The 11th National Health Development Plan under the National Economic and Social Development Plan
B.E. 2555-2559 (A.D. 2012-2016)

Steering Committee on Formulation of 11th National Health Development Plan, 2012-2016
Ministry of Public Health Thailand
The Ministry of Public Health is the lead agency in developing the nation's health system with the aim of making all Thais healthy in the Green and Happiness Society based on the sufficiency economy philosophy adopted when formulating the 11th National Health Development Plan (11th Health Plan) under the 11th National Economic and Social Development Plan, 2012-2016. During such a period, Thailand has to cope with socio-economic changes within and outside the country which widely affect the people's livelihood. Thus, the formulation of the 11th Health Plan emphasized the importance of public participation involving the communities and all sectors concerned in undertaking such an effort in a step-by-step and continuous manner.

The 11th Health Plan formulation process began in 2010 with the review of various situations and factors affecting the public health; and in 2011, a brainstorming meeting was held for public and private agencies concerned including local government organizations and civic groups to determine the directions of the Plan, which led to the creation of strategies and plan for national health development. The 11th Health Plan was preliminarily endorsed by the Steering Committee on 11th Health Plan Formulation on 1 June 2012 and then approved by the Cabinet on 9 October 2012 for use by relevant health agencies, organizations, and network members as a directive framework for national health development.

The Ministry of Public Health hopes that the 11th National Health Development Plan, 2012-2016, will be the framework for further development and useful for all health and relevant agencies, organizations, and network members in implementing their respective programmes in a concrete manner, further leading to the national health development that is dynamically responsive to changes.

Steering Committee on Formulation of 11th National Health Development Plan, 2012-2016
Ministry of Public Health, October 2012
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## Acronyms and Abbreviations

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<th>Acronym</th>
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<tr>
<td>ACMECS</td>
<td>Ayeyawady-Chao Phraya-Mekong Economic Cooperation Strategy</td>
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<td>AEC</td>
<td>ASEAN Economic Community</td>
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<td>AFTA</td>
<td>ASEAN Free Trade Area</td>
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<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
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<td>ASEAN</td>
<td>Association of Southeast Asian Nations</td>
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<td>B.E.</td>
<td>Buddhist Era</td>
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<td>BIMSTEC</td>
<td>Bay of Bengal Initiative for MultiSectoral Technical and Economic Cooperation</td>
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<td>BMI</td>
<td>body mass index</td>
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<td>CSMBS</td>
<td>Civil Servant Medical Benefit Scheme</td>
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<td>DALY</td>
<td>disability-adjusted life year</td>
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<td>DRG</td>
<td>diagnosis related group</td>
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<td>EID</td>
<td>emerging infectious disease</td>
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<td>GDP</td>
<td>gross domestic product</td>
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<td>GMS</td>
<td>Greater Mekong Subregion</td>
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<td>HALE</td>
<td>health-adjusted life expectancy</td>
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<td>HIA</td>
<td>health impact assessment</td>
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<td>HIV</td>
<td>human immunodeficiency virus</td>
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<td>IMT-GT</td>
<td>Indonesia-Malaysia-Thailand Growth Triangle Development Project</td>
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<td>IQ</td>
<td>intelligence quotient</td>
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<td>JDS</td>
<td>Thailand-Malaysia Committee on Joint Development Strategy for Border Areas</td>
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<td>LGO</td>
<td>local government organization</td>
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<td>MoPH</td>
<td>Ministry of Public Health</td>
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<td>NCD</td>
<td>non-communicable disease</td>
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<td>NHSO</td>
<td>National Health Security Office</td>
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<td>PPP</td>
<td>public-private partnership</td>
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<td>R&amp;D</td>
<td>research and development</td>
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<td>RW</td>
<td>relative weight</td>
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<td>STI</td>
<td>sexually transmitted infection</td>
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<td>ThaiHealth</td>
<td>Thai Health Promotion Foundation</td>
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<td>TPHH</td>
<td>tambon (subdistrict) health-promoting hospital</td>
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<td>UC</td>
<td>universal coverage (of health care)</td>
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<td>UHC</td>
<td>universal health coverage</td>
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<td>VIHV</td>
<td>village health volunteer</td>
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<td>WHO</td>
<td>World Health Organization</td>
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During the period of the 10th National Health Development Plan, 2007–2011 (or 10th Health Plan), Thailand invested in several health programmes, namely infrastructure for health services at various levels, human resources production and development, technical development, and knowledge creation for people's health development, especially for mothers and children and the underprivileged, all leading to the achievement of the Millennium Development Goals (MDGs) related to health.

Thailand is regarded as one of the countries that have made much progress towards the achievement of MDGs, many of which have been achieved. However, there are two challenges related to maternal and child mortality. The first challenge is related to the variety of data sources and agencies concerned are conducting a comparative study and making adjustments to their information systems so that they are up to standards with better coverage and efficiency. And the second challenge is the slow progress in the implementation of certain area-based activities focusing on pregnant women as the starting point for human development and it is important for all agencies concerned to work together at all levels.

However, Thailand needs to develop policies and strategies especially for the development of human resources for health so that health personnel are able to improve the quality of health care, the creation of health security or insurance for the people, particularly in the long run for the ageing society, the health development for mothers and children essentially for the northern highlands and the three southernmost provinces, the promotion of access to reproductive health services for all population groups, the halting and prevention of new outbreaks of AIDS and tuberculosis, and the promotion of health for reducing and preventing cancer and cardiovascular disease.

The study on burden of disease in Thai people reveals that the major causes of disability-adjusted life years lost are non-communicable diseases followed by certain infectious diseases particularly HIV/AIDS transmitted through risky health behaviours and injuries due to traffic accidents.
Social determinants of health play a major role in changing the health problems of Thai people. Economic development efforts in the past have resulted in the better health status of Thais considered as “well-being”, while creating resultant problems especially inappropriate health behaviours, pollution, and social problems related to income distribution leading to social exclusion and political unrest, all causing physical and mental health problems.

Becoming an ageing society will unavoidably result in higher health-care costs as medical expenses rise with age: that means health-care spending will be high during the newborn phase of life, decline to the lowest level during young adulthood, and rise again during the middle-age life and highest during the old age stage.

At present, even though the Thai health service system has been successful in extending the coverage of health services through the establishment of primary, secondary and tertiary health-care facilities in all provinces across the country as well as the provision of universal health care for all Thai people, chiefly aiming to create equity in getting access to essential health services, it has been found that there are still inequities in accessing health care. This is due to the inequitable distribution of health personnel, medical technologies, and tertiary medical services that are clustered in certain areas such as Bangkok, while some other areas do not have such services. And essential health care for emerging health problems such as medium-term and long-term care for dependent older persons as well as disabled persons in the communities and institutions has not been developed as expected. Almost all physical rehabilitation services, both temporary and permanent, are provided only in large hospitals which limit the accessibility of the patients with disabilities especially those living in rural areas. The primary care system is of low quality and weak even though there has been the concept to create such a system with primary health care. This is because most of the primary care units are under the Ministry of Public Health (MoPH), the people lack understanding and confidence in the system, and personnel’s capacity is limited in dealing the changing and more complex health problems. And this effort requires the cooperation of other sectors and the community.

**Summary of the Evaluation of the 10th Health Plan**

As the human and social development as well as the rehabilitation of natural resources and deteriorating environment was progressing rather slowly, the overall development effort was unbalanced and unsustainable. Thus, the new development paradigm that focuses on the people-centred approach as well as the use of economic tools in making humans happy with a better quality of life has to be adopted; moreover, the fragmented approach to development has to be replaced by the integrated approach with public participation in all steps of the paradigm development process. The new development model was derived from His Majesty the King’s "Sufficiency Economy" principles. During the first year of the 8th Health Plan, the national policy implementation focused on resolving economic problems and reviving the economy so that it was stable and secure to minimize the impact of rapidly rising unemployment and poverty as well as to undertake the management system reforms in both public and private sectors. The national development plan formulation process during the 9th and 10th Health Plan periods and in the future was still based on the Sufficiency Economy philosophy, especially in the national administration to ensure sustainable and balanced development and living together peacefully among humans, nature and the environment. The aim of the 10th Health Plan was the development of the sufficiency Thai health system according to the Sufficiency Economy philosophy as the major policy on health development.

Concerning the use of strategies for health development, the users of the strategies were mostly MoPH agencies in both central and provincial administrations, except for some agencies under some hospitals, and indicated that they did not use any strategies because they had no units or personnel directly responsible for policy and plan analysis and transforming plan into action.

The strategic relationship has actually been in place between national level agencies and operational units. At the national level, major achievements include: the development of educational curriculums into which morality and ethics have been integrated; the opening of educational opportunity to disabled and underprivileged children; the creation of youth’s interest in vocational education; the production and development of quality workforce based on the self-reliance approach with modern technology; the management of knowledge about economy, society, natural resources and the environment favourable to life-long learning and knowledge extension; the setting up of medical and health services systems with good quality that cover all population groups; the quality assurance of drugs and cosmetics; the safety testing of foods and herbal medicines; the transfer of knowledge about health care; the strengthening of the family institution; the issuance of land deeds for poor people; the provision of funding sources for disaster-affected people; the financial assistance for indebted teachers and educational personnel; the protection of labour in both formal and informal sectors; and the creation of people’s attitudes towards peaceful and harmonious living.

With regard to the knowledge management and full-cycle community learning system, efforts have been made to create community’s preparedness and immunity to deal with any changes in the future, develop households’ database, establish the community activity standards system, build up family security, develop integrated/balanced occupational skills and community enterprise networks, support the establishment of community groups, support the use of Thai wisdom for increasing product values, promote cooperation with the private sector in creating occupations and revenues, and promote community’s rights and community participation in the preservation,
conservation, rehabilitation and development of natural resources and the environment.

Regarding research and development (R&D), the achievements include the R&D on improvement of produce and food quality, production and value addition of agricultural products, development of farmers’ institutions, promotion of sustainable agriculture, development of a national master plan for efficiency enhancement, development of value chain and new industries with high capacity, development of system for applied research on innovation of product models and production process, development of industrial clusters, promotion and development of related services, development of service business quality, promotion of tourism and related service business clientele, development of supportive factors, development and production of knowledge and personnel in science, promotion of R&D on commercial innovations, creation of logistical networks with foreign countries, promotion of transport with low energy consumption, development of international cooperation under the GMS, AOMECS, IMT-GT, JDS, and BIMSTEC frameworks, improvement of financial and monetary management, promotion of the capital market for economic expansion and stability, promotion of savings systems, creation of energy security, expansion of grassroots financial systems, and development of income sources for local government organizations (LGOs).

Concerning the information system, the achievements include the development of a geographic information system and 1:4000 scale maps, the establishment of a state land use management project, the prevention and suppression of the destruction of natural resources and environment, the promotion and development of community forests, the reforestation of degraded forests, and the establishment of earthquake warning networks, measures for environmentally friendly procurement, an integrated project for the management of Bang Pakong, Tha Chin, and Chao Phraya river basins to reduce pollution from paddy fields, a plan for rehabilitation and improvement of wastewater collection and treatment system, the Thailand Greenhouse Gas Management Organization, and the Biodiversity-based Economy Development Office (Public Organization), etc.

Other achievements include the promotion and development of democratic culture and good governance as Thai ways of life, the promotion of clean politics through public forums on the 2007 Constitution drafting process, the establishment a centre for development of national administration under the constitutional monarchy, the establishment of students council for reconciliation and good governance, the preparation of ethical standards for politicians and state officials, the empowerment of the popular sector for participation in state administration, the revision of policies for resolving southern border unrest, and the enhancement of public sector’s efficiency and good governance emphasizing facilitation rather than controlling and cooperation through development partnerships.

The results of the evaluation of the health development strategies are summarized below:

1. Strategy 1: Creating unity and good governance of health system management. Based on the 6 targets, the National Health Act has been enacted and the law’s implementation has been found to be effective; the health decentralization including the transfer of missions related to medical as well as public health services to LGOs has been partially undertaken, i.e. the transfer of 28 health centres to LGOs; and for the other 4 targets, their abstract levels were rather high.

2. Strategy 2: Creating health culture and happy lifestyles in a well-being society. Based on the 7 targets, there have been the development and use of indicators for healthy conditions, happiness and well-being of society, the development of new working models for village health volunteers with full-scale health promotion activities, and the development of systems for the safety of foods, nutrition, medicines, environment, occupations and health products; while the other 3 targets had no clear operational activities.

3. Strategy 3: Establishing health and medical services systems with recipient satisfaction and provider happiness. Based on the 9 indicators, 4 have been achieved, namely the system for compensation and mediation of medical disputes, the quality improvement of primary medical care, the assessment of service recipient/provider satisfaction, and the reduction of complaints to no more than 15%. However, the other 5 targets have not been achieved, namely the reduction of waiting time at state hospitals to less than 30 minutes, the closure of outpatient services at tertiary hospitals, the healthcare accreditation for all hospitals registered with the Universal Coverage of Health-care Scheme (UC or UHC Scheme), and the reduction of disparities among health insurance schemes, and care for patients including poor or disabled persons.

4. Strategy 4: Creating immunity to minimize the impact from illnesses and health threats. Based on the 8 targets, 5 have been achieved, namely the establishment of the emergency medical services system and disaster preparedness, the mechanism for control and prevention of emerging and re-emerging diseases, the capability to control and prevent diseases with major causes of morbidity and mortality, the promulgation of the Alcoholic Beverage Control Act and the implementation of social measures, and the measures for controlling major risk factors. However, the other 3 targets, whose policies were still unclear, include the immunity system for protecting against the effect of globalization and free trade, the health impact assessment (HIA) of major policies and projects with possible health threats, and the setting up of targets and systems for surveillance of health risk factors.

5. Strategy 5: Creating diverse health-care alternatives which are integrated with Thai and international wisdom. Based on the 7 targets, most of them have not been achieved.
6. Strategy 6: Establishing knowledge-based health systems for knowledge management. Based on the 4 targets, most of them have not been achieved.

In the implementation of the 10th Health Plan, it was actually the process of transforming policies into action or converting the intention into activities with continuous interactions, beginning with stimulating factors, followed by political movements to formulate policies and then drawing up detailed action plans for further actual implementation.

When analysing the process for transforming policy into action, the programme implementation could be measured, based on their major goals and describing the events as well as factors resulting from the national policies with the details on statement communications, law enforcement, characteristics of implementing agencies, political conditions, socio-economic conditions, or operating staff's stance or attitudes.

The transformation of policy into action under the 10th Health Plan was carried out under the leadership of four governments with five public health ministers, resulting in the policy continuity being less than what it should have been. Some policies were abolished or changed in some of their essential elements. The factors found in relation to this matter are as follows:

1. The strategies selected for transforming policy into action were not suitable.
2. The strategies for transforming policy into action were suitable, but the selected implementing agencies or mechanisms were not suitable.
3. The clarity of policies was inadequate.
4. The lack of organizational support for certain strategies.
5. The political will in using the strategies under the 10th Health Plan for further action was inadequate.

Recommendations for the formulation of the 11th National Health Development Plan (2012-2016)

1. More evidence should be used with more participation of all sectors concerned in the review and exchange of ideas, knowledge and information, and the conceptual framework for drafting the plan should be made clear, understood and jointly followed with unity.
2. The Plan should serve as the real national health development plan with the management and communication processes to create a common understanding after the Plan has been finalized.
3. The strategic planning for development should be carried out in such a way that there are linkages among the strategies and the tactics in the action plan as well as the budget plan.
4. The implementation of the Plan should be pushed forward with a clear model in a systematic and continuous manner with clearly designated agencies and officials.
5. The system and mechanism for transforming the Plan into action should be clearly and concretely established.

6. The system and process for budget allocation and spending should be in line with the National Health Development Plan and the National Economic and Social Development Plan.
7. The development of strategic plans, strategies, programmes and projects should be based on a unified planning framework for all relevant agencies.
8. The development of strategies and programmes at various levels in response to the upper level programmes should have a consistent paradigm.
9. The models and roles of technical agencies at the departmental/bureau/divisional levels within the MoPH should be restructured to facilitate the work of provincial or field-level agencies.

10. There should be linkages in the management of the 11th Health Plan, especially for turning the Plan into action, through creating and using a self-performance assessment form to follow up on the progress of the overall strategy implementation. This should also be done by using the evaluation indicators in a concrete manner, beginning with the understanding of objectives and participatory process or partnerships, the acceptance as important activities, and the creation of methods/tools for converting the Plan into action and monitoring and evaluation system.

The key element in turning the Plan into action is the understanding of the relationship between policy implementation and policy evaluation, which is an important mechanism to indicate how much the policy implementation has succeeded or failed and why.

The issues that remain to be essentially considered as health problems are as follows:
1. The shortages of human resources for health. This problem has been more and more serious partly due to the medical system focussing more on curative care rather than preventive and health promotion services. As a result, many people become ill with preventable diseases. Moreover, the medical care system using complex technologies and making such services become the duties of medical specialists, whose proportion has risen to 77.7%. In the meanwhile, the proactive primary care system at the community and family levels has been supported to provide holistic health services, including health promotion, disease prevention, curative care and rehabilitation, in a thorough and close-to-home manner, as an important strategy for resolving the problem of medical personnel shortages in the long run.
2. The shortages of medical personnel result from the “brain drain” of physicians or doctors resigning from state hospitals that provide medical services to the general public to work in the private health sector. As medical care business has been growing rapidly, private hospitals have been expanding in the regions with economic prosperity. In 2004, there were 47 private hospitals throughout the country, 129 of which were in Bangkok. The expansion of the private medical services causes the misdistribution of medical personnel in terms of quantity and quality with the
drain of such personnel from the public to the private sector and from rural to urban areas. As a result, as many as 663 doctors resigned from state-run hospitals in 2005. Besides, the promotion of medical hub policy aiming to commercialize medical services and gain revenues from foreign patients with good economic status has resulted in a huge brain drain from the public to the private sector with high remuneration. In this respect, it is estimated that worldwide the number of medical tourists will increase from 33 million in 2000 to 121 million and 328 million in 2010 and 2020 (an average annual increase of 26.7% and 17.1%), respectively.

3. Achieving the goal of “Health for All” does not only involve medical and health personnel, but everyone in every sector or society has to also collaborate in an “All for Health” manner. Political leadership and new partnership have to be created in the public, private and popular sectors so that all concerned have to take part in establishing the culture favourable to health and enhancing the learning ability of Thais to adapt and respond appropriately to changes. Moreover, it is necessary to establish cooperation and responsibility for any development activities negatively affecting health as well as to develop international health policy and good governance in the global health forum, especially in connection with the Millennium Development Goals (MDGs), most of which Thailand has already achieved.

4. The problem of budget allocation to health-care facilities based on the capitation principle: the rate is lower than the actual health-care cost, resulting in funding inadequacy especially in the public sector. As nearly 40% of the budget is personnel cost, most health-care facilities are indebted and have to bear the burden related to the lack of financial liquidity. This situation will cause a budgetary burden for the government in the future. Besides, the expansion of benefit packages under the UC Scheme to cover kidney dialysis services for approximately 14,000 patients with chronic renal failure will require an additional budget of 20,000 to 30,000 baht per case per month. And it is estimated that in the next 18 years, the number of such patients will rise to 188,435; if there is no management system and alternative selection, there might be a health spending crisis.

5. The trends of medical spending will be rising considerably in the future due to several factors, namely: (1) the pressure of the free trade requirements making Thailand buy higher-priced medicines as Thailand is unable to produce raw materials for drug manufacture; (2) the rising proportions of older persons with chronic illnesses such as diabetes, hypertension, cancer, bone/joint disease, cataract, and dental illness; (3) doctors’ prescription behaviours favouring high-priced drugs and technologies; (4) the rising medical litigation resulting in the over-prescription of medications and diagnostic tests to avoid a lawsuit for incomplete service provision; and (5) commercialized medicine using luxurious and unnecessary medical technologies.

1. Major changes at the global level

1.1 Globalization and regionalization. Globalization has a widespread impact not only on trade but also on social, cultural, health and other issues, partly due to cross-border population migration with decreased limitations. Cross-border transmissions of infectious diseases and pandemics have occurred more frequently [most recently being influenza A(H1N1)pdm09, formerly known as pandemic (H1N1) 2009]. Foreign workers are the economic driving forces in several localities: foreign men married to Thai women have become members of a number of families in Northeastern villages; Korean culture has been widely popular among Thai teenagers, etc. The idea of establishing the ASEAN Economic Community (AEC) was proposed in 2003 and the AEC will begin to function in 2015. The adoption of the ASEAN Free Trade Area (AFTA) with the reduction of all import duties to 0-5% and the abolition of non-tariff trade barriers in all Member States have resulted in more intensive linkages among the countries in the region.

Thailand has begun to play a more active role in global health forums, particularly after the Thai government has announced the Medical Hub policy for Thailand to become a regional centre of medical services, based on the country’s comparative advantages in terms of health-care costs and strong tourism industry. This has resulted in more foreign patients coming in for medical care with huge-revenues for the nation, while the problem of medical brain drain arises – medical personnel moving from state hospitals to private ones that provide such services. Recently, there have been debates about opening an international medical curriculum in a state medical school in response to the globalization of the Thai health-care system. However, there have been arguments about the inadequacy of material and human resources for health care for Thai people and Thailand's compulsory licensing of seven drugs (two antiretrovirals, one anti-cardiovascular and four anti-cancer) and a number of high-priced drugs to increase people's access to essential medicines under the UC Scheme. Such actions have prompted reactions from transnational companies and
1.2 Environmental problem and global warming. As a result of industrial development, heads of state worldwide have given importance to environmental problems and global warming leading to the adoption of the 1997 Kyoto Protocol urging all industrialized nations to reduce greenhouse gas emission by 5.2% by the year 2010, compared with that for 1990. As of 2006, 169 countries had ratified the Protocol except the USA and China, which are among the leading countries emitting greenhouse gases. Between 2000 and 2006, the greenhouse gas emission rates rose by 2.3% annually on average. However, the frequent occurrences of natural disasters in various countries are expected to be due to global warming. In 2004, the greenhouse gas emission rate rose by 5.6% compared with that for 2003, the highest proportion being the energy sector. As for Thailand, its ratification of the Protocol in 2002 has led to the adoption of the Clean Development Mechanism whereby the country can choose any operational procedures on a voluntary basis. Campaigns on global warming reduction have been undertaken to some extent, focusing on urging the people to cut down on energy consumption. But the issues that Thai technocrats are interested in are environmental problems resulting from industrial development; the latest one involving the Map Ta Phut Industrial Estate with a problem of odour nuisance in 2000-2003 and water shortages in 2005. In 2009, the Administrative Court gave a verdict to the National Environment Board to notify that the Map Ta Phut municipal area including its vicinity is a pollution control zone with measures for controlling, reducing and eliminating pollution. But the private business sector deemed that such a notification might affect investments and economic expansion. Thus, the environmental problems due to industrial development as well as the provisions of the 2007 National Health Act [Sections 10, 11 and 29(5)] have made the health impact assessment become a system and tool for dealing with such problems, especially in monitoring the health impacts from negative environmental conditions, whereas the provision of remedies for people’s damages and sufferings is another mechanism related to this matter and is in its early stage of development.

1.3 Global ageing society. As the population structure changes, Thailand is now an ageing society and will become an aged society in 2025 due to better health care and people’s longevity. The proportion of elderly persons was 13.0% of the total population in 2010 (Population and Housing Census 2010, National Statistical Office) and is expected to rise to 17.5% in 2020 (Population Projections for Thailand, 2000-2030, Office of the National Economic and Social Development Board). Over the same period, the ageing index was also on the rise to nearly half of the child population or 47.7% in 2007; and the potential support ratio had a declining trend from 7.0 in 2002 to 6.3 in 2007. Moreover, it has been found that the proportion of elderly single-person households rose from 3.6% in 2002 to 7.7% in 2007, resulting in an increase in the old-age dependency ratio and changes in the health-care delivery system which requires more specialized medical and health personnel.

1.4 Global food security and energy. The needs for energy crops, agricultural goods and food are on the rise, but the food crop production is declining due to limitations in farmland and technology resulting in conflicts between food and energy crop production efforts in the future. Besides, the radiation leakage from Japan’s Fukuoka Nuclear Power Station has caused many countries to review their nuclear power plant construction programmes and turn to other kinds of power sources, especially biomass energy, which will also affect food security.

1.5 Technological advances. Such advances have played both positive and negative roles in health development as medical technologies have progressed rapidly, resulting in more efficient and efficacious medical treatment, while the medical spending is also rising. Thus, there are challenges in enhancing the competitive capacity and reducing disparities.

2. Major changes within the country

2.1 Economic situation

Thailand’s economic structure, income distribution and poverty. After the 1997 economic crisis, Thailand deployed monetary and fiscal measures resulting in the positive economic growth of 4.2% in 1999 and 7.6% in 2003. Again during the 2008 global economic recession, the economic growth of -2.2% in 2009 rose to 7.0% in 2010 due to global economic recovery, but dropped to only 1.5% in 2011 due to nationwide flooding beginning in September of that year. Anyhow, the national economic structure has changed in such a way that the growth in the industrial sector has surpassed that in the agricultural sector; and the rich-poor gap has steadily widened with more disparities in income distribution after the crisis.

2.2 Political situation

Political system. Despite the promulgation of the Constitution of the Kingdom of Thailand B.E. 2550 (2007) and the general elections in the same year, the results of the elections have not helped lessen the country’s political conflicts. Differences in opinions are still prevalent in society in terms of the righteousness of the government in national administration, resulting in social conflicts and divides with the nation’s lower political stability, sluggish movements of national policies, loss of economic development opportunity, and declining quality of life and well-being of the people.

2.3 Decentralization and health system reforms

1) Decentralization. Over the past 10 years, health decentralization has not progressed as expected chiefly due to some high-level executives’ centralization concept, resulting in
programme discontinuity and unclear operational policy and direction. So more than 100 LGOs that did not want to wait for the health mission transfer and decided to set up their own health-care facilities, which is regarded as redundant investments. Besides, on the issue of operational linkages between central and local agencies after the mission transfer, relevant central agencies, as mentors, have to continue providing technical support to the local agencies, but in reality there have been no clear cooperation mechanisms; and thus the local agencies have to proceed by themselves, which negatively affects the people.

2) The National Health Act B.E. 2550 (2007) and public policy process. The enactment of the National Health Act is regarded as a major change in the Thai health system as the concept of "health" has been extended to cover physical, mental, social and spiritual dimensions; and the term "well-being" (sukka-pha) is used instead to communicate the new meaning. Besides, supportive mechanisms and structures have been established for promoting the participatory healthy public policy process by holding sessions of national health assembly, area-based health assembly, and issue-based health assembly, and for establishing the 2009 Statute on National Health System for use until 2020 as the framework and guide for formulating national health policies, strategies and operational guidelines.

3) The Health Promotion Foundation Act. Based on the successful lessons learned from the last decade’s non-smoking campaigns, multisectoral cooperation has led to the 2% additional taxation on alcohol and tobacco and the establishment of the Thai Health Promotion Foundation (Thai Health) to support all relevant sectors to play a proactive role, with no framework or procedural limitation, in implementing new or creative approaches that will efficiently lead to the propagation of health promotion values and behaviours to the general public.

4) The National Health Security Act B.E. 2545 (2002). Since 2001, one of the government’s health policies has focused on giving the right to all Thai citizens, especially the poor, to have access to free health care under the UC Scheme. As a result, the health financing system of the Ministry of Public Health (MoPH) has been changed to capitation payment; and despite changes in the cabinet, the new scheme cannot be abolished even though the medical spending has more than doubled over the past 10 years (1,202.4 baht/person in 2002 and 2,755.60 baht/person in 2012).

5) Policy on upgrading health centres as tambon (subdistrict) health-promoting hospitals (THPHs). This policy has been implemented since 2009: 2,000 health centres were upgraded in 2009/2010 with the funding of 1,490 million baht under the Thailand: Investing from Strength to Strength or Thai Khem Khaeng (economic stimulus) Programme, and the other 7,750 health centres were upgraded in 2011 with a budget of 6,000 million baht, totalling 7,490 million baht, which was the largest amount ever received for primary care system development. All 9,750 tambon health-promoting hospitals across the country have met the preliminary evaluation criteria; however, their quality and capacity in resolving health problems of the country need to be further enhanced.

6) Policy on promotion of proactive village health volunteers (VHVs). This policy has been implemented since 2009 with the monthly allowance payment of 600 baht to each health volunteer according to the MoPH notification on guidelines for proactive VHVs’ operations, resulting in the faster receipt of community health information for problem-solving purposes in a timely manner. Under this programme, the volunteers’ performance is monitored and reported and the allowance budget for this purpose was initially set at LGOs. The allowance is not to be regarded as "salary" or performance remuneration which will be against the voluntarism principle and cause a negative effect in the long run.

7) Welfare state. Thailand provides social welfare services in four areas, i.e. social services, social-assistance, social security, and popular sector assistance. The government has set policies on health security (free universal health care including health promotion and disease prevention services), free 15 years of education for all, development of community child care centres, free education for disabled persons, student loans, provision of facilities for disabled or elderly persons, and old age allowance.

2.4 Social situation

1) Disabilities, a major problem of the country. The proportion of persons with disabilities rose from 0.5% in 1974 to 1.7% in 2002 and 2.9% in 2007, excluding those with mental disorders and intellectual disabilities; however, for all kinds of disabilities, the prevalence would be as high as 8.1% of total population.

2) Intelligence quotient or IQ of Thai children. According to the 2011 survey of IQ levels among Thai children aged 6–15 years, their average IQ score was 98.59, which is regarded as normal but lower than the international average (mean IQ = 100). For the whole country, 28.4% of Thai children had an IQ score lower than normal (IQ <90); and in the educational system, 6.5% of Thai children had intellectual disabilities (IQ <70), which is higher than the international standard of 2%; and there was an intellectual gap between the good and poor IQ groups (Mental Health Department’s Intellectual Capacity Building for Thai Children, 2011).

3) Rising teenage motherhood and premature pregnancies are Thailand’s social problems. The number of pregnant women aged under 20 years is steadily rising. The Public Health Statistics shows that the number of teenage pregnancies (among women aged 15–19 years) rose from 123,447 in 2005 to 131,748 in 2009; and in 2009, the number of young mothers (aged <20 years) delivering babies was 106,726, which was 13.5% of mothers of all age groups; the rate is higher than the 10% average set by WHO. And among all abortions, 46.8% of whom were under 25
years of age. The major causes of teenage pregnancy are changes in sexual values, younger-age sexual relationship, lack of self-respect and self-love, and needs for love. Changes in global trends have created conditions for teenagers to decide to have sex, leading to unprepared pregnancy.

4) Sexually transmitted infections (STIs) among teenagers and youth are rising. Among teenagers and youth aged 15–24 years, the prevalence of STIs rose from 41.5 per 100,000 population in 2005 to 76.5 per 100,000 population in 2009 due to non-use of condoms when having sex and multiple sex partner behaviours.

5) Spread of HIV/AIDS to the general public. The Bureau of Epidemiology, Department of Disease Control, reported that, between 1984 and 2010, Thailand had a total of 366,945 AIDS cases, 97,179 of whom had died. The largest proportion of patients was found among working-age population (30–34 years), 25.06%; and most of them were employees getting infected through sexual relationship (84.3%). The HIV sentinel surveillance data have shown that the HIV/AIDS epidemic is generalized and concentrated. The prevalence of HIV infections tends to be declining in almost all age groups, but remains high among infection drug users and rising among men who have sex with men. A study on HIV infection incidence shows a signal for the country to conduct the HIV infection surveillance again.

6) Drug abuse is on the rise. Between 2006 and 2010, the total number drug addicts undergoing drug dependence treatment was 468,170: among them, children and youth were new drug users. Drug abuse among youth in educational institutions rose 7.5-fold over the past 14 years. In 2010, there were 114,074 clients attending drug rehabilitation centres (data from the drug abuse monitoring system). of whom 61% were drug users, 36% were addicts, and 3% were severe addicts. The drugs mostly used are methamphetamine or ya ba, followed by marijuana, inhalants, heroine, kratom (Mitragyna speciosa). Criminal cases related to narcotics were rising over the past 8 years; in 2010, the number of arrested cases was as high as 266,010, an 11.6% increase compared with the previous year, most of whom were 20–24 years of age.

7) Influx of foreign workers. The number of legal and illegal migrant workers rose from 797,113 in 2008 to 1,590,281 in 2010, resulting in the transmission of communicable diseases whose incidence was 16,303 cases for acute diarrhoea, 7,137 cases for malaria, and 1,164 cases for tuberculosis. Moreover, some of them were found to have multidrug-resistant and extensively drug-resistant tuberculosis and malaria. Such diseases have been transmitted to more Thai people.

2.5 Health status of Thai people

1) Thais’ life expectancy is longer. The life expectancy for males was 69.1 years in 2010 and will rise to 71.1 years in 2020; and for females, the life expectancy will rise from 75.7 years to 77 years over the same period (Population Projections for Thailand, 2005–2025, Institute for Population and Social Research, Mahidol University). Regarding the health-adjusted life expectancy (HALE), the trends are on the rise from 57.7 years in 2002 to 59 years in 2009 for males and from 62.4 years to 68 years for females over the same period (Working Group on Burden of Disease and Risk Factors, 2004). However, the gap between HALE and life expectancy is rather wide, indicating the longevity with illness.

2) Loss of disability-adjusted life years (DALYs). Among Thai males, the major causes of DALYs lost were alcohol abuse, traffic accidents and cerebrovascular disease; the leading cause of DALYs lost was HIV/AIDS in 2004 and alcohol abuse in 2009. For females, the leading causes were diabetes, cerebrovascular disease and depression, which are different from those for 2004 in the ranking for HIV/AIDS and depression. It is noteworthy that the ranking of HIV/AIDS that used to be the leading cause of DALYs lost dropped in both males and females because the major causes of such loss were chronic non-communicable diseases (NCDs).

3) Causes of death. The estimation of deaths due to various diseases among Thai people for 1994–2009, based on the causes of death specified in the birth certificates, shows that in 2019, traffic accidents, liver cancer, and cerebrovascular disease will be the leading causes of death in Thai males, while diabetes, cerebrovascular disease, and liver cancer will be the leading causes in females. It should be noted that NCDs, especially coronary heart disease, cancer and diabetes are the major health problems causing more and more deaths among Thai people. This is consistent with the morbidity situation report which shows that the prevalence rates of preventable chronic diseases among Thai people have been rising over the past two decades.

4) Suicide rate is declining. Between 2001 and 2010, the suicide rate per 100,000 population among Thai people dropped from 7.68 to 5.90 (Assistance for People with Suicide Risk Project. www.suicidethai.com). However, the problem is more critical in certain areas such as the upper northern region of the country.

5) Emerging infectious diseases (EIDs). The outbreaks of EIDs tend to be more severe with considerable impacts on economic systems and people's health across the globe (the most recent outbreak was the 2009 H1N1 influenza pandemic). Over the past three decades, 75% of EIDs are zoonotic diseases (transmitted from animals to humans), especially related to wild animals, such as avian influenza (associated with migratory and wild birds) and SARS transmitted from civets. At present, global attention has been paid to ecological health which comprises the relationships between ecosystem health and human health and deals with the integrated management of the disease occurrence in humans and animals as well as environmental changes, which can be used to explain the rising number of EIDs. The management of EIDs requires extensive multisectoral cooperation at both national and international levels, based on the principles of knowledge management and development of new technologies such as those for disease diagnosis, disease prevention, etc. to urgently respond to the outbreak. At the same time,
there must be efforts for developing the systems for disease surveillance, prevention and control, focusing on the cooperation of NGOs and the popular sector, rather than deploying only government’s efforts as in the past. Besides, the Second National Health Assembly held in December 2009 passed a resolution requesting that the Cabinet set up a National Committee on EIDs to draw up a strategic plan for integrated management of EIDs within one year and to establish a national mechanism to deal with such problems.

6) Occupational and environmental diseases as well as other risk factors. Environmental pollution has greater impacts on human health, but most research studies have not been able to clearly point out that certain diseases are caused by industrial pollution. However, the 2007–2009 disease surveillance reports from the Bureau of Epidemiology, Department of Disease Control, reveal that the number of patients with occupational chemical poisoning is rising, mostly caused by chemical pesticides used in the agricultural sector, chemical substances used in the industrial sector, and physical environments such as heat, cold, vibration, noise, light, and radiation in the workplaces.

7) Severity of NCDs related to changes in lifestyles. Lifestyle changes are related to globalization, capitalism and materialistic development, deterioration and collapse of family and social institutions, and non-responsible business operations resulting in the values and culture of insufficient/imbalanced ways of life. Other negative effects include the lack of attention to the control and prevention of health risk factors, living in unsafe environments with health threats and conditions unfavourable to health promotion, and risky behaviours such as eating sweet, fatty and salty foods, inadequate intake of vegetables and fruits, tobacco smoking, alcohol drinking, and physical inactivity. Such factors are the causes of stress and inability to appropriately manage emotions, overweight, abdominal obesity, hypertension, high blood cholesterol, high blood sugar, and metabolic syndrome. These are the major risk factors of preventable chronic NCDs or lifestyle diseases that have spread all over the world.

Thailand is also facing this crisis as evidence has shown that, in 2008–2009, among Thai people aged 15 years and over, 34.7% (17.6 million) were overweight or obese (BMI >25 kg/sqm), 32.1% (16.2 million) were abnormally obese (waist circumference >90 cm for males and >80 cm for females), 6.9% had diabetes, 21.4% had high blood pressure, and 19.4% had high blood cholesterol, resulting in 1.2-fold to 1.6-fold increases in the hospitalization rates of patients with cancer, cerebrovascular disease, diabetes and hypertension to 505, 684, 297, 845 and 1,149 per 100,000 population, respectively.

If such rising trends are not halted, the illnesses will result in complications, disabilities, and premature deaths with high health-care costs as well as huge economic losses. It is thus essential that all sectors have to join forces to change people’s lifestyles to adopt the sufficiency principles with appropriate consumption, adequate physical exercise, and suitable emotional management, based on the sufficiency economy philosophy and sufficiency health approach, for the prevention and resolution of negative health impacts from lifestyle diseases, which will lead to the creation of Thai healthy lifestyles in a concrete and sustainable manner.

2.6 Health-care system

The Thai health-care system has steadily progressed in all dimensions with health-care units or facilities covering all localities. The health-care structure has major components including primary care, secondary care and tertiary care as well as specialized services and a referral system. In addition, there are important support systems dealing with resources allocation, technical assistance, research, and health information.

1) Health-care facilities in both public and private sectors, most of which are in the public sector and under the MoPH.

- State-run health-care facilities altogether have 109,161 beds in Bangkok, there are 5 medical, schools, 26 general hospitals, 13 specialized hospitals/institutions, and 68 public health centres (and 76 branches) in all districts; and in the provinces. There are 6 medical schools, 48 specialized hospitals, 25 regional hospitals, 70 general hospitals, 748 community hospitals (in all districts), 284 municipal health centres, 9,750 tambon (subdistrict) health-promoting hospitals, 151 community health posts, 48,049 rural primary health care centres, and 3,108 urban primary health care centres.

- During the period 2009–2011, private health-care facilities included 316 private hospitals (with a total of 32,872 beds), 18,505 clinics, 1,268 health-related establishments, 11,603 modern drugstores, 3,838 drugstores selling modern non-hazardous pre-packaged medicines, and 2,022 traditional drugstores.

2) Referral system. The 2007 Constitution of Thailand prescribes that the State shall provide and promote public health services for the people to receive standard public health services thoroughly and efficiently. In each province, a referral system has been established for referring the patients in a continual and concrete manner under the supervision and guidance of a provincial referral system development committee. The referral system also includes mechanisms for monitoring and evaluation, meetings to review the lessons learned for resolving the problems related to referrals. “Refer Online” innovation, and coordination for more efficient referrals. The refusal rates at all levels have decreased slightly compared with last year, but the refusal rates for cross-boundary and central transfers are rather high in almost all provinces; and it takes a long time to coordinate, especially in Bangkok, in which the refusal rate is rather high.

3) Health security. The proportion of Thai citizens with health insurance coverage increased from 92.5% in 2002 to 99.9% in 2011, resulting in more people getting access to health care. The number of outpatient visits to health-care facilities rose from 102.9 million in 2002 to
153.4 million in 2010; and the number of health-care recipients rose from 3.4 million to 5.6 million over the same period (National Health Security Office or NHSO, 2011).

4) Health-care utilization rate. The rate of health-care utilization at health-care facilities with inpatient beds rose from 1.8 visits/person/year in 2001 to 3.4 visits/person/year in 2009. Over the same period, the health-care use rate was highest (4–6 visits/person/year) in Bangkok and lowest in the Northeast (1.2–3 visits/person/year), while the hospital admission rate rose from 10% in 1995 to 14.7% in 2007, the highest in Bangkok and lowest in the Northeast, indicating the clustering of health-care resources in Bangkok.

5) Health-care utilization classified by type of parent organizations of health-care facilities. Between 2002 and 2009, the proportion of outpatient visits was highest for MoPH’s hospitals (approximately two-thirds or 65% of all visits), followed by private hospitals (one-fifth or 24%), and university hospitals (4%). Similarly for inpatient care, the proportion of admissions was highest for MoPH’s hospitals (73%), followed by private hospitals (20%), and university hospitals (3%).

6) Access to health care. The implementation of the universal health-care policy resulted in the increase in the rate of access to and use of health-care facilities when ill from 49% in 1991 to 75.3% in 2005 and 68.5% in 2009. Among those without any health insurance coverage, their access rate rose from 47% to 66.6% and 55% over the same period. Those under the Civil Servant Medical Benefit Scheme (CSMBS) and the UC Scheme had the highest health-care utilization rates compared with other groups.

2.7 Human resources for health

1) Situation of health workforce

- Medical workforce: In 2009, according to the Secretariat of the Medical Council of Thailand, there were 39,187 doctors registered with the Council (excluding those who could not be contacted, had died, had licences revoked, and were permanently working abroad). It was estimated that there were 35,789 doctors working within the country, the doctor/population ratio of 1:1.77.5. But according to a survey conducted by the Human Resources for Health Research and Development Office and a health resources survey conducted by the Bureau of Policy and Strategy, there were only 26,126 doctors working at health-care facilities in 2010, or a doctor/population ratio of 1:2,428, whereas the ratio needed for the country is 1:1,500–1,800. Besides the shortages, there is a problem of workforce distribution; it has been found that only 50.4% of all doctors work for the MoPH, which is responsible for health care for more than 80% of the entire population. Regarding the loss of medical personnel, the Office of the Permanent Secretary for Public Health has been faced with a large number of doctor resignations; as many as 795 doctors resigned in 2003. At present, the loss is still huge.

- Dental workforce: In 2009, there were 10,571 dentists working in the country (The Dental Council, 2010). But according to a survey conducted by the Human Resources for Health Research and Development Office and a health resources survey conducted by the Bureau of Policy and Strategy, there were only 5,112 dentists working at health-care facilities in 2010; a dentist/population ratio of 1:32,427.

- Pharmaceutical workforce: In 2009, there were 24,401 pharmacists working in the country (The Pharmacy Council, 2010). But according to a survey conducted by the Human Resources for Health Research and Development Office and a health resources survey conducted by the Bureau of Policy and Strategy, there were only 8,134 pharmacists working at health-care facilities in 2010; a pharmacist/population ratio of 1:7,810.

- Nursing workforce (professional or registered nurses): In 2009, there were 120,948 registered nurses working in the country (Thailand Nursing and Midwifery Council, 2010). But according to a survey conducted by the Human Resources for Health Research and Development Office and a health resources survey conducted by the Bureau of Policy and Strategy, there were 138,710 registered nurses working at health-care facilities in 2010; a nurse/population ratio of 1:458.

2) Health workforce production

- Production of doctors: The number of new medical graduates has been rising steadily each year from 500–700 annually in around 1992; later on with the Programme on Increased Production of Medical Doctors for Thailand proposed by the then Ministry of University Affairs, an additional 340 doctors were produced each year between 1993 and 2001, resulting in the total number of medical graduates of approximately 1,300 per year. And in 1994, the Cabinet approved the production of 5,000 additional doctors for rural people for the period 1995–2004 (later extended to 2006), resulting in the admission of 1,500 medical students per year. In 2004, the Cabinet approved the production of 500–700 doctors annually for the period 2004–2013 and again in 2006 approved the production of an additional 4,530 doctors for the period 2006–2011 as well as the establishment of another 7 medical schools. As a result, currently more than 2,300 new medical students are admitted each year; and under the Thai Khem Khaeng Scheme for 2009–2012, there is a plan to produce an additional 1,718 doctors.

- Production of dentists: Currently, 9 dental schools (8 public and 1 private) can produce 600 dentists each year; and since 2005, an additional 290 dental students have been admitted annually; the additional students began graduating in 2011 onwards (under the Increased Production of Dentists of the Higher Education Commission as needed by the MoPH) to resolve the problem of dentist shortages especially in rural areas.

- Production of pharmacists: At present, approximately 1,950 pharmacists are produced each year by 16 public and private schools of pharmacy. The system of compulsory
Production of professional or registered nurses: At present, each year all state and private nursing schools can produce approximately 8,300 nurses, of whom 2,500 are produced by MoPH's institutions.

Health workforce for primary care level: For each tambon health-promoting hospital (THPH), the ratio of health worker to population is set at 1:1.250; and as many as 40,000 health personnel with an appropriate skill mix are needed (currently there are only 30,655) for all THPHs; and among them there must be at least 1 or 2 registered nurses at each THPH (2 nurses for a large THPH serving as the node for a network of THPHs). Totally, approximately 13,500 registered nurses are required for all THPHs (currently there are only 6,599).

Establishing the remuneration system

The payment of remuneration (in addition to salaries) to medical and health personnel with health-care facility’s revenue is made in accordance with MoPH’s regulations on payment of remuneration to staff working at MoPH’s health-care facilities of 2001 as well as other relevant criteria. For example, the remuneration for the nurses working on the afternoon and night shifts, the special allowance for doctors without private practice, and the lump-sum per diem (previously disbursed from hospital revenue and since 2010 from the government budget). The government budget has been allocated as remuneration or allowance for 11 categories of medical and health personnel with special duties and qualifications specified in the regulations on this matter issued by the Civil Service Commission.

Medical litigation

The statistics on law suits against medical malpractice or errors have been steadily rising in Thailand, while the workload of medical personnel is higher. In particular, each doctor in a state hospital has to work for 120–122 hours a week, which is longer than other civil servants who normally work for about 40 hours a week. Importantly, working continuously for long hours without adequate rest may result in fatigue and more medical errors. The increased workload, low remuneration and rising litigations are the three reasons for young doctors’ resignations from government service.

The historic case is the provincial court's verdict to imprison a doctor at a community hospital for three years with no jail-term suspension in 2007 for medical negligence, involving the injection of anaesthesia into the spinal cord, during an appendectomy in 2002. Despite the Appeals Court’s overturn of the verdict, changes have been effected in several aspects in medical practice and society; doctors at community hospitals dare not perform any surgery and the patients have to be referred to a regional or general hospital for such medical care. In the long run, the rate of disabilities and the case-fatality ratio related to referrals will be higher, resulting in service provider-recipient conflicts in getting the Medical Malpractice Compensation Bill into the legislation process. However, there are some issues with different opinions between the service providers and recipients.

2.6 Health financing situation

1) A number of households have to bear a rather high burden of health-care cost while the country can increase the government budget for health spending. The overall national health spending increased from 3.8% of the gross domestic product (GDP) in 1980 to 6.4% in 2008. The rate of increase in health spending is greater than that for GDP, i.e. the health spending rose by 7.6% annually on average, but the GDP growth was only 5.0% per annum (health expenditure in Thailand Health Profile, 2008–2010). According to the National Health Accounts, 2006–2007, 4% of GDP and 19% of overall health spending (approximately 59,951 million baht) were paid by the households out of pocket for such care as self-medications and medical expenses at private clinics or hospitals. The proportion of such spending is rather high compared with the poor families’ income.

The 2006/2007 National Health Accounts have shown that the proportion of government health spending rose from 56% in 2000/2001 (before the launch of the UC Scheme) to 75% in 2008; there is still room for the public sector spending to be increased.

2) The lack of liquidity in MoPH health-care facilities. In 2010, 585 state-run hospitals faced the problem of liquidity amounting to 7,300 million baht. As a result, most of them had to control their spending for survival financially and were not able to bear the burden of medical expenses for referred patients with lower-than-reality compensation. It has been found that, under the UC Scheme for regional and general hospitals, for every 100 baht of actual expenditure, only 48 baht was received as compensation (the uncompensated difference was totally 19,000 million baht). The resources were so subdivided that they were insufficient; with the lack of resource integration for jointly resolving the systemic problem. The problems of health-care delivery are caused by the limitations in accessing services, resulting in delays in receiving health care and double sufferings for the people. Discrepancies in the budget allocation to different hospitals are huge; and due to inequalities in capitation budget allocation and benefits from different health insurance schemes, the hospitals have to provide the services according to each scheme’s requirements. The inability to increase the number of beds in state health-care facilities as well as financial constraints results in a full bed-occupancy situation and doctor shortages in several localities, resulting in admission and referral refusals, which are regarded as inequalities in the health-care system. The lack of investment budget, with only depreciation budget, results in the lack of infrastructure development to respond to the rapidly rising health-care needs. Between 2002 and
2011, the number of outpatient visits rose by 35%, whereas that for inpatients rose by 22%, but for nearly 10 years the investment budget has not been proportionately provided for the state health infrastructure development.

3) The three health insurance schemes are different in many aspects, resulting in inequalities in health-care accessibility and services. The three state health insurance schemes have differences in the funding sources, benefit packages, government's budgetary support, and payment mechanisms to health-care facilities.

- The CSMB is financed through general taxation and uses the fee-for-service payment mechanism for outpatient services and the payment based on diagnosis related groups (DRGs) with global budget for inpatient care.

- The Social Security Scheme is funded through contributions from the employees, employers and government and uses the capitation payment method chiefly for both outpatient and inpatient care whose relative weight (RW) is less than 2 and the DRG-based payment method for inpatient care whose RW is 2 or higher. Besides, several additional payments are made to health-care facilities as incentives for better quality services according to the medical care standards such as risk-adjusted payments for chronically ill patients, payments for prostheses and orthoses, and payments for drugs on List for (2) of the National List of Essential Medicines.

- The UC Scheme is funded with general taxation and deploys the capitation payment for outpatient care and the DRG-based payment with global budget for inpatient care.

There has been evidence showing that there are inequalities in accessing or receiving health care and in the quality of care including medications among the three schemes; and insured persons under the Social Security Scheme have requested that the Social Security Office review their benefit packages and improve service quality.

4) Investment in health promotion and disease prevention is rather small for the country's major NCDs with a high burden of disease such as diabetes, hypertension, obesity, tobacco/alcohol-related illnesses, and cervical, liver and breast cancer, as well as some major communicable diseases such as HIV/AIDS. According to the 2006–07 National Health Accounts, Thailand spent only 4.8% of the national spending on health promotion and disease control. As a result, the NHIS has established a five-year (2012–2016) programme for health promotion and disease prevention reforms with a budget increase from 9.5% in 2011 to 20% in 2016.

5) Drug spending is rather high with irrational and inefficient use of antibiotics. Thailand's expenditure on medicines or drugs increased from 52,823 million baht in 1994 to 120,290 million baht in 2002, an average increase rate of 6.77% per annum, which was higher than the national GDP growth.

2.9 Situation and problems related to health information system

The major problems include: (1) inadequate and non-continuous support mechanisms and resources for operations; (2) poor quality/coverage and redundant health information systems due to lack of data verification process; (3) lack of efficient data management system; and (4) improper accessibility to and utilization of data due to lack of understanding of information for decision-making purposes.

2.10 Public-private partnership (PPP) for health

Efforts to promote PPP for health aim to change public sector management mechanisms and reduce government investments in health care. What have been practised are cooperative or lump sum rental/service contracts for high-cost medical equipment, laundry services, security guard services, catering services, building space or land rentals as well as information and communication technology services, most of which have problems related to government rules/regulations, procedures, and policy guidance aiming to really facilitate transparency and benefits for the health service system. In connection with large projects such as building construction and management services, so far no such projects have been operated by the private sector; however, a study to determine an appropriate model is already underway.

2.11 Popular health sector and partners

The rising number of entities dealing with health system management in the public and private sectors, including non-governmental organizations, has resulted in the diversity of missions and levels of health-care management and the change in MoPH's missions. Such entities are, for example, the National Health Commission Office (responsible for making health policy and strategy recommendations for the government and all sectors in society), the National Health Security Office (monitoring and ensuring that all the people under the UC Scheme have the right to receive quality health services), the Thai Health Promotion Foundation (supporting health promotion programmes/projects without restrictions on mythological framework, but open to new operating procedures that are creative for efficiently and extensively disseminating the values and practices for health promotion for the people), the Health Systems Research Institute (creating knowledge and supporting medical and health research), the Emergency Medical Institute of Thailand (managing the coordination among relevant public and private agencies, and encouraging LGOs to take part in the management of medical emergencies), the Healthcare Accreditation Institute (dealing with the assessment and accreditation of health-care facilities), and the National Healthcare Financing Office (responsible for improving the healthcare financing system for the country so that it is sustainable and responsive to health problems).

As the situations within and outside the country have been changing rapidly and become more serious, the cooperation to jointly create and move forward the directive strategies with adequate power is extremely important.
Part 3

Directions of the 11th National Health Development Plan


(11th Health Plan):

Focusing on development with the sufficiency economy philosophy, creating unity and good governance in the health system, giving importance to the participation of all sectors in society, creating health security and service delivery systems in a thorough and equitable manner, and valuing the creation of good provider-recipient relationships.

2. Vision of the 11th Health Plan:

“All Thai citizens are healthy and take part in creating sufficiency health system with equity leading to social well-being.”

“Sufficiency Health System” means the process for developing people’s health towards physical, mental, social and spiritual well-being using the health-care system with good quality, standards, strengths, sufficiency and convenient accessibility, really responsive to people’s health problems and needs, at suitable costs.

3. Mission:

To develop the Sufficiency Health System, based on the principles of good governance, immunity against threats, and partnerships of all sectors as well as the use of Thai wisdom.

4. Goals:

1. The people, communities, local authorities, and partners have the capacity for health promotion and disease prevention, reducing morbidity due to preventable diseases or lifestyle-related diseases, and using Thai wisdom as well as public participation in dealing with individual and community health problems.

2. Having in place disaster monitoring and warning systems that are sensitive and able to provide timely information for efficiently responding to health threats.

3. Having in place efficient proactive health systems, focusing on health promotion, disease prevention, and consumer protection in health.

4. Having in place health-care systems of good quality and standards that are able to respond to people’s health needs and problems with good provider-recipient relationships.

5. Having in place an efficient and unified healthcare financing system.

5. Indicators:

1) Percentage of subdistricts with strong health management systems according to the established standards.

2) Morbidity and mortality rates due to disasters, epidemics and health threats: (i) morbidity rates due to emerging and re-emerging infectious diseases; (ii) mortality rates due to natural disasters; and (iii) morbidity rates due to occupational and environmental diseases.

3) Morbidity rates due to heart disease, cerebrovascular disease, and cancer; rates of patients with controlled blood-sugar and blood-pressure levels.

4) Percentage of target population with proper health behaviours (exercise, vegetable and fruit consumption, sweet/fatty/salty diet consumption, buying health products with FDA logo, tobacco smoking and alcohol drinking).

5) Proportion of investment in health promotion and disease prevention.

6) Patient referral refusal rate.

7) Death rate of inpatients within 28 days.

8) Doctor/population ratio and regional disparities.

9) Percentage of hospitals with financial problems.

6. Health development strategies

6.1 Strategy to strengthen partners for health promotion and self-reliance in health with Thai wisdom: Giving importance to the enhancement of the roles of the people, communities, local authorities, and health networks/partners to have better capacity and strengths in health promotion and disease prevention, good health-care culture at the individual, family and community levels to help each other, consciousness and cooperation in creating healthy environments, and community health problem management, through collaboration among all sectors in both public and private sectors including academics and the popular sector, using sufficient data and information on all aspects to jointly determine solutions with mutual agreement. Moreover, efforts are to be made to strengthen international cooperation at the global, regional and...
national (border) levels, promote Thai healthy lifestyles using Thai wisdom with safety and acceptable qualities, develop systems for learning and knowledge management for Thai traditional, indigenous and alternative medicine to be of acceptable standards, promote more use of appropriate technology in Thai traditional medicine for diagnostic and therapeutic purposes, and promote research and development for self-reliance in health.

6.2 Strategy for further development of systems for monitoring, warning and management of disasters, accidents and health threats. Giving importance to the preparedness for disasters (such as floods, land/mud slides, earthquakes, leakage of toxic/chemical substances, terrorism, etc.), epidemics (emerging and re-emerging), contamination with hazardous substances in the environment and food, environmental pollution, accidents and other health threats, and the development of systems for monitoring, warning and management of disasters, health threats and rehabilitation after the occurrences of disasters, accidents and threats.

6.3 Strategy to focus on health promotion, disease prevention and consumer protection in health for Thais to be physically, mentally, socially and spiritually healthy. Giving importance to developing proactive health systems through effective health promotion, disease prevention and control, and consumer protection systems: increasing the proportion of investment in health promotion and disease prevention; creating health awareness for society; setting good public policies on the safety of food, drugs and health products as well as nutrition and occupation; creating healthy environments; developing health promotion services for all age groups; promoting physical, mental and intellectual development for Thai children; developing systems for controlling/preventing the use of precursors for narcotic production and for monitoring the spread of new narcotics; developing and promoting people’s healthy behaviours; creating social measures for controlling health risk behaviours; and promoting exercise and good mental health.

6.4 Strategy to strengthen health-care systems with quality and standards at all levels in response to health needs of all age groups and improve seamless referral systems. Giving importance to improving health infrastructure and services at all levels to be of acceptable quality and standards and accessible to people in both normal and emergency situations; disseminating health resources appropriately with adequate medical and health personnel at all levels; using appropriate technologies; developing medical specialties to cover all localities as needed for people’s convenient access to quality services; providing health care for specific target groups (eg. children, women, and elderly, disabled, and marginalized persons); improving access to emergency medical services; strengthening the referral systems to ensure good care during transport and non-refusals; paying attention to patient safety while receiving care; expanding drug dependence treatment services; creating good recipient-provider relationships and conflict resolution/reconciliation in case an adverse effect occurs; promoting a good understanding between medical personnel and people about treatment eligibility and expectations for providers’ happiness and recipients’ satisfaction.

6.5 Strategy to create national mechanisms for enhancing the efficiency of health-care system governance and resources management systems. Giving importance to the creation of the management mechanisms of health-care system with unity and good governance by setting up a National Health Service Delivery Board to establish the health-care system of the country; setting the balance between the needs of purchasers and providers; setting an efficient health-care financing direction of the country; decreasing the disparities among the three health insurance schemes (CSMBS, UC Scheme, and Social Security Scheme); developing the migrant health-care system; managing resources allocation appropriately; accelerating the production and development of health workforce with adequate quantities and appropriate qualities; distributing personnel in an equitable and thorough manner; improving the health information system in terms of accuracy, completeness, and timeliness for application; creating working systems for boosting morale and incentives for medical and health personnel to work with happiness and worthiness; encouraging public-private partnership to set up a mechanism for integrating programmes/projects and activities for resource sharing among public and private health-care facilities as well as local agencies; and supporting research on major medical and health issues of the country and the use of the knowledge for work improvement.
Part 4

Development Strategies in the 11th National Health Development Plan

Strategy 1: Strengthen partners for health promotion and self-reliance in health with Thai wisdom.

Giving importance to the enhancement of the roles of the people, communities, local authorities, and health networks/partners to have better capacity and strengths in health promotion and disease prevention, good health-care culture at the individual, family and community levels to help each other, consciousness and cooperation in creating healthy environments, and community health problem management, through collaboration among all sectors in both public and private sectors including academics and the popular sector, using sufficient data and information on all aspects to jointly determine solutions with mutual agreement. Moreover, efforts are to be made to strengthen international cooperation at the global, regional and border levels, promote Thai healthy lifestyles using Thai wisdom with safety and acceptable qualities, develop systems for learning and knowledge management for Thai traditional, indigenous and alternative medicine to be of acceptable standards, promote more use of appropriate technology in Thai traditional medicine for diagnostic and therapeutic purposes, and promote research and development for self-reliance in health.

1.1 Objectives

1.1.1 To raise health consciousness for society and the people to be alert and give importance to health care as people’s culture; to gain well-being through people’s participation in all undertakings based on their capacity and the sufficiency principle.

1.1.2 To promote more effective health actions among various partners including international networks or agencies.

1.1.3 To enhance Thai wisdom’s role as an alternative in the health-care system.

1.2 Development goals

1.2.1 The people, communities, local agencies and health partners perceive, understand, and be conscious of health promotion, disease prevention, and are able to deal with their own health problems.

1.2.2 Having in place an organization with the capacity to create cooperation at international forums.

1.2.3 Having in place the knowledge of Thai wisdom that is safe for health and more acceptable to people.

1.3 Tactics and measures

1.3.1 Support people’s role in health promotion and disease prevention for individuals, families, communities and society.

1.3.2 Enhance the capacity of community leaders and health networks/partners such as health volunteers, NGOs, non-governmental organizations, the media and others in adopting and coordinating the proactive health service approach in the community.

1.3.3 Develop the health assembly process and other coordinating mechanisms in enhancing coordination among health partners.

1.3.4 Create and share knowledge about Thai wisdom for use in health-care delivery.

1.3.5 Promote international health cooperation and strengthen the role of Thailand in global health forums.

Strategy 2: Further develop systems for monitoring, warning and management of disasters, accidents and health threats.

Giving importance to the preparedness for disasters (such as floods, land/mud slides, earthquakes, leakage of toxic/chemical substances, terrorism, etc.), epidemics (emerging and re-emerging), contamination with hazardous substances in the environment and food, environmental pollution, accidents and other health threats, and the development of systems for monitoring, warning and management of disasters, health threats and rehabilitation after the occurrences of disasters, accidents and threats.

2.1 Objective

To establish preparedness with monitoring and warning systems that the people trust and when a disaster occurs, appropriate actions can be undertaken in a timely manner.

2.2 Development goals

2.2.1 Having quality monitoring and warning systems in place for disasters, accidents and health threats.

2.2.2 Having efficient management systems in place to cope with disasters, accidents and health threats, before, during and after the incidents occur.

2.3 Tactics and measures

2.3.1 Establish effective medical and health monitoring and warning systems.
2.3.2 Further develop medical and health preparedness systems to efficiently respond to disasters, accidents and health threats.

2.3.3 Further develop medical and health management systems during and after the occurrences of disasters, accidents and health threats.

Strategy 3: Focus on health promotion, disease prevention and consumer protection in health for Thais to be physically, mentally, socially and spiritually healthy.

Giving importance to developing proactive health systems through effective health promotion, disease prevention and control, and consumer protection systems: increasing the proportion of investment in health promotion and disease prevention; creating health awareness for society; setting good public policies on the safety of food, drugs and health products as well as nutrition and occupation; creating healthy environments; developing health promotion services for all age groups; promoting physical, mental and intellectual development for Thai children; developing systems for controlling/preventing the use of precursors for narcotic production and for monitoring the spread of new narcotics; developing and promoting people's healthy behaviours; creating social measures for controlling health risk behaviours; and promoting exercise and good mental health.

3.1 Objectives

3.1.1 To change people's health behaviours that are the root causes of today's major burden of disease.

3.1.2 To ensure that there are sufficiently increased investments and operations in health promotion and disease prevention.

3.2 Development goals

3.2.1 Having in place public policies favourable to health promotion and health risk reduction.

3.2.2 Having in place sufficiently strong public communications for health behaviour changes.

3.2.3 Having in place actions for detecting patients with infectious and chronic illnesses from early onset for effective treatment and complication reduction.

3.2.4 Having an increased proportion of investments in health promotion and disease prevention, particularly in the public sector.

3.3 Tactics and measures

3.3.1 Establish healthy public policies through developing and moving forward legislations and law enforcement efforts to reduce health risk factors, and create the process for health impact assessment.

3.3.2 Promote social mobilization and public communications for health behaviour changes, essentially those related to alcohol abuse, traffic accidents, cerebrovascular disease, heart disease, diabetes, cancer, AIDS, drug abuse, and mental disorders.

3.3.3 Further develop the systems for monitoring, case finding, screening and management for communicable and chronic diseases as appropriate, depending on disease severity.

3.3.4 Focus on health promotion for mothers and children such as newborn screening, intellectual development for Thai children of various age groups, and women's health screening.

3.3.5 Further develop the systems for controlling and preventing the use of precursors in narcotic production; and monitor the spread of new types of narcotics.

3.3.6 Increase investments in health promotion and disease prevention.

Strategy 4: Strengthen health-care systems with quality and standards at all levels in response to health needs of all age groups and improve seamless referral systems.

Giving importance to improving health infrastructure and services at all levels to be of acceptable quality and standards and accessible to people in both normal and emergency situations; disseminating health resources appropriately with adequate medical and health personnel at all levels; using appropriate technologies; developing medical specialties to cover all localities as needed for people's convenient access to quality services; providing health care for specific target groups (e.g., children, women, and elderly, disabled, and marginalized persons); improving access to emergency medical services; strengthening the referral systems to ensure good care during transport and non-refusals; paying attention to patient safety while receiving care; expanding drug dependence treatment services; creating good recipient-provider relationships and conflict resolution/reconciliation in case an adverse effect occurs; promoting a good understanding between medical personnel and people about treatment eligibility and expectations for provider happiness and recipient satisfaction.

4.1 Objectives

4.1.1 To establish health-care systems with good quality and standards to which the people can have thorough and equitable access.

4.1.2 To create good health provider-recipient relationships that will result in provider happiness and recipient satisfaction.

4.2 Development goals

4.2.1 Having in place expanded coverage and enhanced quality of health-care facilities
so that they are appropriately accessible to all population groups and reduce people’s major illnesses.

4.2.2 Having systems and mechanisms in place for creating health provider-recipient relationships and medical dispute mediation and conciliation.

4.3 Tactics and measures

4.3.1 Enhance the capacity of primary care to be up to the established standards and responsive to community’s needs.

4.3.2 Further develop the standard systems of medical and health services as well as specialties for each health-care level.

4.3.3 Allocate resources according to the health-care system development plan, or health service plan.

4.3.4 Further develop the patient referral systems in an efficient and seamless manner.

4.3.5 Improve elderly care systems, for example, long-term care to respond to the ageing society, day care centres for older persons, etc.

4.3.6 Improve the rehabilitative care system for people with disabilities to gain better access to such services.

4.3.7 Extend the capacity for the treatment and rehabilitation of narcotic drug users and addicts.

4.3.8 Create the systems for patient safety and better provider-recipient relationships.

4.3.9 Further develop the emergency medical services system with better coverage and accessibility for the people in both normal and disaster situations.

4.3.10 Promote the Medical Hub policy to serve foreign patients in such a way that there will be no negative effects on the overall health-care system for Thais, emphasizing services related to spa, health promotion, Thai traditional medicine, health products and Thai herbs.

Strategy 5: Create national mechanisms for enhancing the efficiency of health-care system governance and resources management systems.

Giving importance to the creation of the management mechanisms of health-care system with unity and good governance by setting up a National Health Service Delivery Board to establish the health-care system of the country; setting the balance between the needs of purchasers and providers; setting an efficient health-care financing direction of the country; decreasing the disparities among the three health insurance schemes (CSMBS, UC Scheme, and Social Security Scheme); developing the migrant health-care system; managing resources allocation appropriately; accelerating the production and development of health workforce with adequate quantities and appropriate qualities; distributing personnel in an equitable and thorough manner; improving the health information system in terms of accuracy, completeness, and timeliness for application; creating working systems for boosting morale and incentives for medical and health personnel to work with happiness and worthiness; encouraging public-private partnership to set up a mechanism for integrating programmes/projects and activities for resource sharing among public and private health-care facilities as well as local agencies; and supporting research on major medical and health issues of the country and the use of the knowledge for work improvement.

5.1 Objectives

5.1.1 To protect the health system through good governance and unity for system’s stability and sustainability.

5.1.2 To set policy and guidance for developing sufficient support facilities for the health-care system.

5.2 Development goals

5.2.1 Having in place a National Health Service Delivery Board.

5.2.2 Having in place mechanisms for suitable health resources management and opening an opportunity for the private sector to take part in health development.

5.3 Tactics and measures

5.3.1 Establish a national system for the governance of health-care systems with unity.

5.3.2 Support all health security schemes of the country to provide services with linkages, consistency, and harmony to reduce the disparities among the three schemes.

5.3.3 Promote health resources management with good governance principles.

5.3.4 Draw up plans for workforce production and development as well as distribution and retention in the health system.

5.3.5 Further develop the health information system in an appropriate and user-responsive manner.

5.3.6 Develop a clear model and mechanism for resolving and reducing health impacts from transnational labourers or immigrant workers.

5.3.7 Promote the public-private partnership (PPP) in medical and health-care delivery, based on people’s benefits.

5.3.8 Establish mechanisms for designing integrated programmes/projects on sharing resources among medical and health agencies in the public and private sectors as well as local agencies.

5.3.9 Support research programmes/projects that are consistent with major health problems and knowledge management for use in medical and health development.
Part 5
Transforming the 11th National Health Development Plan into Action

According to the results of the evaluation of the 10th National Health Development Plan (2007-2011), the implementation of the 10th Health Plan was carried out under the four governments with five public health ministers, resulting in the continuity of policy implementation being less effective than expected. Some of the policies were abolished or essentially changed. However, the factors identified related to the 10th Health Plan implementation are as follows:

1. The selected strategies for policy implementation were inappropriate.
2. The selected strategies were appropriate, but the selected implementing agencies and mechanisms were inappropriate.
3. The clarity of policies was insufficient.
4. The lack of organizational support for some strategies.
5. The political will to move the 10th Health Plan strategies was inadequate.

Guidelines for transforming the 11th Health Plan into action

To implement the health development strategies under the 11th Health Plan to achieve the established goals for national medical and health development in a realistically concrete manner, there must be major processes or steps/guidelines as follows:

1. Carry out communication and public relations activities to provide knowledge and create an understanding for public health community and health partners about the 11th Health Plan. Even though an effort was made during the plan formulation process to create an understanding about the draft 11th Health Plan for a large number of partners, not all key partners involved could be reached; so the effort was undertaken only to a certain extent. The additional activities in this effort to create an understanding about the directions and essence of health development are necessary through the following means:
   1.1 Send documents to institutional and non-institutional partners who will be the players in moving the 11th Health Plan to the widest extent possible as well as through other channels such as social networks on websites, web links, and others.
   1.2 Hold forums to create an understanding and identify issues and measures with priorities and get them submitted to policy-makers for advocating through various channels to implement depending on locality’s context.
   1.3 Coordinate with educational institutions, especially those offering health or public health programmes to incorporate the content on the 11th Health Plan into their curriculums by providing appropriate learning materials for such institutions.
   1.4 Organize training of trainers on the 11th Health Plan in adequate numbers to serve as first tier trainers (khu kor) in various curriculum development training courses of the MoPH and relevant partners to broaden the learning about the 11th Health Plan especially during the first phase of the plan period.

2. Create linkages between the 11th Health Plan and government policies in the national administration plan as well as action and budget request plans of various state agencies, such as investment plans, information development plans, and personnel production plans, through the analysis of the linkages in a concrete manner to illustrate how such plans are implemented, especially how the budget or strategic plans are consistent with the directions and essence of the 11th Health Plan. If not, what the discrepancies are; and knowledge sharing forums have to be held periodically to move for the revision of the 11th Health Plan. Such efforts should begin with the formulation or review of subdistrict health development plans, where the first level linkages can be established for the national and subdistrict plans to be complementary to each other in moving health actions for sustainably resolving national health problems in a concrete manner in line with the 11th Health Plan principles.

3. All levels of executives of relevant agencies have to give importance to the 11th Health Plan including its strategies as the framework for undertaking their health development actions and formulating their action plans. Health partners are expected to use various forums with their executives participating in making the 11th Health Plan’s directions and essence understood and adopted by a large number of their leaders to the extent possible.

4. Establish a monitoring committee to oversee the direction for moving forward the 11th Health Plan, to ensure that it is implemented, monitored and evaluated periodically and continually, to set up a system for reporting the evaluation results on a timely basis for use in improving the plan implementation process to efficiently achieve the established goals, and to get a mid-term evaluation of the 11th Health Plan undertaken and get the results presented at a suitable forum to seek ways to correct any weaknesses identified or revise the directions or strategies as appropriate.
5. Establish mechanisms for developing methods or processes for drafting a 12th National Health Development Plan by conducting a study aiming to develop the process for formulating long-term and medium-term national strategies for national administration and use as a guide for formulating the 12th Health Plan through the participation and ownership of all concerned so that the 12th Health Plan will be broad-based and mostly acceptable.

References


Chiang Mai University. *Executive Summary: A Study on Thailand’s Future Directions and Preparedness Strategies over the Next 10 Years.*


Office of the National Economic and Social Development Board. (2011, Feb.). *Social Situation and Outlook 2010.* 7(5).


### Process and Steps in Formulating (Drafting) 11th National Health Development Plan (2012–2016) of the Working Group on Plan Formulation

<table>
<thead>
<tr>
<th>Meeting no.</th>
<th>Date/Month/Year</th>
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| 2553/1      | 14 Oct 2010     | Review:  
- Draft orders appointing working groups and committees  
- Draft plan and steps for operations  
- Framework and issues of the 11th Health Plan |
| 2553/2      | 24 Nov 2010     | The Working Group presents the draft situation and determinants of health  
- The meeting provides comments on missing parts |
| 2553/3      | 23 Dec 2010     | Review details of situation and issues and give comments  
- Assign responsible officials to prepare details for each health situation/issue of each determinant of health with evidence |
| 2554/1      | 14 Feb 2011     | Review the draft health situation and determinants of health based on the document "findings & evidence" |
| 2554/2      | 18 Mar 2011     | Progress of the 11th Health Plan formulation and drafting |
| Meeting to draft the Plan Richmond Hotel, Nonthaburi | 20–21 May 2011 | Identify major issues and evidence  
- Draft the vision, mission and goals |
| 2554/3      | 6 June 2011     | Review the draft vision, mission and goals |
| 2554/4      | 16 June 2011    | Review the draft vision, mission and goals  
- Draft strategies and indicators that are consistent with the determinants of health |
| 2554/5      | 23 June 2011    | Conduct SWOT analysis for drafting development strategies |
| 2554/6      | 24 June 2011    | Conduct SWOT analysis and draft development strategies of the 11th Health Plan and draw up indicators for each of the strategies |
| Meeting to solicit comments | 11 July 2011 | Hold public hearings to solicit comments and recommendations from representatives from MoPH’s central agencies (departments and divisions) |

### Meeting Schedule

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<th>Meeting no.</th>
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<tr>
<td>2554/7</td>
<td>4 Aug 2011</td>
<td>Revise the draft Health Plan for presenting to public hearings to solicit comments and recommendations from target groups within and outside MoPH</td>
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| Public hearing No. 1, Imperial Queen’s Park Hotel | 17 Aug 2011 | Hold public hearings to solicit comments and recommendations from target groups:  
- Representatives from MoPH’s provincial administrative agencies  
- Representatives from departments’ technical agencies located outside Bangkok |
| Public hearing No. 2, Richmond | 22 Aug 2011 | Hold public hearings to solicit comments and recommendations from target groups:  
- Representatives from National Socio-Economic Advisory Council; Civil Service Commission; Public Sector Development Commission; Medical Services Departments of the Army, the Navy, the Air Force and the Thai Police; Medical Services and Health Departments of the Bangkok Metropolitan Administration; Board of Investment  
- Representatives from local government organizations  
- Representatives from various civil society organizations |
| 2554/8      | 7 Dec 2011      | The Working Group presents the summaries of comments and recommendations from public hearings for plan revision to the meeting; the issues to be revised and/or undertaken include:  
- Revision of indicators  
- Revision of tactics and measures  
- Revision of movement mechanisms  
- Preparation of content and printing dummy  
- Preparation for proposing the final draft 11th Health Plan to the Steering Committee |
Order of the Ministry of Public Health
No. 2307/2553
Subject: Appointment of Steering Committee on Formulation of

Whereas we are now in the process of drafting an 11th National Health Development Plan, 2012–2016 (or 11th Health Plan), for use as a tool for further developing people’s health, in order that the 11th Health Plan will be formulated with the participation of all sectors concerned and is acceptable to, and implementable by, all involved in people’s health care, a Steering Committee on Formulation of 11th National Health Development Plan is hereby appointed comprising the following:

1. Minister of Public Health
2. Deputy Minister of Public Health
3. Chairperson, Senate Standing Committee on Public Health
4. Chairperson, House Standing Committee on Public Health
5. Secretary-General, National Health Commission
6. Secretary-General, National Economic & Social Development Board
7. Secretary-General, Civil Service Commission
8. Budget Director, Bureau of the Budget
9. Permanent Secretary, Ministry of Public Health (MoPH)
10. Permanent Secretary, Bangkok Metropolitan Administration
11. Permanent Secretary, Ministry of Defence
12. Permanent Secretary, Ministry of Labour
13. Permanent Secretary, Ministry of Commerce
14. Permanent Secretary, Ministry of Interior
15. Permanent Secretary, Ministry of Education
16. Permanent Secretary, Ministry of Industry
17. Permanent Secretary, Ministry of Agriculture & Cooperatives
18. Permanent Secretary, Ministry of Natural Resources & Environment
19. Permanent Secretary, Ministry of Social Development & Human Security
20. Deputy Permanent Secretary, MoPH
   (Medical Service Development)
21. Deputy Permanent Secretary, MoPH
   (Public Health Development)
22. Deputy Permanent Secretary, MoPH (Health Service Support)
23. Secretary-General, National Health Security Office
24. Secretary-General, Emergency Medical Institute of Thailand
25. Director, Health Systems Research Development
26. Manager, Thai Health Promotion Foundation
27. Director, Government Pharmaceutical Organization
28. Deputy Permanent Secretary, MoPH (Administration)
29. Director, Bureau of Policy & Strategy, Office of the Permanent Secretary, MoPH

The Steering Committee has the following powers and duties:
1. To specify policies and directions for national public health development as a guide for formulating the 11th Health Plan.
2. To review and endorse recommendations on health development strategies.
3. To review and endorse recommendations and suggestions for relevant public and private agencies in formulating the 11th Health Plan.
4. To appoint subcommittees and working groups as deemed appropriate.

This order is effective on this day onwards.
Given on the 29th of December B.E. 2553 (A.D. 2009)
Signature: Jurin Laksanawisit
(Mr. Jurin Laksanawisit)
Minister of Public Health

Certified correct copy
Signature: Darane Khampera
(Ms. Darane Khampera)
Policy and Plan Analyst, Senior Professional Level
Order of the Ministry of Public Health
No. 2309/2553
Subject: Appointment of Committee on Formulation of
11th National Health Development Plan, 2012-2016

As the 10th National Health Development Plan, 2007-2011, has been implemented since 2007 and will end in 2011; and an 11th National Health Development Plan, 2012-2016 (or 11th Health Plan), will be issued for use in October 2011, in order for the 11th Health Plan under the strategic framework of the 11th National Economic and Social Development Plan over the same period, to be clearly formulated and acceptable to, and implementable by, all concerned in a concrete manner to achieve its objectives, a Committee on Formulation of 11th National Health Development Plan is hereby appointed comprising the following:

1. Permanent Secretary, Ministry of Public Health (MoPH) Chairperson
2. Deputy Secretary-General, National Health Commission Member (to be assigned)
3. Deputy Secretary-General, National Economic & Social Development Board (to be assigned) Member
4. Deputy Budget Director, Bureau of the Budget (Social Sector 2) Member
5. Deputy Permanent Secretary, Bangkok Metropolitan Administration (for Medical & Health Services) Member
6. Deputy Permanent Secretary, Ministry of Social Development & Human Security (to be assigned) Member
7. Deputy Permanent Secretary, Ministry of Natural Resources & Environment (to be assigned) Member
8. Deputy Permanent Secretary, Ministry of Agriculture and Cooperatives (to be assigned) Member
9. Deputy Permanent Secretary, Ministry of Education (to be assigned) Member
10. Mr. Sowit Wibulpolprasert, Senior Advisor on Disease Control, MoPH Member
11. Director-General, Department for Development of Thai Traditional & Alternative Medicine, MoPH Member
12. Director-General, Department of Medical Services, MoPH Member
13. Director-General, Department of Disease Control, MoPH Member
14. Director-General, Department of Medical Sciences, MoPH Member
15. Director-General, Department of Health Service Support, MoPH Member
16. Director-General, Department of Mental Health, MoPH Member
17. Director-General, Department of Health, MoPH Member
18. Secretary-General, Food & Drug Administration, MoPH Member
19. Director, Praboromrachanhon Institute, Office of the Permanent Secretary, MoPH (OPS/MoPH) Member
20. Director, Information & Communication Technology Centre, OPS/MoPH Member
21. Representative, National Health Security Office Member
22. Representative, Healthcare Accreditation Institute Member
23. Representative, Government Pharmaceutical Organization Member
24. Representative, Thai Health Promotion Foundation Member
25. Representative, Emergency Medical Institute of Thailand Member
26. Deputy Permanent Secretary, MoPH (Administration) Member & Secretary
27. Director, Bureau of Policy & Strategy, OPS/MoPH Member & Asst. Secretary
28. Director, Cluster for Health Policy & Strategy Development, Bureau of Policy & Strategy, OPS/MoPH Member & Asst. Secretary

The Committee has the following powers and duties:
1. To prepare guidelines and steps for formulating the 11th Health Plan.
2. To review documents and data to be used in formulating the 11th Health Plan.
3. To coordinate with relevant agencies in formulating the 11th Health Plan.
4. To consider and make recommendations for submission to brainstorming meetings and seminars on the formulation of the 11th Health Plan.
5. To report on the progress of the 11th Health Plan formulation to the Steering Committee periodically.
6. To prepare the 11th Health Plan and get it submitted to administrators concerned.
7. To appoint working groups as deemed appropriate.
8. To perform other duties to be assigned.

This order is effective on this day onwards.

Given on the 29th of December B.E. 2553 (A.D. 2009)
Signature: Jurin Laksanawisit (Mr. Jurin Laksanawisit)
Minister of Public Health

Certified correct copy
Signature: Daranee Khampaer
(Ms. Daranee Khampaer)
Policy and Plan Analyst, Senior Professional Level
Order of the Ministry of Public Health
No. 2309/2553
Subject: Appointment of Working Group on Coordination in Formulating 11th National Health Development Plan, 2012–2016

As the 10th National Health Development Plan, 2007–2011, has been implemented since 2007 and will end in 2011, in order for the 11th National Health Development Plan, 2012–2016 (or 11th Health Plan), to be formulated and implemented to improve people’s health during the 11th Health Plan period, a Working Group on Coordination in Formulating 11th National Health Development Plan is hereby appointed comprising the following:

1. Permanent Secretary, Ministry of Public Health (MoPH) Advisor
2. Secretary-General, National Health Commission Advisor
3. Mr. Supakit Sirilak, Director, Bureau of Policy & Strategy, Office of the Permanent Secretary, MoPH (OPS/MoPH) Chairperson
4. Mrs. Orapan Srissorskatana, National Health Commission Member
5. Mr. Amsak Supaporn, National Health Commission Member
6. Mr. Sura Wisedsak, Chaiyaphum Provincial Public Health Office, OPS/MoPH Member
7. Director, Cluster for Health Policy & Strategy Development, Bureau of Policy & Strategy, OPS/MoPH Member
8. Director, Cluster for Health Information, Bureau of Policy & Strategy, OPS/MoPH Member
9. Director, Cluster for Evaluation, Bureau of Policy & Strategy, OPS/MoPH Member
10. Mr. Komatra Chuengsatiansup, Bureau of Policy & Strategy, OPS/MoPH Member
11. Mr. Phusit Prakongsai, Bureau of Policy & Strategy, OPS/MoPH Member
12. Ms. Orasa Kovindha, Bureau of Policy & Strategy, OPS/MoPH Member
13. Mrs. Yaovaman Suasangthong, Bureau of Policy & Strategy, OPS/MoPH Member
14. Mrs. Achara Netsiri, Bureau of Policy & Strategy, OPS/MoPH Member
15. Mrs. Suchada Ativanitchayapong, Bureau of Policy & Strategy, OPS/MoPH Member
16. Mrs. Phannapa Phuangphadung, Bureau of Policy & Strategy, OPS/MoPH Member
17. Mrs. Nichakorn Sirikanokvilai, Bureau of Policy & Strategy, OPS/MoPH Member
18. Ms. Sunaporn Saelim, Bureau of Policy & Strategy, OPS/MoPH Member
19. Ms. Pintusorn Hempisut, Bureau of Policy & Strategy, OPS/MoPH Member
20. Ms. Panbunee Ekachampaka, Bureau of Policy & Strategy, OPS/MoPH Member
21. Mrs. Areewadwongtham, Bureau of Policy & Strategy, OPS/MoPH Member
22. Mr. Niis Wattanamanono, Bureau of Policy & Strategy, OPS/MoPH Member
23. Ms. Daraneek Khampa, Bureau of Policy & Strategy, OPS/MoPH Member
24. Mr. Surut Glaithaiyalerk, Bureau of Policy & Strategy, OPS/MoPH Member
25. Ms. Poosin Sriwrayoon, Bureau of Policy & Strategy, OPS/MoPH Member

The Working Group has the following powers and duties:

1. To prepare framework, issues and directions of the 11th Health Plan.
2. To coordinate with relevant agencies in formulating the 11th Health Plan.
3. To prepare and analyze relevant data for use in formulating the 11th Health Plan.
4. To prepare documents and data on the 11th Health Plan formulation for consideration at meetings of the Steering Committee.
5. To hold brainstorming meetings and seminars to formulate the 11th Health Plan.
6. To prepare the draft 11th Health Plan.
7. To edit the 11th Health Plan document.
8. To publish the 11th Health Plan.
9. To perform other duties to be assigned.

This order is effective on this day onwards.

Given on the 29th of December B.E. 2553 (A.D. 2009)
Signature: Jurin Laksanawisit (Mr. Jurin Laksanawisit)
Minister of Public Health

Certified correct copy
Signature: Daraneek Khampa
(Ms. Daraneek Khampa)
Policy and Plan Analyst, Senior Professional Level