



# CHAPTER 3

## IMAGE OF THAI PEOPLE'S HEALTH AND THE HEALTH DEVELOPMENT PLAN UNDER THE 8<sup>th</sup> NATIONAL ECONOMIC AND SOCIAL DEVELOPMENT PLAN (1997-2001)

### 1. Image of the Future Thai People's Health

The Executive Committee on Health Development Plan has set a desirable “image” of health conditions of the Thai population in the future from the conception through the end of life as follows:

All Thai citizens, regardless of sex, age, occupation, religion, locality, race, education and economic status, are **those who live a normally happy life, physically, mentally and socially**, with the following characteristics and/or services:

- 1) Being born and growing up in a well prepared and warm family environment.
- 2) Being adequately developed physically, mentally and intellectually, to be capable of adjusting themselves in a rapid changing world, and able to make rational consumer decisions, maintaining good health behaviour and living happily with peaceful mind.
- 3) Having health security or insurance and access to rational and appropriate health services, with good quality and at reasonable, equitable cost.
- 4) Living in a well organized community where resources are pooled and responsibilities are shared, particularly in taking care of health of individuals, families and communities with emphasis on children, the elderly, the underprivileged and the disabled.
- 5) Maintaining lives and working in a safe and sound environment.
- 6) Living a long life with good quality, without any unjustifiable illness, and dying with human dignity.

### 2. Conceptual Framework of the 8<sup>th</sup> Plan

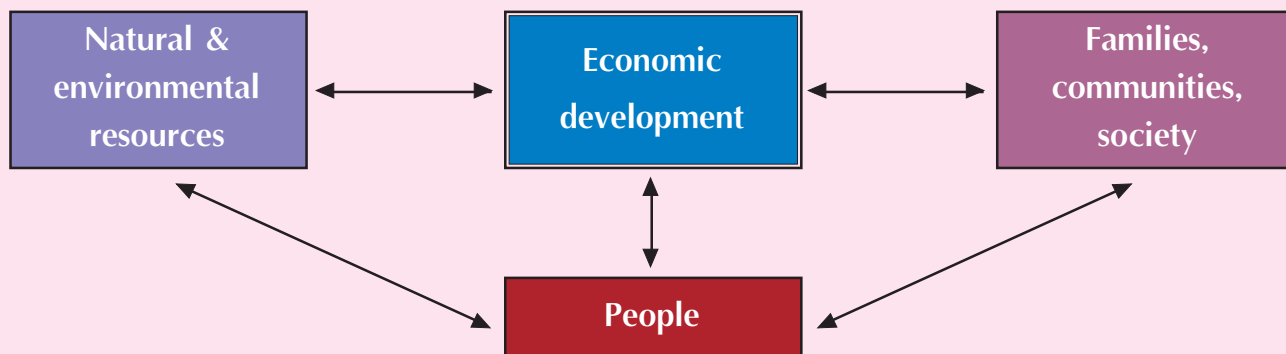
According to the concept of “human-centred” development, humans are a determining factor for the achievement of all aspects of development. Human health development, therefore, is a fundamental and key determinant for human potential development (Figure 3.1). And thus, health development is extremely important for human development.

Development of the public health is associated with several individual environmental,

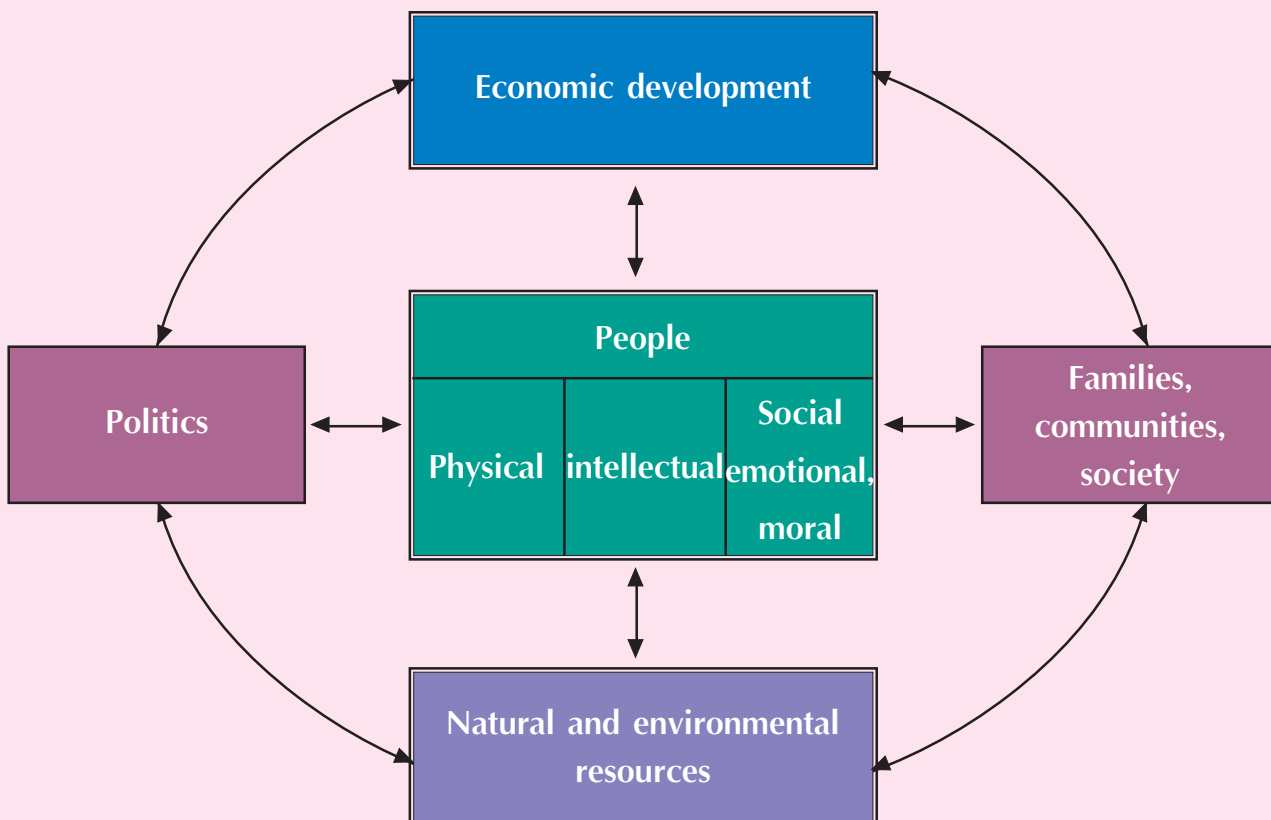
economic, social, physical, and biological factors, and health service systems (see Chapter 4). Thus, the conceptual framework for health development in the 8<sup>th</sup> National Economic and Social Development Plan has focused on development of all components simultaneously.

Figure 3.1 Concept of Development in Thailand

Former philosophy: People = Resources for production



New philosophy: People = Goal of development



### 3. Objectives of the Health Development Plan

In order to ensure Thai population's good health and to support the country to assume a leading role in this region, the 8<sup>th</sup> Plan has set its objectives as follows:

- 1) To ensure that the people are knowledgeable, having right attitudes towards good health and having suitable health behaviours, both individually and collectively within the family.
- 2) To decrease the morbidity and mortality due to diseases caused by high-risk behaviours and preventable diseases.
- 3) To ensure that the people are entitled to health insurance and have access to holistic health services which are efficient, of good standard, and equitable, particularly for the underprivileged and the disabled.
- 4) To protect consumers with standard and safety of health-related products while enabling them to be knowledgeable about selecting and using suitable products.
- 5) To enable the people to live and work in a pleasant and safe environment.
- 6) To support community organizations to take care of the health of their members seriously and efficiently.
- 7) To enable families to be healthy--pregnant women and children, in particular, are provided with quality care.
- 8) To support the elderly to be healthy and living a valuable life.
- 9) To enable all Thais to be capable of making use of health-related wisdom at all levels and to become leaders in health development at the regional level.

### 4. Targets of the Health Development Plan

Principal targets at the end of the Health Development Plan under the 8<sup>th</sup> Plan (1997-2001) are classified into five groups as follows:

**Table 3.1** Targets and Situations under the Health Development Plan under the 8<sup>th</sup> Plan

Target	Latest situation
<b>4.1 Targets for health impact</b>	
4.1.1 Reduce infant mortality rate to 21 per 1,000 live births.	33.0 per 1,000 live births (1997)
4.1.2 Reduce maternal mortality rate to 20 per 100,000 live births.	12.9 per 100,000 live births (2001)
4.1.3 Increase life expectancy at birth:	
- Female to 72.20 years	- Female 74.9 years (1997)
- Male to 67.91 years	- Male 69.9 years (1997)

Target	Latest situation
<b>4.2 Targets for reduction of health problems</b>	
4.2.1 Reduce malnutrition: at least 80% of children aged 0-5 years grow up according to the standard growth rate by age, weight and height.	Children with normal growth, 91% (Malnourished children -2001) <ul style="list-style-type: none"> <li>● 1<sup>st</sup> degree, 8.6%</li> <li>● 2<sup>nd</sup> degree, 0.7%</li> <li>● 3<sup>rd</sup> degree, 0.00%</li> </ul>
4.2.2 Reduce the rate of HIV infection - in conscripts to not exceeding 1%; - in pregnant women (aged under 25 years) to not exceeding 1%.	0.8% (second batch, 2001) 1.37% (2001)
4.2.3 Reduce mortality rate from all kinds of accidents to not exceeding 50 per 100,000 population.	36.54 per 100,000 population (2001)
4.2.4 Reduce mortality rate due to cardiovascular disease to not exceeding 50 per 100,000 population.	30.29 per 100,000 population (2001)
4.2.5 Reduce mortality rate due to cancer to not exceeding 40 per 100,000 population.	68.44 per 100,000 population (2001)
4.2.6 Reduce acute diarrhoea morbidity rate to not exceeding 1,000 per 100,000 population.	1,945.67 per 100,000 population (2001)
4.2.7 Reduce morbidity rate due to dengue haemorrhagic fever to not exceeding 60 per 100,000 population.	226.53 per 100,000 population (2001)
4.2.8 Control the prevalence of pulmonary tuberculosis to not exceeding 76 per 100,000 population.	70 per 100,000 population (2001)
4.2.9 Reduce tobacco consumption in smokers aged 15 and over to not exceeding 25%.	20.6% in population aged 11 and over: males 39.3% and females 2.2% (2001)
4.2.10 Reduce mental health problems to not exceeding 25%.	N/A
4.2.11 Reduce disability from mental retardation in infants resulted from congenital hypothyroidism and phenylketonuria by 50%.	<ul style="list-style-type: none"> <li>- Phenylketonuria ; 0.64 per 100,000 population(2000)</li> <li>- Congenital hypothyroidism ; 30.04 per 100,000 population(2000)</li> </ul>
<b>4.3 Targets for the underprivileged</b>	
Increase accessibility to health service for all underprivileged people.	N/A
<b>4.4 Targets on accessibility to health services</b>	
4.4.1 Improve the health resources allocation as follows: - <b>Bed</b> to population ratio from 1:540 to 1:500 - <b>Doctor</b> to population ratio from 1:4,165 to 1:3,300	1:454 (2000) 1:3,427 (2000)



Target	Latest situation
- <b>Dentist</b> to population ratio from 1:19,677 to 1: 9,800	1:14,917 (2000)
- <b>Pharmacist</b> to population ratio from 1:10,532 to 1: 5,200	1: 9,676 (2000)
- <b>Professional nurse</b> to population ratio from 1:1,150 to 1: 900	1: 870 (2000)
4.4.2 Improve the quality and standard in 80 % of all health facilities.	13 hospitals are HA certified
4.4.3 Increase the coverage of health insurance to 100% of total population.	71.0% (2001)
<b>4.5 Target on self-reliance and people's participation in health</b>	
4.5.1 Local administration agencies are able to handle their own area-based health problems:	
- In 50% of municipalities	N/A
- In 25% of sanitary districts	N/A
- In 20% of Tambon administrative organizations and Tambon councils	N/A

**Notes:** The underprivileged groups include:

- a) Children with difficulties such as those who are affected by HIV/AIDS, homeless, poor, or lacking continuing education;
- b) Children and women in sex industry, including those who are violence victims;
- c) The disabled;
- d) The poor elderly without relatives or caretakers;
- e) The poor in rural and urban areas;
- f) People on probation, detainees and prisoners; and
- g) The minority groups with different cultures such as hilltribes and “Le” fishermen.

## 5. Strategies and Tactics for Health Development

### 5.1 Development Strategies

To ensure that the 8<sup>th</sup> Plan is implemented in the direction aimed at achieving the desirable **image** of health for the Thai population in the future, the following health development strategies have been formulated (Figures 3.2 and 3.3):

- 1) Reform the health management systems.
- 2) Develop the efficiency and ability to access health services.
- 3) Develop health behaviours for disease prevention control and health promotion.

4) Develop a system for consumer protection in the areas of medical services and health-related products.

5) Produce and develop human resources for health in a systematic and continuous manner in all areas.

6) Promote and encourage effective behavioural changes for health.

7) Promote studies, research and development of health-related products and health technologies.

## 5.2 Development Tactics

For each of the above strategies, the following **tactics** have been designated.

### 5.2.1 Reform the Health Management Systems

(1) Decentralize management authorities and allocate health resources to provincial, municipality and community levels, and NGOs.

(2) Reform health care financing systems by emphasizing efficiency and equity in health resources allocation and utilization.

(3) Reduce unnecessary procedures and regulations which hamper development, while accelerating the enforcement of essential laws and regulations, i.e., laws on drugs and public health; and promote the rational use of new technology and business management techniques to improve public health programme management.

(4) Promote the networking of health development at all levels, in cooperation with all parties concerned, including governmental agencies, NGOs, the business sector, professionals, people's organizations and the media.

### 5.2.2 Develop the Efficiency and Ability to Access Health Services

(1) Improve the quality and standards of government health care services with emphasis on friendliness and timeliness in order to enhance consumers' satisfaction by using financial measures and reforming the management systems.

(2) Promote the private sector to get directly involved or become joint-venture partners in various forms of health care delivery with emphasis on quality and appropriate prices.

(3) Seriously support the development of Thai traditional medicine by allocating at least 2 percent of the total health budget for this undertaking.

(4) Accelerate the universal coverage of health insurance system, particularly for the poor and the underprivileged. Health insurance schemes shall cover all health services, including, health promotion, disease prevention, curative care, and medical rehabilitation.

### 5.2.3 Develop Health Behaviours for Disease Prevention/Control and Health Promotion

(1) Develop effective technologies and innovations for disease prevention and control of both emerging and re-emerging communicable and non-communicable diseases, particularly those with high morbidity and mortality rates, including AIDS, accident, cardiovascular disease,



cancer, and mental health problems.

(2) Improve the environment to ensure safe living and working conditions which are conducive to good health by abating pollution problems including occupational hazards, and by promoting a healthy environment to encourage exercise and recreation, emphasizing the use of legal and financial measures including taxation, while encouraging active participation of communities and the general public.

(3) Promote workers' health by establishing standards of safety, undertaking workers' educational programmes and providing health examinations, depending on the type of work, and necessary medical rehabilitation, to ensure timely return to work.

5.2.4 Develop a System for Consumer Protection in the Areas of Medical Services and Health-related Products.

(1) Strengthen the government's monitoring and control systems to ensure quality, safety and reasonable pricing of health-related products.

(2) Develop mechanisms and an autonomous agency for quality assurance of public and private hospitals, and promote the dissemination of information on quality, standards and pricing of hospital services to stimulate market competition for consumer protection.

(3) Promote the participation of the private sector in health systems research, laboratory services, information dissemination, and campaigns for consumer protection by providing budgetary support, information and technical documents, while reducing unnecessary control with government regulations.

5.2.5 Develop the Systems for Production and Development of Human Resources for Health

(1) Establish a network for human resources development for health with an effective mechanism for collaboration between all public and private educational and health service institutions in order to mobilize all available resources within society for the development of human resources for health.

(2) Provide an opportunity for the community to participate in selecting students and sharing the cost of education in addition to decentralizing authorities to the provincial/local administration and the private sector to produce and develop human resources for health.

(3) Establish the teacher-cum-learner potential and values within all health personnel in both training and service institutions.

(4) Reorient the system for development of human resources for health to be more responsive to the health service system, based on a sound knowledge and real life situations in a holistic approach in society.

(5) Revise and develop plans for production and development of human resources for health to be more efficient, equitable, and responsive to the national plan for human resources development while increasing the efficiency of relevant administrative and managerial systems.

(6) Develop an appropriate mechanism for promoting career development, boosting morale, and devising new methods of work to ensure that human resources for health are utilized as efficiently as possible.

#### 5.2.6 Promote and Encourage Effective Behavioural Changes for Health

(1) Conduct intensive health campaigns to promote good health behaviours in collaboration with the private sector. At least 5 percent of the national health budget should be allocated for these endeavours and campaigns, directed towards reshaping people's behaviours which are the underlying causes of major health problems.

(2) Allocate the budget to be managed by communities and provide them with technologies and other technical assistance to ensure the community participation in self-care, family care and community care which would reinforce the strengths of family and community institutions. Operational research and development on this aspect should be adequately encouraged and supported.

(3) Develop the people's potential in self-care, with an effective referral system using the government health service system. Community participation activities are to be initiated by the people with minimal directive from the government sector.

#### 5.2.7 Promote Studies, Research and Development of Health-related Products and Health Technologies

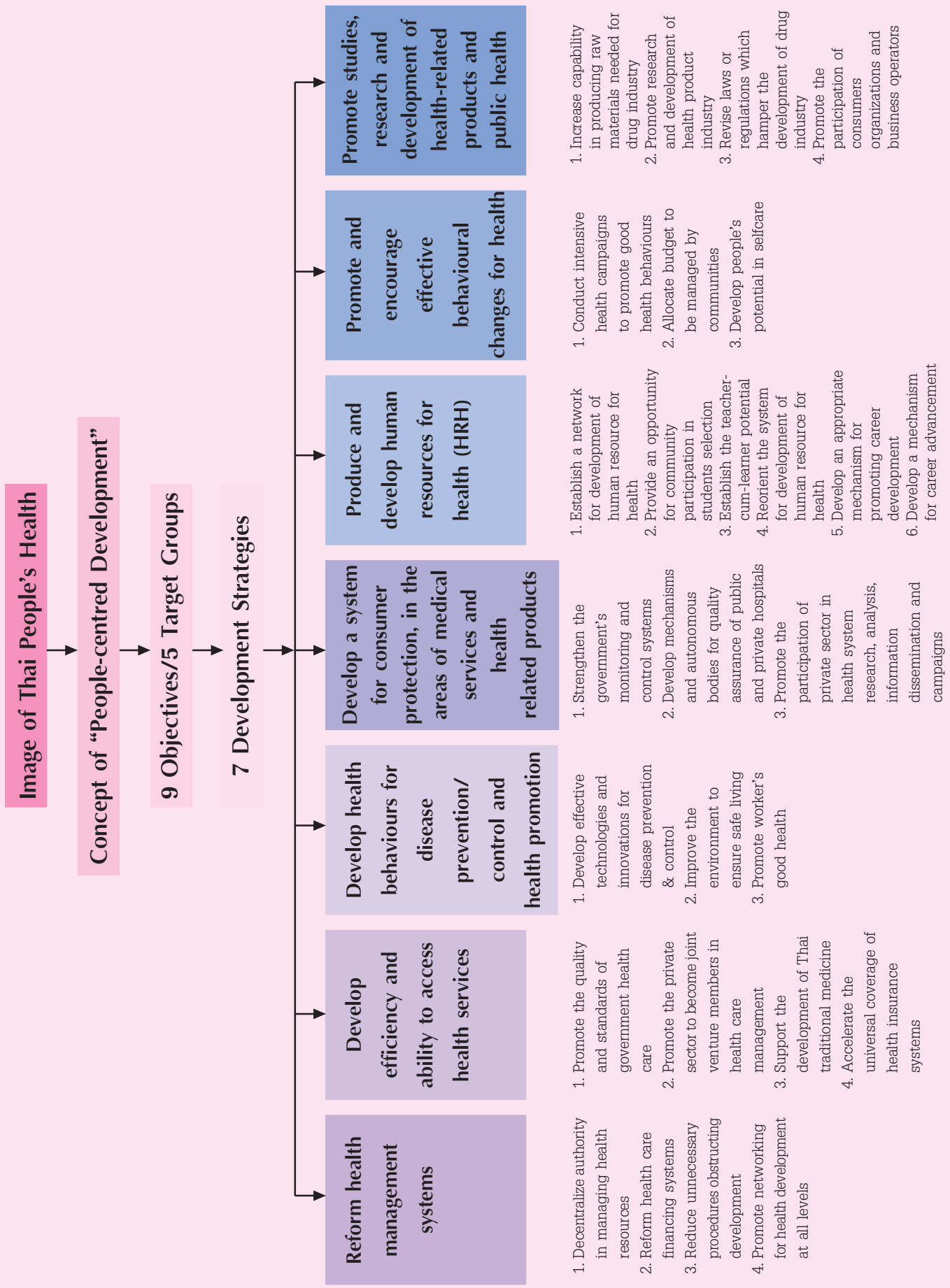
(1) Increase capability in producing raw materials needed for domestic manufacturing of modern and traditional medicines by revising the structure of customs duties or import taxes on raw materials, and by promoting cross-licensing or joint ventures in drug manufacturing.

(2) Promote research and development on health products in both public and private sectors.

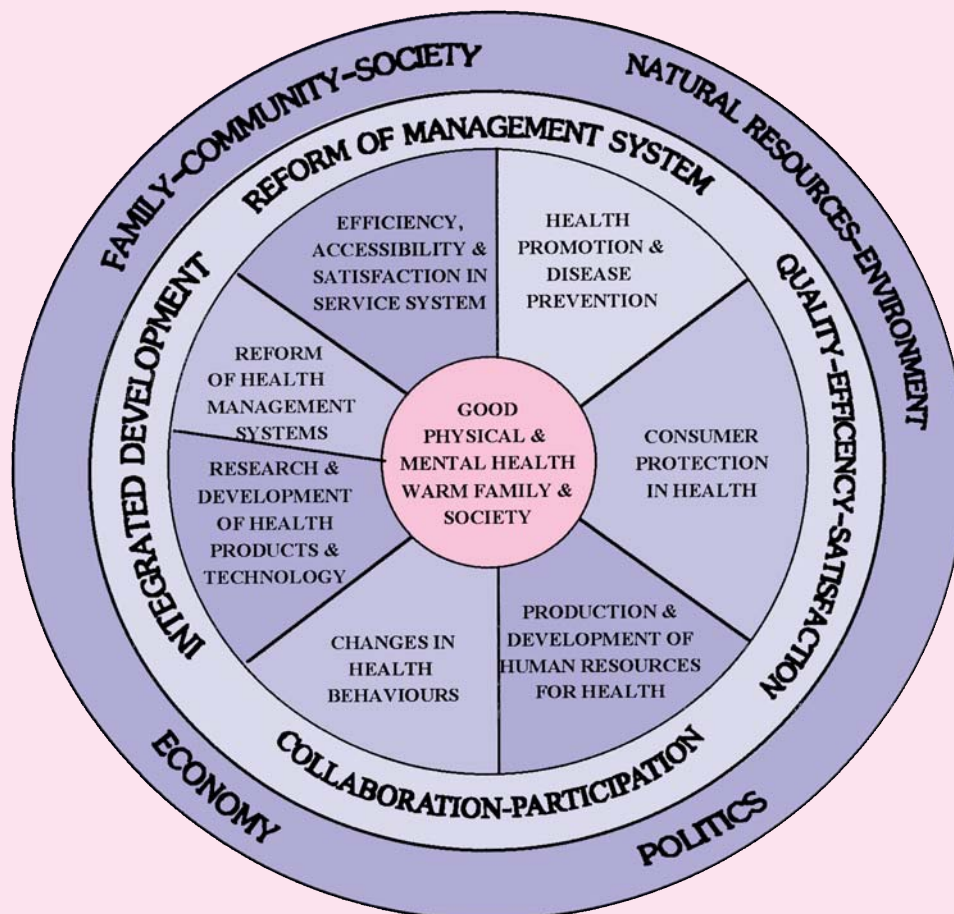
(3) Revise laws and regulations which hamper the growth of health industry, both for domestic consumption and exports.

(4) Promote the participation of consumer organizations and manufacturer associations in monitoring and controlling the standards, efficiency and quality of health products.

Figure 3.2 Strategies and Tactics in the Health Development Plan under the 8<sup>th</sup> National Economic and Social Development Plan (1997 - 2001)



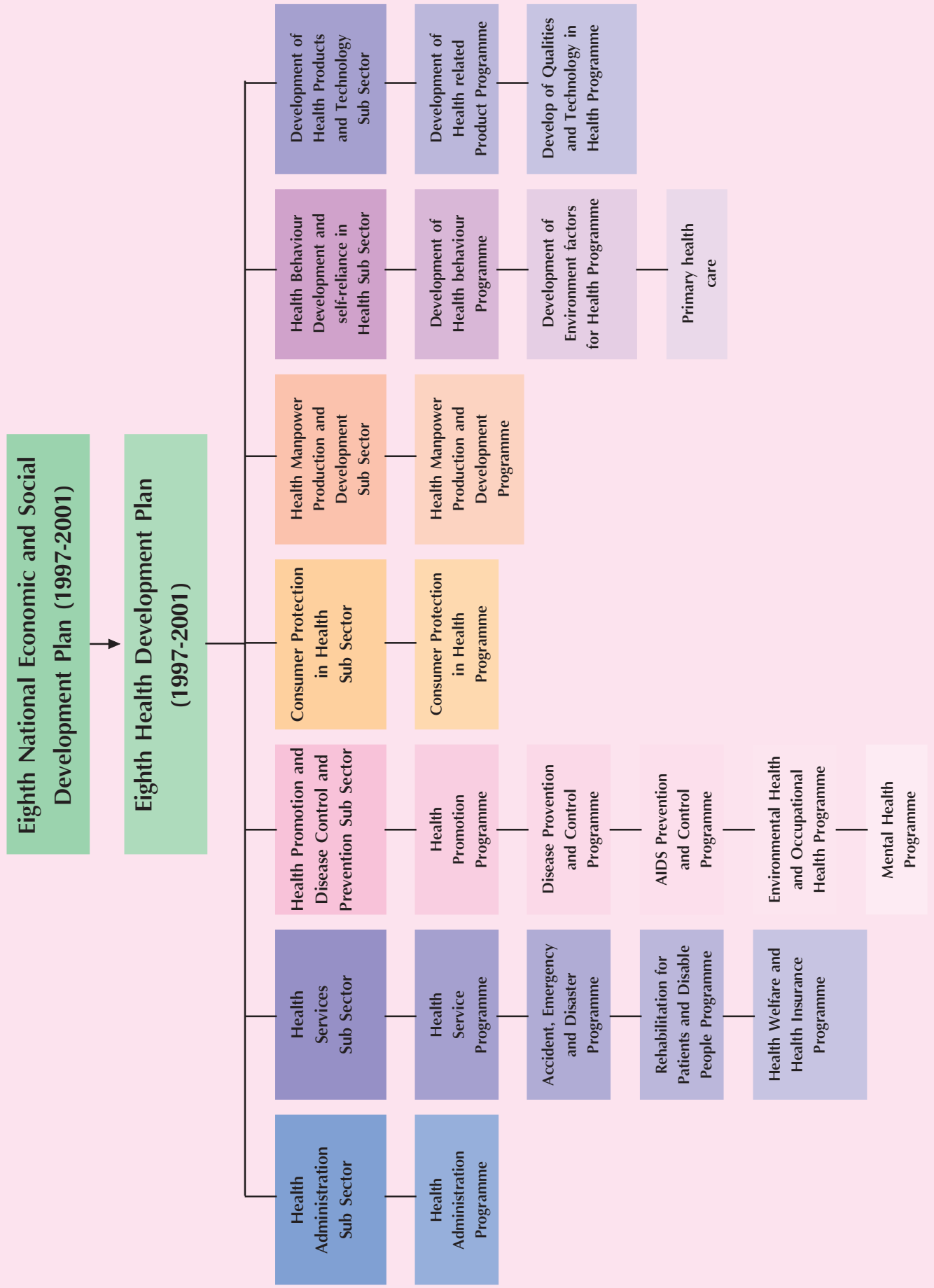
**Figure 3.3** Development Strategies in the Health Development Plan under the 8<sup>th</sup> National Economic and Social Development Plan (1997 - 2001)



## 6. Structure of Project under the 8<sup>th</sup> Health Development Plan

The 8<sup>th</sup> Health Development Plan consisted of 7 programmes, 17 master plans, 35 plans and 110 projects/activities (Figure 3.4).

Figure 3.4 Structure of programmes/projects under the 8<sup>th</sup> Health Development Plan



## 7. Evolution of Health Development Plans

The five year plan in Thailand has been developed since 1961. Before 1961 the sixth year plan was formulated. The first 3 plans focused on the economic development, hence it is called the **Economic Development Plan**. Later on, the social problems became alarming coupled with the civic movements, the name of the plan therefore has been changed to the Economic and Social Development Plan since the 4<sup>th</sup> plan.

The main contexts of the 1<sup>st</sup> - 8<sup>th</sup> Economic and Social Development Plans and Health Development Plans and their achievement are summaries in Table 3.2.

**Table 3.2** The main contexts of the 1<sup>st</sup> - 8<sup>th</sup> Economic and Social Development Plans and Health Development Plans and their achievement

Plan No.	Key features		Development Outcomes	
	NESDPs	HDPs	NESDPs	HDPs
1 <sup>st</sup> Plan 1961-1966	Focuses on economic growth, particularly, construction of basic communication transport, irrigation electrical generating system, and other basic infrastructures. These investments aimed at supporting resources investment in the private sector.	Focuses on expansion of health service facilities, such as provincial hospitals and health centers, to provide basic services for health development.	<ul style="list-style-type: none"> <li>●Economic growth and increase of GDP for 8 percent annually.</li> <li>●Surplus balance of payment resulting in US\$800 million of reserves fund in 1966.</li> <li>●Initiation of Mae Klong and Nan River Project</li> <li>●Beginning of distributing electric power from Yanhi Plan and lignite generating plant in Krabi</li> <li>●Beginning of highway renovation project.</li> </ul>	A number of new hospitals were built, every provincial has a hospital. Health promotion and disease prevention/control programmes were successful as targeted; but medical and nursing personnel shortages remained a problem in the rural areas.
2 <sup>nd</sup> Plan 1967-1971	Based on the 1 <sup>st</sup> Plan, covering the development initiated by the government particularly in rural areas. There are projects other than the normal functions	Acceleration of medical and health personnel production ; improvement of health services by expanding the scope of services to people in rural areas. <b>The</b>	<ul style="list-style-type: none"> <li>●There was the economic slump for the first time at the end of the 2<sup>nd</sup> plan resulting from foreign economy, reduction of US military expense and foreign</li> </ul>	Achievements were similar to those in the 1 <sup>st</sup> Plan. The production of doctors and nurses was not as planned. Achievement of immunization activities



Plan No.	Key features		Development Outcomes	
	NESDPs	HDPs	NESDPs	HDPs
	of the government agencies, such as regional development project, the accelerated rural development project and farmer supporting project, etc.	<b>compulsory government services for new medical graduates was enforced for the first time in 1965.</b>	investment in Thailand. However, GDP still increased at 7.5% annually. <ul style="list-style-type: none"> <li>● Income difference among national population and between geographical areas.</li> <li>● Doubled electrical generation, 38% increase of roads and increase of irrigation areas from 9.7 million rais to 13.3 million rais.</li> </ul>	was higher than in the 1 <sup>st</sup> Plan, e.g. the rate of BCG vaccination increased three times; the curative care covered 11% of the population; and the number of district-level health facilities increased from 42.3% to 54.9% of all districts.
3 <sup>rd</sup> Plan 1972-1976	Still on the same focus but increased strategies of reducing the income gap. <ul style="list-style-type: none"> <li>● Maintained the economic stability by maintaining the currency expansion rate, maintaining the price of essential products, maintaining the international monetary stability, export promotion and improvement of import structure.</li> <li>● Improving the economic structure and production, accelerating the exportation and import substitution,</li> </ul>	Focus on maternal and child health, family planning, communicable disease control, curative care improvement and expansion. The pilot project environmental health development using the community participation was carried out. <b>The policy on free medical services for the poor was implemented for the first time in 1975.</b>	<ul style="list-style-type: none"> <li>● Fluctuation of the global economy since 1971 resulting in devaluation of US\$, high-priced food and raw materials, 4-time increased oil price, inflation and unemployment in developing countries.</li> <li>● Inflation in Thailand reached the highest peak resulting in economic depression, reduction of financial expansion in both public and private sectors, investment and construction cessation. However, the government used financial monetary</li> </ul>	The population growth rate per 1,000 population dropped from 31.5 (1971) to 26.1 (1976) and the crude death rate per 1,000 population decreased from 11.6 in the 2 <sup>nd</sup> Plan to 10.9 in the 3 <sup>rd</sup> Plan. The production of health personnel was lower than the targets. Newly graduated medical students with compulsory government service contract began to work in 1972, resulting in a significant increase of doctors serving in the rural areas. Health services expansion was not as planned in terms of the numbers of beds and

Plan No.	Key features		Development Outcomes	
	NESDPs	HDPs	NESDPs	HDPs
	<p>transferring the investment an infrastructure to invest on projects to make use of those infrastructures.</p> <ul style="list-style-type: none"> <li>● Income and social service distribution and by reducing population growth rate, distributing economic and social services to rural areas, strengthening agricultural-related institutions and maintaining the prices of agricultural products.</li> </ul>		<p>measures to solve the problems, consequently, GDP increased for 7.1% annually and individual's income increased for 4.1% annually on average.</p> <ul style="list-style-type: none"> <li>● Irrigation areas increased to 20.6 million rais, however, only 0.3% received water after improving the water distribution system. And most was in the central region.</li> <li>● The road distances increased to 31,087 km, population growth rate reduced from 3.1% in 1971 to 2.6% in 1976, and 56% of school age children did not attend the formal education.</li> </ul>	<p>health facilities, and the EPI coverage. First class health centers were established in 70% of all districts while second class health centers were established in 68.5% of all Tambons.</p>
4 <sup>th</sup> Plan 1977-1981	<ul style="list-style-type: none"> <li>● Focus on economic revival by expansion of agricultural production, improving the industrial production for export, income and employment distribution in regional levels, and improving the balance of payment and budget deficit.</li> <li>● Acstoration and improve the natural re-</li> </ul>	<p>Focus on resolving and reducing gaps in the provision of integrated health services to all the people. <b>The goal of Health for All by the Year 2000 with primary health care strategies was developed in 1979.</b></p>	<ul style="list-style-type: none"> <li>● GDP still increased at 7.1% annually, however, due to the change of production structure the average income of farmers in 1980 was 11,464 Baht /person/year as compare to the national income of 29,949 Baht/person/ year, this was 5 times lower</li> </ul>	<p>Incidence of some diseases, such as plague and smallpox, decreased to the levels that they are no longer health problems. Health status of rural population was not good due to unhygienic environment, lack of safe drinking water, and improper health behaviours. Regarding health ser-</p>



Plan No.	Key features		Development Outcomes	
	NESDPs	HDPs	NESDPs	HDPs
	<p>source management including the use of natural resources such as land, water, forest and minerals. Accelerate the land reform, use of water source, conservation of seas, survey and development of energy sources in the Gulf of Thailand and east coast of the Southern region.</p>		<p>than those in the industrial and commercial sectors and 2 times lower than those in the service sector.</p> <ul style="list-style-type: none"> <li>● The crude oil price increased rapidly, coupled with 75% of energy used from other countries, the trade deficit was 45,000 million Baht annually or 7.6% of GDP (it was 13,000 million Baht or 5.1% of GDP during the 3<sup>rd</sup> Plan). The increase at a lower rate than the average inflation rate, which was 11.6% annually.</li> <li>● 1/3 of rural population were poor and 70-80% of school age children did not have sufficient food.</li> </ul>	<p>vices, district hospitals were established to replace medical and health centers. The basic immunization programme began for the first time in 1978. The training for village health communicators (VHCs) and village health volunteers (VHVs) began for the first time in 1977.</p>
5 <sup>th</sup> Plan 1982-1986	<p>Shifted to the “new direction” of national development with the following focuses.</p> <ul style="list-style-type: none"> <li>● Focused on area development plans and projects to enable effective results in both government and private sectors.</li> </ul>	<p><b>Establishment of district hospitals in all districts</b>, upgrading all midwifery stations as health centers. For primary health care, community participation in the form of several funds, and survey on basic needs are initiated. Con-</p>	<ul style="list-style-type: none"> <li>● Global economic and financial fluctuation and continuous economic depression since the 2<sup>nd</sup> oil crisis pressured every country to adjust for survival.</li> <li>● The government implemented the</li> </ul>	<p>Establishment of district-level community hospitals covering 85.2% of all districts and health centers covering 97.9%. The production of medical and nursing personnel reached 93.6% and 93.8% of the targets, respectively. The train-</p>

Plan No.	Key features		Development Outcomes	
	NESDPs	HDPs	NESDPs	HDPs
	<ul style="list-style-type: none"> <li>● Maintaining national economic/ financial stability by reserve mobilization, development of financial discipline and modifying the economic structure.</li> <li>● The balance in solving economic and social problems.</li> <li>● Solving poverty problem in remote rural areas with the target geographical areas of 286 districts and sub-districts.</li> <li>● Put policy and plan into practice for example the implementation of the new rural development administrative system which began in 1984.</li> <li>● Increase the Role and participation of the private sector.</li> </ul>	<p>sequently, health development is incorporated into total development.</p>	<p>financial measure strictly with the floating Baht value. Moreover, the oil price and interest rate were decreased at the end of the 5<sup>th</sup> Plan so the economic situation improved.</p> <ul style="list-style-type: none"> <li>- Trade balance and balance of current account declined to 54 and 34.9 million Baht, respectively or 5.6% and 3.6% GDP.</li> <li>- The inflation rate reduced to 2.8%</li> </ul> <ul style="list-style-type: none"> <li>● The poverty alleviation projects were implemented in 12,562 villages.</li> <li>● Economic recession resulted in 1 million unemployed population (3.5% of the working aged population), the saving did not reach the plan, more reliance on investment from trading, and increased foreign debts.</li> </ul>	<p>ing of VHCs and VHVs achieved 126.9% and 119.6% of the targets, respectively. The establishment of village drug funds achieved 232.2% of the targets.</p>
6 <sup>th</sup> Plan 1987 - 1991	<ul style="list-style-type: none"> <li>● Focus on economic expansion together with maintaining of financial stability, by focusing on internal</li> </ul>	<p>Expansion of health service facilities to cover all target areas; and emphasis on public participation in health</p>	<ul style="list-style-type: none"> <li>● Expansion of GDP at 10.5% annually, the economic structure was more internationalized and the interna-</li> </ul>	<p>Life expectancy was 62.8 and 64.8 years in male and female respectively. Maternal mortality and infant mortality rates</p>



Plan No.	Key features		Development Outcomes	
	NESDPs	HDPs	NESDPs	HDPs
	<p>saving, economized the governmental expenditure and encourage private sector's participation in development.</p> <ul style="list-style-type: none"> <li>● Focus on development of labouring skills and quality of life.</li> <li>● Increase the roles of local organizations in natural resource and environmental development.</li> <li>● Beginning of the master plan for science and technological development.</li> <li>● Revise the roles of the government in traditional development.</li> <li>● Having the state enterprise development plan.</li> <li>● Modified the production and marketing structures to be more distributed.</li> <li>● Utilize the existing basic service facilities.</li> <li>● Develop specific city and locality for</li> </ul>	<p>development and campaigns against HIV/AIDS, in order to avoid the impact on national security. Health insurance was initiated.</p>	<p>tional trade share increased to 80% of GDP (from 60% in 1986).</p> <ul style="list-style-type: none"> <li>● Stable economic and financial status, the foreign currency reserved increased for almost US\$17,000 million and foreign debts decreased from 38.5 to 34% of GDP, and there was positive budget balance since 1988 due to the high income.</li> <li>● The inflation rate increased from 2.5% in 1987 to 5% in 1991.</li> <li>● The average income increased from 21,000 Baht in 1986 to 41,000 Baht in 1991. However, the development was imbalance in several aspects:               <ol style="list-style-type: none"> <li>1. The 20% richest people shared 55.6% of income in 1987/1988 increased from 49.3% in 1975/1976.</li> <li>2. Severe shortage of basic services.</li> </ol> </li> </ul>	<p>decreased. Health facilities were expanded to cover all districts and Tambons. Emerging health problems such as AIDS, accident, heart disease, cancer and mental health were of high priorities.</p>

Plan No.	Key features		Development Outcomes	
	NESDPs	HDPs	NESDPs	HDPs
	<p>decentralization.</p> <ul style="list-style-type: none"> <li>● National coverage of the rural development.</li> </ul>		<p>3.The increasing trend of the gap between internal saving and investment.</p> <p>4.Problems of adapting the country to fit with the economic changes.</p> <p>5.Destruction of resources and environment.</p> <p>6.The bureaucratic system could not catch up with and response to the economic and social changes, and there was a brain drain problem.</p>	
7 <sup>th</sup> Plan 1992 - 1996	<ul style="list-style-type: none"> <li>● Focus on maintaining continuous and stable economic growth.</li> <li>● Focus on income and development distribution to rural areas.</li> <li>● Focus on development of human resources, quality of life and the environment.</li> <li>● Focus on legal development and the development of state enterprise and the bureaucratic system.</li> </ul>	<ul style="list-style-type: none"> <li>● Focus on health centers development to be a contact point of Health-for-All and quality development of health service facilities.</li> <li>● Focus on efforts to provide health insurance for all Thai people.</li> <li>● High priority was given to service quality improvement and resolution of brain-drain problems due to personnel moving to the private sector.</li> </ul>	<ul style="list-style-type: none"> <li>● During 30 years of development, GDP increased to 7.8% annually. The average income increased to 68,000 Baht in 1996 and the proportion of people living in poverty decreased to 11.7%.</li> <li>● The income gap was widened, i.e. the income per head of people living in the northeast was 12 times lower than those in Bangkok and vicinity. The 20% high-income households shared 59.5% of all income (1992) while 20% lowest income shared only 3.8%.</li> </ul>	<p>Health facilities at all levels were scattered to cover all urban and rural areas, but with severe shortages of manpower, especially doctors. The population growth rate dropped to 1.3% in 1994. Health security schemes covered 45.5% of all Thai people. Immunization, particularly basic immunization for children under one, covered over 80% of the target population, resulting in substantial declines in morbidity due to such diseases.</p>



Plan No.	Key features		Development Outcomes	
	NESDPs	HDPs	NESDPs	HDPs
			<ul style="list-style-type: none"> <li>● 97.7% of rural villages had access to electrical power, 75% of urban households and 32 % of rural households had tap water. The roads connecting districts and provinces was 210,000 km long and 123,400 km for the roads connecting villages. The rate com compulsory education attendance was 97.7%.</li> <li>● About 1 million rais of forest were destroyed annually, lands were washed off and the water quality was changed to the level that cannot be used, environmental conditions were also damaged.</li> <li>● The human value was overlooked, local wisdom and traditional lifestyle were ignored.</li> </ul>	
8 <sup>th</sup> Plan 1997 - 2001	<p>Focus on human resources development as a main objective. With the economic crisis in 1997, the development plan was revised accordingly.</p>	<ul style="list-style-type: none"> <li>● Focus on human capacity in health, particularly appropriate health behaviours.</li> <li>● Coverage of health insurance with quality and efficient care.</li> <li>● Development of</li> </ul>	<ul style="list-style-type: none"> <li>● Expansion of fundamental education but could not be achieved in some areas.</li> <li>● Distribution of civilization and poverty alleviation were not as good. Unemployment rate</li> </ul>	<p>The 8<sup>th</sup> Plan including the Health Development Plan was revised in accordance with the economic crisis, drastically minimizing the capital investment while increasing the health insurance</p>

Plan No.	Key features		Development Outcomes	
	NESDPs	HDPs	NESDPs	HDPs
		health-related industries.	was doubled while the income per capital decreased. <ul style="list-style-type: none"> <li>● Economic stability was affected and thus the economic growth stopped.</li> <li>● The export potential was decreased.</li> <li>● The overall environmental problems started to recover</li> </ul>	coverage, particularly for the poor, the unemployed, and strengthening the programmes on vaccine-preventable diseases control, maternal & child health and HIV/AIDS prevention/control.

- Sources :** (1) Adapted from “50 years of the Establishment of the Ministry of Public Health”.
- (2) Pinprateep, P. Being Thais by local powers: the conceptual framework for the 9<sup>th</sup> National Economic and Social Development Plan, 1999.