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Thailand's Private Health Care before the 2000s: Is it the Impact of Neo-Liberalism on Health Disparities?

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Abstract

This paper discusses private health care in Thailand before the 2000s whether it is a fruit of neo-liberalism impacting on the issue of health disparities. Promoted by advanced industrialised countries during the 1980s, it is believed that neo-liberalism could generate economic efficiencies provided that the statist role in social services is minimised. This would eventually create economic growth and well-being of people with the role of private sector. While the introduction of neo-liberalism to the Latin American health care sector created adverse effects, the increasing role of private health care in Thailand offered greater choices for the better-off. In regard of greater role of private health care, concerns about the hindrance of health disparities should be taken into account. Based on historical investigation, it is suggested that careful management of private health care in order to mitigate the clue of growth in health disparities having been accentuated.

Keywords: neo-liberalism, private health care, health disparities, Thailand

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Introduction

This paper discusses Thailand's private health care whether it is a fruit of neo-liberalism impacting on health disparities. It focuses only on the provision side of private health care before the 2000s. The rationale behind this focus is the fact that there was a noticeably increasing role of private health care in Thailand during the period. In theoretical part, the paper is inspired by an introduction of neo-liberalism advocated by advanced industrialised countries during the 1980s as the means to create economic efficiencies by reducing government tasks in social services. This concept is based on the concept that the private sector should take an increasing role in social services. This would eventually lead to economic prosperity and people's well-being as inefficiencies incurred by government management have been eradicated. To achieve this, an increasing role of the private sector in social services is needed. Thereafter, the concept has been adopted by developing countries such as in Latin America and extended to health care. In Thailand, private health care began to bolster in the mid-1980s when the country achieved the highest economic growth rate in the world influenced by large-scale private capital. There have been many private hospitals established in response to a growing demand of health care from the better-off. However, it is doubted whether the growth of private health care in Thailand has created any impact on health disparities. Discussions and conclusions on Thailand's private health care with regard to health disparities are also provided.

Concept of Neo-Liberalism: Political Economic Perspective

The concept of neo-liberalism can be bluntly suggested by its own definition. That is, neo-liberalism is a resurgence of liberalism. As a political ideology, it is suggested that this definition explains the absence of liberalism from political debates and policy-making processes for a period of time, and it has recently emerged in a revived form. In terms of politics, neo-liberalism is categorised equally as American neo-conservatism which has revived from a

conventional conservative ideology. However, pragmatically, people writing about neo-liberalism tend to customarily offer it in a view of economic liberalism which is basically a conviction that the state should refrain from intervening in the economy leaving individuals' role in free markets as much as possible (Thorsen & Lie, 2010).

To elaborate, in political economic perspective, neo-liberalism belongs to one of the political economic concepts proposing that people's well-being can be best progressed by extricating oneself from individual entrepreneurial bondage and incapability within an institutional framework determined by strong private rights, free trade, and free markets. To originate and preserve such institutional framework, the statist role is indispensable. For instance, the state has to guarantee the monetary integrity and quality. In addition, regulative and legal structures and functions must be created to secure private rights and appropriate functioning of the markets. If markets of social services do not exist, it is the task for the state to generate them. But the state should not venture in markets, and state interventions in markets should be kept at minimum level (Harvey, 2005). More concretely, the key concept of neo-liberalism is the belief that markets are liberated from government interventions. Markets are believed to be the most efficient and the best resource allocators in production and distribution. Markets are also believed to be the most effective mechanism for promoting public goods, including health care. To achieve this, government interventions should be kept minimal as it is believed that outputs and outcomes generated from the state are burdensome, wasteful, and contradictory to innovation. Therefore, the ultimate goal of policy is the reduction of the statist role in social services as the presence of the state would eventually bring about inefficiencies. However, freedom must be granted to markets whose search for their interests would create economic growth and generate wealth the most rapidly. This is the key for improving well-being for all people. Thus market processes can be counted on as they can distribute the benefits of economic prosperity through all levels of society (WHO, 2005).

Principles of Neo-Liberalism and Increasing Role of Private Sector

Essence of the neo-liberal concept may involve individualism and free markets. Individualism is a basic assumption that people will always attempt to favour themselves. From neo-liberalists' view, the government has no need to intervene in social services to redistribute wealth and narrow the gap between the rich and the poor. Public expenditures for welfare are judged harmful to the rules of free markets. There should not be any group given preferences from the government receiving welfare benefits. This leads to the second principle of free markets in order to sustain economic growth, competition, innovation, and free trade. Therefore, the neo-liberalists aim at increasing the role of private sector in social services such as schools, universities, hospitals, and infrastructures etc. Any services run by the government are blamed for causing economic inefficiencies because of heavy spending on social services (McGregor, 2001).

In short, neo-liberalism from the political economic perspective involves the minimisation of the statist role in welfare. The role of private sector must be promoted in order to substitute for the restrained role of government. This is based on the conviction that the dependency on public expenditures will cause economic inefficiencies because of the lack of competitiveness from the public sector. Increasing the role of private sector must be implemented under market liberalisation based on individualism and free markets.

The Rise of Neo-Liberalism and Globalisation

The term 'neo-liberalism' can be referred to a determination by American dominance in international organisations' practices during the 1980s known as 'Washington consensus' involved by the US government, the International Monetary Fund (IMF), and the World Bank (WB) trying to promote the concept of market liberalisation worldwide. Initially, neo-liberalism was promoted successfully in wealthy industrialised economies by their leaders

such as the US's Ronald Reagan, the UK's Margaret Thatcher and Germany's Helmut Kohl (WHO, 2005). In the USA, Paul Volcker as the Chairman of the Federal Reserve strikingly changed the US monetary policy, preparing the US for fighting against inflation and unemployment. In 1980, President Reagan pledged himself to revitalising the US economy by supporting Volcker's role at the Fed and introduced his own initiatives such as the curb on power of labour, the deregulation of industry and agriculture, and the liberation of financial powers domestically and internationally. Across the ocean, Thatcher also curbed the power of trade union and solved the inflation problem and economic stagnation (Harvey, 2005). Although Kohl did not introduce any meaningful neo-liberal policies in Germany, he participated with the two leaders in the dissemination of neo-liberalism (Overbeek, 1993). Withdrawal of the statist role in social services has also been adopted in other industrialised countries including the former Soviet Union and the social democratic states such as Sweden (Harvey, 2005).

Effects on Developing Countries

Adoption of neo-liberalism did not only take place in the advanced developed but also in the developing countries such as China. By the end of the 1970s, Deng Xiaoping began to reform a communist-ruled economy by liberating China's economic structure. He was inspired by the rising wealth in Japan, Hong Kong, Singapore, South Korea, and Taiwan thus seeking market socialism in place of central planning to advance China's interests. This path led China to the transformation of its economy from a closed system to an open and dynamic growth centre within two decades. Post-apartheid South Africa also embraced neo-liberalism as the means for economic reform (Harvey, 2005). Neo-liberalism has been inceasingly introduced in the developing third world. In relation to international development, there was an attempt to promote neo-liberalism by advanced industrialised donor governments though bilateral development programmes led by the IMF and the WB. The success of neo-liberal promotion to the developing world was because of the prolonged economic recession associated with debt

crisis during the 1980s pushing many developing countries to the brink of economic collapse. This provided a circumstance in which powerful industrialised governments and international financial institutions could directly intervene in the economies of several low- and middle-income developing countries. These countries were required by the advanced industrialised donor governments that they restructure their economies according to neo-liberal practices if they wished to qualify for continued aid and debt restructuring (WHO, 2005).

In Africa, new development programmes in cooperation with local developmental projects are normally funded and administered externally by international financial organisations and large NGOs from the West. The efforts to promote well-being notwithstanding, African countries have to depend on the international financial organisations to solve their painful debt crisis. The donors have therefore created conditions that debt-ridden countries have to heavily rely on external markets. This has fulfilled the goal of capitalist expansion for the West (Kihika, 2009). To qualify for aid and lending, African governments have been coerced by global external pressures to embrace neo-liberal economic policies by restructuring their markets and welcoming private investments and external interventions (Harrison, 2005). Before the 1997 financial crisis, East Asian economic development was praised by gurus for 'miraculous achievements'. However, they later condemned East Asian economies causing the crisis as 'failed' cases of 'crony capitalism' after the crisis. To qualify for financial aid in order to rescue the economic collapse, the IMF issued the so-called 'Letters of Intent' (LoI) posing for crisis-ridden countries including Indonesia, Thailand, and South Korea. The key proposal of the LoI was the liberalisation of their economies (Beeson & Islam, 2005, p.186). More recently in Latin America, the IMF offered a $6.6 billion debt restructuring programme with a view to ending the financial crisis in Argentina in exchange for greater market liberalisation (Munck, 2003, p.509).

With a view to increasing economic efficiencies and solving problems of the government incapacity, market liberalisation aims

at wide range of socio-economic programmes, including social services formerly administrated under public framework. Health care is also one of the important areas that have been liberated from the statist administration. The role of private sector in health care has increased. Affected by globalisation and international mandate, national health care policy in many countries has been reshaped by neo-liberalism.

Neo-Liberalism, Health Care, and Health Disparities: A Case of Latin America

Neo-liberal mandate has affected health care through two major mechanisms: 1) the reforms of health care sector implemented by many developing countries at the beginning in the 1980s; and 2) the broader programmes on adjustment of economic structure of many countries in exchange of debt restructuring, development loans and other forms of international aid. International trade agreements established by international financial organisations such as the World Trade Organisation (WTO) were also added as the third component in the mid-1990s. The neo-liberal reforms of health care between the 1980s and the 1990s targeted structural problems in health care systems, especially the need to limit on health care expenditures, to utilise resources more efficiently, to improve poor management, and to improve access to health care. Policy recommendations include increasing private participation, separation of service provision functions such as financing and purchasing, decentralisation, and emphasis on efficiencies (WHO, 2005).

A presupposition of neo-liberalism since the 1980s was that countries should aim at rigorously implementing policies toward economic stimulation and development as it was postulated that an economic growth was the solution of rapid development bringing about a better life for all (WHO, 2005). An underlying case of the neo-liberal health care reforms is the case of Latin America. For many decades, Latin America's health care systems had been notorious for inefficiencies. However, by the late 1970s and the early 1980s, Latin American political leaders, health care users, providers,

and researchers became aware that their health care systems needed some changes because of the increase of dissatisfaction from users, decrease of service equalities and system efficiencies. The economic crisis during the 1980s worsened the problems and the health status of the Latin American did not cope with the amount of resources spent on health care and the level of development. The IMF and the WB therefore took advantage of the economic crisis and raised the issue of health care reforms as condition for loans. To decrease the large-scale amount of public debts, the IMF and the WB required the Latin American countries to adjust their economic structures and reduced public expenditures on health care.

By the end of the 1980s, the WB had become the major lender for health care restructuring to Brazil, Chile, Colombia, Costa Rica, and Mexico. The WB, together with the Inter-American Development Bank (IDB), and the US Agency for International Development (USAID), also provided technical and financial assistance to implement the health care reforms. The WB suggested the central governments to only regulate health care policies whereas the private sector provided health care. However, because of the lack of institutions to regulate private health providers including pharmaceutical companies, the restructuring failed to create efficiencies and quality services to protect consumers. However, while the government could alleviate the burden on health care by attracting private investments (Homedes & Ugalde, 2005), the beneficiaries were the international health companies that became partners with local health care businesses and elites. There were still unequal distributions of health status and access to health care among different socio-economic groups, especially the poor. It is claimed that the failure was because of the unpreparedness of the Latin American structures having adopted the neo-liberal policies (Armada, Muntaner, & Navarro, 2001; Casas, Dachs, & Bambas, 2001).

While the question of economic efficiencies is emphasised, there is a little concern for social consequences. For some policy-makers, whereas growth-oriented policies such as government

cutbacks on health spending and emphasis on private health care might generate 'short-term pain' for disadvantaged communities (WHO, 2005, p.18), health care problems might not be totally eradicated. Although such policies would generate favourable investment climate accelerating economic development creating 'creative destruction' to public institutional framework (Harvey, 2005, p.3), people could still suffer from existing or even worsened problems. However, such generalisation is not fully applied to the case of Thailand.

Private Health Care in Thailand until the Beginning of 2000s

Since the beginning of modern health care in Thailand, health care was dominantly served by the public sector. However, the Thai government has advocated the role of private sector in health care. It is governed and regulated by the Medical Registration Division under the Department of Health Service Support of the Ministry of Public Health (MoPH) following the 1998 Sanatorium Act (http://www.mrd.go.th/mrd/#). In the mid-1960s, about 98 per cent of hospital beds belonged to the public providers. With gradual growth of private hospitals at an estimated rate of about 12-15 per cent each year, the total number of beds in public hospitals decreased to almost 75 per cent in the 1990s (Bangkok Post, 19 October 1994, as cited in Ramesh, & Asher, 2000, p.101).

The boom in private health care began after the second half of the 1980s because of high economic growth. Between 1991 and 1995, the average annual growth rate of gross domestic product (GDP) recorded over 8 per cent (World Bank Atlas, 1996). During the period of economic boom, the investment in private hospitals expanded rapidly. From 1993 to 1997, there were 86 new private hospitals established, including an expansion of the existing 85 facilities (Wibulpolprasert, et al., 1998, as cited in Australian Government Overseas Aid Program, n.d., p.19). The number of beds also increased more than double, from 14,927 in 1991 to 38,275 in 1997 (Harryono, et al., 2006, p.14). The increase was in part because of

the government policy enhancing the role of private investment in health care. The Health Minister Arthit Uorairat announced that it was the government policy to reduce the role of public sector in health care. He proposed that "Rather than relying on governments to act as fathers who know the best, people should look for opportunities where the private sector could be brought in as an alternative or complement to the public dominated schemes" (Bangkok Post, 19 October 1994, as cited in Ramesh, & Asher, 2000, p.102). Until 1997, there were 491 private hospitals in Thailand, 143 of which were situated in Bangkok. However, there was an oversupply of about 300 per cent. This was explained by a 42 to 60 per cent of bed occupancy (Wibulpolprasert, et al., 1998, as cited in Australian Government Overseas Aid Program, n.d., p.19). The oversupply in hospital beds alongside other sectors such as real estate during this period hinted at triggering the financial crisis in 1997. Probably, the point that Arthit ignored was that the sick did not know better than the government what was best for them. This was the ignorance about the profit-maximising behaviours of the private providers (Ramesh, & Asher, 2000).

An interesting phenomenon was the allowance and promotion of foreign participation in private health care. Despite the fact that Thailand has not committed to open and fully marketise the health care sector under the General Agreement on Trade in Services (GATS) directed by the WTO, Thailand has promoted the role of private sector in health care through tax incentives advocated by the Board of Investment (BOI) (Blouin, Drager, & Smith, 2006). When the country was severely hit by the 1997 financial crisis, health care businesses by the private sector were also affected because of a decrease in demand. Patients of high- and middle-income group shifted to lower-cost public health care as their purchasing power declined. As a quest for survival, this coerced many stand-alone private hospitals to join bigger private hospital conglomerates to form groups of private hospital network (Yap, et al., 2011). To rescue the private health care businesses, the government therefore enhanced private investments in health care through greater foreign participation.

Although there had been 199 private hospitals benefiting from the BOI investment and tax incentive policy until 2002, there were few of these hospitals belonging to foreign ownership. On the supply side, the government had facilitated foreign investors to invest in health care by directly requesting to the Ministry of Commerce to become the major share holder of health care facilities. In 2001, there were 24 hospitals in Thailand, principally located in Bangkok, having foreign shares. The foreign funds in these hospitals mainly belonged to the Japanese, Singaporean, Mainland Chinese, European, and American. In addition, there were 13 private hospitals registered in the Stock Exchange of Thailand (SET) similar to other private businesses (Blouin, Drager, & Smith, 2006, p.177).

Situations on Health Care Services until the Beginning of 2000s

The period when neo-liberalism burgeoned was concurrent to the period when Thailand was enjoying high economic growth. The economic boom between the mid-1980s and the mid-1990s brought about improvement of economic standards of Thai people. Important evidence is shown from the reduction of poverty. Thailand has been successful in reducing poverty especially since the economic boom after the mid-1980s. Significant reductions in poverty were obvious across poverty measures. The poverty rate had reduced continuously from 32.6 per cent of the population in 1988 to 11.4 per cent in 1996. The number of poor people also declined from 17.9 million to 6.8 million, meaning that there were 11 per cent of the poor lifted out from poverty every year (Krongkaew, Chamnivickorn, & Nitithanprapas, 2006, p.6). As the economy grew, the poverty rate declined, and the personal income increased, the demands for health care also increased consequently. Therefore, more private hospitals were established responsively.

Health expenditures increased more than the economic growth rate of about 8 per cent during the economic boom (Nittayaramphong, & Pannarunothai, 1997, p.153). Of the total health

care expenditures, the share in the public sector decreased from one-third in 1978 to a quarter in 1994. In private hospitals, the increase in the share of health care expenditures was the result of out-of-pocket payment and payment by third parties such as private insurance (Pannarunothai, 1996). With 15 per cent of total population using private health care in 1991, the richer groups tended to use private health care services more. The share of the wealthiest quintile using private health care increased from 20.3 per cent in 1986 to 27 per cent in 1991. This outnumbered the poorest quintile of 3.3 per cent in 1986 and 8.2 per cent in 1991 (Makinen, et al., 2000, p.55). The increase attested to growing demands and purchasing power of people, especially from the wealthy groups using more costly private health care. As Pannarunothai and Mills (1997) put it, the less wealthy used public hospitals more than the average whereas the rich also used private hospitals more than the average. In addition, the poor were less likely to be admitted, especially to private hospitals.

However, when the financial crisis hit Thailand in 1997, the use of expensive private health care decreased because of the decrease in household income and expenditure capacity of people. In mid-1997, the health care expenditures decreased by 41 per cent compared with the 1996 level. Most of the decrease was from institutional and medical care. The total decrease in health care expenditures was greater among the non-poor group by minus 29 per cent (Australian Government Overseas Aid Program, n.d., p.6). In fact, this group had mainly used private health care prior to the crisis, and there was a shift from using the costly private to cheaper public health care. However, when the economic situation improved at the beginning of the 2000s, the use of private health care increased again. However, pondering over the figures of users and expenditures, the private sector has shared only one-fifth to a quarter of national health care (cf. WHO, 2010, as cited in Yap, et al., 2011, p.5).

Nonetheless, worrisome situation has occurred among the group of medical personnel. Since the burgeoning period of private

health care, the brain drain of medical personnel from the public to the private sector became obvious. The share of doctors working in the public sector decreased from 93 per cent in 1970 to 72 per cent in 1989. The area where the phenomenon could clearly be seen was Bangkok where there was 37 per cent of all private hospitals and over 50 per cent of all beds. However, most of these doctors in the public sector earned extra income by working part-time at private hospitals and clinics (Nittayaramphong, & Tangcharoensathien, 1994, p. 35). It is concluded that the main reason of a 132 per cent increase of doctors employed in the private sector comparing to only a 27 per cent increase in the public sector since 1987 was that the average pay in the private sector is 4 to 9 times higher than the public sector (COMLINE Daily News, 21 May 1997, as cited in Ramesh, & Asher, 2000, p.101). The proportion of medical personnel including nurses working in the private sector continued rising especially after the economy had recovered from the 1997 financial crisis (Pagaiya, & Noree, 2009). This implies an influx of doctors formerly catering for the rural poor to the urban private sector (Blouin, Drager, & Smith, 2006).

Discussions and Conclusions

During the 1980s, based on individualism and free markets, neo-liberalism was promoted by advanced industrialised economies with a view to creating well-being of people. The regime is based on the conviction that social services should be liberated from strong state interventions. The state should refrain from directly involving in market system. The advanced industrialised countries and international organisations have attempted to promote neo-liberalism concept by taking advantage of the economic recession in developing countries, requiring them to restructure their economies based on neo-liberalism in exchange of financial aid for debt restructuring. Neo-liberal practices were extended to health care in the third world such as Latin American nations. Consequently, the statist role in health care was minimised and replaced by the role of private sector. However, as the Latin American governments were not well-prepared for the change, the result of health care reforms

did not generate efficiencies as claimed. Instead, the neo-liberal health care reforms created disparities in the health care systems as true beneficiaries were international health care companies, not the locals

However, neo-liberalism cannot be used to fully explain the Thai case. Situations of health care services by the private sector in Thailand before the 2000s were dissimilar to what happened in Latin America. Unlike Latin America, the wave of neo-liberalism spread to Thailand during the period of economic boom in the mid-1980s. As a consequence, Thai people became wealthier because of income increase. With government investment promotions such as tax incentives through the BOI, there were more private hospitals established in response to the increasing demands of the better-off in search of health care despite expensive costs. Therefore, health care has been extended to broader income groups depending on their financial capacities. The increasing role of private health care has therefore contributed to the role of public sector in filling the gaps in health care delivery beyond the capacity of public providers in response to individual needs. This clearly attests to individualism as a concept of neo-liberalism. As Yap et al. (2011, p.3) put it, "With investment in healthcare..., both public and private sectors must consider the best methods of delivery if the demands of (the) population(s) are to be met." The public and private sector can act as co-providers in order to provide health care to specific target groups. Health care provisions formerly dominated by the public sector have been more participated by the private sector in response to the dynamic of 'consumer choice' (Blomqvist, 2004, p.139).

Nonetheless, the increasing role of private health care in Thailand before the 2000s did not represent free markets as the role of public sector in health care has not totally been dismantled and replaced by the private sector. In fact, the share of private health care is only about one fifth to a quarter of the national health sector. In addition, private health care was not fully liberated as it was operated under the control of the government through the MoPH. As already mentioned, the government wished to promote private

health care investments just to fill the health care gaps beyond public capacities. Therefore, the regulative role of government to steer and manage Thailand's private health care was evident. As the state has still continued to provide health care for the middle- to low-income groups with greater proportion, the picture of co-providers between public and private health care was revealed.

Although any evaluation of economic efficiencies between the public and private sector is not included in this paper, at least, it is known that the collaboration between the public and the private sector in health care has provided a greater availability to broader social groups. However, with the greater role of private health care, the question of disparities needs to be oncerned. With regard to profit-seeking nature of the private sector, private hospitals and clinics usually charge more in exchange of better services. The situations of the Thai private health care before the 2000s shows that the poor were likely to be marginalised from health provisions by the private sector. Based on historical investigation, the situations before the 2000s suggests that, in order to avoid accentuated situations of health disparities, the polarisation in health care should therefore be aware of in contemporary period. It must be the role of the state to regulate viable solutions to assist the poor preventing a clear-cut dual health care system. It must be the task of the state to regulate appropriate policies to balance between public and private health care. Moreover, because of higher pay in the private sector, the brain drain of medical personnel from the public sector became obvious since the period before the 2000s. This may soon affect the whole health care system because of inadequacy of medical personnel in the public sector. It is also the task for the government to regulate suitable policies to control the brain drain. The requirement to the government of today is based the conviction that it should not let private health care fully be operated under the concept of free markets of neo-liberalism. Its management under the regulative role of the state should be continued in order to prevent greater disparities.

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