Consulting report on
Family medicine training needs in northern Thailand

February 1, 2013

MJ Morikawa, MD, MPH
Associate Professor
Dept of Family Medicine & Community Health
Case Western Reserve University
University Hospitals Case Medical Center
Cleveland, OH
USA

Purpose of the visit:

Thailand is a rising star among middle-income countries in Asia. Besides strong economic growth and relatively stable political system, health statistics are better than any other countries in Southeast Asia. Rapid urbanization and mass migration to major cities has stirred redistribution of resources in the country in the past 20 years. Even though Thailand has a long tradition of tiered health care system, strong emphasis on primary care, and centralized public health system, these recent changes sustained medical community in Thailand to struggle to mobilize healthcare manpower to rural areas and in primary care.

Family medicine was established as an academic discipline in Thailand in major medical schools approximately 15 years ago. The CASE-FM-GHT has been involved in assisting to establish family medicine in Thailand more than 10 years; two Thai graduates from our residency program are now back in Thailand actively engaging research, education and patient care. In January, our program CASE-FM-GHT was consulted to assess and evaluate the need for strengthening primary care training in Chiang Rai province, northern Thailand.

Findings:

1. PCU (Primary care unit) clinic are busy both in district and provincial hospitals with more than 120-130 patient visits per day.

2. Reasons for visit analysis showed distinctively different disease distribution between primary care unit, district hospital and provincial hospital. This finding suggests tiered approach in health care pyramid is functioning in the area.

3. There is an ongoing difficulty to recruit qualified healthcare professionals including nurses and physicians at district level due to various reasons, remoteness, family reasons, life style issues etc, even provincial health authority often offers 2-3 times more salaries than working at the city.

4. Some PCUs in some districts are staffed with CHWs, others are staffed with nurses.

5. There are several different types of CHWs varying the length of training coexist in the village. It is not clear whether the standardized training system is implemented or in transition.

6. There is only two family medicine residency program exist in the country; Ramathibodi hospital in Bangkok and Chiang Mai university hospital.

7. Majority of the so-called family physicians are made through 'practice-based' track, without formal family medicine residency programs but after 2-3 years of service at the district hospital, obtain part-time additional training offered by the established residency programs to be eligible to sit for board examination.

8. Due to the universal screening policy above age 15 for DM and HTN, there are epidemics of both conditions in northern Thailand.

9. Thai health system is based on three-tier approach; employer-based insurance, government insurance for government employees, and 30 Baht flat rate for the rest.

10. The actual practice of private sector is not well studied and actual health care seeking behavior including private sector is largely unknown. In major cities such as Bangkok, many well-renowned private hospitals and clinics attract patients not only from Thailand but also from abroad.

11. There is no continuing medical education requirement or recertification by the board of family medicine in Thailand. It is uncertain how they maintain the quality of professionals currently.

12. With more influx of tourists from neighboring countries as well as refugees, northern Thailand is now exposed to massive globalization. It is also accelerated by the construction of Asian Highway connecting Thailand and China. Global health, however, is still relatively unknown in medical community and it is not part of the curriculum in medical school or residency programs in Thailand.

Recommendations:

1. Practical, hands-on primary care training tailored to the need for each healthcare tier should be developed and implemented.

   There are enormous needs for primary care in observed areas. Majority of care providers including physicians, nurses or community health workers (CHWs) are practicing without preceptors or continuing education opportunities.

   In order to provide standardized care in different communities, it is essential to implement training programs for all level of providers. Based on our observation, basic wound care, principles of emergency care should be incorporated into CHW training in remote communities. Diagnosis and management of T2DM, HTN is essential for district hospital personnel.

Coordination of care and long-term care for NCD at the provincial level hospital is also important.

Bedside ultrasound training would have a special value since district hospitals visited either in Laos or Thailand already employ ultrasound as essential tools for diagnosis and management of patients. FAST scan was conducted routinely at ED, soft tissue diagnostic scans are used frequency in district hospital. Bedside point-of-care ultrasound is, however, not available at district level and we witnessed a case of ADHF patient was referred for echocardiogram to provincial hospital.

2. Global health curriculum should be developed incorporating local context and needs.

Emerging infections and surveillance is one of the examples of global health topics needed in this community since they are now experiencing dengue outbreak and increasing population migration. Environmental health, social determinants of health is another important approach to address the health disparity in this community. Case studies should be developed for discussions for residents and medical students.

3. Primary care research should be conducted and nurtured as a discipline.

One of the main topics in primary care/family medicine research in outcome and impact of primary care delivery. There are numerous research questions we can generate and conduct research to improve the quality of care. Some of the questions we discussed were: 1) Is there any difference among villages with PCU staffed with CHWs versus nurses in terms of U5MR, MMR, or crude mortality, life expectancy? 2) Is there any difference in referral practice among villages staffed with CHWs versus nurses? If there are differences, that would provide several insights on how to strengthen clinical skills via training.

Another important topic would be to find out the nature of healthcare seeking behavior in villages. What people do when they get sick, visit PCU or private doctor or pharmacists?