

PREFACE

This second issue of the *Thailand Social Monitor* focuses on the education and health sectors, from two perspectives: did the early expectations of severe impacts actually materialize in education and health; and what are the policy lessons to be drawn from how Thai families and the Thai Government coped with the crisis impacts? Other important crisis impacts, such as unemployment and breakdown of social capital, will be analyzed in future issues of the *Thailand Social Monitor*.

At the turbulent outset of the crisis, many expected the worst, and this was especially true for education and health. *The Social Monitor* examines the best available data, on a national scale, to measure actual results. Did education and health outcomes decline during the crisis, as predicted? Did use of services, such as school enrollments and visits to public health facilities, go down during the crisis, as was expected? Did families cut back on vital social expenditures so they could spend their reduced incomes on other priorities? Did the Government cut back on education and health budgets and thus reduce the quality and availability of education and health services?

The answer to those questions is encouraging: overall, on a national scale, the expectations of dire consequences have not materialized. However, This conclusion needs to be qualified: there are areas where crisis response was inadequate, poorly targeted, or ineffective, and some families and some Government programs have suffered unduly. Indeed, the crisis is still being felt in health and education, and impacts could worsen if the economy does not recover. However, the available data show that Thai families and Thai policy makers have cushioned and in some cases eliminated expected negative consequences of the crisis in health and education.

These results have many interesting implications for the future but none more important than these two: first, Thai families, including the poor, are more resilient and responsible than many anticipated; and two, Government and local officials in particular have proven more adept at crisis response than many predicted. At the outset of the crisis, Thai leadership at the highest levels called for self reliance and mutual self help as a way to survive the crisis. Those guiding principles seem to have found many adherents among the Thai people.

We would like to express our thanks to the many experts from Government, development agencies and civil society who provided generously their information and their perspectives for *The Social Monitor*. I would like to single out the cooperation of the two government ministries concerned – Education and Health; as well as the NESDB and the National Statistical Office. The Asian Development Bank has provided particularly valuable inputs. We of course remain responsible for any errors in fact or interpretation.

J. Shivakumar
Country Director
World Bank Thailand Office

CHAPTER I: INTRODUCTION AND OVERVIEW

Two years have passed since the onset of the economic and financial crisis in Thailand, and it is now opportune to assess the crisis responses in two very important sectors, education and health. Both sectors involve almost all Thai citizens, either as deliverers or users of services, and outcomes in these sectors are vital to the future of Thailand. Other serious impacts of the crisis are not analyzed here, such as unemployment, income loss, and breakdown of social capital. These will be assessed in future issues of *The Social Monitor*.

This second issue of *The Social Monitor* thus reviews available data from many sources to assess crisis responses in four broad areas of impact: outcomes (longer-term measures of welfare in health and education); expenditure (by both families and Government on health and education); utilization (measures of enrollments and patient visits); and efficiency (mostly of government programs and budgets).

The initial manifestation of the crisis was in the currency markets, followed by a rapid contraction of overall economic activity, mainly through sharp declines in consumer spending and long-term investment. Soon thereafter, Thailand experienced declining levels of employment, wages and tax revenues, as firms either closed down or cut back production.

In those dark days, many feared, with some justification, that the economic and financial reversals would impose severe hardship on the social welfare of Thai families. Beyond the employment and wages impacts, it was expected that

government social programs would be cut back, that the prices of key social commodities such as imported medicines would escalate, that families would reduce drastically their expenditures for health and education, and that education and health services would be out of reach to a growing number of impoverished families.

These expectations, echoed in other East Asia countries, were perhaps reasonable given the chaos in Asia's markets in 1997. But severe social impacts were not inevitable, and certainly not in Thailand. Over the last two years, a growing body of evidence is showing that families and government programs acted to cushion impacts in health and education:

- Health and education outcomes have shown little or no discernible declines from past positive trends.
- Families rapidly and substantially adjusted their spending and savings strategies to cope with less income security and to preserve health and education attainments.
- The Ministries of Education and Health adjusted expenditure priorities and supplemented sensitive programs to sustain service availability at or above pre-crisis levels and to contain out-of-pocket costs to Thai families.
- Use of public health and education services expanded during the crisis, including basic services, and school dropouts in particular show a limited or negligible crisis response depending on the data source.
- Although precise targeting of the poor and unemployed proved

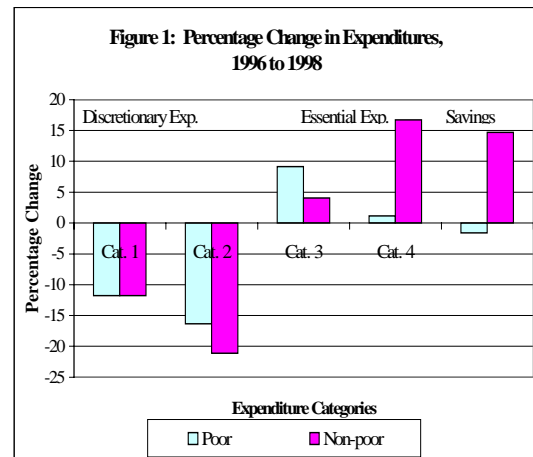
difficult to accomplish, government programs and budgets during the crisis appear to have preserved or bettered pre-crisis efficiency levels for costs and revenue.

These positive findings need some qualification. The aggregate results summarized in this issue of *The Social Monitor* almost certainly mask severe impacts on segments of Thai society. Much more work is needed to understand access to education and health services for the poor and the unemployed during the crisis. And the crisis is not yet over. The positive results seen in the aggregate data could change substantially if another year of economic contraction or stagnation follows in 1999-2000. Particularly at the community and family level, savings and other resources could be drawn down to critical levels, and families could be compelled to take more drastic steps to survive. Finally, these results do not measure the responses of all actors in health and education, and so the findings miss the coping efforts of NGOs, philanthropic organizations, and community groups.

However, at this stage of the crisis, the results for education and health show a remarkably agile and resilient response, at the family level and at the level of government services. The severity of impacts expected at the outset of the crisis have not materialized for health and education.

Illustrating these overall findings are three graphs shown below. The first presents the changes in household expenditure categories between 1996 and 1998 (pre and during the crisis). This graph does not capture the sharp

decline from 1997 to 1998 in total household expenditure, but it does show how families reacted to that decline, by adjusting down luxury and non-essential expenditures and increasing or holding steady more vital expenditures. Notably basic education and health expenditures were preserved or expanded by Thai families.



Source : Socio-Economic Survey.

Notes: Total real expenditures remained roughly constant between 1996 and 1998.

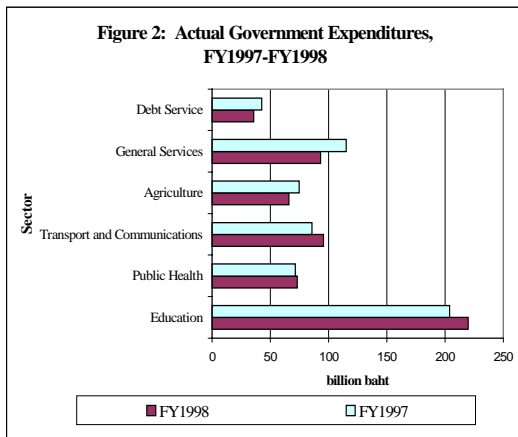
Category 1 includes expenditures on alcohol and tobacco, household goods, personal care and other luxury items.

Category 2 includes clothing and footwear, transportation and communications, and medical services.

Category 3 includes food and shelter expenditures.

Category 4 includes education, medical supplies, and fuel.

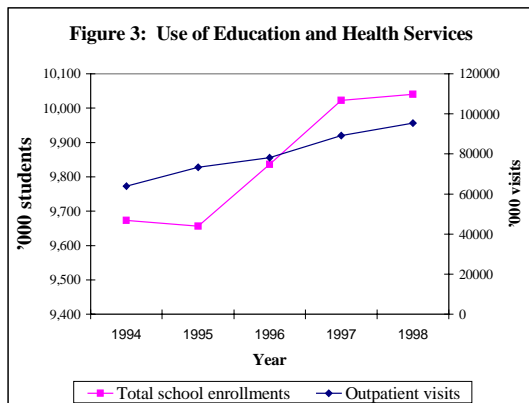
The second graph shows the overall picture of government expenditures for selected sectors in FY 1997 (a pre-crisis year) and in FY98 (the first full year of the crisis). Health, education and transport sectors show increases while agriculture, general services and debt service show declines.



Source: Mokoro, 1999.

The third graph presents two measures of health and education utilization, total public school enrollments through upper secondary for education and outpatient visits to Ministry of Health facilities.

Both show increases close to trend during the crisis. How this was achieved is a more complex story, involving shifts on the demand and supply side, which the following chapters describe in more detail. Such increasing utilization, however, for both sectors is a strong indication of positive crisis response. Parents did not withdraw their children in large numbers and continued to pay the costs of education; and families expanded their use of basic public health services, perhaps to limit costs but clearly to maintain health outcomes.



Source: ONEC and MOPH.

What are implications of these findings for longer-term issues in the education and health sectors? Clearly, the crisis response mechanisms in health and education have been surprisingly effective. But are they sufficient for the longer term? In health, was the public insurance system properly targeted and funded to maximize access by the poor and unemployed during the crisis? It appears that the Public Assistance Scheme, the expected vehicle for assisting these groups, was not nearly as active as the Voluntary Scheme, which aims at the near poor and up. In education, were the expanded scholarship and loan programs implemented on a timely basis and were they targeted well to families that were likely to withdraw their children from school? The evidence is incomplete, but suggests targeting lapses. What can be said about central vs. local management during the crisis? Were local managers of schools and health facilities better positioned to guide the crisis interventions to the intended beneficiaries? And finally, has the crisis served as an opportunity to improve allocative efficiency in health and education? Can more be done to direct public funding to basic programs for which the public sector has a clear and urgent mandate?

Underlying many of the findings is the crucial question on public vs. private responsibility in cushioning crisis impacts. In education and health, families adapted well during the crisis. Their willingness to pay for services and their own sense of responsibility are a striking feature of the crisis response so far, and need to be taken into account in debates on Thai social policy.

CHAPTER II : EDUCATION

As the magnitude of the economic crisis became more evident, concerns quickly mounted about the possible negative consequences for children's education. Many predicted drastic cuts in spending, large price increases, significant shifts from private to public schools, declines in the quality of education, the withdrawal of large numbers of children from schools given the actual and opportunity costs of education, and increases in child labor. For poor children in particular, it was feared that the impacts might be irreversible.

Have these expectations been realized? What do the actual impacts to date tell us about the level of preparedness of the Thai Government and people to cope with economic downturn and its widespread effects?

Two years into the crisis, it is possible to analyze data which reveal the patterns of crisis responses in education, mainly through the coping mechanisms of families and government programs. The chapter examines educational outcomes, real government and household expenditures on education, and shifts in the utilization of education services. Finally, it concludes with implications for the education reform agenda.

Achievements and Outcomes

Thailand's achievements in education have been substantial, particularly in terms of expanding opportunities for education. Enrollments at most general education levels and in vocational and technical training have grown rapidly. Education has been made compulsory through grade nine. In part as a

consequence, child labor rates have declined. The literacy rate for all age groups is estimated at about 90 percent.¹

Outcome impacts limited

In light of fears that the crisis would threaten these achievements, how have education outcomes been affected? Data inadequacies and measurement difficulties, combined with the lag between inputs and outcomes, limit an assessment of crisis impacts on outcomes. However, several early indicators show that the crisis has had no immediate negative effects. Most enrollment ratios have continued to grow as discussed in following sections. Based on an analysis of Socio-Economic Survey data, both the functional literacy rate and average educational attainment of the population 15 years and over increased between 1996 and 1998.

Education Financing

Summary: During the crisis, in the face of early stabilization measures which imposed fiscal constraints, the Government succeeded in maintaining real expenditures on education and sensible allocations within the aggregate budget. Because of irregular disbursements of public funds and some decreases in non-governmental sources of revenue, schools confronted financial uncertainties, but were able to manage resources and sustain services. With declining incomes and rising costs, households made optimal reallocation decisions – reducing expenditures on tobacco and alcohol, clothing and

¹ NESDB/ADB Newsletter, April 1999.

footwear, and household goods while increasing expenditures on education.

Government education expenditures

Reflecting the critical role education plays in Thailand's development, the education sector since FY1992 has commanded an increasingly larger share of the central budget. The rate of growth in the nominal education budget has averaged 19 percent over the five years prior to the crisis to where, in FY1997, education expenditures accounted for almost 22 percent of total central spending. The share of rapidly growing GDP devoted to public education expenditures fluctuated between 2.5 and 4.0 percent.

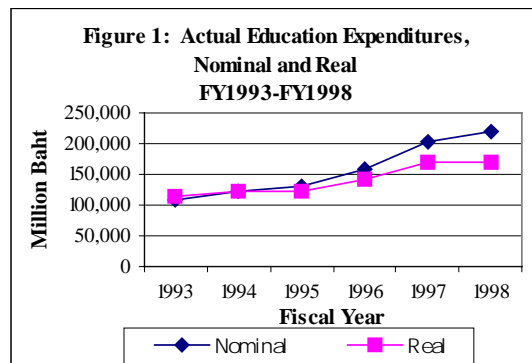
During crisis, real expenditures held constant

With the onset of the crisis in July 1997, Government undertook overall budget cuts of 15 percent in FY1998. But for education, central budget appropriations as well as actual education expenditures in FY1998 continued to grow in nominal terms, although more slowly than in previous years.

Reflecting a continuing high commitment to funding of education, the final FY1998 education budget totaled 207 billion baht.² The share of the total budget increased from 21.9 percent in FY1997 to 24.9 percent. The FY1999 budget shows a modest nominal increase to 207.3 billion baht, while the FY2000 budget bill submitted to

Parliament allocates 221 billion baht to education, or 25.7 percent of Government's total budget.³ Actual education expenditures in FY1998 totaled 220 billion baht (compared to a budget of 207 billion baht) or 25.1 percent of total actual expenditure.

Adjusting for inflation, real actual expenditures on education remained constant between FY1997 and FY1998 (see Figure 1). Thus, at the height of the crisis, despite fiscal constraints, Government succeeded in protecting real expenditures in education.

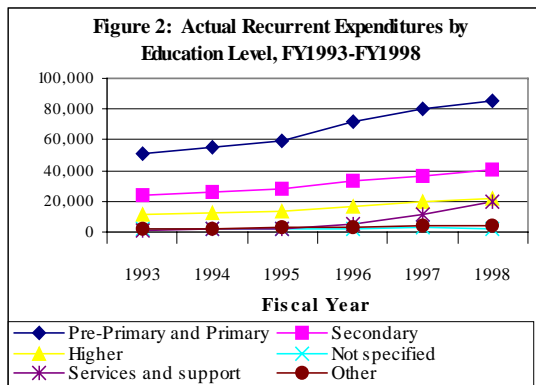


Source : Mokoro, 1999.

Within its aggregate budget, the education sector continued to expand recurrent expenditures for basic education (pre-primary, primary and lower secondary levels) at a faster rate than other levels. This increase was achieved primarily from a sensible reallocation from capital expenditures to basic education services (see Figure 2).

² Budget and actual figures based on the **functional** classification of education expenditures.

³ Mokoro, 1999 and data provided by Bureau of the Budget.



Source : Mokoro, 1999.

Prior to the crisis, Thailand had achieved a relatively good balance between salary and non-salary costs. Administrative costs were contained and did not consume a high proportion of the non-salary costs, thereby allowing adequate investment in educational materials. During the crisis, the Government has also been able to maintain this rather favorable proportion of the budget allocated to non-salary costs as compared to other countries in the region and at a comparable income level.

Schools

In small-scale surveys financed by both UNICEF and the Asian Development Bank (ADB) to measure crisis impacts,⁴ school administrators complained of irregular disbursements complicating financial management decisions. Budget shortfalls were reported by some schools in some areas, including the school milk and lunch programs. Although the aggregate budgets for these programs were not reduced,⁵ distributional and allocative deficiencies continued. There is also evidence that the level of donations from non-governmental

⁴ UNICEF, 1998 and ADB/NESDB/Brooker, 1999.

⁵ Policy and Planning Dept., ONPEC.

sources (including parents and local communities) decreased in some districts.

Schools coped with financial uncertainty

However, in the face of uncertainty, schools proved resilient - employing a number of innovative coping strategies. Principals successfully elicited in-kind and cash contributions from parents and community members; administrators and teachers provided food; students receiving free lunches and milk were rotated; unused spaces were converted; and materials were reused. Also importantly, school principals expressed confidence in managing reduced budgets even if cuts were to continue.

Government programs

In response to projected crisis impacts, the Government introduced measures to protect educational opportunities for vulnerable groups. At the school level, these included: allowing parents to pay tuition fees in installments; permitting schools to waive tuition fees on a case-by-case basis; introducing scholarships; expanding the education loan program with special emphasis on the needs of unemployed parents; encouraging private schools to extend payment deadlines and prohibiting them from increasing tuition fees; providing vouchers to private school children in the Bangkok Metropolitan Area to allow them to continue at those schools; and encouraging local international schools to accommodate students returning from overseas.

Private schools. Parents appear to have taken advantage of the opportunity to

defer tuition payments to private schools. The Ministry of Education reported that for the second semester of the 1997 school year parents owed private schools nationwide some 923 million baht in overdue tuition payments.⁶ An ADB study on education financing also reports that the numbers of private school students owing tuition and the average amount of tuition owed by students increased at all education levels in 1998 compared to the previous year.⁷

Scholarship fund. The Government allocated US\$25 million from budget support provided by the ADB under its Social Sector Program Loan to provide grant scholarships to students in primary and secondary schools who had dropped out or were unable to continue their education. As of early June 1999, over 328,000 students had received approximately 835 million baht.⁸ Given high demand, the funds appear to have been rationed.⁹

Education Loan Program. The Education Loan Fund for the Student Loans Scheme (SLS) was established in 1996, prior to the crisis, to expand educational opportunities for students from low-income families by reducing the parental burden of education financing. Eligible beneficiaries include those studying at upper secondary and tertiary public and private educational institutions with incomes above baht 150,000 per year.

⁶ Bangkok Post, April 16, 1998.

⁷ Cresswell, 1999.

⁸ Data provided by ONEC.

⁹ Some students reportedly received considerably less than the 4,000 baht per year for primary students and 5,000 baht per year for lower secondary students originally allocated. Bangkok Post, June 10, 1999.

As a result of the crisis, much attention has focused on the potential role of the SLS in preventing school dropouts. Annual budget allocations and actual expenditures increased significantly over the past several years whether calculated on a fiscal or school year basis (in line with the ADB's Social Sector Program Loan condition to increase the budget to baht 17,000 million by February 1998). The number of recipients increased more than four-fold between 1996 and 1998 (see Table 1).

Table 1: Student Loans Scheme Expenditures and Recipients, 1996-1999 (million baht)

<i>School Year</i>	Budget	Actuals	No. of Loan Recipients
1996	6,000	3,764	148,444
1997	14,736	12,515	435,426
1998	18,250	18,338	675,614
1999	24,300		

Source: Ziderman, 1999.

As with the scholarship program, loans were rationed given the increased demand. Because the budget for new borrowers was fixed and the demand for loans increased dramatically, the average nominal loan size to new recipients decreased by 30 percent between 1997 and 1998.¹⁰

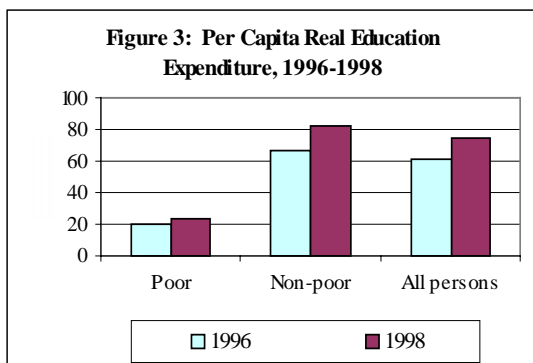
Information to evaluate the success of all of these crisis-response interventions, especially the effectiveness of targeting, and the extent to which they may be responsible for outcomes is not available. But the high demand for loans and assistance in meeting education-related costs, combined with the impact on enrollments discussed later in the report, suggests their value.

¹⁰ Ziderman, 1999.

Household expenditure on education

Private household expenditures are substantial. The costs of education are a critical factor influencing families' educational decisions, particularly for low-income households. An analysis of the 1996 and 1998 Socio-Economic Surveys reveals how households reallocated spending during the crisis compared to the last non-crisis year. This comparison leaves out the intervening year, 1997, during which the economy grew by eight percent. Thus, the decline in income from 1996 to 1998 is far less than from 1997 to 1998.

As per capita real income declined, poor and non-poor households made similar changes in their expenditure patterns: decreasing significantly their consumption of alcohol and tobacco, clothing and footwear, household goods, and transport and communications. (Spending on medical services also declined which is analyzed in the next chapter). The largest increase in real spending, for both poor and non-poor households, was on education (see Figure 3). Per capita real savings also increased, but only for non-poor families.



Source : Socio-Economic Surveys.

The level of education spending was influenced most significantly by income. Regression analysis reveals that an increase in per capita income of one baht increased education expenditure by 0.12 baht. Other factors influencing spending on education include the number of children attending school, and the household size (the larger the household the smaller the per capita expenditure on education). In addition, the more educated the household head, the more the family spent on education.

Further disaggregation of the survey data by type of educational expenditure explains where the expenditure increases occurred. Two expenditure categories account for over 80 percent of the rise in real education expenditures: tuition fees for higher education in private institutions (increased over 80 percent) and higher education fees at public institutions (increased over 70 percent). Despite the rising costs, enrollments at both private and public tertiary institutions increased, by 400,000 and 300,000 students, respectively.

At the levels below tertiary, the expenditure per child attending private school increased from 262 baht per month in 1996 to 297 baht per month in 1998. The average monthly expenditure per child attending public school decreased from 67 baht to 59 baht during the same period. These changes are mirrored in enrollment shifts, with the number of private school students declining by seven percent between 1996 and 1998. Reduced public school expenditures may be attributable to Government's policy to waive tuition fees for those in need.

In sum, between 1996 and 1998, per capita expenditures on education in real terms increased because enrollments in both public and private tertiary institutions continued to grow and fees at private tertiary institutions increased. In the midst of the crisis with declining real incomes and price increases, families continued to invest in higher education. For non-tertiary levels, some students shifted from private to public schools to reduce expenditures. Both attest to the commitment of Thai families to education.

Utilization Changes

Summary: *As the crisis quickly spread beyond the economic sector, many predicted significant declines in school enrollments, shifts from higher quality private to public schools, and increases in the number of dropouts. In the year following the onset of the crisis, overall enrollments in education increased. As seen in the household survey data discussed previously, there was some shift from private to public schools as families sought to reduce educational expenditures. Although trends in enrollment rates may have been interrupted, dropouts did not increase significantly, and the available data does not show a discernible increase in child labor.*

Enrollments increase

In the decade prior to the crisis, Thailand had made remarkable progress in expanding education with gross enrollment ratios increasing significantly at most levels of education. According to statistics published by the Office of

the National Education Commission,¹¹ near universal enrollment in primary education has been achieved. Gross enrollment ratios at the lower secondary level increased from 40 percent in school year (SY) 1990/91 to 72 percent in SY 1997/98. Upper secondary and vocational enrollment ratios almost doubled to 47 percent. Analysis of the 1992 and 1997 Child and Youth Surveys confirms these trends, although the enrollment ratios differ by education level (perhaps due to different population estimates).

In the year following the onset of the crisis, although the rate of increase slowed, total enrollments in primary and general upper secondary levels grew and the total gross enrollment ratio continued its upward trend. Between SY1997/98 and SY1998/99, an additional 18,000 children entered school driving up the total enrollment ratio from 74.8 percent to 75.5 percent.

Some shift from private to public schools

As incomes declined, enrollments at private schools were expected to decrease given their higher costs. An ADB-financed study compared *planned* with *actual* enrollments at private institutions and found declines at all education levels. *Actual* enrollments in 1998 compared with *actuals* in 1997, however, were slightly lower only at the primary level (where the discrepancy between public and private education costs is greatest), but about the same at

¹¹ ONEC calculates gross enrollment ratios based on the actual number of enrollees divided by population projections for relevant age groups. Thus, they may be highly sensitive to the population projections used.

other levels.¹² These findings are supported by the household expenditure data previously cited.

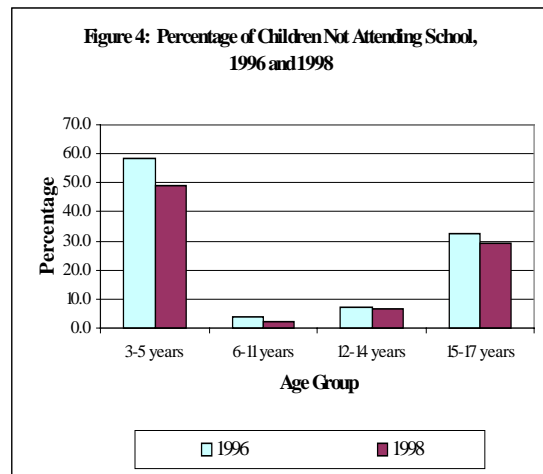
School dropouts the main concern

Of the concerns voiced about potential crisis impacts on education, by far the most serious was the possible increase in school dropouts. Rising unemployment and price increases have reduced family incomes and thus threaten to dampen the demand for education. With studies reporting that the principal cause of low enrollments is the high cost of schooling with poverty a major constraint to continued school enrollment, potentially large increases in dropouts appeared likely. Large numbers of dropouts would reverse the significant gains in enrollment achievement in the past.

Between 1992 and 1997, prior to the crisis, the number of dropouts declined. The Child and Youth Survey reveals that over three million more students (pre-primary through secondary levels) attended school in 1997 than in 1992.¹³ ONEC reports a steady decline in the numbers of children not continuing to higher grades between school years 1992/93 and 1996/97.

Between 1996 and 1998, number of students not attending school declines

To capture crisis impacts on school attendance, the World Bank analyzed data from the 1996 and 1998 rounds of the Socio-Economic Survey. Figure 4 reveals that the dropout ratio – defined as those children of school-age



Source : Socio-Economic Survey

population not attending school¹⁴ - continued to decline for all education levels between 1996 and 1998.

The largest decline in dropouts occurred in the pre-school age group 3 to 5 years: with an additional 310,000 children attending pre-school in 1998. At the primary level, the dropout rate declined slightly to 2 percent in 1998, resulting in an additional 100,000 enrollees.

As children progress to higher education levels, the dropout ratios also decline, but by not as much as at the primary level. In 1996, the percentage of children not attending school in the lower secondary age group 12 to 14 years was 7 percent which dropped only slightly to 6.7 percent in 1998. For the upper secondary 15 to 17 age group, the dropout ratio was 32.7 percent in 1996 and declined to 29 percent in 1998. Thus, at the secondary level in 1998, almost 1.2 million children were not attending school.

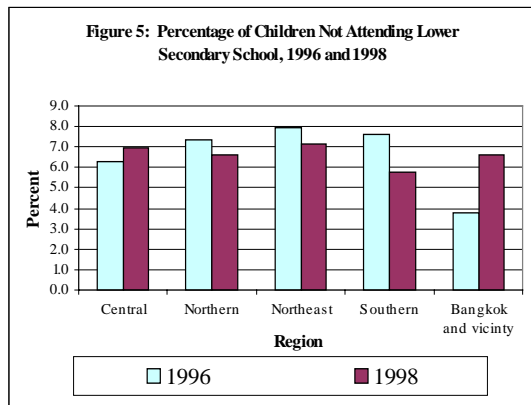
As before the crisis, male and female dropout rates do not differ substantially,

¹² Cresswell, 1999.

¹³ Data from 1992 and 1997 Child and Youth Surveys as reported in NESDB/ADB's April 1999 Newsletter.

¹⁴ This definition of dropouts is given in NESDB/ADB's April 1999 Newsletter.

but there are rural/urban differences. Rural areas have significantly higher dropout rates than urban areas, with the largest discrepancies at the pre-school and higher education levels. The dropout rates between 1996 and 1998 declined in both rural and urban areas with no adverse impact of the crisis evident. Dropout rates decreased at all education levels in all regions of the country with one exception: At the lower secondary level, dropouts increased slightly in the Central region and significantly in Bangkok and the vicinity. As dropouts declined in other regions, this increase may reflect the movement of children with their parents from Bangkok to the North and Northeast regions, but this cannot be confirmed by the data (see Figure 5).

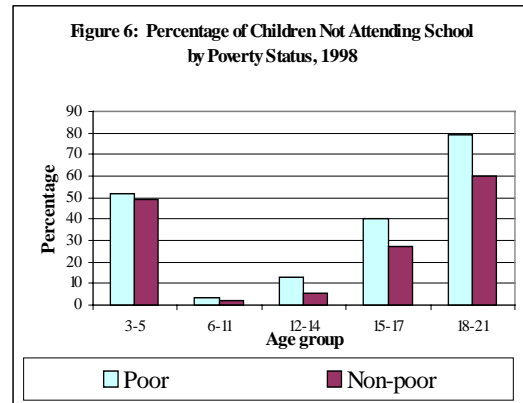


Source : Socio-Economic Survey.

Despite overall improvements in school attendance, poor households are still disadvantaged

In an equitable education system, every child would be able to access educational services irrespective of his or her family circumstances. But further analysis of the SES data reveals that the gap in dropout rates between poor and non-poor households is large. Even in the primary age group, the dropout rate among the poor is almost twice that

among the non-poor. The difference in rates is much wider in the 15 to 17 and 18 to 21 year age groups (see Figure 6).



Source : Socio-Economic Survey.

Information on dropouts can also be obtained from school-level data published by the Office of the National Education Commission (ONEC), as opposed to household survey data. Defining dropouts as the number of students who do not advance from one grade to the next each year plus those enrolled in the final years who do not graduate,¹⁵ analysis reveals a small increase in the number of dropouts as a percentage of population for all education levels.¹⁶

Between school years 1997/98 and 1998/99, an additional 129,330 students did not move to a higher grade or did not graduate, and this increase can be considered crisis-related. Of this total, primary school dropouts accounted for a low 4 percent, lower secondary students a higher 12 percent, and general upper secondary less than 2 percent. The increase in students leaving vocational

¹⁵ These dropout figures obtained from schools may not capture students who remain officially enrolled but have left school, students who leave and return in a given year, or students who never entered school.

¹⁶ Brimble and Suwannarat, 1999.

schools (public and private) accounted for 38 percent of the total increase. The remainder did not transition between primary and lower-secondary and lower-secondary to upper-secondary levels as discussed below. Overall, as a percentage of the school age population, dropouts increased from 5.5 percent in SY1997/98 to 6.7 percent in SY1998/99.

Transition rates. Analysis of the ONEC data does reveal some reason for concern about the number of children leaving school at the crucial transition points to lower and upper secondary school. Over the last ten years, as an increasing number of families enroll children in higher and higher education levels, transition rates have increased. Between 1997/98 and 1998/98, the number of students not moving from primary to lower secondary school accounted for 21 percent of the total increase in dropouts. The number of students not moving to upper secondary (general and vocational) accounted for 25 percent. Thus, according to school-based data, the crisis has contributed to a worsening of these two key transition rates, reversing the upward trend in transition rates between primary and lower-secondary education levels.

Household vs. school-based data

Household and school-based data show somewhat different results, with school-based data revealing a more noticeable dropout impact of the crisis. Both data sources have their limitations, and neither is inherently superior. But both are consistent in not reporting dramatic declines in enrollments or transition rates.

The enrollment counts and relatively low number of dropouts reported are further corroborated by school-level spot surveys. At the primary level, a study conducted for UNICEF found that in general the numbers of dropouts were not significant. Schools reported both decreases and increases in enrollments due primarily to migration of children with parents. The ADB-funded survey conducted several months later also did not reveal significant increases in primary students leaving schools compared to previous years: of 99 primary schools surveyed, only five reported dropouts in 1998 – with only one dropout from each school.¹⁷ Results from an ONEC survey also appear to confirm relatively minor impacts on dropouts.¹⁸

Child labor rates steady

At least in theory, parents might withdraw their children from school in order to supplement family incomes. Thus, school dropouts might be reflected in increases in child labor statistics.

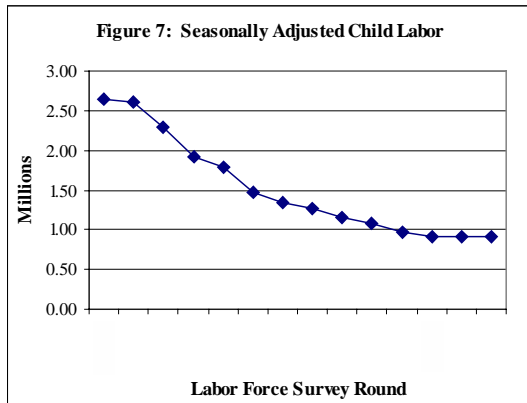
Child labor is defined as those children aged 13 to 17 (inclusive)¹⁹ who are not attending school because they are either in the labor force or working at home. Data from the Labor Force Survey reveals that the magnitude of seasonally adjusted child labor has declined steadily

¹⁷ Both UNICEF and ADB studies note the difficulty in determining dropouts in this type of survey both because of the lack of effective and reliable monitoring mechanisms at all levels, and the disincentive to report dropouts as school budgets are proportional to numbers of student enrolled.

¹⁸ ONEC, 1999.

¹⁹ The Labor Force Survey does not capture data on workers younger than age 13. The upper bound of 17 is consistent with the Constitutional right to 12 years of education.

since 1992 with no significant increase as a result of the crisis (see Figure 7).



Source : Labor Force Survey

Furthermore, the unemployment rate among those children aged 13 to 17 who were looking for work increased significantly between the third quarters of 1997 and 1998. The increase in total unemployment as a result of the crisis may have lowered the incentive for parents to withdraw their children from school or for children to dropout voluntarily.

Conclusion

As the analysis has shown, predictions of drastic cuts in education expenditures, large shifts from private to public schools, and significant declines in school enrollments and increases in dropouts *to date* have not been realized. The crisis has interrupted the rate of increases in spending on education, enrollment ratios and transition rates at key levels of education. But these slowdowns do not appear substantial or irreversible.

Families, Government and schools prove commitment to education

How were these positive outcomes attained? The correlation between

education and income is deeply appreciated by Thai families and underlies their unwavering commitment to education. The economic crisis has proven the robustness of the relationship: Although the crisis led to a significant reduction in real income among people at all education levels, its impact has been most severe on those with education equal to or below the primary level.²⁰

Families employed a variety of strategies to keep their children in school, thereby helping ensure future earnings: sacrificing expenditures on non-essential consumables; using savings or borrowing from mostly informal sources to help meet the higher costs of education; accessing scholarship and loan programs; and lowering costs by shifting their children from private to public schools.

Continued parental commitment to education was reinforced by: (i) past high levels of investment in education, and Government's maintenance of real education expenditures and sensible allocations; as well as (ii) the innovative coping mechanisms used by school administrators to help prevent adverse impacts. The cumulative effect of these actions at all three levels appears, at least during the year following the onset of the crisis, to have prevented detrimental or irreversible impacts on the education sector. How long this salutary result will endure is the question, especially if employment opportunities and wage levels persist at their present low levels.

These positive results, however, should not give cause for complacency. The crisis has made starker the points of

²⁰ Kakwani and Pothong, 1998.

strain on the education system. The challenges that existed before the crisis remain, with the crisis highlighting the need for acceleration of government's reform agenda.

Toward Reform

The resiliency of Thai families and the Thai education system in dealing with the economic crisis so far is remarkable. Demand for education has been rising steadily over the past decade, and is apparently sufficiently strong to lead families to invest more in education despite the crisis. Action responses of the Education Ministry in the form of relaxed payment policies and expanded student aid have been appropriate, and appear to have helped.

Of great importance for the future of Thai education is the commitment and creativity shown by school principals and communities in managing resource uncertainties. The education reform agenda for Thailand, which is embodied in the new Education Act that has just passed through the Senate, envisions a new national education system in which the responsibility and authority of principals, teachers and communities will be greatly enhanced. The accomplishments at this level of the system over the past two years give considerable confidence that this aspect of reform, "decentralization," is very likely to succeed.

The reform program further envisions a broad set of social partnerships for the delivery of education. "Education for all, and all for education" is the common slogan. With growing levels of parental demand for education, and the Constitutional mandate for 12 years of education for all, both public and private education institutions will need to respond. Following through on reform strategies aimed at reducing constraints on the expansion of private education and at a reduced role for central public education authorities will be important.

Although the effects of the crisis on school dropouts overall have been minor, the numbers of children not attending school and those not graduating, particularly from the primary level, both before and during the crisis, remain priority concerns.

Finally, although the impact of the crisis on school attendance has been well managed by families, schools and the Ministry, achievements come at the cost of increased family debt to private schools and to the student loan program. While the terms of the latter are quite favorable to borrowers, short-term commercial debt to schools may prove difficult to manage.

CHAPTER III: HEALTH

Over the last thirty years, Thailand has achieved remarkable progress in terms of health. Access to care has been ensured through an extensive network of public facilities, which reaches each sub-district. Health indicators have improved dramatically and coverage of health insurance has increased rapidly.

Most analysts feared the 1997 crisis would threaten the sustainability of these achievements. Effectiveness, affordability, financial viability and equity of health care supply were likely to be affected by the increase in costs of drugs and other imported inputs, and the decrease of funding of public health services. Services would have to become more efficient to sustain their performance in a context of reduced resources.

On the demand side, there has been concern that households capacity to pay for health services would be diminished; utilization of health services would decline overall; subsidies for insurance schemes would become uncertain; and new health needs (e.g., child nutrition, drug addiction and AIDS) would emerge in the context of increased unemployment, lowered income and decreased consumption. Two years into the crisis, mounting evidence helps understand better whether these expectations have been realized.

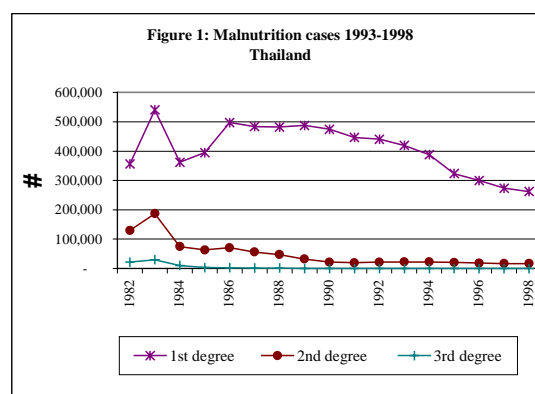
Health Outcomes

Summary: *Two years after the onset of the 1997 economic crisis, there is little if any evidence of its impact on health outcomes. Mother and Child Health outputs and outcomes are stable or*

increasing. There is no indication of an increase in health needs.

Detailed information on outputs and outcomes of various health programs are generally not available, which makes the assessment of the impact through routine data difficult. But to-date there has been no clear evidence of an impact of the economic crisis on national health outcomes.

Routine data as well as surveys have shown no increase in the number of cases of malnutrition reported (see Figure 1).



Source : Ministry of Public Health.

The HIV prevalence is going down in Northern Thailand region, once the most affected by HIV in East Asia. The MOPH reports a fall in the demand for commercial sex services in 1998 compared to 1997 (4 clients per day down to 1.5 clients per day). There is no indication of decrease in essential services outputs (deliveries, Ante Natal Care, vaccination) in district hospitals as reported numbers are stable.

The trend to decreased use of MOPH family planning services does not seem to have been accelerated by the crisis,

but follows a progressive trend of increased self-medication and use of private sector services. EPI coverage numbers remain high. Interviews of provincial managers suggest that the budget decrease in some public health programs¹ did not affect outcomes. A survey conducted in October 1998 in selected health centers and district hospitals did not retrieve evidence of increased health needs, even in areas particularly affected by poverty and unemployment.²

This lack of evidence does not preclude the potential impact of the crisis on “hard to reach” groups, both in remote rural areas and urban slums. However, socio-economic studies of these groups do not provide evidence for such an impact. Much is unknown in this area.

Health Financing

Summary: During the crisis, the government sustained its level of investment in health. Growth of public health budget was interrupted, but budget cuts have been limited. Between 1996 and 1998, the budget of the Ministry of Public Health decreased by about 5 percent when adjusted for inflation. Yet the budget cuts did not translate in equivalent decreases into expenditures. In real terms, the actual public expenditures on the health sector increased by 11 percent between 1996 and 1998. The expenditures for the Civil Servants Medical Benefit Scheme, not directly accounted for in the government health expenditure, also increased by 6 percent in real terms over the same period. Crisis-driven budget reductions

¹ Mainly programs of Control of Diseases, and Health Promotion

² ADB/NESDB/Brooker, 1999.

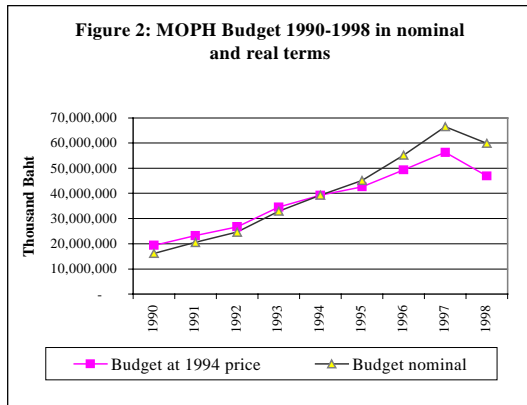
were focussed on capital investment, and to a lesser extent on the expenditures of specific programs such as health promotion and communicable diseases including HIV.

Government and private expenditures on health have been growing at a rapid pace in the 1990s. Public expenditures per capita increased by 132 percent between 1978 and 1992, while private expenditures increased by approximately 235 percent. Public spending for the Ministry of Public Health increased from 6 percent of the national budget in 1992 to 7.8 percent in 1997. Government contributions to insurance schemes such as the Civil Servants Medical Benefit Scheme, and the Social Security Scheme as well as funding of health facilities which are part of other public agencies³, have raised public funding for health to about 10 percent of the budget.

Cuts in Public Health Expenditures Limited

The economic crisis triggered a reassessment of both the level and the allocation of the health budget. However, the Royal Thai government protected the budget of the Ministry of Public Health for FY1998. In comparison with the previous years and adjusting for inflation, the revised FY 1998 budget was 17 percent lower than the health budget of 1997 and 5 percent lower than the budget of 1996. Yet it represented an increase of 10 percent in comparison to the 1995 budget (see Figure 2).

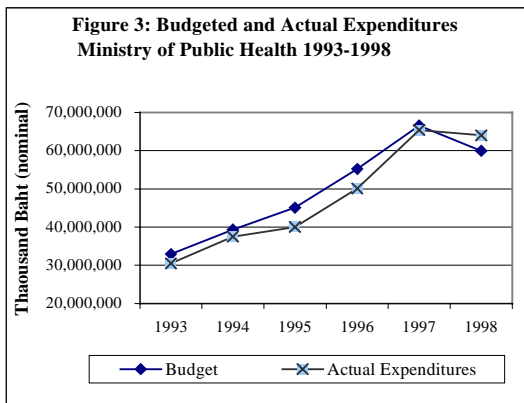
³ Both the Ministry of Defense, Ministry of University (University Hospitals), and the Ministry of Interior own and run hospitals and other health facilities.



Source : Health Policy and Planning Bureau, MOPH and World Bank CPI

Other health-related non-MOPH budgets were also adjusted. The 1998 budget of the Civil Servant Medical Benefit Scheme was reduced from 18.3 billion to 17.3 billion baht as compared to the pre-crisis plan.

The budget cuts did not translate into equivalent decreases in expenditures. Total actual amounts disbursed for the Ministry of Public Health in 1998, including spending from that year's budget and encumbrances from 1997, exceeded the budget allocation for FY 1998 (see Figure 3). As a result, nominal actual expenditures for the MOPH decreased by only 2 percent between 1997 and 1998, but increased by 28 percent between 1996 and 1998.

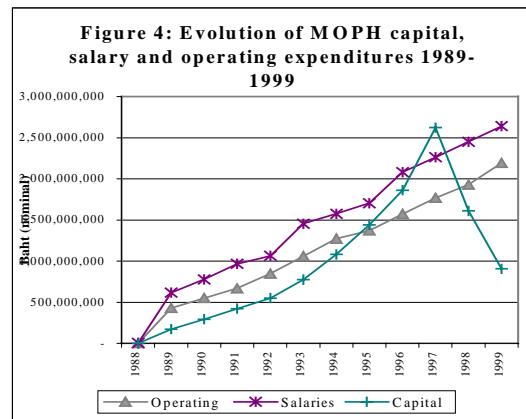


Source : Mokoro, 1999, and Bureau of Budget

Overall government health expenditures (MOPH and other ministries)⁴ decreased in real terms by 5 percent between 1997 and 1998, yet increased by 11 percent when compared to 1996.

Budget allocations

Looking at the composition of budget adjustments in 1998, the cuts affected mainly the planned investments of the MOPH. In nominal terms, the budget for capital investment decreased by 38.5 percent between 1996 and 1998, whereas the budget for salaries and for operating expenses both increased by 9 percent and 8.3 percent respectively (see Figure 4). Salary of personnel currently absorbs more than 40 percent of the MOPH expenditures.

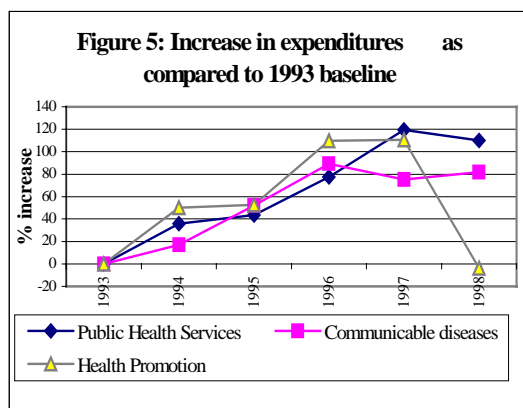


Source: Mokoro, 1999.

Turning to the level of expenditures by budget program, the classification system changed between 1996 and 1998 and some harmonizing of the classifications is necessary to make a preliminary inference on the actual programmatic redistribution of the resources within the MOPH. Public health services represent the largest

⁴ Including facilities run by the Ministry of Interior, Ministry of Universities and Ministry of Defense

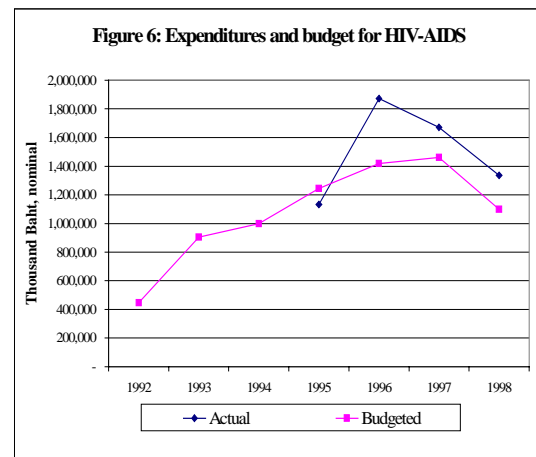
share of the budget, absorbing 75 percent in 1996 and 72 percent in 1998. In nominal terms, between 1996 and 1998, the MOPH increased its funding of most categories. Yet, contributions to disease control programs decreased slightly in both nominal and real terms. Expenditures on health promotion programs decreased dramatically (-54 percent in nominal terms) and there is a clear downward trend for this sub-sector (see Figure 5).⁵



Source: Mokoro, 1999.

Within the disease control budget, the HIV/AIDS control program is a special case. Between 1996 and 1998, the AIDS budget decreased by 23 percent and the actual expenditures by 29 percent. This decrease corresponds mainly to a decrease of the budget for anti-retroviral therapy for AIDS patients, following a policy decision regarding the low cost-effectiveness of double therapy. This decrease does not take into account the foreign-financed spending for this program. The decrease of the budget for condoms was initiated before the crisis and corresponds to a policy decision reducing free distribution of condoms and promoting cost-sharing (see Figure 6).

⁵ Yet, an allotment of 2.4 billion baht for sanitation promotion has not been taken into account in the 1998 expenditures.



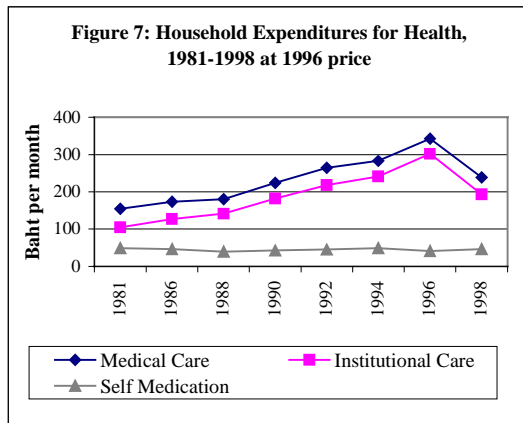
Source: Mokoro, 1999.

Household health expenditures

Summary: *The expected decrease in health expenditures overall by households was realized, as people spent significantly less after the crisis than before on health services. Expenditures on public and private services were both reduced. Expenditures on medical services declined steeply, but self-medication expenses rose slightly, suggesting that more expensive treatments may have been postponed. And the decrease has been significantly less dramatic for the poor than for the non-poor. The poor have most likely sustained their essential health expenditures, and probably have been protected by the public health insurance safety nets.*

The National Statistic Office's Socio-economic Survey shows a clear impact of the crisis on household out-of-pocket expenditures, with households spending significantly less in real terms after the crisis than before, on medical and institutional care (-36 percent) and increasing slightly their expenditures for self-medication (+12 percent) (see Figure 7). Health expenditures on public and private services were both reduced

in the same proportion. It is difficult to establish whether this decrease corresponds to a lesser use of health services overall, a shift to less expensive services (i.e., public rather than private), or a reduction of the cost of services provided through improved cost efficiency or reduced quality.

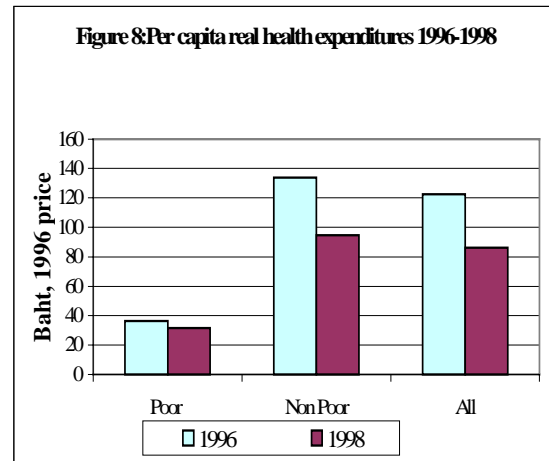


Source: National Statistics Office, SES.

A combination of these events is likely to have occurred. The decrease of overall out-of-pocket health expenditures was more dramatic among the non-poor (-29 percent) than among the poor (-13 percent). This supports the hypothesis of a shift to less costly sources of care and reduced use of elective care by better-off people (Figure 8). The poor have likely attempted to sustain their essential health expenditures. But the poor may also have benefited more from access to public health insurance schemes.

Utilization Shifts

Summary: *The expected drop in utilization of public services was not realized during the crisis. On the contrary, there was increased use of public services, particularly for outpatient services. The government has enlarged its health safety net by increasing the coverage of public health*



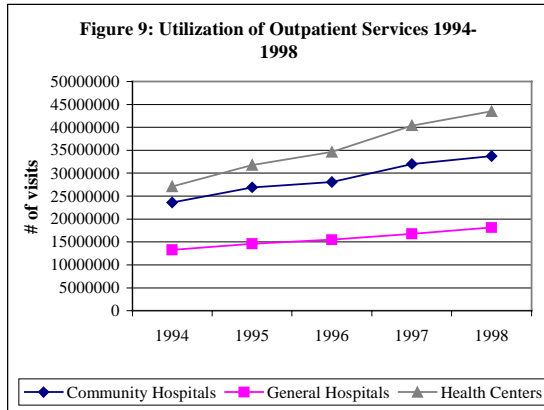
Source: NSO, SES survey.

insurance. Utilization of health services increased within the schemes aiming at protecting the vulnerable (Public Assistance Scheme) and the near poor (Voluntary Health Card scheme). The Government sustained or increased the subsidy to these schemes. The Voluntary Health Card Scheme proved more popular than the Low-Income Card offered free to the newly unemployed. Concerning utilization of private facilities, indirect evidence suggests that a shift from the fee for service private sector to the subsidized public sector is likely to have occurred.

Use of public health services increases

There has been no survey among the population to assess the evolution of utilization of health services over time. Facility-based evidence of the increase of the utilization of public services is nevertheless consistent and convincing. Following the crisis, people have increasingly used the public health services — either by shifting from private services, or because of increased confidence in and demand for the public health services as suggested by the 1994-1998 trend. Between 1996 and 1998, the total number of outpatient visits

(regional, provincial, district hospitals as well as health centers) has increased by 22 percent (see Figure 9).⁶



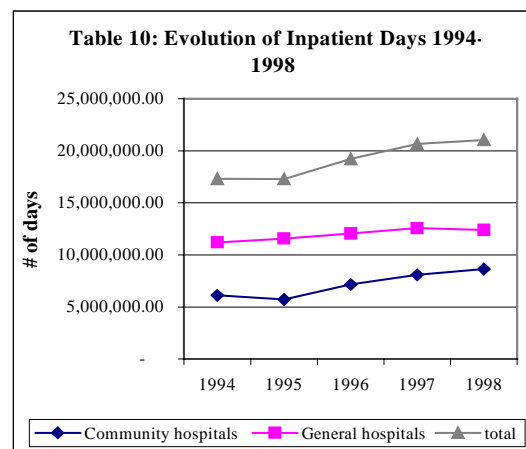
Source : MOPH.

The situation is quite similar for the use of inpatient services (IPD) although less dramatic. The number of IPD days increased by 9 percent between 1996 and 1998, largely due to the increase in the number of IPD days in district ‘community’ hospitals (+21 percent) (see Figure 10). In provincial and regional ‘general hospitals’, a small increase is noted, but the number of surgery treatments increased during the crisis (+16 percent), suggesting a shift from the private sector for high cost procedures. This could also be due to the shift of civil servants to the public sector for inpatient care as private sector inpatient services were no longer reimbursed by the Civil Service Scheme following the crisis.

Regional survey data confirm the increased utilization. A UNICEF-financed⁷ survey of hospitals and health centers in the poor North and North-East concluded that the increased flow of patients to rural public health facilities

⁶ This does not take into account visits to the public facilities belonging to other ministries (University and Army hospitals) as well as to Bangkok Metropolitan Administration facilities, under the responsibility of the Ministry of Interior
⁷ UNICEF, October 1998.

was directly linked to increased unemployment and falls in disposable income from inflation and underemployment. Hospital and health staff reported that additional patients comprised both returning migrants and patients switching from private health clinics. A survey conducted for the ADB⁸ in August-November 1998 reported a rise of 15 percent in new patients and 11 percent in outpatient visits since the beginning of the crisis.



Source : MOPH.

Health insurance coverage expands

This increase in utilization can be at least partially related to the increase in the number of people enrolled in health insurance schemes.⁹ Between 1992 and 1996, the proportion of the population covered by health insurance increased from about 56 percent to 77 percent with private insurance accounting for less than 2 percent.¹⁰ One of the

⁸ ADB/NESDB/Brooker, 1999.

⁹ Data show no increase of the number of visits per enrollee, suggesting no increase in needs.

¹⁰ Four main schemes receive public support:

- Public Assistance Scheme, including the Low-Income Card. Under this scheme, the poor, elderly, children and other vulnerable groups receive free medical care. (46% in 1996)
- Civil Servant Medical Benefit Scheme. Civil servants receive free medical care in public facilities (13%).
- Compulsory Health Insurance. This scheme covers formal sector employees and includes Social Security and Workmen Compensation schemes (7.6%).

objectives of the Thai government expressed in the 8th Plan was to reach universal coverage. The crisis may have slowed process towards this goal. nonetheless progress has been registered.

To alleviate the impact of the crisis on the most vulnerable, the government strengthened its support to the Public Assistance and the Voluntary Health Card insurance schemes. The MOPH sustained the subsidy to the Public Assistance Scheme through budget and external resources from the World Bank. The Government offered a program of free Low-Income Cards for the unemployed provided they register at the Ministry of Labor and Social Welfare.

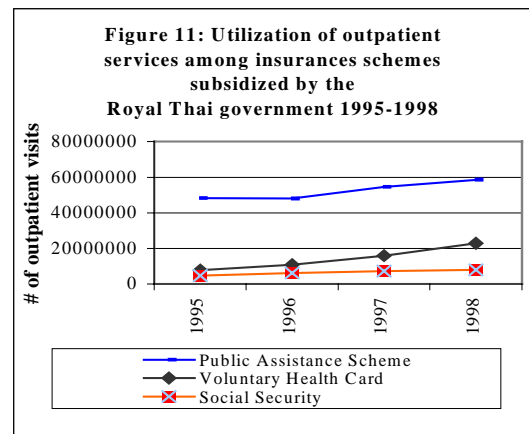
The Government subsidy to the Voluntary Health Card has been doubled (from 500 to 1,000 baht per card) and a loan from ADB is to be used in 1999-2000 to finance this increase. An additional 900,000 households have purchased voluntary insurance (Voluntary Health Card or VHC). Hence, the number of people insured is likely to have increased in absolute number, largely because of the increase in coverage through the Social Security and the Voluntary Health Card schemes.

Among the 1.4 million unemployed expected to need low cost health insurance, few¹¹ have taken the opportunity to enroll in the free Public Assistance Low-Income Card Scheme. Thai families, including the unemployed, seem to have favored the cost-shared Voluntary Health Card Scheme over the fully subsidized but more stigmatizing Low Income Scheme.

• Voluntary Health Insurance. This scheme intends to serve the near-poor. For an annual contribution of B 500 a cardholder receives free medical care (9%).

¹¹ Probably less than 10,000.

The overall increase in the number of outpatients visits in the public sector is to be attributed particularly to the increased use of the Public Assistance Scheme (+22 percent) and Voluntary Health Card (+ 110 percent in 1998 compared to 1996) (see Figure 11). Utilization of services increased also for the Social Security Scheme (+28 percent)¹².



Source : Office of Health Insurance, MOPH

Shift from private to public providers?

Turning to the possible shift from private to public facilities, the combination of the increase in the number of people insured by a public financed scheme, increased use of public facilities by Public Assistance beneficiaries and Voluntary Health Card holders, as well as decreased out-of pocket expenditures suggests that a large group of patients may have shifted from private to public services. In the study conducted for the ADB¹³, health centers and district hospitals reported a 272 percent increase of card-holders between 1997 and 1998, which could account for two-thirds of the new patients in the public health

¹² Yet, as Social Security contracts out with both public and private hospitals it is not possible to assess how much of this increase actually happened in the public sector.

¹³ ADB/NESDB/Brooker, 1999.

facilities. Anecdotal reports point out at a decrease of private sector activities of 50 percent for IPD and 30 percent for OPD. However, direct evidence of such a shift in utilization is not available.

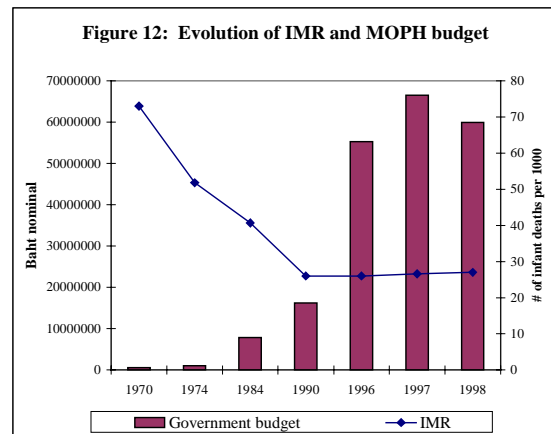
Efficiency of Resource Use

Summary: Before the onset of the crisis, rapidly growing private and public expenditures were not matched by improving health outcomes. The crisis has been seen by Thai health policy makers as an opportunity to increase the efficiency of the use of resources. Early evidence shows that allocative efficiency may have lessened. On the other hand, progress can be noted on cost containment and cost-efficiency may have improved during the economic crisis.

Government and private expenditures on health have been growing at a rapid pace in the 1990s, yet these have not been matched by improvements in public health outcomes (see Figure 12). This growing imbalance is of concern to Thai policy makers, who have sought to improve public health outcomes through stronger budget support to primary care, communicable disease control, AIDS program, and other public health activities.

During the crisis, however, these efforts were not sustained in the health sector. While provision of health services¹⁴—including high cost hospital care—were protected and expanded to additional groups, health promotion programs were cut and programs for disease control were not expanded. Provinces report cuts mainly for the

¹⁴ including health center services which provide preventive care and promotion in sub-districts.

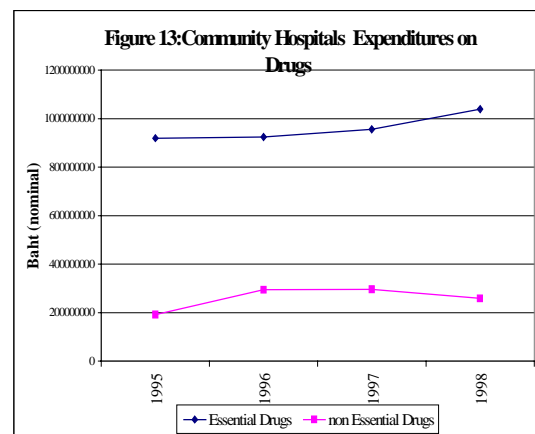


Source: MOPH.

public health programs. Hence, allocative efficiency may have decreased.

On the other hand, the economic crisis seems to have increased the cost-efficiency of the government health budget.

In 1997, the government initiated a “Good Health at Low Cost” plan, which recommended raising the utilization of essential drugs and reduce the cost of utilities. Some gains in cost containment can already be observed with a positive shift from the use of non-essential drugs to the use of essential drugs in both provincial and community hospitals (see Figure 13).



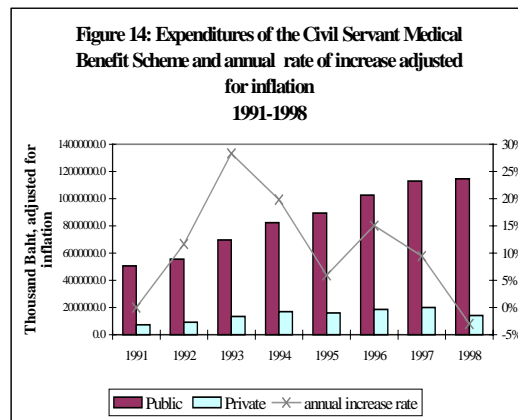
Source: MOPH.

At the hospital level, the total expenditures of community hospitals per equivalent visit remained stable over time in nominal terms and decreased in real terms. Despite increase in the total expenditures due to raised inputs cost and increased utilization, this represents a slight gain in efficiency largely due to economies of scale of treating more patients within the same number of facilities.

On the revenue side of hospital operations, hospitals have been able to increase “extra-budgetary” revenue coming from both payments of the health insurance schemes and user fees. Variable revenue thus has increased along with the increase in utilization of services. Between 1996 and 1998 additional revenue on top of budgetary allotment increased by 34 percent in community hospitals and by 23 percent in provincial hospitals. It is not yet clear whether the increase in revenue has matched the increase in caseload, and it is possible that hospitals may have reduced the quality of care.

On other fronts, costs have been better contained than in the pre-crisis period. Expenditures of CMSBS have decreased between 1997 and 1998 in real terms, largely because of cuts in reimbursements for private services (see Figure 14). Cost sharing of insurance premiums has been developed with the increased enrollments in the voluntary Health Card Scheme. This revenue efficiency gain is likely to have been obtained while protecting the near poor, who enrolled in the voluntary Health Card Program. The poor may have used the Public Assistance Scheme for children and elderly, or presented

themselves to the public health services to be treated free.



Source: Comptroller General's Office.

These preliminary findings on efficiency of health program and budgets require further analysis before conclusions can be drawn.

Conclusions

Two years after the onset of the 1997 economic crisis, *most of the pessimistic expectations did not materialize*. There is little if any evidence of a crisis impact on health needs and outcomes. The growth of public health budget was interrupted, but budget cuts have been limited. When adjusted for inflation, the 1998 post-crisis expenditures are at a similar level to the pre-crisis 1996 level, and operating budgets have increased. The crisis halted the trend of sustained high level capital investment.

Overall, household health expenditures declined, but poor people were less affected than the non-poor. Poor people's decrease in health expenditures affected mainly the larger expenditures for clinical services. Poor groups may have benefited more from subsidized services as the Government has enlarged its health insurance safety net during the crisis. The number of people

covered by a scheme subsidized by public funding has increased and people have increasingly used public facilities. A shift from the private sector to the public sector is likely to have occurred.

Among the mechanisms used to preserve access to services, the Voluntary Health Card has been favored by Thai households during the crisis. One of the crisis mitigation measures gave free access to the Public Assistance Scheme to all newly unemployed. Yet, the overwhelming majority did not use this mechanism, perhaps fearing the stigma linked to being registered as “poor”. On the other hand, more than 900,000 additional households enrolled in the Voluntary Health Scheme, despite having to pay a small insurance premium.

Many policy analysts hoped the crisis would be an opportunity for positive changes. Some progress towards more efficiency can be perceived. Although allocative efficiency may have suffered as some Public Health Programs were cut, the crisis has accelerated the implementation of cost containment measures, and revenue gains have also accompanied the crisis.

The insufficiency of targeting of the subsidies to vulnerable groups remains an important issue. Over the two crisis years, the MOPH has attempted, with some degree of success, to better register the beneficiaries of the Public Assistance Scheme including Low-Income Card holders. But the Public Assistance Scheme covers all children and elderly regardless of the income level of the households. The Voluntary Health Card program, which was expanded during the crisis, does not have income-related

eligibility criteria. This scheme is likely to have benefited the vulnerable near poor in the crisis. But part of the beneficiaries may belong to more wealthy groups which may not be the most in need of government subsidies.

Issues for the Future

The Ministry of Public Health has been engaged in a wide range of initiatives to reform the health sector, with the main goals aimed at improving the efficiency and equity of public services. The MOPH efforts pre-dated the onset of the crisis, and were framed within a long-term context of prosperity and growth. The onset of the crisis has shifted Government’s attention to more short-term priorities, such as protecting key programs, expanding health insurance coverage to those in need during the crisis, managing higher costs of imported goods, and other challenges presented by the crisis. These more urgent issues have served to highlight two main areas of reform: ensuring equity and access to services during a volatile economic downturn; and using the crisis as an opportunity to improve efficiencies.

Under the issue of equity of services, the MOPH was able to expand utilization and health insurance scheme coverage during the crisis, both notable achievements. However, this was accomplished through unexpected instruments, namely the health insurance schemes that require premium payments from enrollees. More analysis of this development will be needed to better appreciate who took advantage of these schemes, and in particular, how the poor and unemployed sustained their access to health services during the crisis.

Those findings will be instrumental in designing improvements to the health insurance system so that it can provide subsidized coverage to those in need should there be another economic downturn.

The equivocal performance of MOPH in regard to low-income targeting remains an important aspect of the crisis experience. How best to allocate budget resources to poor regions or provinces, and within programs, how to ensure that subsidized services are taken up by the poor remain core challenges for the reformers in the MOPH.

Concerning efficiency of services, the crisis-driven budget shifts point to a vital long term issue, that is, the role of true public health services in the overall mandate of the MOPH. Communicable disease control, health awareness and other traditionally public interventions

were not the winners during the crisis, but they probably should be for the long term. As the role of the private sector expands in Thailand, these key public goods may well rise in importance for the MOPH.

Also concerning efficiency of services, the crisis seems to have accelerated the search for more cost-efficient services. The emphasis on use of generic drugs, long an MOPH priority, accelerated during the crisis. For the future, the MOPH intends to introduce more rigorous cost standards, particularly for more sophisticated disease interventions, so as to limit overall budget increases and to allocate resources according to standardized unit costs. The expansion of utilization during the crisis without accompanying budget increases suggests that there is further scope for cost controls in hospitals.

BIBLIOGRAPHY

Asian Development Bank. 1998. "Health Financing in Thailand". Prepared by Management Sciences for Health under ADB Technical Assistance No. 2997.

Asian Development Bank. 1999a. Social Sector Program Loan Quarterly Newsletter, January 1999 available at <www.sspl.org/qnews2/Qn2budg.htm>.

Asian Development Bank. 1999b. "The Social Sector Impact Draft Final Report on Socio-economic Challenges of the Economic Crisis in Thailand" prepared by the Brooker Group Consortium for the National Economic and Social Development Board under ADB Technical Assistance No. 2995, Capacity Building for Social Sector Reform.

Boonyoen D., and K. Wongboonsin, V. Tanshcharoensathien, P. Wongboosin. 1998. Effect of Economic Crisis in Thailand. Paper presented at the ANU-UNFPA study on the effects of the economic crisis on the attainment of ICPD goals in the East and South East Asian region, Hotel Atlet Century Park, Jakarta, July 9-11, 1998.

Brimble, Peter, and G. Suwannarat. 1999. "Seeking the Real Picture on School Dropouts." (mimeo)

Cresswell, Anthony. 1999. "Educational Finance in Thailand : A Review and Recommendations for Improving Allocative Efficiency". Report prepared for UNESCO-Bangkok as part of the Asian Development Bank Social Sector Program Loan.

De Franchesca, Bryant. 1997. "Can Private Hospitals Provide Service? Bangkok: Asia bio systems Co. Ltd, (mimeograph in Thai).

ESCAP. 1999. "Social Impact of the Economic Crisis." Economic and Social Survey of Asia and the Pacific 1999.

Esfandiar, Moini. 1998. "Impact of Economic crisis on Health Insurance schemes: Efficiency, Financing and Sustainability". Thesis for the Master of Science in Health Economics, Faculty of Economics, Graduate School, Chulalongkorn University, 1998.

Juntopas, Muanpong. 1998. "Social Impact of the Economic Crisis on Vulnerable Children in Thailand." A Field Study in Khon Kaen and Nong Khai Province, Thailand.

Kakwani, Nanak and Pothong J. 1999. "Impact of Economic Crisis on the Standard of Living in Thailand." Asian Development Bank and the Development Evaluation Division, National Economic and Social Development Board.

National Economic and Social Development Board/Asian Development Bank. 1999. "Indicators of Well-being and Policy Analysis: Education in Transition: Thailand's Case". Volume 3, Number 2: April 1999. A Newsletter of NESDB published under Asian Development Bank Technical Assistance (TA No. THA 29614).

McCleary and Sakol. 1999. "Review of Public Expenditures in Thailand : Budget Plans and Outcomes (draft)". Thammasat University, Faculty of Economics.

Medical Registration Division. 1998. Survey of Private Hospital's Debt. Bangkok: Medical Registration Division, 1998 (mimeograph in Thai).

- Ministry of Public Health. 1997. "Health in Thailand: 1995-1996". Bureau of Health Policy and Planning, MOPH. Bangkok: Veteran's Press, 1997:154.
- Ministry of Public Health – European Union, 1998. "Strategy of Health Care Reform Project and Results of Project Implementation".
- Mokoro. 1999. "Thailand Public Expenditures Review". Report prepared for the Bureau of the Budget, Government of Thailand, February 1999.
- Nitayarumphong S. et. al., 1999. "Past and Present of Health Care Reform in Thailand" (draft). Office of Health Care Reform, Ministry of Public Health, Thailand.
- Office of the National Education Commission. 1999. "Estimates of School Dropouts in 1998" and ONEC Poll: Survey of Primary School Enrollees. 1999.
- Pothisiri, P. and V. Tangcharoensathien, J. Lertiendumrong, V. Kasemsup, P. Hanvoravongchai., 1998. "Funding Priorities for HIV/AIDS Crisis in Thailand". Paper Presented at the 1998 World AIDS Conference in Geneva.
- Sussangkarn, and Chalongphob, Flatters, Frank, and Kittiprapas, Sauwalak. 1999. "Social Impacts of the Asian Economic Crisis in Thailand, Indonesia, Malaysia and the Philippines." Thailand Development Research Institute.
- Tangcharoensathien V. and S. Nittayarumphong. 1994. "Thailand: a private sector out of control?" Health Policy and Planning; 9 (1):31-40.
- Thavornwanchai, A. and P. Tae-Arak, S. Wongkongkathep. 1999. "Thai Children Health in the Economic Crisis". Health Intelligence Unit, MOPH, 1999.
- UNFPA. 1998. "Impact of the Economic Crisis on Population and Reproductive Health in Thailand."
- UNICEF. 1998. "Thailand : Impact of Economic Crisis on Children." UNICEF Thailand Office.
- Wibulpolprasert S., and V. Tancharoensathien and J. Lertiendumrong. 1998. "The Economic Crisis and Responses By Health Sector in Thailand in 1997-1998".
- World Bank. 1998a. "Thailand Education Achievements, Issues and Policies." Washington, D.C.
- World Bank. 1998b. *East Asia: The Road to Recovery*. Washington, D.C.
- World Bank. 1998c. *Social Consequences of the East Asian Financial Crisis*. Washington, D.C.
- World Bank. 1999. "Thailand Social Monitor: Challenge for Social Reform." World Bank Thailand Office.
- Ziderman, Adrian. 1999. "The Student Loans Scheme in Thailand : A Review and Recommendations for Efficient and Equitable Functioning of the Scheme". Report prepared for UNESCO-Bangkok as part of the Asian Development Bank Social Sector Program Loan.