

Chapter 4

Transforming the ASEAN Economic Community (AEC) into A Global Services Hub: Enhancing the Competitiveness of the Health Services Sector in Thailand

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March 2012

This chapter should be cited as

Supakankunti, S. and C. Herberholz (2012), 'Transforming the ASEAN Economic Community (AEC) into A Global Services Hub: Enhancing the Competitiveness of the Health Services Sectors in Thailand' in Tullao, T. S. and H. H. Lim (eds.), *Developing ASEAN Economic Community (AEC) into A Global Services Hub*, ERIA Research Project Report 2011-1, Jakarta: ERIA, pp.147-171.

CHAPTER 4

Transforming the ASEAN Economic Community (AEC) into A Global Services Hub: Enhancing the Competitiveness of the Health Services Sector in Thailand

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1. Introduction

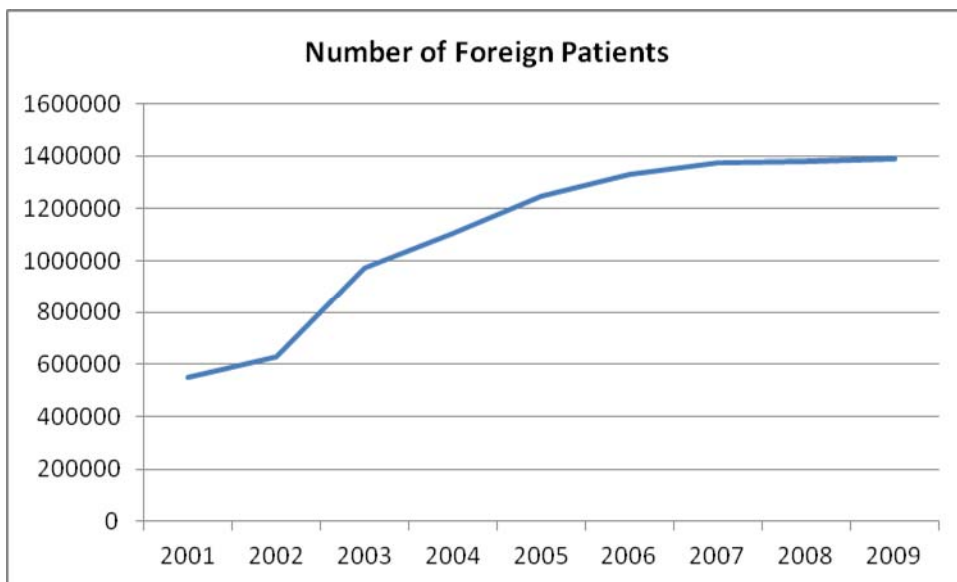
Over the past decades, Thailand has seen a strong trend towards globalisation of trade in goods and services, which was made possible through the evolution of the international trading system as well as advances in information technology and transportation systems. Thailand is classified as an upper middle income country and the country's economy is highly dependent on exports, with exports accounting for 71 percent of gross domestic product (GDP) in 2010. (World Bank) Thailand's GDP was worth USD (PPP) 591 billion in 2010, with per capita GDP reaching USD (PPP) 8,554 USD. (World Bank) Over the period 1961 to 2010, GDP growth was 6.4 percent on average. (World Bank) In 2009, however, GDP contracted by 2.3 percent due to the global financial crisis, which together with domestic political uncertainties also had an impact on the growth rate of international patients from abroad seeking medical treatment in Thailand.

While Thailand has been an open country and a well-known tourist destination for many decades, it was not until this present decade that medical tourism started to surge. In the wake of the 1997 Asian economic crisis, bed occupancy in most private hospitals significantly declined, prompting high-end private hospitals, which invested substantially

during the economic boom, to seek out medical tourists from abroad. Since then, every Thai government has announced various policy measures to promote medical tourism in order to generate revenues for the country.

Although medical travel is several thousand years old its more recent history dates back to the 1970s when (rich) individuals from developing countries started traveling to developed countries for medical care. At the end of the 1980s, with Cuba taking the lead, medical tourism emerged and under its present form sees developing countries serving international patients from developed and developing countries. (UN ESCAP, 2009) Thailand like many other countries followed and has sought to become an explicit “Medical Hub” for the past 10 years. The number of international patients was 1.4 million in 2009 including general tourists and foreigners who work or live in Thailand as shown in Figure 1, with medical tourists accounting for an estimated 30 percent (NaRanong & NaRanong 2011), reflecting that Thailand has become a leading destination for medical tourists from almost all continents. However, the growth rate of the number of international patients decreased during the past couple of years due to Thailand’s political problems and the global financial crisis as mentioned above.

Figure 1: Number of Foreign Patients Treated in Thailand



Data source: Department of Export Promotion, Ministry of Commerce in (MoPH, 2009), <http://www.thailandmedicaltourismcluster.org> (Retrieved on February 24, 2012)

Trade in health services was estimated to be worth 63,822 million THB in 2008, of which 62 percent was accounted for by medical services and 27 percent by health promotion. (MoPH, 2009)

The objective of this paper is to:

1. Undertake a SWOT analysis for the health services sector in Thailand.
2. Undertake an analysis of policies/regulatory/institutional support for the health services sector in Thailand.
3. Develop a profiling of firms which are considered key players for the health services industry.
4. Provide recommendations drawn from the results of the SWOT analysis as well as from the results of the analysis of policies/regulatory/institutional support on how Thailand could enhance its positions to be part of the global service hub in the region

Methodology

This study is a descriptive study and involves reviewing and analysing the literature dealing with international trade in health services, medical hub, its various dimensions and implications for national health sectors.

In addition, semi-structured interviews were conducted with experts from a small number of health facilities to give insight into strengths, weaknesses, threats and opportunities of the sector/industry. The findings are preliminary, based on the literature reviewed and analysed with small sample size, so the results should be interpreted with caution.

Background Information and Literature Review¹

This section analyses relevant existing studies. First, an overview of the Thai health sector and national priorities in the Thai health sector is given. Second, multilateral, regional and bilateral approaches to trade in health services negotiations and the issue of policy coherence are reviewed. Subsequently, studies concerned with medical tourism in Thailand and medical hub policy, barriers to trade in health services and implications of international trade in health services for Thailand are examined.

Thai Health Profile

Health policy and strategy in Thailand are based on a “*health for all, and all for health*” approach. Rights and obligations of individuals, the community, and the local

¹ This section is mostly from Supakankunti & Huerberholz (2011), but updated as indicated

and central government in promoting and protecting health are spelled out in the National Health Act of B.E. 2550 (A.D. 2007). Five-year National Health Development Plans are designed and linked to health plans for action, national development plans as well as Thailand's Millennium Declaration. The objectives of the Tenth National Health Development Plan 2007-2011 are *“(1) to promote good health as a lifestyle for all age groups, emphasizing health sufficiency at the family and community levels, (2) to create a good healthcare system, based on the human-being principle, with quality and friendly care, paying attention to the suffering of patients and the delicacy of human being, (3) to build a good society with wellness and health security for the people to feel warm and secure in normal, illness and critical situations and (4) to create a sufficient and sustainable livelihood that is peaceful with a culture that facilitates healthy lifestyle and leads to the attainment of the highest level of human potential.”* (MoPH, 2008) The overall health status of Thai people has improved over the past decades. Maternal mortality (48 per 100,000 live births in 2008) as well as infant (11 per 1,000 in 2010) and under 5 (13 per 1,000 in 2010) mortality rates have decreased, while life expectancy has increased (74 years in 2009), with female life expectancy outpacing male life expectancy (World Bank). The fertility rate was 1.6 in 2009 (World Bank) which is below the replacement level. This together with increased life expectancy has triggered significant demographic changes and results in Thailand facing problems of an ageing society. Thailand experienced a transition from communicable diseases to non-communicable diseases and the major causes of death as well as disease burden are non-communicable diseases, accidents and HIV/AIDS.

In 2008, total expenditures on health (in % of GDP) were 4.05 percent. This percentage has remained rather stable since 2002, but increased in 2007 and 2008. (World Bank)

While the Ministry of Public Health (MoPH) is the principal agency responsible for promoting, supporting, controlling and coordinating all health service activities, other agencies such as the Ministry of Education, the Ministry of Interior, the Ministry of Defence, the Bangkok Metropolitan Administration, state enterprises and private sector enterprises also play an important role since they operate health facilities. Hospitals are major health service providers and in 2008 the number of

hospitals reached 1,239, of which 78.05 percent were government hospitals and 21.95 percent private hospitals. (PReMA, 2010)

Seventy eight percent of private clinics and 70 percent of private hospitals, most of which are medium-sized with 51 to 100 beds, are located in provincial areas, while 21 out of 31 large private hospitals, with more than 200 beds, were located in Bangkok. (MoPH, 2011) However, most hospitals beds in Bangkok are in private hospitals while most hospitals beds in the provinces are under the MoPH, with MoPH hospitals having the highest bed-occupancy rate and hospitals under the Ministry of Defense and private hospitals the lowest. (MoPH, 2011) As reported in Sakunphanit (2006), private clinics in urban areas are mostly run by physicians from the public after work. The number of private hospitals increased rapidly between 1994 and 1997, concomitantly with financial liberalization as well as due to tax incentives, some of which experienced financial difficulties in the wake of the 1997 crisis and had to be closed. Most private hospitals are for-profit and 13 private hospitals were listed on the Stock Exchange of Thailand as of June 2011. (SET Market Analysis and Reporting Tool) The distribution of health personnel, however, still is a major problem in Thailand due to significant differences between Bangkok and other provinces and internal brain drain has remained a debated issue. Most doctors in Bangkok are under ministries other than the MoPH (42.5 percent), followed by the private sector (33.8 percent) and the MoPH (12.4 percent). In the provinces, most doctors are under the MoPH (64 percent in the North, 66 percent in the Central region, 71 percent in the South and 82 percent in the Northeast, Thailand's poorest region). (MoPH, 2008)

Thailand has continuously expanded health insurance under various schemes such as civil servants medical benefit (CSMBS), worker compensation (for work-related illnesses and injuries), social security (SSS), medical services for the poor and society supported groups, voluntary health insurance project, private health insurance, vehicle accident victim protection and eventually the universal coverage scheme (UCS). As of 2007, the CSMBS covered 5.1 million beneficiaries (MoPH, 2009), mostly civil servants, and is entirely paid from the general tax revenue. Payments are made based on fee-for-service and retrospective reimbursement for outpatient services and diagnosis related groups (DRG) for inpatient services. Public facilities are the main providers, but patients have a choice of public and private (subject to co-payments)

providers. (MoPH, 2009) The SSS is a contributory scheme that covered 9.6 million employees as of 2007 (MoPH, 2009), based on tripartite contributions made by employees, employers and the government. Payments for inpatient and outpatient services are made based on capitation. In 2009, the Social Security Office contracted with public and private hospitals and of the main contracted hospitals, 152 were public hospitals, 98 were private hospitals and 2,313 were network hospitals. (SSO, 2010) The UCS was launched in 2001 and its population coverage has risen to 46.7 million people or 75 percent in 2007. (MoPH, 2009) The UCS is also entirely financed through the general tax. Providers register with the governing agency, the National Health Security Office (NHSO) and as of 2010, registered providers included 831 hospitals of the MoPH (including more than 10,000 health centres), 75 other public hospitals, 49 private hospitals, 19 public primary care units and 169 private clinics. (NHSO, 2011) Provider payments are made based on capitation for outpatient services and DRG with global budget for inpatient services. The low participation by private facilities may partially reflect that capitation levels are inadequate to cover unit cost. Rapid implementation of UCS has raised serious questions of financial sustainability, especially in light of limited human health resources and funding, that need to be addressed urgently to ensure equitable access to quality health care. Since the introduction of the UCS, many public hospitals have faced very high occupancy rates and workloads, inter alia due to failures at the primary care level and resulting over-referrals (Carrin & Chamchan 2006), while around half of private hospital beds have remained vacant. In addition, the quality of medical services has remained a matter of concern.

With the introduction of UCS, some smaller and medium-sized private hospitals repositioned themselves towards social insurance, while large private hospitals continued to focus on affluent Thai and foreign patients. The number of foreign patients that entered Thailand in 2007 was 1,373,807, of which 17% from Japan, 12% from the Middle East, 62% from South Asia. (Department of Export Promotion, Ministry of Commerce, in MoPH)

Multilateral Trade Negotiations

The General Agreement on Trade in Services (GATS) resulted from the Uruguay Round, which came into force in 1995, and is aimed at establishing a system

of international trade rules based on the principle of non-discrimination. The basic obligations under the GATS are either of general or specific nature. Key components of the general obligations which apply to all members and services sectors are the most-favoured-nation (MFN) treatment as well as transparency. Specific commitments are commitments regarding market access and national treatment in specific sectors. Since member countries are free to determine coverage and content of specific commitments, these mostly reflect national policy objectives and constraints. Each WTO member is required to have a Schedule of Specific Commitments, which consists of horizontal sections that apply to all sectors listed in the schedule, and sector-specific sections that only apply to a specific sector. (WTO, 2011)

The GATS includes a category on Health and Social Services, which in turn includes hospital services. Medical and dental services and the services provided by e.g. nurses, midwives, physiotherapists and para-medical personnel are categorised separately as “Professional Services”. So far, few commitments have been made in the area of health services. Also, Thailand has not made any specific commitments as yet. (WTO, 2011)

Regional Trade Negotiations

The most important regional trade agreement for trade in services is the 1995 ASEAN Framework Agreement on Services (AFAS). Under the GATS-plus principle, ASEAN member states schedule commitments under AFAS that go beyond their GATS commitments or offer new sectors that have not been scheduled under GATS as in the case of Thailand. The Protocol to Implement the 8th Package of Commitments under the AFAS was signed in 2010. The health sector is one of the identified priority areas under AFAS and a Healthcare Services Sectoral Working Group was subsequently set up. In 2006, a Mutual Recognition Agreement (MRA) was signed on nursing services and in 2009, in line with the AEC Blueprint, on medical practitioners and dental practitioners. The first MRA took two years to negotiate, the main barriers being different standards of curriculum and educational institutes, different professional definitions and scopes of practice, different levels of education to enter into professional education programmes, different standards of regulatory systems and licenses to practice, differences in continuing education and

training, professional conservatism and protectionism, language barriers and cultural sensitivity. (Pachanee & Wibulpolprasert 2008) As noted in Pachanee & Wibulpolprasert (2008), the MRA do not really facilitate the movement of natural persons since “*doctors, dentists and nurses from the original countries still need to comply with the requirements of the domestic laws and regulations of host countries which may include, for example, permanent residence and licensing examinations in the local language*”. The AEC Blueprint also stipulates that under Mode 3, foreign (ASEAN) equity participation of not less than 51 % by 2008, and 70% by 2010 for the 4 priority services sectors; not less than 49% by 2008, 51% by 2010, and 70% by 2013 for logistics services; and not less than 49% by 2008, 51 % by 2010, and 70% by 2015 for other services sectors should be allowed. (ASEAN, 2007)

Besides, Thailand is committed through the ASEAN Free Trade Agreement (AFTA) and other regional trade agreements, such as ASEAN-China FTA (2002), ASEAN-India FTA (2003), ASEAN-Korea FTA (2003), BIMSTEC (2004), ASEAN-Japan FTA (2008) and ASEAN-Australia-NewZealand FTA (2009).

Bilateral FTA Negotiations

Thailand entered into bilateral free trade agreements with several countries, namely Laos (limited, 1991), Bahrain (as stepping stone toward an FTA with the Gulf Cooperation Council (GCC) countries, 2002), China (agriculture, 2003), India (2003), Peru (2003), Australia (2004), New Zealand (2005) and Japan (2007). Thailand’s pace of FTA negotiations has somewhat slowed down since 2006 in light of the political tensions.

Policy Coherence

Pachanee & Wibulpolprasert (2004) discuss the need for policy coherence between health-related trade and health-system development and present a review of the evolution of attempts to pursue policy coherence in Thailand over the past decade. This section summarizes key points from their work.

While the Ministry of Commerce was the single agency in charge until 1995, the structure of international trade negotiations was subsequently reformed and a multi-sectoral partnership started to evolve in 1997. The MoPH, through its Bureau of Policy and Strategy, for example worked with the Ministry of Commerce and the Ministry

of Industry in health-related trade issues. Many committees and subcommittees were set up, which utilized inputs of academicians and researchers, thus fostering networking among stakeholders.

With the shift from multilateral negotiations to bilateral trade negotiations the structure of trade negotiations was again reformed. A Committee on International Trade Policy, which includes the ministers of the Ministries of Finance, Foreign Affairs, Agriculture and Cooperatives and Industry in addition to the Secretary-General of the National Economic and Social Development Board, was appointed by the Prime Minister in 2003. The Committee on International Trade Policy, in turn can appoint chief negotiators for the teams negotiating with each country as well as subcommittees and working groups. While the MoPH is not a member of the Committee on International Trade Policy, it is invited to join meetings that deal with health-related issues.

In addition, since preparations for FTA services and investment negotiation positions involve country and sector preparations, the MoPH emerged as the focal point in sector preparations with relevance for the health sector, with the Bureau of Policy and Strategy being the central secretariat. To inter alia assess the implications of trade liberalization policies on the Thai health sector, the MoPH established the Committee on Trade in Health and Social Services in 2004. Besides government agencies, stakeholders from other sectors are also involved. As stated in Pachanee & Wibulpolprasert (2004) comprehensive and solid preparation as well as policy coherence is imperative for successful trade negotiations.

Medical tourism in Thailand and medical hub policy

The vision that “*Thailand will be a world class “Medical Hub. ”*” is explicitly stated in MoPH (2009) and includes the wellness sector and Thai herbal products, which entails collaboration with a number of agencies such as the Tourism Authority of Thailand, the Ministry of Education, the Ministry of Foreign Affairs, the Ministry of Commerce and the Ministry of Labour. The medical hub strategy in general is aimed at developing Thailand into a first-class destination for medical tourists. To provide world-class services, standards for hospital accreditation in Thailand were set and international standards such as ISO and Joint Commission International (JCI)

introduced. In addition, a controversial medical malpractice law is being discussed to strengthen the rights of patients.

The literature (Janjaroen, *et al.*, 1999; among others) identifies several pull and push factors that are conducive to international trade in health-related services. Most commonly cited push factors include, high cost of obtaining services in the home country, limited insurance coverage and long waiting queues. Pull factors discussed in the Thai context are low cost of obtaining services of similar/acceptable quality, price certainty through fixed package prices offered by medical facilities, well developed tourism-industry and other supporting industries (e.g. low cost of traveling, accommodation and food for a companion as well as other tourism activities, attractions and entertainment), excellent hospitality and low entry barriers. Thailand originally focused on tourism related areas such as spas, traditional massages, herbal treatments and other kinds of alternative medicine. In recent years, however, private hospitals have discovered niche markets in elective medical procedures such as plastic surgery.

Barriers to Trade in Health Services

ASEAN Member States compiled an inventory of trade barriers in 2008, a public version of which is available at the ASEAN Secretariat website. (ASEAN, 2008) The barriers to trade in health services for Thailand are reproduced below:

Medical and Dental Services

- Medical Profession Act B.E. 2525 (1982)
- Dental Profession Act B.E. 2537 (1994)
- All foreign medical and dental practitioners who wish to practice in Thailand must possess a basic qualification approved by Medical Registrar Division, register to and obtain a license from the Thai Medical Council or Dental Council and pass the examination set by the relevant Council in Thai language.

Services provided by midwives, nurses, physiotherapists and para-medical personnel

- Nurses and Midwives Profession Act B.E. 2528 (1985)
- Pharmacist Profession Act B.E. 2537 (1994)

- All foreign practitioners who wish to practice in Thailand must possess a basic qualification approved by Medical Registrar Division, register to and obtain a license from the Thai Nursing Council or Pharmacist Council and pass the examination set by the relevant Council in Thai language.
- In addition, a foreigner applying for a nursing license must hold a license to practice from the graduating country.
- Medical Profession License Act B.E. 2542 (1999)
- Practitioners are required to register and obtain a professional license from the professional body for services related to Physical therapy, medical technology, occupational therapy, radiological technology, cardio-thoracic technology and speech-language hearing therapy.
- In addition, a foreigner applying for a license must hold a license to practice from the graduating country.

Implications of International Trade in Health Services for Thailand

Implications from trade in health services are manifold and subject to a lively debate. However, few studies provide a comprehensive analysis of possible advantages and disadvantages. The main implications discussed for the case of Thailand can be summarized as follows (Janjaroen, *et al.* 2007; Arunanondchai & Fink, 2005; among others):

Mode 1

Possible implications of trade in health-related services are hardly discussed in the studies reviewed, reflecting the minor importance of this mode of entry for the case of Thailand.

Mode 2

The main advantage under this mode of entry seems to be the potential to generate foreign exchange earnings from foreign patients. A severe disadvantage, however, is the emergence of a dual market structure worsening the mal-distribution of health resources across urban and rural areas and in terms of specialization. Most studies base their assessment on the income gap between health manpower working in private and public hospitals.

Mode 3

The potential benefit is seen to accrue mainly in the form of increased supply of health services and investment. Trade in health-related services through mode 3, however, may result in a tiered health care system increasing inequality, not only through a diversion of resources to service foreign nationals, but also in education as well as internal brain drain problems. This in turn, requires more incentives to be set for rural doctors such as hardship allowance, no-private-practice allowance, etc.

Mode 4

While the movement in natural persons results in remittances, it causes an external brain drain, which implies loss of investment in educating and training.

Most studies reviewed provide a general discussion of the above advantages and disadvantages rather than quantifying these.

2. Framework of Analysis

2.1. Strengths and weaknesses

Below, the internal characteristics of the health sector and health services providers (HSPs) in Thailand are summarized, followed by external factors affecting HSPs such as supporting industries. Combined, these factors define a favourable business climate for the provision of competitive health services.

2.1.1. Internal Factors (HSPs)

As described earlier, Thailand has been assembling the various factor inputs necessary for a thriving medical tourism business. These internal factors can be broadly classified as (1) Human resources; (2) Modern medical technology; and (3) Internal financial resources for expansion.

Human resources: The strength lies in the quality of medical professionals and weaknesses are the problems caused by internal brain drain and insufficient language skills

Due to an emphasis on producing health personnel, the number of doctors, dentists, pharmacists and nurses per population has improved over the past years, but

still lags the infrastructure prevalent in countries such as for example Singapore. In 2009 for instance, the ratio of physicians to population was 1:3,182 (MoPH, 2010), ranging from 1:1,243 in Bangkok (MoPH, 2010) to 1:5,028 in the Northeast in 2008 (MoPH, 2011), reflecting regional disparities.

Representatives of the six mostly private health care facilities in Bangkok and the Eastern Seaboard interviewed identified internal brain drain as a major problem facing the Thai health system, given that doctors and nurses in the private sector earn 3 to 5 times as much as in the public sector. To overcome the internal brain drain problem the representatives recommended increasing salaries in the public sector. Another major challenge facing the Thai health system was seen to be the maldistribution of health resources among urban and rural areas. If Thailand fails to meet the demand of the population for quality healthcare services, the country will face serious social and political challenges as people will question why the best services are given to foreigners instead of nationals. Representatives recommended increasing the supply of medical professionals and attracting more people to work in rural areas.

While allowing foreign doctors to practice in Thailand could potentially reduce the internal brain drain problems, in practice foreign doctors, who could focus on treating foreign patients, are unable to pass the examination set by the Thai Medical Council or Dental Council and overcome language barriers. The main reason behind this regulation is that someone working in Thailand should be able to communicate in Thai with Thai patients as well as foreign patients.

Thailand's medical professionals consist of highly competent and internationally qualified doctors, nurses and technical staff and the medical capability of Thai medical professionals is generally considered equal to medical professionals in Western European countries and America. According to Suppradit (2010) among others, the only disadvantage of Thailand's medical professionals compared to their counterparts in Western Europe and America lies in the conduct of medical science research due to research funding constraints. Despite this, representatives of HSPs stated that English language skills, especially of Thai nurses, are insufficient compared with countries such as Malaysia, the Philippines and Singapore and need to be strengthened.

Modern medical technology

Modern facilities, medical equipment and medical technology have made Thailand a major destination for medical travel. Many Thai hospitals received Hospital Accreditation of Thailand and international accreditations such as ISO or JCI. In fact, according to the Private Hospital Association, Thailand is leading in standard medical technology. However, the use of modern medical technology, especially high-tech medical equipment, is confined primarily to large urban areas and private hospitals, rather than public hospitals, which explains why public hospitals cannot compete with private hospitals in this business.

Internal financial resources

Some representatives of the HSPs said that they have insufficient financial resources for expansion, especially if access to external funds/partners is limited, and therefore require support from government. This could pose a potential threat for SME expansion in healthcare.

2.1.2. External Factors (HSPs)

External factors consist of a set of features of the environment where the HSPs operate. These external features are not directly influenced by decisions of the firms, individually and collectively. These external factors include the external market environment, domestic market environment, presence of supporting industries and the state of infrastructure such as transport, communications and energy infrastructure.

External market environment

Opportunities and threats presented by global and regional competition in the health sector, demographic, epidemiological and economic changes as well as the expansion of trade in health services are described in this section.

Global and regional players in the health sectors

Thailand's main competitors in medical tourism are regional players, namely Singapore, India and Malaysia, all of which have different strengths and weaknesses. While Singapore and to some extent India focus on more complex medical procedures such as e.g. cardiac surgery, Thailand and Malaysia have traditionally been strong in tourism-related areas and thus rather simple medical procedures such as e.g. cosmetic

surgery, and have only recently started to move toward more complex medical procedures such as e.g. organ transplants and joint replacements in the case of Thailand. (UN ESCAP, 2009) In 2005 an estimated number of 500,000 international patients were treated in India, 370,000 in Singapore, 400,000 in Malaysia and 1,250,000 in Thailand (UN ESCAP, 2009), indicating that Thailand is leading in terms of international patients treated in the country. The Private Hospital Association and Business Council of Thailand assessed the comparative advantage of Thailand relative to its main competitors and their results are shown in Table 1 and discussed in the following paragraphs.

Table 1: Competitive Advantage of Health Facilities in Asian Countries Providing Health Care Services to Foreign Patients

Competitive Advantage	Thai	Singapore	India	Malaysia
Service & Hospitality	*****	**	*	*
Hi-technological Hardware	**	****	**	*
HR Quality	****	****	**	**
International Accredited Hospital	**	**		~
Pre-emptive Move	**	***		*
Synergy/Strategic Partner	*	**		*
Accessibility/Market Channel	**	***	*	**
Reasonable Cost	****	*	****	***

Source: Adapted from Private Hospital Association and Business Council of Thailand (2004) in MoPH (2009)

Singapore, the only high-income country, is generally considered Asia's leading medical travel destination due to its high technology and standards, research capabilities, high quality of human resources as well as international accreditation. In addition, government support for medical tourism can be considered exceptionally strong and Singaporeans generally view medical tourism positive. (UN ESCAP, 2009) Areas for future growth identified include heart, eye and cancer treatment. (UN ESCAP, 2009) Singapore's weakness is generally perceived to be pricing. A heart bypass surgery would for example cost USD 18,500 in Singapore compared with USD 11,000 in Thailand and USD 10,000 in India. (Deloitte) Besides, diversification to tourism-related activities like in Thailand or Malaysia is not possible.

India, which has only recently entered medical travel, is well-known for its inexpensive advanced medical procedures. In fact, reasonable cost of medical procedures can be considered the main advantage. (UN ESCAP, 2009) The cost of

medical procedures is approximately 10 to 20 percent lower than in Thailand and around 50 percent lower than in Singapore. India is catching up fast with other regional players and medical tourism receives strong government support. India's main weakness involves the prevalence of concerns related to treatment and care standards as well as the general infrastructure.

Malaysia is also a new entrant in this business and its medical travel industry is rapidly catching up with Singapore. (UN ESCAP, 2009) Much of the success is due to strong support from the Malaysian government, which is *inter alia* aimed at reducing the country's dependence on manufacturing. (UN ESCAP, 2009) It is likely that Malaysia will become a direct competitor of Singapore in certain markets such as e.g. the Indonesian market and perhaps share resources like doctors and nurses. Reasonable prices are also seen as Malaysia's main advantage together with the potential for tourism-related medical travel like in Thailand.

Thailand's main advantages are its high quality medical professionals and a hospitable and service-minded culture. In addition, the cost of medical treatments is reasonable. Besides, since Thailand has traditionally been a major tourism destination worldwide, its strengths are tourism-related medical treatment and wellness packages. Hence, the general tourism infrastructure like hotels, shopping malls and restaurants is also an important component of the hospital supply chain for international patients and supports Thailand to become a leading medical hub in Asia. However, there are several weaknesses as outlined in the previous chapters, including the unstable political situation.

Demographic and epidemiological changes

Fertility rates in Thailand have dropped to 1.6 in 2009, which is below the replacement level as mentioned previously. This together with increased life expectancy has triggered significant demographic changes. The population in Thailand aged 60 or over was 11.2 percent in 2009 and Thailand was ranked 69th in the country ranking by percentage of population aged 60 or over. (UN, 2010) Thailand has also experienced a significant epidemiological transition and nowadays the major causes of death as well as disease burden are non-communicable diseases, accidents and HIV/AIDS.

On the other hand, increasing demand for medical services in developed countries due to demographic change coupled with limited insurance coverage is one of the main drivers of medical tourism. (UN ESCAP, 2009)

Economic changes

Over the period 1961 to 2010, GDP growth in Thailand was 6.4 percent on average. (World Bank) In 2009, however, GDP contracted by 2.3 percent due to the global financial crisis, which together with domestic political uncertainties also had an impact on the growth rate of international patients from abroad seeking medical treatment in Thailand. Challenges also arise from the on-going European sovereign debt crisis.

Domestic market environment

In the context of firm strategy and rivalry, the private hospital sector in Thailand is exposed to intense domestic and international competition which pushes current players to maintain and upgrade their services. The number of private hospitals increased rapidly between 1994 and 1997, concomitantly with financial liberalization as well as due to tax incentives, some of which experienced financial difficulties in the wake of the 1997 crisis and had to be closed, however. With the introduction of the UCS, some smaller and medium-sized private hospitals repositioned themselves towards social insurance, while large private hospitals continued to focus on affluent Thai and increasingly foreign patients as mentioned before. Seventy eight percent of private clinics and 70 percent of private hospitals, most of which are medium-sized with 51 to 100 beds, are located in provincial areas, while 21 out of 31 large private hospitals, with more than 200 beds, were located in Bangkok. (MoPH, 2011) However, most hospital beds in Bangkok are in private hospitals while most hospital beds in the provinces are under the MoPH, with MoPH hospitals having the highest bed-occupancy rate and hospitals under the Ministry of Defense and private hospitals the lowest. (MoPH, 2011) Most private hospitals are for-profit and 13 large private hospitals were listed on the Stock Exchange of Thailand as of June 2011 (SET Market Analysis and Reporting Tool), giving them needed access to external sources of funds. In addition, there has been a trend towards cross-shareholdings of

the large hospital groups in Thailand to realize economies of scale and scope and strengthen their position in the region.

Supporting industries

Thailand's well-developed tourism industry is the main supporting industry for the medical tourism industry. Main players include travel agencies, tour operators, hotels, restaurants, operators of tourism attractions and entertainment. After medical treatment, during the recovery period, patients typically continue their stay in Thailand, enjoying 5-star hotels and resorts, shopping and sightseeing tours. But so far, unlike in Malaysia, no institution has been set up to coordinate among the key stakeholders, i.e. hospitals, professional associations, tourism sector and government agencies.

Other supporting players include medical research affiliations and educational institutions.

Infrastructure

Thailand's infrastructure is generally considered well-developed and hospitals serving medical tourists are typically located in Bangkok or other urban areas such as Pattaya on the Eastern Seaboard, which are within easy reach of Bangkok.

2.2. Macro Environment

This section describes aspects of the policy and regulatory environment in which HSPs operate, largely determined by government, that pose opportunities and threats to the expansion of Thai health system and its potential to become a major hub for health services.

2.2.1. Policies / Regulation

The vision that "*Thailand will be a world class "Medical Hub."*" is explicitly stated in (MoPH, 2009) and includes the wellness sector and Thai herbal products, which entails collaboration with a number of agencies such as the Tourism Authority of Thailand, the Ministry of Education, the Ministry of Foreign Affairs, the Ministry of Commerce and the Ministry of Labour. The medical hub strategy in general is aimed at developing Thailand into a first-class destination for medical tourists. To

provide world-class services, standards for hospital accreditation in Thailand were set and international standards such as ISO and JCI introduced. In addition, a controversial medical malpractice law is being discussed to strengthen the rights of patients.

One of the major problems that have remained is the policy incoherence discussed in inter alia Pachanee & Wibulpolprasert (2006) which results in continued competition for medical professionals caused by the universal coverage policy and the medical hub policy, potentially worsening the internal brain drain problem.

2.3. SWOT Analysis of the Sector

2.3.1. Identification of Strengths, Weaknesses, Opportunities and Threats The results of the SWOT analysis are shown in Table 2.

Table 2: Results of SWOT Analysis

STRENGTHS	OPPORTUNITIES
<ul style="list-style-type: none"> • High quality medical professional workforce • Hospitality and service mind • Low cost of medical treatments • State of the art medical equipment • High quality and standard of medical care • Variety of services and continuous new product and service development • Good physical infrastructure (hospitals, research centers, educational institutions, tourism sites, transportation etc.) • Large private hospitals run by experienced management teams • Thai medicines, massage, and herbal products 	<ul style="list-style-type: none"> • Increased contribution of medical tourism to economic growth • Increased competitive pressures (which may help improve medical infrastructure and increase the quality of medical professionals further) • Demographic change, rising prevalence of chronic diseases and cost escalation in developed countries • Trend toward health and wellness tourism and use of herbal medicine and traditional treatment alternatives • Strong local demand for cosmetic surgical procedures.

WEAKNESSES	THREATS
<ul style="list-style-type: none"> • Production and distribution of human resources • Possible negative impact of medical tourism on (i) internal brain drain and (ii) equitable access to quality health services for Thai people and (iii) medical expenses for self-paying Thai patients • Lack of foreign language skills • Intense competition among domestic and regional hospitals • Few strategic partnerships • Policy incoherence and lack of cooperation among key stakeholders • Weak medical malpractice law • Most medical equipment and medicines are imported • High energy dependence • Political instability • Lack of funding, especially for SMEs 	<ul style="list-style-type: none"> • Intense competition among domestic and international medical and tourism providers triggering consolidation of the sector • Emergence of new players such as Malaysia • Demographic change in Thailand • No clear dominance in technological or basic research • Lack of support from the population and prevalence of inequities • European sovereign debt crisis

2.3.2. Enhancing the Strengths and Opportunities and Mitigating Weaknesses and Threats: Roles of Policies, Regulations and Institutional Support Government Policy

Investing in modern medical technology, especially high-tech medical equipment as well as establishing a clear dominance in technological or basic research and providing funding for new entrepreneurial ideas will make Thailand a leading destination for medical tourists subject to favourable external factors.

In addition, pull factors such as low cost of obtaining services of similar/acceptable quality, price certainty through fixed package prices offered by medical facilities and well developed tourism-industry and other supporting industries should be strengthened further.

Most important, however, is the identification of government agencies involved, so that a dialogue and cooperation among all stakeholders can be encouraged.

Response to the shortage of medical professionals

To deal with the shortage of medical professionals, the retirement age of doctors could be prolonged as suggested by one of the hospitals interviewed. A related problem is that medical education is largely subsidized, while private hospitals who are recruiting medical graduates from the same pool of graduates, hardly share the costs of producing these. Bonding and offering financial incentives have been employed to prevent the internal brain drain from rural public hospitals to urban private hospitals and more generally from rural to urban areas, which could be strengthened. Besides, given excess capacities in the private sector, attempts should be made to harness the existing private sector better to achieve health systems goals by implementing various strategies such as for example contracting to a fuller extent, which in turn, however, would require a move towards a regulatory framework that is more supportive of public-private partnerships. In addition, a non-prohibitive special tax on revenue earned from medical tourism could be imposed as *inter alia* discussed in Pachanee (2009).

2.3.3. Profiling Key Players in the Sector

Profile: Bangkok Hospital²

Bangkok Hospital is owned by the Bangkok Dusit Medical Services PLC (BGH). BGH is the largest private hospital operator in Thailand and has a very strong network of brand hospitals such as Bangkok Hospitals, Samitivej and Phyathai Hospital Group. (TRIS, 2011a) In 2011, the company owned 28 hospitals, of which 7 have achieved JCI accreditation, with a total of 3,929 registered beds. (TRIS, 2011a) A number of hospitals are highly specialized such as for example the Bangkok Heart Hospital. BGH hospitals predominantly serve the mid- and high-end market. According to TRIS (2011a) BGH's financial performance has been sound and the group realizes economies of scale and scope, especially through the centralized purchase of medicines, medical supplies and medical equipment. BGH is listed on the Stock Exchange of Thailand and therefore has access to capital

BGH's Bangkok Hospital in Bangkok is internationally recognized and considered one of the most technologically advanced hospitals. Having set new standards in patient-focused care, Bangkok Hospital has emphasized personalized attention of doctors, nurses and staff, which is essential to providing the highest quality care. In addition to medical services, a full range of ancillary services are provided for patients, which include limousine transfer to and from any destination in Bangkok, accommodation arrangements, visa extension services, and even tours for patients' families. Bangkok Hospital is one of BGH's hospitals, which is accredited by JCI.

Profile: Samitivej Hospitals³

Samitivej Hospital and its network facilities provide healthcare services for mid- and high-end patients. Like the Bangkok Hospital, Samitivej Hospital is a leading provider of medical care in Thailand and also serves international tourists.

² The information was retrieved from <http://www.bangkokhospital.com> on February 23, 2012 if not indicated otherwise

³ The information was retrieved from <http://www.samitivejhospitals.com> on February 23, 2012 if not indicated otherwise

Samitivej Hospital offers comprehensive health service through a team of physicians in all areas of specialty along with modern medical instruments and warm services. Samitivej Hospital is also accredited by JCI.

Profile: Bumrungrad Hospital⁴

Bumrungrad Hospital PLC operates a multi-specialty stand-alone hospital in Bangkok and holds a leading position in Thailand's private hospital market. The hospital was founded in 1980 and it is headquartered in Bangkok. It has a licensed capacity of 538 beds and 4,000 outpatients per day. (TRIS, 2011b) The hospital targets high-end domestic and international patients, which account for about 60 percent of total revenue (TRIS, 2011b), and competes on the basis of product and market differentiation. (TRIS, 2011b) According to TRIS (2011b), the hospital's financial performance has been strong and it benefits from the hospital's first-mover advantage and strong referral networks abroad. In 2008, the world's largest private outpatient center, the Bumrungrad International Clinic, opened. Besides, there are various medical centers and clinics in its hospital, including for allergy, breast care, dermatology and skin aesthetics, eye laser refraction, fertility and IVF, hypertension, nephrology, neurology and plastic surgery. The company is also involved in the rental of properties, provision of clinical research services and investment in healthcare and related business, in Thailand and abroad.

⁴ The information was retrieved from <http://www.bumrungrad.com/en/about-us/bumrungrad-factsheet> on February 23, 2012 if not indicated otherwise.

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