PUBLIC HEALTH

**Office of the Secretary** to the Minister

**Minister of Public Health**

**Under Secretary of State for Public Health**

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<tr>
<th>Office of the Under-Secretary of State for Public Health</th>
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<tr>
<td><strong>Deputy-Under Secretary</strong> <em>(Administration)</em></td>
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<tr>
<td>- Maintenance &amp; Repair Div.</td>
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<td>- Construction &amp; Design Div.</td>
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**Department of Medical Services**

**Department of Health**

**Provincial Administration**

**Department of Communicable Disease Control**

**Dept. of Medical Sciences**

**Office of Food & Drug Committees**

**Provincial Chief Medical Officer**

- Public Health
- Technical Office

*Details are next page*
duties through the Divisions of Medical Registration, International Health, Food and Drug Control, Nursing and also through the Medical Council, the Committee for the Control of Sale of Drugs, the Committee for Food Quality Control, the Committee for TB Control, the Committee for V.D. Control, the Filariasis Control Board, the Primary Health Care Board, and Office of National Advisory Board for Disease Prevention and Control. Latest additions to this office are the Division of Malaria Eradication, the Division of Filariasis Control, the Division of Vital Statistics and the Health Planning Division.

2. Department of Medical Services:

The Department is responsible essentially for the management or supervision of large governmental hospitals. These include, for example, the mental hospitals operated directly by the Central Ministry and the large general hospitals, at the provincial level. The National Cancer Institute and the Institute of Pathology, which engage themselves in both patient care and research, are also under this Department. It should be noted, however, that there are numerous smaller district hospitals of the MOPH that are not under the supervision of this Department. Furthermore, there are several hospitals under other
ministries of the Government, and also an expanding number of purely private hospitals (both non-profit and for-profit) which are not supervised by the Department of Medical Services.

3. Department of Communicable Disease Control:

This Department is responsible for nation-wide campaigns against several selected communicable diseases of relatively high prevalence in Thailand. These include malaria, tuberculosis, filariasis, venereal disease and leprosy. The operation of these disease control programmes is mainly through a "vertical" flow of authority from the Central Government out to the provinces and municipalities. Although, there has been, in recent years, a movement to decentralize health programmes and enlarge the "horizontal" scope of authority at the provincial level, these communicable disease control programmes are still managed essentially from the top of the pyramidal structure of the MOPH.

4. Department of Health:

This Department is responsible for supervision of most of the other preventively oriented programmes of the Ministry. These include such fields as nutrition, family health, dental health services and environmental sanitation. Highly important has been
the delegation to this Department of responsibility for several special innovative programmes in "primary health care" which will be discussed later. Moreover, since most of the family (maternal and child health and also family-planning) health services are delivered through a nation-wide network of facilities for ambulatory service health centres, midwifery centres, and also 'medical and health centres'—the standards for operation of these facilities are promulgated and supervised by the Department. Most of the 'medical and health centres' are at the district level and contain a small number of beds (10 to 30) for minor illness or emergency cases. These centres have recently come to be designated as "district hospitals". In spite of the functions of these small hospitals being mainly curative rather than preventive, their technical supervision has remained with the Department of Health.

5. Department of Medical Sciences:

This Department has as its main objectives for promotion of research in medical sciences and the provision of modern diagnostic procedures in the treatment of prevention of diseases. It is also responsible for the management of a variety of technical services which are performed mainly at the Central Government level. These include, for
example, a Radiation Protection Service Division, an Entomology Division and a Virus Research Institute. The National Health Laboratories Project Division is exceptional in attempting to organize a network of clinical laboratory services throughout the country, as well as operating a major central laboratory in Bangkok.

6. Office of Food and Drugs Committee:

Office of Food and Drugs Committee, the newest of the major administrative entities of the MOPH, has responsibility for protecting the population against hazards in the consumption of food or drugs or the use of cosmetics. As we shall see, the use of drugs in Thailand—both those that are medically prescribed and those purchased directly 'over the counter' by patients—absorbs a substantial share of all expenditures for health purposes in the nation. The establishment of this Department signifies an effort by the MOPH to introduce greater controls over this important health problem. Tackling the problems of substance abuse (drug addiction) is only part of this larger pharmaceutical problem.

Under the general surveillance of the latter Department but operating as a semi-autonomous government enterprise, is the Governmental
Pharmaceutical Organization (GPO). This public entity was started in 1939, originally under the Ministry of Economics to prepare drugs for use in governmental facilities and to save on foreign exchange.\(^1\) In 1942, when the MOPE was formed, it was transferred there and eventually combined with the Division of Medical Depot of the Department of Medical Sciences. Currently, the GPO produces 364 items which, it is estimated, constitute nearly half of the drugs and vaccines distributed to governmental hospitals and health centres.

Since 1950, the activities of the above departments have been expanded by the assistance of and cooperation with the following international and foreign organizations: the World Health Organization, the United Nations Children's Fund, the United States Agency for International Development, the Rockefeller Foundation, the China Medical Board of New York and several governments under the Technical Co-operation Scheme of the Colombo Plan. The projects which have benefitted by the international and foreign aids are malaria eradication, yaws control, tuberculosis control, maternal and child health including family

health, community health development and village sanitation, environmental health, vital health statistics, medical education, trachoma, leprosy, control, health education of the public nursing and midwifery education, nutrition promotion and training of personnel.

Field Administration: Local Health Administration

Traditionally, the numerous functions of the MOPH just summarized were carried out under higher centralized authority, but in recent years stress has been put on the delegation of responsibilities peripherally towards the local level.¹

Field Offices: The Ministry of Health has field offices spread throughout the country. There are 14 Regional Hospitals, 73 Provincial Hospitals, 323 District Hospitals, 4,204 Health Centres, 2,271 Midwifery Centres and Village Health posts (Refer Chart IV).

Each of the 73 provinces has an office of the Provincial Chief Medical Officer. The PCMO is a public health physician, who is responsible for supervision of both preventive and curative functions

1. Chalard Tirapat, Medical Referral System in CBD Project, Bangkok, Mahidol University, Public Health Faculty, April 1977.
MINISTRY OF HEALTH'S SERVICE INSTITUTION

AT
PROVINCIAL LEVEL

Regional : 9 regions
Regional hospital (19 hosp.)

Provincial : 73 provinces
Provincial and district hospital (73 hosp.)

District : 623 Amphoe
Medical and health Center (323 District hosp.)

Tambon : 5,608 Tambon
Health Center (4204 Centers)

Big Village
Midwifery center (2271 Centers)

Villages : 58,202
Village health post

(included big village)
Thus he oversees the Provincial General Hospital of which there is at least one in each province and sometimes two, making a total of 38. These hospitals vary in size from 60 to as much as 800 beds. The PCMO is also responsible for the technical supervision of the work of the District Health Offices in the province. These offices are headed by a District Health Officer (not a physician), who is typically a sanitarian with additional training in general public health administration.¹

Within some, but not all, of the districts there are District Hospitals of 10 to 30 beds, staffed by at least one physician along with nurses and other health personnel. Also within some but not all of the sub-districts or communes (tambons) there are health centres staffed by nursing and other allied health personnel (but not physicians). In some but not all of the villages, especially the larger ones, there are midwifery stations, staffed simply by a trained auxiliary midwife. The last two types of health facilities come under the general supervision of the

¹ Samlee Pliabangchang, Director of Technical Division, Department of Medical Services. MOPH personal interview, Bangkok, November 1978.
District Health Officer, but the District Hospitals, being staffed with physicians, are more particularly the direct technical and administrative concern of the PCMO.¹

The PCMO is appointed by the central Under-Secretary of State for Public Health, and is technically responsible to him. He may be advised and assisted also, however, on various technical problems by specialists from the several other departments of the central MOH, for example, on problems of time, the PCMO is administratively responsible to the Governor of his province, who is appointed by the Department of Local Administration of the Ministry of Interior. Provincial Governors are important officials in Thailand, and it is evident that the PCMO must exercise great discretion in combining his technical responsibilities to the central MOH with his administrative responsibilities to the Provincial Governor.

In the same way, the District Health Officer, while technically responsible to the PCMO is administratively responsible to the generalized District Officer. The latter official, like the

¹. Uthai Sudsukh, Director of the Rural Health Division, Office of the Under-Secretary of State, MOH, personal interview, Bangkok, November 1978.
Provincial Governor, is part of the network of authority of the Ministry of Interior.

The most recent development in the network of local health services under the MOPH is the programme of training and activity of "village health volunteers" (VHV) and "health communicators" (HC) in selected villages throughout the nation. Starting with the movement to limit population growth by encouraging family planning (FP), this programme has broadened to encompass the provision of general primary health care. These village people are part-time health workers who depend for their livelihood on some other occupation. They are not considered part of the bureaucratic structure of the MOPH or any other Government agency. Their method of selection, functions, and characteristics will be considered in a later Chapter.

Thus, it is evident that MOPH, both centrally and at the several peripheral levels, has a very wide range of functions. They embrace both preventive and curative services, and they involve liaisons with various officials of provincial and local Government

within the nation-wide network of the Ministry of Interior. Even so, as we shall see, there are numerous health activities under the private sector. On the whole, the scope of MOPH authority does not extend to these other activities; when it does the relationship is quite indirect. The Ministry of Public Health must ensure co-operation and co-ordination among allied agencies to achieve good results. It needs to develop an effective information system network to involve all allied agencies (Refer Chart V).

Now we deal with other Ministries which have a good deal of bearing upon the health service system of Thailand.

1. Ministry of Interior: (Refer Chart VI)

As already mentioned, public health responsibilities were carried within the Ministry of Interior before the MOPH was established in 1942. Since then, the Ministry of Interior (MOI) has by no means abandoned all its health responsibilities but continues to exercise them in a variety of ways.

(a) The Department of Local Administration in the MOI was organized around 1911, and was responsible for establishing the basic structure of provinces, districts, communes and villages described earlier. Among other things, the basic law entrusted to each
CHART NO. 5

FUNCTION

Basic data gathering

- Data collection

- Statistical processing & analysis

- Information summary

- Information processing

- Monitoring & Evaluation planning

- Health departments

- Dissemination

LEVEL

Village
Primary Health Care Workers

Taliban
Health Centres Midwife Clinics

Municipality
Sanitary Districts

District
District Information Centre

District hospitals
Health Centres

Province
Provincial Information Centre

Provincial hospitals
municipality
Private sector

Other sectors

Centre

Central Information Centre

NOTES:
National Economic & Social Development Board (National Planning Committee)
**Nao:** National Statistical Office
cluster of villages (tambon) or commune, the protection of the population's health. This was implemented by getting the people to choose a responsible person—the tambon doctor. This official was, of course, not a physician, but usually a traditional healer whom the people knew. The tambon doctor was responsible to the General District Officer, and it was his duty to oversee environmental sanitation, to encourage vaccinations (which might be given by district public health authorities) and to provide first aid or simple remedies to the injured or sick. The quality of performance of these tambon doctors was naturally extremely limited.

About 1950, brief courses of training on elementary hygiene were given by the MOH to the tambon doctors and also to traditional midwives who were appointed to work with them. A supply of simple drugs was provided to the tambon doctor by the Government Pharmaceutical Organization. Today, there are an estimated 5,000 tambon doctors serving under the MOH throughout the nation. Most of them are farmers, and the health work is only part-time; some are health assistants who were formerly in the military forces. They receive a small stipend of
200 baht\(^1\) per month from the Government but they may also collect payments for the drugs they dispense, and some engage in private practice. These tambon doctors are expected to work cooperatively with the network of health personnel of the Ministry of Public Health but the extent to which this occurs is uncertain.

Another quite separate health function of the MOI is the overall supervisory responsibility for public health services in the nation's municipalities. In 118 of the 163 municipalities of Thailand, there are "Municipal Doctors" designated by the MOI. These are the physicians, who are paid about 3,000 baht per month by the Ministry—through subsidies to the municipal government by supervising environmental sanitation and communicable disease control. In the larger municipalities, they are assisted by a staff of sanitarians and nurses, who are paid from municipal revenues entirely. The municipal doctor may operate a small public first aid type of clinic and he serves also as coroner to investigate suspicious deaths. Nearly always, the municipal doctor is also engaged in private medical practice from which he earns his

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1. Dumrong Soonthornsratoot, Director-General of the Department of Local Administration, Ministry of Interior, Personal Interview, Bangkok, Nov. 1978.
principal livelihood. He is administratively responsible to the elected Mayor of the municipality, but he may get technical advice from the MOPH Provincial Health Officer.

Municipalities are responsible also for operating any public systems of water supply or sewage disposal. Outside of Bangkok, municipalities range in size from 10,000 to 50,000 population. In constructing public water supplies, the smaller ones usually work with a state enterprise of the Central Government, known as the Provincial Water Supply Authority.

The Bangkok Metropolitan Authority (BMA) covering more than 4,000,000 population, report directly to the Ministry of Interior while other municipal governments come under the supervision of each Provincial Governor. The entire public health programme of the BMA is, of course, much more highly developed.

(b) Department of Public Welfare:

Quite separate from the health activities of the MOH Department of Local Administration summarized above, are those of the Ministry's Department of Public Welfare. While the several Divisions of this Department are oriented towards general assistance to disadvantaged persons, much of this work has implications
for the health service. Thus, the Division of Child and Youth Welfare operates 21 institutions for orphaned or abandoned children.¹

This Department also operates six Homes for Aged with 1200 residents.² It conducts a programme of rehabilitation of "socially handicapped women" (prostitutes), which includes three institutions with 2,000 residents. Several hundred thousand persons are isolated and illiterate members of "hill-tribes" in northern Thailand, for whom the Public Welfare Department conducts a varied programme oriented to agricultural and social development, including health protection. Opium addiction is a special problem being tackled in this tribal population.

Beyond the Ministry of Public Health and the Ministry of Interior with its diverse Departments, there are numerous activities of other Ministries that contribute to health services to some degree in Thailand. These may be noted briefly.

2. Ministry of Defence:

As in nearly all countries, there is a well-established organization of military forces in

Thailand. In order to assure the efficiency and health of their personnel, the Thai Army, Navy and Air Force operate a network of 18 hospitals.\footnote{World Bank, The National Family Planning Programme--A Sector Report: Thailand, Bangkok, Report No. 724a-Th, 1975, p. 36.} These institutions serve not only the men on active military duty, but also to some extent their families. At all military posts, furthermore, there are military medical officers or auxiliary trained corps men for rendering day-to-day ambulatory medical care.

In addition, there is one hospital maintained by the Ministry of Defence for military veterans who have disabilities related to their military service. An Institute of Pathology is also operated by the Ministry in Bangkok for research purpose, as well as for doing pathological studies on patients.

3. Ministry of Education:

As noted earlier, most primary schools (grades 1 to 4) in Thailand, coming under the supervision of municipalities, are in part a responsibility of the Department of Local Administration of the Ministry of Interior. Financial support for these schools, however, as well as full responsibility for primary schools in rural areas, is provided by the Ministry.
of Education. This Ministry also finances and operates all secondary schools, as well as certain technical training institutions, and some (not all) colleges and universities.¹

In all of these schools, especially those at the secondary level, some instruction is offered in personal hygiene, as well as other aspects of health education. The schools also provide, of course, a convenient setting where children may be reached by public health officials for immunizations or special screening tests.

¹ Office of University Affairs:

Until recently, responsibility for the 14 universities in Thailand was vested in the office of the Prime Minister. In 1976, it was transferred and given a separate status as the Office of University Affairs. The component institutions include six of the nation's seven medical schools, several other faculties for training in the health professions and the large important affiliated teaching hospitals. As we shall see, the cost of operating these health science

schools, and especially their teaching hospitals, involves a substantial portion of national expenditures for separate from the nation-wide network of hospitals supervised by the Ministry of Public Health.

The National Research Council which, among other things, conducts and also subsidizes medical research, has been retained in the Office of the Prime Minister.

5. Ministry of Agriculture and Co-operatives:

Among its many surveillance responsibilities in agricultural production and marketing, this Ministry is responsible for enforcing the law controlling pesticides which may be harmful for human consumption. It is also involved in the vaccination of animals, necessary for the prevention and control of zoonotic diseases (that is, animal diseases which may be spread to humans).

6. Ministry of Industry:

The functions of the Department of Labour in the Ministry of Interior--involving the protection of the safety and health workers--were noted earlier. In addition, the Ministry of Industry, concerned with the overall development of industrial enterprise in Thailand, has certain responsibilities involving the safety of industrial processes and the control of environment
pollution by factories.

The Factory Acts of 1969 authorized this Ministry to inspect and approve of all factories with seven or more workers or utilizing machinery of 2.0 horse-power or above. There are thousands of small workshops below this size, but in all Thailand there are an estimated 40,000 factories which come under the Ministry of Industry's surveillance. The commonest type are rice mills--located throughout the nation--and other types concentrated in Bangkok and a few other cities, which manufacture textiles or wood products, do printing, repair machinery and produce various consumer goods. Factories of the specified size require licensing every three years, and this entails inspection by one of 120 inspectors of the Factory Control Division. These inspections are expected to identify accident hazards, and the Division may enforce the safeguarding of machinery or the use of protective equipment (such as masks or ear-muffs) by the workers. Another common problem is stream pollution from industrial by-products. In 1977, for example, about 200 factories were temporarily closed down by the Ministry of Industry until these problems were corrected.

There seems to be some overlap between the factory inspection functions of the Ministry of Industry
and the worker-protection functions of the Department of Labour in the Ministry of Interior. The latter agency also has 88 inspectors for occupational safety and health. Labour legislation requires that firms with 500 to 1000 workers must maintain a clinic staffed by a nurse in the factory; if there are over 1,000 workers, a physician is supposed to be within access at all times.¹ It is the Labour Department of the Ministry of Interior that is expected to enforce this legal requirement, as well as to identify hazards for accidents or occupational diseases and enforce their correction. There is also an Occupational Health Division in the Department of Health of the Ministry of Public Health, which may make special studies of occupational disease problems on invitation.

7. Ministry of Finance and Other Ministries:

    Under the Ministry of Finance is the Bank of Thailand, the National Tobacco Monopoly and numerous other "state enterprises". These may be wholly governmental operations or partnerships between the Government and private investors. Most public utilities, such as for electricity, public water supplies or

telephone service, are of this nature. Some such as
the Port Authority are under the Ministry of
Communications or elsewhere in the Government.

Altogether, there are some 72 of these state
enterprises, which tend to be large organizations with
hundreds or even thousands of workers. Virtually all
these enterprises provide some type of health service
to their employees. The Port Authority and the rail-
road system even operate special hospitals for their
workers.

Non-Profit Organizations:

Outside the sphere of government, Thailand, like
nearly all countries, has numerous private non-profit
organizations, with various charitable functions
including health service. It is required that these
organizations—many of which are linked to religious
bodies—be registered with the Department of
Religious Affairs in the Ministry of Education. An
official of this agency estimates that there are as
many as 6,000 charitable agencies officially
registered and that about 100 of these are principally
or entirely devoted to the provision of health
services.¹

¹. Rangab Wantansaing, Chief of the Cultural Division,
Department of Religious Affairs, Ministry of
The largest voluntary health organization is probably the Red Cross of Thailand. This organization collects donations of blood, operates blood bank, an eye bank and furnishes blood for transfusions to hospitals throughout the country. The Red Cross operates first-aid emergency clinics in Bangkok and a few other cities, as well as some ambulances. One of the largest hospitals in Thailand, the Chulalongkorn Hospital in Bangkok, was founded by the Red Cross and is still nominally owned by it, although it is financed almost entirely by the Central Government. In addition to the funds it raises from private philanthropy, the Red Cross receives regular subsidies from the national Government.

Anti-Tuberculosis Association of Thailand:

Another important voluntary health agency is the Anti-Tuberculosis Association of Thailand. Most of the activities of this organization are conducted in Bangkok, where it operates a chest clinic and a 100 bed chest hospital. The Association also operates two

1. Songkram Supcharoen, Secretary-General of the Anti-Tuberculosis Association of Thailand, Personal Interview, Bangkok, Nov. 1978.
mobile chest X-ray units, which do screening surveys in factories and schools of the Bangkok metropolitan area. It maintains a laboratory for sputum examinations, and provides continuing education to doctors on tuberculosis and other chest diseases.

It is noteworthy that, in spite of its voluntary non-profit character, the Anti-Tuberculosis Association requires payments for most of its services. The hospital budget, for example, amounts to about 6,000,000 baht per year, but only about 150,000 baht of this amount is contributed by the Association from charitable sources; the rest is derived from patients' fees. A substantial proportion of patients are government employees, whose care is paid for by their employing Ministries. For chest X-rays, a small charge is also made (10 baht) to cover the cost of the film. One of the services that is free of charge is the BCG vaccination.

Community-Based Family Planning Services:

The world-wide movement to limit population growth has given rise to several voluntary health agencies in Thailand. Perhaps the most effective of these is the Community-Based Family Planning Society, which promotes family planning practices in thousands of villages throughout the nation. This organization
co-operates closely with the Ministry of Public Health, which coordinates Thailand's overall National Family Planning Programme. As was noted for the Anti-Tuberculosis Association, only a small portion of the costs of this family planning society is derived from grants given by international and national governmental bodies and from fees paid by patients for the contraceptive pills or other birth control supplies.*

Within Thailand, there are numerous "foundations" supported by charitable contributions from members of certain ethnic groups. Chinese merchants, for example, support the Kwong Soo Hospital Foundation, which maintains maternity homes for women of Chinese background. There are similar foundations supported by Japanese donors, by Moslem groups and others. Buddhism, as the predominant religion of Thailand, of course, is associated with many charitable activities impinging on health.

Profit Motive Private Health Service:

Finally, one must recognize the operation of a


* For details refer to a separate Chapter on CEFPS.
purely private for private (or proprietary) sector in
the health care system of Thailand. Although this
section has been devoted mainly to an analysis of
organized health programme under various governmental
and non-governmental sponsorships, the dimensions of
the non-organized or free-market private health care
sector are exceptionally so large in Thailand that it
requires special attention. These can be classified
as follows:

(a) Traditional Healers and Related Resources:

For centuries before modern "Western medicine"
was introduced into Thailand in the early 19th
century, healing services were rendered by Buddhist
priests and by a variety of non-clerical healers.
The latter persons employed a variety of treatment
methods, including both invocation of supernatural
forces through magic and also empirical physical
procedures such as massage and ingestion of various
herbal remedies.¹

Thousands of these traditional healers still
render services to the sick in rural villages and
even to some extent in the towns. As more effective,
scientific services have become available, the

¹ James W. Riley and Santhat Sersi, The Variegated
Thai Medical System as a Context for Birth
Control Services, Bangkok, Mahidol University,
Institute for Population and Social Research, 1974.
relative importance of traditional healing has declined, but it has by no means disappeared. In fact, many traditional healers have learned of the effectiveness of certain modern drugs such as antibiotics, and obtain them for administration to patients along with various magical procedures.

(b) Traditional Birth Attendants:

Another form of traditional health worker is the untrained midwife or traditional birth attendant. These are almost invariably older women, who have given birth to many children of their own and who gradually acquire skills in helping to attend child birth for their neighbours. Along with the physical delivery process they often employ certain policies of maternity care which reflect long tradition even though they may actually be harmful to the mother or infant. Many traditional midwives, on the other hand, have been given training by public health authorities and play roles within organized modern health programme.

(c) Drug Sellers:

Quite separate from traditional healers are various types of stores selling drugs—usually a combination of modern pharmaceutical and ancient traditional remedies. In addition, however, there
are thousands of stores selling food or other merchandise in the towns and villages, where drugs may also be purchased.

(d) Private Physicians and Dentists:

Relatively few graduates of modern schools of medicine or dentistry in Thailand are exclusively devoted to private practice. On the other hand, almost all medical and dental practitioners, who are employed in one of the governmental or other organized health programmes described earlier, spend part of their time in private practice. When they complete their duties in a hospital, health centre or other facility, they serve patients in private "clinics". They charge patients on a fee-for-service basis and typically gain much higher earnings from this private work than from their salaried positions.

(e) Private Hospital Care:

In Bangkok and other principal cities of Thailand (typically provincial capitals) there are an increasing number of purely private proprietary hospitals. In these facilities, which usually have small bed capacities, the patients are attended either by a selected staff of private physicians or sometimes by any private practitioner in the area. These
hospitals are to be distinguished from voluntary (non-governmental) and non-profit hospitals, even though patients in the latter institutions must also pay private charges for their hospital care.

In addition, many government hospitals, especially the large ones, maintain a small percentage of their beds for private patients. The physicians serving these patients unlike those in purely proprietary hospitals, must always be members of the salaried medical staff of that public hospital. When a patient is served in a private room of a public hospital or in any bed of a private hospital, payment must be made separately for the hospital care and often for the physician's services. Taken together, private health service of all the types—traditional self-care or modern described briefly above—although not socially organized, encompasses actually the greater part of all health services rendered to the people of Thailand. Thus, in the total health care system of Thailand whether quantified by volume of services or expenditures for them, the private sector is larger than the aggregate of all organized programmes, governmental or voluntary.

Challenges of Health Care Administration:

Before we analyze the specific health problems
in Thailand, we discuss the challenges of health administration. There is a great potential in Thailand to solve all the present and emerging health problems. This needs resolute determination to solve health problems based on proper planning. Health services have become more complex as a result of technological, social and economic advances. In order to reap the benefits of modernization, a recent UN report has indicated that in both developed and developing countries, "a growing awareness has emerged out of the need for a more efficient administration, management and delivery of health care services, which will have to be more adapted to local conditions."\(^1\)

We discuss the challenges of health administration which need the attention of policy-makers, planners and health administrators, to provide adequate and effective health care to all at the earliest. This calls for strengthening the administration and management of the national health services. One of the WHO publications very ably remarks:

"Effective administration and management call for more intensive preparation and training of senior medical and non-medical

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administrative personnel, whose functions must be considered in the wider context of the national public administration and not just in the mere limited sphere of public health administration. The major share of national budgets in the future will most certainly go to the departments that develop and use the best systems of planning, performance and programmes-accountability."

Following shortcomings in the field of health administration have been mentioned in general:

(a) The inability of the health care system to make available the services required to meet the demands of those most in need, who are usually too poor or too geographically or socially remote to benefit from such facilities.

(b) Wide differences in resources distribution and service and a multiplicity of institutions which are unrelated and not functioning as a system.

(c) The placing of emphasis on medical rather than overall health care. The curative aspect of


2. Based upon discussion with the Officials and Experts in the Ministry of Health.
care has been stressed with insufficient priority to promotive, preventive and rehabilitative care. This has resulted in a fragmentation of the care provided to the individual.

(d) Training of health personnel directed primarily towards medical and institutional care, and largely irrelevant to the tasks and functions required outside institutional settings.

(e) The education and training of health professionals in such a manner as to accentuate the social distance between health professionals and the population, resulting in an inability on the part of the providers of health services to identify with the consumers.

(f) A lack of recognition as well as a rejection of useful, traditional healing practices.

(g) An inadequate assessment of other community resources, imposing unnecessary limitations on the scope of action of health services and often preventing them from approaching major community needs in an effective manner.
(h) The people have rarely been given the opportunity to play an active role in deciding the types of activities they want and have not participated in the actual services they receive. Community interest and resources have too often been inadequately expressed and activated because there has been a failure to recognize that people will be most interested in and responsive to activities related to their own priority concerns.

We have discussed in detail some of these problems in the various Chapters that would follow. We shall concentrate here only on some of the challenges of health care administration which must be solved to provide health care to the people.

1. Lack of Co-ordination and Linkages:

Co-ordination means bringing about consistent and harmonious action of persons and programmes with each other towards a common goal. The co-ordination is lacking in the field of health care administration resulting in poor delivery of health services. We have already seen that there a large number of agencies engaged in the provision of health services, but without common policy. Professor Kofide (Iran) has rightly indicated that there exists a fragmentation
of responsibilities for the delivery of health care, with overlapping, conflicting and competing organizations within the health system and widely scattered funding mechanism with little control over costs. Health services authorities give only token recognition to those segments of the services that are not under their direct executive or financial control and often plan only for that part of the national budget that is said to be their responsibility. The state of affairs is unjustified and harmful.¹

Resources for the health care delivery are limited in Thailand. An effective health approach and strategy requires the co-ordinated efforts of sectors and agencies that can contribute directly or indirectly to the promotion of health care. Such coordinated efforts would promote health services that will be more efficient and effective from both the standpoints of the providers and that of the beneficiaries. The need of co-ordination is so great that according to Findlay, "It expresses the principles of organization into nothing less."²

The first essential requisite to achieve

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1. WHO, WORLD HEALTH PAPER 55, p. 83.
coordination is to develop meaningful linkages with sectors of social and economic development which can influence the promotion of health care, e.g., agriculture, public works, housing, communication, education, etc.

The second step is to pool the efforts of all health agencies at all levels in a system to achieve maximum output: public and private; national and international; curative and promotive; peripheral, intermediate, and central; western medicine and traditional medicine. This would avoid the dangers of disfunctional attitudes.

In Thailand, there is no coordination or as is commonly known Regionalization (Pyramidal Model). At provincial hospitals, the staffs have no contact with District hospitals in the same province. Likewise, health centres at the sub-district or "tambon" level are not regarded as functional satellites of district hospitals, but rather are simply supervised by the non-medical District Health Offices. The midwifery stations and Village Health Posts, moreover, get little guidance from the local health centre, but are simply supervised by the District Health Officer. Thailand should adopt a co-ordinated concept of regionalization as the mechanism by which quality may be assured in peripheral
or isolated institutions.1

Third, there is the need of welding different aspects of health services into a total health package, e.g., integration of maternal and child health care, family planning, prevention of communicable diseases, health education and environmental sanitation.

Coordination and linkages on a systematic, rather than on ad hoc basis, will definitely reduce costly duplications of efforts and lead to increased health coverage of the needy population and neglected area, while making the optimum use of the resources. Most of the health experts, in their reply to the author, admitted that the lack of co-ordination in health care delivery system is a serious challenge. Even WHO has recognized it. To quote WHO:

"The consensus of opinion is that the most important managerial problems are foreseen in the continued reduction of the imbalance of the system and the lack of integration in the distribution of care with the existence of parallel systems with different objectives. Fragmentation and division of responsibility between the different levels of care have led to a lack of effective communication between the health and social

welfare agencies... As there are several agencies providing medical care there is overlapping and duplication of activities. The major managerial problems... is to recognize the various components of this system in a way that reflects complementarity, eliminates duplication, and minimizes waste of resources.\(^1\)

How can we achieve effective co-ordination? According to Dr. White, its achievement may require "the most delicate insights, the most mature wisdom and perception of a truly artistic quality."\(^2\)

It has to be achieved through formal as well as informal methods.

The effective co-ordination and linkages would automatically result from effecting planning, policy-making and manpower planning.\(^3\) After planning and policy-making, the effective instrument to achieve co-ordination is to design a sound organization. Dr White says:

"An organization characterized by clear lines of authority, adequate powers,

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1. WHO: Public Health Papers, 55, p. 83.
3. For details, refer to the respective Chapters.
well-understood allocation of functions
absence of overlapping and duplication
of effort and proper delegation of work
in itself reduce the necessities of
co-ordination." 1

Besides, if the organizational boundaries are
properly demarcated, there would be little scope of
confusion and misunderstanding and co-ordination
would naturally flow from this inherent structure.

The co-ordination among different agencies,
however, can be obtained through mutual consultation
or information. This mutual consultation should be
encouraged through setting up of inter-departmental
agency/committees for joint planning, joint-decision-
making and joint action in areas concerning more than
one agency. While achieving co-ordination, we may
keep the cost factor in mind. Such inter or intra
agencies can serve a useful purpose when the members
come duly prepared with a sense of urgency and
commitment. According to Key "a session of an inter-
departmental committee tends to be a place where
departmental representatives come well prepared to
defend their position and leave more convinced than
before the correctness of their attitudes." 2

2. V.O. Key, Politics and Administration in White (Ed.),
The Future of Government in the United States,
p. 155.
2. Lack of Equity of Distribution and Adequacy of Coverage in Relationship to Need

Three quarters of our population is rural, yet three quarters of our medical resources are spent in the towns where three quarters of our doctors live. Three quarters of the people die from diseases which could be prevented at low cost and yet three quarters of medical budgets are spent on curative services.

The large population of the people living in rural areas are not being provided even rudimentary health care in this age of modern medicine. The doctor to population ratio in Bangkok is 1:833, while in the rest of Thailand it is 1:24,000. Likewise, the absence of District Hospitals in some 45 per cent of the nation's 5% districts and of Health Centres in 27 per cent of the nation's 5,547 "tambons" or sub-districts underlies the extent of shortages in health facilities. The Government must serve the millions of people who suffer from chronic poverty, ignorance, disease and inequality of opportunity.

Have we lived up to the expectations and aspirations of the people? The answer is plain and simple: certainly not. What can we do in future to devise technology and organization objectives and structure that would benefit the largest number of
the people. What is required is change of ideology, philosophy and priorities in favour of the poor people, i.e., any device to improve health care should ensure improvement in the health status of the whole population. This may be possible if our planning in future takes care of the following:

(a) We should attend to the needs of the largest groups rather than meet the demands of a particular group or section of society. We can ascertain the need of the target groups through epidemiological studies.

(b) We may provide the health care to the people through the technology that may reach all. We may not invest in highly sophisticated technology only to be used by the few. The dilemma can be best described as an attempt to ride two horses galloping in different directions. On the one hand is maintenance of the high standard of medical excellence taught in the west. The other is the problem of providing health care for the millions of poor who cannot possibly provide an economic support base for our Western-styled health systems. There is no particular merit in promoting the highest level of medical services when the direct result is medical care
cost beyond the reach of four-fifths of the population.¹

We must train more and more health personnel of lower categories who can serve the people at large and restrict the few specialities only for referral services.

3. Poor Financial Allocation to the Health Care Delivery and Improper Utilization of Existing Resources:

Thailand does not give high priority to the allocation of resources to the health care of their people. Table 1 presents Government expenditure on health (1975-80). The analysis of the table indicates that total government expenditure has been rising from 4.78 per cent in 1975 to 6.61 in 1980. Besides, the ratio of Government expenditure on health to private expenditure on health is very high. It varies between 1:3.48 (1975) and 1:2.34 (1980). Table 2 presents the Ministry of Public Health budget compared with the national budget (1967-1980). The analysis indicates that the expenditure has been increasing from 2.87 per cent in 1967 to 4.44 per cent in 1980. However, the percentage of health budget increase from the previous year has been low as compared to the percentage of budget increase from the previous year. The health

Table 2
The MOPH budget compared with the national budget (1967-1980)

<table>
<thead>
<tr>
<th>Year</th>
<th>Health Expenditure (Million $)</th>
<th>National Budget (Million $)</th>
<th>Health Budget as Percentage of National Budget</th>
<th>% of budget increase (from the previous year)</th>
<th>% of health budget increase (from the previous year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1967</td>
<td>551,524</td>
<td>19,228</td>
<td>2.87</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1968</td>
<td>587,568</td>
<td>21,262</td>
<td>2.77</td>
<td>10.58</td>
<td>6.59</td>
</tr>
<tr>
<td>1969</td>
<td>643,610</td>
<td>23,960</td>
<td>2.69</td>
<td>12.69</td>
<td>9.47</td>
</tr>
<tr>
<td>1970</td>
<td>785,116</td>
<td>27,300</td>
<td>2.88</td>
<td>13.94</td>
<td>21.97</td>
</tr>
<tr>
<td>1971</td>
<td>977,967</td>
<td>28,645</td>
<td>3.41</td>
<td>4.93</td>
<td>24.58</td>
</tr>
<tr>
<td>1972</td>
<td>956,931</td>
<td>29,000</td>
<td>3.30</td>
<td>1.24</td>
<td>-2.2</td>
</tr>
<tr>
<td>1973</td>
<td>1,023,161</td>
<td>31,600</td>
<td>3.24</td>
<td>8.97</td>
<td>6.99</td>
</tr>
<tr>
<td>1974</td>
<td>1,113,161</td>
<td>36,000</td>
<td>3.09</td>
<td>13.93</td>
<td>8.84</td>
</tr>
<tr>
<td>1975</td>
<td>1,547,356</td>
<td>48,000</td>
<td>3.22</td>
<td>33.34</td>
<td>38.96</td>
</tr>
<tr>
<td>1976</td>
<td>2,725,286</td>
<td>62,650</td>
<td>4.35</td>
<td>30.52</td>
<td>76.13</td>
</tr>
<tr>
<td>1977</td>
<td>3,520,608</td>
<td>68,790</td>
<td>5.12</td>
<td>9.8</td>
<td>29.19</td>
</tr>
<tr>
<td>1978</td>
<td>3,405,700</td>
<td>81,000</td>
<td>4.20</td>
<td>17.7</td>
<td>-3.26</td>
</tr>
<tr>
<td>1979</td>
<td>4,206,800</td>
<td>92,000</td>
<td>4.58</td>
<td>13.6</td>
<td>23.5</td>
</tr>
<tr>
<td>1980</td>
<td>4,840,000</td>
<td>109,000</td>
<td>4.44</td>
<td>18.48</td>
<td>15.0</td>
</tr>
</tbody>
</table>
expenditure to the total expenditure has been very low in South-East Asian countries, i.e., 1.6 per cent in Indonesia, 2.1 per cent in India, 3.8 per cent in Bangla Desh. Mongolia has been spending 10 per cent for the health care of its people. There is a need to raise the health allocations to improve the quality of life. Dr White has rightly said, "Nothing can be done without the expenditure of money. . . . Available financial resources set a maximum limit on administrative activity as a whole and on each of its separate parts."¹

A sound state of finance is of paramount importance to the political health of a nation. . . . The soundness of public finance depends both upon the right policy and good organization, but a great deal upon the latter.² The scarcity of resources affect all aspects of the health delivery system. There is a need to step up the health allocations to the minimum of 10 per cent of the total budget.

Secondly, there is maldistribution of health resources. Most of the health budgets (about 80 per cent) are being spent only on a few people (20 per cent)

in the urban and cosmopolitan areas. This deprives the
people living in rural areas and urban slums. A WHO
study group on the Financing of Health Services which
met in Geneva from 21 to 25 November, 1977 mentioned
the following characteristics which reflect the
situation in the developing countries.¹

(a) Disproportionate concentration of
expenditure on health services in
urban areas compared with expenditure
in rural areas.

(b) Heavy concentration of expenditure
on secondary and tertiary care
services compared with expenditure on
primary care services.

(c) Heavy concentration of expenditure on
curative services compared with
expenditure on preventive services.

We can correct this imbalance through the
innovative health policies developed in tune with the
needs of the country rather than based on any foreign
model.²

2. S.L. Goel: Health Care Administration, Sterling
The third serious problem in this area is of inefficient use of expenditure and non-utilization of actual and potential resources, judiciously and properly. In the developing countries, huge resources are being wasted because of the selection of inappropriate technology, inefficient management, and unsatisfactory control mechanisms.

"It is necessary that public revenue should be raised in an equitable manner and spent economically so that the tax-payers may get full value of his money."^3

The objects of financial control are to ensure (i) that no wastage of resources occurs; (ii) that public money is not misused; and (iii) that intended results are obtained with the money spent. We can exploit the potential resources through careful planning and management. The traditional system of medicine can be of immense value to provide health care at a very low cost provided this is properly tapped by the designers of health services. It was reported in a recent UN Survey (1976) that these


3. P.K. Wattal, Parliamentary Financial Control in India.
adverse trends are despite the higher percentage of
government expenditure being devoted to health,
compared with 1960s and the fact that ratio of
population to the numbers of beds and of medical
personnel, have moved favourably. Essentially, the
continuance of poor health standards is indicative of
a less-than-optimal use of resources available. Some
aspects of this are the emphasis on curative, as
opposed to preventive techniques, embodied in the
existing hospital systems on which there is a continued
reliance and the limited coverage of available medical
facilities particularly in rural areas.¹

In a paper presented by M. Siegel, Assistant
Director-General, Department of Administration and
Finance, WHO, Geneva, to the Advisory Group on Nursing
Administration (16 December, 1957), rightly remarked:

"If the resources for health work, in
trained persons and in finances, were
unlimited, the need for constant
attention to these factors would not be
so great. But the limitation in the
number of trained personnel and the lack
of adequate financial resources are
major obstacles to greatly improved
health in the world today. We must,

¹. U.N.(ESCAP) Economic and Social Survey of Asia and
the Pacific, 1976, Bangkok, April, 1977, p. 18.
therefore, husband our resources carefully to accomplish as much as possible with what we have available."

The fourth serious challenge in this field is the rising cost of health services, beyond the reach of the most of the people inhabiting the developing societies. It is very difficult to afford the costly urban-based hospitals, using highly sophisticated technology. A huge amount is being spent on costly buildings and equipment which the developing countries cannot afford. The only services which can meet the health needs of the people are low cost services which should be efficient and effective. This is possible if we use methods and equipment appropriate to the socio-economic environment existing in a country, e.g., the people can contribute voluntary labour to maintain health services. This would reduce the cost. We must take decisions and think of alternative solutions to provide health care to the people, as financing and decision-making are complementary functions. The health administration should encourage the low-cost service programmes beneficial to the larger section of the community.

The fifth problem in this connection is the lack of co-ordination among different agencies financing health care services. This may result in
wasteful duplication of efforts. Besides, many health services may not get the desired financial allocation because of this wastage. The situation can be improved through proper co-ordination among such agencies.

4. Lack of Adequate Information Required for Health Planning, Implementation and Evaluation

Information is the life-blood of an organization. According to R.R. Duerach, "It is a system which provides management with the information it requires to monitor progress, measure performance, detect trends, evaluate alternatives, make decisions and to take corrective action."¹

There is no centralized department in the health organizations to collect, analyze, interpret, store and retrieve information. Confusion between 'statistical data' and 'information' still prevails, with the result that many statistical services fail to provide public health administrators with the information they need for sound decision-making, planning and evaluation. In most of the health organizations, the data collected from the fields is either not of the required type or is not presented

In a form or in time to be really useful to health administrators. Besides, the data is collected without a clear understanding about the use that such information will have. The routine collection of data which is neither reliable nor timely serves no purpose. These defects can be weeded out if we can design a scientific Health Information System or Management Information System (MIS). MIS is an analytical tool which facilitates more informal and better decision to be made and it helps to identify problem areas and to take timely remedial measures. It is in no case a substitute for management decisions but it is management's most important tool for decision-making. As Horton puts it:

"Good management information system is no cure for bad management. Bad information always leads to bad management, but good information does not in itself ensure good management. Information is only a tool of management. The ability to put information to work is what determines a successful manager."

Four basic processes involved in an information system are—the collection of data, storing of data, processing of data and transmission of information. The term data is used to denote the input into the

information system while information is the output. MIS should be designed to ensure smooth and proper flow of information into the desired channels. The information must be made available to the management at the required time and in right quantity and quality. It is also to be borne in mind that supplying unnecessary or unwanted information is also a sign of inefficiency of the system. To quote a UNICEF Report:

"Information Services should be recast according to the priorities of health system and should be aimed strictly at problem solving."

5. Lack of Organization Concept in Planning and Developing the System:

The absence of a clear national health policy in Thailand has created an environment in which fragmented health services have sprung up haphazardly. There is a need of a balanced health policy. Besides, the health planning, though picking up, has yet to be adopted in the right earnest. The planning of health services and their expansion requires special skills and knowledge which must be cultivated among the personnel responsible for planning. Proper identification of the health needs and priorities of the general population, is essential for the

1. UNICEF, Health and Basic Services: Keys to Development, p. 50.
development of a comprehensive national health plan.”

One of the serious defects in the process of health planning has been the concentration on the planning only in the governmental or public sector of health services.\(^1\) Moreover, even within the public sector, nearly all planning impacts are limited to the Ministry of Public Health and only indirectly on the numerous other Government agencies involved in health activities.\(^2\)

The output of physicians and other professional health professionals, for example, is a responsibility of the State University Bureau, which is officially independent of the Health Ministry. There is, of course, some interchange of ideas among these separate Government agencies but the final decisions rest with different authorities.\(^3\)

6. Lack of a Sound Health Manpower Policy

A sound health manpower policy is the main requirement for the development of any functionally

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effective health care system. Thailand has never formulated or implemented such a policy.

"The most crucial factor for the improvement of the world health situation... is undoubtedly the development of health manpower that is properly attuned to the health problems of the people and suitably trained to respond to health programme and service need."¹

We must find the method to achieve greater productivity, efficiency and cost-effectiveness in health manpower utilization. No society, especially the developing, can long justify investing years of education and training in individuals who later on perform rudimentary duties that could be achieved satisfactorily by people trained in half that time. The critical decisions in health manpower planning, concern the kinds of personnel required, the type and adequacy of education and training and financial resources necessary to produce them their relationship to each other in the health team, and where and how they would practise.

7. Lack of Community Participation and Involvement:*  
Merle Fainsod remarks: "The most favourable

* Refer to Chart VII for proposed Model on Planning Through Participation.
PROPOSED MODEL OF HEALTH PLANNING THROUGH PARTICIPATION

**TOP DOWN**
1. HEALTH DEVELOPMENT
2. GOVERNMENTAL BUDGET ALLOCATION FOR HEALTH

**BOTTOM UP**
1. FELT NEEDS
2. AREA ORIENTED
3. BUDGET ALLOCATION (PUBLIC AND PRIVATE)

THE INTEGRATION OF THE BOTTOM UP AND TOP DOWN PLANNING PROCESS
setting for progress in development administration exists where a politically influential and dynamic modernizing elite, strongly desires development and can successfully project this attitude into both the bureaucracy and the population at large.¹

Many well-intentioned and technically sound programmes aimed at solving health problems have been frustrated by a lack of popular acceptance and community participation. It has been observed that such programmes are either not actively associated or passively ignored because they do not 'belong' to the population they are designed to help; they are rather seen by the population as imposed external programmes that belong to the government and consequently deserve and require little, if any, of the population's attention, action, or other response.² We must be clear that health cannot be imposed. It can only be acquired. This requires participation based on enlightenment of the beneficiaries.³

2. WHO Chronicle, 30 (1976), pp. 177-78.
3. For details, refer to Chapter on Primary Health Care Administration.
Dr Madiou Toure, Director of Hygiene and Health Protection, Ministry of Public Health, Republic of Senegal, in his article, "The Health Revolution", in World Health (November 1979) has rightly said, "The medicine of tomorrow will be shaped by the people for the people, because the people themselves will determine their own condition, their own destiny."

Popular participation in the process of development planning and implementation is important for two main reasons. By defining development goals at the local level without paying attention to the people's own perception of their needs and aspirations, there is a great risk that development programmes evolved on this basis will not address root problems and will not be consistent with real life situations. Secondly, despite urgings by government officials to cooperate with government programmes, not having taken part in their elaboration, the people come to look upon them as the responsibility of the government, and upon themselves as spectators rather than actors in development project implementation.

The major fault of an exclusively top to bottom approach to development is that rather than generate self-reliance which is increasingly considered to be a major objective of development, it results in increasing dependence of the people on government
initiatives. It is proposed that the top to bottom strategy of development be complemented by a bottom-up approach involving participation of the people in the process of development planning and implementation. Besides promoting self-reliance, the approach will contribute to assuring that development programmes are on target and are implemented more efficiently and economically by mobilizing hitherto untapped local human and material resources.

The first step in implementation of the popular development strategy is to provide information on the new policy and strategy and to solicit cooperation by a sustained public relations campaign directed to the rural population in general and to tambon councils and village committees in particular. This is to be done through the mass media, official communications, and at the occasion of meetings with the villagers. The message should stress the new relationship of village communities to the administration, both working in partnership for more effective community development. The scheme should definitely not be presented as a bonanza by which increased government largesse will accrue to the villages but as a strategy which will make more effective use of existing resources mainly by supporting the villagers' efforts to improve their
own situation. The villagers should be informed of their right as citizens to participate in the decision making concerning the allocation of national resources but also of their duty to do so responsibly, understanding the nation resources are limited and that they, the villagers, have the prime responsibility for the development of their own communities.¹

7. Lack of Administrative Capability and Competence:

Administrative capability is sine qua non for the success of any programme. It is a major and crucial factor in the success or failure of development programmes. It is the scarcest of all resources in the developing world. With the significant increase in the complexity and magnitude of health functions, the need for administrative capability has been felt much greater to solve complex health problems. The general administrator is fit only for the maintenance of law and order and he is not suitably equipped to deal with the problems of development and welfare economics.

According to R.N.Rao, "Unlike advanced countries there is no pool of experienced and well informed leaders of thought available as potential leaders for

ministerial positions which greatly handicap their assuming policy-making and decision-making responsibilities in the Government. This results in over-dependence on the Secretaries who are non-technical general administrators.  

The technical experts must be given training in public health administration to make them competent in the art of health planning and administration.

On the basis of our discussion and analysis, the following suggestions are given in brief to revitalize the health care delivery system, to meet the challenges and fulfil the basic health needs of the people.

(i) Need of will and determination on the part of the political elite, to accept innovative measures to meet the population's health needs and priorities.

(ii) Identification and implementation of a clear and comprehensive National Health Policy.

(iii) Need of decentralized planning involving the participation of the target communities.

(iv) Mobilization of existing and untapped resources--community, government(local and national), bilateral, multilateral and non-governmental

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1. R.M.Rao, "Some Challenges in Health Administration," Background document to Xth Staff College Course at MHPW, Mimeographed.
to provide adequate health care for all.

(v) Establishment of appropriate administrative structures with necessary competence and capability and devolution of authority and responsibility for the implementation and development of the programme in a team spirit and a well-designed information system to help in planning, implementation and evaluation.

(vi) Manpower development for national health needs.

(vii) Strengthening existing rural establishment and graded extension of national administrative structures to provide adequate and accessible referral, supervisory logistical and other supporting services to ensure the judicious use of health services.

(viii) More allocation of financial resources based on the principles of equitable distribution and maximum utility.

(ix) Encouraging integration and co-ordination.

(x) Reorientation of Medical Education to suit the needs of the community.

(xi) Designing health technology to suit the environment and making the best use of existing technology of traditional system of medicine.
(xii) Improving research and development capacity to solve health problems.

(xiii) Devising measures to promote the use of simple, standardized equipment and drugs, placing reliance on available local resources whenever possible to foster self-reliance.

(xiv) Preventive health measures are crucial for sustained improvement and must be intensified to attain:

(a) Total coverage of the entire urban and rural population in the country with assured potable drinking water supply and sewerage;

(b) The disposal of urban wastes should also be given a high priority to ensure clean environment;

(c) For improving the environmental sanitation and hygiene, high priority must be given to town and country planning, provision of better working and living conditions, removal of congestion through the increased tempo of housing construction, slum clearance and prevention of water and air pollution;
(d) The nutritional status of the population must be raised and total prevention of food adulteration and drugs control should be achieved through rigorous controls;

(e) Health education should be an integral part of all health programmes.

It is hoped that the implementation of these suggestions would ensure wider and more evenly distributed health care based on social justice, greater involvement and satisfaction of the beneficiaries and more efficient and more economical health services. An efficient health administration and well-trained personnel of health care services will improve the quality of health of the people.