ROLE OF WHO IN THE DEVELOPMENT OF COUNTRY HEALTH PROGRAMMING IN THAILAND

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1. INTRODUCTION

Before the advent of national economic and social development planning, annual budget needs were estimated by each agency based upon allocations made in preceding years and additional needs in terms of manpower and institutional expansion. System approach in budget formulation had been extremely limited even among Departments and Divisions of the same Ministry. As a juristic entity each department had the liberty to propose its annual budget request to the Budget Bureau, defend their respective programmes and projects and be responsible for implementing them after annual budget allocations. Conventional budget allocations were based upon incremental considerations designating specific percentage of increase whereby new proposals were to be made accordingly. There had not been any policy guidance nor long-term scenario for national economic and social development with designated role of each sector in overall national development.

Following the establishment of the **National Economic and Social Development Board (NESDB),** the first medium-term **National Economic and Social Development Plan** was formulated in the year **1961** with **National Health Development Plan** as an integral part. However the first 3 plans were still based upon budget needs of individual Departments and their respective Divisions and focussed primarily on institutional expansion, increase in health manpower and operating expenses.

In **1972** when the **Health Planning Division** was extablished under the Office of Permanent Secretary of Public Health, system approach in health policy formulation and health development planning has gradually been developed under WHO technical assistance.

This paper aims at documenting WHO assistance in country health programming since the year 1972 commencing with a provincial planning exercise called **Project Systems Analysis (PSA)** undertaken in Chonburi province and then expanded to the national level during the period of the 4^{th} and 5^{th} five-year National Health Development Plans and thereafter. It is also intended that this paper be a reminder for all policy makers that future scenario for health and social development and its corresponding development planning could best be done through active

people participation and involvement as well as effective intra and inter-sectoral collaborations.

2. HISTORY AND BACKGROUND OF COLLABORATION WITH WHO IN COUNTRY HEALTH PROGRAMMING

2.1 National Medium-Term Economic and Social Development Planning (1st - 3rd Plans from 1961 - 1976)

The first medium-term National Economic and Social Development Plan was formulated in **1961** with **Health Development Plan** as its essential integral part. Due to limited experience and expertise as well as lack of qualified personnel in development planning it was noted that the 1st - 3rd plans were based upon sectoral needs and the role and responsibility of each individual Department and its respective Divisions. The contents of those plans were thus oriented towards institutional expansions, establishment of health service infrastructure, manpower and increase of operating expenses. Programmes and projects as proposed by MOPH's Departments and Divisions were not adequately integrated nor interrelated under any mutually agreed concept, philosophy or long-term scenario for health development. Programme objectives, policy oriented priority and most particularly, target in health problem reduction such as reduction of morbidity rate of certain disease had not been clearly stated. Only in the 3rd **Five-Year Plan** that the target of population growth was clearly designated to be reduced from 3% to 2.6%.

During the 1st - 3rd Plans, the process of proposing and authorizing programmes and projects of each individual Department as a juristic entity within the Ministry of Public Health were done vertically without any collaboration with other related Departments and Divisions. The proposals submitted were to be authorized by the **National Economic and Social Development Board (NESDB)** and then utilized as guideline in annual budget preparation and allocation by the **Budget Bureau.** As a result the **Health Ministry's** role in comprehensive health policy formulation and coordination among all concerned Departments and Divisions was quite limited, not to mention external collaborations with other related Ministries in social development.

Recognizing the limitations and the needs for a more systematic and comprehensive health policy formulation and country health programming under active involvement of all concerned sectors, senior health administrators of the **Ministry of Public Health** then requested for **WHO** technical assistance in developing the system, pattern and methodologies for national health development and project formulation, rational use of existing resources and yield outputs that meet the needs for solving high priority health problems.

WHO's decision in collaborating with the Thai authorities was also based upon its own need in making best use of **WHO** country programme resources in the Thai context, emphasizing closer collaboration and commitments both within the **Ministry of Public Health** and other concerned Ministries so that the programme could be more effective in addressing priority health problems. Concurrently the **Health Planning Division** was newly set up in the **MOPH's Office of Permanent Secretary** in the year 1972 to be in charge of health development planning.

In preparation of the 4th Five-Year Plan a provincial planning exercise called **Project Systems Analysis (PSA)** was jointly undertaken by Health Planning Team and **WHO** Consultants in Chonburi Province. The exercise had helped senior officials of the **Health Planning Division** in having a hand-on experiences in problem identification and analysis, designating rational and systematic planning process and corresponding methodologies as well as indulging in actual provincial health development planning. This valuable exercise had aroused interests among health planners in using their experiences in national health development planning.

Another facilitating factor which should not be left out was the significant political change in October 1973 which had brought about new atmosphere and direction for national economic and social development including health policy reorientations which emphasized intersectoral collaboration, decentralization and increase coverage of essential services for the population while further reducing the rate of population growth.

2.2 WHO Technical Input During the 1st Cycle of Country Health Programming in Thailand (4th Five-Year National Health Development Plan - 1977-1981)

During the period of significant political change in 1973, national economic and social development policies were reorientated to be more agressive in addressing the pressing problems and needs of the country and the strong political commitment for supporting innovative strategies in development planning.

The health sector's policy emphasized accelerating and increasing coverage of medical and healthcare services to meet the need of the rural population while enhancing the effectiveness of such services. Its implication had led to major reorientation of the Ministry's organization structure enhancing the integration of comprehensive health promotion, disease prevention and curative services under a single administration of the **Department of Medical Services** instead of having them separately planned and implemented under different Departments and Divisions. In order to pave way for decentralization of authorities from the central to provincial level, the **Offices of the Provincial Public Health Officer** which used to be under the **Department of Health** has been transferred under the jurisdiction of the **Office of the Permanent Secretary** since 1973 with increasing role and responsibility in planning, coordinating and managing overall provincial healthcare services.

National health development planning and country health programming had become critical activities for the **Ministry of Public Health** as they constituted essential tools for controlling, monitoring and collaborating health development while ensuring that budget allocation and management were in accordance with the health sector's policy. With **WHO** technical assistance, **Country Health Programming (CHP)** methodology and process were applied in preparation of the **4th Five-Year National Health Development Plan** in 1972.

The **Sub-Committee for Health Development Planning** under chairmanship of **Prof. Dr.Sem Pringpuangkeo** was appointed to be in charge of this activity with senior health officials of the Health Planning Division as the secretariat. There were concerned officials from **NESDB**

and other related ministries represented in this **Sub-Committee.** It should be noted that **WHO** experts in country health programming did not take part in any decision making process concerning national policy and strategies. They contributed primarily in recommending practical methodologies in problem identification and analysis, formulation of objectives, targets, strategies, programming and project formulation including estimation of resources needed. Eventhough **WHO CHP's Guidelines and Project Management Mannual** were used as guiding principles in this undertaking, **WHO** experts had taken into account country-specific socio-economic and political background as well as cultural and managerial orientation in applying the concepts and principles inherant therein. In practise considerable flexibility and initiatives were allowed while the main philosophy, conceptual orientation, basic principles as well as methodologies and process were maintained particularly in situational analysis and problem identification, setting of development objectives and targets, formulation of strategies, programmes and projects, assessment of resources needed all of which were divided into 4 essential phases. Actual timing used in achieving all the 4 phases appeared as follows :

		Time frame	
Phase I	**Preparatory**	January - December	1974
Phase II	**Programming**	January - April	1975
Phase III	**Project Formulation**	April - September	1975
Phase IV	**Review/Decision Making**	October - December	1975

The overall process of country health programming as applied in the formulation of the **4th Five year National Health Development Plan** had yielded tangible benefits not only in terms of rational planning and programming but also in the following aspects :

(1) Sense of partnership and mutual commitment among planners from all concerned Ministries, Departments and Divisions

The **CHP** approaches and methodologies called for active participation of planners from different professions and sectors. Through **" learning by doing "** they worked together right from the initial task of data collection, problem identification and analysis up to the final phase of reviewing and decision making. During the process they had ample opportunity in

presenting their opinions, providing recommendations as well as joining in decision making which might occur in each phase of work. After a year of mutual commitment to put forth their product - the **4th Plan**-into actual implementation. The friendship had strengthened institutional network for health development.

(2) Clear-cut programme and projects which were mutually complementary

Changes from the conventional system whereby each individual Department or Division formulated its own plan separately into the system of problem-based integrated planning had widened the vision of planners in approaching health problems, enable them to forsee new opportunities for solving such problems and formulate the medium-term plan as well as programme and projects which were mutually complimentary and could meet the agreeable objectives and targets. Through this approach the sense of "empire building" and inappropriate budget allocations gave way to a more rational programming and budgeting principle and increasing intra and intersectoral collaborations in health development.

(3) Decentralization of authorities and responsibilities

As the CHP process could lead to rational programme and project formulation with clear cut objectives, targets and plan of actions are to be undertaken at all levels. Meanwhile the organizational structure of the **MOPH** as well as roles and responsibilities of its Departments, Divisions and health service institutions were reorientated in 1973 with a will to decentralize more management authorities to the rural health administration. National health development policy and corresponding plan, programmes and projects were used as master plan whereby operational plan at the provincial and district levels must be based upon with such performance indicators that field personnel could use as the basis for follow-up and evaluation.

Based on a study on the impact of the **4th Plan** on health conditions of the people made by the **Health Planning Division** in 1982, the standard of healthcare delivery in general had improved considerably and expansion of coverage had been achieved to a certain extent. It was understandable that some health problems could not be successfully tackled or eradicated within a short period of time and it might take more than the 5-year period of the

medium-term plan before any tangible effects or problem reduction could occur. In addition the dynamism of socio-economic as well as political and environmental changes has born continuing effects upon health of the people both positively and negatively. It was thus evident that at the end of the **4th Five-Year Health Development Plan** in 1981 a large proportion of the people, particularly those residing in rural areas did not have access to quality healthcare services and continued to suffer from health problems related to poor living conditions, inappropriate sanitation facilities, deteriorated natural environment, malnutrition while the incidence of preventable diseases was still high. Some population groups suffered from emerging health problems such as accidents, sexually transmitted diseases, chronic degenerative diseases, mental health, drug addition, etc.

Role of **WHO** in health development planning was not merely in advising about the methodologies or techniques in country health programming but had extended toward recommending new directions for health policy development such as the 1978 **World Health Assembly's** resolution endorsing the long-term goal of **Health for All by the Year 2000.** For reinforcing implementation in accordance with this global goal, the historic international meeting was held at **Alma Ata, former USSR** to further promote **HFA/2000** concept and strategies emphasizing **primary health care (PHC's) approaches** which underscored the importance of people participation, intersectoral collaboration and reorientation of the health service system to meet basic health needs of the people. In **Thailand** the **cabinet approved the PHC principles in March 1979** and allocated resources and administrative mechanism to ensure the achievement of the PHC endeavours.

Another notable initiative during the 4th Plan was the formulation of National Drug Policy, national formulary and list of essential drugs which will be presented in a separate paper. Long-term health manpower development plan was also formulated by the Ministry of Public Health and other concerned universities or essentially between users and producers. It would be said that intersectoral collaboration for health had been firmly established at the end of the **4th Five-Year Health Development Plan.**

2.3 Experience in Apply the Second Cycle of Country Health Programming in Thailand (5th Five-Year National Health Development Plan, 1982-1986)

The concept of intersectoral planning was particularly emphasized during the course of planning of the **5th Five-Year National Economic and Social Development Plan.** In February 1981 the **National Economic and Social Development Board (NESDB)** appointed a **high-level Sub-Committee** headed by the Deputy Prime Minister to monitor the development of the **National 5th Five-Year Plan.** To facilitate the development of broad programmings within various components of the economic and social sectors, 25 sub-committees were further appointed by the **NESDB.**

In the social sector, a Sub-Committee for Overall Social Development was set up to facilitate and supervise broad programming for social development. Within the scope of this Sub-Committee, the **Health Development Planning Sub-committee** was authorized in March 1982. In contrast to conventional health development planning body which comprised only key persons of the health sector, this sub-committee was functioning in close collaboration with the overall **Social Development Planning Sub-Committee** and thus enable it to incorporate the overall social development guidance into the process. **Basic Minimum Needs (BMN's)** indicators were developed as parameters for measuring progress of integrated rural development. **Dr.Amorn Nondasuta,** the Deputy Under-Secretary of State for Public Health who was the **Chairman of the Health Development Sub-Committee** authorized a working group to make a through assessment of changes of the health problems and health system development during the past 20 years, emphasizing their strengths and weaknesses and recommending appropriate means for future health development in support of **HFA/2000.** In addition 18 Working Groups were appointed to make detailed planning of the 18 major health development programmes as deemed essential by the **Health Development Planning Sub-Committee.**

A series of consultative meetings and seminars were arranged for members of the **Health Development Planning Sub-Committee** and the Working Groups during the course of preparation of broad programming and detailed programming. The **Health Planning Division** served as the secretariat for the **Health Development Planning Sub-Committee** and

assumed role of technical and managerial consultant for the 18 Working Groups.

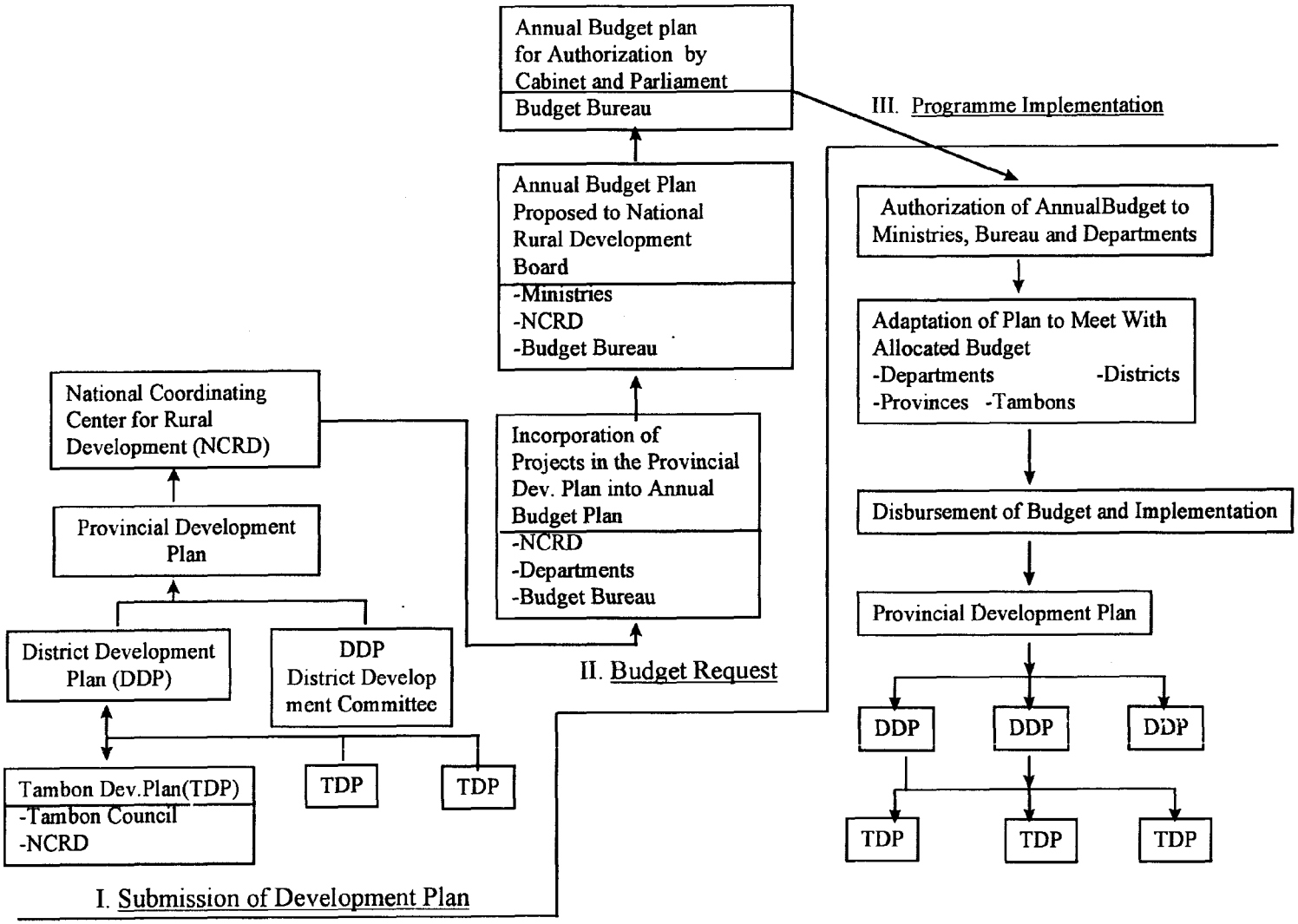
The final product or the **5th Five-Year National Health Development Plan** constituted a detailed description of the development policy, strategies, broad programming and detailed programmming of 18 major health development projects.

WHO technical and financial support was provided during the course of institutional preparation as well as supplementing the actual planning endeavour of the **5th Five-Year National Health Development Plan,** particularly in funding assessment studies, arranging seminars and consultative meetings for formulation of development strategies and broad programming, as well as providing subsidies for the working group during the period of intensive service in connection with detailed programming.

In recognition of the importance of intersectoral coordination for total rural development, the governement had established the **National Coordinating Center for Rural Development** to facilitate a sound system of upward planning and downward support. The functional linkage of this center in the whole process of development planning, budget request, and programme implementation appeared in **Figure 2.**

It was evident from this newly established mechamism that development plans of the grassroot level as generated by **Tambon Councils** could be used as a basis for guiding implementation of the **5th Five-Year National Economic and Social Development Plan.** This was one of the major innovative development during the second cycle of **CHP.** Also, through this new system of total rural development, intersectoral coordination and cooperation were extensively reinforced, right from the Tambol level up to the Provincial, Departmental and Ministerial levels particularly in the formulation of development policies and plans the decision on budget allocation and the actual implementation of development programmes.

Figure 2: Process of Upward Planning and Downward support for Total Rural Development



2.4 General Observation and Experiences

The process of applying the second cycle of **CHP** and the implications of the **5th Five-Year National Health Development Plan** had helped promoted the leading role of government in the reorientation of national health care system to be more PHC based in pursuance of long-term goal of HFA/2000. The broad programming process and the 5-year programmes served as a mechanism for introducing changes and development according to the long-term strategy for HFA/2000.

Concurrently, the government had adopted an explicit policy on total rural development through intersectoral coordination, upward planning and downward suport, and attempts had been made to strengthen the planning capability of all levels of government and community organizations. All of these observations witnessed a very promising progress and achievement in rural health development. However, it was notable to all concerned that social, political and economic factors may affect the whole process in an unfavorable manner for example the changing lifestyle of rural dwellers to depend more and more on cash income rather than self reliance and subsistence farming may negate their interest in community involvement.

The requirement for political changes was thus expected to be very important in enabling upward planning and downward support to become really pragmatic. The reorientation of the national health care system as well as health manpower development needed to be not only technically feasible but also politically and socially viable. To become really PHC based system, the communities must be well organized and sufficiently capable of continuously providing 8 essential elements of **PHC** in an integrated manner. These communities evidently require appropriate financial, technical and other resources support, especially a dynamic leadership of both the community leaders and the responsible health personnel.

Accruing from this observation, health administrators and planners were fully aware of the needs to obtain continuous feedback from what will be really happening in the system. A refined method of monitoring and evaluation was developed to ensure effective programme implementation. It was also anticipated that administrative organization and management within the health sector have to be analysed and deficiencies in this area have to be overcome as quickly as possible. In this sense, serveral programmes within the **5th Five-Year National health Development Plan**

had included components of innovative activities, health system research studies and the like.

It could be said that after the 2nd cycle of health development planning, the system and process have become an integral part of national health development with the **Health Planning Division** as the focal point for all successive planning endeavours.

2.5 Current Practise and Future Trend in National Health Development Planning

The role of **WHO** in **National Health Development Planning** after the **5th Five-Year** Plan was fairly limited and had merely evolved in the changing concept, direction and areas of emphasis during **the 6th and 7th plans. WHO** technical support in training or consultation on palnning methodology or managerial process for national health development has gradually been reduced as national potential in development planning increased quite favorably. It could be said that during **the 6th and 7th plans Thailand** had used her own national potential and experiences as the basis for health development planning and programming with **WHO's** support in providing updated information about the movements at international level. In many instances **WHO** had requested for Thai consultants to help other developing countries both within **WHO/SEAR** or other regions such as **WHO/EMRO** in transferring technology on health development planning with particular emphasis on primary health care and basic minimum needs approaches.

Currently, it was observed that the national health service system and the underlying health problems have become more complex as a result of rapid socio-economic, political and environmental changes both within the country and at regional and global levels. There have also been considerable changes in the Thai population in regard to age structure, migration and ways of life which inevitably bore impact upon health and the government healthcare delivery system. The establishment of the **Health Systems Research Institute** in the year 1992 reflected the urgent need of the **Ministry of Public Health** in reviewing, follow-up, investigating and analysing the strengths and weaknesses of the health system to further reinventing to meet the changing situation and problems. It is envisaged that new approaches in health development planning would require active participation of both the public and private sectors including the people themselves as the government bureaucratic system gradually

gives way to public society or people state system. New horizen in health development planning thus needs multidisciplinary scientific bases, for example economics, social and behavioral sciences, political sciences, management sciences, public health and epidemiology, information technology, etc. This area is particularly challenging for Thailand and WHO as well as our regional and global counterparts in reinventing the health system and health development planning to meet the emerging problems and needs with the HSRI as focal point for supportive research and development.

3. EXECUTIVE SUMMARY

A study based upon literature review of **WHO** assistance to **Thailand** in health development planning has been made. A brief background information of national efforts in formulation of the medium-term economic and social development plan was documented particularly from the first to the third plan before the advent of **WHO's** technical collaboration in country health programming.

With the establishment of the **National Economic and Social Development Board (NESDB)** all concerned sectors has assumed new role and responsibility in development planning since the beginning of the first plan in 1960's. After the **Health Planning Division** was set up under the **Office of Permanent Secretary** in the year 1973, the **Ministry of Public Health** had indulged in reinventing the overall process of health development planning to really addressing the country's priority health problems. Beginning with a provincial planning exercise called **Project Systems Analysis (PSA)** in Chonburi Province, the **Country Health Programming (CHP)** principles and methodologies were applied during the formulation of the **4th Five-Year National Health Development Plan** and also during the successive plan.

WHO's concept and strategies for **HFA/2000** through **Primary Health Care** had been addressed in the process of health development planning and had been a tool for promoting intersectoral collaboration in health and quality of life development through basic minimum needs (BMN's) approach.

It could be said that the systematic, problem-based and people oriented country health planning and programming under **WHO** technical collaboration has been instrumental for national health development. This could been in increasing recognition of health and social development with corresponding increase of annual budget allocated for the social sector. Overall health system and its managerial process have also been reorientated to address the needs of the underprivileged population, particularly those residing in rural areas, more efficiently and effectively. Gradual decentralization of authorities and responsibilities to the provincial and district administrations with increasing role of the people themselves in village-based self-managed PHC projects which has increased people's

potential and realization of their capabilities in planning for their own future which are essential groundwork for social development..

It is quite encouraging to observe the success of " **enterprising minded** " village leaders who, through a series of trial and error running of their small drug cooperatives or village development funds, now own village cooperatives or communal funds in several million Baht and could cater for health and welfare as well as annual profits for their members.

In facing the heavy turbulences of the bubble economy **His Majesty's Royal** initiatives in propagating self-contained integrated farming throughout the Kingdom and the promotion of subsistence economy were the key strategies for rural reconstruction whereby the people with " **awakening spirit** " could well be mobilized for national development.

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