Chapter 9
Economic Dynamics and Health Implications

In Thailand, there was a severe economic recession during 1978-1987, an economic boom between 1988-1996, which ended with another severe economic crisis started in 1997, followed by recovery since 2002. This section analyses the impact of these economic dynamics on health systems. The strategies that were developed after the 1997 economic crisis are also discussed.

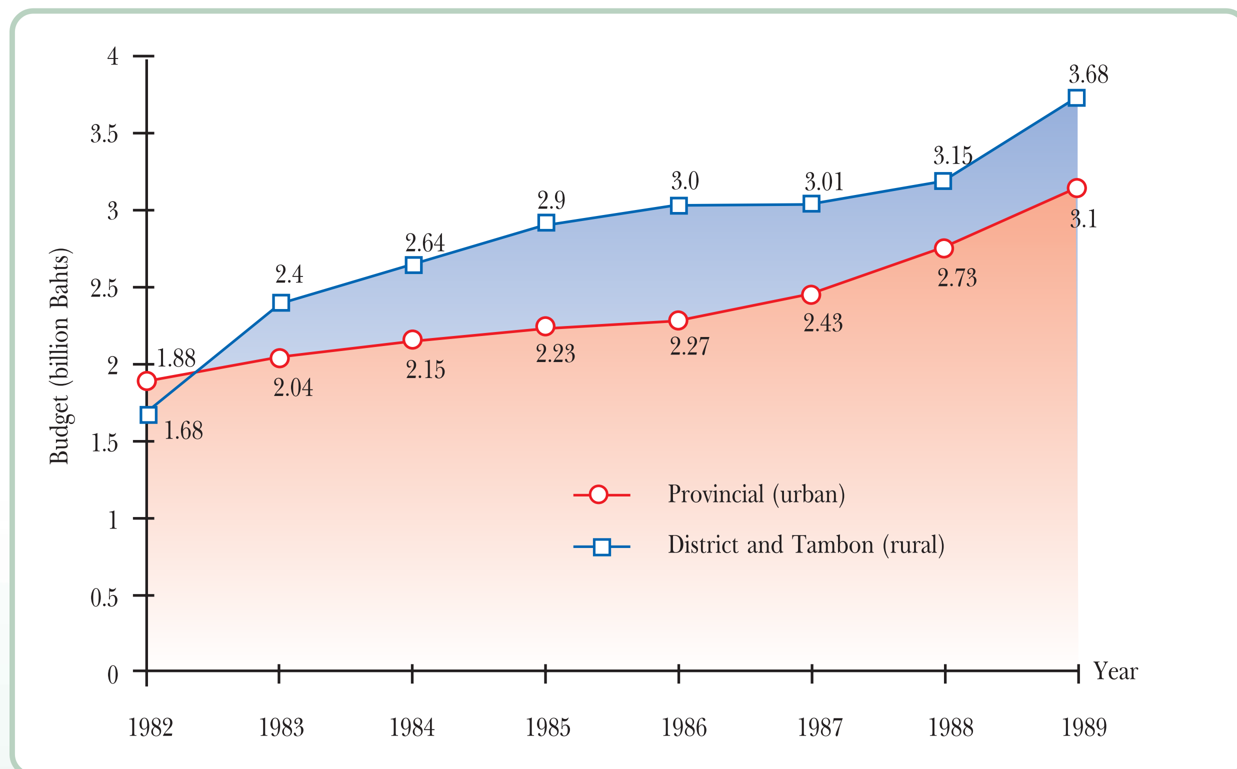
1. Good Health and Health Care Systems in the Economic Recession (1978-1987)

Before 1997, Thailand faced with economic crisis twice, in 1978 and 1983. Such crises were attributable not only to over-borrowing but also to oil price rises, resulting in inflation, high interest rates and reduced liquidity. In 1985 the government had to devalue the Baht by approximately 15 percent. An IMF credit loan of US$1,500 million, equivalent to the 1998 value of about US$3,600 million, was obtained. At that time, due to cuts in the government budget, the MOPH had to reduce the targets of a number of development programmes such as those on construction of community hospitals and manpower production. The proportion of the investment budget in 1987 was reduced to a mere 11.3 percent, similar to the level in the year 2000 (Figure 7.13). During the decade of 1978-1986, the Thai people's health status improved greatly with a more equitable and efficient health services delivery system, even though the economy was not so good at that time.

That was the decade of integrated rural development based on the basic minimum needs (BMN) approach, which resulted in the universal coverage of rural health facilities. It was the decade of primary health care development and health for all, with successes realized through increased coverage of immunization, family planning, maternal and child health, nutrition, and sanitation programmes.

These movements were made possible through **strong political leadership and commitment,** in spite of the more or less dictatorial military governments. There was a definite policy to reform budget allocations - by minimizing investments in urban hospitals and increasing investments at the district and subdistrict levels. 1983 was the first year that the budget for rural health centers and community hospitals combined was higher than that of the urban provincial hospitals (Figure 9.1).

Figure 9.1 Shift of budget allocation due to the rural development program



Source: Bureau of Health Policy and Plan, MoPH.

Among a number of tangible achievements, three are demonstrated below:

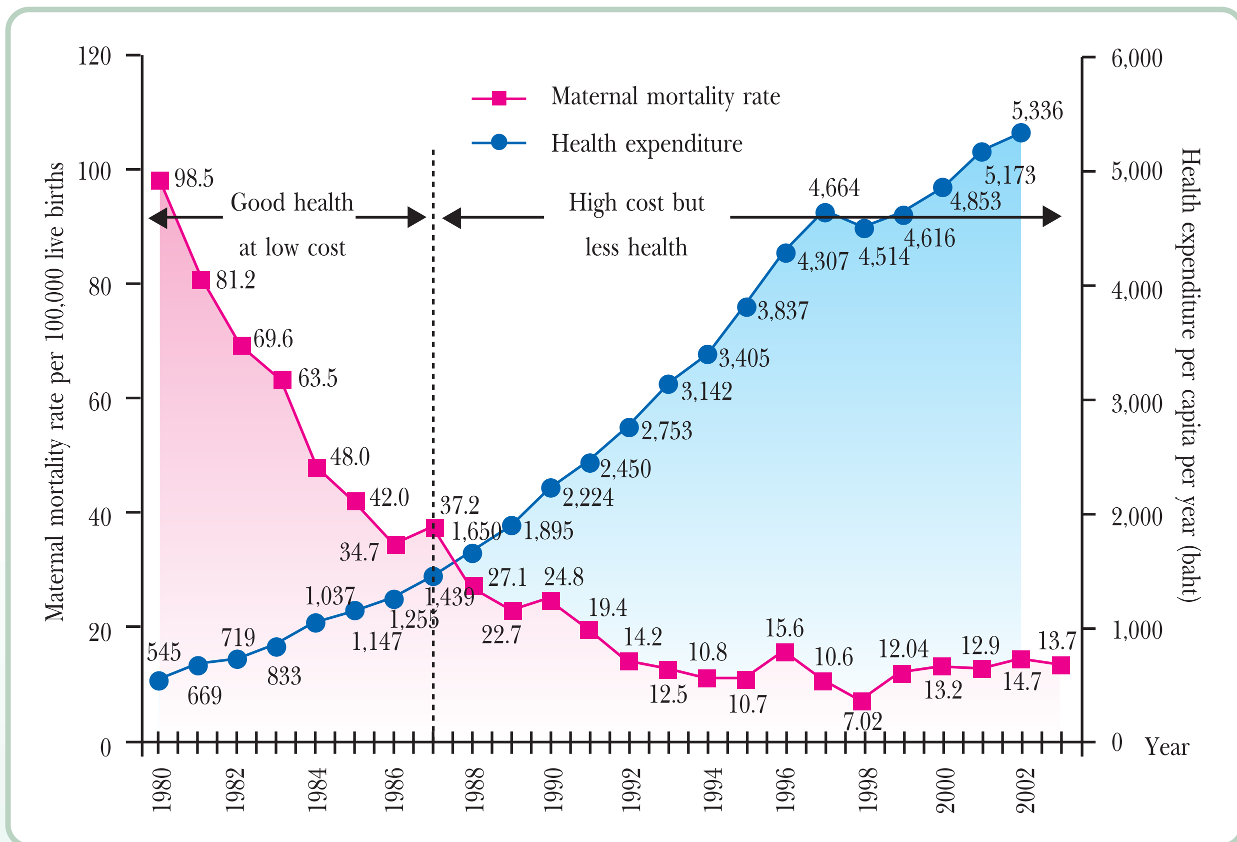
1.1 Better distribution of health facilities and personnel. The difference in population-to-doctor ratios of the poorest region (the Northeast) as compared to the richest region (the capital, Bangkok), used to be as high as 21-fold in 1979, but dropped to 9-fold in 1987 (Figure 6.3). The distribution of health facilities, particularly community/district hospitals also improved. Between 1977-1987, the number of district hospitals was doubled while the number of beds quadrupled. The doctor-to-bed ratio was also reduced from 1:10.8 in 1979 to 1:8.1 in 1987 (Figure 6.7).

1.2 Increasing coverage of essential public health services. The coverage of basic immunization, particularly OPV_3 and DPT_3, rose from 20-30 percent in 1982 to 70 percent in 1986 (Table 5.8 and Figure 5.12). During the same period, the coverage of sanitary latrines increased from 35 percent to 70 percent, and those with access to safe drinking water also increased from 20 percent to 60 percent (Figure 4.35 and Figure 4.37).

1.3 Improvement of the overall health status. The maternal mortality rate fell by four-fold, from 130.3 per 100,000 live births in 1978 to less than 30 per 100,000 live births in 1988 (Figure 5.1). The infant mortality ratio also declined, although to a lesser extent, from 50 per 1,000 live births to 38 per 1,000 live births during the same period (Figure 5.2).

Thus the decade 1978-1986, despite the economic down turn was virtually the decade of **"Good Health at Low Cost"** (Figure 9.2).

Figure 9.2 "Good Health at Low Cost" and "High Cost but Less Health"



Source: Updated from Thailand Health Profile 1997-1998.

2. Worsening Health Systems During the Economic Boom (1988-1996)

During the economic boom years of 1988-1996, Thailand enjoyed double-digit economic growth and was regarded as the fifth tiger in Asia. The public budget was large and the government paid a great deal of attention to the social sector, increasing the MoPH budget by over 10 percent annually for many years. In this decade, the MOPH budget increased **more than four-fold,** and health and drug expenditure increased three-fold, in real terms (Table 6.50 and Figure 6.37). The proportion of health budget in the overall government budget increased from 4.2 percent in 1989 to 7.7 percent in 1998 (Figure 6.37). However, a huge amount of budget was earmarked for investment activities, e.g., new buildings and sophisticated medical equipment. The MoPH's capital expense category went up to 38.7 percent in 1997, the highest ever in the last 35 years (Figure 7.13). Despite the large amounts of budget and health expenses, there were many problems.

In one health insurance scheme, the civil servant medical benefits scheme (CSMBS), expenses had risen from 4,316 million Baht in 1990 to 16,440 million Baht in 1998, a four-fold increase in just eight years (Table 9.1). This occurred with less than 2 percent annual increase in the number of civil servants during the same period. Such a rapid rise in expenditures was attributable to the extravagant use of expensive imported drugs and technologies and to embezzlement in the health system infrastructure, particularly in the private sector.

Table 9.1 Expenditure in the Civil Servant Medical Benefits Scheme, 1990-2003

Fiscal year	Expenditure (million ฿)	Increase (percent)
1990	4,316	-
1991	5,127	18.79
1992	5,854	14.17
1993	7,906	35.05
1994	9,954	25.90
1995	11,156	12.08
1996	13,587	21.79
1997	15,503	14.10
1998	16,440	6.04
1999	15,174	-7.7
2000	17,062	12.44
2001	19,180	12.41
2002	20,475	6.75
2003	22,679	10.76

Source: Comptroller Department, Ministry of Finance.

It was the decade of bubble growth in the private sector, mainly among the for- profit hospitals, with a rise from 9,974 beds and 1,094 doctors in 1987, to 29,945 beds and 3,244 doctors in 1997, a more than three-fold increase in ten years (Table 6.6 and Table 6.32). The proportion of beds in the private sector rose from 11.4 percent to 22.6 percent (Table 6.32 and Figure 6.24), and the proportion of doctors increased from 11.4 percent to 19.6 percent, in the same period (Table 6.6 and Figure 6.4). But the bed-occupancy rate was only slightly above 44.3 percent, an oversupply of 235 percent. As a result, a false demand was created. For example, the average caesarian section rate in private hospitals was above 50 percent, and in some hospitals it went up to 75 percent.

It was the decade of investments in high technologies that were complex and expensive. That was evidenced by rapid increases in the number of CT scanners, as well as MRI machines from 6 in 1990 to 26 in 1999 (Figure 6.29). Less attention was paid to the national drug policy and the national essential drug list. During the last five years of that decade, drug expenses increased as high as 20 percent in some years, surpassing those of health spending and GDP. Imported drugs were increasingly popular, with the proportion of imported drugs rising from 27.7 percent in 1988 to 40.7 percent in 1997 (Figure 6.27).

It was the decade of expansion of the nontransparent health care system, from irrational prescribing, kickbacks from prescribing drugs and using high technology equipment, including referring patients to private hospitals, to commissions from the procurement of health technologies, and unreasonable charges for private health services.

It was the decade of increased inequities in the health system as evidenced by the disparities in the Northeast's and Bangkok's population-to-doctor ratios, which rose from 9-fold in 1987 to 14-fold in 1997 (Figure 6.3). That was due to the internal brain drain from the rural public sector to the urban private sector. In 1997, before the burst of the bubble economy, 126 MoPH doctors representing 22 percent of the new doctor recruits, resigned while serving in their second year of compulsory service (Table 6.7). As a result, some 21 district hospitals had no doctors. The net loss of MoPH's doctors increased from 8 percent of the new recruits in 1994 to 45.1, 60.6 and 52.8 percent in 1995, 1996 and 1997, respectively. The doctor-to-bed ratio of the district hospitals decreased from 1:8.1 in 1987 to 1:15.3 in 1998 (Figure 6.7).

More importantly, it was found that the poor, despite holding free medical care cards, had to pay for health services such as buying drugs for self-medication or from private facilities. In 1992, health spending in relation to income of the poorest decile was 8.2 percent, more than six times higher than that of the richest decile which was 1.3 percent (Figure 4.10). It is worth noting that this proportion has declined to 3.4 times in 1998, following the economic crisis.

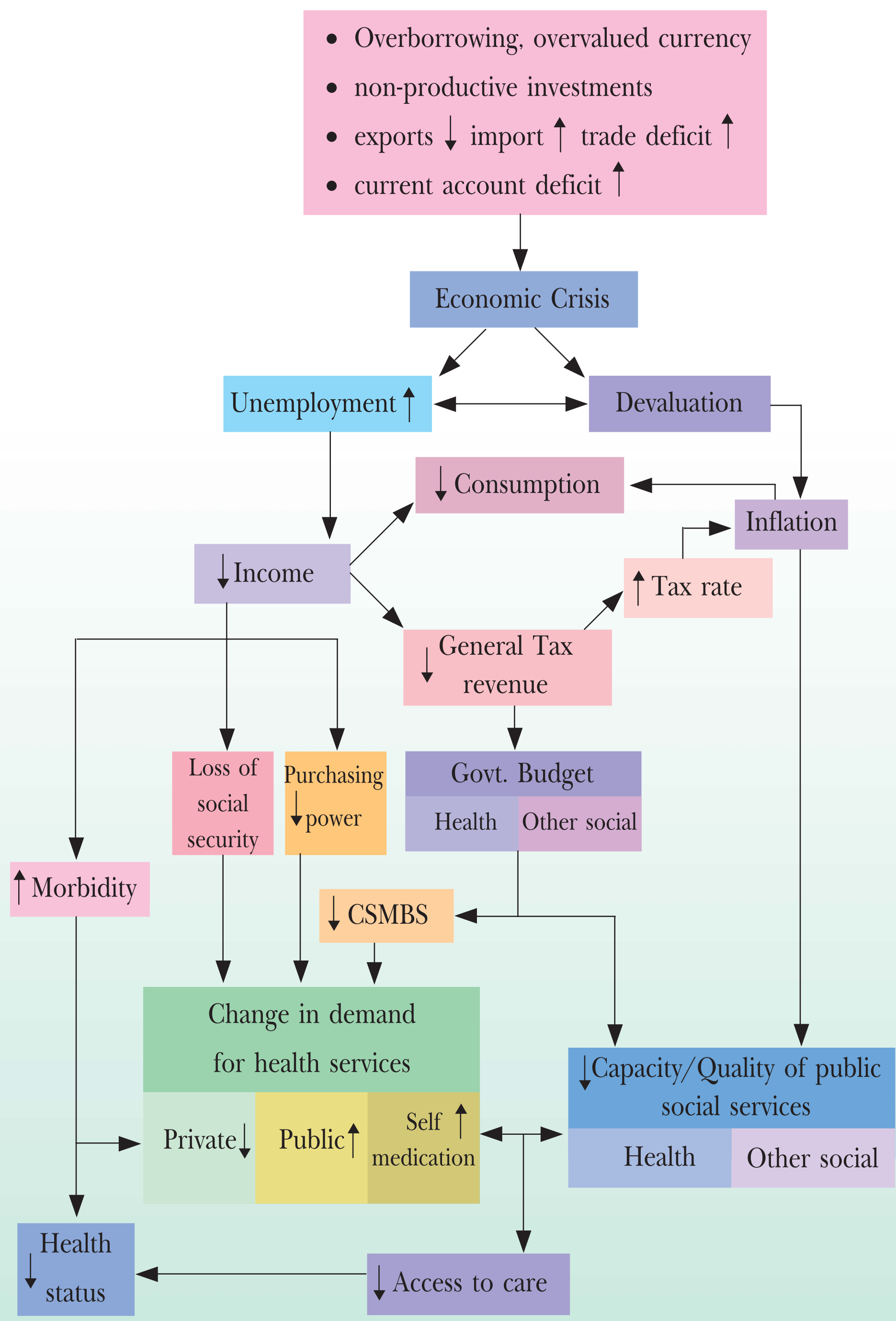
It was the decade of emerging and re-emerging health problems, with increased severity, such as HIV/AIDS, violence, drug abuse, accidents, cancer, and cardiovascular diseases. The estimated HIV positive patients increased from less than 10,000 in 1987 to 850,000 in 1997. Some diseases once under control have re-emerged as a health threat, such as tuberculosis.

Although the decade of 1988-1997 was considered the decade of high economic growth, it was also the decade of **"High Cost but Less Health"** (Figure 9.2).

3. Health Systems Implications from the 1997 Economic Crisis

The decision of the Thai government to open its financial market in 1993 with the permission of the Bangkok International Banking Facilities (BIBF), without good monitoring and control measures inplace, was the starting point of the 1997 economic crisis. Huge amounts of foreign currency were brought in for non-productive investments, particularly in the oil refinery, automobile, real estate and private hospital industries. The overvalued currency reduced its competitiveness and slowed down exports, resulting in the large current account deficit which was as high as 8 percent of GDP in 1996. Attacks on the local currency in early and mid-1997 resulted in great loss of foreign reserves and rapid devaluation after the introduction of the "managed float" policy of the Central Bank of Thailand on 2 July 1997. The major outcomes were bankruptcy of industries and businesses, increased unemployment, high interest rates and high inflation. This in turn resulted in decreases in income, consumption, general tax revenue and the total government as well as health budgets. These changes, coupled with their implications on education and other social sectors, are expected to pose serious health repercussions. The conceptual framework of the overall health implications is shown in Figure 9.3

Figure 9.3 Framework of Analysis: Health Impact from the Economic Crisis in Thailand



CSMBS = Civil Servant Medical Benefit Scheme

Source: Adapted from Musgrove P., The Economic crisis and its impact on health care in Latin America and the Caribbean, 1994.

3.1 Impact on Health Status

The impact of the economic crisis on physical health has been more apparent in relation to nutritional status. The prevalence of underweight schoolchildren increased from 10.5 percent in 1994, to 12.2, 12.2, 10.6, 11.5 and 11.5 percent in 1997, 1998, 1999, 2000 and 2001, respectively (Figure 5.9). The prevalence of low-birth-weight newborns increased from 8.2 percent in 1996, to 8.5, 8.6, 8.5, 8.8, 8.1 and 8.9 percent in 1997, 1998, 1999, 2000, 2001, and 2002 respectively (Figure 5.3). Prevalence of anemia in pregnant women also increased from 12.9 percent in 1996, to 13.0, 13.9, 13.3, 12.6, 11.9 and 12.0 percent in 1997, 1998, 1999, 2000, 2001, and 2002, respectively (Figure 5.10). Those living below the poverty line and the unemployed were more affected. However, the overall nutritional status of children under 5 remained unchanged. Some infectious diseases experienced slight increases in incidence but not mortality, e.g., Malaria, Measles, diarrhea in children, and Dengue Haemorrhagic Fever. The incidence of malaria increased from 1.5 in 1996, to 1.8, 2.2, 2.1, 1.6, 1.2, 0.82 and 0.64 per 100,000 population in 1997, 1998, 1999, 2000, 2001, 2002, and 2003, respectively (Figure 5.16). This increase in malaria incidence also occurred during the previous economic crises (1979-1982 and 1986-1988).

The under five mortality rate also increased from 11.6 per 1,000 live births in 1995 to 16.7, 14.5, 11.9, 12.3, 11.7 and 12.0 per 1,000 population in 1998, 1999, 2000, 2001, 2002 and 2003, respectively (Figure 5.4).

At the same time, some health problems seem to be improving, e.g., road traffic accidents and occupational diseases have decreased (Figure 5.34). The reduction in traffic accidents may relate to the reduction in the number of vehicles. The number of automobiles sold decreased from 589,126 in 1996 to 144,065 in 1998 a 75.5 percent reduction (Table 5.21). The incidence of occupational injuries decreased from 4.5 percent in 1996, to 3.8, 3.4, 3.0, 3.3, 3.2, 2.9 and 3.0 percent in 1997, 1998, 1999, 2000, 2001, 2002, and 2003, respectively (Figure 4.12). Furthermore, the prevalence of smoking, the number of cigarettes and the amount of alcoholic beverages sold declined. Smoking prevalence which increased from 22.8 percent in 1993 to 23.4 percent in 1996, decreased to 20.6 percent in 2001 and increase to 21.6 percent in 2003. There was a total reduction of one million smokers from 1996 to 1999. From 1997 to 2000, the quantity of tobacco sold went down by 24.6 percent, but increased again at 6.3 percent in 2003 (Table 4.60). The per capita consumption of alcoholic beverages went down by 19.0 percent from 1997 to 1999 but since 2003 there was an increased alcoholic consumption (Table 4.64).

Other physical health indicators did not show any clear changes in trends.

On the other hand, the mental health status seems to be more sensitive, with the impact immediately detected among the unemployed. The results of 11 telephone surveys conducted in 1997 and 1998, by the Department of Mental Health, clearly show that the prevalence of stress and suicidal ideas were approximately two-fold higher among the unemployed.

3.2 Impact on the Pattern of Health Seeking Behaviour

A greater number of people not able to afford institutional health services resorted to buying drugs at pharmacies for self-medication. A survey conducted by the National Statistical Office revealed a drop

in monthly household health spending at public health facilities from 343 Baht in 1996 to 264 Baht in 2001, a 23.0 percent reduction. On the other hand, there was an increase in monthly household expenses on self medication from 41 Baht in 1996 to 46 Baht in 2001, a 12.2 percent increase (Table 6.52). A survey in 1999 found that the number of outpatients attending private hospitals decreased by 20-70 percent. For the public sector, the most recent statistics from MOPH provincial and district hospitals show an average annual increase in outpatient visits of 6-15 percent between 1992 and 2000 (Table 4.5), and an average annual increase in inpatients of 4.8 percent during the same period (Table 4.6) because the expenditure for health care at the pubic facilities is more affordable. Several sporadic surveys also show the same trend (Table 4.98 and 4.99 in Thailand Health Profile 1999-2000).

3.3 Impact on Health Expenditures and Public Health Budget

The rate of real term increase in total health expenditures in 1997 dropped to only 3.7 percent and then plunged to -9.5 percent in 1998, for the first time ever (Table 6.50). The drug expense was also reduced by -17.3 percent in 1998 (Table 6.50). The government health expenditure fell at a rate greater than that in the private sector, and the proportion of public expenditures to the total health expense declined from 37.8 percent in 1997, to 32.95 percent in 2000 (Table 6.49). The MOPH's budget was reduced from 67.57 billion Baht in 1997, to 61,097 billion Baht in 2001, a 9.6 percent reduction in real terms (Figure 6.37). This decrease in public health budget, initially, will not affect operations, as the Ministry responded by reducing its capital investments. Its proportion of capital budget reduced to 11.5 percent and 8.8 percent in 2000 and 2001, respectively (Figure 7.13).

In 1999, while total health expense increased by 2.63 percent, the GDP expanded by -0.08 percent. Thus the percentage of GDP on health increased to 6.1 percent in 2000 (Table 6.50).

3.4 Impact on Private Health Care Facilities

When people's purchasing power falls, the utilization of private health services also drops, resulting in a decrease in private hospitals' revenue. With a greater burden of foreign debt due to the Baht devaluation and increasing interest rates, all private hospitals are in great difficulty. A survey in December 1997, when the Baht was devalued by 40 percent, revealed an increase in debt of approximately 10 billion Baht or $US250 million. Almost every hospital had to close down some buildings or floors. All private hospitals reduced overtime payments and salaries of staff, and some resorted to laying off a number of employees. It has been predicted that one-third of private hospital beds will be closed down in 2000-2001. All private hospitals had to undergo restructuring, such as joining the social security health insurance scheme, revising marketing strategies focusing on packaged services and inviting more health package tours. In 1999, 25 private hospitals joined the Social Security Health Insurance Scheme, an increase of 32.05 percent from 1998 (Table 9.2). Generic drugs were also used to replace the more expensive imported products previously used. Since 2000, some foreign investors started to hold big shares of some big private hospitals.

Table 9.2 Number and Proportion of Hospitals Having Entered into a Contract with the Social Security Office, 1991-2005

Year	Principal contractor/hospitals					Subcontractor/hospitals				
	Public		Private		Total	Public		Private		Total
	No.	Percent	No.	Percent		No.	Percent	No.	Percent	
1991	119	86.9	18	13.1	137	-	-	0	-	-
1992	118	81.4	27	18.6	145	838	92.4	69	7.6	907
1993	119	76.3	37	23.7	156	748	89.2	91	10.8	839
1994	122	68.9	55	31.1	177	1,019	78.7	275	21.3	1,294
1995	126	66.7	63	33.3	189	1,206	63.6	691	36.4	1,897
1996	126	63.6	72	36.4	198	1,210	42.6	1,629	57.4	2,839
1997	127	64.5	70	35.5	197	1,340	46.9	1,517	53.1	2,857
1998	127	62.0	78	38.0	205	1,263	56.0	994	44.0	2,257
1999	128	55.2	104	44.8	232	1,522	39.9	2,294	60.1	3,816
2000	130	52.8	116	47.2	246	1,621	40.4	2,393	59.6	4,014
2001	133	50.8	129	49.2	262	801	39.1	1,247	60.9	2,048
2002	136	50.7	132	49.3	268	899	40.0	1,351	60.0	2,250
2003	137	50.9	132	49.1	269	946	36.4	1,654	63.6	2,600
2004	144	51.8	134	48.2	278	931	37.0	1,586	63.0	2,517
2005	147	53.6	127	46.4	274	919	35.0	1,706	65.0	2,625

Source: Social Security Office, Ministry of Labour.

Note: Since 2001, numbers of subcontractors are not accumulated numbers.

4. Health Strategies in Response to the Economic Crisis

4.1 Strategy 1: Establishment of an Equitable Health System

4.1.1 Expansion of Health Insurance Coverage. In 2001, 71 percent of the Thai people are covered by one of the many health insurance schemes, mainly tax based finance. The 29 percent uninsured are the low and middle income self- employed. During the crisis, there were more poor people and the coverage had to be even further expanded. The main schemes of expansion are the publicly subsidised voluntary health card scheme and the social welfare health insurance scheme. The coverage of the social welfare scheme increased from 12.7 percent in 1991 to 31.5 percent in 2001. The health card scheme also increased from 4.5 percent in 1991 to 22.1 percent in 2001. (Table 6.69). The new government started a universal health insurance scheme which cover every Thai from 1st October 2001. This resulted in 95 percent of coverage in 2003. The next step, apart from universal coverage, is to reduce the gap between the benefits and expenses of each scheme. This is the mandate under the National Health Security Act, 2002.

4.1.2 Protection of Safety Net

It is notable that despite the decrease in the overall MOPH budget during the crisis, the budget for the social welfare health insurance was increased to 25.3 percent in real terms in 1997. Thus, the proportion of the MOPH budget for this scheme rose from 9.4 percent in 1997 to 15.3 percent in 2001. (Table 7.8 and Figure 7.12). Nevertheless, we need to make sure that there will be equitable and transparent distribution for the efficient use of these resources. National and provincial level committees were set up including involvement of senior citizens and the media, to oversee the allocation and use of this budget.

4.1.3 Sustaining of the Production of Rural Doctors

In 1995, in response to rapid internal brain drain, a project for the production of doctors for rural people was launched. Students whose domiciles are in provincial areas are selected to study medicine at provincial hospitals; and upon graduation they are required to work in their own domicile for at least three years. One important point is to build up a **"crusading spirit"** towards social services among these students. After the economic crisis, even though there was a great reduction in the enrollment of students in other programs, the number of students in this project increased and was maintained at 300 per year.

The problem of doctor shortages has also become less severe. It is worth noting that in 1998 the MOPH had a net loss of doctors of only 33.3 percent of the new recruits as compared to 52.8 percent in 1997. This figure reduced to 11.5 percent in the year 2000 (Table 6.7). Those who had resigned some time ago reapplied for civil service, resulting in a situation of **"reverse brain drain"**. The doctor-to-bed ratio in the district hospitals increased from 1:15.3 in 1998 to 1:13.9, and 1:10.9 in 1999, and 2001, respectively (Figure 6.7).

4.2 Strategy 2: Creation of a more Efficient Health Service System

4.2.1 Technical Efficiency

(1) Reform of drug management. This was done through reducing the number of drug items in all of MOPH's facilities, and enforcing more use of Essential Drugs. A collective provincial procurement system for all district and provincial hospitals, which was developed since 1990, was implemented nationwide in 1998. As only drug factories with Good Manufacturing Practice (GMP) were included in the system, the drug quality can be assured. In 2001, a 24.62 percent saving was achieved with Baht 507 million saved from drug purchases (Table 9.3). This savings occurred despite the fact that drug prices were allowed to increase from 1997 to 1999 by 22.85 percent for imported products and 20.63 percent for locally produced products. This system has been further expanded to regional level.

Table 9.3 Progress of the collective provincial bargaining system, 1997-2003

Year	Coverage		Value of Purchase (Million Baht)		Saving		Average collective purchasing per province (Million Baht)
	Provinces	Items	Usual	Collective	Amount (Million Baht)	% saving	
1997	33	-	247.14	189.23	57.91	23.44	5.73
1998	60	2,168	691.30	523.69	171.47	24.67	8.73
1999	75	4,491	1,209.90	874.21	335.69	27.75	11.65
2000	74	8,173	1,831.10	1,286.74	549.46	30.01	17.39
2001	74	9,041	2,060.57	1,553.29	507.28	24.62	21.57
2002	70	8,581	2,443.36	1,956.01	487.30	16.70	16.34
2003	67	7,889	n.a.	1,593.8	n.a.	n.a.	15.96

Source: Provincial Hospital Division, Ministry of Public Health.

(2) Reform of the Civil Servant Medical Benefit Scheme (CSMBS). Under the current reform, actions have been taken with regard to reducing inpatient bed-days in special wards, and abolishing the use of private sector services, and prescribing only essential drugs. With such measures, about 1,187 million Baht was saved in 1999 (Table 9.3). However, after 2000 the expenditure started to rise. A DRG based payment for in-patient will be started in 2002. In the future, this scheme should be harmonized with the Social Security System, using the capitation payment method that would result in a further savings.

(3) Autonomous Hospital. Another way of improving management efficiency is to allow public hospitals more autonomy in managing their financial and manpower resources as **"state-supervised hospitals"** under the **Public Organization Act.** This is to provide flexibility in management, increased efficiency, and most importantly, increased community participation. An action plan to allow 7 MOPH hospitals to became "Autonomous Hospitals" in the year 2000 was approved by the cabinet. Nevertheless, lessons about autonomous hospitals learned from other countries, like Malaysia, Singapore and Zambia warn Thailand to proceed cautiously. So far only one 180 beds district hospital was autonomized. Decentralization of health facilities to local governments is also in process, which parallels the process of political decentralization.

4.2.2 Efficiency in Allocation of Health Resources. It is well known that health expenditures that focus on community-based health promotion, disease prevention and primary medical care will be more efficient than those focussing on curative care. Therefore, during this crisis, one of the important strategies was to invest in persuading/encouraging the Thai people to exercise, control their diet, quit smoking, avoid drunk driving, and avoid sexual promiscuity. An Act to establish a **"Health Promotion Fund"** financed with earmarking from 2 percent of tobacco and alcohol excise taxes was promulgated in late 2001. After the economic crisis, through the conditions set under an ADB loan, the budget for EPI vaccines, MCH programmes, and community HIV/AIDS prevention were either saved or reduced less. The current government has also embarked on an integrated national 'Healthy Thailand' policy, which started at the end of 2004.

4.3 Strategy 3: Development of Quality Health Service System

The public sector health care system in Thailand is regarded as fairly acceptable as evidenced by a high number of clients at all levels, from health centers to hospitals in large cities. But it has not been rated so satisfactory by the clients.

Thus, in addition to increasing the health insurance coverage, it is needed to improve the quality of all health facilities, including those at the Tambon level. This can be achieved through financial incentives, after-hour services, and the **hospital accreditation system.** This system has been developed since 1997 under the Institute for Hospital Development and Quality Accreditation. Until 2004, 82 hospitals have been accredited. Under the UC system, it will be expanded to cover the entire nation in the near future.

4.4 Strategy 4: Empowering Society

This is a horizontal strategy that cuts across the above 3 strategies. Stronger and wiser civil societies need to be created and supported, from the village to the national level. It is the strength and conjoined efforts of these empowered civic groups that will ensure that those who hold the power will try their best to achieve better quality, more efficient and equitable health systems. Since 1992, the MOPH allocated about $US 1.5 million per year to support health service oriented NGOs and $US 2.4 million to support NGOs on HIV/AIDS. These budgets were maintained after the economic crisis.

A new constitution, the so-called “people’s constitution” was enacted in 1997, despite resistance from most politicians. Political and social reform have become the national agenda. A new national education act was also passed in 1999. A Prime Minister Office’s regulation setting up a “Health Systems Reform Office”, was announced in July 2000. Its purpose is to work towards enactment of a comprehensive National Health Act in three years. This act will focus on health systems reform toward **promoting health rather than curing diseases.** It is expected that through nation wide social movements, this act will ensure future sustainable health development for the Thai.

5. Health in the economic recovery phase (from 2002)

The recovery of the Thai economy started in 2002. The economic growth rate increased from 2.1 percent in 2001 to 5.4, 6.3 and 6.0 in 2002, 2003, and 2004, respectively. This is inspite of the negative impact from the Avian Influenza outbreak and the Tsunami’s disaster.

The recovery resulted in rapid increase in the demand for private health services (Table 9.4). In addition, this demand is also further increased by the government policy to invite influx of foreign patients.

The result is another episode of ‘brain drain’ from public rural hospitals to the private urban hospitals. The number of resigned doctors in the MoPH, which used to reduce greatly after economic crisis, increased to 756 or 74.6 percent of new recruits (Table 6.7).

In order to respond to increasing demand on human resources, the government approved a project to increase production of 10,678 doctors from 2005 to 2014.

Table 9.4 Health Seeking Behavior

Behavior	1991	1996	2001	2003	2004
No treatment	15.9	6.9	5.4	5.9	5.3
Traditional	5.7	2.8	2.5	2.9	4.4
Self proscription	38.3	37.9	24.2	21.5	20.9
Health Centre	14.8	20.8	17.4	23.9	24.6
Public Hospitals	12.9	12.9	34.8	33.1	30.2
Private facilitate	12.4	18.7	15.0	19.4	22.7

Source: Health and Welfare Survey, National Statistical Office, 1991, 1996, 2001, 2003, 2004.