Planning and budgeting for human resources for health requirement for primary care: lesson learned from Thailand

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Aug 5, 2024

Thailand At A Glance

Population: 71.8 million (2024), 52% in Urban

Non-Thai Population: 4.9 million

Health status

- Life expectancy at birth: 77.7 (both sex)
- Skilled Birth Attendant: 99.8%
- U5MR = 7.8/1,000 LB
- MMR = 37/100,000 LB

GDP per capita: US$ 7,801 (2023)

Total Health Expenditure: US$ 305 per capita, 4.36% of GDP

Public source: 78% THE

Out of pocket: 8.67% of current health expenditure

Catastrophic health expenditure: 1.9%

Source: https://www.worldometers.info/demographics/thailand-demographics/#life-exp, World Bank Data

Thai health system

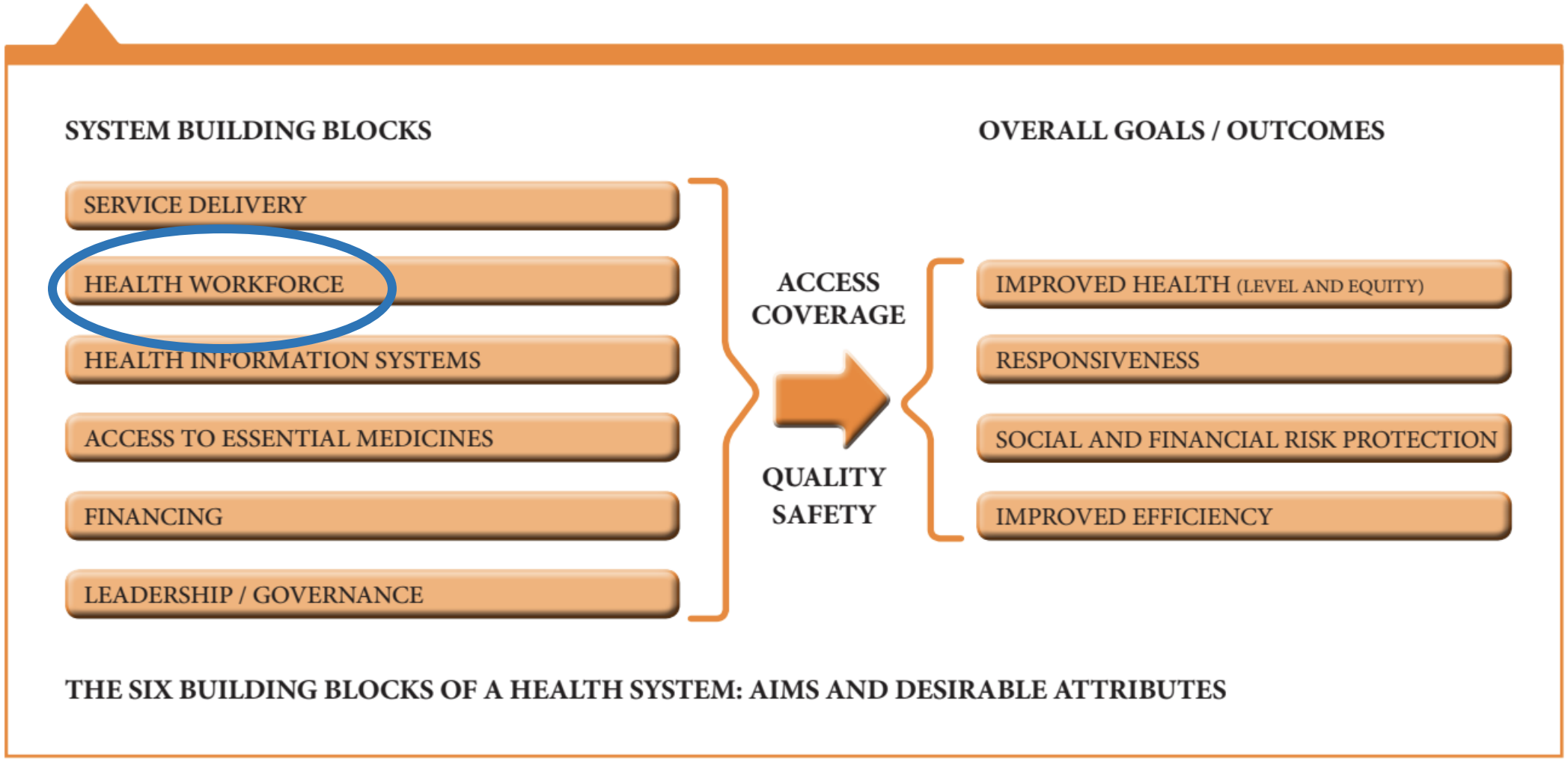
- Highly centralized public dominant (MoPH) -> pro-poor idealogy
- The Ministry of Public Health (MoPH) is the leading provider
- MoPH facilities accounted for 70% of the nation's hospital beds
- The SEA financial crisis in 1997 led to political instability
- The window of opportunity for healthcare reform -> UCH in 2002

https://documents1.worldbank.org/curated/en/099052523201027923/pdf/P1771570af8b360b40aab305f0be65a2678.pdf

“Health services cannot be delivered without health workers”

https://iris.who.int/handle/10665/333611

Six Building Blocks (WHO) to strengthening health system



Everybody's business — Strengthening health systems to improve health outcomes. WHO's framework for action. Geneva, World Health Organization, 2007 (http://www.who.int/healthsystems/strategy/everybodys_business.pdf, accessed 26 April 2010).

THAI HEALTH SYSTEM EVOLUTION

A brief history of Thai health system

1970s - 1990s

- MoPH -> main health providers and purchasers
- Building primary care infrastructure
- Trained Health workforces, VHV
- Vertical Disease Control

1997 - 1999

- SEA Economic Crisis
- Political Instability
- Health care reform (Decentralized Act 1999)
- Emerging of Universal Coverage Scheme (30 baht Scheme)

2000 - 2002

- National Health Security Act 2000 -> NHSO
- Purchaser-Provider Split
- Achieved UHC 2002

2003 - 2013

- Inclusive health service packages -> comprehensive care
- Improve health indicators
- Aging society -> more NCD
- National Health Act 2007 -> Multiple Stakeholders
- The political party won 3 consecutive national election until 2014

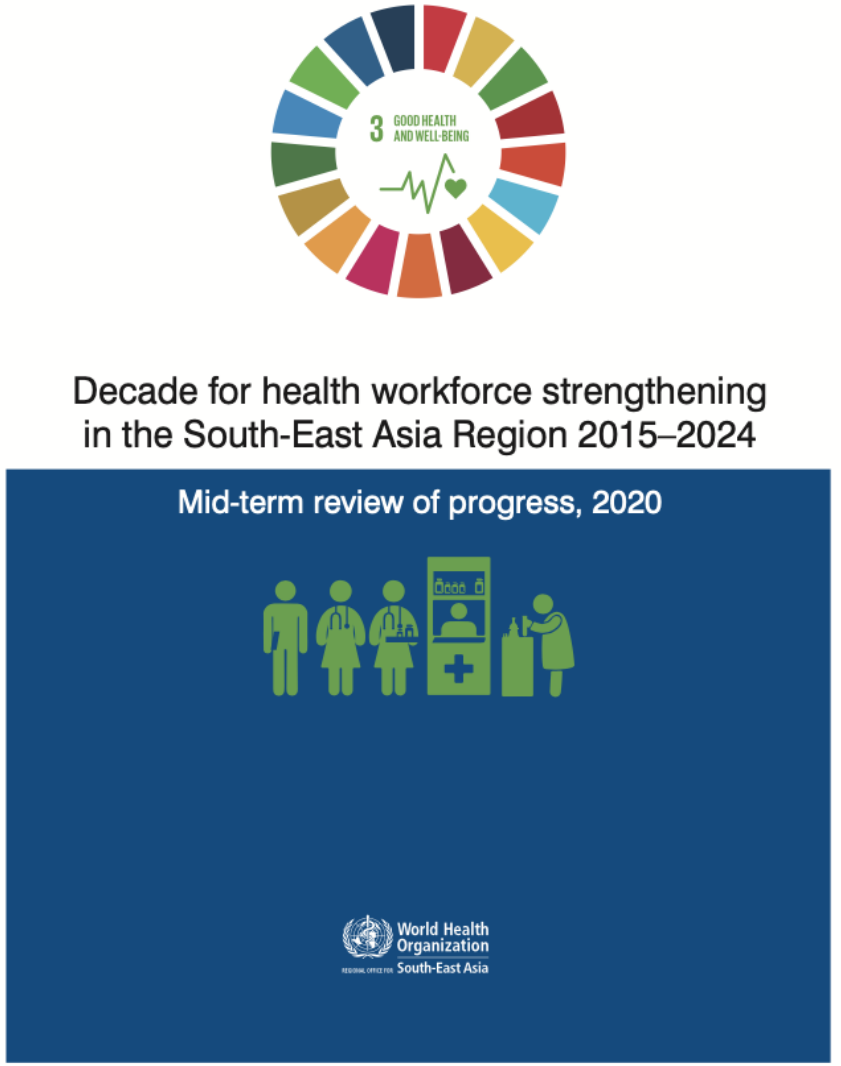
2014 - 2018

- 2014 Coup D'Etat
- Military government also support UHC

2019 - present

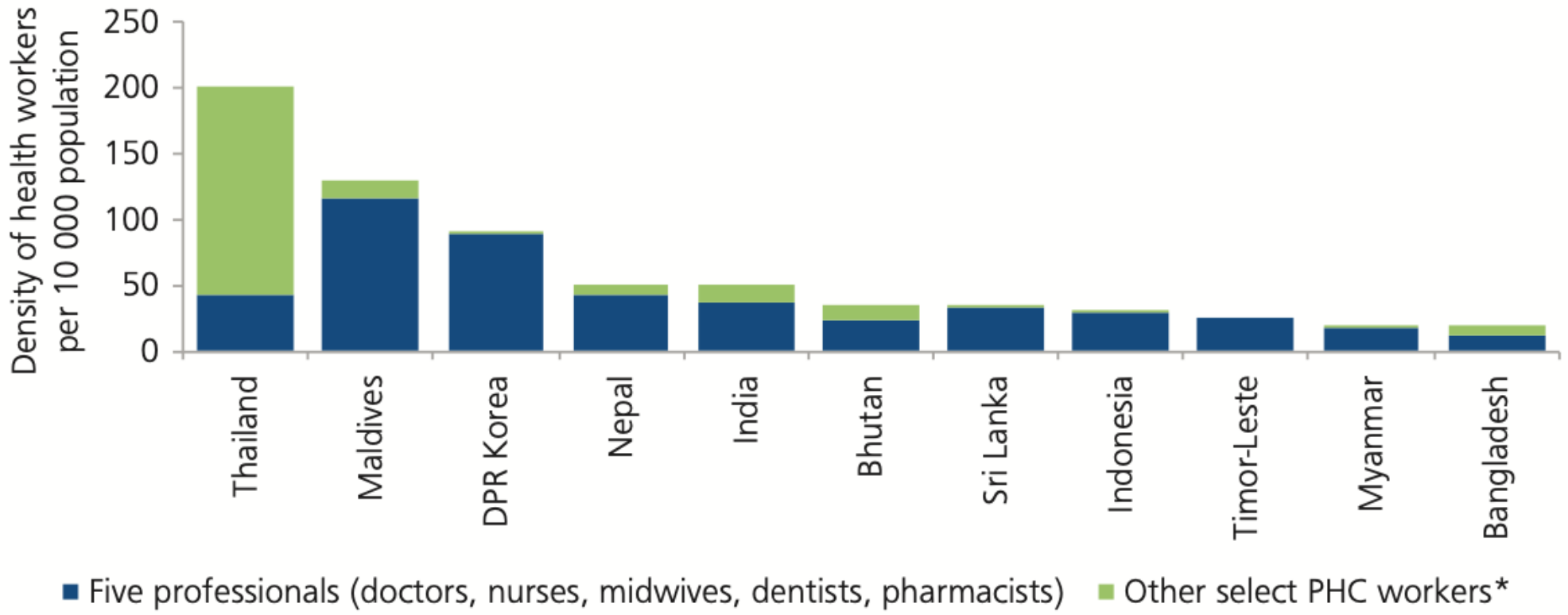
- Primary Care System Act 2019 -> Ensure equity access to essential care
- Public -Private Partnership in primary care
- Progress in decentralization of primary care
- Digital health

Significant commitment to a full Decade for Health Workforce Strengthening 2015–2024



https://iris.who.int/handle/10665/333611

Fig. 5 Availability of health workers, including PHC workers, per 10 000 population in 2018



*Note: Same as Fig. 4

Source: Country data reported to WHO through NHWA online platform as of 15 December 2019.

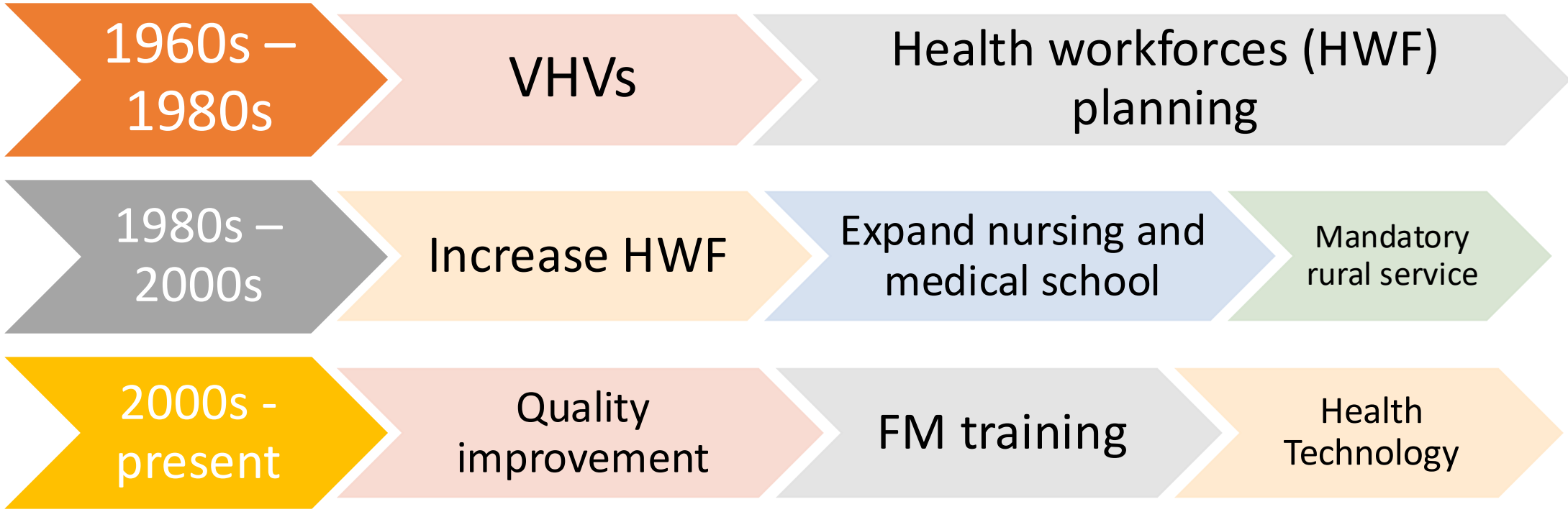
https://iris.who.int/handle/10665/333611

Three types of necessary response in health workforces shortage

- Increase number of health workforces
- Increase the flexibility of health workforces: task shifting, upskill, reskill, expand roles, health technology
- Increase support for workers in practice

Coates, A., Fuad, AO., Hodgson, A. *et al.* Health workforce strategies in response to major health events: a rapid scoping review with lessons learned for the response to the COVID-19 pandemic. *Hum Resour Health* **19**, 154 (2021). https://doi.org/10.1186/s12960-021-00698-6

Health Workforce Development in Thailand: Four Decades of Progress



Health Workforce Development: 1960s-1980s

Village Health Volunteers (VHVs)

- **History and Development:**
  - Initiated in the 1960s as part of primary health care strategy
  - Expanded nationwide in the 1980s
- **Role and Responsibilities:**
  - Health education and promotion
  - Basic health screening and monitoring
  - Assist in disease prevention and control
  - Link between community and health facilities

Health Workforce Development: 1960s-1980s

Village Health Volunteers (VHVs)

- **Training and Support**:
  - Initial training provided by public health officials
  - Ongoing capacity building and refresher courses
  - Regular supervision from local health centers
- **Impact:**
  - Improved access to basic health services in rural areas
  - Enhanced community participation in health
  - Crucial role in health emergencies (e.g., COVID-19 response)

Health Workforce Development: 1960s-1980s

Village Health Volunteers (VHVs)

- **Challenges and Adaptations:**
  - Aging volunteer workforce
  - Adapting to changing health needs (e.g., non-communicable diseases)
  - Integration with urban health initiatives

https://www.who.int/thailand/news/feature-stories/detail/thailands-1-million-village-health-volunteers-unsung-heroes-are-helping-guard-communities-nationwide-from-covid-19

Health Workforce Development: 1980s-2000s

- **1980s:**
  - Focus on increasing the number of healthcare workers
  - Establishment of rural health centers
- **1990s:**
  - Introduction of mandatory rural service for medical graduates
  - Expansion of medical and nursing schools
- **2000s:**
  - Implementation of Universal Health Coverage
  - Increased emphasis on primary healthcare (Family Medicine Training)

Health Workforce Development: 2000s-Present

- **2010s-2020s:**
  - Focus on quality improvement and specialized care
  - Integration of technology in healthcare delivery

Strategies to Address Workforce Shortages

- **Training**
  - Increased capacity of medical and nursing schools
  - Establishment of new health science universities in rural areas
  - Short-term training programs for existing health workers
  - Continuing education and professional development opportunities

Collaborative Project to Increase Production of Rural Doctor

Public Health Officers School

Nursing Colleges

Strategies to Address Workforce Shortages

- **Task Shifting:**
  - Empowering nurses and community health workers to perform tasks traditionally done by doctors
  - Training primary care workers in basic diagnostic and treatment skills
  - Utilizing pharmacists for basic health screenings and chronic disease management

Strategies to Address Workforce Shortages

- **Innovative Strategies:**
  - Telemedicine to connect rural areas with specialist care
  - Financial incentives for health workers in rural areas
  - Partnerships with private sector for training and service delivery
  - Community engagement through health volunteers

Strategies to Address Workforce Shortages

- **Long-term Planning:**
  - Workforce forecasting and needs assessment
  - Regular review and adjustment of health professional education curricula
  - Collaboration with international organizations for technical support and best practices

Incentives for Thai Health Workforces

Financial Incentives:

Rural Allowances: Additional payments for working in remote or underserved areas

Tiered system based on location difficulty

Hardship Allowances: Extra compensation for working in challenging conditions or high-risk areas

Performance-Based Bonuses:

Rewards for meeting specific health targets or quality indicators

Additional Financial Incentives

- Overtime Pay:
  - Additional compensation for extra hours worked, especially common in public hospitals
  - Extra payment for remote setting and specialists

Career Development incentives

Fast-Track Promotion

Specialized Training Opportunities

Research Grants

Educational Incentives

TARGETED ADMISSION PROGRAMS: CPIRD

LOAN FORGIVENESS

Quality of Time Incentives

Housing Benefits: Provision of free or subsidized housing, especially in rural postings

Family Support: Educational support for children of health workers in rural areas

Job opportunities for spouses in government sectors

Additional Leave: Extra vacation time or study leave for those in demanding posts

Challenges in incentives program

Balancing financial incentives with budget constraints

Ensuring equitable distribution of incentives across different health professions

Maintaining long-term effectiveness of incentive programs

Addressing potential unintended consequences (e.g., internal brain drain from public to private sector)

Future Directions

Regular review and adjustment of incentive packages

Exploring non-financial incentives to complement monetary rewards

Involving health workers in the design of incentive programs

Evaluating the impact of incentives on health outcomes and workforce distribution

Key Success Factors

Strong health professional education system

Rural retention policies

Task shifting and skill mixed innovation

Health workforces planning

Continued professional development (CPD)