School of Social Work and Social Policy

Health Care Challenges and Human Resources for Health in Thailand:
Migrations, Social and Political Tensions, and Human Rights Implications

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DECLARATION

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

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ABSTRACT

The global shortage of human resources for health and the brain drain of health care professionals exacerbate health care challenges in many small and medium sized economies, including efforts to curb the HIV/AIDS pandemic. This research investigated attitudes, perceptions, and dynamics among health care students and professionals in Thailand related to human resources for health, migration, inequitable distribution between rural and urban areas as well as between the public and private sector, and influences on migration ambitions. This included contemporary social and political parameters. Perceptions and attitudes among health care students and professionals were explored through a questionnaire survey and semi-structured interviews with health care professionals. Additional interviews with key-informants encapsulated contemporary events, dynamics, adversities, and challenges specific to the Thai context. It is argued that both the right to health care and health care professionals' right to free movement must be protected and upheld.

This research adds to the knowledge and insight into the specific health care challenges in Thailand and reflections upon the sustainability of the health care system; both in light of these health care challenges and the principles of sustainability as proposed by The World Commission on Environment and Development, the Brundtland Report (1990). It will enhance the scope from which health care, manpower expansion, and reform is pursued. Any approach to stem the exodus of health care professionals must recognise the rights of all stakeholders, including health care professionals and health care consumers, and all stakeholders must be engaged in the pursuit of sustainable health care through the principles of sustainable development and global sustainability.

ACKNOWLEDGEMENTS

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LIST OF ABBREVIATIONS

ARV   Antiretroviral (drugs/treatment)

CNS   Council of National Security

CSMBS   Civil Servant Medical Benefit Scheme

ER   Emergency Room

FTA   Free Trade Agreement

GDP   Gross Domestic Product

GPO-VIR   Government Pharmaceutical Organization's Antiretroviral Cocktail with three antiretroviral drugs

HHD   High Human Development

HIV/AIDS   Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome; while the differences between HIV and AIDS are important, this research generally refers to HIV and AIDS singularly, with the exception of a few references where it is more accurate to utilise only one term

LHD   Low Human Development

MDGs   Millennium Development Goals

MHD   Medium Human Development

MP   Member of Parliament

OPD   Out Patient Department

PAD   People's Alliance for Democracy

PLHA   People Living with HIV/AIDS

PPP   People Power Party

SSS   Social Security Scheme

UC   Universal Coverage; referring to the newly introduced Thai health policy previously known as the 30 Bath Health Care Cover or Policy

UDHR   Universal Declaration of Human Rights

LIST OF ABBREVIATED ORGANISATIONS

AFP   Agence France Presse

GPO   Government Pharmaceutical Organization (Thailand)

IMF   International Monetary Fund

MoPH   Ministry of Public Health (Thailand)

MSF   Medecins Sans Frontieres

NSO   National Statistical Office (Thailand)

UN   United Nations

UNAIDS   Joint United Nations Programme on HIV/AIDS

UNDP   United Nations Development Programme

UNHCHR   United Nations High Commissioner for Human Rights

UNHCR   United Nations High Commission for Refugees

UNICEF   United Nations Children's Fund,

UNITAR   United Nations' Institute for Training and Research

WHO   World Health Organization

WTO   World Trade Organization

LIST OF THAI TERMINOLOGY

Kaa	A particle at the end of a sentence to indicate courtesy and respect. *Kaa* is used by females.
Khrap	A particle at the end of a sentence to indicate courtesy and respect. *Khrap* is used by females.
Nong	Prefix when addressing someone younger.
Phi	Prefix when addressing someone older.
Thai Rak Thai	Thai Loves Thai: Former political party in Thailand founded and lead by ousted Prime Minister and multimillionaire Thaksin Shinawatra.
Wai	Traditional way of greeting people curiously by clasping hands together in front of ones face while bowing. This greeting also indicate relative social status, as the placement of the hands and depth of the bow reflects superiority or inferiority. One would greet a superior person with the hands held towards the forehead or nose and a deep bow, while one would greet an inferior person with the hands held towards the chest or lower region of the face and the bow is shallow.

There is no standard procedure for translating Thai into Latin letters. As such, there may be alternative spellings for different terms, including names. Some alternative spelling of Thai names have been offered through the footnotes.

CHAPTER 1

Parameters and the Local Setting

"Thailand, as many other countries, has faced extremely difficult problems-political, economic, social, cultural, environmental, etc., culminating in the phenomenon of social crisis, severely affecting health. The problems are inter-connected, complex and extremely difficult to solve" (Wasi 2000).

1.0 Introduction

The Thai health care system, as is the case regarding most health care systems world wide, is facing extensive, interrelated, and resource consuming health care challenges, which also impact human resources for health. While Thailand has implemented ambitious health care policies, the contemporary economical, social, and political tensions are of concern as negative perceptions and future opportunities among the health workforce may lead these professionals to migrate; towards urban areas; the private sector; or across boarders. Recognising that the complexities of any health care challenge are inevitably rooted in the specific local cultural, socioeconomic, environmental, and political parameters, this research investigates the predicaments and challenges regarding the migration, or brain drain, of health care professionals, the challenges and interrelated predicaments of current health care challenges, particularly the HIV/AIDS pandemic, human resources for health, and the pursuit of sustainable health care in Thailand. While medical care is a basic human right, this right does not have precedence over the individual rights of health care professionals. If individual health care professionals' actions are jeopardising the public's right to medical care, there is a conflict of rights. This predicament cannot be solved by prioritising the rights of one group, but requires a solution which recognises the rights, concerns and interests of all stakeholders.

This chapter provides a guide to the structure of this thesis. The following section provides a brief outline of the research methodology; framework; significance and objectives; as well as the research instruments and procedures. This is followed by an introduction to the issues and parameters constituting the backdrop and predicaments in the pursuit of an equitable distribution of the health workforce: Perceptions of health and health care; human resources for health; the brain drain of health care professionals; fused with the calamities of the

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HIV/AIDS pandemic; and challenges of rights and obligations. This is argued to be a precondition for sustainable health care.

1.1 Scope and Parameters

This research utilises human rights as an analytical framework, which reflects the epistemology of researcher. It is implied that the researcher subscribes to certain irreducible values in being a human being. Furthermore, although human rights may be presented and argued from the vantage point of irrefutable individual rights, specific scenarios may reveal a conflict of rights between individuals or groups. For example a conflict of rights may arise when a group exercises their collective rights, and this action may jeopardise the individual rights of other parts of the population. In particular, if health care professionals, collectively, act on their individual right to migrate, this adversely impact the general population's right to medical care. Human rights are in this research applied as a holistic and inclusive approach to this predicament, applied as an analytical tool as well as a plateau from which sustainable health care and global sustainability might be pursued equitably. Thus, health care challenges; the concerns regarding the flow of health care professionals from rural to urban areas, public to private sectors, and across boarders; as well as current social and political volatilities, are the parameters through which the prospect of robust and sustainable health care policy and continued development are investigated.

1.1.1 Significance and Objectives

This research aims to enhance knowledge for the specific circumstances and trends in Thailand. By utilising a holistic human rights framework, which is generally underrepresented in research investigating skilled migration, this research will enhance knowledge and add a new discourse to the complexities of health care policy and the prospects of comprehensive and sustainable health care. At this specific point in time, both the urgency of curbing the HIV/AIDS pandemic and the increasing importance of retaining and attracting health care professionals are key elements in development, generally, and the pursuit of fulfilling the United Nations' (UN) Millennium Development Goals (MDGs) specifically. This research will not only supplement and account for Thailand's development prospects within this framework, but may provide recommendations and outline general development challenges, as the predicaments in the pursuit of sustainable health care are interconnected with global health care challenges requiring global cooperation and efforts to ensure equitable health care, both globally and for future generations.

Acknowledging that the issues relating to migration among health care professionals and the health care system in Thailand are complex; are consistently being affected by social, political and cultural factors and concerns; and are currently experiencing tensions and challenges unique to the contemporary situation, this research recognises, as will be shown in the following chapters, that:

I.   The health care system in Thailand is complex with a variety of internal and external dynamics.

II. Various health care challenges are currently straining resources from the health care system in Thailand, including the HIV/AIDS pandemic.

III. Contemporary political social and cultural dynamics and ambitions are fluctuating and changing in Thailand, with great impact on health care efforts and may even spur heath care professionals' desire to emigrate.

IV. There is a tradition of both in- and out- migration in Thailand, including highly trained and skilled professionals.

Based on the cited acknowledgements, the objectives and aims for this research are:

I.   To investigate contemporary tensions and dynamics in the Thai health care system as perceived by health care professionals themselves. This is the core aim and includes perceptions related to health care challenges such as the HIV/AIDS pandemic, as well as attitudes and perceptions related to differences between:

   a. public and private services; and

   b. services in rural and urban areas

II. To identify possible motivations for leaving the public health care sector among Thai health care professionals.

III. To explore the conflict of rights between health care professionals' right to migrate and the remaining population's right to adequate and affordable health care.

1.1.2 Research Methodology

This research is centred on questions seeking to ensure sustainable health care in Thailand in light of the current crisis in human resources for health, utilising a case study methodology. More specifically, this thesis will review the brain drain of health care professionals and its impact on the Thai health care system. Although the impact of the HIV/AIDS pandemic on the

Thai health care system is immense, this is not the only health care challenge adversely affecting the availability of human resources for health. The inequitable distribution and internal migration patterns are threatening the effective delivery of health care and may have the same detrimental impacts as the exodus of health care professionals.

This research has utilised a mixed methods approach, consisting of an illustrative, but non-representative, survey questionnaire and semi-structured interviews among health care students and professionals in Thailand. Additional interviews with key informants, senior government bureaucrats or politicians, individuals from the non-government sector as well as individuals from and familiar with the current political, security, and social situation in the southern provinces currently experiencing significant violence and volatility, were also carried out. Although qualitative and quantitative research instruments may derive from diverging methodologies, these instruments have been used complementary in this research, investigating different aspects of the objectives as well as for triangulation to strengthen the responses rather than contradict each other.

This thesis and the research it is based on, is not trying to map the emigration trends from Thailand, but rather investigate the subjective motivations and perceptions regarding emigration from Thailand. This follows the trends from Glaser and Habers (1978:xxii), who on behalf of the United Nations' Institute for Training and Research (UNITAR) initiated research into students from developing countries who studied in developing countries and "the motivations and factors that influence the specific choices". Although this research does not investigating students studying in developed countries, it follows the tradition of investigating the motivations and the social dimensions of emigrants', or potential emigrants', motivations in the contemporary context.

It must be acknowledged that there are several significant predicaments relating to the issues of sustainable health care. As indicated earlier, the potential conflict of rights between health care professionals' right to free movement and migration versus the general population's right to adequate and affordable health care is indicative. The pursuit of rigorous health system research is of utmost importance, not only to improve health care specifically, but also regarding development generally. The target date for the MDGs is approaching rapidly, and research on how to improve health care systems to effectively and equitably improve capacity and enhance health is of utmost urgency (Task Force on Health System Research 2004). This must be pursued holistically, where the rights of all involved are considered. A human rights framework will embrace the rights of all parties, although it intuitively places highest emphasis

on the least powerful or most marginalised groups, which may relate to race, gender, ethnicity, sexuality, religion, political orientation, or professional skills and capacities.

1.2 Background: Issues and Parameters

This background section will outline the issues and parameters which need to be accounted for in order to understand the interrelationships between the crisis in human resources for health and health care challenges. Arguably, global and national shortages in human resources for health must by itself be viewed as a tremendous health care challenge, although the adversities of this are multiplied and manifold when viewed in context with other significant and detrimental health care challenges, such as the HIV/AIDS pandemic. The following sub-section defines and sets the parameters of health, health care, health workers and health care providers, as defined by the World Health Organization (WHO) and as adopted in this research. The subsequent sub-sections briefly engage and outline the issues related to the human resources for health, particularly the global shortages, the brain drain of health care professionals, while this chapter-section is rounded off with outlining the predicaments relating to rights and obligations, which in specific circumstances may be conflicting, within a rights based approach to health care, which inevitably has to account for the rights of health care professionals as well as health care consumers.

1.2.1 Health, Health Care, Health Workers and Health Care Providers

The World Health Organization's Constitution from 1946 defines health as: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 2006a). This paradigm, which encapsulates a positive definition of health, as the emphasis is on wellbeing and not the absence of disease. The WHO's commitment to a broad and inclusive approach to health was reinforced in the Alma-Alta Declaration from the WHO's international conference on primary health care which put forth the goal of "health for all". This should be pursued through primary health care, preventive measures, and not only health treatment or curative measures (WHO and UNICEF 1978). This concept of health as holistic and inclusive is also manifested in the Thai health care system; embedded in the 9th National Economic and Social Development Plan from 2002 to 2006. Here health is defined as "the state of physical, mental, social and spiritual well-being that is interrelated holistically" (cited in Wilbulpolprasert et al. 2004b:21).

When health, and hence health care, is defined in these terms, it is not limited to disease and infirmity, but rather all influences on our physical, mental and social wellbeing. This holistic and positive definition of health inevitably also challenges our perception of health care and the health care workforce. Health workers, or promoters of health, are hence not only those professionals trained and certified in medical sciences at different levels, including medical doctors and specialists; all levels of nurses; pharmacists; midwives; and dental professionals. This intuitive perception of health care workers as skilled professionals inevitably only covers a sub-category of health workers as the WHO's definition of health and health care workers includes anyone who contributes to the advancement of health, within the broad definition of health, including family members caring for a sick relative, friends and co-workers enhancing each others' mental wellbeing, as well as health care professionals providing care, and health care support workers' contribution to the health care infrastructure at health care institutions, including administrators, cleaners, and all other workers at health care institutions (WHO 2006b).

It follows from the WHO definition of health that health care would be the advancement of mental and physical wellbeing, and not only treatment of disease. However, for the purpose of this research, health care generally refers to the limited perception of preventive and curative medical treatment, and hence health care refers to medical care, or services provided by a trained health care professional. Such professional services would include consultations, examinations, and physical treatment by doctors, dentists, and nurses at private and public institutions; consultations and services by pharmacists and technical staff such as x-ray technicians; laboratory technicians, and assistants; community outreach and primary health care by community health workers, emergency services by paramedics and ambulance personnel; as well as all professionals with these backgrounds engaged in research, development, and production of treatment and medication regimes, in addition to those engaged in the education and training of new health cadres.

Health care institutions, throughout this thesis, refer to hospitals, medical and dental clinics, community health stations, and other institutions providing medical services, rather than social services or social infrastructure enhancing mental and physical wellbeing. The latter could have included recreational sports trainers and facilitators enhancing the physical stamina and wellbeing of participants, teachers at schools educating and promoting healthy lifestyles, and special interest groups promoting mental wellbeing through actively engaging members in social activities. Indeed, such institutions and individuals are important partners in the

advancement of health. However, this research has focused on a narrow perception of health, health care, health care workers, and health care providers as identified in the WHO and is limited to the investigation of health care professionals as recognised through their professional qualifications.

It should be noted that the WHO (2006b:2) acknowledge that when they refer to health workers, this generally only reflects paid health workers, who can be classified into two sub-categories; "health service providers" and "health management and support workers". In this research, the preferred characteristic or term utilised is *health care professionals*, which encompasses what otherwise is also referred to as health personnel, health workers, or human resources for health. These terms are equivalent to what the WHO classifies as "health service providers". The exclusion of "health management and support workers" as part of *health care professionals* in this research was not to undermine their importance within the health care system or their valuable contribution to the advancement of health, but a choice was made to limit the scope and reduce some of the complexities of this research.

In addition, the contributions of some health care professionals which are not part of the public sphere, including privately employed health care professionals such as nurses looking after an ill or elderly person in his or her home, are not accounted for in this research. Neither does this research investigate the role of non-paid professionals, friends, relatives, or other community members providing care and health care. This is not to diminish their contributions or the importance of their contributions in the advancement of health. Research into the role and contributions of these actors may significantly enhance our understanding and knowledge in the advancement of health; both within the Thai context and generally, and would complement and account for some of the limitations of this research.

Terminology and the different perceptions between positive and restrictive views of health, health care professionals, and promoting health can create dualities and inconsistencies. This, although valid within its own premises, does not encompass the multifaceted, multidisciplinary, multicultural, and multidimensional aspects of humanity, human needs, health care and the multitude realities with which we interpret the world. Although consistency and unambiguous definitions are needed for comparisons and the calculations of relationships, the technicalities of terminology should not be overemphasised in this case, as this research is not constructed as a comparative study and furthermore aims at enhancing our limited understanding and application of human resources for health, health care, and how health care challenges are

perceived, rather than focusing on definitions, relationships, and unfulfilled responsibilities in the lead-up to today's adverse health care challenges, both in Thailand and internationally.

1.2.2 Human Resources for Health and Sustainable Health Care

It has been argued that there is a global crisis in human resources for health with a global shortage of 4.3 million health care professionals (WHO 2006b), and although there are shortages worldwide, the effects are most adversely felt in countries with low and medium levels of human development[1] as more affluent countries are able to attract health care professionals by offering greater economic remuneration. It is this dynamic, the exodus from the countries with least financial and human resources to educate and train new professionals, together with the undesired inequitable distribution of health care professionals which constitute the crisis in human resources for health. Although some re-distribution or centralisation of highly skilled health care professionals is desired and legitimate, particularly at teaching hospitals (ibid), consistent shortages of health care professionals in countries and regions indicate trends threatening the sustainability of the respective health care systems. As such, the crisis in human resources for health is affected by the lack and migration of health care professionals; the inequitable distribution of health personnel; and the tensions between public and private health care, which all impact on the availability of human resources for health.

Human capital, the health care professionals themselves, is the backbone of any health care system. It is essential to not only have sufficient numbers of health care professionals, as it is equally essential to have a sufficient skills mix of different professionals as well as an appropriate internal distribution within different regions and sectors of the health care system. This requires a significant and continuous commitment and central planning for health, and is a central premise for sustainable health care. Sustainable development, through the premise of intergenerational sustainability, as outlined by Bruntland (1990), is defined as development which approaches current demands without jeopardising future generations' opportunities to meet their demands. In this research, the notion of sustainable health care assumes the same premises as sustainable development, that is, sustainable health care has to cater for current health care demands without jeopardising future generations' health care requirements.

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[1]The labels developed and developing countries are generally avoided due to the connotations of these dichotomous terms. Rather, the classification of Human Development, categorised into Low, Medium and High Human Development (LHD, MHD and HHD), as described by the United Nations Development Programme (UNDP) and elaborated on in the Human Development Reports and Indexes, are adopted.

A limited, or narrow minded, approach to sustainable health care would simply be to review the allocation of resources, particularly economic resources: As long as the financial allocations remain stable, or increase appropriately according to population growth or inflation, the health care system's progress is sustainable. This notion is challenged here as such an approach cannot distinguish between an underdeveloped, or a non-performing, and a well developed health care system. Another interpretation is offered here; that the standard of life and health care should be the parameters rather than the allocation of resources. This is due to the fact that resources alone cannot serve adequate health care, but relies on current health care challenges and human resources, to mention a few additional variables. Furthermore, in line with the premise of development, or progress, the goal of sustainable health care, in line with sustainable development, must be to continually pursue progress and development which does not undermine current achievements and standards as well as not compromise the prospects for future generations.

In this context, sustainable health care equates to not only ensuring that the same resources for health are allocated but rather builds on a notion of global sustainability, which arguably is a corollary of sustainable development, in the discourse of sustainable health care. A more equitable distribution of the 59 million health workers in the world could eradicate the critical shortages of health care professionals in national health care systems, as these professionals are "predominantly in richer areas where health needs are less severe" (WHO 2006b:15). There is a need for 2.4 million additional health care professionals in the 57 countries classified with critical shortage of physicians, nurses and midwives (ibid). However, the brain drain, or flow of health care professionals from LHD and MHD countries to HHD countries can be interpreted as a mechanism by which "poor developing countries … indirectly subsidizing the health-care systems of richer countries" (Ahmad 2004:797). The issue of ensuring sufficient human resources for health is complex and there is a need to ensure that legitimate shortages of health care professionals in HHD countries are addressed without jeopardizing the health care systems of LHD and MHD countries (ibid). The World Health Assembly stated in 2004 that there is a need to "establish a mechanism for compensating developing countries for the loss of health personnel through migration" (cited in Zarocostas 2004:387).

1.2.3 Brain Drain of Health Care Professionals and the HIV/AIDS Pandemic

Brain drain generally refers to the movement of skilled professionals. The term was "invented by the British" characterising the loss of skilled professionals through emigration (United States Congress House Committee on Government Operations 1967). The term does not

refer solely to the flow of skilled migrants from LHD and MHD countries to HHD countries, but is commonly applied to the flow of professionals among countries with similar levels of human development, including among industrialised countries, as well as to movements within a country, between geographical areas, sectors, and industries. The brain drain of health care professionals does not only imply the loss of professionals for the source country, but also the investment of training and educating these professionals (Adams and Stilwell 2004). An exodus of health care professionals may led further ripple effects on the source countries, as the predicted returns on this investment; namely the increased productivity of the workforce as health care professionals maintain and improve the health of the workforce as well as other community members, are lost.

Although Thailand has been presented as a case-study of how to effectively curb the HIV/AIDS pandemic (Bjorkman 2005), current evidence from sub-Saharan Africa, the continent most severely hit by the pandemic, shows that migration of health care personnel is having an adverse impact on the effort to mitigate the effects of the pandemic (Kapp 2004, Kober and Van Damme 2004; Martineau et al. 2004; Narasimhan et al. 2004; Task Force on Health System Research 2004; Zarocostas 2004). Policymakers in Mozambique, Malawi, South Africa and Swaziland no longer regard the lack of financial resources as the main concern in the fight against HIV/AIDS, but rather the lack of health professionals (Kober and Van Damme 2004). In order to combat the pandemic, policymakers have or are contemplating introducing nursing degrees, and other medical related qualifications, which are not internationally recognised in order to reduce the attractiveness of their health personnel on the international recruitment market (Andersson 2004; de Castella 2003; Kober and Van Damme 2004; Martineau et al. 2004).

1.2.4 Rights and Obligations

We are witnessing a crucial point in time, where not only the spread and growth rate of HIV/AIDS is of concern, but has been recognised and supported by international community and more importantly, is backed by international financial commitments. The irony is that the current struggle is not solely for financial resources and recognition of the severity of this challenge, but to retain professionals from leaving for greener pastures. The risk of not urgently addressing these interrelated issues of combating the pandemic and ensuring sufficient human resources for health, is not only failure in achieving the MDGs, but may constitute treason towards future generations, our fellow human beings and the neglect of basic human rights: According to Mukherjee (2004:1272):

> "AIDS care must be provided on the basis of the right to health and the right to share in the remarkable advances in AIDS medicine ...[i]n fact, the ambitious targets in the 3 by 5 initiative will be met only if a rights-based framework is undertaken".

Although the moral responsibility for ensuring adequate health care standards must also fall on the host countries who actively seek skilled professionals from countries with lower levels of human development is a valid argument, these issues cannot be viewed solely as a moral crusade for a more equitable world distribution of human and economic resources. A balance between both rights and obligations must be sought among actors, be they individual health care professionals; nation-states; health care institutions; health care providers; health care systems; manpower and recruitment agencies; as well as health care consumers. It has bee proposed by Martineau et al. (2004:7) that it may be inevitable that some flow of professionals from LHD and MHD countries to countries with higher levels of human development will take place, and in this case, the "policy debate should move on to ensuring that the needs of stakeholders in source countries are met". Furthermore, many of the contributing factors to the exodus of health care professionals are outside the influence of the health care sector (Narasimhan et al. 2004). The challenge is to approach the lack of human resources for health, both globally and in counties with LHD and MHD, equitably and recognising the rights of all actors; both the right to emigrate for health care professionals and the general population's right to medical care.

The issue of rights and obligations, in particular in relationship with the predicaments of ensuring global and local sustainable health care, will be revisited at several stages throughout this dissertation. At this stage, it should be noted that there are no singular or absolute solutions, although it is argued here that any approach will need to be holistic. Arguably, the issues of health and health care are extremely complex and interrelated with not only political and civil society, but also the environment, culture, spiritual and epistemological believes. These concepts and elusive perceptions relating to professional, inter-human and moral obligations and rights cannot be rightfully, and should not be, viewed within the limitations of this dissertation. It is recognised here that this research is limited and that further research into these areas is recommended. Although this research aims to approach the predicaments of equitable and sustainable health care through a rights based approach to health care, it is recognised that this cannot be pursued through a singular approach, and that this ambition must be reviewed, applied, and renewed for different local cultural and social setting in addition to the international arena if we are to achieve sustainable health care and health for all.

The following chapter reviews the issues of brain drain and health care challenges. The subsequent chapter engages mores specifically with the parameters and experiences in Thailand, regarding economic development and migration–particularly in the context of ensuring sustainable health care. Chapter four accounts for the research methodology and theoretical framework of this research, and presents the research instruments. The subsequent chapter engages in the contemporary political and security volatilities in Thailand, including perceptions among research participants, with the following chapter accounting for tensions and adversities in the Thai health care system as indicated by research participants. The subsequent chapter engages specifically with attitudes and perceptions among the health workforce and related to HIV/AIDS in the country, while chapter eight explores the predicaments and challenges regarding rights and obligations–in particularly the potential conflict of rights between health care professionals' individual rights and the collective rights of the Thai public to adequate and affordable health care.

The concluding chapters will return to the issues of sustainable development and sustainable health care, particularly with regards to global implications and the need for world wide sustainability through global action, cooperation and equitable policy adaptations which will expand the global workforce of health care professionals. All world regions must have sufficient human resources for health and measurements to ensure this cannot restrict the mobility of health care professionals in a fashion which will breach their fundamental right to free movement. At the same time, the right to health care, particularly for the inhabitants of the least developed world regions and the regions with the highest disease burdens, must not be undermined by scrupulous agencies recruiting health care professionals from countries with critical shortages of human resources for health and policies in more affluent countries which consciously do not train and educate sufficient professionals to met their own demands.

CHAPTER 2

Brain Drain and Health Care Challenges

"Intuitively, the indiscriminate poaching of skilled health professionals is unlikely to be a neutral phenomenon. It is potentially damaging to the effective delivery of health services in the source country, where it constitutes a huge financial loss and could have a negative impact on the economy. Indeed, the likelihood that poor developing countries may be indirectly subsidizing the health-care systems of richer countries raises ethical and moral questions" (Ahmad 2004:797).

2.0 Introduction

The literature engaged with migration, health care, development, HIV/AIDS, and human rights is extensive and an attempt to account for all aspects and views represented within these fields of study would be futile. Although most of these fields are interrelated and contributes to the background of this research, only an introduction to the topics can be offered here. While it is not possible to outline all the influential and significant views, theories, and aspects of each field, this chapter aims to create a tableau, offering a glimpse into the vast body of research and theories of these fields. The following chapter will focus on the specific parameters of Thailand and Thai health care. These two chapters, together with the subsequent methodology chapter, combine to create the vectors by which this research navigates. The following section provides a historical account of the brain drain and migration discourses; particularly related to the brain drain from countries with low and medium levels of human development. The focus then shifts to the migration of health care professionals, including the predicament caused by the exodus of health care professionals combined with adverse health care challenges, such as the HIV/AIDS pandemic.

2.1 Brain Drain

Brain drain is generally viewed as the exodus of skilled and highly skilled professionals through emigration from a particular region, sector, country, or even continent. This term was introduced by the British to describe their losses of professional manpower through emigrations, including scientists, engineers, and physicians, subsequent to World War II (Skeldon 2005; United States Congress House Committee on Government Operations 1967).

A common assumption is that brain drain refers to migration trends from areas with LHD or MHD to areas with HHD, as opportunities for both greater financial remuneration and professional development are higher in HHD countries. Contrary to this assumption, the brain drain is not a phenomenon isolated to the movement of people from countries with lower to higher levels of human development. It is found among countries within the same level of human development as well as within nations, between regions, and even among sectors or industries. For example, a study by Miller et al. (1998) investigated the trends of New Zealand and Australian physicians who migrated to the United States, which is not insignificant. The recent enlargement of the European Union, in 2004, sparked anxiety of brain drain from EU newcomers to Western European countries (Easton 2004; Lungescu 2004). This section will provide a general review and evaluation of brain drain and migration; present and evaluate dichotomous views of the brain drain, investigate how LHD and MDH countries can capitalise or benefit from the brain drain; before presenting concerns regarding brain drain from a developmental perspective.

2.1.1 Brain Drain and Migration

Migration is as old as history (Diamantides 1992; Henderson 1970; Khadria 1999; Van Rooyen 2000), and must be viewed as the result of a continuous effort of humankind to better our way of life. Although this research will not engage with labour economics and migration per se, a few reflections on the nature of migration are appropriate. Migration is generally defined as the movement of people, implying a shift in the geographical location of the migrant(s). The theoretical approach to migration began roughly a century ago when Ravenstein proposed his laws of migration (Coombs 1978-1979; Diamantides 1992; Grigg 1977). The literature and field has since been significantly elaborated, although few additional generalisations have been added subsequent to Ravenstein's hypothesises on migration (Grigg 1977; Diner 2000). Ravenstein proposed five, or possible seven, "laws of migration"; outlined in Textbox 2.1.

When evaluating motivations for migration, distinctions between circumstances at the origin and the destination are generally made by the terms *push factors* and *pull factors*, respectively. Pull factors are viewed as "perceived ameliorating circumstances offered by the country of intended destination" (Diamantides 1992:275), while push factors would be subjectively perceived circumstances at the (potential) migrants' origin. Similarly, the terms *source country* generally refers to the migrants' country of origin, while the *host* or *recipient country* refers to the country of destination. Circumstances in the source country can be

viewed as more influential in the decision making process, as knowledge of the host or destination country is inevitably less rigid and some circumstance can only be understood by actually living in this particular area (Lee 1966).It has also been argued that there are other circumstances in the source and host, or recipient, country labelled by Akl et al. (2007) as "*repel*" and "*retain*" factors, which constitutes the "attributes" in the source and host country. The distinctions between the repel and retain dimension and push and pull forces as proposed by Akl et al., however, are vague, and are clearly encompassed in the positive, negative, and neutral evaluations for circumstance at the source and recipient area which Lee (1966) utilised to characterise the evaluation of process for potential migrants.

Ravenstein's Laws of Migration

1. Most migrants travel short distances
2. Migration over longer distance are generally in stages and these travels are directed towards commercial centres
3. Where there is a migration stream there is an opposite counter-stream
4. Greater migration from rural areas than urban
5. Females are more likely to undertake short-distance migration

It is possible to deduce two more laws, which would be:

6. Technological advances (in transportation) aids migration
7. Most migration is motivated by financial betterment

Textbox 2.1: Ravenstein's Laws of Migration
Source: Lee (1966)

Brain drain in distinction from general migration refers to skilled migrants and the term in itself, although the use is inconsistent, generally carries connotations of a significant loss for the source country, region, or sector. Although brain drain is the most common term used when referring to this phenomenon, other terms, such as: the "human resource crisis" (Narasimhan et al. 2004); "emigration of highly skilled manpower" (Henderson 1970); "talent migration" (ibid) "migration of knowledge workers" (Peter Drucker, cited in Khadria 1999); or the "loss" or "flight of human capital" (Ahmad 2004), are also used. Scholars and institutions wary of the brain drain argue that an adverse brain drain can take place at different levels: From countries with LHD to countries with HHD; among countries with similar levels of human development; within regions, which generally implies a flow from rural to urban regions; and from the public to the private sectors. However, brain drain sceptics argue that there is no such thing as the brain drain, or more explicitly; that the brain drain actually is a "brain gain" (Beine et al. 2001;

Lien 2006; Mountford 1997; Stark et al. 1997; Stark 2004), or "brain circulation" (Lien 2006). By generalising the arguments and perspectives relating to this field, we can identify two distinct schools of thoughts; the *nationalist* and the *internationalist* or *cosmopolitan* (Miller et al. 1998). These dichotomous views will be reviewed in more detail in the following sub-section, although it should be noted here that this epistemological divergence between the internationalists and nationalists significantly inform the validity of the brain drain as an actual phenomenon. Brain drain can then be viewed as sub-category of migration; it simply concerns itself with migrants with high human capital and perceptions on whether this flow of skilled migrants is having a negative impact on the development of the source country, region, or sector, would be determined by the epistemological standpoint.

Another sub-category of migration with potential adverse impact on development is *chain migration*. Chain migration is generally viewed as certain patterns of migration, where migrants follow the same migration routes or destinations as previous migrants from their source country or region; or migrants with similar ethnic or socioeconomic background, and these migrants may be aided by migration agents (Shah and Indu 1999). This suggests that chain migration leads to less heterogeneity, as migrants prefer to follow previous migrants with similar characteristics as themselves. An additional characteristic of chain migration is that successful migrants often try to bring family members, friends, and acquaintances to the host country at a later stage (Adepoju 2006; Diamantides 1992). Chain migration is not a distinct characteristic of the brain drain, but rather one of the characteristics of migration in general.

However, the socioeconomic compositions of migrants, which directly relates to the brain drain, suggests that migrants with high professional skills often have spouses and other family members with high professional skills (Bhagwati 1976b; Khadria 1999), and chain and family migration may hence exacerbate the brain drain. These migrants will not only constitute a loss of human capital for the source country, but more significantly, as visa and other restrictions may impose working restrictions in the host country, constitute a net loss of human capital as they may be unable to undertake skilled employment in the host country. Indeed, skilled migration to HHD countries has led to a *brain waste* as educational backgrounds often are not fully recognised and additional barriers often lead to highly skilled professional migrants to working at a lower professional level in the host country (Bach 2003). It has also been indicated that chain migration considerably contributes to the exodus of physicians in Nigeria and Ghana, and although some migrants return, their experiences and contacts may encourage newly graduated physicians to emigrate (Hagopian et al. 2005).

Although skilled and highly skilled professionals generally have higher levels of education than unskilled labourers or professionals, the motivations to migrate can be very similar across the skill levels. As already mentioned, economic gains were determined to be single-most important factor for migrations as determined by Ravenstein (Grigg 1977; Lee 1966; Wareing 1981). However, there are other significant motivations to migrate, and some scholars question economical gains as the most significant factor for (skilled) migration (Bhagwati and Dellalfar 1976; Seers 1969); for skilled emigrants there is an emphasis on professional development (Akl et al. 2007; Lee 1966) while Van Rooyen (2000:vii) summarise "better material conditions and the avoidance of physical danger" as the universal motivation for migration. The avoidance of physical danger directly relates to another sub-category of migrants, namely refugees, whether officially recognised or not. This aspect falls outside the scope of this research. Nevertheless, avoidance of physical harm is a key motivation for migration, where, for example, a study by Rule (1994) found a consistently high correlation of emigration from South Africa with increased level of violence in the country. This corresponds with other reports finding political stability and security to constitute key components in the decision process of whether to emigrate or not (Hale 2003; Rule 1994; Van Rooyen 2000). However, the opportunity to migrate (legally) may not be the same for individuals with low professional skills as for those with higher professional skills, as is shown by the fact that most of the emigrants from South Africa are middle or high income earners (Rule 1994).

Although some scholars question the high emphasis on differences in income potential between the source and host countries, regions, or sectors, this does not lead to the conclusion that salary levels are not important factors for professionals, but rather that other, perhaps more illusive factors are significantly restraining or encouraging migration. Political instability, violence, nationalism, sense of belonging, professional development, social status, family ties, and non monetary benefits have all been determined as influential in the decision making process for migrants and potential migrants. As pointed out by Isard (cited in Coombs 1978-1979), there is a limitation to the analysis of migration in terms of cost in time, money, or energy. Diamatides (1992:275) views the individual potential migrant's evaluation of whether to migrate to also be determined by the "person's bonds with family, home territory, and in the case of international migration, mother country". These "bonds" can be considered as important factors mitigating emigration, including among health care professionals, which will be illustrated at a later stage of this research. Schloenhardt (2001), views the decision to migrate as a rational choice based on a cost-benefit evaluation of four push and pull forces;

political, demographic, socioeconomic and environmental. Accepting the proposition that the brain drain is a sub-set of migration, explicitly the movement of skilled and highly skilled professionals, the attention will now shift to the discussion of whether this phenomenon is beneficial or if it depletes development prospects for the source countries.

2.1.2 Dichotomous Views on Brain Drain

Migration is generally associated with, and in this case limited to, the movement of people; and is traditionally classified according to distance of movement; reasons for movement; period of time involved; and perhaps the volume of migrants. Brain drain theorists however, argue that it is not only the distance involved in the movement which is significant, but also the level of human capital between the source and destination country, region, or sector, in addition to the human capital of the migrants themselves. This is due to the potential adverse effects the movement of skilled professionals can impose on a relatively less developed country, region, or sector. Thus, if the migrant has a higher level of human capital than the average level of human capital in the country of origin, and the average level of human capital is relatively lower at the source than the destination country or region, a potential deteriorating brain drain is taking place. This is argued from the perspective that developing countries, or countries with LHD and MHD, need to maintain and strengthen their human capital in order to become developed countries, or countries with high levels of human development. This can be classified into the school of *nationalist* theorists, who emphasise the needs of the source country, region, or sector, to maintain their human capital. The dichotomous view would be that of the *cosmopolitan* or *internationalist* who believe that the migration of skilled and highly skilled professionals may ultimately be beneficial (Miller et al. 1998).

Theorists within the internationalist paradigm believe that a "beneficial brain drain" can take place (Beine et al. 2001); creating a "brain gain" as the limited opportunity to migrate for higher skilled professionals will encouraging higher human capital formation in the source country or region (Beine, et al. 2001; Lien 2006; Mountford 1997; Stark et al. 1997; Stark 2004). It is also argued that as these migrants will have higher levels of productivity in the destination country or region than at the source, which will lead to greater world productivity (Moses and Letnes 2004). In addition, a brain drain can be beneficial if migrants return to their country or region of origin with new skills and knowledge, creating "brain circulation" (Lien 2006). Theorists from both schools have postulated models estimating costs and benefits; formulas projecting trends; and illustrations of human capital formation. In most LHD and MHD countries, higher education and particular tertiary education is an expense individuals have to cover

themselves, sometimes in full, and is not readily available for everyone. In these circumstances, education can be viewed as an investment. Numerous models have been drafted arguing the possibility or potential opportunity to migrate increase individual will investment in education, or human capital formation (Beine et al. 2001; Mountford 1997; Stark, et al. 1997; Stark 2004). However, Wong & Yip (1999:721) argue that a brain drain "tends to hurt later generations since it lower the growth rate of human capital"; the dichotomous conclusion. They also argue that the brain drain is decreasing salary levels for unskilled workers, although it improves the salary levels for skilled workers in the source countries.

Other studies addressing the cost-benefit of free migration have looked at the total global gain. Moses & Letnes (2004) calculated a theoretical potential world gain by total liberation of immigration control to total greater than the current world's Gross Development Product, while the gain from the current level of migration accumulates to US$ 32 billion. Although these are astonishing potential economical gains, and the authors argue that the "smallest (most cautious) estimates exceed the combined current levels of development assistance and foreign direct investment to the developing world" (ibid:1620), we should ask ourselves who capitalises on these gains, and more importantly for the purposes of this research, the relevance and transferability of these estimates, particularly when referring to migration of health care professionals. The economical gains for employers of illegal migrants in Thailand could be as much as US$ 300 million per year (Chalamwong 2001), although most of these benefits will not reach the source countries of these illegal migrants, but rather the illegal traffickers and the employers of these illegal migrants. If the economic gains outlined by Moses & Letnes mainly benefit the employers, particularly major employers such as larger multinational companies, it is questionable if these economical gains will lead to development or rather increase the development gap between HHD countries versus LHD and MHD countries.

Governments across the word, particularly those who are loosing their skilled workers, are gravely concerned about the possible adverse effects of the brain drain. Arguments centre on the potential deterioration of economic growth, education, income distribution, and welfare, which directly relates to the fact that the brain drain is viewed as the loss of human capital for the source country (Wong and Yip 1999). Although academics from the international or cosmopolitan field accounts for several limitations to their theories, for example that they rely on theoretical or constructed heterogeneity or homogeneity, there seems to be an epistemological divergence between these theorists and those from the nationalist paradigm.

Lien, (2004) critiques the premises of Beine et al. (2001) who concluded that the brain drain will encourage and lead to higher levels of investment in education. Lien and Wang however, "comes to the opposite conclusion when human capital transferability and budget constraint are taken into account" (cited in Lien, 2004:1).

Wong and Yip (1999:719) can also be classified as nationalistic as they concluded that "an outflow of a finite number of skilled workers will hurt those left behind", based on "an endogenous growth model of overlapping generations to analyse the effects of the brain drain on growth, education, income distribution and welfare" (ibid:700). Although the different perceptions of whether the brain drain is beneficial to development is likely to persist, both schools of thought are perceptive to the prospect that a mass exodus of skilled professionals from the least developed countries can have a negative impact for these countries. For example, reservations are made by Beine et al (2001:288) in their argument for a beneficial brain drain, as this can occur if the "economy is originally closed to an underdevelopment trap and that migration probabilities are not too high". It becomes clear that skilled migration may have particular adverse effects when it involves the emigration of professionals from the least developed countries.

2.1.3 Capitalising on the Brain Drain

The loss of highly skilled professionals imply a loss of both investment into human capital and loss of income for the source countries, either from lost tax revenues or potential gains from economical development. An approach to mitigate the negative effects of skilled migration, which to some degree recognises the potential development trap caused by a continuous exodus of skilled and highly skilled professionals from countries with lower human development to countries with higher human development, was proposed by Bhagwati through a paper in Daedalus in 1972 (Bhagwati 1976b). The proposition was to levy surtax on migrants for a period of up to ten years (ibid) and was developed further by a series of articles edited by Bhagwati and Partington (1976) and Bhagwati (1976a). These articles were motivated by a desire to make individuals who managed to break through migration barriers to "contribute to those in other parts of the less developed world who were unable to manage such an entry" (Mendlovitz 1976:xii).

This surtax was estimated to exceed $62 million in tax revenue among immigrants in the United States for 1969, equivalent to more than ten percent of the annual foreign development aid from the USA (Bhagwati and Dellalfar 1976). However, recalculations of this estimate

suggested that this could be four times as high as originally thought (Bhagwati and Pelcovits 1976). A similar calculation of the revenue from this surtax among immigrants in Canadian for 1972 exceeded $38 million (DeVoretz and Maki 1976). A more differentiated calculation estimated the revenue among immigrants from the New Commonwealth into the United Kingdom to be £6.2 million net, with an additional £2.2 million gross from professional immigrants from other Low Developed Countries (Balacs and Gordon 1976). The cost of collecting this tax was estimated to be "1.71 percent of the total revenue receipts" for the UK (Partington 1976:151). Although the theoretical gains by migration should be carefully evaluated, it is acknowledged that migrants as a group are increasingly of economic significance and importance. The pursuit of redistributing some of the economical gains of migrants and skilled migrants can be said to take place without governmental encouragement or involvement; namely through remittances. Remittances from migrants have become vital cash supplements for the migrants' family, and a significant source of foreign capital for numerous source countries (Amuedo-Dorantes and Pozo 2004).

Remittances are generally defined as a contractual or voluntary amount of the migrants' income which is sent back to the home country (Poirine 1997; Vanwey 2004). They can be cash supplements for family members; constitute repayments of the migrants' loans; go towards investments made on behalf of the migrants; and sometimes non-monetary gifts are included in calculations of remittances. As such, remittances are very broadly defined, there are no distinction between the migrants' skill level, and they do not necessarily contribute to the development of the migrants' source country; rather it leads to increased consumption and investments by recipients (Poirine 1997). Although both the nature and effects of remittances are disputed, it is generally acknowledged that remittances are one of the important gains from migration (Adams and Page 2005; Amuedo-Dorantes and Pozo 2004; Henderson 1970; Khadria 1999; Russell 1986). Clearly, remittances can, and do, take place within a county as a result of domestic migration, particularly in countries with large rural to urban migration, although there is no consensus, in contrast to the case of international remittances, on the value or effect of remittances within an economy (Russell 1986).

Estimates on worker remittances are carried out by the International Monetary Fund (IMF). These constitute significant figures. For example, remittances to Thailand in 2005 were estimated to be valued at US $ 1.2 billion, which actually was a decrease from previous years. Contextualising the significance of remittances; remittances for Thailand in 2005 constituted 0.68 percent of the national Gross Domestic Product (GDP), while for 2004; remittances

constituted a larger sum than foreign direct investments (World Bank Group n.d.). According to the UN, more than 175 million people were working in a foreign host country at the beginning of this century and the World Bank estimated that total world remittances is double that of foreign aid (Koechlin and Leon 2007). In light of the current and past flows of remittances from migrants, it may not be necessary to impose surtax on immigrants in order to ensure a capital flow from migrants in HHD countries to their source countries. Indeed, the researchers who investigated the potential magnitude of this surtax for Canada acknowledged that the surtax may reduce remittances, although the justification for the surtax was "compensation for the loss imposed by the emigrant on those left behind or alternatively as a method of earning, for a poor country" and is similar to a tax levied by the Soviet Union on emigrants as "compensation for the Soviet investment in educating the emigrants" (Bhagwati and Dellalfar 1976:45). The arguments are that the government and public sector of the source countries should be compensated or benefit from skilled emigration.

The Philippines, however, explored the formalisation of remittances as a criterion to have passports reviewed through an executive order signed by President Marcos in December 1982 (Russell 1986). There is still discussion relating to how LHD and MHD countries can capitalise or restrain migration of skilled professionals, although it should be noted that while capital flows are already be in place between emigrants and the source country, these may not benefit the public sector, but rather the migrants' families. If it is argued that some form of compensation to the public sector for the loss of professionals and investment in education should be levied, there is a case for a similar form of compensation if professionals leave the public service to work in the private sector. This might actually be more achievable, as this only will require a single national governments' intervention, rather than rely on bilateral or multilateral agreements.

2.1.4 Brain Drain from a Developmental Perspective

There has been a rising and continuous awareness and concern regarding the emigration of skilled professionals from LHD and MHD countries to HHD countries by the UN (Henderson 1970). The concern is, independent of total gains from free labour liberalisation and migration, that developing countries do not have sufficient numbers of skilled manpower, and that these countries need to retain their skilled workforce in order to develop and not fall into an underdevelopment-trap. Migrants from LHD and MHD countries to countries with HHD are required to have high human capital in order to successfully migrate (legally). This directly relates to the entry requirements for migrants to countries with HHD, where western countries

in order to stem an influx of unskilled migrants are increasingly tightening entry criteria. Skilled migrants with high levels of human capital may add value to the country they enter, and are therefore usually welcomed, if not actively recruited, while unskilled migrants are viewed as resource draining; particularly for countries with generous welfare benefits.

It has also been noted that although the volume of migrants globally probably is less than during the 1890-1914 period, and definitely as a proportion of the global population, the numbers of skilled migrants are continuously growing (Henderson 1970). It is doubtful that the desire to migrate is decreasing among unskilled individuals while increasing among skilled professionals, but that this trend reflects a shift in migration opportunities. As migration is shaped by national immigration policies, which emphasise control rather than freedom (ibid), the brain drain can be said to be a direct result of richer countries restrictive immigration policies. Clearly, every country has the right to limit and control their in-migration (Phongpaichit 1999), although the question of utmost importance for LHD and MHD countries is how to negotiate an equitable migration policy with HHD countries as there is a general consensus that no country can outlaw emigration.

Advocates for developing countries' need to retain their human capital view the emigration of skilled professionals from these countries as one of the most dominant challenges to development. The basic premise is that in order to develop, countries with LHD and MHD need to retain their human capital, as this is essential for further development. The United States Congress House Committee on Government Operations (1967:8) recognised four decades ago that:

> "The loss of even a few exceptional individuals in a poor country can mean an important development venture not undertaken, the denial of high-quality instruction and training for the future leaders of development, and the diminution of the energy, drive and vision without which there is no development."

More adversely, the brain drain from LHD and MHD countries to HHD countries can further widen the gulf between the developing and developed countries, as highly skilled migrants contribute to the research and development in their host country. It was found during the 1960s that scientists and engineers from developing countries in the USA where not only partaking in research and development, but were proportionately more active than their American counterpart (ibid). Research towards the end of the millennium confirmed that the brain drain from LHD and MHD countries has directly enhanced the knowledge-based developments in HHD countries (Khadria 1999). Perhaps the end of the Cold War, the

advances in information technology combined with globalisation, and the closing of the millennium catalysed what can be viewed as a revived international effort for a more equitable global distribution of human development.

During the past few decades we have witnessed an increased effort and commitment by the international community for global human development where international conventions and commitments have been followed by action and positive results. This is not to undermine the immense challenges which remain to achieve equitable global human development, but rather to acknowledge the positive international commitment to development. Most dominantly, the MDGs and the increased commitment by HHD countries and the international community towards achieving these, has led to positive steps towards the realisation of some of these benchmarks for development. A fuller review of the MDGs, in particular health related MDGs, follows in the next section, including an outline of these goals in Textbox 2.2. The paradox of some of these positive achievements towards a more equitable global human development is that they are generally funded by Western or HHD countries, sometimes relying in full on professional expatriates from these countries and displacing development efforts, commitments and funding. This includes challenges induced by the lack of health care professionals, through a brain drain from countries with low levels to countries with higher levels of human development.

2.2 Brain Drain of Health Care Professionals

The migration on health care professionals, particularly physicians and nurses, has been given much attention during the past half century, particularly after the inauguration of the MDGs at the turn of the century (Adams and Stilwell 2004; Ahmad 2004; Akl et al. 2007; Awofeso n.d.; Bach 2003; Bach 2004; Buchan and Sochalski 2004; Bundred and Levitt 2000; Chen et al. 2004; Connell et al. 2007; Diallo 2004; Egger and Adams 1999; Hagopian et al. 2005; Henderson 1970; Martineau et al. 2004; Mejia et al. 1976; Mejia 1978; Nullis-Kapp 2005; Ojo 1990; Pond and McPake 2006; Saravia and Miranda 2004; Stilwell et al. 2004). There is recognition that a mass exodus of health workers may have a negative impact on the health care system in the source countries. This assumption falls into the nationalist paradigm and follows the line of argument by the field of developmental studies which emphasises the need for countries with LHD and MHD to maintain their skilled professionals. More significantly, the health care systems ultimately maintain the health of the workforce in their

respective countries, and as such, the country's stock of human capital. As such, a mass exodus of health care professionals can cause detrimental ripple effects for development.

2.2.1 Health Challenges and Development

The MDGs, together with the United Nations Development Programme's (UNDP) Human Development Reports are perhaps the most important benchmarks for development. The MDGs strongly link development with combating health challenges, as four of the eight MDGs relates to health for the poor (Wyss 2004), and the remaining MDGs can be linked with promoting health or ensuring health care. The MDGs are outlined in Textbox 2.2. The eradication of extreme poverty and hunger will have positive effects on health as extreme poverty and hunger leads to poor nutrition and detrimental health effects. Universal primary education can improve health as knowledge will enhance individuals' ability to look after their health and the health of family members and friends. As women are the main providers of care, achieving gender equality and empowerment of women can effectively improve health, particularly when combined with primary health care, maternal health and child health programmes with the education of women. Child mortality, maternal health and diseases such as HIV/AIDS and malaria are measurements of health and the MDG of ensuring environmental sustainability includes ensuring safe drinking water and improving the lives of slum dwellers, which also directly contribute to improved health. As the MDGs clearly relates to health, managing health care challenges becomes an integrated part of development.

The adversities induced by the HIV/AIDS pandemic are manifold. Firstly, as HIV/AIDS affect people in their most productive working years (Armstrong 1995), which leads to additional adversities for development as the loss of workers ultimately has a negative impact on economic productivity and development. When facing large scale health challenges such as the HIV/AIDS pandemic, the ripple effects and loss for society and development can become enormous. This has already been demonstrated in numerous sub-Saharan African countries where teenagers, kids, or grandparents have become primary care givers to AIDS patients in addition to being the main bread winners (Kober and Van Damme 2004). The numbers of AIDS orphans, independent of the definition of what AIDS orphans are, have on an international scale become a critical challenge. The detrimental effects of the pandemic are not isolated to the loss of the infected individuals and their contribution to development and economic activity, but in the cases where children and teenagers are required to look after themselves and often an infected parent HIV/AIDS leads to a loss of investment and the opportunity for education.

United Nations' Millennium Development Goals

- Eradication of extreme poverty and hunger

- Universal primary education

- Gender equality and powering women

- Reducing child mortality

- Improving maternal health

- Combating HIV/AIDS, malaria and other diseases

- Environmental sustainability

- Global partnership for development

Textbox 2.2: United Nations Millennium Development Goals
Source: United Nations Development Programme (2002)

The *3 by 5* initiative spearheaded by the United Nations Joint Taskforce against HIV/AIDS (UNAIDS) set the goal of treating 3 million with ARV treatment by 2005. This project was launched on the World AIDS day, December 1, 2003. Although *3 by 5* fell short of its target, 1.3 million people in low and middle income countries had received ARVs in December 2005, and every world region experienced an escalation in the distribution of ARVs, encouraging a move towards universal access to treatment by 2010 (WHO and UNAIDS 2006). At the same time there are:

> "Obstacles to scaling up HIV treatment and prevention … [which] include poorly harmonized partnerships; constraints on the procurement and supply of drugs, diagnostic s (sic) and other commodities; strained human resources capac ity (sic) and other critical weaknesses in health systems; difficulties in ensuring equitable access; and lack of standardized systems for the management of programmes and monitoring progress" (ibid).

Hence, significant challenges remain, and the goal of universal access to ARVs by 2010 will require a continued commitment from both the international community and local governments. More importantly, which this thesis highlights, the lack of human recourses for health and distribution of health care professionals, will be a major challenge in the combating the pandemic and provide treatment for individuals with HIV/AIDS, as well as combating other health challenges.

It should be noted at this stage that statistics related to development, including statistics from international development agencies such as UNDP and UNAIDS are at best estimates and care should be taken when referring to these. This should not be interpreted as a de-

legitimatisation of these figures, including figures frequently cited throughout this thesis, but rather to highlight the complexities of the processes through which these figures are reached. Claes Johansson, who is a statistician with UNDP and workers with the Human Development Reports, acknowledge that there are huge limitations to the statistics (Nikolaisen 2007). There are several reasons for the lack and limitations of data from the poorest countries in the world. Furthermore, advances in UNAIDS' methodology in 2007 as well as increased access saw a revamp of estimates with worldwide estimates of people living with HIV being reduced by 16 percent to 33.2 million from 39.5 million for 2006 to 2007, mainly due to reduction in estimates of HIV/AIDS cases in Angola, India, Kenya, Mozambique, Nigeria and Zimbabwe; were the reduction in these countries constituted 70 percent of the global reductions from 2006 to 2007 (UNAIDS and WHO 2007).

2.2.2 The Global Stock, Distribution, and Lack of Health Workers

As noted by Skeldon (2005), the migration of health workers has been identified as one of the distinct strands of research into the brain drain. Health workers, as defined by the WHO, "are all people primarily engaged in actions with the primary intent of enhancing health" and includes volunteers, family care givers, and community workers, in addition to recognised and specially trained health care professionals (WHO 2006b:xvi). Furthermore, the definition distinguishes between two main groups of health workers; health service providers and health management and support workers. However, as has been observed in numerous research the definitions of a health worker, health service provider, or health care professional, are not consistent across countries and regions, and therefore most data obtained must be viewed as incomplete estimates, and care should be taken when reviewing and comparing these figures (WHO 2006b; Poz et al. 2006).

The predicament relating to the migration of health care professionals is directly linked to the global deficit of skilled health care professionals and that these professionals are migrating from the regions with the lowest densities of health care professionals. Currently, there are 59.22 million paid full-time health workers globally, where 49.47 million or 67 percent are what the WHO refers to as health service providers. The remaining 19.75 million health workers or 33 percent are labelled as health management and support workers. However, it is estimated by the WHO that there is a global deficit of more than 2.3 million medical doctors, nurses, and midwives to address the lack of health personnel in countries with critical shortages of health care professionals. Further calculations, including estimates of health support workers and other health care professionals, suggests the global deficit is approaching 4.3 million health

workers (WHO 2006b). Although these figures suggest a critical shortage of health workers with an urgent need to increase the stock of health workers by more than 7 percent, globally, these numbers might actually be significantly underestimates. This is not based on the global stock, but rather the inequitable distribution of health workers, which is likely to continue to become even more adverse.

The estimates by WHO are based on the assumption that western countries do not require additional health care professionals. However, many HHD countries are revamping their health care system, anticipating an aging population which will require increasingly labour-demanding care and health care. For example, Norway, with a current population of less than 5 million, anticipates a need of 100,000 to 130,000 health workers in the near future (Solvang 2007). The new health plan for the UK requires 10,000 additional physician (Martineau et al. 2004), while the National Health Scheme of England sought additional 20,000 nurses by 2004 compared to 2000, and 35,000 additional nurses by 2005 compared to 2001 (Wibulpolprasert et al. 2004a). The revamp and expansion of the health care systems in these HHD countries should be viewed as indicative of the changes in the health care systems of countries with HHD. A similar expansion of health systems in other HHD countries is probable. It is not anticipated that these richer countries will actually train or retrain the full number of required health care professionals, but rather rely on recruiting health care professionals from less affluent countries. It is of utmost importance to introduce practices that will ensure equitable distributions of health care professionals, which does not only consist of voluntary guidelines emphasising modesty when recruiting health care professionals from countries with LHD.

The proposal for the expansion of the Norwegian health care system opens the possibility of training some of these new health care professionals in developing countries. Although opposition parties and professional unions highly oppose this proposal (Bakken 2007), it is probable that the flow of health care professionals from LHD and MHD countries to HHD countries will continue. The WHO estimates outlining the global shortages of health workers are based on shortages in 57 countries, generally with LHD and MHD, and does not take into account the 135 other countries' future need for health workers; as their needs are not critical for maintaining health in their territories (WHO 2006b). As HHD generally offers higher salaries than these countries can without intergovernmental intervention, HHD countries will continue to attract health workers from poorer countries. The global shortage of 4.3 million health workers does not take into account the continued global pull to HHD countries. As such even if the training of these professionals were carried out, there are no guarantee that these

professionals will (continue to) work in the regions and countries which the most critical shortages of human resources for health.

Table 2.1 outlines the global disease burdens for the respective WHO regions, as well as the number and density of health workers and estimated numbers of additional doctors, nurses and midwives required; both in real terms and percentage, in countries with critical shortage of health workers. If health care professionals in LHD and MHD countries chose not to work in the health sector or are migrating to HHD countries in need of health worker, and if this is indicative of future trends, it will not suffice to train the 4.3 million health workers currently needed.

WHO Region	Percentage of Global Disease Burden	Total health workforce (number)	Density (per 1000 population)	In Countries with Shortages	
				Estimated critical shortage of doctors, nurses and midwives	Percent increase required
Africa	24[a]	1,640,000[a]	2.3[a]	817,992[a]	139[a]
Americas	10[a]	21,740,00[a]	24.8[a]	37,886[a]	40[a]
South-East Asia	29[b]	7,040,000[a]	4.3[a]	1,164,001[a]	50[a]
Europe	10[b]	16,630,000[a]	18.9[a]	N/A[a]	N/A[a]
Eastern Mediterranean	9[b]	2,100,000[a]	4.0[a]	306,031[a]	98[a]
Western Pacific	18[b]	10,070,000[a]	5.8[a]	32,560[a]	119[a]
World	100	59,220,000[a]	9.3[a]	2,358,470[a]	70[a]

Table 2.1: Health Workforce and Disease Burdon according to WHO Regions
Sources: [a]WHO (2006b) and [b]WHO (2003)

The global shortage of health care professionals and HHD countries' current and future need for these professionals enable individuals with these traits to migrate more easily and readily. There is, however, high international acknowledgement of the importance for LHD and MHD countries to maintain their stock of health care professionals, particularly in light of current health challenges and international commitment to surmount these. Strong advocacy for ethical recruitment of health care professionals from countries with LHD and MHD, combined with political pressure, has led to greater vigilance when employing health workers from these countries. For example, the International Confederation of Midwives and International Council of Nurses have adopted ethical recruitment codes (Wibulpolprasert et al. 2004a) and the Commonwealth adopted a non-biding code of practise for ethical recruitments from member countries (Ahmad 2004). However, a survey among internationally recruited nurses in London indicated that two-thirds had been recruited through migration agencies (Buchan et al. 2006) and little effort has been taken to stem individual professionals who migrate on their own merit as this generally is viewed as a violation of these professionals' basic human rights (Wong and Yip 1999).

2.2.3 Mitigating the Brain Drain of Health Care Professionals

There have been numerous attempts to restrain and reverse the brain drain of health care professionals. Most drastic are the measures of educating professionals not internationally recognised. Malawi is flirting with the thought of "under-training" nurses, so that they will not be attractive on the European or Western market (Andersson 2004) and several other African countries are contemplating introducing degrees equivalent to lower trained nurses or clinical officers. However, in Uganda and Zimbabwe such attempts have been met with resistance from associations viewing these steps as threats to professionalism and international competitiveness (Kober and Van Damme 2004). The World Health Assembly in 2004 tried to approach the combined effects of the brain drain and the HIV/AIDS pandemic with an initial text urging for the need to "establish a mechanism for compensation developing countries for the loss of health personnel through migration", although the adopted texts was a compromise calling "for the development of strategies to mitigate the adverse effects of the "brain drain" of health personnel on national health systems" (Zarocostas 2004:387).

Ahmad (2004) proposed systematic strategies, at different levels, to mitigate the brain drain of health workers and acknowledged that there is no "inexpensive" way for LHD and MHD countries to retain their skilled professionals and mitigate the flow of professionals from these countries to richer countries which are able to offer higher salaries. It is explicitly stated that developing countries should not train "substandard health professionals," but include determining the motivations for migration; liaison with local and rural communities in student selection; and improving working conditions (see Textbox 2.3 for a summary of the proposed strategies for LHD and MHD countries). Ahmad also suggests bilateral agreements to control the flow of professionals. Among the suggested strategies for developed countries is to train more health professionals; adopt ethical guidelines for recruitment; and offer economic compensation to source countries (see Textbox 2.4 for a summary of the proposed strategies for HHD countries).

Strategies for LHD and MHD countries to Mitigate Brain Drain

- Restructure training programmes–not produce substandard health professionals but attempt to respond to national needs

- Engaging local and rural communities in selecting students and scholarship candidates for health institutions

- Rather than importing foreign health workers, utilise these resources for incentives to work in rural areas

- Improve working conditions for health workers

- Pursue scientific and technological research

- Bilateral agreements with host countries to control and receive compensation for the loss of health workers through migration

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Textbox 2.3: National strategies for LHD and MHD countries to **stem brain drain of health care professionals** as proposed by Ahmad (2004)

Although the proposed strategies for stemming the brain drain of health care professionals by Ahmad are not unique, and have been used with limited success, for example in Thailand where quotas for medicine students from rural areas have been trialled (Wibulpolprasert 1999) the suggestions by Ahmad aims at approaching the predicaments for both the source and host countries. At the same time the need for international regulations and cooperation to monitor and offer guidelines is recognised. At an international level, Ahmad include the need to identify source countries which should not be subjected to recruitment of health workers, safeguard rights of the individual health workers, and set guidelines for the appropriate levels of compensation to the source countries. As such, Ahmad has offered a set of strategies for approaching and stemming the brain drain of health workers, several echoed elsewhere including present procedures for recruiting health care professionals.

It is generally recognised that individual health care professionals have the right to migrate, independent of the density of health workers in the source country. As long as health care professionals, even those from countries with significant shortages of human resources for health, migrate independently of recruitment agencies, this is a personal and individual choice which should not be restricted by external forces as the right to migrate is viewed as a basic human right. As such, there are limitations to the extent in which the international community or bilateral agreements can be utilised to limit these migrants. In light of the vast health care challenges facing many of the LHD and MHD countries combined with scares human

resources for health, there is an urgent need to retain, train, and monitor the health workforce in these countries. In addition, measures to actively stem, or hinder, the emigration of health care professionals from LHD and MHD countries cannot only be pursued through measures to restrict the organised recruitment of health care professionals to work in HHD countries through agencies, but must include measures which encourage health care professionals to work in the source country.

Textbox 2.4: National strategies for HHD countries to stem brain drain of health care professionals

> **Strategies for HHD countries to Mitigate Brain Drain**
>
> - Train more health care professionals
> - Develop and implement ethical code of conduct for recruitment of health care professionals
> - Limit recruitment from countries with clear shortages
> - Use non-extendable visas
> - Compensate source countries of the health care professionals
> - Facilitate for re-entry into the workforce in the host country after a period of work in the source country for skilled professionals

as proposed by Ahmad (2004)

2.3 Chapter Summary

This chapter has provided a general introduction to the nature, views, and arguments related to skilled migration generally and the brain drain of health care professionals in particular. This account has included the dichotomous views of the *nationalists* and *internationalists* on brain drain; past and present approaches to capitalise on skilled migration; and an investigation of the brain drain from a developmental perspective. It is clear that the various approaches and views relating to skilled migration relies on the epistemological foundation of the arguments, which ultimately will determine if the brain drain is a threat to development or a potential for development. However, there seems to be high recognition that for the least developed countries, a mass exodus of highly skilled professionals can have negative effects. The brain drain of health care professionals, in particular, may have adverse effects, as a result of the interrelationship between health, health care, and development; the global shortage of health workers; and the impact of the shortages of human resources for health on health care challenges such as the HIV/AIDS pandemic. Although several well founded proposals to mitigate the effects of the exodus of health workers have been put forth, there are significant

challenges which need to be overcome in order to progress. It is also necessary to account for and capitalise on local, cultural, and national dynamics for each individual health care system to implement the most appropriate and effective measures to stem and mitigate adverse brain drain of health care professionals.

CHAPTER 3

Economic Development, Migration, and Sustainable Health Care

"Good health is the foundation of human welfare and productivity. Hence a broad-based health policy is essential for sustainable development. In the developing world, the critical problems of ill health are closely related to environmental conditions and development problems" (Brundtland 1990:153).

3.0 Introduction

This chapter will provide a brief background account of Thailand's economic development before immersing into the complexities of sustainable health care through the parameters of human resources for health and health care challenges. Although the economic development of Thailand is tangential to health and health care, general economic trends, attitudes and perceptions regarding migration, and the commercialisation of health care inevitably relate to the sustainability of the health care sector as it drives the movement of human resources for health through migration. These factors also influence the internal mechanisms of the health care system and the dynamics between private and public health care. The following section will provide a brief, contemporary background of the economic development in Thailand as well as the general migration trends and among Thai health care professionals. As sufficient human resources for health are a precondition for sustainable health care, a review of these professionals is appropriate. This is followed by an introduction to the Thai health care infrastructure, while the subsequent section will explicitly review the parameters of human resources for health in Thailand. This is followed by a section which reviews some of the contemporary health care challenges.

3.1 Thai Economic Development and General Migration Trends

It could be argued that it would suffice to present Thailand as a medium sized economy without reviewing other aspects of the nation's economic development. However, health care professionals are generally viewed as economic migrants, seeking better economical remuneration and a higher standard of living overseas, as is the case for migrants generally. This, as illustrated in the previous chapter, is an oversimplification, although economic and

socio-economic factors are significantly influencing potential migrants, including health care professionals. As such, the economic development and general migration trends within and from Thailand become key indicators for understanding the movement of health care professionals, including whether the assumption that personal economical gain is the main driving force for health care professionals contemplating migration. The following sub-section will account for the recent economic development of Thailand, while the subsequent sub-section will review general migration trends, followed a sub-section reviewing the social and political influences and perceived volatilities, which may contribute significantly to individuals' migration ambitions.

3.1.1 Recent Economic Development

Thailand has experienced strong economic growth and has until just recently, in spite of political turbulence, experienced economic stability and continued economic growth[2]. Thailand experienced a rapid economic and socio-economic development from the 1960's. This was predominantly due to a shift from agricultural to manufacturing industries, although the majority of Thais still work in the agricultural sector (McCargo 1997). The Thai economy has had a remarkable growth up to the Asian Financial Crisis in 1997, with more than 4 percent annual growth from the 1950's, and an average of 7.4 percent annual growth from 1971 to 1993, which by 1995 was matching the Chinese growth of more than doubling the output in a decade (Van Praagh 1996). However, the financial crisis of 1997 saw the stock markets of Thailand, Malaysia and Indonesia lose a quarter of their value in the first nine months of that year (Goldstein 2003). Thailand, in comparison with for example Malaysia, faced the financial crisis by decisive action as Thailand sought a US$16 billion loan from the IMF. In return, Thailand promised to "close dozens of indebted banks, raise taxes, cut government deficits, and lower economic growth rates by more than half" (ibid:363).

The 1997 financial crisis had significant impact on the health care sector and the availability of human resources for health in Thailand. This will be reviewed in further detail in a later section of this chapter, although it should be noted that macro economics have a significant impact on the health care sector. There are two main, and interrelated, dynamics: Firstly, economic growth and progression leads to greater consumption power, generally higher private

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[2]Although the military appointed government, after the coup in 2006, has been criticised as not being as liberal or predicable with regards to marked liberalisation for foreign investors as the ousted government lead by Thaksin Shinawatra, which they argued was necessary to both reverse and stem corrupt and inequitable management by the ousted government. However, the economic growth of the country has not been adversely effected compared with larger world economy or comparable nations.

consumption. In relation to health care, the consumption of private health care services can be said to increase if the economy is growing. The opposite can be said for a recession. Secondly, within the market structures internally, economic growth in Thailand and the Southeast and East Asian countries has over the last few decades led to a high degree of migration flows internally in Thailand as well as within the region and to other countries with high labour demands, such as the oil-rich Middle Eastern countries.

Economic labour migration in and from Thailand has been significant, and has followed the greater economic trends of the country. Although these migrants are historically unskilled or semi-skilled migrants, in particular internal migrants, these flows relate to the economic development of the country and influence the opportunities and migration patterns of the skilled and highly skilled. Internal labour migration is to a large extent the backbone of Thai industry, which now includes highly technical products such as electronics, machines and automobiles, in addition to the more traditional export sectors such as agriculture products and textiles. Thailand is the world's largest exporter of maize and sugar (Hirsch 1990) as well as a main rice exporter. The economic progress of the country has led to a booming construction industry in the country, as well as a new form of migrants. Not only cheap construction labourers are now leaving Thailand for work in Southeast and East Asia and the Middle East, but also highly skilled engineers, managers, and support workers.

Thailand in the twenty-first century has again experienced remarkable economic growth. Although the calamities of the 1997 Asian Financial Crisis may be lurking in the background and warrant caution, particularly in the current climate of volatility in world financial and credit markets due to the U.S. sub-prime financing worries, the Thai economy is not particularly vulnerable. Thai exports have diversified and less competitive businesses are holding a decreased market share, and the vulnerability of exposure or trickle down effect from the U.S. market is decreased as the U.S. share of Thai exports in the first nine months of 2007 was 12.9 percent compared to 20 percent 3 years earlier (Deboonme 2007). However, continued political volatility and the worsening of global financial and economic prospects after the realisation of the severity of global credit markets is beginning to affect Thailand's credit rating with a prospect of a rating downgrade (Polkuamdeen 2008).

A concern for the Thai economy in the current global financial market, particularly for independent merchants, as is probably the case world wide, is the rise in petrol prices, which is likely to trickle down and led to a general price increase. Such price increases have the potential to adversely affect the general Thai population, indicating that the economic growth

Thailand has and is experiencing is not necessarily benefiting the whole Thai population. For example, the State Railway of Thailand is anticipating a 120 million bath loss due to the increase in diesel oil. This price hike has not been passed on to consumers as there is a promise of not increasing fares. However, food prices have increased due to increased transportation costs, creating a shift in shopping habits from supermarkets to fresh markets due to the lower cost of at the latter (The Nation 2007d). There is also evidence that farmers are backtracking and abandoning the mechanical innovations in domestic agriculture, as they return to the use of buffalos for cultivation rather than diesel based machinery (Hinkoen 2008).

3.1.2 Labour Migration

"Thailand has a long history of labour emigration" (Sussangkarn, 1995, cited in Hugo 1999:191) and is a regional migration hub, with both large numbers of immigrants and emigrants. Each year one million migrate within the East Asian region (Jones and Findlay 1998). Reviewing estimates for 1998, Thailand is a net exporter of legal migrants, but when including estimates for undocumented migrants, Thailand is a net importer. Almost 200,000 Thais migrated legally, and an additional estimated 50,000 Thais emigrated illegally in 1998. At the same time more than 170,000 legal migrants came to Thailand, while it was estimated that close to one million illegal immigrants were in the country (Chalamwong 2001). Migration is often associated with opportunities and the prospect of betterment and as such, temporary and semi-permanent migrations have become a norm, and sometimes encouraged path for Thai youth, particularly from rural areas. Migration from rural to urban areas has become a key aspect of the migration patterns in Asia and the Asia-Pacific region (Schloenhardt 2001; Wong 1999).

Migrants and returned migrants are often given high social status in Thailand. Not necessarily due to the fact that they have migrated, but explicitly as a result of remittances they send back or bring home with them, as this is considered to comply with cultural norms of bettering and providing for their family and relatives. These funds are generally spent on consumer artefacts, such as electronics, transportations vehicles, as well as basic infrastructure. In 1999, remittances from Thai nationals working abroad equated to almost US$1.5 billion, ranking Thailand as the tenth highest developing country according to the value of remittances in absolute terms, although as percent of GDP Thailand would rank eighteenth out of the twenty highest ranked countries (Saravia and Miranda 2004). Remittances from nationals working overseas constituted for 1999 1.1 percent of GDP, indicating that remittances constitute a significant part of the Thai economy, although remittances are not as dominant as

in for example The Philippines, ranked 2nd in absolute terms of remittances, where more than US$7 billion, or 8.9 percent of GDP, were remitted for 1999. For comparison purposes, it should be noted that the estimated population for Thailand in 1999 was 60.0 million while the Philippines' population was estimated to be 74.2 million (UNDP 2001).

The actual amounts of remittances are difficult to estimate due to most migrants preferring to bring cash or send cash with trusted acquaintances rather than utilise official channels, which leads to high understatements and underestimates of actual transfers. Remittances from internal migrants are even more difficult to estimate and trace than remittances from overseas migrants, and are vital cash infusions to the household budgets for many Thai families in rural areas. In particular, rural-urban migration patters can also be traced according to the agricultural seasons, where rural youth may seek employment in the manufacturing industry in the outside the labour-intensive harvest and sowing seasons. A survey conducted in 1992 estimates a "12% difference (approximately 1 million) between the dry-season and wet-season population of Bangkok" (Jones and Pardthaisong 2000). However, not all migrants are able to earn and save sufficient capital to migrate, and this may become a family investment where the savings of several family members are combined to support the migrant. It has been argued that remittances from migrants in these circumstances are part of an "implicit family loan arrangement" (Poirine 1997).

Do Thai health care professionals have the same migration aspirations as their lower skilled fellow citizens? Do their professional traits, which make them more easily employable in overseas countries, encourage these professionals to migrate overseas or is the drive towards urban areas domestically more dominant? This research has investigated and provides some answers to these questions, particularly regarding the subjective motivations among Thai health care professionals which are presented in chapter six. The next section will account for the Thai health care infrastructure, while the subsequent section will account for past and current migration trends among Thai health care professionals, particularly physicians.

3.2 The Thai Health Care Infrastructure

The health care infrastructure implicitly relates to the structures providing care; in particular health care institutions These are informed by the health care policies in place, cultural and epistemological perspectives on health and care, and ultimately the available resources for health–both human and financial resources. Combined these resources will dictate and inform not only policy but more significantly the feasibility and probability of successfully providing

health care in accordance with these policies. It must be noted, however, that the health care infrastructure does not necessarily reflect upon the quality of the heath care provided and that access to health care may be restricted. However, without a strong and sufficient infrastructure, it will not be possible to provide adequate health care, and the health care infrastructure is one of the pillars of sustainable health care.

3.2.1 Thai Health Care Policies

Thailand has recently reformed its health care policies to provide universal coverage (UC) initiated in October 2001 (Tangcharoensathien et al. 2002; Tangcharoensathien, et al. 2004). Prior to this policy shift, there were four main public health care schemes in the country; the Public Welfare Scheme for the elderly and children under 12; the Civil Servant Medical Benefit Scheme (CSMBS) which covered government employers and their dependents; the Social Security Scheme (SSS) which covered employees in the private sector; while the Voluntary Health Card Scheme covered the borderline poor who were not eligible for the Public Welfare Scheme. These four different schemes for the different sectors of Thai society differed in nature and drew on both models of universal health care and insurance based health care. The UC replaced the Public Welfare Scheme and the Voluntary Health Card Scheme, but the CSMBS and SSS coexists alongside the UC. A Traffic Accident Protection Scheme for motor vehicle owners also exists to share the cost of accidents and is provided through private insurance companies and managed under the Ministry of Commerce (Pannarunothai et al. 2004).

The SSS, where the social security office purchase cover and services from competing public and private health care providers, utilises the principles of insurance based health care. This policy is funded on financial incentives to maximise the numbers of members on their list, although these members would preferably be healthy to minimise the cost to the social security office. The Voluntary Health Card Scheme followed the same incentives as the SSS, with risk selection of members, although this scheme has been discontinued and absorbed by the UC. Although the other health care schemes can be seen as variants of the universal model, they differed in degree of services offered to the eligible members. The Public Welfare Scheme suffered from lack of funds and low satisfaction from their members, while the CSMBS was very generous and was criticised as inefficient as providers had the "perverse incentive to provide more and sometime unnecessary services in order to generate more revenue" (Tangcharoensathien et al. 2002:60). The benefits available through this scheme have been reduced after the introduction of the UC.

The UC was initially referred to as the 30 Bath Health Care Cover or Policy, as it initially required a 30 bath co-payment for service; equivalent to approximately one Australian dollar. Prior to the implementation of the UC in 2001, 30 percent of the Thai population was not covered by any health scheme (Tangcharoensathien et al. 2004). The remaining 70 percent of the population was not necessary fully covered, but had at least partial cover by a health care scheme (Tangcharoensathien et al. 2002). The UC ensures health coverage for all Thai nationals although there are some individuals who have greater difficulties in accessing the UC, particularly among Indigenous groups who do not have sufficient documentation.

The UC was one of three populist programmes which brought the Thai Rak Thai party (directly translated to *Thai Loves Thai*) and Thaksin Shinawatra into government in January 2001, with strong public support (Tangcharoensathien et al. 2004). The government preceding the Thai Rak Thai government, the Democracy Party, did not embrace the UC when first proposed by a feasibility study. Independent of the political characteristics and relationships regarding the birth of the UC, this policy needs to be reviewed on its merits and the implications it has for access to health care among the general population. In addition, the relationship between this health policy and sentiments among the health care workforce was explored. These parameters are accounted for in chapter six, eight, and nine. It should be acknowledged that health care institutions, as elsewhere world wide, are under immense financial strains, and the UC has led to a high influx of individuals seeking health care which induces greater strains on health care providers offering services under this scheme. This concern does not apply to all health care institutions in Thailand, as some have been able to capitalise on the financing of this scheme, while other health care institutions, often more renowned institutions, are becoming indebted as a result of high-cost patients who are entitled to treatment under the government's health care plan and requiring tertiary health care (Khwankhom 2006).

3.2.2 Health Care Providers

In Thailand, health care facilities would include hospitals, which are categorised according to location, size and purpose, as well as health centres and clinics, pharmacies, and perhaps primary health care programmes, education campaigns, and emergency services[3]. These

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[3]In most countries this would be synonymous with ambulance services. Although this issue will not be pursued in detail, it should be noted that the emergency services in Thailand cannot be compared to the services of HHD or *western* countries, and a review of emergency and ambulance services in Thailand would in itself constitute a significant are for research which should be pursued. As in many other countries, there are different providers of emergency and ambulance services, particularly in Bangkok, and some operated by charity organisations, often under "Chinese shrines", and financially supported by members of the same shire (Sateanrakarn and Kangvallert 1997). These organisations generally provide transportation services to injured and deceased from traffic

facilities can again be divided into public and private service providers and facilities. The public-private divide also relates to the training of health care professionals, as there are both private and public tertiary health care education institutions in Thailand, contributing to the stock of human resources for health in the country. Table 3.1 provides an overview over the numbers of institutions training and educating health care professionals within the different fields.

	Public	Private
Medicine [a]	16[2]	1
Dentistry [a]	8	none
Pharmacy [a]	11	2
Nursing [a]	56[3]	10
Ministry of Education	*13*	
Ministry of Public Health	*35*	
Ministry of Defence	*3*	
Royal Thai Police	*1*	
Physical therapy [b]	6	2
Laboratory Technologists [b]	7	2
Radiology Technologists [b]	2	none
Community Health Workers [b]	6	none
Technical nurses [b1]	13	none
Dental Nurses [b]	6	none
Pharmacy technicians [b]	6	none
Laboratory assistants [b]	2	none

Table 3.1: Institutions Education Health Care Professionals
Sources: [a] Wilbulpolprasert et al. (2004b) and [b] Jindawatana et al. (1998)
Notes: [1]The education of technical nurses was discontinued from 2000, and only professional nurses trained from this point; [2]Includes 6 additional institutions from 2004; [3]Includes 2 additional intuitions from 2004.

There are 70 institutions training and education health care professionals in Thailand. Ten of these are in the private sector, including the Thai Red Cross Society. Forty-three of the public health care education institutions are under the Ministry of Public Health (MoPH), thirteen under the Ministry of Education, three under the Ministry of Defence, and one under the Ministry of Interior (Wilbulpolprasert et al. 2004b). Table 3.1 indicates that Thailand increased the number of institutions educating and training health care professionals in 2004, with the introduction of six new medical schools and two nursing collages. In addition to these, a general increase in the capacities and number of students at the other institutions were carried out as well. The national average numbers of physicians trained between 1997 and 2003 were

accidents and other accidents, as the "Chinese believe that helping these victims give them the best chances to do good" (Ibid:4). There are generally no medical services provided for those transported by these organisations, though there are some exceptions. Some even perceive these organisations as a nuisance rather than providing a service; scavenging for traffic accidents, media publicity, and in adverse cases a being a public (traffic) safety threat. It is necessary to distinguish between these operators and ambulance services connected to hospitals and health care institutions. Although there is no national mobile emergency medical service system in Thailand, there is in very rare cases emergency transportation available by helicopter, and a private hospital in Bangkok provides an emergency service by motorcycle, which can manoeuvre through the congested capital, with a nurse to provide basic life support until an ambulance arrives (ibid).

1,300-1,500 annually, while an accelerated training programme will educate additional 600 annually from 2004 to 2013 (ibid).

Although this review is limited to the traditional and limited perception of health care facilities, consisting of *western* medical institutions, people have a more holistic or alternative approach to health and health care in many countries; including Thailand. This would include traditional medicine, remedies, and healers, and recognition that health care can be provided by caregivers who are not trained as health care professionals. Accounting for the composition and distribution of health care institutions within the traditional western concept of medical care offers only a limited vantage point into the structures providing care and health care in a country like Thailand. Despite these limitations, it is crucial to account for the formal health care structure and health care institutions to gain an understanding of the delivery and access to health care services.

In Thailand hospitals are classified according to their location and service they provide, and in some cases also if they are privately or publicly funded. This review will in general be limited to the public health care institutions. Hospitals can be classified on three different levels: University Hospitals are the largest and most sophisticated hospitals located in urban areas with capability of providing extensive medical examination, tertiary treatment, surgery, and research. Provincial, Regional and General Hospitals are larger hospitals with specialist's capacities, including surgeries. Smaller District or Community Hospitals are located in rural areas and are often combined with a health centre, with sometimes as few as ten beds. These hospitals generally provide primary health care and less sophisticated medical treatment. District Hospitals, in particular, have to refer patients to larger Provincial or University Hospitals if more advanced treatment is needed. In such cases these District Hospitals may be responsible for the costs associated at the larger hospitals. After the introduction of the UC, individuals have to be registered with a public hospital which is then responsible for providing the health care for all registered individuals. In smaller and rural communities, there is not necessarily a choice of where to register, although people in urban areas and larger cities often have a choice between different health care institutions. Hospitals funding is based on the number of individuals registered at the hospital and this hospital is billed by the other hospital if patients are treated at hospitals they are not registered with.

Overall, it must be acknowledged that Thailand has a good health care infrastructure. According to the National Statistical Office (NSO) of Thailand (2005), there were 1,224 hospitals in Thailand in 2002, of which 309 were private, while according to Wilbulpolprasert et

al. (2004b) there were 1296 hospitals of which 319 were private in Thailand in 2002. Independently of the actual figures of hospitals or classification of these hospitals, there is a hospital in each of Thailand's 76 provinces. There are 700 hospitals at the district level as well as over 7,000 health stations in sub-districts (Wasi 2000). However, access to quality health care is not implicit, as "people are not satisfied" and "health personnel are overworked" (ibid). This issue, combined with perceptions among health care professionals, is revisited at several stages of this research, particularly in chapter six. Chapter nine returns to the issue of sustainable health care. Here, the issue of health care policy, within the contemporary framework and perceptions among the heath care workforce is explored further.

Access to medicaments is a vital component of any health care system, and includes private pharmacies and medicaments provided at hospitals and by physicians, as well as the pharmaceutical industry. Although the domestic pharmaceutical industry is and has played a significant role in Thai health care, including in the response to the HIV/AIDS pandemic through generic ARV drug production, most aspects relating to the pharmaceutical industry, which is a sub-section of the health care sector, has not been pursued in this research. This should not be perceived as diminishing the contributions and significance of this industry, and challenges with regards to drug regime in the combat against HIV/AIDS as accounted for in chapter seven.

3.2.3 Human Resources for Health

Thailand is <u>not</u> characterised by the WHO as a country with critical shortages of human resources for health (WHO 2006b). This is based on the definition of having a minimum of 2.28 health care professionals per 1,000 capita, were health care professionals within this context are defined as doctors, nurses and midwifes. Globally, there are 57 countries which fall under this threshold, and most of Thailand's neighbouring countries fall into this category of countries with critical shortage of human resources for health. These countries are: Myanmar, Laos, and Cambodia, while regional neighbours with critical shortages include Indonesia, India and Bangladesh (ibid). Table 3.2 represents information from the WHO outlining Thailand's stock of human resources for health. Thailand had in the year 2000, on average, 3.20 physicians, nurses and midwives per 1,000 capita although this rate is more than doubled when including the other categories of health care professionals as shown in this table.

The distribution of health care professionals is not uniform throughout any country and as such it is possible that there are communities in Thailand which does not have the WHO benchmark of 2.28 doctors, nurses, and midwives per 1,000 capita. The national statistics are important indications of the viability of the health care system, although internal dynamics will have to be investigated. Additionally, internal inequities and disparities may leave regions without sufficient human resources for health. There are significant dichotomies between rural and urban areas, as well as between services in the public and private health care sectors, which are not implicit when reviewing national statistics. In 2002, the physician to population rate in Bangkok was 1:767, while the physician to population ratio for the Northeast region was1:7,251 (Wilbulpolprasert et al. 2004b). Concerns regarding the inequitable distribution of health care professionals in Thailand are outlined and addressed in sub-section 3.2.3.

	Number or Professionals	Per 1000 capita
Physicians	22,435	0.37
Nurses	171,605	2.82
Pharmacists	15,480	0.25
Community Health Workers	39,780	0.65
Public Health Workers	2,151	0.04
Other Health Workers	14,117	0.23
Midwives	872	0.01
Dentists	10,459	0.17
Health Management & Support Workers	117,384	1.93

Table 3.2: Number of Health Care Professionals in Thailand 2000 according to WHO
Source: WHO (n.d.)

It should also be recognised that the figures in Table 3.2 may not accurately reflect Thailand's situation in regards to human resources for health, despite these figures being for the year 2000. Newer statistics released from the Thai Ministry of Public Health indicate that there are currently 33,946 doctors in the country (cited in Treerutkuarkul 2007), more than 50 percent more doctors than indicated in Table 3.1. This significant discrepancy inevitably questions the validity of these figures. Has Thailand managed to increase its stock of doctors by over 50 percent in less than a decade? Is the figure of 33,946 doctors only referring to physicians or can there be a double-counting of physicians who have specialised? Are the figures by the WHO in Table 3.2 significantly flawed or inaccurate, or are the new figures reported by the Thai Ministry of Public Health overestimations?

There are some plausible explanations for some of the significant discrepancies between these two figures. Firstly, Thailand has continuously worked to scale up its stock of medical doctors through increased education of new physicians, including an escalation of the number of medical students and schools. Also, increased allowances for newly graduated medical

doctors, for physicians not working in private practice, and special allowances for those working in rural areas may have attracted Thai physicians who were working overseas and retired physicians in Thailand to work in the country's public health system. Secondly, the figure of 33,946 doctors is labelled as the number of doctors in the country rather than doctors working in the medical field. Although this is a semantic differentiation, an interpretation of the new figure of 33,946 doctors could be that this is census data which could include retirees. Thirdly, there is a possibility of double counting as it is a common practice for physicians, as well as other health care professionals to hold two or maybe more positions. For example, a medical doctor, either specialist or general practitioner, may have a daytime job at a public hospital, and in the evening work at a private clinic. However, an increase from 22,435 doctors in 2000 to 33,946 doctors in 2007, or an increase of 11,511 doctors; more than fifty percent in 7 years, is extraordinary if credible. Reviewing the stock of health care professionals in Thailand over the past few years may reveal a trend which supports an extensive scaling up of medical doctors.
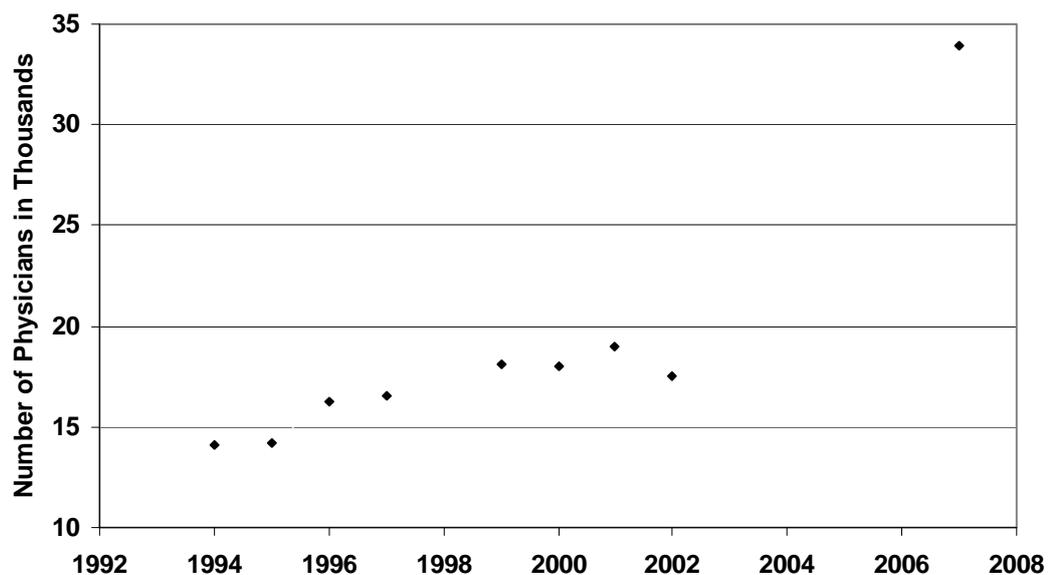
Figure 3.1: Number of Physicians in Thailand 1994-1997; 1999-2002 and 2007
Sources: 1994-1997: NSO (n.d.a); 1999-2002: NSO (2005); and 2007: Treerutkuarkul (2007).

Recognising that the exact number of health care professionals in Thailand may be difficult to determine, and that the published numbers of for example physicians may not be congruent with numbers published elsewhere, reviewing the trend in numbers of physicians over time may reveal some interesting trends. Figure 3.1 plots the number of physicians for different years from 1994 to 2007. Although the sources for these figures are different and the parameters for these statistics may not be congruent, there is a rise in the number of

physicians, although this is somewhat oscillating. The singular value which seems to fall outside the general pattern is the value for 2007 of 33,946 physicians. As such, some reservation about this latest figure is warranted.

The discrepancies in the reported numbers of physicians in Thailand may also be a result of different sources which look at the numbers of physicians registered with the Medical Council of Thailand and those actually practising. For example, in 2003, which is not included in table 3.1, there were 28,920 living physicians registered with the Medical Council of Thailand while the population census of 2000 indicated that there were 22,465 physicians working in their profession (Wilbulpolprasert et al. 2004b). The figures cited in the example indicate the discrepancies between registered and working physicians, although these figures are also incongruent with the number of physicians outlined in Figure 3.1. As such, statistical representations even of something as fundamental as numbers of physicians in a country needs to be scrutinised and while it is of utmost importance to continuously monitor the stock of human resources for health, different purposes and methodologies may yield different statistical representations of the stock of human resources for health.

It is natural to also scrutinise the statistics from the WHO (n.d.) indicating the stock of human resources in Thailand for 2000. Table 3.3 presents the frequencies of various health care professionals in Thailand for 2000 according to the NSO (2005). Although the categories of health care professionals are not identical to those used by the WHO in Table 3.2, focusing on the total numbers of physicians in Thailand we see that according to the NSO there were 18,025 physicians in Thailand while according to the WHO, there were 22,435 physicians in Thailand in 2000. There are 4,410 more physicians according to the WHO than according to the NSO, making the escalation to 33,946 physicians in 2007 even more remarkable; or rather places this achievement in further doubt.

	Government	State Enterprise	Municipal	Private	Total
Physicians	12,763	769	573	3,920	18,025
Pharmacists	5,368	110	125	781	6,384
Nurses	56,325	2,614	3,130	8,909	70,978
Technical Nurses	28,427	17	413	608	29,465
Dentists	3,443	76	161	461	4,141

Table 3.3: Number of Health Care Professionals in Thailand 2000 according to NSO
Sources: NSO (2005).

Table 3.4 compares the statistics of health care professionals as accounted for by both the WHO and the NSO to enable comparison between these two figures. Although the categorisation of health care professionals by the WHO and NSO are not identical, comparing

these figures reveals significant discrepancies. Can these significant discrepancies be accounted for by different methodological definitions? Looking at the category "nurses", concessions for discrepancies through different definitions or specifications should be made, where the NSO includes a subcategory of nurses as an independent health care professional category; namely technical nurses. Statistics for 1997 introduces another subcategory; auxiliary nurses, although it is unclear whether these professionals are included in the category "nurses" for 2000. Similarly, it is possible that the NSO statistics for physicians does not include specialists, which may account for some of the discrepancies. However, the apparent uniform category of health care professionals "pharmacists", reveals unequivocal discrepancies between the WHO and NSO statistics. According to the WHO there were 15,480 pharmacists in Thailand in 2000, versus only 6,384 according to NSO.

	WHO[a]	NSO[b]
Physicians	22,435	18,025
Nurses	171,605	70,978
Technical Nurses		29,465
Pharmacists	15,480	6,384
Community Health Workers	39,780	
Public Health Workers	2,151	
Other Health Workers	14,117	
Midwives	872	
Dentists	10,459	4,141
Health Management & Support Workers	117,384	

Table 3.4: Thai Health Care Professionals 2000: WHO versus NSO statistics
Sources: [a]WHO (n.d.) and [b]NSO (2005).

NSO statistics are derived from a variety of sources, and can be considered census data. As these statistics are based on self-reporting and reporting from public and private enterprises, there may be significant underreporting, particularly as statistics were sought from the institutions and enterprises, rather than household census. As such, particularly smaller enterprises such as family clinics, pharmacies and other small and privately run health centres may not have been included in these statistics, which explains that the most significant discrepancies are for professions which may be run as small private enterprises, particularly pharmacies but also dental clinics.

The gathering of national statistics is a complex undertaking with innate inaccuracies. It should also be noted that national statistics, particularly if viewed as development indicators, which health statistics generally are, are highly political and there may be different agendas among actors. Hence, there may be incentives for underestimating or overestimating figures for different actors and if data is based on self-reporting, and different groups have different agendas, it is difficult to get an accurate estimate and difficult to evaluate if the estimate is an

over- or under- estimation. For example, the reported and published figures for under 5 child mortality by United Nations Children's Fund (UNICEF) has recently been criticised for consistently overestimating child mortality, for some years the overestimation exceeded 3 million child deaths (Murray et al. 2007).

The immense difference between WHO and NSO statistics can perhaps be accounted for through different definitions or methodology. As seen in Table 3.3 the NSO only accounts for 781 pharmacists in the private sector for 2000. This, surely, cannot be accurate as according to Wilbulpolprasert et al. (2004b) there are 8,225 modern pharmacies in Thailand, in addition to 4,653 pharmacies selling only packaged drugs. These figures exclude the 2,106 traditional medicine drugstores which are registered. Hence, the 781 pharmacists working in the private sector in 2000 according to NSO are likely to have been those pharmacists associated with a private hospital and not pharmaceutical shops. As such, the statistical presentation of the health workforce or human resources for health within a country cannot be viewed objectively without a context and understanding of the parameters. The parameters are not always a given and significant interpretation has to be applied.

3.2.4 Health Care Expenditure

In 2000, national health expenditure in Thailand constituted nearly 300 billion Thai Bath, or approximately *A$10 billion*[4], with a trend suggesting an increase of almost 10 percent per annum on national health expenditure (Wasi 2000). In terms of percentage of GDP, the public and private expenditure on health was for 2001; 2.1 and 1.6 percent respectively, averaging 254 US$ per capita in Purchasing Power Parity (UNDP 2004a). It is interesting to note that for 2003, public and private health expenditure as percentage of GDP was 2.0 and 1.3 percent respectively, constituting on average per capita 260 US$ in Purchasing Power Parity (UNDP 2006), indicating that there was a minor increase in average health expenditure per capita in Purchasing Power Parity from 2001 to 2003, although both public and private expenditure on health dropped as percentage of GDP. The provision of health care and division of health care cost, however, were not uniform, and indeed had adverse effects on both household and public budgets. Figure 3.2 presents the annual expenditure on the CSMBS health coverage,

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[4] During the process of this research, fluctuation in the currency marked has taken place. Although these fluctuation are significant enough to have impact export/import markets and the economy as a whole, these fluctuations will not be reviewed in further and for the purposes of conversions between Thai bath and Australian dollars, a rate of 30 Thai bath = 1 Australian dollar has been used unless otherwise stated by a specific reference based on another's conversion rate as this would have been a reflective rate during the data collection process and field visits, despite recent depreciation of the Australian dollar. Conversions in the text which has utilised this conversion rate are highlighted in *italic*.

arguably the least cost-efficient health care scheme until the introduction of the UC, from 1990 to 2003. This health care coverage has been criticised as being ineffective and costly. What Figure 3.2 indicates is a continuous and strong increase in health expenditure which more than trebled in the 1990's despite a minor dip at the end of the decade, with continuous strong growth in the beginning of the following decade. The increase in annual expenditure on this health policy increased more than five-fold in the fourteen year period mapped in Figure 3.2. In Australian dollars, the increase was from just above *140 million* in 1990 to just below *760 million* in 2003.
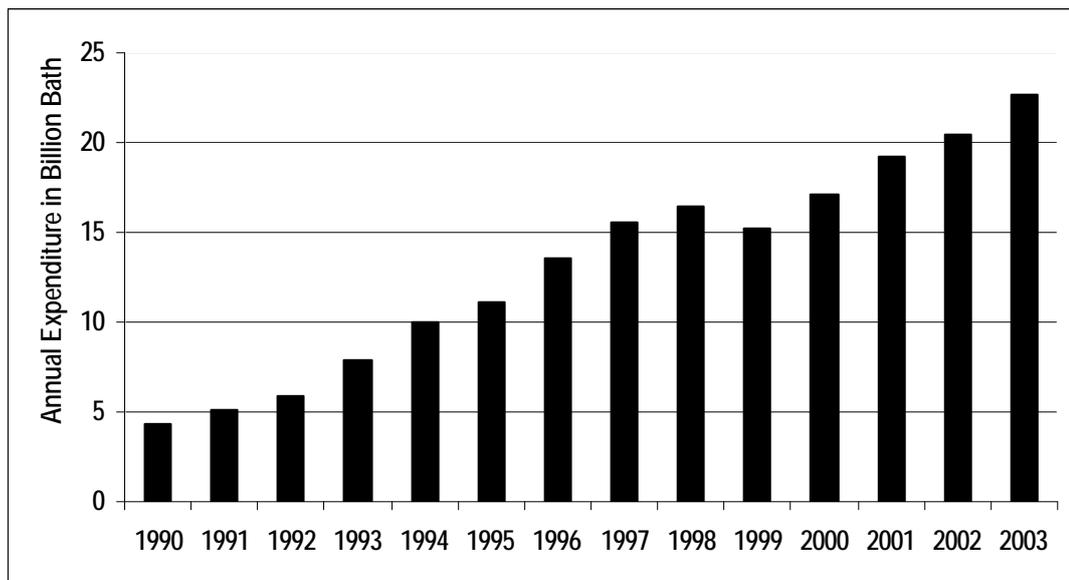
Figure 3.2: Annual Cost of the Civil Servant Medical Benefits Scheme 1990-2003, in bath billion.
Source: Wilbulpolprasert et al. (2004b)

It is clear that health care costs can become a significant burden, particularly for low-income earners. Rather than looking at absolute health care expenditure, but reviewing the proportion of disposable income, this latter parameter can indicate the proportion of the population for whom private health care expenditure becomes "catastrophic". There is no standard definition on when household health care expenditure becomes catastrophic, but a range from 5 to 20 percent has been frequently used previously (Xu et al. 2003). Tangcharoensathien et al. (2004) labelled household health expenditure as catastrophic if 25 percent or more of the household income after food expenditure went towards medical bills and other health expenditure. It was found that medical bills actually pushed people below the national poverty line, with an impact of 0.65 percent, from 10.87 percent up to 11.52 percent (Vasavid et al. cited in Tangcharoensathien et al 2004). Utilising the definition of catastrophic health expenditure as 25 percent or more of non-food household expenditure on health, it was found that prior to the implementation of the UC the proportion of Thais with catastrophic health

expenditure was falling from 4.9 percent in 1996 to 3.8 percent in 2000. After the introduction of the UC in 2001, the proportion of Thais with catastrophic health expenditure fell further, down to 3.0 percent in 2002 (ibid). Xu et al. (2003) utilised a definition of catastrophic health expenditure as 40 percent of household expenditure and found that 0.8 of Thais had catastrophic health care costs according to this definition, and that between 40 and 45 percent of health care costs were covered through out-of-pocket payments.
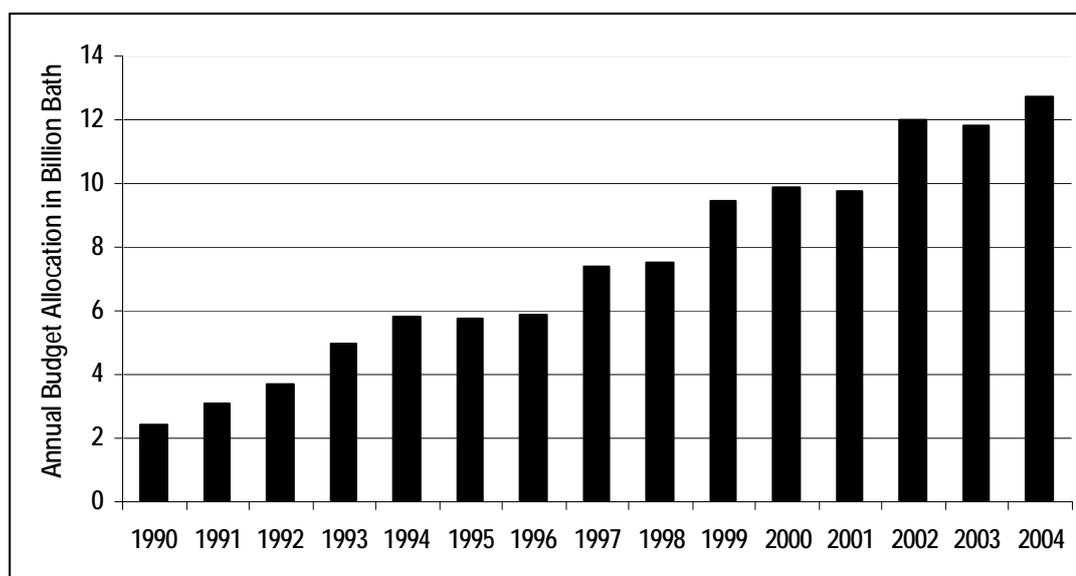
Figure 3.3: Annual Budget Allocation for Free Medical Services for the Poor and Underprivileged 1990-2004, in bath billion (2004 value),
Source: Wilbulpolprasert et al. (2004b)
Note: Figures for 1999, 2000 and 2001 includes allocation through loans from the Asian Development Bank and the World Bank

The annual budget allocation to free health care for the poor and underprivileged, although less in real terms, followed the same form of increases as the CSMBS. As can be seen from Figure 3.3, the are a general increase from 1990 to 2004 in the annual allocations to provide free health care services, and was even greater than that of the CSMBS in relative terms. During the 1990's the budget allocation almost quadrupled, while the increase for the fifteen year span accounted for in Figure 3.3 saw a greater than five-fold increase. However, the overall allocation to this free programme was approximately half of the allocations to the CSMBS. In Australian dollars, this figure reflects an increase from *80 million* in 1990 to *420 million* in 2004.

With further inclusions of benefits and medications in the UC and the abolishment of the 30 bath co-payment for service, it is probable that household expenditure on health will continue to decrease, and reduce the proportion of households with catastrophic health care expenditure. Recognising that Thailand is a medium sized economy and that the economic

growth of the country has been solid and it is expected that this growth will continue the question is whether the UC and extensive public funding of health care can be sustained. Arguably, public expenditure on health is an investment in human capital and maintaining and improving the public's health will lead to greater productivity, although the sustainability of the current health policies implies that these policies also have to be economically viable. This is a common predicament within any health care system, and cost-efficiency is inevitably an essential part of the sustainability of any policy.
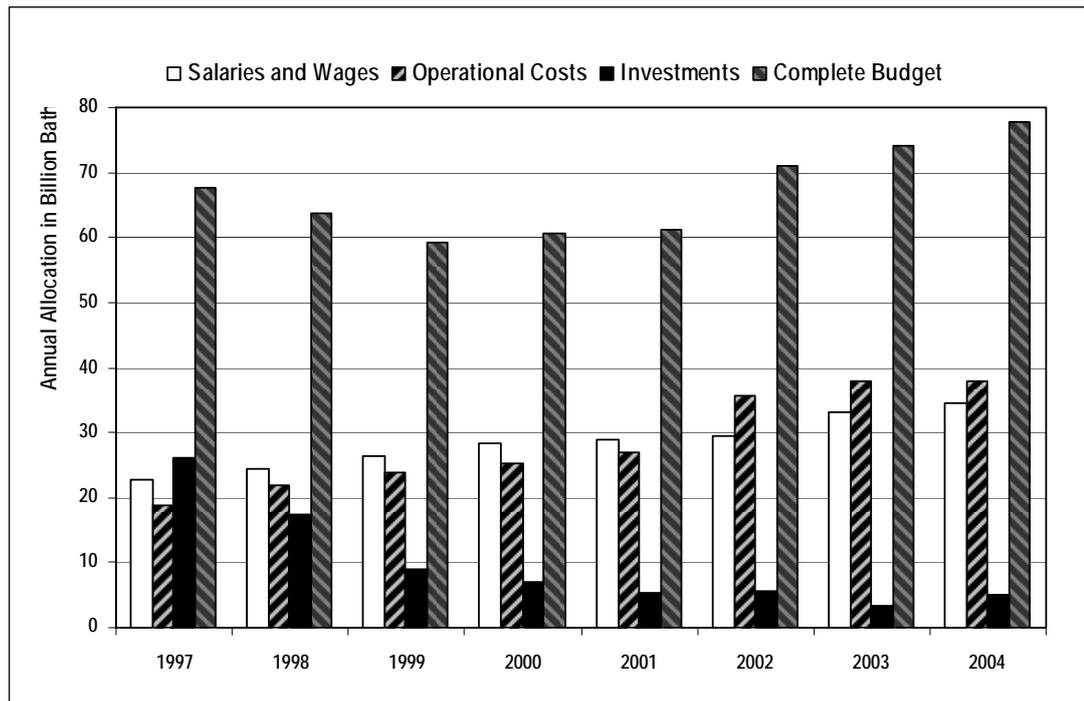
Figure 3.4: Annual Budget Allocation to MoPH in Billion Bath (2004 value)
Source: Wilbulpolprasert et al. (2004b)

Figure 3.4 shows the breakdown of the annual budget allocations to the MoPH, the main educator of health care professionals and provided of health care in Thailand, in the year just prior and just after the introduction of the UC. It is interesting to note the dip in overall allocation towards the end of the 1990's and until the initiation of the UC. This dip in funding is despite a steady increase in both allocation to wages and operational costs, but reflects the significant decrease in funding for investments. Although it is reasonable that some decreases in funding took place in the aftermath of the Asian Financial Crisis of 1997, it would be reasonable that a return to new investments for the MoPH would occur ones the difficulties of this crisis were overcome around the turn of the century. However, the significant increase in overall funding from 2001 to 2002 is through the jump in operational costs with an increase of almost 9 billion bath, or about 33 percent.

Challenges and inequities, both as a result of health care policies as well as structural inequities, will be explored further and reviewed together with health care professionals' perceptions and attitude regarding these inequities in chapter six. While chapter six also reviews perceptions and tensions between the public and private sectors, it is important to acknowledge the role of the private health care sector both in the education and training of health care professionals as well as in the provision of health care service. This mixed economy within the health care sector, based on marked dynamics, thus has the potential to maximise the efficiency and provide a diversification of health care services. However, not only based on objections from an epistemological standpoint, there are several concerns regarding this model, particularly from an egalitarian point of view which may interpret this as a two-tier health care system.

3.3 Insufficient Human Resources for Health

Sustainable health care ultimately relies on sufficient human resources within the health care system. An account of and evaluation of the current stock of human resources for health was carried out in section 3.2.3, while this section will review dimensions depleting the stock of health care professionals. Firstly, an account of the historic exodus of physicians from Thailand is outlined, followed by a review of the inequitable distribution of physicians in Thailand. This is followed by a section engaging in the planning on human resources for health for the future. This exodus of health care professionals, particularly medical doctors, relates explicitly to the brain drain of human resources for health, and is revisited, in light of the findings from this research, in chapter nine.

3.3.1 Exodus of Health Care Professionals

Based on Thailand's economic growth and labour migration trends, it is not surprising that Thailand has had an extensive brain drain of health care professionals. External brain drain of medical doctors took place from 1960 to 1975, when approximately 1,500 Thai physicians migrated to the USA during this time period and most did not return (Wibulpolprasert 1999; Wilbulpolprasert and Pengpaibon 2003). In 1970 the number of Thai physicians in the USA was equivalent to approximately 20 percent of physicians in Thailand, and the numbers of Thai doctors in the USA increased by over 20 percent from 1970 to 1972 (Mejia et al. 1976). It has also been noted in a U.S. Congressional report that medical graduates from the same school in the Northern Province of Thailand charted flights in order to migrate to the USA (cited in Wibulpolprasert 1999). This period of external brain drain was particularly adverse for

the rural health system, as there were less than 300 physicians servicing this sector (Wilbulpolprasert and Pengpaibon 2003).

Although the annual losses of medical doctors for some years exceeded 50 percent of new medical graduates (ibid), the 1960's saw a continuous net growth in the stock of physicians in Thailand (Mejia et al. 1976). However, as indicated previously, statistics such as these are somewhat incomplete, and the numbers of physicians emigrating are either estimates or derived from immigration and emigration figures which are generally based on self-reporting and hence not completely reliable. Table 3.4 indicates the number of new medical graduates, net losses through emigration and stock of physicians in Thailand for the 1960's. However, these figures are incomplete and not consistent.

Year	Stock of Physicians	New Graduates	Net losses through emigration	Losses as percent of Medical Graduates
1961	3,399[a]	227[a]		
1962	3,588[a]	230[a]		
1963	3,815[a]	218[a]/233[bcd]	56[bcd]	23/[c]24[bd]
1964	4,054[a]	321[a]/236[bd]	82[b]/81[cd]	34[bcd]
1965	4,323[a]	190[a]/276[bcd]	136[a]/140[bcd]	72[a]/52[bcd]
1966	4,590[a]	241[a]	236[a]	98[a]
1967	4,835[a]		108[a]	
1968	5,097[a]		279[a]	
1969	5,322[a]		369[a]	

Table 3.5: Stock of Physicians, New Graduates and Losses of Medical Graduates during the 1960's
Sources: [a]Mejia et al. (1976); [b]Wilbulpolprasert and Pengpaibon (2003); [c]Wongwatcharapaiboon et al. (1999); and [d]Wilbulpolprasert (1999).

Although the figures in Table 3.4 are incomplete, which is a general characteristic of migration statistics, the significant losses of physicians and the continued growth in stock of physicians in the same time period should be noted. Although the stock of physicians in Thailand increased during the 1960's, the extensive exodus, particularly to the USA, indicates significant losses on the investments in training and educating these doctors, as their professional contribution was lost. From 1967 (Wibulpolprasert 1999; Wongwatcharapaiboon et al.1999) or 1968 (Wilbulpolprasert and Pengpaibon 2003) a compulsory public service period of 3 years for medical doctors was introduced as medical students who received funding and highly subsidised tuition fees had to sign a contract with the government. The medical student signing such contracts paid less than five percent of their educational costs (Wongwatcharapaiboon et al. 1999). Hence, from 1972 newly graduated medical doctors had to work for the government for at least three years or pay heavy exit fees (Wibulpolprasert 1999; Wilbulpolprasert and Pengpaibon 2003; Wongwatcharapaiboon et al. 1999). This significantly curbed the exodus of Thai physicians, at least in the short term. For comparison purposes, it should be noted that in 1970, the standard monthly salary for newly graduated

physicians was 2,000-2,500 bath in Thailand, compared to 30,000-40,000 bath in the USA (Wilbulpolprasert and Pengpaibon 2003).

Although physicians are important professionals in advancing and promoting the health of the general population, health care systems do not only depend upon physicians but a range of other health care professionals as well. The movement of physicians have been traced and researched more vigorously, while less is known of the movement for other groups of health care professionals. However, it has been documented that significant numbers of Thai nurses entered and were licensed in the United States of America. During the 1960's this was equivalent to one-third of newly graduated nurses emigrating each year, although these statistics also indicated that Thai nurses eventually returned home to Thailand (Mejia et al. 1976). Recent research also indicate that Thai nurses are emigrating more frequently (Martineau et al. 2004), although other sources suggest that Thai nurses are not emigrating in significant numbers, at least compared to the influx to the UK of nurses from English-speaking sub-Saharan countries and the flow from Asian countries such as India and the Philippines (Wibulpolprasert et al. 2004a). While the emigration patterns of Thai physicians and nurses appear to be similar, their behaviour and/or opportunities they encounter after they leave Thailand appears to differ from the behaviour and/or opportunities of physicians, as nurses return to Thailand while there is little evidence that the physicians who emigrated in the 1960's did so. As this data mainly presents figures from a decade or two, it might be that physicians return as well, although after a longer stay. However, while these figures are indicative, the migration patterns of the mid twentieth century may not apply to today's migrants.

After approaching the external exodus of physicians from Thailand in the late 1960's and early 1970's through the introduction of compulsory public service for newly graduated physicians, rural health development became a priority for the Thailand. From 1977 a great expansion of rural health care took place which was sustained for a decade (Wilbulpolprasert and Pengpaibon 2003). As stated earlier, Thailand experienced strong and continued economic growth in the latter part of the twentieth century, including a national aspiration towards "NICdom"[5] (Reynolds 2002). Both the private and public health sectors benefited from continued economic growth. The expansion of the health workforce, with more professionals retained in the country as a result of the introduced mandatory public service for physicians,

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[5]NIC is a common abbreviation for Newly Industrialised Country. Although Thailand has experienced significant economic growth, and at declared itself as "developed" based on a UNDP Human Development Report classifying Thailand as a country with HHD towards the end of the 1990's, this was premature as new adjusted figures for the same year again classified Thailand within the MHD tier.

led to the development of rural health care facilities, although significant inequities are apparent in the Thai health care system, accounted for in the following sub-section.

3.3.3 Inequitable Distribution of Human Resources for Health

The three year compulsory public service for newly graduated physicians greatly improved the ratio of doctors in rural areas and doubled the number of physicians in the MoPH (Wongwatcharapaiboon et al. 1999). In 1976 there were 200 rural hospitals with 300 doctors, which increased to 425 hospitals with 1,162 doctors in 1985; a fourfold increase in rural doctors in a decade and more than a forty percent increase in the number of rural hospitals (Wilbulpolprasert and Pengpaibon 2003). Reviewing the ratio of doctors per capita for Bangkok and the poorest North-eastern region, this was in 1979 twenty-one times higher in Bangkok, while in 1985 it had decreased to 8.6 times higher in Bangkok (Wongwatcharapaiboon et al. 1999), indicating a more equitable distribution of doctors. As newly graduated physicians had to pay an exit fine of between US$10,000[6] and US$15,000 to leave the compulsory service (ibid), this policy significantly retained doctors, and created a more equitable distribution of doctors. Three-quarters of newly graduated medical doctors are assigned to work for the MoPH and this Ministry is responsible for all public hospitals. As the rural hospitals have the highest vacancy rates, most of the newly graduated physicians are assigned to work here. However, the strong economic growth in the late 1980's and early 90's, also lead to strong growth in the private health sector, which grew threefold in this decade. The number of physicians working at private hospitals increased from 1,000 in 1985 to 3,300 in 1995 (Wilbulpolprasert and Pengpaibon 2003). The ratio of private to public hospital beds and doctors was about 10 percent in 1986, which increased to 25 percent in 1995 (ibid).

A structural change in 1991 led to the number of doctors at district hospitals levelling off, and decreased in 1995, as the three year public service contract now included one year at an urban provincial hospital (Wongwatcharapaiboon et al. 1999). At the same time, due to higher salaries in the expanding private health care sector new graduates increasingly exited their public service contract and paid the exit fine. This peaked in 1997, when 126 or 22 percent of the newly graduated physicians resigned from their contract with the Ministry of Public Health (ibid). In 1997, physicians working at a MoPH hospital would earn 8,190-27,980 bath per month, compared to 50,000-300,000 bath at a for profit hospital (Wilbulpolprasert et al.

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[6]Initially, the exit fee was US$4,800, and was increased to US$8,000 in 1971 and then to US$16,000 in 1973. Due to inflation, this would be US$10,000 in 1998 value, but if adjustments are made to compensate for inflation, it would equate to US$50,000 (Wibulpolprasert 1999).

2004a). Physicians exiting the public service contract would be able to recuperate the exit fee through the significantly higher salaries in the private sector within a few months. The net exodus from the MoPH in proportion to annual graduates, when looking at all physicians, increased from 8 percent in 1994 to 30 percent in 1997 (Wilbulpolprasert and Pengpaibon 2003).

As the economic growth in Thailand came to a halt due to the Asian Financial Crisis in 1997, this event marks a climax of the internal inequities in the Thai health care system. The trend of convergence of doctor-to-population ratio in the poorest north-eastern region and Bangkok in the decade until 1986 was reversed and increased from 8.6 times to 13.7 times in the decade up to 1997 (Wilbulpolprasert and Pengpaibon 2003; Wongwatcharapaiboon et al. 1999). It was found that 21 rural district hospitals in April 1997, just prior to the Asian Financial Crisis, did not have a single full-time physician among their staff (Wibulpolprasert et al. 2004a). In May 1998 only 1,874 physicians were employed at these hospitals while 3,161 physicians were required, indicating that the rural district hospitals had less than 60 percent of the required medical doctors (Wibulpolprasert 1999).

Further evidence that the economic crisis of 1997 reduced opportunities for physicians in the private sector is illustrated by the net loss of physicians from the MoPH was proportionality less than four percent of the physician graduating that year. However, this was a temporary shift, as the net losses for the MoPH again exceeded thirty percent of annual medical graduates in 2001 (Wilbulpolprasert and Pengpaibon 2003; Wibulpolprasert et al. 2004a; Wongwatcharapaiboon et al. 1999). The 1997 Asian Financial Crisis did create a reverse brain drain, channelling physicians from the private sector back into rural district hospitals (Wibulpolprasert 1999). However, this should be viewed as a temporary trend as newly graduated physicians may have been reluctant to pay the high exit fines in times of economic uncertainty; there were fewer opportunities for employment in the private sector, and economic uncertainties in the East and Southeast Asian regions also reduced opportunities for international migration. However, as the economy recovered a few years later, the losses of physicians from the MoPH in relation to medical graduates each year again reached alarming levels.

The movement of health care professionals from the public health care system is caused by multiple forces; professionals may leave the profession temporarily to pursue specialisation and further education, and there is a natural loss of professionals through retirement. However, if there is a significant loss of individuals seeking employment outside their

profession, an exodus through emigration and an extensive move towards the private sector, this may adversely affect the sustainability of the public health care sector. These losses may be temporary or permanent, and this will inevitably have a different impact on the health care sector. Temporary migrations may have some benefits, particularly if professional development and further specialisation takes place, or if there are internal migrations towards regions with lower doctor-patient ratios, although it can be argued that Thai physicians are overspecialised (Wilbulpolprasert and Pengpaibon 2003). While the MoPH is Thailand's largest employer of health care professionals, a move away from this Ministry does not in itself unequivocally equate to a crisis in human resources for health in the country. Private health care and private health care providers play an essential part of numerous health care systems, and although some individuals may not be able to obtain private health care cover or afford paying the fees charged at the private health care institutions, this does not undermine a mixed health care economy. Rather, advocates of private health care institutions or agencies promoting private health care would argue that this is exactly the purpose of private health care; namely to cater for those who are covered or otherwise can afford private health care, freeing up resources, including human resources, in the public health care system.

There are significant concerns and implications of the inequitable distributions of health care professionals as sufficient human resources for health is one irrefutable criterion for ensuring sustainable health care, although what is considered sufficient is debatable. This sub-section has identified significant and adverse trends challenging human resources for health in Thailand; the historic exodus of physicians to the USA, indications that nurses are leaving Thailand, the flow of physicians from the public to the private sector, and the challenges in ensuring health care professionals, particularly physicians, in rural areas. However, proactive and extensive attempts to mitigate these adversities have been implemented in Thailand. In particular, the mandatory public service of physicians reduced the exodus and allowed these physicians to be placed in the rural areas with most critical shortages of medical personnel. However, opportunities in the private sector have led to increasing numbers of physicians exiting this programme. These issues and the questions they raise are fundamental when evaluating and debating sustainable health care and will be pursued further, from a variety of angles, in chapters six, eight, and nine.

3.3.4 Planning Human Resources for Health for the Future

There are significant challenges and complexities when reviewing human resources for health, where the issue of external exodus and internal inequitable distribution of manpower is only

one side of the equation. Pursuing sufficient human resources for health for the future also consists of education and training health care professionals according to estimates of future disease burden which incorporate calculations of losses through emigration of some of these professionals. An appropriate skills mix is equally important, including between different professions, such as the ratio of nurses to doctors, but also the ratio of specialists to general practitioners. This exercise, as complex as it is, also reveals one of the fundamental world wide challenges which adversely affects health care globally, namely "free riding". Free riding in this scenario refers to countries which do not train health care professionals in sufficient numbers to meet the demand for health care professionals in their own health care systems, but rely on immigrants. In particular, this practice is most common for the HHD countries, which are able to attract professionals as they offer relatively higher salary levels. An unfortunate result is that countries with lower levels of human development, and financial resources, are directly subsidising the education and training of health care professionals for more affluent countries.

The training of health care professionals, particularly highly skilled professionals such as physicians, requires significant capital and is a costly investment. Policy makers are therefore generally very reluctant to educate excess health care professionals. Allowing health care professionals to immigrate, or even directly recruiting health care professionals from overseas, is a short term solution for countries with insufficient human resources for health and a common practice among more affluent nations. This is a predicament for the not-so-affluent countries, as they lose both health care professionals as well as the investment in training these professionals. Should these countries continue to train and educate health care professionals when a significant proportion of these may emigrate? Planning for future human resources for health in these LHD and MHD countries is significantly hampered by the uncertainties of future emigration patterns. There is a need for an international accord, preferably through international organisations such as the WHO and the UN, to guide or even regulate the flow of health care professionals from countries with LHD and MHD to countries with HHD.

Thailand, as a growing economy and country of MHD, inevitably faces an enormous challenge in planning for future human resources for health, and this task in itself is saturated with unpredictable assumptions. A reverse exercise would be to project the supply of health care professionals, which in Thailand has been attempted, at least 8 times for physicians (Suwannakij et al. 1998). In the past, these projections have underestimated the number of

Thai physicians, however, as these estimates showed a deficit of physicians compared to requirements, they may have affected the outcome as increased education and training of physicians were sought (ibid). The current projections for supply of physicians until 2020, by Suwannakij et al. (1998), were partly based on previous projections which underestimated the supply of physicians, and their estimates of annual losses have been reduced from 3 percent to an annual loss rate of 0.45 percent.

The danger of reducing the rate of annual losses without sound evidence of lower numbers of net emigrants is that this may lead to a significant overestimation of projected stock of physicians. This would be a reversal of the previous interrelationship between projections which would not reach the requirements and lead to an escalation in the training of physicians. The current situation may lead to a reduction in the training and education of physicians, as it is assumed that the attrition rate due to emigration is only 0.45 percent. The figures outlined in Table 3.5 indicate that the annual net loss rates through emigration for the 1960's reached seven percent towards the end of the decade. Although significant deterrents have been implemented to stem the external exodus of physicians, it may be premature to assume that past trends of significant external exodus will not be a characteristic of future trends, particularly as the current international trend is that physicians migrate from countries with low and medium levels of human development to countries with higher human development.

Another issue regarding the availability of human capital or human resources for health arises when projecting the stock attempts to predict the percentage of professionals who will actually be working within their profession. As cited earlier, there were 28,920 living physicians registered with the Medical Council in 2003, while according to the population census of 2000 only 22,465 physicians were working in their profession (Wilbulpolprasert et al. 2004b). While these figures are for two different years, assuming these two figures are representative for the respective numbers of physicians registered and practicing, this suggests that about 78 percent of physicians are working within their profession.

A projection of the number of professional nurses in Thailand for 2015 has been estimated to be between 120,197 and 173,321 (Srisuphan et al. 1998), calculated by different annual loss rates. The low projection was an annual loss rate of 1.5 percent, the medium loss rate was 3.14 percent and the high loss rate was 5 percent. As the annual loss rate of nurses has decreased during the past decades, it may be appropriate to calculate with a medium to low loss rate, although it should also be noted that the past trends indicated high annual loss rates; 8.23 percent in 1969, 5.8 percent from 1976-1985, 4.69 percent from 1986-1990, and

finally 3.14 percent in 1993 (ibid). This past trend of decreasing annual loss rates of nurses may continue, and if it does this will translate to an annual loss rate of 1.5 percent in 2015. However, external influences; opportunities and pressures, may adversely affect this positive trend, as increasing numbers of nurses are migrating from Thailand and this research has found active recruitment of nurses in Thailand for employment opportunities in the USA.

Regarding other health care cadres and projections of future stock of human resources for health, it will have to suffice to acknowledge that the same limitations and challenges as outlined for professionals nurses and physicians are applicable to these professionals. It has been estimated that in 2015 there will be 15,292 dentists in the active workforce (Lexomboon and Punyashingh 2000); between 24,401 and 25,846 pharmacists; and between 6,191 and 6,560 pharmacy technicians (Payanantana et al. 1998). These projections are inevitably based on several assumptions, as is the projection of required numbers of the various categories of health care professionals. On the other hand, it is predicted that in 2015, 12,677 to 13,237 pharmacy technicians are required, indicating a deficit of 6,117-6,677 technicians and that the required number of pharmacists would be 32,761 and 33,968, indicating a deficit of 6,915-9,122 pharmacists (ibid). The projected supply of dentists is compatible with the projected demand for dentists (Lexomboon and Punyashingh 2000) and the projected requirements of professional nurses for 2015 is 142,366; which is within the boundaries of the estimated supply of professional nurses of 120,197 to 173,321 (Srisuphan et al. 1998).

It should also be noted that although there may be sufficient human resources for health within a country, the distribution, both between rural and urban areas and between the public and private sector, may not be equitable. This may result, potentially, in the same adverse effects as of a mass exodus of health care professionals. Another related issue, which is particularly relevant for any expanding health care system, is the skills mix within the health care system. It has been argued that Thai physicians are overspecialised (Wilbulpolprasert and Pengpaibon 2003). In 1971, more than 97 percent of physicians in Thailand were general practitioners and 3 percent were specialists. The trend over the next three decades was a significant increase in specialists, until the number of specialists passed the number of general practitioners in the mid 1990's; and in 2003, almost 70 percent of Thai physicians were specialists, and just above 30 percent of Thai physicians were general practitioners (Wilbulpolprasert et al. 2004b).

The characteristics, attributes, motivations, and flow of health care professionals, through migration or even change of profession are unpredictable and uncertain. Although further evidence on the dynamics of the push and pull factors for health care professionals

contemplating migration have been accounted for over the past decades, there is still significant unpredictability surrounding these dynamics and the future trends. This constitutes a significant challenge when planning for future human resources for health (Mejia 1978). In addition, the desired stock, distribution and composition of human resources for health must be viewed together with current and future health care challenges.

3.4 Health Care Challenges

The exodus of health care professionals from Thailand and from the public health care system carries significant implications for health care challenges in the country. This relates not only to the availability of human resources for health, but more importantly, impacts how other, particularly disease related, health care challenges are approached. Even if appropriate and extensive policies are put forth and implemented the availability of human resources for health will inevitably dictate the outcomes. As illustrated in the previous chapter, an international commitment and increase in funds to combat HIV/AIDS by the lack of health care professionals. A review of current health care challenges for Thailand is appropriate and, when merged with the review of the availability of human resources for health in the country, can indicate the impact of the current crisis in human resources for health in Thailand.

3.4.1 The HIV/AIDS Pandemic in Thailand

There is a general consensus that Thailand has been able to reduce the spread of HIV/AIDS (Ainsworth et al. 2003; Bjorkman 2005; UNDP 2004b), particularly in comparison with countries from sub-Saharan Africa. However, Thailand still faces major challenges with regards to HIV/AIDS, and although it has been claimed that the HIV/AIDS related MDG of halting and reversing the spread of HIV/AIDS has already been achieved within the Thai context (Bjorkman 2005), this might actually have been a premature announcement, as the same report suggests a possible reversal of the positive trend in 2004. It has been estimated by UNAIDS that more than 1 million Thais have been infected by HIV/AIDS (UNDP 2004b), although the apparent peak of the pandemic took place in the early 1990's. The spread of HIV/AIDS in Thailand has been explicitly linked to the commercial sex industry (Maticka-Tyndale et al. 1997; Shannon 1999; Simonet 2004). Government intervention stemmed the spread of the disease and earned international praise. Intervention strategies have been described as particularly relevant for the Thai context, as they explicitly targeted the domestic sex-industry (UNAIDS 2004). If it had not been for decisive action by the government, it is estimated that additional 7 million Thais could have been infected by the virus (UNDP 2004b).

The adverse impact of the HIV/AIDS pandemic is not as great in Thailand as in sub-Saharan Africa, although the pandemic imposes significant challenges and strains, not only on the health care system, but on society, and may even hinder some of the economic and social development progress of the country. The UN's MDGs state combating HIV/AIDS (Goal 6) as one of the major goals on the international development agenda (UNDP 2003). Combating HIV/AIDS has at least two dimensions. Firstly, combating the spread of the virus, and secondly treating and caring for those already infected. In addition, as will be briefly accounted for in chapter seven, HIV/AIDS also relate to other diseases, particularly tuberculoses, among the infected population, which also impact attitudes and perceptions of fear of becoming ill in the line of work among health care professionals.

One of the major contemporary challenges with regards to HIV/AIDS in Thailand is the changing nature of the disease. Traditionally, the spread of HIV/AIDS has been attributed to the commercial sex industry. By acknowledging this mechanism and specifically targeting and reinforcing mandatory condom use at brothels as well as educating the population of the risk of contracting HIV/AIDS at brothels, the commercial sex industry is no longer the most concerning factor in the spread of HIV/AIDS in Thailand. Rather, partnership transmissions and mother-to-child transmissions; often labelled as second generation transmissions, have become more dominant. In addition, the spread of HIV/AIDS is increasingly linked with drug-injections and more alarmingly among teenagers and young adults (UNAIDS 2004). In fact, it has been reported that the spread of HIV/AIDS in Thailand is most commonly taking place within "marriages and regular relationships" (ibid), and AIDS is the most common cause of death among young adults in Thailand (UNDP 2004b).

The past and current progress in stemming the HIV/AIDS pandemic in Thailand, which includes the continued decline in new annual infections (UNAIDS and WHO 2008), cannot become a cause for complacency as continued vigilance is needed to accommodate the changing nature of the disease. Indirectly, past progress is changing individuals' behaviour, panning the way for new patterns of spreading the virus. For example, since the traditional sex workers in brothels were early recognised as major source of spreading HIV/AIDS, this has led to a shift away from these traditional brothels and commercial sex workers to *casual sex workers* who operate outside brothels, or even disguised brothels, for example through bars, restaurants, and massage parlours, making it more difficult to reach, educate, and reinforce prevention strategies (UNDP 2004b).

With regards to treatment of HIV/AIDS through generic ARVs manufactured domestically, Thailand is again an international example of proactive measures as several ARVs are licensed in Thailand and generic copies distributed among HIV/AIDS positive individuals through the universal health care plan. Although this is a controversial approach, and at times problematic, Thailand is providing ARVs to neighbouring countries such as Cambodia, Laos and Myanmar, and planning to provide drugs to African countries as well (Bjorkman 2005). However, this action is not universally applauded, as it is viewed as interfering with the principles of free trade, and indeed is a major obstacle in current Free Trade Agreement (FTA) negotiations.[7] It is feared that an FTA with the USA will adversely impact the quality and availability of ARVs among Thais (AIDS Access Foundation et al. n.d.).

Acknowledging the range of significant and successful measures Thailand has taken in both combating the spread of HIV/AIDS as well as treating infected people, there are still significant challenges in combating HIV/AIDS. This is still one of the most significant challenges for the Thai health care system and requires significant human and economic resources. Indeed, as new ARVs are significantly improving and prolonging the lives of HIV/AIDS patients, the number of people living with HIV/AIDS will increase, in the short and intermediate term. This does not only imply that the number of people living with HIV/AIDS requiring medical attention, at least to access ARVs, will continue to rise, but this poses a growing threat for the health workforce of contamination through the line of work, as well as secondary diseases among the HIV/AIDS positive population. In many sub-Saharan African countries, heath care professionals are in fear of attracting HIV/AIDS through their workplace (Kober and Van Damme 2004), and universal precautions such as double gloving and plastic aprons cannot always prevent infections through needle pricks or sticking oneself on sharp instruments (de Castella 2003).

These issues: Stemming the spread of the virus; treating patients; ensuring sufficient human and economic capital; as well as the wellbeing of the health workforce, are crucial in the continued effort of stemming and combating the pandemic. Furthermore, attitudes and perceptions inevitably shape behaviour and this dimension, both in the general population and among health care professionals, may significantly affect efforts in combating HIV/AIDS. This is the reason that the attitudes and perceptions of health care professionals and students were

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[7]These have been on-hold as a result of the military coup and military appointed government, as the U.S.A. and other countries are reluctant to negotiate and sign such treaties in the absence of a democratically elected counterpart.

explicitly sought in this research. The issues of the HIV/AIDS pandemic and the Thai health care system are pursued further in chapter seven in light of the findings from this research.

3.4.2 Other Health Care Challenges

Although the HIV/AIDS pandemic is a significant and severe health care challenge, it is not the only dominant health care challenge. In 1995, the two leading causes of death were traffic accidents and heart disease (Sateanrakarn and Kangvallert 1997). The estimated annual economic loss from traffic accidents in 1993 was estimated by Thailand's Development Research Institute to be between U$2.5 billion and U$3.7billion, or 7-10 million USD per day (ibid). This statistic, by its own right, is a major cause for concern and further investigation into both the phenomenon and interrelationships are warranted. More recent statistics suggest that the leading cause of death in Thailand is now cancer, followed by HIV/AIDS and stroke before traffic accidents. Although for young people, 15-44 years, HIV/AIDS is the leading cause of deaths followed by traffic accidents (UNDP 2004b). The straining impact of both traffic accidents and HIV/AIDS on the health care system is significant. According to statistics from the Bureau of AIDS, TB and STIs (2003) and the Thai Working Group on Burden of Disease (2002), both at the Ministry of Public Health, traffic accidents accounted for 24,415 deaths among the general population whereof 16,381 deaths were among individuals between 15 and 44 years, while HIV/AIDS accounted for 53,375 deaths in the general population whereof 41,443 were aged 15-44 (cited UNDP 2004b). This equates, on average, to 146 HIV/AIDS deaths a day, 6 deaths per hour, or one death per 10 minutes, while traffic accidents account for 67 deaths a day, almost 3 and hour or one every 22 minutes.

Based on the premise that most of these deaths are preventable, that nobody has to die from HIV/AIDS or traffic accidents, significant prevention strategies to educate the public and prevent most of these deaths, are of immense importance. This is a huge task, which relates to changing attitudes in a number of areas and specific focus on preventing deaths caused by traffic accidents are required, of which the most tangible issues are related to driving patterns; such as speed and aggressive driving, and the casual use of seatbelts in cars and helmets for motorcyclists, as well as drink driving. In 2002, 91 percent of injuries among motorcycle drivers involved drivers not wearing helmets, and 97.2 percent of all injuries among motorcycle passengers were among passengers without helmets (Wilbulpolprasert et al. 2004b). It was estimated that 4.2 percent of the total disease burden, through "disability adjusted life years" in 1999 was attributed to not wearing helmets (ibid). Another major influence in the high number of traffic deaths is related to alcohol consumption and drink

driving. In 2002, it was found that 41.9 percent of all serious injuries among motorcyclists involved alcohol, a fairly steady rate from previous years of 41.7 percent and 42.2 percent for 2000 and 2001 respectively (ibid).

Alcohol consumption, by itself, particularly if habitual, can adversely affect health and hence become another strain on the health care system. Over the last few decades total per capita alcohol consumption among Thais aged 15 and over has increased steadily; from around 20 litres per capita per year in the late 1980s to almost 32 litres in 1995, and almost 40 litres in 2000. However, there was a significant increase from 2002 to 2003, from 40.9 litres to 81.7 litres, (ibid). If these figures are accurate, this is an alarming trend which needs to be reversed. It should be noted that these statistics are cumulative figures for combined beer, wine and spirits, not the equivalent pure alcohol levels. The beer consumption increased most in terms of litres and wine consumption increased most in terms of percentage increase, while consumption of spirits fluctuated. However, a very significant increase in consumption from 2002 to 2003 was registered among the different types of alcoholic beverages.

Another habit affecting health and with the potential of becoming a significant health hazard, is tobacco and cigarette smoking. In 2003, 21.6 percent of the population aged 11 and over were categorised as smokers (ibid). The difference between the genders is astonishing, as 44.1 percent of the males aged 11 and over are categorised as smokers, compared to only 2.9 percent of females. This can be attributed to social or cultural stigma around female smokers, although increased outside influences such as multimedia and the entertainment industry, may alter some of these attitudes. In light of these significant differences between the genders, it would be appropriate to investigate the issue of tobacco consumption in Thailand through a gender perspective, although this has not been undertaken in this research. A small, but steady increase in the proportion of Thais over 11 years who smoke is registered from 1999 to 2003. This trend was based on a steady increase of males who smoked, although the proportion of females who smoked fluctuated (ibid). An indication of the increased health care load caused by smoking can be seen by the increased prevalence rate of emphysema in the population. In 1989, the mortality rate per 100,000 due to emphysema was 0.07, which increased to 6.7 in 2003 (ibid).

With the continued economic and social development in Thailand, new health care challenges are emerging, based on life-style. The most dominant and visible are alcohol and tobacco related illnesses, although illness related to diet, such as obesity and diabetes, is also more frequent and has the potential of becoming a major health care challenge. According to

statistics for 2004, among the 53 million people aged 11 and over, only 15.6 million were found to exercise, or 29 percent of this population (NSO 2005). Almost one-third of the males exercised, compared to just above one-quarter of the females exercised (ibid). It would, again, be interesting to investigate these differences between the genders through a gender perspective. As illustrated in Figure 3.5, the rate of mortality among those aged 60 and over due to diabetes in Thailand is increasing, although this figure illustrates there are some fluctuations. This, together with other illnesses related to old age will inevitably continue to demand resources and strain the Thai health care system as the demographic composition of the Thai population changes towards an aging population. This demographic trend is sometimes associated with the development of the country, and although this is may be an aspiration, new health care challenges inevitably follow this transition.
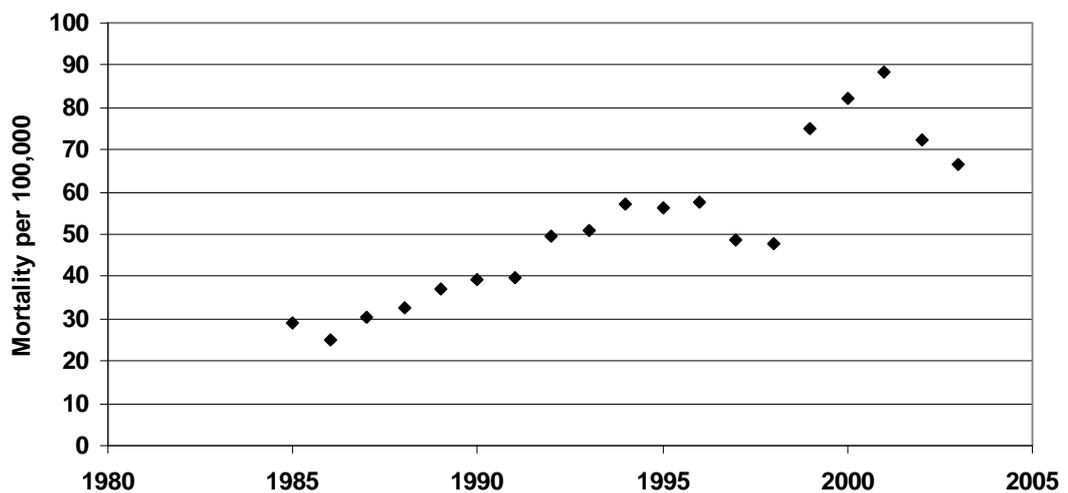
Figure 3.5: Mortality rate from diabetes per 100,000 aged 60 and over, 1985-2003
Source: Wilbulpolprasert (2004b).

Although there are new emerging health care challenges for the Thai health care system, related to changing lifestyle and demographic composition, there are still health care challenges, in addition to the HIV/AIDS pandemic, which are not traditionally linked to these parameters. Some are linked with environmental circumstances, such as malaria and dengue, although human activities may exacerbate the spread of these diseases, which are linked to mosquitoes and their breading in still and clear water. Mosquitoes may bread in excess numbers as a result of improperly managed garbage and sanitary systems spreading disease, particularly in unplanned or poorly planned urban areas and hence properly managed development of urbanisation, particularly regarding controlling mosquito breading in urban and semi-urban areas, can significantly prevent the spread of these diseases. The monsoon season of 2007 has seen a significant increase in dengue across Southeast Asia killing

thousands (Percy 2007), where Indonesia has seen a doubling in the number of dengue[8] cases compared to the same period of 2005. In Thailand there was an increase of 17 percent of dengue cases in Thailand for the monsoon season of 2007 compared to that of 2005 (Plianbangchang 2007). Malaria is also a consistent health care challenge in Thailand, although not an extensive epidemic. The malaria prevalence rate was 117 incidences per 100,000 persons in 2001, with a death rate of 0.7 per 100,000 persons in 2001 and death rate among children 0-4 years of 0.014 per 100,000 in 2003 (WHO n.d.). As such, both malaria and dengue must be viewed as persistent and significant health care challenges, and should not be ignored even in light of the new and emerging health care challenges.

It is appropriate to also mention another emerging health care challenges, which has receive high international attention, namely the avian influenza, or bird-flue pandemic, in East and Southeast Asia. Although there are only a handful of documented cases in humans, in Thailand as of 2nd February 2006, there were 22 human cases including 14 fatalities (Narain and Salunke 2006), the fear is that avian influenza will devastate human health in the region and internationally. As the fatality rate is extraordinary high, 14 out of 22, or 64 percent, in Thailand, and 86 out of 161, or 53 percent, for combined cases in Cambodia, China, Indonesia, Iraq, Thailand, Turkey and Vietnam from 2003 until 2nd February 2006, it is feared that an avian influenza pandemic among humans will have a devastating impact on humankind. Thailand, however, is recognised, as one of the countries best prepared and with the best infrastructure to cope with a potential full scale avian influenza pandemic in the region. The efforts to stem the potential adverse effects of avian influenza indicate that Thailand has a good health infrastructure capable of preventing and stemming adversities. Although this infrastructure must also be attributed the success in curbing HIV/AIDS in the country, this is clearly an ongoing challenge and other current and future health care challenges, mostly preventable such as traffic accidents and disease related to consumption and lifestyle, are likely to continue straining financial and human resources for health.

While the following chapter explicitly outlines the research parameters and approaches utilised in this research, it is appropriate to reflect on some of the parameters and definitions outlined reviewed in these first few chapters. Furthermore, this will have a direct impact on how we interpret and contextualise this research, both within the Thai health care system and within the larger framework of sustainable health care and global sustainability. These first few chapters have illustrated that there are few standard definitions, varying utilisation of

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[8]Also referred to as dengue hemorrhagic fever or dengue fever.

terminology, and discrepant accounts of movement of health care professionals, current stock of human resources for health, and numerous health care challenges for the Thai health care system. It should be noted that the mapping of the brain drain, exodus, or migration of health care professionals within the context of this research are not an objective in itself, but rather the perceptions and attitudes among individual health care professionals related to these issues, as well as contemporary health care challenges, social and political parameters, and the local contexts. It is an underlying assumption that significant and continues flows of health care professionals may adversely affect the sustainability of the health care system, either by significant losses of human resources for health or insufficient numbers of required professionals in specific sectors or geographical areas. Sustainable health care is thus dependent on sufficient and an appropriate distribution of human resources for health, while continued improvements in the measurements of health are indicators of sustainable development.

3.5 Chapter Summary

Thailand can be viewed as a country in transition, or as a country with one foot planted into the HHD sphere while the other remains in the LHD sphere. There has been strong economic development and although both past and current economic hurdles are influencing the economic growth of the country, Thailand's potential for continued growth is strong. However, the domestic political and security volatilities, particularly in southern Thailand, continue to be of concern, and may even hamper the economic growth. Economic development and recession have had significant impact on the availability of human resources for health. This includes the extensive external exodus of physicians in the 1960's, the reform which placed financial penalties for exits enabling rural health development in the following decades, and the development of a strong domestic private health sector; also competing for human resources for health. Although the flow from the MoPH to the private sector decreased sharply as a result of the 1997 Asian Financial Crisis, renewed economic development at the beginning of this decade saw a return to the flow of physicians away from the MoPH.

Strong economic development is changing the nature of health care challenges. There are current health care challenges arguably perceived as traditional developmental challenges, including infectious diseases. HIV/AIDS is still a dominant, if no longer the most dominant, health care challenge in Thailand, together with cancer and heart disease. Traffic accidents also constitute significant strains on the health care system while consumption and lifestyle

choices, such as diabetes together with illnesses related to an aging population are emerging health care challenges. It is necessary that Thailand not only retains and educates sufficient numbers of health care professionals to deal with these health care challenges, but also engage with appropriate education measure aimed at prevention and encouraging healthy lifestyles. The following chapter will outline the methodological framework of this research, while the subsequent chapters engage with the perceptions and attitudes among the research participants as well as the challenges raised throughout the research process.

CHAPTER 4

Research Parameters and Theoretical Framework

"The migration of health-care workers may be a feature of globalized labour markets, and it may be here to sty. Although knowledge about the itineraries of health-care workers who migrate is incomplete, it is thought that migration is influenced by many factors, some of which are amenable to strategic interventions. A greater understanding of the qualitative factors that influence health worker (that is, some of the key influences on the decision to migrate) will assist policy-makers in devising strategies to recruit and retain health staff in both source and destination countries" (Stilwell et al. 2004:599).

4.0 Introduction

This research was designed to investigate perceptions and attitudes among health care students and professionals, and as such it can be viewed as a case study of the Thai health care system. It is important to capture the perceptions and attitudes of these students and professionals as this will assist in making informed policy decisions to ensure sufficient human resources for health. These perceptions and attitudes will also shed light on the dynamics behind the internal and geographical inequities regarding the distribution of health care professionals in Thailand. This chapter outlines the epistemology, instruments, and procedure for this research. As stated in the initial chapter, the objectives of this research were:

I. To investigate contemporary tensions and dynamics in the Thai health care system as perceived by health care professionals themselves. This is the core aim and includes perceptions related to health care challenges such as the HIV/AIDS pandemic, as well as attitudes and perceptions related to differences between:

a. public and private services; and

b. services in rural and urban areas

II. To identify possible motivations for leaving the public health care sector among Thai health care professionals.

III. To explore the conflict of rights between health care professionals' right to migrate and the remaining population's right to adequate and affordable health care.

The following section briefly outlines the epistemology behind this research. This is followed by an account on how data, information, or knowledge was collected and constructed and includes an explicit account of the research instruments. A review of ethical concerns and how these were addressed and an outline on how the organisation of data and the construction of meaning are presented in this thesis are included towards the end of this chapter.

4.1 Epistemology

Human rights and the discourses constructed within the axioms of human rights are interconnected and relate to a perception of intrinsic value in human kind and every human being. However, human rights may conflict, such as when in specific scenarios the rights of different groups or individuals may infringe the rights of others. Although critics will argue that this renders human rights and rights based approaches relativist, ineffective, and even irrelevant, the perception here is that it is an opportunity to move forwards from a zero-sum game perception of human interaction to a holistic and inclusive view on how humanity must excel and develop for the betterment of all. As such, despite predicaments arising when the rights of some infringe upon the rights of others, human rights and a rights based approach become a prism and catalyst through which progress can be sought. It is argued here that a rights-based approach, based on holistic and inclusive premises, is not appeasement or enslavement to relativism. The principles of human rights, the axioms upon which humanity is defined, are irreducible, universal, and non-negotiable; attempts to consolidate and rectify specific inequities, however, may be relative, inconsistent, inadequate, and incoherent.

The UN's Universal Declaration of Human Rights (UDHR) from 1948 is a natural origin for investigations utilising human rights as it outlines our individual, irreducible, and innate human rights, but also constitutes an international, even legal, framework, through which human rights are perceived and pursued. Despite strong legitimacy of the UDHR today, the inauguration of this framework in 1948 was by states of which too many were "authoritarian and oblivious to the social responsibility of the state to make the implementation of human rights seen as if it were a genuine political project" (Falk 2000:189). Although the UDHR is now the epitome of human rights, one of the early driving forces for human rights were grassroots activism and voluntary associations in North America and Western Europe following the introduction of the UDHR (ibid). However, the UDHR is not unproblematic, and even if we include subsequent treaties and international agreements, there are critics who

view the UDHR as incomplete and overtly focused on *Western* values and perceptions. Falk (2000:192) noticed:

> "Islamic and Confucian scholars have both complained about the excessive individualism and permissiveness of the human rights tradition as written into international law. They have also complained about its failure to balance the rights of the individual against responsibilities to the community …"

While notions of human rights can be arbitrary, it is argued here that the complexities of human rights explicitly call for a holistic and universal application of human rights rather than selective and one-sided enforcement of singular standards. Dilemmas arising from scenarios when rights or the rights of different parties are in conflict are not valid arguments for dismissing either human rights, nor a human rights framework for research. Rather than being evidence of a faulty discourse, this reflects some of the remaining challenges in developing human rights and a human rights framework in an inequitable world. Within our contemporary setting the application of human rights are pragmatic and relative, and often the ambition is to find an acceptable and appropriate approach rather than universal and equitable applications of human rights. While the commitment to human rights should be relentless, emotional attachment and application of human rights can lead to arbitrary inconsistencies, in contradiction with the premise of human rights as a set of interrelated principles and values. Human rights must be viewed holistically; otherwise, these rights become individual principles without moral authority.

According to Harvard Law Professor Mary Ann Glendon, the UDHR "is a closely integrated document: there is no place for the 'relativist' demand that certain rights be relegated to secondary status in light of 'Asian values' or some other pretext" (cited in Chomsky 2003:52). This research does not indicate that human rights or the UDHR are relative, but rather, that humans are integrated beings and as such, the actions of some will affect the opportunities of others. The case in this research is that the individual rights of health care professionals to migrate may, in specific scenarios, jeopardise the general population's right to medical care: The individual rights of these professionals may jeopardise the collective rights of the general population. If the UDHR is perceived as individual principles, rather than a set of interrelated values, Glendon's concerns become valid. It is argued here that Glendon's concern that aspects of the UDHR are given "secondary status" in certain scenarios is not a valid argument for giving secondary status to the rights of the community or general public. Rights of the individuals as well as the rights of the community are equally important. When there are conflicting rights between individuals and the general public, the rights of some are not to yield

to accommodate the rights of the general public, or vice-versa. It is argued in this research that this is a false dichotomy and new solutions and approaches which bypass this predicament are required, rather than promoting the rights of some and giving the rights of others "secondary status". This particularly relates to the scenario when individual and collective rights are in conflict. While this specific predicament often relates back to liberal theory and conviction, emphasising individual rights rather than collective notions of rights, the conceptual framework of human rights as the methodological framework of this research encompass both these dimensions. It is argued here that human rights have both individual and collective dimensions and repercussions.

4.2 Research Methodology

As stated in chapter one, this research utilised a mixed-methods approach, applying both quantitative and qualitative methods to gather data and information. The research procedure which took place can be viewed as what Creswell (2003) refers to as a "sequential procedure", as the questionnaire survey took place prior to most semi-structured interviews were carried out. Although the responses from the questionnaire survey informed the structuring of the semi-structured interviews, an initial five interviews were also carried out parallel to the conduction of the questionnaire. This can be viewed as "concurrent procedures", which takes place, according to Creswell (2003:16), when "the researcher converges quantitative and qualitative data in order to provide a comprehensive analysis of the research problem".

This research is a case study as the main object of the research is the "intensive analysis of a single case" (Bryman 2004:537); namely the Thai health care system. The objective is to account for both the explicit applications to Thailand as well as global or international impact and applications of the trends uncovered. This can be viewed as a merging of what Stake (2005) calls "intrinsic" or "instrumental" case-studies, where the aim is to gain a better understanding of a particular case or the aim is to gain insight and make generalisations based on findings from a particular case, respectively. This research aims at accounting for both the "intrinsic" case study; Thailand, and the "instrumental" applications of the trends uncovered here. It is acknowledged that the cultural and local parameters in Thailand are unique, and cannot be directly converted to other settings. However, uncovering perceptions and attitudes among health care students and professionals may contribute to new approaches to mitigate the adversities of insufficient human resource for health and the flow of

health care professionals to HHD countries from countries with lower levels of human development, and understand how current health care challenges may interact with this.

4.2.1 Research Parameters

This research was initiated as a master by research degree, and the information collected as part of this framework has been included in this thesis. As such, this research took place over two stages. Information was collected in Thailand through a questionnaire survey among health care students and professionals and through several rounds of semi-structured interviews with health care professionals and key informants: Including government and non-government officials; individuals familiar with the volatilities in southern Thailand; as well as health care professionals in these regions. The questionnaire survey and the first five semi-structured interviews with health care professionals were carried out within the framework of the master degree. Additional semi-structured interviews with both health care professionals and key informants followed within the framework of a doctoral degree. The perceptions and attitudes outlined in both the questionnaire and the interviews were then contextualised with current literature and media reports regarding contemporary social, political, and security developments and concerns. The questionnaire survey and the semi-structured interviews targeted different aspects of the research objectives and the research instruments were intended to complement each other and enhance insight into these issues rather than narrowly investigate singular aspects of the research objectives. The combination of the questionnaire survey and the semi-structured interviews hence triangulates this research, which ideally enhances the strength and validity of the research (Berg 2004).

The main objective of this research, to investigate contemporary tensions and dynamics in the Thai health care system, was pursued through both the questionnaire survey and the semi-structured interviews. Contemporary issues, both within the Thai health care system and with regard to developing domestic adversities emerged. Throughout the research there was significant political and social volatility which would be expected to impact attitudes and perceptions and further investigation into these issues was sought. This is discussed in chapter five, which accounts for the perceptions among participants regarding these issues, particularly the developments which took place during the research process relating to political and security volatilities, supplemented with literature and media reports. This contextualisation is critical for a comprehensive understanding of the contemporary tensions and predicaments facing the Thai health care system, and perceptions of volatilities and desires to emigrate.

The survey questionnaire and the semi-structured interviews were designed to examine attitudes and beliefs among health care professionals and health care students in a setting in which migration and the HIV/AIDS pandemic were features for potential human rights tensions. Migration theory generally accepts perceptions as more influential as motivation in the (potential) migrants' decision making process. As stated by Lee (1966:51):

> "…we must note that it is not so much the actual factors at origin and destination as the perception of these factors which results in migration. Personal sensitivities, intelligence, and awareness of conditions elsewhere enter into the evaluation of the situation at origin, and knowledge at the situation at destination depends upon personal contacts or upon sources of information which are not universally available. … The decision to migrate, therefore, is never completely rational, and for some persons the rational component is much less than the irrational."

As such, these research instruments will not map trends or actual circumstances but rather account for the subjective views and aspirations of health care professionals and students and in this way outline the possible future trends. While examples presented from the interviews in the following chapters outline both past experiences and hypothetical scenarios, it is the perceptions and attitudes among the participants to these incidents, rather than the incidents themselves, which are of interest.

It is important to declare that the scope of this research is limited to the internal dynamics of the Thai health care system, particularly attitudes and perceptions among health care professionals, and does not include a comprehensive account of the health care consumers. It could be argued that this one sided account is not representative and will not accurately reflect circumstances within the Thai health care system. This criticism is partly correct. Although the majority of participants in this research are health care students and professionals, and the research reflects their subjective perceptions and attitudes, some contextualisation of these responses through the input of key informants is carried out. Furthermore, reports of contemporary volatility, social and civil concerns through media reports and other cited sources account for the backdrop of this research. However, the purpose and objectives of this research were not to map actual trends or represent all stakeholders, but to present an account of health care professionals' and students' subjective perceptions. These are then contextualised with current internal dynamics in the Thai health care system as well a few reflections on global interrelationships and the endeavour to achieve sustainable health care.

4.2.2 Survey Questionnaire

The survey questionnaire was distributed among health care professionals and health care students in Thailand during 2005. Subjects were approached through a combination of key informants, convenience sampling, and snowballing techniques among medical professionals and students; primarily in the Bangkok metropolitan area and the Northern Provinces of Thailand. In addition, four faculties at tertiary teaching institutions, including medical schools associated with university hospitals, were approached in order to disseminate the questionnaire survey among their students. These Thai institutions had existing Memorandums of Understanding with the university in which this research was conducted and were approached through these channels. A letter of introduction by the Higher Degree Research Coordinator of the Department was forwarded to these institutions, and is attached in Appendix A, together with a letter of introduction by the researcher attached in Appendix B[9]. Due to time constraints and lengthy internal review and ethical approval processes at the Thai teaching institutions, the questionnaire survey was only distributed among the students at one of these faculties. In total, including respondents from this tertiary teaching institution and the participants identified through snowballing and convenience sampling, 93 questionnaires were completed.

As questionnaire participants were sought through convenience and snowballing techniques, it is not possible to give an accurate response rate, although these sampling techniques rely on established social networks and existing relationships which would be expected to enhance response rates. However, as the purpose of the questionnaire survey was to review perceptions and attitudes rather than map actual trends, and participants were not sought through any form of probability sampling, participant response rate is not a major concern. Rather, the representativeness of these participants, or who they represent, is the main interest when evaluating the information from this survey (Bryman 2004). An account of this, regarding participants from both the questionnaire survey and the semi-structured interviews is outlined in section 4.2.4.

The questionnaire and supporting material were translated into Thai prior to dissemination, which took place during a three week period in August and September in 2005. Although only

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[9]At the time this data collection process took place, the research was within the frameworks of a Master by Research degree, and therefore these letters of introduction refer to the research as a Master by Research at Curtin University of Technology. It should also be noted that the title of this thesis changed as a result of the recommendation of the examiners. Therefore the material in the attachments refers to this research under the title "The HIV/AIDS Pandemic, Human Rights and the Brain Drain: Ensuring Sustainable Health Care in Thailand."

one interpreter and translator assisted with this research, the translated questionnaire survey and supporting material was reviewed by a couple of individuals familiar with social research and official government language and etiquette in Thailand. This process created a merging of what Neuman (2006) refers to as single translation and parallel translation. Single translation implies the use of one translator, while parallel translation implies that several translators independently translate the material and then come together to evaluate these translations together. This research only utilised one translator, however, two different resource persons then reviewed the translations and discussed the material with the translator, which led to minor revisions prior to dissemination. This process was also applied to the material presented to participants in the semi-structured interviews.

All questionnaire participants were presented with an information sheet, a consent form, and the questionnaire. The participant consent form also allowed for individuals interested in participating in the later round(s) of interviews to volunteer for interviews. However, very few participants partook in both the questionnaire survey and the semi-structured interviews[10]. The information sheet indicated that the return of a completed questionnaire would be interpreted as consent to utilise the answers, which allowed participants to remain completely anonymous to the researcher in the cases where questionnaires were returned without a completed consent form. The information sheet for questionnaire participants is attached in Appendix C, the consent form is attached in Appendix D, and the questionnaire survey is attached in Appendix E.

All questionnaire participants, both health care students and health care professionals participated on a voluntary basis and no incentives were offered to participants. The questionnaire consisted of two sections: The first section was devoted to gather demographic data while the second section consisted of 39 closed questions, or statements, which participants were asked to rank their agreement or disagreement with, in accordance with a 5-point Likert scale (Bryman 2004). In addition, one open-ended question rounded off the questionnaire. The primary purpose of the closed questions was to identify motivations for emigration and to differentiate between push and pull forces; the perceived circumstances at the origin and destination. The questionnaire included statements related to salary levels, political and security issues, the desire to live and work in rural and urban areas, as well as the dichotomy between urban and rural areas, as brain drain and migration studies have

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[10]Only a couple of participants were both interviewed and completed a questionnaire, while a handful of participants assisted with both processes. For example, some interviewees assisted with the distribution of the questionnaire survey.

identified security; political stability; and good income opportunities as the highest ranked key motivations for emigration (Beare 1999; Chalamwong 2001; Diamantides 1992; Martineau et al. 2004; Mills 1993; Rule 1994; Van Rooyen 2000).

Based on concerns that the adverse impact of the HIV/AIDS pandemic in sub-Saharan Africa is associated with an exodus of health care professionals, the survey questionnaire also sought to investigate attitudes regarding HIV/AIDS in Thailand, and to explore if this health care challenge has become a push-factor for migration here. Schloenhardt (2001:334) views the decision to migrate as a rational choice based on a cost-benefit evaluation of 4 push-pull forces; political, demographic, socioeconomic and environmental. HIV/AIDS encompass numerous dimensions and it constitutes an occupational hazard, both regarding the risk of attracting the disease through the line of work but also with regards to associated diseases among HIV/AIDS positive clients, such as tuberculosis (de Castella 2003; Kober and Van Damme 2004; MacGillis 2004; Martineau et al. 2004).

The final question in the questionnaire survey was an open-ended question. Participants were asked to outline the impact on the health care system of health care professionals emigrating according to their perceptions and experience. Although a large proportion participants chose not to complete this question or gave answers which did not reflect the questions, those who did make an effort to reply to the question revealed insightful and interesting attitudes and perceptions. The non-response rate to the closed questions, however, was insignificant, as between 97 and 99 percent of participants replied to the closed questions. While a few references to participants' response to this open question are made in the following chapters, these responses also informed the construction of the semi-structured interviews.

4.2.3 Semi-Structured Interviews

The semi-structured interviews took place during five separate field visits to Thailand from September 2005 to January 2007. Participants for semi-structured interviews were selected through a combination of convenience and snowballing sampling. The majority of interviewees were health care professionals and great effort was taken to spread the geographical location of these participants. Interviews with these health care professionals, working at both public and private institutions, took place in the urban Bangkok Metropolitan Area; rural and urban North-Eastern Thailand; rural and urban Northern Thailand; rural Central Thailand; and rural Western Thailand. In addition, written correspondence and phone interviews were used with nurses and a key informant in Southern Thailand to contextualise and gain further insight into

the volatilities in the southern provinces. Other interviews with individuals from and with insight into the issues of the Southern violence took place in the Bangkok Metropolitan Area. Key informants from the non-government sector, both Thais and an Australian, were interviewed in Bangkok, while key informants working in the government sector, including one with a political background, were interviewed in Bangkok as well as in Northern Thailand. These strategies to include and identity different traits among the interviewees, geographical location, professional experiences and backgrounds, including the sub-groups of interviewees who are not related to the health care system, and ensuring a mix of heath care professionals in rural and urban areas as well as in the private and public sector combines three of the four types of Berg's (2004) non-probability samples; namely convenience sampling, purposive sampling, and snowball sampling, but not quota sampling.

Prior to each interview, participants were given an information sheet and a consent form. Once participants gave informed consent to participate, they were also asked to complete what Bryman (2004) refers to as a "fact sheet"; consisting of questions aimed at gathering demographic information such as age, gender, and a short summary of their professional background. The semi-structured interviews with the health care professionals were centred on health care policy and the different forms of health care coverage; the HIV/AIDS pandemic, migration, rural-urban disparities, and perceived rights and obligations. A complete set of the prepared guiding questions for the semi-structured interviews with health care professionals and supporting material is attached in Appendix I. The information sheet for the interviews with the health care professionals is attached in Appendix F and the complementary consent form is attached in Appendix G. This consent form was also used by the key informants from different professional backgrounds.

The guiding questions for the semi-structured interviews with health care professionals were adapted after the first round of five interviews, which took place in September and October of 2005 within the framework of a master degree. This first round of interviews can be viewed as a pilot test of the guiding questions. However, the information from these first five interviews is very significant, and has been included as part of this research and citations from these interviewees are included in the following chapters. The guiding questions for these first five interviews are attached in Appendix J. Although these different guiding questions vary from the rest of the interviews, the changes represent an organic refinement and development rather than a regeneration of concerns: The guiding questions are engaging the same topics and address the same health care challenges. It should also be noted that as these were

semi-structured interviews, additional and new prompts were added when participants gave answers which introduced new significant topics, and no interview utilised all the prepared questions and prompts. This is consistent with the proposition by Bryman (2004) that semi-structured interviews consist of guiding questions that are not in a fixed or rigid structure.

Thirty-three health care professionals were interviewed, in person, with the assistance of an interpreter. In addition, three nurses from the southern provinces of Thailand contributed to the research. The key informants had different professional backgrounds. Three individuals were from the non-government sector, three persons worked as government officers as well as five individuals with insight into the southern violence, including these three nurses. All of these interviewees, including the three nurses, were interviewed to contextualise the contemporary social, political, security, and development challenges. All interviewees were given both an information sheet and consent form prior to the interviews. These varied marginally among the sub-groups of interviewees, as did the information sheets. The information sheet for interviewees from the non-government sector is attached in Appendix K; the fact sheet for these participants is included in Appendix L; while the guiding questions are in Appendix M. Similarly, the information sheet, fact sheet and guiding questions for the interviews with government officers are attached in Appendix N, O, and P, respectively; while the information sheet, fact sheet and guiding questions for the interviewees familiar with the South and Southern violence can be found in Appendix Q, R, and S, respectively.

The questions put to health care professionals were classified into questions regarding the three different health care schemes; regarding HIV/AIDS; related to migration; rural/urban disparities; and perceptions of rights and obligations. Persons from the non-government sector were asked questions regarding public services; HIV/AIDS; political dynamics and current tensions; and the Southern violence/tensions. The interviews with government officers were centred on the new universal health care cover and the medical scheme for government officers; HIV/AIDS; political dynamics and current tensions; and the Southern violence. Questions for the key informants familiar with the South were centred on perceptions related to migration and the tensions around the southern violence. As already implied, some interviewees could be classified into several categories, i.e. being both a government officer and familiar with the Southern violence, or health care professionals in Southern Thailand and in these cases the interviews utilised a combination of questions.

Although several interviews were conducted in English, and many interviewees were sufficiently skilled for the interviews to be carried out in English, all interviews were carried out

in the presence, and generally with the aid, of an interpreter. This was the same person throughout the research which ensured informed and consistent interpretation and linguistic translation throughout the research process. Some of the concerns regarding utilising an interpreter are addressed together with other ethical issues in section 4.3, although for this research it was clearly an asset rather than any form of liability or inconvenience to have an interpreter assisting.

4.2.4 Characteristics of Participants

As participants for neither the questionnaire nor the semi-structured interviews were based on any form of probability sampling, an account of the representativeness of the participants is warranted. Do the participants in this research reflect a reasonable sample of Thai health care professionals, or are their responses reflective of the perceptions and attitudes of a specific section of health care professionals in Thailand? Although one cannot address this question with certainty, it is possible to indicate that although the participants may not represent the whole spectrum of health care professionals, they may represent significant sub-groups. This section will account for the traits of the research participants, rather than attempt to argue that these participants proportionally reflect or represent all health care students and professionals in Thailand. There are some traits, for example the average age of participants, which suggests that research participants are not proportionate representatives of the general population of health care students and professionals.

Of the 93 questionnaire survey participants, 30 were males and 63 were females. Although it may be argued that there is a significant overrepresentation of females in the survey, as the ratio of females to males is about 2:1, this may be a result of the professional or educational stream of participants. There is also a high proportion of females among the health care professionals interviewed, as 25 of the 33 interviews are females, or a ratio of females to males of about 4:1. As some health care professions are generally viewed as female professions, particularly nursing and midwifery, and there has become a greater equity between the genders for other professions such as pharmacy, dentistry, and medicine, the significant higher proportion of female participants in this research may be a result of the higher proportion of female health care professionals and students. It is common that 70 percent of all nurses are females, and 70 percent of all physicians are males in different health care systems (WHO 2006b). While there is a historical gender imbalance among Thai physicians, this is closing, as the number of male and female medical students are now about the same (Wibulpolprasert 1999), although there is no apparent gender equity among nurses

and midwives. It is also possible that the high number of female interviewees is a result of several key resource persons that initiated the snowballing of participants themselves were females. These key resource persons were relatively young, in their twenties and thirties, and hence may have contributed to the low average age of participants as they may have referred their peers rather than their mentors to assist with this research. This may also be valid in relation to the key resource persons assisting with the questionnaire survey.

Age group	Questionnaire	Interviews
21-25	38	1
26-30	40	9
31-35	4	8
36-40	9	2
41-50	1	9
51-60	1	-
61 and older	-	1
No Response	-	3
Total	93	33

Table 4.1: Health Care Students' and Professionals Age

Table 4.1 indicates that the health care professionals taking part in this research, particularly the questionnaire survey participants, are relatively young. As participants for the questionnaire includes students, while the interviewees were all graduate professionals, it is reasonable that the average age of the questionnaire participants is lower than that of the interview participants. Thirty-eight questionnaire participants were students, fifty-two were professionals, and three participants were both graduated professionals and students. The mean age of questionnaire participants is just over 27 years, while the mean age of the health care interviewees is almost 44 years. For the purpose of this research, this is an important characteristic of participants, as traditional migration theory indicates that migrants tend to be young adults and teenagers (Lee 1966). Another characteristic which may increase or decrease the probability to migrate is the marital status of participants, as being in a relationship could mean leaving this person behind, and in this case would constitute a restraint or disincentive to migrate.

As outlined in Table 4.2, the proportion of participants who are single is very high for both questionnaire and interview participants. This follows from the low mean age of questionnaire participants, and with more than seventy percent of questionnaire participants identified as single, it is reasonable that a significant proportion of these participants are both willing and capable to migrate, compared to the larger population of health care students and professionals. The questionnaire survey can hence be interpreted to over represent the willingness to migrate among health care students and professionals. However, if we view the questionnaire to reflect attitudes and perceptions among a section of young professionals and

students, the demographic of the questionnaire participants should not inhibit reflecting on perceptions and attitudes outlined from the questionnaire. Although the mean age of the interviewed health care professionals is much higher than for the questionnaire participants, the proportion of singles among these participants is also high, with more than half of these participants identifying themselves as single. In addition to martial status, dependant children may constitute a constraint for some participants from contemplating migration. Of the 93 questionnaire participants, only 9 indicated they had dependant children, while 10 of the 33 interviewees stated they had children under the age of 18 years.

Marital Status	Questionnaire		Interviews	
	Frequency	Percent	Frequency	Percent
Single	68	73	18	55
Long Term Relationship	5	5	-	-
Married	18	19	11	33
Divorced	1	1	3	9
No Response	1	1	1	3
Total	93	99	33	100

Table 4.2: Health Care Students' and Professionals Marital Status

Region	Questionnaire	Interviews
Bangkok and Metropolitan Area	53	9
Central	8	1
East	2	-
Northeast	-	8
North	20	10
West		1
South	-	-
Missing	10	4
Total	93	33

Table 4.3: Health Care Students' and Professionals' Region of Residence

Table 4.3 indicates the geographical distribution of participants according to their province of residence, while Table 4.4 outlines participants' province of origin. These tables are included to present the geographical spread of participants, both in accordance to where they reside and where they consider they come from. Previous research into labour migration in Thailand has indicated that attitudes and patterns regarding migration may be characteristics of certain regions or provinces, particularly from the North and Northeastern provinces (Jones and Findlay 1998; Jones and Kittisuksathit 2003; Jones and Pardthaisong 1999; Mills 1993). This attribute of Thai migration is not considered to be significant in this research as this aspect or characteristic regarding migrants and migration in Thailand is specifically related to unskilled and semi-skilled labour migration, and particularly rural to urban migration. Rural to urban migration, or attitudes towards working in these settings, are important factors with regards to the internal inequities of health care professionals in Thailand, and are examined further in chapter six. The geographical distribution of participants, including the specific dynamics

regarding attitudes and perceptions of being a metropolitan, or *Bangkokian*, are accounted for in section 6.1.

Region	Questionnaire	Interviews
Bangkok and Metropolitan Area	28	6
Central	15	3
East	2	-
Northeast	9	8
North	24	8
West	-	-
South	7	2
Missing	8	6
Total	93	33

Table 4.4: Health Care Students' and Professionals' Region of Origin

Profession	Questionnaire[1][2]		Interviews
	Student	Professional	
Medicine (all levels)	25	15	8
Residence		*1*	*1*
Specialised	*2*	*3*	*2*
Director			*1*
Private Enterprise			*1*
Dentist		1	3
Specialist		*1*	
Nurse (all levels)		33	19
Lower Level			*2*
Specialised			*3*
Registered Nurse		*6*	*1*
Retired			*1*
Private Sector			*1*
Radiological Technician			2
Pharmacist		3	1
Aged and Child Carer		1	
Teaching (undisclosed field)		1	
Missing	16	1	-
Total	41	55	33

Table 4.5: Professional Stream and Background among Participants
[1]Questionnaire participants were not asked whether they were working in the public or private sector.
[2]Includes three professionals studying: two doctors specialising, and one nurse studying medicine

Efforts were made to interview participants from a wide spread of professional background. Table 4.5 outlines the professional backgrounds of interviewees, and indicates the stream or profession of the questionnaire participants. While a significant proportion of students did not declare their stream of study, there is a variety of professional backgrounds among the participants. Firstly, there are more professionals among the questionnaire participants than students, suggesting the questionnaire reflects perceptions and attitudes for both professionals and students. It is also noteworthy that physicians and medicine students are highly represented, about one-third of interviewees were physicians and more than forty percent of questionnaire participants were either physicians or medical students; a clear overrepresentation with respect to the general composition of health care professionals in the

Thai health care system. In 2002, there were almost 114,000 registered nurses in Thailand (Wilbulpolprasert et al. 2004b), while estimates for the number of physicians in Thailand in 2000 varied from 18,000 to just below 22,500 (see Table 3.3). This suggests that there are about 5 nurses per physician in Thailand, while among the research participants, there are about as many physicians and medical students as there are nurses. However, as there has been more documentation of physicians emigrating from Thailand than nurses, it is appropriate to have a large sample of medical students and physicians.

These traits of the research participants are an integrated component of the background and context of this research, and are illustrative of their attitudes and perceptions which are presented in the following chapters. While participants come from a variety of backgrounds, and it would be interesting to explore the impact of these factors on perceptions and attitudes among participants, the sample sizes are too small to make any meaningful generalisations. Furthermore, the absence of any form of probability sampling in the selection of research participants implies that generalisations would not be representative for the larger population of health care professionals. While this can be viewed as a limitation of this research, particularly from a naturalistic research methodological epistemology, the purpose of this research is to investigate and explore the tensions and dynamics in the Thai health care system, as well as motivations for exodus and the conflict of rights between health care professionals' individual right to migrate and the public's right to medical care. As stated earlier; the decisions influencing migration are not entirely rational (Lee 1966); hence this research investigated attitudes and perceptions.

4.3 Ethical Concerns

There is a fundamental requirement to conduct research which abides ethical etiquettes and standards, and the utilisation of human rights in the epistemology directly implies that the research cannot utilise procedures which are viewed as unethical. It is important to note that ethical standards are different and a derivative of social and cultural norms, although this does not imply that human rights are relative. In fact, although it is important to comply with cultural and social norms, research which does not completely embrace all these parameters, particularly when resulting from unintentional and innocent omissions or mistakes, should not necessarily be viewed or labelled as unethical. However, complying with local cultural and social norms, particularly when doing research in a foreign setting, reflects the researcher's

respect of participants and their cultural values and may ease the research process and is an initiation of rapport.

Although Thailand has become part of the globalised and integrated world, particularly the Bangkok Metropolitan Area and major tourist destinations, there is a strong nationalistic pride among Thais of their culture and unique heritage. Great effort was therefore taken to comply with Thai cultural and social norms throughout the research by consulting and relying on the aid of local gate keepers. In particular, the interpreter, who assisted throughout the research process, function as a major resource person in the efforts to conform to local practices. Participants were only contacted after introduction or referral from local gate-keepers, including those participants identified through snowball sampling. The tertiary teaching institutions training and educating health care professionals that were contacted to assist with the dissemination of the questionnaire survey were approached through formal channels and letters of introduction, as previously outlined.

There is a general concern regarding research involving humans to ensure both informed consent as well as protecting the participants from coercion or concealed research. This research did not engage or utilise any form of coercion, often referred to as disguised or covert observation, or covert participant observation (Bryman 2004), at any stage, and great care was taken to ensure informed consent by all participants. As accounted for previously, all participants were presented with an information sheet and had to sign a consent form. However, consent was assumed if a questionnaire survey was returned without an attached consent form, as explicitly outlined in the information sheet prepared for the questionnaire. Returning a questionnaire without a consent form allowed participants complete anonymity. It should be noted that all health care professionals in this research are tertiary students or professionals, and capable of giving informed consent and understanding the basic dynamics of this research and social research processes in general. Although some of the key informants may not have had extensive higher education, they were selected on a voluntary basis and based on their capacities and knowledge as resource persons.

Great care was taken to ensure rigorous ethical standards throughout the research process. Ethical approval from the University's Human Research Ethics Committee was sought and approved at the early stages of this research. Although some adverse political and security development took place during the period the interviews were carried out, these were not perceived to constitute a threat. However, some changes to itineraries took place as a result of these volatilities. Of particular concern was the military coup d'état in September 2006 and

the detonation of explosive devices in Bangkok and Chiang Mai on New Years Eve 2006 and the following months, in addition to the continuous violence in the Southern regions of Thailand. The incident in the capital led to an end of interviews in the Bangkok Metropolitan Area, with the exception of those already scheduled, in early 2007. However, the 2006 New Years Eve fatal attacks and the detonation of explosive devices in the following months can in hindsight also be viewed as temporary volatility, although at the time grave concern characterised these incidences.

Although important for the contextualisation of this research to investigate perceptions and attitudes relating to the Southern violence, it was never an intention to visit the regions affected by the atrocities. Participants, who could offer insight into the dynamics and impact on the individuals affected by the violence and who resided outside these provinces, were interviewed in person, although further insight particularly regarding attitudes and perceptions among those living in these provinces was sought through various means, including contact by phone and post. It was never perceived that participation in this research, including by individuals living in Southern Thailand, would place anyone at greater risk. However, extra care has been taken to avoid the identification of participants. References made to participants in the following chapters will provide brief background of participants' capacities. In particular, some participants have multiple professional capacities, which when linked, may make them identifiable to some. As such, although participants may be cited and referred to in different capacities, they are not linked and cannot be identified through their responses quoted in this research.

While at times, there are concerns regarding utilising interpreters in social research, not doing so automatically excludes participants with specific characteristics (Boynton 2005). While several participants were capable of communicating in English, and more interviewees had sufficient language skills to be interviewed in English, the assistance of an interpreter throughout this research was invaluable. Although there are some concerns when relying on translations and the assistance of an interpreter as part of any research, these concerns particularly for this research were of little impact. The assistance of an interpreter was an asset throughout the research processes, and allowed conformity with the cultural and social etiquettes and enhanced the insight into Thai civil life. The interpreter undertook a role of research assistant rather than just translating; contributing to the wealth of information generated as well as contextualising responses regarding policy, history, politics, policy, social, and cultural aspects. This implied that the interpreter not only mediated linguistics, but

became a cultural guide, key informant into social dynamics, and a bridge-builder throughout the data-collection process. Rather than being an ethical liability, the assistance of the interpreter can be viewed as enhancing the rigour of the interpretations and be characterised as what Denzin (1989) refers to as: "investigator triangulation" as there was more than one observer.

It is important to clarify that the interpreter for this research was highly qualified, not only through linguistic experiences and expertise, but also through her educational and professional background. The interpreter is Thai and holders a Bachelor degree from a Thai university as well as a Masters degree from an Australian university. She has experience in social research in both Thailand and Australia and her professional as well as linguistic contributions, in addition to her cultural and social insight, were of immense value. The value of this interpreter and research assistance cannot be overstated, and it became evident that it was an absolute necessity to have an interpreter assisting with this research. Even when interviews were carried out in English, clarifications and explicit references were often made in Thai, and the richness of these interviews would have been lost without the aid of the interpreter. It was also implicit that in several circumstances it would not have been possible to carry out the interviews without the assistance of an interpreter as even graduated and highly trained professionals such as physicians indicated that they did not have confidence in their abilities in English, and were reluctant and uncomfortable to communicate in English without the possibility to consult the interpreter regarding specific terminology.

4.4 Organisation and Presentation

It has already been argued that the author does not perceive a conflict between qualitative and qualitative research instruments and methodologies, although this research arguably tilts more towards qualitative research methodologies and ontology, which does not exclude the research's subscription to the attributes of quantitative research and its axioms. This is reflected by this research being presented within the traditional purview of modern and quantitative research. This is primarily a result of the traditions within the fields investigating the interdisciplinary issues addressed in this research, particularly; the field of migration study, quantification of human resources for health, and even health care related research. In particular, international organisations, including those under the UN umbrella and associated organisations generally adopt this traditional approach of presenting research, data, and generating knowledge, even if research tools and methodologies include qualitative and

postmodern approaches. However, some newer studies have adopted a more postmodern style and language, including the subjective presentation of research.

The utilisation of human rights as the epistemology is illustrative of the balance between modern and postmodern methodologies. It has been argued that human rights are irreducible values, very much within the modernist tradition of perceptions. However, it is also argued that human rights must be viewed holistically and within the specific social and cultural context, tilting towards the postmodern interpretations. The emphasis of this research on a holistic and inclusive approach to health care is because conflicting rights must be approached holistically. While human rights are integrated into the epistemology, human rights also form an analytical framework for this research. This has two dimensions: Firstly to explore challenges to acceptable and appropriate policy principles within contemporary standards, which do not breach the rights of any stakeholders. This relates explicitly to health care challenges in Thailand, particularly the inequitable distribution of health care professionals in the country as well as the emigration of these professionals, but does not exclude the international dimensions of these challenges. It will be argued that, some of the solutions must be pursued at an international and inter-governmental level, bilaterally and multilaterally, as there is a global shortage of human resources for health. Secondly, the human rights framework in this research alludes to the ambition of universal sustainable health care within the principles of sustainable development and global sustainability. This ambition must be pursued in principle and be a continuous ambition for generations to come throughout the millennia. The goal must be universal human development; which cannot be achieved without strong international cooperation.

One of the key principles of sustainable development outlined in the Brundtland Report (1990) is the notion of intergenerational sustainability; the conservation of the resource base for future generations. This premise implies that future generations have equal right to a high living-standard as the current generation has. With regards to renewable resources, the principle of sustainability is to only consume these resources in such a fashion that these resources will be available for future generations; consumption that does not threaten the resource base. With regard to non-renewable resources, the principle is that "resources should not run out before acceptable substitutes are available" (Brundtland 1990:90). These principles from the field of sustainable development are applicable to this scenario of conflicting rights. It is argued in this research that health care consumption must be sustainable. Health care systems cannot be based on unsustainable recruitment of health

care professionals from countries with lower levels of human development. Substitutes to current market forces and recruitment practices which threaten the stock of human resources for health in many LHD and MHD countries have to be developed. There is also a need for internal equity and sustainability within each health care system; ensuring that current health care standards are equitable distributed and can be sustained for future generations.

4.5 Chapter Summary

This research utilised a mixed methods approach; consisting of a questionnaire survey and semi-structured interviews. Research participants were mainly Thai health care students and professionals, although some key informants with different professional backgrounds contributed with their insight to contextualise current events, were also carried out. Despite participants not being selected through any form of probability sampling, the attitudes and perceptions of these participants will offer insight as great care was taken to ensure a geographical and professional diverse background of these participants. Some of the characteristics of these participants may not be representative for all health care professionals in Thailand, although these characteristics, such as age, profession, and physical location, are associated with subgroups with higher propensity to migrate within the traditional migration literature. As such, attitudes and perceptions among these participants are valuable to the discussion regarding the brain drain of health care professionals

The following four chapters will present, explore, and analyse the data from the questionnaires and the interviews based on a thematic presentation rather than attempt to present and organise these findings according to the methodological origins. Chapter five explicitly reviews attitudes and perceptions to the contemporary political and security volatilities, and the interrelationship of these on health care students' and professionals' attitudes or desire to migrate. Chapter six accounts for tensions within the Thai health care system: Between rural and urban areas; the public and private sector; and tensions induced by health care reform. The subsequent chapter reviews the challenges of HIV/AIDS in Thailand, including perceptions and attitudes among health care professionals and possible contemporary developments which will have adverse effects on Thailand's achievements in stemming the pandemic. Chapter eight explores the dynamics between rights and obligations; including one of the dynamics currently ensuring sufficient human resources for health in Thailand, viewed in this research as a social contract. This chapter also explores the predicaments of conflicting rights and advocates a rights-based approach to health care. Chapter nine elaborates on the

themes and concerns relating explicitly to insufficient human resources for health and the migration of health care professionals. Based on both the Thai concerns uncovered in this research, as well as international dynamics, this chapter aims to propose a new framework and approach to stem the adversities of insufficient human resources for health and create international cooperation in the education and training of more health care professionals, before chapter ten concludes this research.

CHAPTER 5

Contemporary Political and Security Volatilities

"Right after the military coup d'état on 19 September 2006, the international media reported with fascination its peaceful nature. … Well-known academics and social critics argued in chorus that the coup was a necessary step backwards in order to go forward to genuine democracy. For such people, the Thaksin Shinawatra government was "the worst crisis in the world." … To prolific Thaksin critic Kasian Tejapira … the Thaksin regime was an "elected capitalist absolutism" that had committed grievous crimes, namely: the extra-judicial killings of over 2000 people during the "War on Drugs;" the deaths of several thousand more due to the mishandling of the crisis in the Malay Muslim region of southern Thailand; and Thaksin's manipulation of the media and the supposedly independent regulatory bodies" (Winichakul 2008:11)

5.0 Introduction

This chapter will present attitudes and perceptions among health care students and professionals with regards to contemporary political and security concerns in the context of events which where current in Thailand at the time of the research. Views and perceptions from key informants regarding these issues are also included. As the perception of personal security, whether notions of insecurity are well founded or not, has been determined to be one of the most significant factors in the decision making process for potential migrants, the current political and security situation is a seminal issue which has to be reviewed and can be classified as social and political push-factors for migrants and potential migrants. This chapter will first outline current events followed by a section of the concerns of health care professionals, with a subsequent section of the implications of these perceptions in the context of current events. The following chapters will review in greater detail other elements of great importance for health care professionals contemplating migration.

5.1 Contemporary Political Tensions and Security Concerns

Thai history has been filled with political turmoil. The birth of Thai democracy took place in 1932 after a "bloodless revolution" (McCargo 1997), and both military regimes and renewed democratic rule have since followed. The 1932 revolution ended the absolute monarchy,

although "it was also the beginning of military rule lasting, with brief breaks, until 1973 (Winichakul 2008:12). The last military takeover on 19th September 2006 was the 18th coup since 1932. The previous coup of 1991 turned bloody the following year when troops shot protestors demanding democracy (The Economist 2006). This section will account for contemporary political and security volatilities; it will give a brief insight into the current insurgency and violence in the southern provinces of the country; account for the military coup of September 2006; and review some of the allegations of corruption, conflicts of interests and human rights abuses by the ousted government. Negative perceptions, or concern regarding these volatilities, may impact the decision making process for potential migrants and contribute to the exodus of health care professionals, and other individuals concerned by these issues, and have therefore been included to contextualise the concerns raised and encountered during this research.

5.1.1 The Current Insurgence and Violence in the Southern Provinces

According to the United States Department of State; "Thailand's biggest domestic security challenge remained the ongoing separatist movement in the far southern provinces of Narathiwat, Yala, Pattani, and Songkhla" (United States Department of State and Office of the Coordinator for Counterterrorism 2007). Similarly, the Australian Department of Foreign Affairs and Trade (2008) has consistently over the last few years advised Australians to reconsider their need to travel to and/or through these provinces bordering Malaysia and the current travel advice, as of August 2008, states; "do not travel" to the provinces of Yala, Pattani, Narathiwat and Songkhla. Hence the Southern violence is a continuous security concern for Thais, particularly those living in these southern provinces. Pattani, Yala and Narathiwat became part of Thailand in 1909 and there has been "a long history of resistance to the authority of Bangkok" in southern Thailand, including an "insurgency ... linked to an explicit "separatist" movement" (McCargo 2007a:3). The latest round of violence was ignited in January 2004, with almost daily attacks in these provinces (Australian Government, 2007; United States Department of State and Office of the Coordinator for Counterterrorism 2007), and a "severe state of emergency" was declared for Pattani, Yala and Narathiwat on 19 July 2005.

The Southern violence had been dormant, although incidents had taken place prior to the resurgence in January 2004, and there are still different theories or perspectives on current dynamics and triggers as the death toll passed 3,000 in 2008 (AFP 2008b). The intricate dynamics, relating to both the separatists and the power structures in Southern Thailand are

very complex, and a brief review of recent events follows. Some believe that this conflict has been exacerbated by former Prime Minister Thaksin Shinawatra (McCargo 2007b; Pathmanand 2007; Winichakul 2008). Although the armed separatist movement in Southern Thailand has operated from the 1950's, with its height in the 1970's, cultural sensitivity and political liberalisation of Muslim elites during the 1980's and policies of amnesty and development programmes during the 1990's this movement was believed to be in "terminal decline" by the close of the twentieth century (Connors 2007).

Former Prime Minister, Thaksin Shinawatra, has been accused of badly politically motivated manoeuvring and reshuffling of the power-structures in these provinces which sparked and fuelled the southern violence, one of the rationalisations of the military coup-makers who ousted him on 19 September 2006. McCargo (2007b:35) argues that "the renewed violence reflects a direct challenge by Prime Minister Thaksin Shinawatra to well-established networks of power relations centred on the palace". By assigning Major General Songkitti Chakkabhatra, a former classmate of Thaksin with an international profile as he served as deputy commander of the East Timor international peacekeeping force, Thaksin was criticised of assigning an ally to study and work on this "southern problem" in October 2001. When major General Songkitti reported back in early 2002 arguing "that there was no real insurgency" and that the security situation should be "normalised" (ibid:45), irreversible events were put in play, facilitating a political parody with devastating consequences in these provinces as this convinced Thaksin to withdraw the paramilitary ranger divisions 41 and 43 and the marine corps out of these provinces (Wasanna Nanuam cited in McCargo 2007b:45-6).

Thaksin's perception was that most of the Southern violence was not caused by insurgents, but rather criminal acts committed by bandits. It is suggested that the attacks and violence in these provinces from 2002 to 2004 was believed by Thaksin's government to have been instigated by local politicians, including a senator for the province of Pattani, as well as by police and army commanders in the regions, characterised as conspiracy theories, although also supported by local Muslims:

> "Arson attacks were particularly suspicious–burning down schools in the middle of the night made alarming national headlines, but left no one hurt, and meant an additional budget allocation for their reconstruction. … The major beneficiaries of the long-standing conflict in the South were the officers of the Fourth Army Region: the supposed insurgency provided the justification for their extensive "development" projects, and their jurisdiction over the border (for which read, control of smuggling)" (McCargo 2007b:42).

As Thaksin viewed the Fourth Army Region military station in southern Thailand with scepticism, this led to continuous changes and reshuffles to the command of the military and security forces in this region which in turn caused a weakening of the security situation as tensions and conflicts arose within the military and security forces (ibid). Furthermore, Thaksin has been charged with mishandling and exacerbating the violence (Pathmanand 2007) in the lead up to the renewed Southern violence in early 2004. To a large extent, the reshuffles in the army and security forces weakened their ability to respond to the coordinated and increased violence in 2004, and the heavy-handed response which then followed, in for example the incident in Tak Bai in October 2004 where 78 protestors died in government custody, may have exacerbated the volatility further. It is of utmost importance to understand the dynamics and actors in this conflict to grasp the repercussions and the complexities regarding the Southern violence. For example: Who are the insurgents? What are the repercussions of this conflict, domestically and regionally? And in particular, how participants and health care professionals perceive and are influenced by these events. Although individuals living in these provinces are most adversely affected by the volatilities here, perceptions may persuade individuals living elsewhere to emigrate. Further elaboration and reflections upon these questions and particularly attitudes and perceptions among interviewees and key informants are presented in section 5.2.2.

5.1.2 The Military Coup D'état and Security Volatility

Early in 2006, public discontent with Thaksin Shinawatra, particularly regarding his and his family's personal gains from the sale of Shin Corp to the Singaporean company Thameasek, accumulated into mass protests in the capital[11]. Discontent with Thaksin and his government had been voiced and demonstrations had taken place prior to the sale of the family cooperation. The sale was perceived by many as the dealings of a businessman looking after his own interests rather than a politician with the best interests of the Thai public, which galvanised mass protest against Thaksin, eventually leading to the downfall of his reign. The demonstrations and condemnations from public commentators gathered momentum, with 50,000 protesters gathering in early February 2006 calling on His Royal Highness King Bhumibol Adulyadej[12] to oust Thaksin (Post Reporters 2006b). In a move to appease the growing public discontent over his financial dealings and perhaps in a bid to renew legitimacy,

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[11]An outline of actions and events related to former Prime Minister Thaksin Shinawatra and allegations of corruption have been included in Appendix T.
[12]The spelling of His Royal Highness' name here is that of Reynolds (2002), while for example McCargo (2007b) and Pathmanand (2007) refers to His Royal Highness as King Bhumipol Adulyadej.

Thaksin called for new elections for March 2006, 3 years ahead of schedule. The decision to hold early elections might also have been influenced by the fact that the opposition, through by-elections in October 2005, gaining the power to impeach Ministers for corruption (Ruangdit and Suksamran 2005). Thaksin had, and still has, overwhelming support particularly in rural communities and in the North, as he is from this region, and although massive demonstrations in Bangkok called for his resignation, support for Thaksin was also evident. In Northern Thailand, supporters in numerous districts gathered in the thousands condemning the anti-Thaksin protests in Bangkok (Post Reporters 2006c).

Thaksin's attempt to gain a renewed mandate and term as Prime Minister through the snap elections in April 2006 backfired when all major opposition parties decided to boycott the elections. The Thai constitution stated that in order to become an elected representative when unchallenged in an electorate, the representative had to gain a minimum of 20 percent of the registered votes. Thaksin and TRT would not be able to get a renewed mandate in the electorates in Southern Thailand where the violence and Thaksin's War on Drugs made it virtually impossible for the TRT to gain the required 20 percent of the votes. The Parliament, consisting of 400 elected Members of Parliament and 100 party-list members could not convene unless all seats had been filled. Only 485 of 500 members of the House of Representatives were approved after the April 2nd general election and the April 23rd by-election (Bobb 2006; Thai News Service 2006). Despite the April elections failing to re-elect the TRT government or appoint a new government and a remonstrance from the King, Thaksin continued to act as Prime Minister in a caretaker position and new elections were to be held in October 2006 (Ginsburg 2008).

It was not perceived that the new election due to take place in October of 2006 would resolve the political deadlock in Thailand, as the opposition parties continued to boycott the elections in a move to pressure Thaksin to resign from politics. It was also widely perceived that Thaksin and TRT could not gain needed support in all the electorates which had failed to elect a Member of Parliament (MP) in March, at least for the electorates in Southern Thailand. During the March elections, insurgents had attacked the election booths after the polling closed, wounding nine. Locals had lined up in hundreds, claiming to cast blank votes, as encouraged by critics of Thaksin, prior to the explosions on the Election Day (AFP 2006). As such, this political deadlock was perceived to continue, and without some outside intervention, i.e. by His Royal Highness King Bhumibol Adulyadejor or by the courts declaring that all seats

of the Lower House did not need to be filled for the Parliament to convene, no perceivable solution could resolve the political stalemate.

A military coup d'état on 19 September 2006 while the caretaker Prime Minister Thaksin Shinawatra was overseas toppled the government and obliterated the scheduled October elections. Although the coup must be viewed as step backwards for democracy in Thailand (Ginsburg 2008), the military coup was not for the military but can be labelled a royalist coup with the support of the "people's sector" instigated by the mass protests of the Peoples' Alliance for Democracy (PAD) (Winichakul 2008). "On the streets of Bangkok flowers and warm greetings showered over tanks and armed soldiers" (ibid:11). The coup makers officially handed over the political governing of the country to their appointed government led by interim Prime Minister Surayud Chulanont, but they remained in power by introducing a Counsel of National Security (CNS) where the coup makers had de facto control of the country. The Thai public may have viewed this bloodless coup as relieving the tensions in the political deadlock as a newspaper survey reported ninety percent support for the military appointed government lead by interim Prime Minister Surayud Chulanont. This support fell sharply, to less than fifty percent, following the growing political tensions and fears instigated by the New Year's Eve bombings (Chokchaimadon et al. 2007).

On New Years Eve, 2006, several bombs where detonated in Bangkok killing 3 and wounding numerous Thais as well as 6 tourists (Australian Government 2007; United States Department of State and Office of the Coordinator for Counterterrorism 2007). An explosive device targeted a Buddhist Temple the following morning in Chiang Mai, wounding the caretaker of the Temple. On 30 January 2007, two grenade attacks took place in Bangkok, at Rama Gardens Hotel, frequently used for government and government sponsored conferences, and the Daily News. Both were fired by a grenade launcher from an elevated road (Post Reporters 2007a). The separatist movement in Southern Thailand was explicitly ruled out as the perpetrators of the Bangkok and Chiang Mai bombings by the military appointed government, although numerous allegations linked them to followers of the ousted Prime Minister Thaksin Shinawatra (The Nation 2007e). Thaksin Shinawatra denied strongly any involvement in the Bangkok bombings, stating "I swear that I have never thought of hurting and spoiling the happiness of people, or destroying the country's credibility for political goals". Thaksin, despite the statements by the military appointed government and other sources saying otherwise, stated that these bombings were carried out by militants from the deep South (The Nation 2007a). On January 20, 2007, thirteen suspects from both military and non-military

background were arrested (The Nation 2007c). In total, nineteen suspects were identified, but all were release as there was insufficient evidence to press charges (The Nation 2007b) No perpetrators of the New Year's Eve bombings have been charged.

Critics, both independent and former allies to the ousted Prime Minister Thaksin and the TRT party, criticised the CNS and interim government of playing politics rather than rectifying and facilitating for new elections and a return to democracy in Thailand. The dissolution of the TRT party, in particular, enraged the Thaksin supporters, who reformed into the new People Power Party (PPP). The return to democracy, despite taking longer time than the coup makers initially outlined, was marked by the December 23 general elections in 2007. After courting minor parties the PPP's leader Samak Sundaravej was elected as new Prime Minister in January 2008 (Percy 2008). Many of Thaksin's supporters and former aides were included in the PPP cabinet (AFP 2008a).

Despite the return to democracy, the political turmoil and volatility continued. The tensions between the newly instated government and the opposition can be reflected in the physical altercation between a government and opposition MP which took place on April 2, 2008. A verbal altercation regarding whether a member of the opposition also was a member of the anti-government PAD which was strongly involved in the toppling of the Thaksin government in 2006 lead to a government MP physically assaulting an opposition MP after a heated house debate (Thip-Osod 2008). The PPP is being investigated for being a nominee of Thaksin's defunct TRT party and Prime Minister Samak Sundaravej is trying to amend the constitution to avoid the PPP being dissolved (AFP and Reuters 2008). The deputy leader of the PPP was found guilty of buying votes (ibid) and mass protests against the PPP government is currently taking place with 35,000 protestors around Government House (Australian Associated Press 2008), spearheaded by the PAD which was instrumental in the lead-up to the coup in 2006[13]. The PAD were also instrumental in the protests regarding a temple dispute with Cambodia, "accusing the cabinet of agreeing to cede land to Cambodia in return for business concessions for ousted Prime Minister Thaksin Shinawatra" (Reuters 2008a). The controversies of this dispute lead to the resignation of the Foreign Minister, the second minister to resign from Samak's PPP government. Earlier the Public Health Minister resigned after failing to declare that his wife had more shares than permitted under the new constitution (Reuters 2008b).

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[13]Updates with regards to the contemporary political volatility and changing political scene in Thailand ended in late August 2008.

The political volatilities are likely to continue as the PPP government and its connections with ousted Prime Minister Thaksin Shinawatra are controversial. Thaksin is currently seeking refuge overseas, after being allowed to leave Thailand for the Beijing Olympics. Instead of returning to Bangkok Thaksin and Potjaman, his wife, skipped bail and fled to London (The Economist 2008). Potjaman, was recently sentenced to three years jail for tax evasion. Her brother was also sentenced to three years jail, while her secretary was sentenced to two years jail in the same case (Mydans 2008). The Thai Supreme Court has issued arrest warrants for the couple and is contemplating seeking extradition from Britain as the Supreme Court is proceeding with another corruption charge against the couple in absentia (BBC News 2008).

5.1.3 Allegations of Human Rights Violations

There are many dimensions to the allegations of human rights abuse by the former Thaksin government. The declared War on Drugs and its approach in combating drug traffickers and dealers illustrate brutal state violence. During a three month period in 2003 more than 2,000 people, officially drug traffickers, were killed (Beech 2007). In total, it is alleged that the War on Drugs led to almost 3,000 extrajudicial executions (Pathmanand 2007). Following the toppling of Thaksin's government, the National Human Rights Commission of Thailand, together with the Lawyers Council of Thailand began pressing the interim government to ratify the convention of the International Criminal Court and to press charges against Thaksin for the extrajudicial killings as Crimes Against Humanity (Ruangdit 2006). As argued by the network of drug users; the War on Drugs and the classification of drug users as criminals also had detrimental consequences for the fight against HIV/AIDS (Assavanonda 2005).

Besides targeting drug traffickers, Thaksin's War on Drugs "gave the police carte blanche to target selected locals [in the Southern provinces] for extrajudicial execution" (McCargo 2007b:50) which may also have been a factor in reigniting the Southern violence:

> "The renewed wave of violence began in the Thai South on 4 January 2004, with an attack on a Narathiwat army base (marked by four fatalities), coupled with twenty school burnings. Prime Minister Thaksin Shinawatra adopted a hard-line response, including use of martial law. The police in particular appeared to be complicit in the unexplained disappearances of numerous Malay-Muslim suspects. Another 113 men died on 28 April. These deaths resulted from eleven separate attacks on security posts in three provinces by groups of young Muslim men wearing black. … there is evidence of extrajudicial killings by security forces in several places, notably at Saba Yoi marked, where fifteen of the nineteen attackers killed had gunshot wounds to the back of the head" (McCargo 2007b:36).

The extrajudicial executions by government forces complete an overall perception of harsh state-violence by the Thaksin government in Southern Thailand. An incident in Tak Bai in October 2004 received international attention including "strong criticism from Malaysia and Indonesia". The incident began as a peaceful protest outside a police station in Tak Bai, with devastating effects when several of the peaceful protestors were shot dead. More than a thousands protestors were subsequently rounded up by the military and cramped into trucks to be detained in military camps. On arrival, 78 of these detainees were dead, apparently having suffocated during the transportation (McCargo 2007b:37). Despite international concern regarding this incident, the Thaksin government insisted that the detainees were legitimate and charges were laid against 92 of the protestors. More than two years later, after the Thaksin government was ousted, these charges were dropped by the Attorney-General the day after the military appointed Prime Minister Surayud Chulanont apologised for the mismanagement of the Southern conflict by the former government (Post Reporters 2006a).

The Thaksin government's disregard for human rights and use of extrajudicial killings in the War on Drugs and in relationship with the Southern violence must be reviewed jointly. When the War on Drugs was initiated in January 2003, the Thaksin government believed that the violence in the South consisted mainly of criminals, drug traffickers and smugglers in the Southern border regions. In fact, it was even claimed that the demonstrators in the Tak Bai incidents were protesting under the influence of drugs (Jitpiromsri and Sobhonvasu 2007). Admittedly, there are higher frequencies of drug and substance abuse in the Southern provinces of Thailand. The drugs abused, are in most cases marijuana or ganja and cough medicines containing codeine mixed with caffeinated drinks, and are not considered to lead to violent behaviour (ibid). Although evidence of substance abuse in Southern Thailand has been documented, and the Thai-Malaysian border is considered porous, catering for smugglers, this in itself does not justify the severe allegations of systemic extrajudicial killings. More seriously, if the War on Drugs was a pretext to eliminate individuals or groups for political gains, there are sever deficiencies in notions and perceptions of human rights. Although this falls outside the parameters of this research, it must be acknowledged that in Thailand, there are multiple perceptions and dimensions of human rights. Indeed, it could be argued that in Asia, or the Asia-Pacific region, perceptions of human rights can be classified into views of; universality; indivisibility; a dimension of rights and duties; and a dimension of Asian values (Muntarbhorn 2002).

These two examples, the War on Drugs and actions against perceived insurgents in Southern Thailand, are distinct incidences which illustrates the low value of human rights in such circumstances during Thaksin's reign. There are other significant challenges regarding human rights in Thailand which are not specifically linked with the actions of Thaksin's government, but may be associated with poverty, underdevelopment, and organised crime. This includes issues related to the commercial sex industry, particularly forced prostitution; child sex; illegal trafficking of women and children; as well as challenges regarding illegal immigrants; child labour; and conflicts regarding Indigenous and tribal populations; environmental protection and land rights. Combating these challenges are fundamental to sustainable development, as they directly challenge the sustainable usage of land and natural resources, as well as the poverty dimension of sustainable development. "Poverty reduces people's capacity to use resources in a sustainable manner" (Brundtland 1990:93). Alleviation and development in these areas is crucial and cannot be successful without further research into these issues. Regrettably, the parameters surrounding these challenges cannot be pursued further within the limitations of this research.

5.2 Perceptions of Volatility

This section presents attitudes and perceptions among health care students and professionals regarding political and security volatilities. These perceptions may become push-factors for migration if it is perceived that these volatilities constitute a direct threat to the security or well-being of individuals and their families. Perceptions among key informants and their insight into these issues are also presented to contextualise the attitudes among the health care students and professionals with regards to the current political and security volatilities. The perceptions among health care students and professionals may allude to future migration patterns. Currently, there is no evidence of a mass exodus of health care professionals. It was outlined in chapter three that an extensive exodus of physicians from Thailand took place in the 1960's, and there are reports that nurses are emigrating from Thailand in increasing numbers (Martineau et al. 2004). Perceptions of insecurity resulting from perceived political volatility and violence may lead to a substantial exodus of health care professionals from Thailand, as these professionals are able to obtain visas to work in HHD countries with greater ease as a result of their attractive professional skills.

5.2.1 Perceptions Regarding Political Stability, Political Freedom, Violence and Security

The questionnaire survey was conducted among health care students and health care professionals in late 2005 and early 2006, prior to the political deadlock and volatility related to the failed elections in April 2006 and the military coup d'état later that year. However, political polarisation and public discontent with the Thaksin's government was smouldering at the time the questionnaire was distributed. It is also worthwhile to reinforce that although the Southern violence at this time was severe, and the past couple of years had seen extensive violence in the Southern provinces, the military coup d'état on September 19, 2006 and the New Year's Eve bombings in Bangkok and Chiang Mai later that year; with further explosions in the capital in early 2007, may have further exacerbated perceptions of political and security volatility than reported in the questionnaire. Within this context it is of great interest to review the attitudes from the questionnaire survey regarding political freedom; political stability; and violence and crime in Thailand prior to the most volatile political and security events. These are presented in Table 5.1.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
There is a high level of political stability in Thailand	7.7	34.1	42.9	14.3	1.1
There is a high degree of political freedom in Thailand	11.0	23.1	42.9	20.9	2.2
There are low levels of violence and crime in Thailand	17.6	45.1	29.7	6.6	1.1

Table 5.1: Perceptions of political freedom; political stability; violence and crime in Thailand
Figures are in percent, n=91.

Although it is a very high frequency of neutral respondents in this table, the indications are that the participants disagreed with there being a high degree of political stability and political freedom in Thailand: While forty-three percent replied neutrally, over forty percent of respondents disagreed or strongly disagreed with this statement, while just above fifteen percent agreed or strongly agreed. The proportion of neutral responses is the same as for the statement of there being a high degree of political freedom in Thailand. The remaining respondents tilted towards disagreement with there being a high degree of political freedom. More than one-third of respondents strongly disagreed or disagreed with this statement while less than one-quarter of respondents agreed or strongly agreed. The respondents are more unified regarding the final statement in this table, relating to there being low levels of violence and crime in Thailand. Almost thirty percent of respondents replied neutrally, while more than sixty percent of respondents disagreed or strongly disagreed. Less than eight percent agreed and strongly agreed.

Table 5.1 alludes to the perceptions and underlying currents dominating the political sphere. Thailand experienced political turmoil since the election in early 2006 which failed to elect a Parliament and current political volatility in the country reflects the events of mass protests against the government which took place before the ousting of the Thaksin government. While the military coup in September 2006 ended fourteen years of parliamentary democracy and overturned one of the most popular governments in Thai history (Winichakul 2008), military coups and political volatility has dominated Thai political history. Since the end of the absolute monarchy in 1932, there have been 18 coups (The Economist 2006). The significant political turmoil which took place shortly after the completion of the questionnaire should be viewed as a manifestation of the tensions and undercurrents which were alluded to among questionnaire participants. The high frequency of neutral responses to certain questions, including those in Table 5.1, may be attributed to these tensions. This may be of concern, as political stability and freedom, together with low levels of violence and perceptions of security are key elements which can induce mass migrations and an exodus among those with sufficient human and financial capital.

Although all questionnaire participants where asked questions regarding political stability, political freedom, violence and crime, further information regarding these issues was mainly sought through the key informants. Some nurses working in the Southern provinces currently experiencing the insurgency were asked questions regarding the volatilities which will be accounted for in the following sub-section. Health care professionals living in other provinces were also asked general questions regarding the current volatilities. A nurse working at a public urban hospital replied when questioned about security issues and how to encourage health care professionals to work in risk areas:

> *Accidents can happen any time. Bombings can happen any time. So, as we have already decided to take the risk voluntarily, we have to accept whatever will happen.*

It is noteworthy that this interview took place after the military coup d'état, but prior to the New Years Eve bombings in Bangkok and Chiang Mai. In hindsight, she was right; the bombings happened, repeatedly, in Bangkok and without any prior indications or warnings except the general perceptions of volatility. Further insight into these issues was sought from key informants from both the government and non-government sector. An interviewee working in the domestic non-government sector, although funded through government programmes, characterised Thai democracy as "*rather shaky*":

> *People only know of voting, which takes two minutes at the ballot. There are no checks and balances, and no investigation by the people. Democracy in Thailand is just voting. Thai*

> *society never learnt the other dimensions of democracy such as public monitoring of the politicians, expressions of thoughts and participation in policy formulations. That is why people did not have any mechanism to remove Thaksin from power although they know he is the king of corruption.*

A retired Senator and former Minister characterised the current political situation, when interviewed in early 2007, just a week after the Bangkok bombings and three-four months into the military appointed government's rule:

> *The current political situation is mandated by the coup. My perception is that Thai people do not like it at all. They have become familiar with the democratic system over many decades ... nobody thought there would be any coups again. People do not like it. At the beginning they were glad that Thaksin was expelled but after that, three or four months later, people are starting to dislike the coup.*

These statements indicate that the ousting of Thaksin was popular although the means through which this was achieved were not. Despite the return to democracy earlier this year with the election of a government chiefly consisting of Thaksin supporters (AFP 2008a), and in light of renewed mass protests against he government by the PAD, instrumental in the ousting of the Thaksin government (Australian Associated Press 2008), it is probable that the political volatility in the country will continue. This scenario was alluded to in interviews with government bureaucrats and individuals from the non-government sector who voiced concern that the elections could lead to the return of Thaksin, perhaps not in person but by proxy.

Despite the majority of the interviewees characterising Thai politics and the strength of the democracy as ominous, some actually highlighted civil society as strengthening in certain areas. An interviewee, who acknowledged that civil society was not as strong as it was a decade ago, stated she believed that "*consumer groups are becoming stronger*". With regards to the health care system, patients have become empowered and now have the right to sue for malpractice. Also, networks and support for people with HIV/AIDS and related advocacy programmes were also highlighted to be strengthening, although some reservations to the quality of this support were raised. An Australian expatriate viewed the Thai civil society as "*quite strong*".

5.2.2. Perceptions Regarding the Southern Violence

Three female nurses living and working in the Southern provinces identified by the Australian Government (2007; 2008) as areas one should not travel to were asked questions related to their perception regarding the Southern violence. When asked if they wished or planned to migrate, they all answered no, replying that they were born in this area, or did not know where

to move to. Two of these health care professionals also answered, when probed, that the violence in the area had not made an impact on their views whether or not to emigrate. All key informants in these areas, these three nurses and a local businessman/merchant; expressed no plan or desire to migrate. Perhaps, as the violence has been a constant threat in these provinces for several years, most of those with opportunities or ambitions of migration have already left. This is validated by another key informant from one of the Southern provinces, who was interviewed in Bangkok, indicated that the security volatility in addition to work opportunities had impacted her decision to move from the South, and she did not intend to move back. However, she did visit on occasions as she has family in the Southern provinces.

The response from one nurse in particular revealed some of the tensions experienced by individuals living in these provinces. She stated that she did not plan or wish to migrate and that the current situation had not impacted on her desires to migrate. She then stated that "*the violence is increasing every day*" and that she "*would like the government to solve the problem very soon*". Some frustration or aggression towards the perpetrators was indicated when she replied that if they found someone who really can be proved to be a perpetrator in the violence, she saw it fit to "*give them the death penalty*". Although other informants were divided regarding whether Thais, in general, had a good understanding of the Southern conflict, this participant did not believed so and believe that the current conflict could have a spill-over-effect.

Factors affecting individuals in these provinces differ based on their circumstances. An independent business man/merchant living and working in one of the Southern cities claimed that his business profits had been reduced by fifty percent in the past three years due to the violence in the region. Although life in the city remained fairly consistent, travel outside required careful planning, as explosive devices along the roadside, snipers, and other obstacles such as nails on the road made travelling outside of the city a hazardous activity. Some government assistance for citizens in these provinces has been offered. This is basically economical assistance which does not relate to the security concerns. Income taxes, generally at 30 percent, were in 2007 reduced to 3 percent for these provinces, and interest rates on government provided loans where reduced from 5 or 6 percent to 1.5 percent. However, this businessman stated "*this does not help much; I would prefer help to create peace*".

The continued severity of the Southern violence, despite the ousting of the Thaksin government, was illustrated by 12 bombs being detonated in the city where this business

man/merchant resided in February 2007. The stark outlook according to this interviewee was that he believes "*the violence will increase extremely*". Another key informant, a retired Army General, with experience with the Southern insurgency offered his insight into the current dilemmas, emphasising that the problem "*can be solved*". He was highly critical of the military appointed government claiming that they did not have the capacity to solve this problem:

> *Now the situation is getting more and more intense because we let the rebels become stronger. They kill people every day. There are plenty of people who die from explosions, mines and the Thai-Buddhists are leaving these areas. This is not good. The government is a mess, not capable of solving the problem. Right now people start to hate them and want them to leave. People used to give flowers to the coup government, but now people want to throw bricks and rocks on them instead.*

When questioned regarding the use of military force by the interim military appointed government he stated that the use of military force was necessary. However:

> *There is no need to send so many of them. I think different from the government. Right now they are thinking to send more military troops. I think it is no need to send more. There are perhaps only 5,000-6,000 rebels but we have about 300,000 solders, police and local volunteers. … But we still cannot do anything. The government is stupid, they have no brains.*

Although the specific dynamics and compositions, or perceived dynamics and compositions, of the parties involved in this conflict is not directly linked with the objectives of this research, it is important to pursue some of these perceptions. The volatilities in the Southern provinces are directly threatening the security of people living here and as such constitute significant and valid motivations for moving from these areas. However, as the violence in these provinces is reflected in the national media and is a political and security challenge for the whole nation, this conflict may deteriorate perceptions of security among the population in other provinces of Thailand, legitimising and persuading individuals to emigrate. The severity of this conflict suggests that the Southern violence may have an adverse impact on availability of human resources for health in these provinces.

A sign of the severity and danger for health care professionals working in these provinces relates to a disturbing incident on August 8, 2007; the direct attack on a health station in Pattani which killed two health workers and left one unharmed. This incident highlights the problematic situation health care professionals in this area have been placed in. Previously, health care professionals were perceived to be impartial, and even were warned of attacks to escape harm. As stated by Dr Supat, a member of a Public Health Ministry committee:

> "Rural doctors were often warned of attacks beforehand. They were told to avoid using certain routes … But they could not help but worry because security officials were now

turning to them for information when any suspects were hospitalised" (cited in Post Reporters 2007b).

The neutrality of medical personnel has been further compromised by health stations being used as temporary military camps, doctors being approached by security personnel about locals, and the arrests of suspected insurgents at hospitals (ibid). This is of particular concern, as teachers, Buddhist monks, police and security forces have so far been the main targets of the insurgents as these groups are perceived to be instruments of the Thai Buddhist state. However, if health care professionals are now included in this category and becomes a legitimate target for the insurgents, an extensive exodus of these professionals from the Southern provinces may be imminent.

5.3 Health Care Professionals Attitudes Regarding Migration

The previous sections have accounted for political and security volatilities, and perceptions regarding these adversities. The impact of these volatilities on migration ambitions among the research participants have only been alluded to previously despite these volatilities being identified as instrumental for potential migrants in their decision making process. This section accounts for health care professionals' perceptions and attitudes towards migration and reviews social and political push-factors within Thailand, as well as perceived factors regarding migrating to developed, or HHD, countries. The following chapter will explicitly engaged and review the Thai health care system, and account for internal tensions and dynamics, both regarding internal migration and the challenges from health care reform which may foster a desire among health care professionals to leave the Thai health care system altogether.

5.3.1 Political Stability, Corruption, Security and Crime as Push-Factors for Migration

Table 5.2[14] presents attitudes among health care professionals regarding political stability, corruption, security and crime levels as influencing factors fuelling desires to migrate from the questionnaire survey. The responses to the statements outlined in Table 5.2 are much more unanimous than those in Table 5.1. There is an overwhelming level of agreement and no significant disagreement towards the desires of migrating to areas where; there is more political stability; less corruption; lower crime levels; and higher security. Less than five percent of the respondents disagree or strongly disagree with any of these statements, and for

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[14] The data presented in this table was originally presented, in a different format, at the International Sociological Association's XVI World Congress of Sociology, Durban, South Africa, 23-29 July 2006, in a conference paper.

the statements regarding security and crime levels, the level of disagreement is only 1.1 percent. Although more than one-third of respondents replied neutrally to the statement "I would like to migrate to a place with more political stability", one-third agreed and almost thirty percent strongly agreed with this statement.

Regarding the statement "I would like to migrate to a place with less corruption", more than forty-five percent agreed and more than thirty percent strongly agreed with this statement, while less than twenty percent replied neutrally. Slightly less than forty percent agreed and slightly more than forty percent strongly agreed with the statement "I would like to migrate to a place with higher security", while almost twenty percent of the respondents to these two statements replied neutrally. The proportion of neutral respondents decreased for the statement "I would like to migrate to a place with lower crime levels", with less than fifteen percent replying neutrally. Responses to this statement showed a substantial level of agreement; in excess of thirty-five percent of respondents agreed while almost fifty percent strongly agreed.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I would like to migrate to a place with more political stability[1]	-	3.3	35.6	33.3	27.8
I would like to migrate to a place with less corruption[2]	1.1	3.3	18.7	45.1	31.9
I would like to migrate to a place with higher security [2]	-	1.1	18.7	38.5	41.8
I would like to migrate to a place with lower crime levels [2]	-	1.1	14.3	36.3	48.4

Table 5.2: Attitudes towards Migration, Political Stability, Corruption, Security and Crime Levels
Figures are in percent; [1]n=90; [2]n=91.

It should be reinforcing that this survey is not necessarily representative for the larger population, as participants were not selected based on probability sampling. It should also be reinforced that the responses outlined in this table were collected from mid 2005 until early 2006, prior to the political polarisation and volatility accumulated from Thaksin's Shin Corp sale, the failed elections of 2006 and ultimately the military takeover later that year, as accounted for in section 5.1. The question is whether these attitudes outlined in Table 5.2 reflects a general perception among Thais of insufficient political stability and security and too much corruption and crime levels, or if these attitudes are particularly dominant among health care students and professionals. Secondly, it needs to be clarified if the attitudes in Table 5.2 reflect a genuine discontent with current political and security volatilities, or more adversely is the result of disillusion regarding domestic circumstances. As the figures in this table outline a strong willingness or desire to migrate, it is necessary to question if this relates to internal

migration or international migration. More importantly, does this imply an exodus of health care professionals to developed countries? This will be pursued further in the following sub-section which specifically investigates attitudes towards migrating to a developed country.

Table 5.3 can be viewed as consisting of control questions to the responses for the statements in Table 5.2, as it encompasses the same issues. However, the statements in Table 5.3 are framed as general perceptions or principles, while those in Table 5.2 were explicitly investigating willingness to migrate. There is a notable lower frequency of neutral responses in Table 5.3 than 5.2 reflecting that framing the questions as general perceptions generates a lower proportion of neutral responses, although almost thirty percent of responses were neutral to the statement "high degree of political stability is a key factor when I choose where to work". About three percent disagreed with this statement, while almost fifty percent agree, and more than twenty percent strongly agreed. Less than eight percent of responses were in disagreement with the statement "low level of corruption is a key factor when I choose where to work", the same frequency as neutral responses to this statement. Slightly less than forty percent agreed and slightly less than fifty percent strongly agreed with this statement. There was no disagreement to the statement "high level of security is a key factor when I choose where to work" and less than eight percent responded neutrally to this statement. One-third of responses agreed, while almost sixty percent strongly agreed. Similarly, no responses where in disagreement to the statement "low crime level is a key factor when I choose where to work"; ten percent of the responses were neutral; one-quarter of respondents agreed; while more than sixty-five percent of the respondents strongly agreed with this statement.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
High degree of political stability is a key factor when I choose where to work	-	3.3	27.5	47.3	22.0
Low level of corruption is a key factor when I choose where to work	3.3	4.4	7.7	37.4	47.3
High level of security is a key factor when I choose where to work	-	-	7.7	33.0	59.3
Low crime level is a key factor when I choose where to work	-	-	9.9	24.2	65.9

Table 5.3: Impact of Political Stability, Corruption, Security and Crime Levels on Where to Work
Figures are in percent; n=91.

Unfortunately, the parameters of this research have not allowed a fuller review of the extraordinary attitudes and perceptions revealed in Table 5.2 and 5.3. However, the issues regarding corruption, at least on the macro scale with the extensive allegations toward

Thaksin Shinawatra, have been outlined in Appendix T. Similarly, the issue of political stability or volatility was outlined in section 5.1.3. However, the questionnaire survey which Table 5.2 presents the responses from was conducted prior to the climax of these conflicts. Arguably, the tensions surrounding the Southern violence have been contentious from the escalation of the violence in 2004. Table 5.2 and 5.3 strongly indicate discontent with the current level of political, corruption, violence and security volatility among the surveyed population. The responses in Table 5.2 even indicate a high degree of willingness among the surveyed population to migrate. However, it is not indicated whether this implies internal and domestic migration or a desire to migrate to a HHD country. The following sub-section reviews explicitly health care students' and professionals' attitudes regarding this prospect.

5.3.2 Attitudes regarding Migrating to a Developed Country

The questionnaire survey also sought to investigate whether there was a desire among the surveyed population to migrate to a developed country. Firstly, it needs to be indicated whether there is a general pull towards working in a HHD country. Table 5.4 outlines the responses to statements regarding the perceived conditions of different parameters in developed countries. Clearly these perceptions must be reviewed in accordance with comparable perceptions of conditions in Thailand. Table 5.5 presents perceptions of comparable statements of perceived domestic conditions. It should be noted that some of the responses in Table 5.5 are presented elsewhere and the analysis of the content of table 5.5 is limited to the comparison of the content in Table 5.4. Further review of the attitudes outlined in Table 5.5 was provided in section 5.2.1 and follows in section 7.2.

Notably, no respondents indicated they perceived developed countries as not having good health care systems: One-third of the responses were neutral, more than fifty percent agreed and almost fifteen percent strongly agreed with the statement "developed countries have good health care systems". In comparison, a little over twenty percent agreed with "the Thai health care system is good" and just one percent strongly agreed with this. Almost fifty percent replied neutrally, while most respondents indicated disagreement with this statement. More than twenty percent disagreed and more than six percent strongly disagreed. This indicates that a majority of participants perceived developed countries' health care systems as superior to Thailand's. With regards to the education systems, it is clear that the respondents favoured the education systems in developed countries as only one percent disagreed and eleven percent replied neutral to the statement "developed countries have good education systems". More than seventy percent agreed and more than fifteen percent strongly agreed. In

comparison, less than twenty percent agreed with the Thai education system being good, almost fifty percent replied neutral, one-quarter disagreed and ten percent strongly disagreed. This could imply that the respondents would prefer being educated in a developed country, and perhaps have their children educated in a developed country, rather than in Thailand, if they were offered the opportunity. This is consistent with the high number of Thai students in the USA. In excess of 10,000 Thai students were studying in the USA in 1996 and Thailand was the 6th highest source country for foreign students in the U.S. (Khadria 1999).

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Developed countries have good health care systems[1]	-	-	34.1	51.6	14.3
Developed countries have good education systems[1]	-	1.1	11.0	72.5	15.4
Developed countries have low levels of violence and crime[2]	7.6	27.2	33.7	22.8	8.7
Developed countries have high levels of political stability[1]	2.2	12.1	38.5	38.5	8.8
Developed countries have high levels of political freedom[2]	2.2	8.6	44.1	37.6	6.5
Developed countries have low levels of HIV/AIDS infections[1]	6.6	19.8	48.4	19.8	5.5
Developed countries have taken good measures to stem the spread of HIV/AIDS[1]	1.1	8.8	47.3	33.0	9.9

Table 5.4: Perceptions of status in developed countries
Figures are in percent; [1]n=91; [2]n=92.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The Thai health care system is good	6.6	22.0	49.5	20.9	1.1
The education system in Thailand is good	9.9	24.2	47.3	18.7	-
There are low levels of violence and crime in Thailand[a]	17.6	45.1	29.7	6.6	1.1
There is a high level of political stability in Thailand[a]	7.7	34.1	42.9	14.3	1.1
There is a high degree of political freedom in Thailand[a]	11.0	23.1	42.9	20.9	2.2
There are high levels of HIV/AIDS in Thailand[b]	-	2.2	26.4	57.1	14.3
The Thai health care system is effectively targeting the spread of HIV/AIDS[b]	2.2	24.2	44.0	29.7	-

Table 5.5: Perceptions of status in Thailand – Comparable to Table 5.
Figures are in percent; n=91; [a]=included in Table 5.1 and [b]=included in Table 7.1.

Respondents were fairly equally divided in their perceptions of violence and crime in developed countries. One-third of the responses to the statement "developed countries have low levels of violence and crime" were neutral; twenty-three percent agreed and nine percent strongly agreed; whilst twenty-seven percent disagreed and eight percent strongly disagreed with this statement. The perceptions regarding levels of violence and crime in Thailand were

less favourable: While thirty percent replied neutrally, less than eight percent agreed or strongly agreed with the "there are low levels of violence and crime in Thailand". Notably, forty-five percent disagreed and almost twenty percent strongly disagreed, indicating that the perception is that there is significant less violence and crime in developed countries. However, the perceptions regarding violence and crime did not rate developed countries as favourable as perceptions towards the health care and education systems.

The general perception is that developed countries have high levels of political stability and freedom. Almost forty percent agreed and nine percent strongly agreed with this, while almost forty percent of the responses to the statement "developed countries have high levels of political stability" were neutral; only twelve percent disagreed, and two percent strongly disagreed. Similarly, almost forty percent agreed and seven percent strongly agreed with the statement "developed countries have high levels of political freedom", while forty-four percent replied neutral, nine percent disagreed and two percent strongly disagreed. As indicated in section 5.2.1, the level of neutral responses was high, which can be attributed to these statements being perceived as controversial at the time of distribution.

Although the specific perceptions, challenges, and nature of the HIV/AIDS pandemic in Thailand is the focus of chapter seven, it is worthwhile at this stage to note the diverging perceptions regarding circumstances in Thailand and developed countries. Responses to the statement "developed countries have low levels of HIV/AIDS infections" where almost evenly divided between agreement and disagreement; almost fifty percent of respondents replied neutrally, twenty percent agreed and six percent strongly agreed, while twenty percent disagreed and seven percent strongly disagreed. In comparisons, no respondents strongly disagreed and only two percent disagreed with the statement "there are high levels of HIV/AIDS in Thailand". A quarter of respondents replied neutrally, while almost sixty percent agreed and just shy of fifteen percent strongly agreed with this statement. While almost fifty percent of respondents replied neutrally to the statement "developed countries have taken good measures to stem the spread of HIV/AIDS" the level of agreement exceeded that of disagreement. One-third agreed while an additional ten percent strongly agreed with this statement, versus nine percent who disagreed and one percent who strongly disagreed. Regarding responses to perception of Thailand's response to target the spread of HIV/AIDS, forty-four percent replied neutrally. Although nobody strongly agreed with the statement "the Thai health care system is effectively targeting the spread of HIV/AIDS" thirty percent agreed,

versus twenty-four percent who disagreed and two percent who strongly disagreed with this statement.

While the perception among the respondents imply that developed countries have significantly better health care and education systems, greater security, political stability and political freedom, and are relatively better at handling the HIV/AIDS pandemic than Thailand, comparing the responses in Table 5.4 and 5.5 does not explicitly lead to the conclusion that these factors pull health care professionals to developed countries. Indeed, as was seen in chapter three, although a historic exodus of health care professionals from Thailand to developed countries took place a few decades ago, particularly to the USA, there are now opportunities within Thailand, in the private health care sector, which may appeal for individual health care professionals dissatisfied with their current situation. Some of these dynamics are the focus of the following chapter, particularly the dichotomies between rural and urban areas as well as between the public and private sector.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I would like to work in an other country than Thailand	14.3	16.5	39.6	22.0	7.7
I would like to migrate to a developed country (such as Japan, Taiwan or Australia) if the circumstances are right	19.8	19.8	33.0	19.8	7.7
I would like to migrate to a developed country even if it would mean I would have to work in a different field than I am educated and trained for	38.5	39.6	15.4	5.5	1.1
I would try to migrate to a developed country, even if it would mean that in the process I would have to 'bend' or break the law	72.5	16.5	5.5	4.4	1.1

Table 5.6: Attitudes towards Working in Another Country, Migrating to a Developed Country, Willingness to Work in a Different Field and 'Bend' or Break the Law
Figures are in percent; n=91.

Table 5.6 looks explicitly at attitudes among health care professionals to migrate to a developed country. The responses to the statement in this table reveal several interesting attitudes. The agreement towards the statement "I would like to work in another country than Thailand" is not overwhelming. Almost forty percent replied neutrally to this statement while only twenty-two percent agreed and less than eight percent strongly agreed. Remarkably, the level of disagreement is greater, as almost seventeen percent disagreed and almost fifteen percent strongly disagreed with this statement. Comparing the response to this statement with the attitudes portrayed in Table 5.2, there is an apparent inconsistency. It could be argued, however, that Table 5.2 portrays a desire for internal migration or even reflects discontent

rather than an actual urge to emigrate. The attitudes outlined in Table 5.6 indicate that there is no strong urge among the surveyed population to leave Thailand.

Response to the explicit statement of moving to a developed country saw a slightly reduced agreement and stronger disagreement. One-third of respondents replied neutrally to the statement "I would like to migrate to a developed country (such as Japan, Taiwan or Australia) if the circumstances are right"; twenty percent agreed; and almost eight percent strongly agreed with this statement. However, twenty percent disagreed and an additional twenty percent strongly disagreed with this statement. It is clear that the surveyed population did not condone migrating to a developed country if this led to working in a different field than they are educated in, or if it meant bending or breaking the law. Almost forty percent strongly disagreed and an additional forty percent of respondents disagreed with the statement "I would like to migrate to a developed country even if it would mean I would have to work in a different field than I am educated and trained for". Fifteen percent of respondents replied neutrally to this statement with just shy of six percent agreed and one percent strongly agreed with this statement.

It must be highlighted that more than eighty-five percent of respondents indicated disagreement, seventy percent of respondents strongly disagreed and fifteen percent disagreed, with the statement "I would try to migrate to a developed country even if it would meant hat in the process I would have to 'bend' or break the law". Less than six percent of respondents replied neutrally to this statement, while four percent agreed and one percent strongly agreed. The indications from this is that although there are strong indications that the surveyed populations would like to migrate, this is less than what is apparent by reviewing the contents of Table 5.2, and the pull to developed countries is not overwhelming. Acknowledging, again, that participants in the questionnaire survey were generally single and young, under the age of thirty, the mobility of these participants will be higher than those who have greater family commitments or otherwise strong ties to their local communities. Furthermore, the statements in Table 5.6 do not indicate whether migration would be temporarily or permanently. Further exploration of attitudes and perceptions on migrating to a developed country for health care professionals was sought through the interviews. The same perceptions and attitudes as outlined in Table 5.6 were generally reflected, as there was little substance among the health care professionals interviewed regarding migrating to a developed country.

However, there were some plans among the interviewees to migrate overseas. A doctor in private practice stated that he planned to study in America and was waiting for the American medical licensing test. If he passed, he would close his private practice and move immediately with the goal of continuing to work in the USA upon graduation. Another doctor at a rural hospital declared that he also had plans to study, or specialise, overseas, while he in contrast had firm plans of returning to work in Thailand upon the completion of his studies. This appeared to be representative; the majority of those who got the opportunity to study or specialise overseas would do so with the intention of returning upon completion. Another interviewee indicated that even if she got the opportunity to go overseas, and even settling down, she would always yearn for Thailand:

> *I am thinking of going overseas to study something. … …. I can go and settle down over there, but deep down inside I feel a relation … I feel related to the [xxx][15] community, because I was born here and I stayed here and being here is like being one with the [xxx].*

This sense of belonging and strong identity may be a mitigating factor in stemming the exodus of health care professionals from Thailand. Indeed, if this is so, this virtue can be harnessed to retain health care professionals. This aspect and trait of Thai health care professionals is investigated further in chapter eight.

5.4 Chapter Summary

This chapter has accounted for some of the current political and security volatilities which may adversely affect individuals' ambition to migrate. While adverse events inevitably impact perceptions of volatility, the attitudes and perceptions themselves are of great interest, as these will influence behaviour. This chapter has outlined that health care students and professionals are concerned regarding political and security volatilities. This may foster emigration ambitions. As health care professionals, based on attractive professional skills on the international labour marked, are able to obtain working visas and permits with greater ease, these volatilities threatens to reduce the availability of human resources for health in Thailand. The attitudes from this research, particularly among the questionnaire participants, has outlined that there is no great pull towards developed countries among Thai health care professionals. This suggests that combating domestic volatilities is the greatest challenge to retain health care professionals in Thailand.

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[15]The explicit community she mentioned is not referred to here in order to protect the identity of this physician.

CHAPTER 6

Tensions and Adversities in the Health Care System

"Countries have attempted to retain and deploy professional staff in rural areas through a variety of methods. They have decentralized the location of training institutions, introduced recruitment quotas to ensure that the most peripheral areas are represented among medical students and made rural field experiences during medical training compulsory. … Ultimately, the main constraint is the inequitable socio-economic development of rural compared to urban areas and the comparative social, cultural and professional advantages of cities. Cities also offer more opportunities to diversify income generation" (Van Lerberghe et al. 2002:582).

6.0 Introduction

This chapter will review and discuss the internal tensions in the Thai health care system. Some tensions can be viewed as structural tensions, including dichotomies between rural and urban areas as well as between the public and private sector, although tensions have also been introduced through health care reform. The structural tensions should not be viewed as linear relations as the actors, both health care professionals and health care consumers, are complex being with both rational and irrational behaviour. The decision to migrate, as cited numerous times earlier, is not fully based on rational evaluations, and sometimes the irrational dimension is more dominant than the rational dimension (Lee 1966). It must also be acknowledged that these actors may play multiple roles; as both health care consumers and health care professionals or as actors within both the private and public sector. Ultimately, these are highly complex issues and dynamics, which is worthy of further research both with regards to the particularities of the Thai health care system, but also in other local or international settings. These tensions can adversely affect the distribution of health care professionals between rural and urban areas and between the public and private sector. While it would also have been beneficial and interesting to have included a historical account related to how these tensions have been played out, including within past health care policy frameworks and the interrelationships of these with past trends, this is not undertaken systematically due to the limitations of this research.

6.1 Dichotomies between Rural and Urban Areas

Understanding the dichotomies between rural and urban areas with regards to professional manpower and highly skilled professionals is in itself complex and cannot be accounted for fully within the context of this research. The following account is incomplete and will have to be complemented continuously with additional research for a rigorous and contemporary account of the dynamics and tensions between rural and urban health care to inform the implementation of policies to stem detrimental or undesired trends. This section should therefore be reviewed as a brief insight, or glimpse, into the contemporary attitudes and perceptions among Thai health care professionals. The mechanisms instigating migration between rural and urban areas have to be contextualised to the particular setting, and as illustrated in the previous chapter, political and security concerns may significantly impact health care professionals' attitudes and desire to migrate.

6.1.1 Perceptions among Health Care Students and Health Care Professionals

Table 6.1 presents the responses from health care students and professionals from the questionnaire survey regarding attitudes towards working in an urban area and not working in a rural area. One of the interesting observations in this table is the high proportion of neutral responses. One-third of participants responded neutrally regarding the desire to work in an urban area, while more than forty percent responded neutrally to not wanting to work in a rural area. This could indicate that when these health care professionals choose where to work, choosing a rural or urban area is not of great importance for a significant proportion of the respondents. If this is reflective of the attitude among the general health care workforce, one can take advantage of this to ensure sufficient numbers of professionals in rural areas. However, other factors which indirectly impact professionals' desire to work in rural or urban areas may be instrumental, as there is a shortage of health care professionals in rural Thailand, as outlined in chapter three.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I would like to work in an urban area	2.2	2.2	33.0	40.7	17.6
I would not like to work in a rural area	9.9	28.6	42.9	15.4	3.3

Table 6.1: Attitudes related to working in rural and urban areas
Figures are in percent; n=91.

It is not surprising that a high frequency of respondents replied in agreement with wanting to work in an urban area; forty percent agreed and almost eighteen percent strongly agreed with the statement "I would like to work in an urban area". What is surprising, and of importance for

policy makers, is that just above two percent disagreed with this statement with an additional two percent strongly disagreeing. This implies that less than five percent of the respondents explicitly, although indirectly, state they would like to work in rural areas. When confronted with the statement "I would <u>not</u> like to work in a rural area" ten percent strongly disagreed and almost thirty percent disagreed with this statement. This significantly expands the pool of individuals who indicate that they would like, or at least not mind, working in rural areas. However, almost twenty percent indicate they would not like to work in a rural area, as fifteen percent agreed and just above three percent strongly agreed with the statement "I would <u>not</u> like to work in a rural area".

The dynamics between health care professionals and the communities they work in are very different between rural and urban areas. As was pointed out in chapter 3, newly graduated medical doctors who studied at government subsidised medical schools are required to do three years of community service in areas determined by their employer; generally the Ministry of Public Health. However, once this contract is completed, there is no guarantee that health care professionals will remain and work where they were initially assigned. As explained by the Director of a rural hospital

> *After finishing the 3 year contract [of public service for medical doctors] it is up to the individuals' decision where they would like to work. So it is not only about responsibilities but also their feelings or relationship with the place they work. Most nurses [who may also be contracted for public service] prefer to work in their hometown or the community they come from. But doctors, who mostly are from Bangkok, do not feel they belong to the rural community.*

Although other interviewees did not express this divide in attitudes between nurses and doctors as acutely, it is interesting to note that the notion of being a *Bangkokian* among some health care professionals resonated. A dentist, working at a public urban hospital, although not in Bangkok indicated that she would likely move back to the capital:

> *I am from Bangkok and I would prefer to work in Bangkok to be near my family. It is a matter of time. I do not know when I will return to Bangkok.*

It was indicated in chapter three that the rural-urban dichotomy most severely affected the availability of highly skilled professionals in rural areas, such as medical doctors and specialists. However, this notion of being a *Bangkokian* did not only resonate among physicians. A nurse working at a public hospital in Bangkok exclaimed when asked if she ever had worked in a rural area: "Never, I am a Bangkokian!" This attitude, particularly among nurses, is not reflective of the attitude among the majority of respondents. A strong sense of

community loyalty and even perceived obligation to be of service to the community as a result of their professional skills was the predominant attitude. This aspect, or trait, among health care professionals in Thailand is one of the main focuses of chapter 8, and it will be argued that this is currently stemming more adverse disparities in the Thai health care sector.

Programmes to enhance health care and expand health care facilities in rural Thailand was initiated in the 1970's and coincided with the initiation of the three year compulsory public service of the first contracted physicians (Wibulpolprasert 1999). Other strategies to encourage health care professionals to work in rural areas include rural recruitment of nurses, midwives, and other health care students with a mandated 2-4 year public sector employment. Participants in these schemes receive highly subsidised education; and pay as little as 5 percent of their school fees, and they receive free clothing, accommodation, food and learning materials (ibid). Although salary levels are according to position and seniority at public hospitals, there are special allowances for physicians working in rural areas. A newly graduate physician working in the most remote areas may earn 50,000 bath a month (*AU$1,667*), while in an ordinary rural area the salary would be 30,000 (*AU$1,000*) bath a month (Wongwatcharapaiboon et al. 1999). However, as indicated by the Director of a rural hospital, this policy is creating internal disparities between rural areas as well. For example, hospitals that qualify for these extra allowances which are not too far from urban centres are benefiting from this arrangement, while other hospitals may be disadvantaged. It has been found that as little as 10 or 20 kilometres between district hospitals may constitute a five to ten fold difference in allowances (Wibulpolprasert 1999).

It was illustrated in the previous chapter that some health care professionals who currently live and work in the Southern provinces affected by the violent insurgency did not intend to move. Although greatly concerned by the violence, their ties to the local community, in particular their family and friends, was consistently voiced as a seminal restraint for emigration. As such, recruiting health care students from rural areas characterised as without sufficient human resources for health may prove to be a strategy to ensuring health care professionals in the future in these areas and provinces with the greatest shortages of health care professionals. The following subsection will investigate this proposition, presenting the relationship of the responses to the statements in Table 6.1 according to whether the respondents' province of residence and origin is rural or urban, and explore whether the rural or urban background of health care professionals has an impact on their attitudes to working in urban or rural settings.

6.1.2 Impact of Rural or Urban Background

Table 6.2 presents the divide of respondents according to whether they reside and originate from a rural or urban area. Participants from and in urban areas are significantly outnumbering participants from and in rural areas. Almost ninety percent of respondents state that they reside in an urban area while more than seventy percent of participants state that they come from an urban area. While the sample size and methodology in identifying respondents do not allow statistical manipulation, calculations of co-dependency, or relationships between variables, as participants were not selected through probability sampling, an indication of the impact of living or coming from a rural or urban area on the statements in Table 6.1 have been attempted. Table 6.3 and 6.4 presents the responses to the statements in Table 6.1 reorganised according to rural and urban dwelling; both current place of residence and participants' origin. As such, participants' responses are represented twice in these two tables; in accordance to whether their current province of residence and province of origin is urban or rural.

Province of Residence[1]		Province of Origin[2]	
Rural	Urban	Rural	Urban
10.9	89.1	27.5	72.5

Table 6.2: Rural/Urban Divide of Questionnaire Participants
Figures are in percent; [1]n =92; [2]n=91.

	Frequency	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Rural						
Place of residence rural	*9*	-	33.3	44.4	11.1	11.1
Place of origin rural	*24*	4.2	12.5	58.3	16.7	8.3
Combined rural	*33*	*3.0*	*18.2*	*54.5*	*15.2*	*9.1*
Urban						
Place of residence urban	*81*	2.5	3.7	32.1	44.4	17.3
Place of origin urban	*65*	1.5	4.6	24.6	49.2	20.0
Combined urban	*146*	*2.1*	*4.1*	*28.8*	*46.6*	*18.5*

Table 6.3: Respondents to the statement "I would like to work in an urban area" based or rural and urban place of residence and origin
Agreement and Disagreement in percent

As can be seen from Table 6.3, there is a higher degree of disagreement to the statement "I would like to live in an urban area" among health care professionals and students from- and living in rural areas, while there is a much higher degree of agreement to this statement among respondents living in- and coming from urban areas. Despite the sample size being

small, and recognising that generalisations cannot be made as participants were not selected through any probability sampling, it is surprising that the level of disagreement from professionals from and in rural areas is significantly less that the level of agreement from the counterparts in and from urban areas.

	Frequency	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Rural						
Place of residence rural	8	25.0	12.5	50.0	12.5	-
Place of origin rural	23	17.4	17.4	47.8	17.4	-
Combined rural	*31*	*19.4*	*16.1*	*48.4*	*16.1*	-
Urban						
Place of residence urban	82	8.5	30.5	41.5	15.9	3.7
Place of origin urban	66	7.6	33.3	42.4	13.6	3.0
Combined urban	*148*	*8.1*	*31.8*	*41.9*	*14.9*	*3.4*

Table 6.4: Respondents to the statement "I would not like to work in a rural area" based on rural and urban place of residence and origin
Agreement and Disagreement in percent

Participants currently residing in rural areas indicate the greatest level of disagreement towards the ambition of working in an urban area, although the portion of respondents replying neutrally to the statement outnumbers that of disagreement. However, participants who originate from rural areas indicate less disagreement than agreement to the statement "I would like to work in an urban area". This is also the case when reviewing all participants from or residing in rural areas (combined rural). This may contradict the proposition that health care professionals from rural areas are most likely to return to work in rural areas upon the completion of their education and training. It must be acknowledged that there is a high proportion of neutral responses among the participants from- or residing in rural with regards to this statement, exceeding fifty percent for both groups combined, and other incentives may persuade health care professionals and students with connections to rural areas to return to or continue to work here. Respondents who originate from an urban area represent the subgroup with greatest ambition to seek employment in urban areas and it is also the subgroup with lowest frequency of neutral respondents. The critical question then is whether these responses illustrated in Table 6.3 only represents an ambition of working in urban areas, or if it also reflects a general attitude that the health care students and professionals surveyed are shunning employment in rural areas. Table 6.4 presents the responses to the statement "I

would <u>not</u> like to work in rural areas" in accordance to the respondents' rural and urban associations.

A significant proportion of responses to the statement "I would <u>not</u> like to work in a rural area" are neutral; between forty and fifty percent. There are numerous possible explanations for this consistent high frequency of neutral responds. As previously mentioned, the sample size is small which gives greater weight to each participant's response when presented in percentage. Some participants may view it as controversial to directly state that they are unwilling to work in rural areas, as there is an expectation for health care professionals to serve the public's needs in Thailand. Explicit unwillingness to work in rural areas could be viewed as a breach of this trait. Although the differences are marginal, it is interesting to note that the level of disagreement, the combined percentage of those who disagree and strongly disagree, is greater among respondents residing or coming from urban areas (combined urban) than that of those who originate or reside in rural areas (combined rural). Respondents in or from rural areas who voiced disagreement to this statement indicated stronger disagreement than their counterparts from urban areas.

It is encouraging, and in contrast to what would be anticipated or feared based on the attitudes outlined in Table 6.3, that the proportion of surveyed health care students and professionals who explicitly "would <u>not</u> like to work in rural areas" is less than twenty percent for every subgroup. About twenty percent of respondents currently residing in urban areas agreed and strongly agreed with this statement, while about seventeen percent of respondents who originate from urban areas indicated agreement. The level of agreement to the statement "I would <u>not</u> like to work in a rural area" is lowest among respondents who reside in rural areas and highest for the subgroup of health care student and professionals who currently live in urban areas. This could imply that respondents have incorporated their current area of residence into their ambitions of working in urban or rural areas. However, the proposition that recruitment of health care students from rural areas might mitigate shortages of professionals in these areas at a later stage is insufficiently supported by the responses in Table 6.4.

6.1.3 Differences in Opportunities

One related factor to the disparities between rural and urban areas may be differences in opportunities regarding; professional development; leisure activities; and financial remuneration. Issues regarding earning potentials and the impact of salary levels for health care students and professionals in their decision making process of where to seek

employment is pursued further in the following chapter section exploring the dynamics between the private and public health care sector. However, this dynamic also impact dichotomies between rural and urban areas, as most private health care facilities, at least private hospitals, are in urban areas and centres, and the expansion of the private health care sector has been characterised as creating a "second period of brain-drain" from the late 1980's and most of the 1990's, with internal inequities and a flow of physicians "from the rural district and provincial hospitals to the rapidly growing urban private hospitals (Wibulpolprasert 1999).

It should be acknowledged that initiatives to stem the disparities in earning potentials through specific allowances for physicians working in rural areas were introduced in 1975, and towards the end of the 1990's similar allowance were introduce, but at a much lower scale, for dentists, pharmacists and graduate nurses (ibid). Rural allowances may entice newly educated physicians to continue working in rural areas after their obligatory placements, particularly if they are not able to secure jobs in the private sector. The question is whether this is a temporary and short term engagement, or a (semi) permanent arrangement. For newly graduate professionals, even those who had their education expenses subsidised, capital is needed to settle down, starting a family, purchasing land or housing, and additional income through short-term engagements in a rural areas may be viewed by some professionals as an opportunity to acquire the required capital quicker. As such, these special allowances may not constitute a long-term strategy to ensure sufficient highly skilled health care professionals in rural areas. Rather, the risk is that this policy may lead to a high turnover rate of physicians in rural areas and in worst case scenario these physicians, once cashed-up, may decide to leave the public health care system and start up independent private clinics. It is therefore important that the effectiveness of this programme, including parameters of how long health care professionals keep working in rural areas, is investigated further.

It is necessary to take specific measures to ensure sufficient numbers of health care professionals in rural areas. However, if there is an overemphasise on certain professional groups, for example physicians, and special allowances only for these cadres in rural areas, these policies risk leading to lower levelled health care professionals feeling left out. An x-ray technician working full time, 5 days a week, at a rural public hospital and one additional day at an urban private hospital shared his views on the differences between the different health care professionals and the differences in salary levels:

> *I feel satisfied and I am happy, but thinking about the salary compared to other health care professionals who studied like me, I feel I gain less. I think this should be improved. We all studied for four years, same as nurses, but salary and other things are different. ... For instance when nurses take night shifts they have increased overtime payment. ... We do the same work [also at night time] but our overtime is different. Not only about the money but also about the acceptance and respect from other people, for example, between nurses and x-ray technicians like me or compared with other physicians and specialists I feel I am not equal with them. I feel our work loads are similar but we x-ray technicians do not gain the same respect from society, and we do not have the same salary.*

While there are general differences in status and salary between different levels of health care professionals worldwide, the level of community recognition and social status in the community as a whole, is perhaps a special feature of Thai society. Although high social status for medical doctors is an almost universal feature, not all societies revere other, lower ranking health care professionals, such as nurses and community health workers. Indeed the social status for physicians in Thailand will also exceed common perceptions in other societies and may in itself constitute a genuine restraint in the exodus of health care professionals from Thailand. However, for ambitious individuals working within the Thai bureaucracy, including health care professionals, promotions and ranks are not only dependent on their profession, but also where they work. As elaborated by the x-ray technician just cited:

> *If anyone wants to be promoted in the public sector then he or she has to try to work in the main or big hospitals. For me the highest promotion I can get is C7[16] as I am working in the local/district level. If I work at a provincial level, I can reach level C8. This system encourages people to work in the central areas and cities. For doctors at local/district level they will be able to reach level PC8, but at the provincial level he or she can reach level PC9 and perhaps even level PC10 if working at the largest hospitals in Bangkok. This system prohibits people of being promoted further in rural areas.*

While promotions and salary levels for professionals at smaller institutions, including rural health care facilities, may stagnate, and professionals will have to move to a larger urban health care institution to continue their professional development, promotions, and salary increases. On the other hand, leadership positions for young and newly graduated professionals, particularly physicians, are greater in rural areas, where newly graduated physicians easily can climb to the rank of hospital Director, particularly if he or she is the only

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[16]This is known as the PC system among government officers in Thailand and salary levels are associated with individuals' level. The highest level in this system is PC11. PC refers to the level, while C refers to the position. Hence, this technician can research become a level PC7, and he is then know as a C7. This hierarchical system does not only reflect salary levels, but also reflects status and seniority. Each level within the government bureaucracy has different uniforms, and people can easily recognise individuals' PC level. This system is scheduled to be discontinued from October 2008.

physician a the hospital. Although this may be the ambition for some physicians, the lack of mentoring and experience in administration and logistics may for some newly graduated physicians become a hurdle and even discourage taking up positions in rural areas. Hardship from having to manage hospitals from the day of graduation was a reality for many physicians when the mandatory public service came into force in the early 1970's and insufficient support from the MoPH. This led to the formation of the Rural Doctor Society in 1978 and the Rural Doctor Foundation in 1982 which boosts moral among rural physicians, develop management handbooks, training programmes, and peer support (Wibulpolprasert 1999). In addition to provide peer support and professional development, the Rural Doctor Society became and integral part of the health policy sector, won several successful elections to be included in the Medical Council Committee, became an active supporter of public health and even fought corruption. In 1998 they revealed "a nationwide drug purchasing scandal which resulted in the resignation of the health minister and one deputy health minister" (ibid). Dichotomies between rural and urban areas cannot be accounted for in isolation, and at times it is difficult to differentiate the parameters related to tensions between the rural and urban areas or between the public and private sector. These are complex and interrelated variables. The following chapter section engages with the dynamics between the public and private health care sectors and expands the discussion regarding attitudes towards salary levels.

6.2 Dichotomies between the Public and Private Sector

Discrepancies between the public and private sectors do not by itself constitute a challenge or threat to the sustainability of the health care system as many countries and rely on both public and private health care providers. However, if the private sector becomes too dominant or if it through offering significantly higher salaries is able to attract human resources at the expense of the public sector in such a fashion that services to the public is disadvantaged, the dynamic between the public and private sector becomes a challenge. The dichotomies between the private and public health care sector is not a linear algorithm and the private sector's acquisitions of health care professionals may not affect nearby public health care institutions, but perhaps exacerbate the lack of professionals in other regions; particular rural areas. Thailand's past experience, particularly the statistical data leading up to and subsequent to the Asian Financial crisis in the late 1990's are indicators of this relationship, as outlined in chapter three. In addition, the early 1990's saw a rapid expansion of private hospitals in Thailand, which an extensive demand fro health care professionals (Kittidilokkul and Tangcharoensathien 1997).

6.2.1 Attitudes and Characteristics

To recognising the multi-layered and complex nature of the predicament in relation to human resources for health between the public and private sectors, it is necessary to firstly investigate the attitudes among health care professionals towards working in these sectors. Table 6.5 reflects the attitudes of health care students and health care professionals from the questionnaire survey regarding working in the private sector and <u>not</u> working in the public sector. There were a high frequency of neutral responses throughout the survey, and slightly more than fifty percent replied neutrally to the statement "I would like to work in the private sector" while slightly less than fifty percent replied neutrally to the statement "I would <u>not</u> like to work in the public sector". This could reflect that about half the surveyed population did not have an articulated perception of working in the private or public sector. It could also, as alluded to regarding the responses related to working in rural and urban areas, suggest that the high frequency of neutral respondents may mask individual health care professionals' and students' conflict of personal ambitions versus perceived obligations of serving the public.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I would like to work in the private sector	4.4	13.2	51.6	24.2	6.6
I would <u>not</u> like to work in the public sector	14.3	25.3	47.3	11.0	2.2

Table 6.5: Attitudes related to working in the public and private sector
Figures are in percent; n=91.

Although a quarter of the respondents agreed and about seven percent strongly agreed with wanting to work in the private sector, it is surprising that a substantial portion, more than one-in-six, disagreed or strongly disagreed; indicating they would like to work in the public health care sector. When not taking into account the neutral responses, the ratio of those agreeing over those disagreeing with wanting to work in the private sector is less than 2:1. Almost five percent strongly disagreed with wanting to work in the private sector while more than thirteen percent disagreed, versus about thirty percent who agreed and strongly agreed. In contrast, when reviewing the statement "I would <u>not</u> like to work in the public sector" only two percent strongly agreed while eleven percent agreed, while more than a quarter of the respondents disagreed and slightly less than fifteen percent strongly disagreed with this statement. There was a relatively small proportion of respondents who explicitly indicated they would not like to work in the public sector, while the proportion of respondents who indicated they would like to work in the private sector was slightly less than one-third.

By reviewing Table 6.5, it could be argued that the surveyed heath care students and professionals do not have strong preference with regards to working in the private or public sector. In fact, particularly in urban areas where there is a genuine private heath care market, public and private health care can be complementary. Health care professionals themselves may be moving fluidly between the public and private health sector. It is not uncommon to be employed in both the private and public sector, and an estimate suggests that there are more than 2,000 private clinics in Bangkok alone, most run by "government doctors" (Ferrinho et al. 2004). A survey by Macq et al. (2001) among civil servants managing public health in low and medium income countries, including Thailand, found that 87 percent of the respondents had at least one other job. Physicians or dentists with sufficient capital may run a private clinic which is only open in the evenings and weekends, while at the same time being employed at a public health institution. It has been suggested by Suwannakij et al. (1998) that as most Thai health care professionals work more than full-time-equivalent, the statistical need for future Thai health care professionals may be lower than current calculations suggests. Only one interviewee, an x-ray technician, stated that he currently worked at both a private and public hospital, with his working hours totalling 120 percent of full-time-equivalent hours. However, several interviewees had working experiences from both the private and public sector, and another local resource person, who facilitated interviews with other health care professionals but did not partake in the interviews himself, had both his own private dental clinic and a senior position at the local public hospital.

The Thai health care system can be characterised as a blend between private and public actors: The health care system funded by both private and public consumption and contribution, including a mixture of private and public health education institutions, health service providers, and health care schemes. To a certain degree, this mixture in the health care system may be one of the strengths of the Thai health care. However, distinctions need to be drawn between the different forms of private health care services being offered. The health care sector, whether categorised as rural, urban, private, or public, can be divided into two separate and sometimes conflicting fields. When referring to health care in a more advanced health care system, such as the Thai health care system, distinctions need to be made between the sections of the health care which aims at improving health, and the sections which aims at producing profits. These are not necessarily dichotomous sections, as parts of both the private and public health care system can both be improving health as well as yielding a profit, and it is argued by Pongsupap and Van Lerberghe (2006) that in Thailand,

"health care is essentially a commodity". Regulation and attention is required to protect the public from scrupulous profiteering within the health care sector.

This research did not engage with the challenges regarding these aspects, nor has any attention been given to the expanding commercialisation of health care services offered to foreigners, including cosmetic or plastic surgery, often classified as medical tourism. There is a current review of the policies related to private clinics and pharmacies regarding what in many other countries are classified as prescription medications, which is weakly regulated in Thailand. Currently, physicians and dentists are providing medications to their patients directly, sometimes with vague descriptions of what the medications are. For example, a patient seeing a physician at a private clinic for a cold may be given 4-5 different medications; including antibiotics containing penicillin; fever reducing pain killers and/or anti-inflammatory medication containing paracetamol or ibuprofen; and vitamins. However, these medications are not necessarily declared in this fashion; and although there is no perceivable harm, or arguably immediate harm, by this practise, it can be viewed as deceptive[17]. In addition, overmedication or the excessive utilisation of antibiotics, for example, may have undesired side effects, including, in the long term, bacterium resistance to antibiotics.

The introduction of prescriptions which will have to be filled by a doctor but supplied by a pharmacist is proposed to rectify this potentially problematic situation. However, the means by which pharmacies gain revenue is not unproblematic either, as pharmacies' sole means of revenue is through sales. Sales assistances at pharmacies do not necessarily have any specific training related to medicine or pharmacy and are not qualified to give medical advice. Not all pharmacists are identified from sales assistants, through uniforms or name-tags, and some consumers are sceptical of this practise as they have no means of knowing if they are talking to a licensed pharmacist or simply a sales person. Traditional, or Chinese, medicines and practices have not been reviewed in this research either, and although the government issues licenses for such enterprises, the regulation of these is limited.

Scepticism among health care consumers to practices among independent clinics and pharmacies may lead to a sentiment that it is better to seek advice at public health care institutions, which do not profit by distributing, promoting, and prescribing medications. This research, however, has not engaged into these hypothetical tensions and there are little grounds for making continued speculations regarding these issues and relationships. The

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[17]This and the subsequent example are based on personal experiences and observations during one of the field visits.

following subsection engages the differences in earning potentials, and hence attitudes towards salary levels between the public and private health care sector.

6.2.2 Salary Levels

One of the main contributory factors in the dichotomies between the public and private health care sectors is the differences in salary levels. Opportunities for work in the private sector are inevitably higher in urban areas, indicating a merging of the dichotomies between rural and urban areas and those between the private and public sector. As such, attitudes, perceptions, and the pursuit of higher salary levels influence the availability of human resources for health, particularly in rural areas. In the past, the pursuit of higher salaries led health care professionals to emigrate; exiting the Thai health care system and pursuing a career in HHD countries, especially the USA, while more current trends suggest that the private health care sector is now catering for the ambition of higher incomes.

Health care professionals' and health care students' attitudes towards salary levels and their ambitions, or willingness, to pursue this becomes a pivotal aspect of understanding the dynamics regarding internal disparities in the Thai health care system. Furthermore, an insight into the health workforce's perceptions and ambitions of salary can shed light on the brain drain of health care professionals. As accounted for in chapters two and three, the brain drain of health care professionals for Thailand is currently of lesser concern than internal disparities, but at an international level, this movement of professionals from countries with low and medium levels of human capital may constitute a major restraint to development in these countries. As many of these countries, including Thailand, are currently facing major health care challenges, such as the HIV/AIDS pandemic, a loss of even modest numbers of health care professionals, particularly if these are the senior and most experienced professionals, may have significant ramifications, particularly for the continued development of the health care system.

Table 6.6 presents attitudes regarding the significance of salary levels in choosing where to work and the desires to migrate in order to achieve higher salary levels from the questionnaire survey. It is indicated that although there are a significant portion of respondents who replied neutrally to both statements, there was a high degree of agreement to the statement "receiving a high salary is a key factor when I choose where to work". Almost fifty percent of respondents indicated agreement with this statement; thirty-seven percent agreed and eleven percent strongly agreed. In contrast, only fifteen percent indicated disagreement. The pursuit

of receiving higher salaries by migrating had a slightly lower degree of agreement, as forty-four percent of respondents indicated agreement with the statement "I would like to migrate to a place where I can earn more money".

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Receiving a high salary is a key factor when I choose where to work	3.3	12.1	36.3	37.4	11.0
I would like to migrate to a place where I can earn more money	6.6	13.2	36.3	29.7	14.3

Table 6.6: Attitudes regarding salary and migrating to earn more money
Figures are in percent; n=91.

The attitudes reflected in Table 6.6 can be interpreted to reflect several trends and traits among Thai health care professionals. After the Asian Financial Crisis of 1997, there has been downward pressure on salary levels, reflected throughout the workforce. Benefits and perks, including real wages, overtime payments, and social security entitlements have been reduced, and although the financial trends of the past few years have been good, they have not benefited professionals in the country. Indeed, current international financial concerns are likely to put further downward pressure on salary levels[18]. These reductions in benefits and incomes are affecting both the private and the public sector. As indicated earlier, the 1997 Asian Financial Crisis significantly reduced salaries and opportunities in the private health care sector, and a global financial recession may again adversely affect the private health care industry in Thailand. The continuous financial pressure on the health care sectors, both private and public, can be illustrated by the following example: A small rural hospital which was visited during the fieldwork of this research had recently constructed *VIP rooms*. Here, more affluent patients could choose to have private accommodation at the hospital, against a daily rate rather than having a bed in the public ward. Family members could choose to rent these rooms if they would like to stay close to the patients, giving these rooms the added function as hospital hotel rooms. The construction of these rooms had been initiated by the former Director in order to raise revenues at the hospital as budget allocations fell short of meeting the financial needs of the hospital.

Although the focus here is on health care professionals and their attitudes, financial pressures are also placed on health care institutions. Despite the higher salary levels at private health care institutions, there are also financial restrictions in place which individuals contemplating seeking employment in the private sector need to take into account. This relates in particular to financial planning for retirement. Government employees, including most health care

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[18]There is anecdotal evidence that this is already taking place within the general workforce in Thailand.

professionals, who are employed through permanent tenures, are entitled to a pension. Although these pensions are not necessarily very generous, they are substantially better than for those who only work in the private sector, as no standard pensions or pension plans are in place. Rather, it is stipulated that higher salary levels compensate for this and that individuals are themselves responsible for organising a private pension plan through savings from their regular salaries. A nurse who recently retired after a lifetime career in the public health care sector reflected on her modest salary and pension:

> *It was not good, very little. My first salary rate was 660 bath [per month, equivalent to AUD22 in today's rate]. The rate for employees who had a bachelor degree was 750 bath that time [AUD25]. That was in 2510 [1967]. I am now retired and have a pension of 26,000 bath [AUD867]. When I was working I earned that plus overtime pay, so it was around 30,000 bath [AUD1,000]. It is very little for us [health care professionals] who work so hard. It is very tiresome. Our whole life is work. No time to do anything else but we keep doing it because we love our career.*

This retired nurse had been building up her pension and seniority, and hence salary, working for more than forty years at the local hospital. This hospital is now located in a rural centre, currently being urbanised, although when she began her career this was very much a rural area. While she had changed positions within the hospital and between departments, she had devoted her professional life to this hospital, working herself up to head different departments; including Head of Surgery, Head of Out Patient Department (OPD) and Head of the Emergency Room (ER). Despite this retired nurse finding her pension modest, the prospect of having a secure pension at the end of a lifetime of work may for some health care professionals be a determining factor when choosing where to work, particularly in light of current economic uncertainties. Another nurse working at another rural public hospital explained her desire to continue to work there so as to help develop the hospital further:

> *I fell in love with this career and I would like to help develop this hospital. If I work for a private hospital I will have a higher salary, but right now the salaries in the government hospitals are increasing and the differences between the salaries at the public and private hospitals are not that great. The most important difference is that the welfare benefits at the government hospitals are better. I am a government officer so I have the right to claim the Civil Servant Medical Benefit Scheme, which my family also can claim. I can also claim a pension after I retire.*

The different benefits between the public and private health care sector have different significance for individuals, depending on their personal circumstances. However, the opportunity for higher salaries at private hospitals may be restricted to nurses and doctors, as

the x-ray technician cited earlier indicated that his salary was the same at both the private and public institutions he worked at. A nurse, however, working at a public urban hospital, but with previous working experience at a private hospital exclaimed that her salary at the private hospital was: "A lot! A lot, but it is not secure, they can fire me any time."

6.2.3 Health Care Consumers

This section will engage with the working conditions in the private and public sector, which may also impact individuals' desires to work in either sector. While the subsequent chapter section review the impact of the UC on working conditions, this subsection reviews perceptions regarding health care consumers. Clearly, working conditions will vary between sectors and institutions, and although it is generally perceived that workloads at private institutions are less intensive than at public institutions, they may be equally demanding. A nurse working at a private urban hospital, with previous working experience at public health institutions, indicated that patients at her private hospital were more demanding:

> *I used to work at a public hospital shortly. Obviously, the main difference is the kind of patients. Patients at public hospitals are easy persons. In the private hospital I met very few patients who are not fussy. They ask for every little thing … because they think they pay a lot of money to be admitted to our hospital.*

However, she stated that procedures at the private hospital ensured more staff per patient, enabling the staff to better care for their patients and preventing work overloads. Research by Pongsupap and Van Lerberghe (2006) into patient-centredness, among other parameters, found that physicians at private clinics and hospitals were more polite than those at public hospitals. The Thai particles "krap" (used by males) and "kaa" (used by females) are indicative of respect and courtesy. The frequency of these particles were found to be 2.47 times per minute among physicians at private clinics and hospitals, while physicians at public hospitals only used these particles 1.3 times per minutes (ibid).

Comments regarding differences in protection procedures for staff working in private and public health care institutions, potentially placing health care professionals at risk of attracting HIV/AIDS in the line of work, as well as other diseases, were alluded to during the interviews, and are elaborate on in the following chapter. This indicates that there is a different mentality between both the health care service providers in the public and private sectors and between health care consumers in the different sectors. Indeed, reflections regarding health care consumers are often limited to their accessibility of health care. It is acknowledged that access to basic health care is a basic human right, but should there also be an obligation among

health care consumers to ethically limit their consumption, or not exhaust public health care funds disproportionately to their needs? Several candid, and not so candid, responses among health care professionals indicated that health care consumers did not heed any restrain and that the UC exacerbated inequities and put further pressures on already limited health care recourses in the public health care sector. It was also noted by several health care professionals, that more affluent individuals were taking advantage of the UC, increasing workloads in the public health care sector.

A nurse working at a public urban hospital replied when asked if the policy of universal coverage, which at the time required a 30 bath co-payment, should continue and whether any changes should be made:

> It should maybe be changed with regards to the wealthy people who use the 30 bath service, but they can actually [afford to] pay everything themselves. The government has to pay a lot for these people. They should categorise those who can use it [the UC] and those who cannot use it.

This behaviour, where affluent members of the community are perceived to take advantage of the UC, is not only putting additional pressure on health care professionals' workloads and straining the public health care sector for resources, but may instigate perceptions of resentment among health care professionals towards these individuals. A physician working at a public urban hospital replied when asked about the UC:

> I agree with the principle of equal rights and opportunity to access the health care system for both rich and poor people. But in reality, this is impossible. For instance, I had a patient with the 30 bath health card [registered to use the UC at his hospital] who drives a Mercedes Benz. They have the same rights as people who do not really have enough money, but I think people who are in a good financial position, and can afford to pay themselves, should not have the same rights to use the UC … People who have money should pay sometimes in order to support the health care system, otherwise people who can pay will not pay. It is not right that rich people will use the 30 bath card.

If more affluent members of the community are taking advantage of the UC, at the expense of other community members or the health care professionals who care and treat them, by adding to increased workloads, health care professionals can feel resentment towards these individuals. While this in itself is of little consequence, perceptions that individuality and the pursuit of individual ambitions, rather than taking into account the needs of the community, may encourage more health care professionals to pursue individual ambitions without incorporating the needs of the community. Such a development may adversely impact the

provision of public health care and the sustainability of the Thai health care system if it leads to a flow of health care professionals away from the public sector.

6.3 Tensions from Health Care Reform

The popularity of the UC has become a cornerstone in domestic politics, and was a seminal part of Thai Rak Thai, the former governing party of ousted Prime Minister Thaksin Shinawatra, which initiated this policy. The TRT was disbanded and outlawed after the military coup d'état. The military appointed government which followed continued and expanded the UC, and the Peoples Power Party which came to power after the December 2007 elections has continued the TRT party's policy lines, which is not surprising as PPP is claimed to be a nominee of the defunct TRT party by for example the secretary-general of the People's Network against Corruption (Bangprapa 2008). As the PPP was elected into government in the December 2007 elections, in coalition with five smaller parties, on a platform of populist programmes perceived as a continuation of those introduced by the ousted TRT government, it is unlikely that the UC will be discontinued. Indeed, even if the current coalition government fails, or if the PPP is disbanded due to electoral fraud, it is highly unlikely that the Thai public will tolerate a withdrawal or even a phase-down of services offered as part of the UC.

6.3.1 Scepticism and Perceptions

It should be acknowledged that the UC, within the principles of the policy, although not necessarily a reality in all setting or institutions, offers very generous universal health care. In theory, the coverage of the Thai UC is of a much greater span than even in the Scandinavian countries, such as Norway. The UC offers free dental services, with some qualifications and exceptions, in contrast to Norway and most other public and universal health care policies. The question then is whether the services officially freely available under the UC are in reality available, and whether access to these services really is universal. Furthermore, particularly within a discourse of sustainable health care, it needs to be reviewed whether this policy can be sustained and who are bearing the costs of this ambitious policy. The interviews with the health care professionals revealed an *in principle* endorsement of the UC as a fundamental right for individuals, although it was also indicated that this policy adversely affected their working conditions. It was viewed that this policy increased their workloads; constituted a marked shift from preventive or primary health care to curative health care; and it was even seen as a causal event in the decision to leave the public health care system and perhaps even leading to the emigration of an interviewee. However, in spite of consistent claims that

this policy lead to work overload, little resentment toward the UC was voiced. However, one interviewee strongly opposed this policy, bluntly stated his disapproval. The physician, who had already left his position at the local public hospital, exclaimed: "*I can only say one thing about this policy: It sucks!*"

Although health care professionals in principle supported the notion of universal health care, and hence in principle the UC, the political context and motivations in both implementing and promoting this policy were constantly put forth by the interviewees. A physician working at a public urban hospital subtlety replied when asked of the challenges in improving the UC:

> *The 30 bath policy [UC] is quite complicated because it is something which depends upon politics. It is not really health care you know, because it depends on politics and medical [infrastructure], so it has to be on the political agenda for a while. … Many doctors that I am in contact with believe the UC brings the same failures [as previous health care policies] into the health care system.*

Another doctor at a different public hospital indicated that he viewed this policy as purely political and adversely affecting working conditions for health care professionals:

> *The UC is only to get votes. It makes people come to the hospitals a lot until the staff cannot deal with the workloads. The policy is for the election and does not promote health care. When this policy began there was an extreme increase in numbers of patients in the OPD from for example from 800 to 1,600 hundred at the provincial hospital. So at the OPD I almost cannot cope with the workloads. Most of the patients were not really sick and had only very minor symptoms. With more time passing since this policy was introduced patients are likely to demand the right to other services [expanding the scope of the UC] and they become ignorant of primary health care and do not take care of their own health.*

This point to several important trends instigated by the UC which will be followed up in the following sub-sections. In addition to the political motivation behind this policy, this doctor indicate a doubling of patients at the OPD at the hospital he used to work at earlier, in line with other interviewees perceptions of increased number of patients, after the introduction of this policy. The shift in behaviour among those seeking medical advice is a serious indication that this policy may have significant adverse effects on the Thai health care system, not only with regards to working conditions of health care professionals, but more importantly a negative shift in the attitude in the general population regarding their own health. As indicated in chapter three, the introduction of the UC was not only a political ploy, but also based on a real need to reform the health care system, in particular the CSMBS. The irony is that the UC is significantly increasing health care costs without improving health care coverage. A

government officer working with the SSS, which also is a health care coverage, both prior and after the introduction of the UC replied when asked about her views on the UC:

> The 30 bath policy [UC] is quite good because it can cover people who did not have access to care and treatment. ... But the bad thing about it is that the policy does not cover the treatment for every disease such as serious cancer. There are exceptions; the policy does not provide treatment for all diseases.

As a government officer, who works closely with welfare issues including health care, this interviewee is acutely aware that the CSMBS provides much better cover and indicated that the UC should aim at becoming more similar to the CSMBS.

> If the government extends the services to cover treatment for every disease like the Civil Servant Medical Benefit Scheme it would be good; perfect, so that there is welfare for everyone.

However, this interviewee also indicated that the CSMBS had been rolled back since the introduction of the UC, so that government officers could not register to claim health care at private hospitals any longer; and only seek treatment at private hospitals in emergencies. The SSS still allows patients to register at private hospitals. The interviewee also elaborated that people claiming SSS benefits cannot claim health care under the UC. As members of the SSS have to pay an annual fee of 5 percent of their salary, with their employers also being levied the same amount, there may be many people who opt out of this scheme, preferring to be covered by the UC, which offers free treatment, rather than paying this levy. It needs to be noted that the SSS is a welfare scheme which includes health care, while the UC is only health care cover. As outlined by this interviewee working with the SSS:

> There are provisions for treatment [in the UC] but not for compensation or reimbursement in the case of loss of income. This is the difference. Under the Social Security Scheme clients will get money when they are pregnant as well as in case of disability. The 30 bath policy [UC] only provides free treatment, that's it. But the Social Security Scheme will provide financial aid for their lifetime. ... In case of death, the scheme will pay 30,000 bath [AU$1,000] for the funeral and provide money for children left behind for a short while, maybe four or five years.

This alludes to a great risk many middle income earners face, perhaps unwittingly. In a short-term prospect of *gaining* five percent of their salary, individuals may choose to leave the SSS and rather be cover under the UC; which offers fairly similar health coverage. However, those choosing health coverage under the UC are also opting out of a larger welfare plan. Although no information regarding this scenario was uncovered, the opting out of the SSS will reduce the government's revenue for health care expenditure and may create additional workloads for

the public health care sector. If members of the SSS who have been seeking health care at private hospitals are leaving this scheme and seeking health care under the UC, they will now only be entitled to health care at public hospitals. The following subsection reviews the impact of the UC on workloads and cost of health care, as perceived by research participants.

6.3.2 Increased Workloads and Increase Health Care Costs

As indicated earlier, the introduction of the UC, even when it required a 30 bath co-payment, significantly increased the workloads for health care professionals at public health care institutions. Although institutions are not affected equally, and the public hospitals' OPDs are experiencing the most significant increases in workloads, the increases in workloads here leads to increased health care costs by itself, and may adversely affecting the sustainability of providing health care in Thailand. Chapter nine reflects on the ramifications, or impact on sustainable health care, although it must be recognised here, as indicated by several interviewees, that the UC may have adverse affects on the population's concept of health care, particularly with regards to preventive or primary health care. A physician, cited earlier, indicating that the number of patients at his OPD had doubled after the introduction of the UC. This estimate of about a doubling of patients at the OPD was echoed by a nurse working at a rural public hospital:

> *If we talk about the 30 bath policy [UC], before that we really had less number of patients. When the 30 bath policy [UC] began there were really many more patients. This was very obvious at the OPD. We have had to improve and increase the number of beds since 2535 [1992], at the beginning we had only 10 beds and now we have 30 beds. In the past we had about 150-200 patients per day at the OPD but now it has become 250-300 patients. … We have had to change the way we arrange our staff and increase the number of staff who takes care of the patients.*

This particular hospital only had 2-3 doctors. They used to have three physicians, although one recently quit. Inevitably, the high numbers of patients and the loss of one physician, made a great impact on workload for the two remaining physicians. The nurse cited above explained further:

> *I talked to the doctors. Sometime they feel really uncomfortable; they say they feel they are not able to use their knowledge fully, like when they are examining the patients before deciding what medications should be provided. Sometimes the patients request a particular medicine. A doctor does not like anyone to order them like that. They prefer to examine and collect the information and make a diagnosis. … Right now it [the working conditions] is not like that.*

Clearly, smaller hospitals with little staff, particularly physicians, most commonly situated in rural areas, will not be able to provide adequate medical advice with their current workloads. Taking the scenario above, a hospital with up to 300 patients in a day and if we assume it is fully staffed, that is that they have three physicians; this suggest that each doctor would have to look after up to 100 patients each, or 150 patients currently with only two physicians, excluding patients in the wards requiring more extensive care! If a total of five minutes were dedicated to each patient, no time was lost between patients in completing files or otherwise and no breaks were taken, this would require 8 hours and twenty minutes for 100 patients. When the hospital only has two doctors and if there are 300 patients, five minutes per patient equates to 12 hours and thirty minutes. However, if a total of ten minutes is needed per patient, and each doctor has to undertake 100 consultations, this equates to 16 hours and forty minutes. With 150 patients, this escalates to 25 hours, an impossible undertaking! The research by Pongsupap and Van Lerberghe (2006) cited earlier indicated that consultations with doctors are generally short. In their survey they found consultation time at public hospitals to average 3.8 minutes; at private hospitals 5.7 minutes; at private clinics 5.9 minutes; and family practises 6.2 minutes. However, this is the time the patients are with the doctor, and not the time the doctor has to set aside for each patient; the consultation, subscription of medication, completion of paper work, and other associated administrative tasks.

It must also be acknowledged that not all patients in the OPD may actually see a doctor, but are there for simple procedures such as measuring blood-pressure or insulin levels, for example, which can be done by a nurse. Indeed, several interviewees indicated that many patients seeking medical advice under the UC should not seek treatment, but rather take a rest or wait to see if their symptoms are actually linked with illness rather than fatigue. A nurse working at the hospital referred to in the previous citation stated:

> *We feel that patients should take care of themselves before coming to see the doctor. … If they just have a cold for one day then they come to see the doctor. They think there is no need to wait and see the symptoms. If they have just a normal cold or fever they come to see us. Or even if they just feel tiered, like tiered muscles from work, they come! They want to be treated and cured so soon. In the past, there was no need for treatment or medication for these things. We just waited and took some time and rest until we recovered. … I have asked other staff and my co-workers and they have noticed this trend as well.*

This trend of significant influxes of patients after the introduction of the UC, including a significant proportion who did not really need medical advice or care was also observed at the urban hospitals. A doctor working in the ER at a large urban public hospital indicated that

more than half of those seeking treatment at his ER did not really need to seek medical advice and did not have a proper understanding of the services offered at the ER and that the most severe cases where given priority.

> *I work in the ER, there are plenty of problems there. People think like I told you … they [patients covered by the UC] everyone must come and take care of them as equals–like those paying cash [at private clinics and hospitals]. But it is not like that, actually we take care of people equally but there are always a lot of patients at the ER and we cannot take care of everyone … Some patients complain and say that we ignore them because they are not privileged.*

The influx of people seeking medical advice inevitably increases the costs for health care institutions. Extra staff would be required to accommodate the significant increases in patients and as the UC also provides free medication when these are distributed through the hospitals, costs for the hospitals in providing the medications would increase proportionately with the increase in patients. However, the financial structure in financing the UC has one major fault. Rather than reviewing the actual costs of each institution providing care under the UC, the national government has estimated a *per capita annual health care cost*, and every citizen eligible for health care under the UC has to register with a hospital. Each citizen covered by the UC thus has to seek treatment at the hospital they registered with and each hospital is then funded by the government based on the number of registered health care consumers at the institution, not the number of patients seen, services provided, or the real cost of health care provided.

The impact of this financial mechanism, combined with an influx of health care consumption, places the financial burdens on the individual health care institutions and will not impact all hospitals equally. Complex medical procedures are not offered at all hospitals, but are typically only offered at larger central hospitals, or university hospitals. These procedures are generally more costly, and would include cancer treatments, complex surgeries, and treatments requiring costly drugs. As these procedures are only offered at a few health care institutions, and patients requiring these treatments are likely to only register themselves at these hospitals which can offer these services, the distribution of patients requiring costly care and treatment disproportionately becomes the financial responsibility of only a few hospitals. It has been reported that Siriraj Hospital, Thailand's oldest medical school, has accumulated a 500 million bath (*AU$16.7 million*) debt as a result of its number of high-cost patients receiving treatment under the UC (Khwankhom 2006).

However, the financial pressures are not only impacting larger hospitals. Indeed, these larger hospitals may have greater leniency in accumulating debt and are able to get credit with greater ease than small district hospitals. Indeed, all hospitals are liable to pay for any treatment at other hospitals by patients referred from the hospital the patient is registered with. The Director of a small rural district hospital indicated that she needed to be very careful when referring patients to other hospitals, to keep to the hospital's budget in 2006. The chief pharmacists at an urban hospital, when asked about the financial burdens at the hospital indicated that they had to be careful with prescribing medications to keep within the budget, but that it was also possible to apply for extra budget allocations from the government.

The insufficient funding of public hospitals led to calls to increase the annual per person allocation for the UC from 1,396 bath (*AU$47*) to 2,000 bath (*AU$67*) as well as concern over the flow of physicians from the public to the private health care sector (Post Reporters 2005). Other changes, particularly regarding emergency treatment for travellers and temporary or seasonal migrants have and are being addressed as some hospitals are reluctant to provide medical care for persons not registered for UC at their hospitals. This has created difficulties in particular for temporary migrants who are registered, as they themselves are registered through the household register, in a different province. However, the UC has benefited those previously without health care. It was estimated that from 1995-1998 between 20 to 31 percent of Thais were uninsured, while research into the UC during the early stages of the health care reform found that in 2003, only 9 percent were reported as uninsured (Suraratdecha et al. 2005). It was indicated that those uninsured were of lower socio-economic background and reasons for not being covered included problems in the health card being issued and no household register in the area (ibid). As such, there are still further issues regarding the UC which has to be addressed and criticism of this ambitious policy is not only limited to its impact on health care professionals and institutions, but concern that this policy marks a shift from preventive and primary health care to curative health is being voiced.

6.3.3 Primary and Curative Health Care

The UC has ensured that most Thais now have access to health care, which is commendable. However, several interviewees voiced their concern that this policy can be viewed as a shift from primary or preventive health care to a focus on curative health care. A shift away from primary health care is an unfortunate development, as primary health care is an essential and affordable strategy in pursuing good health, particularly when referring back to the WHO (2006b) definition of health as "a state of complete physical, mental and social well-being" The

shift away from primary health care, as perceived by the interviewees, must be viewed as an unfortunate consequence of the UC, rather than a conscious policy shift. This however, does not diminish the importance of rectifying this trend, as it may have profound adverse impact on the sustainability and vitality of the Thai health care system. Recent social and economic development may also change peoples' attitudes which may have unintended impact on health. A nurse working at an urban public hospital gave a lengthy reply when asked what health care challenges she believed Thailand was currently facing, reviewing attitudes, and the impact of media advertisement on attitudes among the Thai population:

> *We [in Thailand] are easily convinced by the media and then we get wrong attitudes such as with regards to soft drinks. For example, kids drink Pepsi in the early morning, not even 8 am yet! When people believe in the media, there is not much doctors and nurses can do. It is up to the policy of the government. … … We [Thai people] do not have very good education yet and we [health care professionals] have to try to make people understand about proper health care. What needs to be done is to make everyone understand about primary health care and avoid things that will harm their health. We need to do it together. Treatment is the last thing to do. …*

A perception that people are not looking after their own health and have erroneous perceptions on health and health care treatment was echoed by a couple of dentists interviewed together at a dental clinic attached to a large urban public university hospital:

> *We found that it appears that some clients do not take care of themselves and then come and expect us to 'cure' their teeth, They ignore their health and think the service fee is only 30 bath so they can come to the clinic whenever they want to. As a result of the budget per capita is very low, this increases the number of patients a lot while it reduces the number of health care professionals.*

Other health care professionals indicate that the shift in attitudes was not only leading to a deterioration of how people were looking after their health, but are now specifically looking for medications. A nurse at a public rural hospital stated:

> *I believe there is more dependence on the medicine. People have become ignorant to look after themselves and depend on medications. Now it is easier to access the medications. For example, when people go to the hospital they request the medicine they want from the hospital and the hospital have to give it to them. I used to discuss this with the doctors and they feel really uncomfortable with this as well.*

As cited earlier, a nurse indicating that people are seeking medical advice for minor or even inappropriate situations. She exclaimed that people seek medical advice at the hospital "if they just feel tiered, like tiered muscles from work, they come!" The dynamics in educating and promoting good health are complex and must expand beyond the health care system. Basic or

primary health care should be included in the curriculum of both primary and secondary schooling and this curriculum needs to be continuously reviewed and updated to include new health care challenges and teach students when it is necessary to seek medical advice and in what circumstances simple rest and restoration is appropriate. Community members should also be educated in primary health care through outreach programmes, which is being done. However, as the allocation of funds to public hospitals, which is based on the number of registered residents with the institution, is intended to include administrative, promotional, and preventive health care costs, in addition to the costs associated with curative health care (Suraratdecha et al. 2005), it is probable that increased cost in curative health care will reduce the availability of funds for preventive measures.

Several interviewees argued that the previous health care policies, which also included health cover for those who could document financial hardship, combined to better ensure health care than the current UC. A physician at an urban public hospital summarised the previous health care covers:

> *Before there were three kinds of health care cards; the 500 bath health care card – where every family would pay 500 bath for health care per year; the Social Security Scheme card, and the poor card for poor people [providing free health care] at every local hospital.*

When reviewing the previous covers with the current UC, he concluded:

> *If we think of the treatment in the long term, it [the previous health cover] was better because the government did not have the expense burden and people took much better care of their health. At the beginning [of the UC] they [Thai Rak Thai] used it to get votes for the election too much, and later the government has a heavy expense burden.*

It must be noted that although the majority of the interviewees had concerns regarding the impact of the UC, some health care professionals did not share this concern. A nurse working at an urban public hospital indicated that she believed that the workloads for health care professionals were about the same after the introduction of the UC. Furthermore, when asked about the weaknesses of the UC she replied "*I have not found any yet; have not found anything bad about it.*" This would suggest that even at public hospitals, there are sections which are not adversely affected by significant increases in workloads or a perceived adverse shift from primary to curative health care. It may be that this interviewee did not feel the same pressures as other interviewed health care professionals or that she felt uncomfortable by criticising the UC; one of the most prestigious and politically charged policies in contemporary Thailand. However, as the following subsection engages in, a few health care professionals have significantly different perceptions of this policy, which may become a push factor leading

some of these individuals to leave the public health care system; or even encourage international migration.

6.3.4 Push towards International Migration

The brain drain of Thai health care professionals has adversely enhanced the inequities between rural and urban areas. The private health care sector also impacts on inequities, and can be interpreted to exacerbate health care adversities in rural areas as the flow of health care professionals to the private sector, particularly physicians, has led to inadequate human resources for health in rural areas. The impact of current international emigration of health care professionals does not have the same connotations of adversities for health care and development as the as the brain drain of Thai physicians during the 1960's. However, as indicated when reviewing the brain drain of Thai health care professionals in chapter three, there are increasing numbers of nurses emigrating from Thailand (Martineau et al. 2004), and there are indications that opportunities for nurses to migrate to developed countries, particularly North America, has increased during the span of this research.

At the outset of his research no indications of a systematic recruitment strategy, through public announcements or advertisements, was observed. However, towards the final stages of this research, an active and repeated advertisement campaign was observed in the newspaper for a "18 month program [which] provides nurses a chance to gain experience in USA, and pass the necessary tests required" (Woodmere Rehabilitation and Health Care Center 2008a; 2008b; 2008c). With a continuous global deficit of health care professionals and increasing health care tasks in HHD countries as the population ages, there are inevitably increasing opportunities for health care professionals to migrate to these countries. As was illustrated in the previous chapter, there is a reasonable proportion of health care professionals and students who indicate they are willing, or would like, to migrate internationally if the circumstances are right, as outlined in Table 5.6. Almost thirty percent agreed or strongly agreed with the statement "I would like to migrate to a developed country (such as Japan, Taiwan or Australia) if the circumstances are right". As current health care reform has been perceived by health care professionals to increase workloads and otherwise adversely affect their working conditions, some professionals may pursue opportunities to migrate and find work overseas, or choose to exit the public health care system. If this is the case, particularly if the UC is perceived to be a determining factor in this decision making process, this health care policy may undermine its own purpose and ambition of ensuring health care for all in Thailand.

A physician, previously working at a rural public hospital, but currently working in the private sector, outlined his strong disapproval of the UC and the public health care system. This physician was cited earlier, exclaiming that the UC "sucks!" His frustration with the UC had led him to leave the public health care sector and open a private clinic. His ambition now is to leave the Thai health care system altogether and move overseas:

> *I plan to study in America, not sure yet in which city. I am waiting for the American Medical Licensing test. If I pass, I will go immediately. I will close down my [private] clinic permanently. After I graduate I will stay and work in America. I will come and visit Thailand and witness the disaster of the Thai public health care system as I believe this government cannot improve it, even if they increase the budget [allocation per registered patient at each public hospital] to 2,000 bath. It is impossible!*

No other interviewee expressed their disapproval of the public health care system or the UC as strongly, although many pointed out flaws and weakness. However, several other health care professionals, particularly physicians, voiced their desire or past plans to study overseas. Not all interviewees were explicitly asked whether they planned or had ever contemplated migrating overseas, either for work or study, although among the interviewees explicitly asked, it was a common theme that they had contemplated studying overseas to specialise, or that they would go if they were given the opportunity. A representative reply was given by a physician at a large urban hospital.

> *If it is for further study, a higher degree, and if I get that opportunity I will take it. I will go abroad for study but I will come back to work in Thailand.*

Another doctor at the same hospital echoed this response although current circumstances did not allow him to leave immediately. A physician at a rural hospital had already arranged to study in the USA, while he insisted that he would return after completing his studies. Another doctor, at a public urban hospital was currently looking for opportunities to study and specialise overseas, and she also insisted that she would eventually return to work in Thailand. A nurse at an urban public health care centre indicated that she had contemplated studying overseas, while family commitments and language skills had deterred her from going. These factors preventing overseas studies were echoed by another nurse at a large urban public hospital. She was currently looking into a short exchange programme to gain working experience overseas. In particular, exchange programmes with Australia or USA appeared enticing, as these do not have to last for more than four months and she currently has to look after her parents.

Although only one physician, among the interviewed health care professionals, indicated that he was leaving Thailand as a result of the UC, another health care professional, a dentist at an urban dental clinic associated with a university hospital, indicated that he was contemplating quitting his profession and beginning a new one.

> *I have an idea: Either quit my job to have a new career or do both; a new job and keep this one.*

Despite indicating his intentions of quitting and changing his career, this dentist also outlined his perceived obligations of serving the interests of the public as a health care professional:

> *I believe doctors and dentists are the only careers related to help other people recover from illness. There are only about ten thousand of us if we include dentists. If we look at the population of 70 million, this is a very small ratio. This make me think that I am one of few thousands people, so I should endure some sacrifice. If we [doctors and dentists] are too selfish, we will leave many tens of thousands of people in trouble, so we have to sacrifice.*

This notion of a professional obligation to serve the public as a health care professional, as well as other notions of rights and obligations, are the focus of chapter eight and will be explored further there. It is important to take note of this perception of an obligation of servitude as a health care professional, which arguably constitute an essential part of the ethos of being a health care professional in Thailand.

6.4 Chapter Summary

This chapter has accounted for tensions between rural and urban health care and the public and private health sector in Thailand, including the attitudes and perceptions among the research participants. In particular, attitudes regarding working in these areas and sectors have been investigated, revealing that there are differences in opportunities and advancements in addition to financial remuneration. While the parameters of this research do not allow for determining relationships, this chapter has indicated that there are both substantial challenges and opportunities to ensure sufficient health care professionals in both the rural areas and at public institutions. More importantly, with regards to sustainable health care and the long term viability of the Thai health care system, are the induced adversities from health care reform and the UC, as perceived by health care professionals, which suggests that this policy has created increased workloads for some sections of the public health care system. The tensions and challenges explored in this chapter have to be contextualised with the contemporary health care challenges. The following chapter explores

perceptions and predicaments with regards to the HIV/AIDS pandemic in Thailand, one of the dominant contemporary health care challenges.

CHAPTER 7

Progress and Challenges in Curbing the HIV/AIDS Pandemic

"HIV/AIDS is a key engine in the generation of poverty, is associated with food insecurity, is consuming both household and government resources, and is even inducing regional instability in Sub-Saharan Africa; as well as fuelling social exclusion and discrimination associated with its stigma" (UNAIDS cited in Jones 2005:421).

7.0 Introduction

Thailand's first documented case of HIV was in 1984 (Maticka-Tyndale et al. 1997; MoPH & WHO 2005; Singhal and Rogers 2003). The following decade of the HIV/AIDS pandemic was characterised by four successive phases where each phase was associated with infections among a distinct sub-group of the population (Maticka-Tyndale et al. 1997). The late 1990's saw another shift in the pandemic as HIV/AIDS was no longer solely related to specific risk groups but to a growing degree became a phenomenon throughout the general population (ibid). It could be argued that this phase, where HIV/AIDS is a general occurrence and does not relate to a specific sub-group, is still characteristic of HIV/AIDS in Thailand today. According to UNAIDS' Report on the global AIDS epidemic, it was estimated that 1.4 percent[19] of the Thai population were living with HIV/AIDS in 2005 (cited in UNAIDS and WHO 2008).

HIV/AIDS is recognised as one of the major health care challenges for Thailand, and without dismissing the significance of other health care challenges it is of utmost importance to account for the impact of the pandemic on the health care system and on attitudes and perceptions among the health care workforce. A review of these attitudes and perceptions can indicate how this challenge impacts the workforce, as well as allude to challenges in the continuous battle to overcome the epidemic. This chapter first reviews, in an overview, the past progress and programmes in Thailand which successfully managed to reduce the prevalence and spread of the pandemic, and outline current prevention and treatment strategies. The following section will present and evaluate the current challenges relating to the nature, or shift in the nature, of the HIV/AIDS pandemic in contemporary Thailand as

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[19]Range between 0.7 percent and 2.1 percent.

viewed through the attitudes and perceptions of health care professionals. This is followed by a section reflecting upon a rights based approach in stemming HIV/AIDS.

7.1 Progress in Curbing HIV/AIDS

There is a general consensus that Thailand has been able to reduce the spread of HIV/AIDS (Ainsworth et al. 2003; Bjorkman 2005; MoPh & WHO 2005; Singhal and Rogers 2003; UNAIDS and WHO 2008; UNDP 2004b). However, Thailand is still facing major challenges with regards to HIV/AIDS, and although it has been claimed that the HIV/AIDS related MDG of halting and reversing the spread of HIV/AIDS has already been achieved within the Thai context (Bjorkman 2005:5), this might actually have been a premature announcement, as the same report suggests a possible reversal of this in 2004. This alludes to a shift in the nature of HIV/AIDS which will be reviewed further in this chapter. In the past, two factors have been identified as significant contributes to the spread of HIV/AIDS; males having multiple sexual partners and the high rate of circular migration (Maticka-Tyndale et al. 1997). It has also been argued by Tarantola (2001:439) that HIV/AIDS in Asia is driven by "female commercial sex work and injecting drug use". However, despite these factors significantly contributing to the spread of HIV/AIDS, it is insufficient to only address these issues as it is now evident that "the virus is spreading increasingly to persons considered to be at lower risk of infection" (UNAIDS and WHO 2008:16).

7.1.1 Prevention Strategies

There has been some significant research into the social, cultural, family, or economic aspects of the commercial sex industry in Thailand (Fordham 2001; Jones and Pardthaisong 2000; Maticka-Tyndale et al. 1997), and it is important to recognise that these factors significantly influence sexual behaviour and attitudes regarding sexuality, and they must be part of any successful long-term prevention strategy against HIV/AIDS. This sub-section will provide a brief review of the commercial sex industry in Thailand; accounting only for the most significant elements related to the HIV/AIDS pandemic. It should also be noted that although this section attempts to give a general and broad introduction to the commercial sex industry in Thailand, certain aspects of this may be more relevant for specific regions of the country, and that the generalisations presented here are not necessarily applicable for all areas or scenarios.

Commercial sex, and the commercial sex industry, refers in this research to sexual services provided by females for male clients against a monetary reimbursement. As such, it will exclude male sex workers as well as mistresses, or lovers[20], although both monetary and non-monetary transfers may take place in these scenarios. This is to limit the scope of this discussion, and as less is known regarding the issues surrounding HIV/AIDS and male prostitutes, mistresses, and lovers, further research into these dimensions are warranted. A commercial sex worker is hence a female who provides sexual services to male clients for cash and is not in a relationship with the client, and this may take place through a brothel or informal setting. We then have formal sex-workers who are associated with a brothel, while there are also informal or casual sex workers, who may at times provide sexual services. These casual sex-workers may work at massage parlours, bars and restaurants and may at times choose to provide sexual services.[21]

The initiation of a comprehensive HIV/AIDS programme in Thailand was lead by the activist Mechai Viravaidya in 1991-92 and has been referred to as "the "Prague Spring" for HIV/AIDS control in Thailand" (Singhal and Rogers 2003:100-101). Mechai was appointed Minister of Tourism, Public Information, and Mass Communication in the Anand Panyarachun government which was a military appointed government after the February 23 1991 coup. This interim government did not have any political agenda as it would not contend for re-election and was able to initiate the successful HIV/AIDS campaign during its 20 month reign through promoting condoms. The campaign consisted of an aggressive promotion of condom use, both towards the commercial sex industry and towards the public to desensitise condoms. This included condom-blowing contests, the distribution of condoms by the police in the red-light districts, referred to as the Cops and Rubber program, and even substituting breath mints with condoms at "Cabbage and Condoms Restaurants". The successful promotion of condoms by the Minister, even lead to condoms being commonly referred to as a "mechai"[22] (ibid).

As a member of cabinet Mechai Viravaidya launched a comprehensive program to stem HIV/AIDS, and convinced Prime Minister Anand Panyarachun to become the chair of the national AIDS Committee. The budget allocation to combat HIV/AIDS increased from US$2.5 million in 1991 to US$48 million in 1992, with 96 percent of this coming from the Thai

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[20]This would also include what is sometimes referred to as minor wives, which is a permanent, semi-accepted, extramarital relationship.
[21]Casual sex workers should not be misinterpreted as illegal sex workers or workers in illegal brothels, which also often go under cover of being bars, massage parlous or other entertainment establishments.
[22]Mechai has become a Thai condom brand.

government rather than international donors. The nations 488 radio stations and 15 television stations were mandated to broadcast 30 seconds advertisements to combat HIV/AIDS per hour, paid for by allowing an equivalent time of new commercial time to be sold. This equated to 73 radio hours and 2 television hours every day providing HIV/AIDS information and prevention. The government also targeted the commercial sex industry. In the early 1990s, 83 percent of HIV/AID infections resulted from sexual activities and commercial sex workers had a 1,000 times higher probability of contracting HIV than other Thais. In Chiang Mai in Northern Thailand which was the centre of this early stage of the epidemic, the HIV/AIDS prevalence rate among commercial sex workers was found to be 44 percent in 1989 (Singhal and Rogers 2003). The first few years of the 1990 saw a significant rate and growth rate of HIV/AIDS among commercial sex workers in Thailand (Mann et al. 1992). By 1992 the 100 Percent Condom Program lead by the Ministry of Public Health provided free condoms to brothels with the rationale that if all brothels demanded 100 percent condom usage, no individual establishment would be adversely affected by demanding patrons to use condoms. In mid 1992, the Ministry provided 60 million condoms to 6,000 brothels and condom usage at brothels had increased to 90 percent (Singhal and Rogers 2003). This commitment by the Ministry to provide free condoms to brothels was reduced from 2007 as a result of other financial priorities, according to an interviewee.

New research is suggesting a moderate reduction in visits to brothels among Thai males and there is a consistently high rate of condom use at brothels. Countering the reduction in visits to brothels, there is an increase of casual sex partners, with increased risks associated with these relationships (Pritchard 2000). Among some socio-economic groups, such as military conscripts, there is a slight reduction in condom usage, including in transactions with commercial sex workers. The research by Tangcharoensathien et al. (2000) also found that the condom usage rate with casual sex-partners is lower than with commercial sex workers for both military conscripts and male workers. It was also indicated that commercial sex workers had fewer clients per night and the frequency of condom usage among commercial sex workers increased. In June 1993 it was reported that condoms were not used in 6.2 percent of transactions with commercial sex workers, while in June 1998 this had dropped to 2.5 percent. The condom usage among military conscripts with commercial sex workers dropped from 60 percent in 1997 to 55 percent in 1998.

When reviewing reports of inconsistent use of condoms when engaging in sexual activities with commercial sex workers and casual sexual partners, the definitions of commercial sex

workers and casual sexual partners must be scrutinised. In the cited examples, it is implied that commercial sex workers only refer to sexual services provided at brothels, and may exclude sexual services rendered for monetary reimbursements in informal settings. Tangcharoensathien et al. (2000:800) argues:

> "When commercial sex workers diversified services from a brothel base to a more informal and casual arrangement not using a condom with casual partners has a high risk for HIV infections. There is a need for effective health messages on 'using condoms with any non-regular partners' by the national HIV/AIDS control programme."

It is difficult to estimate the scale and fluctuation of casual, informal, and commercial sexual transactions. However, the decrease of clients at brothels may suggest that clients have shifted from the formal settings at brothels to casual or informal sex workers at massage parlours, bars, or through phone services. If this is accurate, coupled with the lower use of condoms in these sexual interactions, the success of the government's 100 percent condom policy at brothels may no longer contain the spread of HIV/AIDS in Thailand. The shift from brothels to informal settings may lead to additional risks, including alcohol consumption and impairment, which may be a contributory factor for why casual sex workers are less likely to insist on using condoms. The call for promoting condom usage in all sexual relationships with "non-regular partners" is appropriate, and it may even be necessary to extend this to include regular partners as well, as partnership transmissions are becoming more frequent.

Despite the recognised vulnerable position of women in contracting HIV/AIDS, particularly through unfaithful partners, there is insufficient literature and programs in Thailand engaging with gender, sexuality, power, and HIV/AIDS. It has been argued by Fordham (2001:259) that Thailand's response to the HIV/AIDS pandemic, despite significant success in stabilising the prevalence rate, has been through "the concept of risk groups" which "are now substantially discredited" and the approach of reviewing HIV/AIDS in Thailand through the prism of risk groups may also reinforce social stereotypes. In particular, the association of HIV/AIDS with commercial sex and prostitution in Thailand may lead to adverse stigmatisation and discrimination. Inappropriate policy and stereotypical approach to the predicaments of stemming HIV/AIDS may also entrench these stereotypes, adding to the difficulties in combating the pandemic.

7.1.2 Treatment Strategies

Progress in the fight against HIV/AIDS in Thailand is not isolated to prevention strategies, but Thailand's achievements in combating the pandemic include the production and distribution of

ARV drugs. The Thai Ministry of Public Health introduced an ARV treatment programme in 2001 (Kumphitak et al. 2004) and the current national policy is that all HIV/AIDS infected persons should have access to treatment (Chaiwarith et al. 2007). The health care reforms in recent years, particularly the UC, has led to ARVs now being available free of charge, while there are inclusion criteria as well as limitations to which drugs are offered. In particular, generic ARVs produced by the Government Pharmaceutical Organization (GPO) are the backbone of Thailand's treatment strategies. The GPO produces several ARVs including four in the Nucleoside Reverse Transcriptase Inhibitor group of ARVs: Zidovudine (also called AZT) and Didanosine (also known as ddI), Stavudine (also known as d4T) and Lamivudine (also known as 3TC). The GPO also produces generic Nelfinavir in the Non-Nucleoside Reverse Transcriptase Inhibitor group of ARVs; and Nevirapine in the Protease Inhibitor group of ARVs. Most prestigious and successful is the GPO-VIR which is a single tablet cocktail of Stavudine, Lamivudine, and Nevirapine. This conforms to the WHO's recommendation of combining three ARVs from two different groups which can give protection for up to 15 years. The GPO-VIR costs 20 bath a tablet or approximately US$30 for a month's supply of the medication (AIDS Access Foundation and MSF Belgium 2004).

There are several concerns regarding combining ARVs and other medications, including drugs for Tuberculosis and Methadone. Resistance to ARVs may also develop, rendering the medications ineffective for further treatment. Individuals may experience adverse effects from taking ARVs, including allergic reactions and it is therefore important to have alternative ARV regimes available for continuous treatment and ensuring that drugs are available for patients who rely on other medications which cannot be combined with specific ARVs, for patients who have developed resistance to certain ARVs, and as alternatives for those who experience adverse effects from taking particular ARVs. The relationship between gender and HIV/AIDS is not limited to issues surrounding sexuality and empowerment, but also directly relates to treatment regimes and strategies, as some ARVs should not be used in combination with contraceptive pills and can cause foetal abnormalities. Furthermore, specific drug regimes, the combination of three different ARVs significantly reduce the probability of mother-to-child transmission (ibid).

The free universal provision of ARVs in Thailand labelled the Access to Care Program is limited to first line drugs (Rongkavilit et al. 2007) and advocacy groups are pressuring the government to extend the list of available drugs. The HIV/AIDS advocacy organisations have also been instrumental in combating exclusive rights of pharmaceutical companies. The

backbone of Thailand's ARV program is the generic drugs manufactured by the GPO and pharmaceutical companies' exclusive rights to produce ARVs have limited the dissemination of ARVs as a result of the substantial difference in cost between generic and those produced by pharmaceutical companies under exclusive patents. In 2002 the AIDS Access Foundation won against the pharmaceutical company Bristol-Myers Squibb's exclusive right to manufacture the ARV Didanosine. Thailand's GPO is able to sell Didanosine 125 mg tablets at 45 cents versus Bristol-Myers Squibb at 92 cents. Bristol-Myers Squibb originally had a patent to exclusively produce tablets containing 5-100 mg of ddI, but managed to amend this application later. The court ruling on October 1, 2002 found this amendment unlawful and reversed Bristol-Myers Squibb's patent to the original limits. However, it has been argued that Bristol-Myers Squibb's patent is altogether inappropriate as this patent is a renewal of an old formula with an added buffer. The renewal of the patent through an added buffer is viewed by AIDS advocacy groups as "lacking sufficient inventiveness to warrant a patent" (Ahmad 2002:1231).

The GPO has been instrumental in Thailand's response to the HIV/AIDS pandemic since the government full-scale intervention in the early 1990s. The GPO began generic production of Zidovudine in 1993, reducing the monthly cost per patient from $324 to $87 in 1995 (Singhal and Rogers 2003). The triple ARV cocktail GPO-VIR is currently costing approximately US$1 a day. Initially, these three ARVs had an annual cost of $8,100 in late 1999, but pressure by activists on the GPO saw the annual price drop to $660 within two years, and the price dropped further in 2002. ARVs were not initially included in the UC in 2001, but due to public pressure and demonstrations outside Parliament House by 1,300 activists and people with HIV/AIDS, funds to provide ARVs to 7,000 of Thailand's 70,000 HIV/AIDS positive people with opportunistic infections was announced on December 1, the World AIDS Day, 2001 (ibid).

7.2 Health Care Professionals' Perceptions and Current Challenges

This research set out to both understand and capture the perceptions and attitudes among health care students and professionals regarding the HIV/AIDS pandemic, as one of the major contemporary health care challenges. Although other significant health care challenges are significantly adding to disease burden, as outlined earlier, the subjective attitudes and perceptions of the health workforce was investigated to both get a fuller understanding of the perceived impact of HIV/AIDS on health care professionals' working situation. This section will provide some of the most frequent and most divergent perceptions and attitudes voiced by

health care professionals in both the questionnaire survey and the interviews. Despite initial success in combating the pandemic in the early 1990s, which stemmed and contained the spread of HIV/AIDS, this research has uncovered attitudes and perceptions among Thai health care professionals which may suggest that the early efforts in containing the disease reinforced stereotypes, rather than harnessing comprehensive understanding and holistic approaches to combat the disease. These inadequacies may be contributory factors to the stagnation in the progress of curbing the epidemic.

7.2.1 General Perceptions Regarding the HIV/AIDS Pandemic

The challenges in combating HIV/AIDS in Thailand are continuous and constant vigilance is required to contain, reverse, and eradicate this disease. As health care professionals are the frontline workers in this battle, their perceptions and attitudes are of utmost importance to understand the current challenges. It is crucial to document the concerns, diverging perceptions, and inaccurate conceptualisations among these professionals to enable policymakers to develop and implement appropriate measures. Table 7.1 presents the responses from the questionnaire survey to statements related to HIV/AIDS in Thailand. Some of these figures were included in Table 5.5.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The health system in Thailand is good	6.6	22.0	49.5	20.9	1.1
There are high levels of HIV/AIDS infections in Thailand	-	2.2	26.4	57.1	14.3
The Thai health system is effectively targeting the spread of HIV/AIDS	2.2	24.2	44.0	29.7	-
The Thai health system is effectively treating HIV/AIDS patients	1.1	20.9	51.6	24.2	2.2
The Thai government is effectively creating awareness of HIV/AIDS	5.5	20.9	36.3	35.2	2.2
The Thai government is running effective HIV/AIDS education programmes	6.6	20.9	41.8	30.8	-

Table 7.1: Attitudes regarding HIV/AIDS and the Thai health care system
Figure s are in percent; n=91.

There is a high propotion of neutral responses in Table 7.1, ranging from about one-quarter to about half of the responses for the various statements. Half of the respondents replied neutrally to the statement "the health care system in Thailand is good", with the rest of the respondents fairly evenly divided between agreement and disagreement. It is reasonable to assume that this reflects the characteristics of the Thai health system as the dualities, between public and private institutions and access in rural and urban areas are divergent, as outlined in the previous chapter, and it may be difficult or unreasonable to give a distinctive

overall score. Almost thirty percent disagreed or strongly disagreed with this proposition, against twenty-two percent who agreed or strongly agreed. It is worthwhile to highlight that the proportion of strong disagreement heavily outweighed the proportion of strong agreement, although the premises of this questionnaire does not allow for generalisations.

The response to the statement of there being "high levels of HIV/AIDS in Thailand", indicate a uniform perception among participants. Despite more than one-quarter of the respondents replying neutrally to this statement, only two percent disagreed while more than 70 percent agreed or strongly agreed. The significance of this, independent of factual circumstances, is the dominant perception among the surveyed health care students and professionals of there being high levels of HIV/AIDS in Thailand. One of the corollaries of this perception is that there is a high probability of coming into contact with patients with HIV/AIDS and hence a risk of attracting the virus through their line of work. The proportion of neutral responses to the statement "the Thai health care system is effectively targeting the spread of HIV/AIDS" approaches fifty percent and the overall response pattern is similar to the statement regarding ranking the Thai health system as good, as the level of disagreement and agreement is fairly even. Respondents are, however, tilted towards agreement as thirty percent agreed and twenty-six percent disagreed or strongly disagreed that efforts are effective targeting the spread of HIV/AIDS. The response to the statement "the Thai health care system is effectively treating HIV/AIDS patients" is dominated by neutral replies. More than fifty percent of respondents replied neutrally while twenty-six percent of the respondents agreed or strongly agreed against twenty-two percent who disagreed and strongly disagreed.

Perceptions regarding the government creating awareness of HIV/AIDS showed stronger agreement than disagreement among respondents. Thirty-seven percent agreed and strongly agreed with this statement, while twenty-six percent disagreed and strongly disagreed. With regards to the government running effective education programmes, thirty-one percent agreed with this statements while twenty-eight percent disagreed and strongly disagreed. It is interesting to note that despite the level of agreement outweighing the level of disagreement for these two statements, as well as the statements regarding the Thai health care system being good and effectively targeting the spread of HIV/AIDS, the proportion of strongly weighted responses were higher among participants who disagreed.

There may be several valid reasons for the high proportion of neutral responses to these statements. Respondents may have been uncertain how to rate efforts, as the challenges regarding HIV/AIDS are immense, despite past progress. This was illustrated by a nurse who

in the interviews replied when asked how she viewed the governments' prevention campaigns: "it is alright... if you are asking if it is good, it is not good enough!" Despite past and current initiatives, programmes and campaigns having led to great results, the needs and challenges in combating the pandemic are immense and outweigh this progress. The semi-structured interviews continued the investigation into perceptions and attitudes among health care professionals regarding the HIV/AIDS pandemic. Firstly, perceptions and attitudes regarding risk factors of becoming infected with the virus through their line of work are accounted for in the following sub-section, while perceptions and attitudes regarding other dimensions and dynamics related to the spread of the disease are accounted for in the subsequent sub-sections.

7.2.2 Risk of Attracting HIV/AIDS

Twenty-three health care professionals were asked questions related to the HIV/AIDS pandemic and the risk of attracting HIV/AIDS through their line of work was discussed with ten of these interviewees. There were several different views on both the risk and the implications of this, although all of these interviewees acknowledged the possibility of becoming infected through a workplace accident. As pointed out by the Director of a rural hospital, one of two doctors at this facility, the risk is not limited to attracting HIV/AIDS but also other infectious diseases, such as tuberculosis. She also acknowledged that this risk is higher for nurses than doctors, as they interact more frequently with patients. Despite the risk of attracting HIV/AIDS, some of the interviewees stated that they were not afraid of becoming infected. A nurse at a large urban hospital stated that "*we are not too scared of HIV patients like before*" and another nurse, at a rural hospital, said she could not afford to be concerned as this would hinder her performance:

> *For example, when I have to take a blood sample from my patients and if the needle pierces my hand accidentally, if I feel afraid of that when I work, I cannot concentrate on my work. I never feel bothered by my patients and know that it is not easy to become infected. When we are working we have to feel confident and not afraid and think of the risk.*

Although the interviewees responding to questions related to HIV/AIDS in Thailand all recognised the possibility of becoming infected, most participants indicated that was not a constant worry. However, a doctor at a large urban hospital acknowledged that when working with a patient from an accident, for example, and if there was a wound and the blood from the patient splashed into his eyes by accident, he would "feel worried". A nurse working at a rural

hospital had performed research among health care professionals inquiring into this issue. She stated:

> They [health care professionals] feel afraid when they provide care even if they know how HIV/AIDS spreads. They feel afraid if the patient vomits, or if they have to touch the patient's blood. They can feel terrified of whether the patient has HIV/AIDS, for example if a patient is sent to us from an accident. But we have the universal precautions so we will always protect ourselves, and if we do not know the patient's HIV/AIDS status, we will assume they are positive.

The universal precautions were frequently mentioned during the interviews as the main method for protection against attracting HIV/AIDS through their line of work. This would include wearing masks and gloves. However, one interviewee indicated that this was sometimes problematic and staff at her workplace did not always follow these guidelines. This nurse worked at a private hospital in the metropolitan area and she stated that she believed the services provided at her institution were different from those at public hospitals and she could not always protect herself. In fact they would even "*have a problem to wear gloves to wipe the patient's body*", even if they knew the patient was HIV/AIDS positive, because the patients "*think we mind to be close to them*". It would be a problem if patients felt that the staff were unfriendly, avoided contact, or felt uncomfortable with procedures, as private hospitals rely on raising revenue through bringing in and keeping patients. If patients felt uncomfortable with the procedures or the staff at a private hospital, they would simply transfer to another hospital. She further stated that she believes that health care professionals at public hospitals can protect themselves 100 percent, implying that she cannot because she works in the private sector.

Research at King Chulalongkorn Memorial Hospital, a large university hospital in Bangkok, indicated that despite the universal precautions being in place since 1992, the frequency of occupational exposure remains high. This research by Hiransuthikul et al. (2007) found 315 occupational exposures being reported from January 2002 to December 2004 among 306 health care professionals at this institution. While none of these incidences had led to health care professionals contracting the disease, ARVs had been administered as a precautionary measure. At a national level, between 1992 and 1997 between 10.0 and 51.5 incidences of blood and body fluid exposure were reported per 100 health care professionals, and the frequency of occupational exposure was increasing (ibid). Increased workload at public hospitals as a result of the UC, as reported through the interviews in sub-section 6.3.2, is likely

to exacerbate the frequency of exposure if these increased workloads lead to increased fatigue and stress or a decease in the attentively among health care professionals.

While the workloads at private hospitals and institutions are not necessarily as demanding and intense as at public institutions, reducing precautionary measures at private hospitals to avoid alienating patrons may actually place the staff here at greater risk of attracting HIV/AIDS than staff at public institutions. Anecdotal evidence suggests that precautionary measures are not always followed at private hospitals, and this adds to the duality between public and private hospitals which were reviewed in the previous chapter. It was noted by the MoPH & WHO (2005:20) external review of the health sector response to HIV/AIDS in Thailand that:

> "Private hospitals supply a significant number of PHIV [people living with HIV/AIDS] with treatment and care but there remain concerns about the comprehensiveness of service supplied by some of these hospitals."

However, it is not only health care professionals who are at risk of attracting HIV/AIDS, or other disease, at hospitals. As stated by a nurse at a public urban hospital, if the patients are considered to be within a risk group, or known to have HIV/AIDS, the hospital staff will use masks, among other protective measures; however, these patients will sit and wait among other patients in the hospital hall areas, which are open-air areas. Although this is a reasonable observation, the probability of attracting HIV/AIDS in such an environment is minimal, and the risk of becoming ill at hospital waiting rooms would be greater for other diseases, particularly airborne diseases.

7.2.3 Teenagers and Young Adults

A medical doctor working at a large urban hospital when asked regarding the challenges of containing the HIV/AIDS pandemic answered that Thailand had had success in controlling the situation for a while. However, the situation was now becoming worse as many teenagers explore their sexuality without protecting themselves. She stated that: "*they are afraid of pregnancy, they are not afraid of HIV/AIDS.*" This attitude, that protection is for the sake of preventing pregnancy rather than avoiding sexually transmitted diseases, including HIV/AIDS, is worrying. Furthermore, while promoting condoms is an important tool to prevent HIV/AIDS transmissions, an unbalanced focus on condoms will not lead to long term sustainable behavioural change, and may in itself actually be problematic, as this may sustain attitudes and perceptions that promiscuity, infidelity, and frequenting the commercial sex industry is acceptable as long as one use condoms.

A nurse responsible for HIV/AIDS prevention at a public urban health care centre conceded that the rate of HIV/AIDS in Thailand is still high and that the age of people contracting HIV/AIDS is decreasing; "*they are very young people*". Her view was that rather than promoting 100 percent condom use, the need is to work on changing risk behaviour as the Thai society is currently changing and the media is having a greater impact, implying that the popular media is playing on and promoting sexuality. In addition, she found that alcohol consumption created carelessness. She further exclaimed that in a questionnaire survey she performed among high school students, an attitude of not using condoms with their partners was prevalent. It was also found that the students, particularly girls, felt shy to purchase condoms. Another nurse, at a different rural hospital, stated she had been in contact with teenagers, as young as 14-15 years old, who had become infected with HIV/AIDS as a result of sexual activity.

The issue of teenage sexuality, particularly for females, can be viewed as controversial within the Thai context; "girls are required to be docile, submissive, modest, and disinterested in sex until marriage" (Vuttanont et al. 2006:2069). Furthermore, the attitude of chastity can also hinder appropriate sexual information and education, including appropriate knowledge of STDs. It was estimated that among the Thai population who were HIV/AIDS positive in 2005, 11.2 percent of these were between 15 and 24 years (Rongkavilit et al. 2007). A cross-sectional survey found that 43 percent of girls 17 years or younger reported having had sexual intercourse, of which one-fifth reported this having been coercive and one-quarter became pregnant (Vuttanont et al. 2006). As such, teenage sexuality, despite traditional attitudes and perceptions that unmarried girls and young women are to be chaste, are incongruent with current behaviour and there is a dire need to equip teenagers and young adults with proper education and information on sexuality and sexually transmitted diseases, including HIV/AIDS.

Research by Vuttanont et al. (2006:2071) on sex education in northern Thailand revealed that despite the high concern regarding HIV/AIDS and the need to provide sex education, Thailand has no national curriculum or strategy "resulting in uncertainty and institutional inertia":

> "Sex education curricula and methods of delivery differed widely between schools, but biological issues (bodily changes, differences between the sexes) were prioritised over practicalities (eg, how to put on a condom) and there was almost no formal teaching about emotional issues or negotiation skills. Homosexuality was sometimes mentioned briefly. Public-health advisers supported school-base sex education in principle, but they were rarely proactive in working with, or advising, schools."

It was also recognised by the MoPH and WHO (2005:29) that the education system needs to "urgently strengthen efforts to build appropriate life skills among students" and young people engaging with "high-risk sexual or drug-using practices". Furthermore, as suggested by another informant, it may be difficult to insist on using a condom for young females when exploring their sexuality with a boyfriend, as this may imply that she has had previous sexual experiences. Some boyfriends may also find such a proposition offensive as it can insinuate that she believes he has had previous or currently has other sexual partners. Despite the introduction of sex education at schools, the content and quality varies, and there is generally little openness around sexuality. Even among peers, this is often a taboo, and although close friends may have the same experiences and ponder the same predicaments, their introversion regarding sexuality is likely to prevent consultation with each other. Rather, they are likely to think they are the only one in this situation and that their friends are chaste and seeking advice will mark them as deviant. Further research and development of regional and national strategies in sex education is required to empower teenagers and young adults, particularly females, encourage openness and peer support regarding sexuality, and to ensure that the sex education curriculum include appropriate and necessary elements which will enable young Thais to protect themselves prior to becoming sexual active. To deliver this, teachers are required to be equipped and trained appropriately, as the research by Vurranont et al. (2006:2071) found that:

> "Teachers admitted feeling uncomfortable delivering sex education. Curricula were widely modified, and sometimes overtly censored, by the individuals charged with delivering them; such decisions were strongly affected by personal values (about the immorality of sex), knowledge of sexual health, and past experiences (especially memories of their own sex education)."

7.2.4 Other Risk Groups

As stated earlier, Fordham (2001:259) has characterised Thailand's efforts and approach to address HIV/AIDS within the notions of risk groups as a model which has "been subject to extensive criticism in the western bio-medical and social science literature". Risk groups is still the prism through which HIV/AIDS is addressed in Thailand, and Fordham (2001:260) suggests:

> "that the concept of 'risk group' found enduring favour not solely because of its heuristic value, but because, at a time of rapid social change, it rendered visible the entire social body of modern Thailand as a hierarchy of risk groups, with specific groups' attributed behaviours necessitating control. Importantly, it also legitimated and reinforced existing social prejudices

about such groups: the male underclass, prostitutes, injecting drug users (IDUs) and homosexuals who, defined as dangerous and deviant populations, became the target of reformist interventions. Thus I will argue that much Thai HIV/AIDS research has been partisan in as much as it has started out with ready-made moral judgements and it has proceeded to validate those judgements."

Fordham's approach to HIV/AIDS campaigns in Thailand alters the perception of the past success, and in light of current shifts, or the identification of new risk groups, challenge the sustainability of these achievements. Fordham (2001:261) argues that "the concept of risk group constituted less a means for reducing the rate of HIV transmission than a tool of state control of female sexuality". This argument can be transferred to the issue of teenage sexuality, as Vuttanont et al. (2006:2069), cited in the previous sub-section stated that "girls are required to be docile, submissive, modest, and disinterested in sex until marriage". As it is becoming apparent that HIV/AIDS in Thailand is no longer associated with singular risk groups, but becoming more frequent among the population previously considered not at risk (UNAIDS and WHO 2008), Fordham's argument may account for the apparent inaction in addressing the concern of HIV/AIDS having become a general phenomenon, and individuals previously not considered at risk becoming infected. An indication that we are entering a second-generation HIV/AIDS pandemic in Thailand is the increase of partnership transmissions and mother–to–child transmissions. Although government programmes are in place regarding mother–to–child transmission there is little dissemination of the risk of partnership transmissions. This issue was raised by an informant working in the non-government sector:

> *For example, the statistical data recently showed that the HIV/AIDS prevalence pattern is shifting from people visiting prostitutes to male-female couples forming families together. But there are no campaigns to promote female condoms or condom usage among husbands and wives. In this case the campaign of risk groups has become entrenched in the current public health policy, and consequently, married couples don't see themselves at risk and therefore no preventions [condoms] are used.*

With regards to partnership transmission, health care professionals are placed in a precarious situation. Does a spouse have the right to know if their partner is HIV/AIDS positive? This dilemma is faced by health care professionals who are working with HIV/AIDS patients who do not want their families to know that they have attracted the disease. Standard practice and guidelines, in accordance with doctor-patient confidentiality, states that health care professionals are not permitted to reveal any patient's HIV/AIDS status to their family members, even spouses. As stated by a doctor working at a rural hospital:

> *Some HIV patients do not want us to tell their family members and relatives. But we see the family members as very important to care for the patients. This is a problem for health care professionals. It is a difficult part of out work. We are not sure which side we should take; it is hard to make a decision. For example, a husband becomes a HIV patient but he does not tell his wife, who wishes to become pregnant, of his disease. He is afraid that no one will take care of him. I can only advise him to tell his wife.*

The government has been actively engaged in stemming mother–to–child–transmissions. Even prior to ARVs being freely available through the UC in Thailand, efforts were made to prevent such transmission, by providing ARV to HIV/AIDS positive pregnant women. There are also breast-milk substitute programmes in place to prevent transmissions by breast-feeding. Several of the interviewees were actively working in association with such programmes, or otherwise had first hand knowledge of the dynamics of these programmes. A nurse working at a rural hospital indicated that the fathers of the children were most likely to come to get the breast-milk substitute. She explained that although the wives, or mothers, are entitled to have their HIV/AIDS status confidential, they actively encourage mothers and expectant mothers to tell their husbands as "they can help each other and take care of each other better".

It must be noted that most health care professionals, at least those who had experience working with HIV/AIDS patients and programmes, clearly outlines and elaborates on the issues of partnership transmissions and mother–to–child transmissions. However, not many health care professionals directly identified drug addicts or men who have sex with men as being at risk of attracting HIV/AIDS. In fact, there may be a great deal of misconception regarding the risks and dynamics particularly regarding the sub-group of men who have sex with men. As stated by a key informant working with an NGO which is mainly an HIV/AIDS advocacy organisation:

> *I think they [the government] need to do a specific campaign directed towards men who have sex with men, which is quite different to developed countries where this is the main co-sector of the community which is infected, but here I have heard even that these men think they are less at risk than the heterosexual section of the community. So I think they really need to target this, and tell them that they are at risk and how to prevent it.*

According to this NGO worker, one of the main reasons why there appear to be less government or public campaigns regarding injection drug users and men who have sex with men, may be that:

> *These are sensitive issues and the government doesn't really want to address these issues directly.*

As such, it is very interesting to note that very few of the health care professionals who were interviewed identified these groups as at risk, as emerging risk-groups, or otherwise commented on these groups. However, when explicitly asked, a nurse at a rural hospital recalled a couple HIV/AIDS patients at the hospital as injection drug users. This nurse also explicitly outlined men who have sex with men as a group in which HIV/AIDS was found frequently. According to the WHO the HIV/AIDS prevalence rate among injection drug users has been constantly high since the early 1990's, ranging from 30 percent to 50 percent (cited in UNAIDS and WHO 2008). It is not surprising that few health care professionals recognised men-who-have-sex-with-men as an explicit risk group, as the 100 percent condom use programme did not focus on this sub-group and there has been little government initiatives to disseminate information to this group. Among all new infections in 2005, it has been estimated that 21 percent was among men who have sex with men, and the HIV prevalence among this group in Bangkok increased from 17 percent in 2003 to 28 percent in 2005 (ibid).

7.3 Rights and Predicaments

The following chapter will explicitly engage with perceptions and attitudes regarding rights and obligations as perceived among health care professionals in relationship with their communities. This section introduces some of the dilemmas regarding rights: As will be illustrated in the next chapter, rights may in certain scenarios be in conflict or the rights of one group may jeopardise the rights of others. The universal right for medical care, as outlined in the objectives of this research, may be jeopardised if health care professionals collectively exercise their right to migrate. While this predicament is approached in the following chapter, it is fitting to note that the HIV/AIDS pandemic has been instrumental in clarification of the relationship been health care and human rights (Grusking et al. 2007). Any right based approach related to the HIV/AIDS pandemic need to engage, account for and aim at protecting the rights of all stakeholders; people living with HIV/AIDS, their families, the general population, groups considered at risk, and health care professionals. Measures to address the concerns of some cannot compromise nor have precedence over the rights of others, including people living with HIV/AIDS.

7.3.1 People Living with HIV/AIDS

Attracting HIV/AIDS may lead to stigmatisation or discrimination (Knodel and VanLandingham 2003). As indicated earlier, it has been argued by Fordham (2001:260) that the public HIV/AIDS campaigns in Thailand which "legitimated and reinforced existing social prejudices",

and discrimination and stigmatisation of People living with HIV/AIDS (PLHA) has been viewed as a result of public prevention and health programmes, specifically during the early 1990's (Ichikawa and Natpratan 2004) which linked HIV/AIDS explicitly to the commercial sex industry. While there is a cultural "double standard" which allows males, both single or married, sexual promiscuity without social stigmatisation while females are to be chase (Jones and Pardthaisong 2000) the association of HIV/AIDS with the commercial sex lead PLHA do not necessarily disclose their status to their family and friends. As attracting HIV/AIDS can be viewed as confirmation of infidelity, men who attract the disease through extramarital sexual relationships may fear their partners will leave them if they disclose their HIV/AIDS status. This perception was witnessed during this research process: During a visit to a rural hospital in late 2005, the Director disclosed that a young patient held in isolation at the hospital was at the late stages of AIDS. He begged her not to disclose his diagnosis to his family, but rather have it declared as aggressive hepatitis or another illness.

While stigmatisation, discrimination, and the fear of not being supported and cared for by family and friends at the terminal stages of AIDS may lead PLHA not to disclose their status, these individuals should not be viewed as a powerless or inept group. PLHA is an important and invaluable source of peer support for other persons in the same situation, and has been encouraged for several years in Thailand (Kumphitak et al. 2004). Often organised into "positive groups" or "positive networks", the assembly and organisation of PLHA have in Thailand, and internationally, increasingly contributed to strategies to enhance the quality of life of members, aided in the dissemination of information among themselves as well as to the general public, and lobbying policymakers (Thai Network of People Living with HIV/AIDS n.d.; Kumphitak et al. 2004). The organisation of these groups has not only pressured the Thai government to provide ARVs, but the AIDS Access Foundation even won a court case against the pharmaceutical company Bristol-Myers Squibb, enabling generic production of the ARV Didanosine (Ahmad 2002).

An expatriate NGO worker working with PLHA and positive networks in Thailand was interviewed in early 2007. Although she acknowledged that there are significant levels of discrimination towards PLHA, she pointed out that this had significantly decreased from previous levels. She further emphasised that Thailand is not a violent culture, in spite of contemporary violence in the Southern provinces, and as such discrimination does not generate the fear of violence. The issues of discrimination and alienation are important, as they directly impact the quality of life for PLHA. However, fears of discrimination or retaliation

are not always well founded, but can stem from uncertainty, qualms, and scepticism, and fear itself may exacerbate this apprehension. For example, as outlined by this expatriate, some women who know they are HIV/AIDS positive wish to have children but do now know how to go about it:

> *They are scared, if they do get pregnant, they are scared to go to the doctor straight away because they think the doctor will tell them to have an abortion.*

Although some health care professionals may have strong personal believes, and state these, there are no polices to encourage abortions among people with HIV/AIDS. A nurse working at a rural public hospital, when asked directly, acknowledged that she had had some consultations with pregnant women who were HIV/AIDS positive regarding abortion:

> *It is up to the mothers, they have the right to make the decision. We do not do any abortions [at this hospital] but we will provide information.*

Combating HIV/AIDS through education and prevention is clearly the way forward in stemming the spread of the disease, but this must not take precedence over treating and empowering PLHA. These individuals are a vital resource for educating the public and offer peer support for each other in the challenges with living with HIV/AIDS. These groups or networks constitute important support for PLHA, both socially and for information. A nurse working at a rural hospital identified herself as the person at this hospital responsible for gathering and networking PLHA in her district and funding from the Global Fund had provided a volunteer to help out during these meetings and provide counselling. These monthly meetings in this district also included monitoring the CD4 levels[23] and distribution of ARVs. The nurse announced that this group had about 300 or 400 members and around 100 people would attend each meeting.

While continued prevention and education campaigns to stem the spread of HIV/AIDS continue to operate, it is a challenge to ensure that these initiatives do not alienate or reinforce stereotypes and social stigma. PLHA and their associations must be drawn into the public sphere and debate, giving these people voice and face. Rather than having government campaigns which reinforce and indirectly condones social stigma attached to sexuality, gender, and social hierarchies, it is necessary to engage the stakeholders, advocate change through social change, rather than simplistic and short-tern band-aid campaigns, such as

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[23]CD4+ cell counts will indicate the effect of ARVs in controlling HIV/AIDS. According to the MoPH, immunological failure is "the absence of increase or a decrease in the CD4+ cell count of more than 30% from the highest value after at least 6 months of HAART [highly active antiretroviral therapy]" While virological evaluation is considered "the gold standard for monitoring of treatment outcome", CD4+ cell count is recommended to monitor the effect of highly active antiretroviral therapy according to national standards (Chaiwarith et al. 2007)

promoting condoms when being promiscuous with commercial sex workers, rather than address the social dynamics encouraging the sex industry.

A final predicament relating to PLHA, and their rights, is related to the access to treatment and ARVs in particular. Although ARVs do not cure HIV/AIDS, they can if taken correctly prolong and significantly improve the quality of life, enabling PLHA to live a normal life. With increase access, knowledge regarding ARVs has increased. However, severe reactions or side effects may lead some to discontinue their ARV treatment. A key informant narrated a story of a family friend, a young female, who became HIV/AIDS positive. She did initially received ARV treatment for a while at the local hospital, but the side effects of the medication were so painful that she decided to discontinue the treatment. Instead she went home and used traditional medication to treat symptoms, such as vomiting, and ease the pain, until she passed away. There are two interpretations of this story: It can be viewed as a tragic discontinuation of medication which lead to the death of a young adult, or it can be viewed as a young PLHA who utilised her right to discontinue her treatment. While this case illustrate that not all PLHA are willing to undergo ARV treatment, it should not be used as an argument not to universally provide medication. Furthermore, the right to treatment should not trump the right to refuse treatment.

7.3.2 Health Care Professionals and the Public

"Each year, 3 million health workers world-wide are exposed to bloodborne HIV and hepatitis viruses" (World Health Organisation 2006:107). As cited earlier, exposure to blood and body fluids per 100 health care professionals were estimated to be between 10.0 and 51.5 between 1992 and 1997 and a study at King Chulalongkorn Memorial Hospital found 315 reported exposures between January 2002 and December 2005 among the 306 health care professionals partaking in that particular research (Hiransuthikul, Hiransuthikul, and Kanasuk 2007). The proportion of HIV infections resulting from such exposure has been estimated to be 0.3 percent for percutaneous exposure (such as needle pricks, blade and surgical blade cuts), 0.09 percent for mucosal exposure, and non-intact skin exposure has a transmission rate lower than 0.09 percent (ibid). While the probability of contracting HIV/AIDS through workplace exposure for Thai health care professionals is relative low, it cannot be ruled out.

According to the WHO there were almost 200,000 physicians, nurses, and midwifes in Thailand in 2000, as outlined in Table 3.1. If we assume that the proportion of exposure in the year 2000 is at the low end of the scale, at 10 incidences per 100 health care professionals,

there would have been 20,000 professional exposures among doctors, nurses, and midwifes. The study at King Chulalongkorn Memorial Hospital found that more than 90 percent of the exposures were percutaneous of which the majority was needle pricks. If we assume this is accurate, there would have been 18,000 percutaneous exposures in 2000, of which 54 would have become infected with HIV/AIDS with the probability rate of 0.3 percent. This is a conservative estimate of the proportion of Thai health care professionals who became infected. It is probable that the annual exposure rate is towards the higher end of the estimate, particularly after the increased workload induced by the UC, and this estimate only take into account physicians, nurses, and midwifes according to WHO statistics. It does not include other health cadres or health care students, who are also at risk of exposure. A high estimate of 50 incidences per 100 health care professionals, with a workforce of 200,000, of which 90 percent of the incidences will have a 0.3 percent chance of contracting HIV/AIDS would suggest that 270 health care professionals attracted HIV/AIDS through the line of work in 2000. This may still be a conservative estimate for current rates of HIV/AIDS transmission rates to health care professionals through workplace incidences.

Acknowledging unequivocally that health care professionals have the right to protect themselves in their line of work, including precautions to avoid contracting HIV/AIDS, the introduction of universal precautions in the Thai health care system is natural. The nurse working at a private hospital cited in sub-section 7.2.2 stated that it was problematic to wear protective equipment, including glows even with patients known to have HIV/AIDS as her hospital indicates reservations and even instigate a conflict between health care professionals' opportunity to protect themselves and not alienating patients and PLHA. While there is a '"window period before systemic spread [which] provides an opportunity for HIV post-exposure prophylaxis ... using antiretroviral drugs ... to block replication of HIV and prevent establishment of infection" (Hiransuthikul et al. 2007:345), it is still perplexing that health care professionals at private health care intuitions may not be given the opportunity to fully protect themselves through precautionary measures.

As mentioned earlier, another dilemma for health care professionals when dealing with HIV/AIDS, is the issues surrounding privacy and information for individuals and their family members who are diagnosed with HIV/AIDS. This is both an ethical and professional dilemma which cannot be ignored. If it is possible to obtain consent for disclosure through negotiations by health care professionals, the dilemma is resolved. However, if this is not achievable, whose rights have precedence? The concept of privacy and doctor-patient confidentiality will

legally bar health care professionals from informing the patient's family of his HIV/AIDS status. This is unfortunate as it directly puts the family members, particularly spouses, directly at risk of becoming infected themselves, without these individuals having the opportunity to protect themselves accordingly. This dilemma is not unique for Thailand, but a universal dilemma, both directly linked with HIV/AIDS as well as other diseases.

While this research investigated HIV/AIDS in particular, related diseases among HIV/AIDS infected persons are also an occupational hazard for health care professionals. A newly graduated physician working at an urban public hospital stated:

> We have loads of them [HIV/AIDS positive persons] coming, and I don't feel it's bad for me to deal with HIV people, but I feel that it is not good that I deal with Tuberculosis people … it is widespread – it is worse than HIV.

As such, while there is an occupational risk of attracting HIV/AIDS, health care professionals are also at risk of coming in contact with other, more contagious, diseases among PLHA, which may be perceived a greater threat. Unfortunately, this dimension was not investigated further, but it must be acknowledged that this is a significant aspect of HIV/AIDS and should be investigated further.

7.4 Chapter Summary

While significant success in containing HIV/AIDS has become characteristic of Thailand's efforts, there are significant challenges to overcome the adversities of the pandemic. In particular, although efforts have been effective, these may have relied on enforcing social stereotypes and creating stigma and discrimination, rather than being a holistic and inclusive approach in combating the disease. There is a continued need to educate and revamp efforts in stemming HIV/AIDS. In particular, there is a need to embrace the gender dimension of the pandemic and challenge culturally sensitive issues. This cannot be limited to promoting condoms in relationship to the commercial sex industry, but must promote a systematic change, including the dynamics of the commercial sex industry, promiscuity and sexuality, both generally and among teenagers and young adults. While sex education through the education system is a long term strategy to promote safe sex, such programmes must be balanced, informative, and include sensitive issues often omitted by teachers.

CHAPTER 8

Rights and Health Care

> "Everyone has the right to freedom of movement and residence within the borders of each state."

> "Everyone has the right to leave any country, including his (sic) own, and to return to his (sic) country."

> "Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay."

> "Everyone has the right to a standard of living adequate for the health and well-being of himself (sic) and of his (sic) family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (UN 1948).

8.0 Introduction

Human rights, independent of social, cultural, religious, philosophical, or political orientation reflect the belief that human beings have intrinsic value which should be protected. The United Nations Charter in 1945 and the UDHR in 1948 can be viewed as "general human rights norms" reflecting a global institution or institutionalisation of human rights through international law (Koenig 2008). There are different perceptions of human rights, and these may be influenced or even shaped by cultural and social factors. As such, there are different notions or even definitions of human rights. These are not limited to different perceptions between world regions or countries, but can also be found between the government and non-government sections of civil society (Muntarbhorn 2002). The UDHR and the principles therein are a set of principles and rights claimed to be innate for every human being. While these rights are universal and irreducible, they may in specific scenarios and circumstanced be in conflict. This research investigated the potential conflict of rights between the general population's fundamental rights to "medical care" in Thailand, versus the fundamental rights for health care professionals of "freedom of movement", "rest and leisure", and "free choice of employment" (UN 1948).

This chapter will firstly present perceptions and attitudes among health care students and professionals regarding their rights and obligations. The perceptions and attitudes of the

participants, have to be contextualised within the specific cultural and social parameters. This does not imply that rights are derived solely from cultural and social parameters, or that rights are not universal, but rather that social and cultural factors both reinforce and challenge rights and perceptions of obligations. Within this context, it is argued that there is a culturally specific social contract between health care professionals and their local communities in Thailand. This is a mechanism which remunerates health care professionals' personal sacrifices resulting from their professional obligations. Although this social contract restrains health care professionals from emigrating and encourages these individuals to enhance the health of community members, it is argued that current social, political, and economic transitions are challenging the premises of this mechanism. This research argues that the rights of the general population to health care, and the individual and collective rights of health care professionals, can only be ensured through a holistic and inclusive rights-based approach to health care and measures to mitigate adverse trends must be innovative and inclusive, rather than confrontational, alienating, paternal, or reinforcing social stereotypes.

8.1 Social Hierarchies and Perceptions of Rights and Obligations

Perceptions of rights and obligations will yield insight into the dynamics and motivations for health care professionals to pursue professional development; account for their perceived professional obligations and their individual rights; as well as give insight into the dynamics between these professionals and the community. Health care professionals' individual rights, including the right to migrate and rest, as well as time for leisure, may in some circumstances be in conflict with the general public's right to medical care, which can be viewed as a conflict between individual and collective rights, as outlined in chapter four. This predicament is reviewed towards the end of this chapter. This first section will provide a brief introduction to Thai social dynamics and hierarchies, followed by a short account of health care students' and professionals' attitudes and perceptions regarding their professional obligations and individual rights.

8.1.1 Social Hierarchies

While this research cannot engage with all aspects of the cultural and social dimensions and dynamics in Thailand, some of the social and cultural values influencing the dynamics of health care professionals and the attitudes towards health care have to be accounted for. Thai identity is organic and in transition as a result of modernisation, globalisation, urbanisation, and the impact of the large scale economic development of recent decades. Traditional and

conservative idols are still a vibrant part of the contemporary ethos, and civil society can still be viewed as patriarchal with layers of political, economical, and social structures. There are hierarchal structures between the generations, genders, and individuals with high social status such as teachers and educators, prominent members of the community, monks, and even health care professionals. While the specific dynamics of health care professionals' social status in the communities are reviewed in section 8.2, it must be noted that the rigour of hierarchies in Thailand are eroding:

> "Most social scientists in their studies on Thai society agree that the Thai social system is that of a highly hierarchically structured society, in which each member ranks the other in terms of superiority and inferiority and conforms to the numerous, culturally provided practices of etiquette. Across all social classes, the ideal seems to be upheld that life will be smooth and predictable if everybody knows his or her place and acts accordingly. However, Thailand's rapid economic development during recent years has, to a certain degree, begun to undermine the previously rigid and inflexible ascription of status" (Bechstedt 2002:241).

The traditional Thai way of greeting, the *wai*, is an example of the public display of superiority and inferiority according to age and social status. This greeting encompasses the social structures in Thailand, from the Royal Family to the community and even among family members. His Royal Highness King Bhumibol Adulyadej and other members of the Royal Family are to be *waied* with both hands clasped together above the head while bowing and the bow is to continue to the ground with the hands clasped together above the head. Similarly, Buddhist Monks are *waied* with the palms of the hands clasped together with the thumbs touching the forehead while bowing, and in some cases, like in a temple; the bow is to take place to the ground as well. Parents, teachers and older people are also to be treated with great respect. When greeting these persons, the hands are to be clasped together by the nose while bowing. Among equals, such as friends, the *wai* consists of clasping the hands together by the chin and bowing lightly. Hence, the placement of the hands and the depth of the bow reflects the differences in social status when *wai-ing*. There is also a general prefix added to people's names, or nicknames, when addressing each other, according to whether the person one is addressing is older or younger than one self. The prefix *phi* is added to someone older and the prefix *nong* is added to someone younger, which is even followed when twins address each other, as one is born before the other (Bechstedt 2002). It is common when meeting someone for the first time to have to sort out the age of each other to be able to comply with these suffixes, even if the age difference is one of a matter of days or weeks.

Members of the Royal Family are the national paternity figures. In particular, His Royal Highness King Bhumibol Adulyadej, the world's longest reigning monarch, and his wife Her Royal Highness Queen Sirikit are the mother and father figures of the nation. This is also reflected by the fact that Father's Day in Thailand is celebrated on the King's birthday and Mother's Day is celebrated on the Queen's birthday (Winichakul 2008). Furthermore, national loyalty and loyalty to His Royal Highness is reinforced by the playing of the National Anthem on all public broadcasts and often in public places in both the morning and evening, where everyone is expected to stand still when the anthem is being played. A specific tribute to his Royal Highness the King is also played prior to the screening of every movie in all cinema theatres, and patrons are expected to stand during the audiovisual tribute to the King, reinforcing His Majesty's status as the father figure of the country.

The coup in September 2006, characterised as a royalist coup, was seen as a reaction to the "perils of global capitalism – with Thaksin as its conduit – [which] were more dangerous to the country than any other devil" (Winichakul 2008:12). The need to "topple" Thaksin and have "Thaksin's cronies in the political and bureaucratic system … purged" was argued by Kasian (cited in Winichakul 2008) prior to the coup in September 2006. While the aim was to remove Thaksin through political and legal means, the military coup d'état on September 19, 2006 "proceeded to do exactly as Kasian had proposed" (Winichakul 2008:12). The recent volatilities are the backdrop against which this research was carried out and it cannot be trivialised. As stated in chapter two, concerns about political stability and security have been identified as two key components for individuals contemplating migration (Hale 2003; Rule 1994; Van Rooyen 2000). Current political volatility may erode the loyalties or compliance to the social dynamics and hierarchies, leading to an emphasis on individual ambition rather than collective needs.

The proposition by Kasian, that global capitalism is a severe threat to Thailand and that the political forces including Thaksin Shinawatra are grave dangers to the country, are mainly through the threat these present to the internal social structures and hierarchies. While it was argued by Winichakul (2008.12) that the 2006 military coup was a royalist coup, strengthening the loyalties of the monarchy and "embed a royalist democracy", the threat of the extreme capitalism promoted by Thaksin is not limited to the royalists or democratic development of Thailand. Rather, the erosion of social loyalties and bonds with the local communities will weaken as individual ambition and prosperity are given increased emphasis. This may eventually lead to health care professionals emigrating from Thailand in greater numbers.

Before engaging further into these issues a general introduction to attitudes and perceptions among health care students and professionals regarding their rights and obligations is offered.

8.1.2 Perceptions of Rights and Obligations among Health Care Students and Professionals

The attitudes and perceptions regarding rights and obligations among health care students and health care professionals indicate both their individual ambitions and their perceived responsibilities to the community. The questionnaire survey sought to investigate perceptions of rights and obligations among health care students and health care professionals. Table 8.1 outlines some very interesting perceptions: None of the participants disagreed with the statement "I have an obligation to serve my country as a health care student/professional". Although thirteen percent of participants replied neutrally; almost fifty percent strongly agreed and almost forty percent agreed with this statement. This suggests that there is an overwhelming perception among health care students and health care professionals that they have an obligation to their country. As none of the respondents indicate disagreement with this statement, it could be argued that health care students and professionals in Thailand perceive service towards the public as embedded in their profession. The responses to the statement "I have the right to migrate independent of my country's need of my (future) professional services" are striking: While a significant proportion of participants indicated agreement with this statement, almost thirty percent agreed and about eighteen percent strongly agreed, more than sixteen percent of respondents indicated disagreement. Ten percent disagreed and more than six percent strongly disagreed, suggesting that they do not have the right to migrate if there is a need for their professional skills and services in Thailand.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I have an obligation to serve my country as a health care student/professional[1]	-	-	13.0	38.0	48.9
I have the right to migrate independent on my country's need of my (future) professional services[2]	6.6	9.9	37.4	28.6	17.6

Table 8.1: Attitudes related rights and obligations as a health care professional
Figures are in percent; [1]n=92; [2]n=91.

This perception of an obligation among health care professionals and students to serve the needs of their country was reflected and elaborated on through the interviews. While it could be expected that the perception of obligation in caring for people's health would be lower among health care professionals working in the private sector, this is not necessarily the case. A nurse working at an urban private hospital replied when asked regarding her professional obligations:

I believe nursing is a career which we are trained and intended for taking care of people; from they are born until they die. We have to help people have good health so they can go on with their normal way of life. It is not only an obligation but we do this from our own free will and peace of mind. We want to give them our best service; to cure them and make them feel better and recover from illness.

This attitude of obligation, or rather desire, of caring for people was dominant among the interviewees. Thai health care professionals do not necessarily perceive this as an obligation or obstacle impacting their lifestyle, but rather as a part of life, or lifestyle. A dentist at an urban clinic associated with a public university hospital, where treatment is covered under the UC, offered her view on her working conditions:

Sure it is tiresome, but we have gotten used to it since we were young. In Thai society you know. It took a lot of effort to finish the studies. Never eat at proper times, but we get used to it. So I don't feel it is different. If compared with other careers, like office work or private business, they are fine. … But I don't feel troublesome. It is a way of surviving. People who work hard will live their lives this way. We get used to it and have to do it everyday.

When asked how she viewed the rights of health care professionals to choose where to work, including to migrate to other countries, she replied:

It is their right … yes. If they return to work in their hometown or local area and they are not happy or sometimes feel bored, like if they studied in high school there they may want to study further in another city or something like that. They have the right to choose. But if they are at home [area where they are from] and they are happy, have nice co-workers, it may be ok to stay. But they should be able to choose, right?

This reply suggests an uncertainty and an implicit perception that one should stay and work in the community one originates from. The reply from this dentist regarding the right to move or migrate to another country implicitly relates to internal migration rather than migrating to another country. This can be interpreted as suggesting that for some health care professionals, although aware of their individual rights, they perceive that they have some bonds with the community they originate from and the reply from this dentist may suggest that one should try to find work in ones home communities. Referring back to Table 8.1 and the fact that some respondents indicated that they did not have the right to emigrate if there was a need for their professional skills in Thailand, there is a dynamic encouraging health care professionals to work in their home communities, and this mechanism may even be mitigating to an exodus of health care professionals from Thailand.

8.2 A Social Contract Ensuring Human Resources for Health

The attitudes and perceptions among health care students and professionals, as indicated through this research, suggests that there is a social contract between these individuals who work to improve and promote the health of their fellow citizens and the community. The participants indicated a professional obligation to serve the Thai public through their professional services and traits, as was illustrated in the previous section. In return, and for any personal sacrifices endured as a result of professional obligations, health care professionals enjoy a high degree of social status and respect in their communities, independent of their professional capacity or seniority. Hence, a low level community health worker, with relatively low professional qualifications, may have high social status in his or her community. Social status is not only linked to professional expertise and seniority, but is also linked to devotion to the community and looking after the health of community members. This dynamic is particularly strong in rural communities, as the social networks are stronger here, although there is a general awe towards health care professionals throughout Thailand.

It is argued by Ferrinho et al. (2004) that:

> "Doctors and nurses in government employment are labelled 'unproductive', 'poorly motivated', 'inefficient', 'client-unfriendly', 'absent' or even 'corrupt'. These labels are often associated with coping strategies associated with widespread 'demotivation', due partly to 'unfair public salaries'. These are presented as de facto justification of 'inevitable' predatory behaviour and public-to-private brain drain. In many countries, developed and developing alike, this has eroded the implicit psychological and social contracts that underlie the civil service values of well-functioning public organizations."

Within the parameters of this research, this dynamic is characterised as a social contract and can be viewed as a circle of self-reinforcing principle as the communities' awe and esteem reinforce health care professionals' self-perception of obligation towards their community and community members, and vice versa. However, the current shift in health care policy with the introduction of the UC towards a rights based system may undermine the premise of this social contract as it emphasises individuals' rights to health care, and takes health care professionals' obligations to enhance the health of the population for granted. In addition, the modernisation and industrialisation of the country, where the individuals are viewed as the primary actors, further undermines the principles of this social contract as it places emphasis on the individual rather than collective ethos. The greed of politicians, in particular the financial dealings of the former Prime Minister Thaksin Shinawatra and the tax free sale of his family

business Shin Corp. as outlined in Appendix T, emphasise individual advancement rather than obligations towards the public and community.

8.2.1 Health Care Professionals and the Local Communities

Health care professionals' high regard in the local communities is based on their professional contributions to the community. Health care professionals themselves acknowledge this and view their social status in the communities as a result of their commitment to their community. A nurse working at a rural public hospital, who has been working here since her graduation in 1994, alluded to this aspect of earning social status:

> *We gain people's honour in the areas we are responsible for [assigned to] although we do not expect it. It is because we have been working here for a long time.*

Particularly in rural areas, nurses are engaged in community outreach programmes promoting primary health care and performing simple health checks; for example perinatal and maternal health. Nurses in these areas may have specific areas or households assigned to their purview, potentially working with the same households for decades, and as such they become an honoured and revered person in the community. In these cases, specifically in rural areas, the interaction between health care professionals and the community becomes more complex as health care professionals become integral parts of the community and the community a part of their identity. As stated by a physician working at a rural public hospital:

> *I think I have responsibilities because I am a doctor. As a doctor I have to take care of people as much as I can. I have to provide medication and counselling to the patients and to their relatives and partners. This is human services. As a neighbour and a member of the community I have to take care of the patient's relatives by giving them advice and help them to be strong and be able to take care of the patient.*

This statement highlights that it is not only through treating patients that health care professionals are creating and reinforcing bonds with their communities. Although these bonds are more dominant in rural areas, the role health care professionals have in their communities as mentors and educators must not be neglected, undermined or diminished. The doctor, cited above, viewed these issues as part of different roles. She saw herself both as a doctor and as a community member, and these roles carried different commitments. As a doctor, her role was limited to give counselling and medication. As a community member, she would give advice but also encouragement. These roles inevitably become interconnected when health care professionals view themselves as both a community member and a professional, which nurtures and reinforces the dynamics of the social contract.

Health care professionals build social capital and status in their local community through their engagement in the local community, particularly primary health care programmes. While community outreach programmes are important in engaging community members, health care professionals working with patients at clinics and hospitals are also offering a community service, and gain social status through their professional capacities and the services they provide to the community. This dynamic of high social status and awe for health care professionals is not limited to those working in rural areas.

In urban areas, particularly in metropolitan Bangkok, neighbourhood and community identities are less prominent than in rural areas. Independent of the mechanisms of urbanisation and community identity as well as rapid urbanisation, urban health care professionals in Thailand are not excluded from feeling obliged to enhance the health and well-being of their patients or from being revered by community members and the general population. In fact, the dentist cited in the previous section working at an urban clinic indicated that she felt privileged to be a health care professional:

> I think we are lucky that we studied medical sciences to become a doctor, dentist or perhaps another kind of health care professional, because we can help people. I like to help people having better oral health.

Another dentist working at the same clinic and cited in chapter six stated that he felt he should "*endure some sacrifice*" and other health care professionals, particularly doctors and dentists should not be "*too selfish*" as their profession is to look after the health of others as the ratio of doctors and dentist to the general population is very small. Furthermore, these dentists indicated that health care professionals are working to improve the health of the community, even if they work in private practice. The female dentist elaborated:

> I think everyone works in order to gain our basic needs for living, but we will never take advantage of the patients. There are a variety of patients, such as the rich and the poor, but we do not discriminate or choose to provide services to the rich only. … We have values and ethics and intend to help people to become healthy. If we work in a private clinic, we will meet only wealthy people but at least we help this group, but not everyone [such as those who cannot afford to pay] but at least once a year there is a 'dental day' when dentists have to provide free services to everyone[24]. So no matter where we work, we can help people in the community as our career is to help people.

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[24]There is also a "children's day" on the second Saturday in January when children will get free treatment at dental clinics as well as other health services at health clinics. Children may also take public transport and partake in some social activities without charge.

This attitude, that being a health care professional is to help and take care of people's needs, was dominant among the surveyed health care professionals and students, both in the questionnaire survey and among the interviewees. However, current changes in the health care sector combined with contemporary developments in civil society and trends among the political elite, may undermine the premises of this social contract. Health care reform and political and civil volatility may lead health care professionals to pursue individual ambitions rather than feel obligated to look after the needs of the community and community members.

8.2.2 Contemporary Trends Undermining the Social Contract

As alluded to in chapter six, current changes within the health care system may jeopardise the premises facilitating this social contract. With an epistemological shift in the health care system toward treatment, away from primary health care, the component and emphasis on community interaction is eroding. The UC emphasises the rights of patients, independent of health care professionals' and health care institutions needs, and may foster a culture among health care consumers of demanding care. For example, a nurse working at a rural public hospital with health promotion, including maternal and perinatal care and education, as well as caring for seniors, outlined how people in the community now are coming and asking for medication during her visits to the communities:

> *Now everyone comes to the hospital to get medicine, even when I go to the community to promote primary health care. We used to provide some vitamins for the seniors. Yesterday we had a workshop with activities for the seniors and the head of the village announced us as doctors, actually we were only nurses and some other health care workers, and anyone who had any problems should come and get our advice. They perceived that we were a health care team who distribute the medicine [without charging] so they came and asked for the medicine straight away. For example they feel pain in their knees or other parts of their body. We actually intended on promoting getting exercise and change their attitudes and behaviour.*

Although this example does not imply that community members have less regard for health care professionals, it indicates a shift in this community to receive medication from the health care professionals rather than education, prevention, and alternative forms of treatment. If health care professionals are no longer viewed as knowledgeable and revered professionals, but solely as distributors of medication, where individuals already know which medication they want, health care professionals' role in primary health care is undermined. Furthermore, health care professionals themselves may feel that the community members are no longer honouring their part in the social contract, but are becoming consumers seeking specific commodities

rather than taking the health care professionals' advice. This scenario, where patients "*request the medicine they want*" was cited in chapter six. Combined with the increased workloads as a result of the UC as outlined in section 6.3.2, including a doubling of patients in some public hospitals' out-patient departments, some doctors and other health care professionals may cave in to these requests rather than thoroughly examining the patients.

It was indicated that the UC more directly undermines some of the mechanisms reinforcing the social contract. The focus on individual gains and profiting, as the extreme cases of politicians seeking personal gains, arguably at the expense of the public, may undermine health care professionals' perception of obligation towards the public. A nurse working at a private hospital in Bangkok indicated that such a shift among health care professionals may already be taking place:

> *Now I see there are very few persons [who are health care professionals] who really love their career. Mostly people care more about the business. One example is the private hospitals which obviously focus on the business. We take care of our patients and provide the services like the other hospitals but we have to be concerned of the finances as well.*

Financial pressures are increasing as a result of global developments. These are also felt by health care professionals. The dentists working at the public clinic attached to the urban university hospital cited previously, indicated that dentists in the public sector could only earn about 10,000 bath a month (*AU$ 333*) or just in excess of this, while dentist in private clinics would "*earn a lot more*". Attitudes and perceptions regarding salary levels were explored and accounted for in section 6.2.2. It was illustrated that a significant proportion of participants, almost half, saw salary levels as a key factor when choosing where to work, while forty-four percent of participants indicated they would like to migrate to a place where they could earn more. It was further outlined that connections and commitments to the local community mitigated these perceptions, and retained health care professionals in their communities. As this social contract has compensated for low salary levels, high workloads, and mitigated the exodus of health care professionals, particularly from rural areas, the deterioration or undermining of the values the social contract promotes may lead health care professionals to pursue personal ambitions, and not factoring in the needs of the local community when they are contemplating their career.

As indicated in chapter six, some health care professionals are not seeking greater financial benefits, but are sacrificing opportunities of greater income, both from altruistic motives as well as based on the greater long term benefits of working at public hospitals. However, current working conditions combined with low salaries and an undermining of the social contract

which has retained health care professionals in the public health care system may lead to a greater number of health care professionals pursuing ambitions of working overseas. A nurse at a private urban hospital stated:

> *Most health care professionals will think of their obligations and sacrifices less than the perfect health systems in developed countries which provide better payment and benefits than working in Thailand. These are important push factors for emigration.*

The deterioration of this social contract is not only undermining and diminishing the availability of human resources for health in rural areas or the public health care system, but may also generate an exodus of health care professionals from Thailand altogether. Although this social contract is still ensuring human resources for health in the Thai health care system, it is inevitable that a further deterioration of the mechanisms of the social contract threatens to instigate a greater exodus of Thai health care professionals. This predicament needs to be addressed equitably, recognising the rights of both health care professionals and the general public. The actions by politicians pursuing personal wealth rather than the best interests of the country, as accounted for in section 5.1.2, are in sharp contrast with the expectation of individual and personal sacrifices among health care professionals. This may eventually lead to resentment and a shift in the attitudes among health care professionals. If it is perceived that other prominent members of Thai society are placing individual ambitions before the needs of the general public, health care professionals may choose to adopt similar attitudes.

While paternal and hierarchal structures may enforce the social contract and retain health care professionals in their local communities it was also suggested through the open-ended question in the questionnaire survey that health care professionals may emigrate from Thailand as a result of these paternalist or hierarchal dynamics at workplaces. These dynamics may disadvantage some individuals in pursuing professional advancements, which have financial ramifications as salary-levels increase according to seniority and professional advancements, and not necessarily as a result of the length of service at an institution or professional experience. A 22 year old health care student from an urban area gave the following response to the request of describing the effects of emigration of health care professionals on the Thai health care system according to his own experiences:

> *There are some effects as most of the migrant health care professionals are experts and have a lot of capacity and knowledge. If they work in the country they can push and be part of the policy making process and encourage others. But there are some factors such as the family financial situation which make experts who do not get promotion to emigrate. Because Thai society still has a partisan [hierarchal] system so persons who get along with the senior staff, or boss, have better opportunities for promotions.*

In this scenario, the deconstruction of social structures and hierarchies may also have some positive effects. However, the greatest earning potential will always be in overseas markets, and increased consumption ambitions may lead to increasing numbers of Thai health care professionals leaving for greener pastures overseas, particularly if this is increasingly socially acceptable, or at least not viewed as a breach of an implicit obligation to the Thai public. An extensive exodus of health care professionals will eventually strain the health care system and may in some areas or acute situations make access to health care prohibitive for some. There is a moral imperative to prevent this situation, although the right of the general population cannot override health care professionals' right to movement, freely migrate, or change profession.

8.3 Conflicting Rights: Predicaments and Priorities

It is suggested by Vitit Muntarbhorn (2002) that in Asia human rights are perceived from four different angles; as universal rights; through the indivisibility of human rights; as rights and duties; and within parameters of Asian values. In addition, international and domestic law interact with human rights, as these laws set the parameters for legal behaviour. According to Gruskin et al. (2007) the advancement of health and human rights are broadly categorised as "advocacy, application of legal standards, and programming". It is argued here that human rights need to be viewed holistically as well as within the parameters of the specific contexts. In specific scenarios, rights may be in conflict. For example, the rights of individual health care professionals to move, change profession, or not to work unreasonably long shifts may jeopardise the general public's right to medical care. Conversely, the rights of community members to health and medical care may jeopardise the rights of health care professionals who may be pressured to concede their leisure time, restrain their freedom to migrate or leave their profession.

8.3.1 Stemming Collective Emigration

The UDHR unequivocally recognises and acknowledges individuals' right to free movement, which includes the right to migrate. It is also a generally acknowledged principle that any country has the right to implement and enforce legislation which restricts or shapes immigration, justified through a variety of arguments, including: national security and job security for its residents, although such justifications are not necessarily declared. It is these limitations by immigration legislation at destination countries which limit international migration through quotas and immigration criteria (Beine et al. 2001). The critical question is whether

any country, based on similar arguments and justifications, can restrict emigration of professionals with key traits essential to the continued development of the country. Although restrictions or qualified reservations may apply for emigrants, it is a breach of our basic human rights to deny anyone the right to leave his or her country.

Health care professionals have fundamental skills which are required for the coherent existence and development of any society as they maintain and improve the health of the citizens and the workforce. As such, a fundamental lack of health care professionals will in a worst-case scenario lead to a loss of human capital, decreased and even negative economic growth, and the deterioration of human development. This worst-case scenario will not be based solely on the lack of health care professionals, but from the ripple effects of inadequacies exacerbated by the lack of key professionals. Insufficient human resources for health will hence lead to the exodus of other professionals, who can migrate successfully as their professional skills enable them to obtain work and travel permits to international destinations. The need to restrict and limit the exodus of key professionals, such as health care personnel, is implicit. There are two rationales: To compensate or mitigate for the financial losses of the investment in educating these professionals, and to limit the exodus of professionals with skills essential for the development, wellbeing, and welfare of other citizens.

There are mechanisms which mitigate the losses for the source country following emigration of skilled professionals, as outlined in section 2.1.3. While some measures limit or strain the opportunity for emigration, other mechanisms are viewed as transferring some of the benefits of the successful migrants back to the source country. In particular, migrants' remittances are viewed as an indirect economic compensation. Despite the fact that these funds are sent to family members of the migrants, these transfers have economic ripple effects benefiting the local communities and have become a source of foreign currency and infusion of capital for some source countries with large numbers of emigrants. Remittances contribute to significant transfers of money to LHD and MHD countries. Aims to maximise remittances among Philippine emigrants did at one stage lead to contemplations of linking the renewal of passports with the migrants' compliance with remittance schemes (Russell 1986). As cited earlier, remittances to Thailand exceeded foreign direct investments in 2004, and it was estimated that for 2005 remittances constituted US$1.2 billion (World Bank Group).

The "denial of passports for exiting professionals" has also been proposed to stem the exodus of professionals (Bhagwati 1976b). Such a measure would be an outright breach of these professionals' rights. More appropriate would be measures to tax, or levy a charge, on

emigrants. The Soviet Union exercised such an exit fee on professionals emigrating which could be viewed as compensation for the loss of public investment in educating the professionals (Bhagwati and Dellalfar 1976). While these measures can deter emigration and stem the exodus of key professionals, such as physicians and nurses, they have to be proportional and not constitute a breach of these professionals' rights. It is argued that the need to limit the flow of health care professionals is a result of the requirements of their skills in the source countries.

Thailand experienced an extensive exodus of physicians to the U.S. during the 1960's, (Mejia et al. 1976; Wibulpolprasert 1999; Wongwatcharapaiboon et al. 1999), as illustrated throughout section 3.2. The significant losses of physicians and the investment in their education and training led to the introduction of three years public service and high exit fees for those who did not complete this mandatory placement. This practice could be optimised to meet the new health care requirements, with priorities to ensure that the services of these professionals are not lost and that they are employed in the areas and regions in most dire need. As was illustrated in chapter three, new opportunities in the private sector for physicians in the mid 1990's and at the beginning of this century saw a dramatic proportion among the newly gradated physicians leaving the public health sector relative to the numbers of newly graduated physicians (Wongwatcharapaiboon et al. 1999). The proportion of newly graduated physicians who left the compulsory public service during the mid 1990's and early 2000's is comparable in size to the exodus of physicians from Thailand in the 1960's. Although a significant proportion of the physicians leaving the MoPH have completed their 3 year public service, it was found that in 1997, 126 newly graduated physicians, or 22 percent of the physicians contracted through the compulsory public service to the MoPH, left and paid the exit fees of US$10,000-US$15,000, and it has been suggested that this fee can be recuperated by working in the private sector for approximately six months (ibid).

Wongwatcharapaiboon et al. (1999) conducted research into the motivations among the physicians opting out of the mandatory public service in 1997. They were able to trace the new workplaces of 115 of the 126 newly graduated physicians who exited the public service and found that 33 physicians, less than thirty percent, were working at private hospitals or clinics in Thailand. Almost thirty percent, 34 of the physicians, were working at public hospitals in Bangkok; with an additional 13, about eleven percent, were working at public hospitals outside Bangkok. Less than two percent were found to by studying overseas, while 33, less than thirty percent, were undertaking further training at medical schools in Thailand. This

research provides important information which needs to be taken into account to understand the dynamics of the compulsory service and how this policy can be optimised further.

It is interesting to note that only 33 of the physicians who left the compulsory service in 1997 were working in the private sector. It is reasonable to assume that the Asian Financial Crisis of 1997 significantly reduced possibilities for health care professionals to work in the private sector, and earning potentials between working at public or private hospitals converged. As such, it may have been that a number of newly graduated physicians who left the compulsory service believed they had secured employment in the private sector, but found that these opportunities had vanished as a result of the financial crisis. It is equally interesting that a significant proportion, about forty percent, of the physicians who exited the compulsory service were working at public hospitals, with the majority of these situated in Bangkok. In fact, a greater proportion of these physicians were working at public hospitals in Bangkok than those working at private hospitals. It is also noteworthy to observe that seven percent of those who left the compulsory service were working at rural public District Hospitals.

There were three main reasons for these physicians to exit the public service: Further training and specialisation; objection to the compulsory transfer (placement at a hospital without any control in the decision of which province one would be assigned to); and family reasons. Those who objected to the compulsory transfer did feel comfortable to work in rural areas; about two-thirds indicated so. For those who exited the public service due to family reasons, two-thirds indicated they felt uncomfortable working in rural areas. These findings by Wongwatcharapaiboon et al., combined with the attitudes and perceptions from this research, indicate some measures may be adapted to maximise the effect of the compulsory service and ensure health care professionals in the public health care sector and in rural areas.

Rural recruitment of health care professionals and hometown placements after completing their education have been successful among graduate nurses, midwives, and paramedics in Thailand (Wibulpolprasert 1999). The experiences regarding the rural recruitment of medical students have had mixed success since the initial attempt in 1974. In particular, some individuals were taking advantage of the rural recruitment and moved into rural areas to improve their chances of being accepted into medical schools. They would move into rural areas to become eligible for rural recruitment. While the exit rate from the compulsory public service was lower among rural-recruited physicians, problems with managing the rural placement system made many medical schools abandon this system. The proportion of rural medical students was about 47 percent in 1983, but fell to 23 percent in 1994. The inequitable

distribution of physicians saw a reinvention of rural recruitment with a 10-year Collaborative Project to Increase Production of Rural Doctors, with a goal of educating 300 physicians annually to work in rural areas. This project started with 30 students in 1995. By 1998, 250 students were recruited through this initiative (ibid).

In light of high exit rates of physicians from the compulsory public service due to family reasons, and the scepticism among these participants to work in rural areas, it may be more effective for the Collaborative Project to Increase Production of Rural Doctors to effectively select participants from rural areas who are genuinely associated with these rural areas. This could imply that participants eligible will have to have resided in the specific community for a minimum of ten years, for example. Furthermore, it is important that there are genuine opportunities for these recruits to return and work in the specific provinces they were selected from (Wibulpolprasert 1999). As this research has uncovered an attitude among some health care professionals which values being a *Bangkokian*, as outlined in section 6.1.1, it is important that medical students are not only from the metropolitan area, but come from all regions of the country. It may be necessary to rethink the funding scheme of educating health care professionals, particularly physicians. While the compulsory public service for physicians is still retaining these professionals from emigrating, this policy is not effectively ensuring doctors in rural areas.

8.3.2 Health Care Professionals' Rights

Health care professionals share individual rights with all other individuals and professionals. Their specific professional traits, however, may require some personal sacrifice. Their professional expertise may be required in cases when lives and the wellbeing of others are at stake, even outside their working hours or place of employment. For example; if a person travelling by air experiences a medical emergency, the airline crew will make an announcement and ask for any medical professional to identify themselves and assist. Similarly, if a health care professional witnesses a traffic accident, it is expected that he or she assist without being requested to do so. In these circumstances, it is a social responsibility to provide their professional skills and assist. If the life or well-being of someone is threatened, anyone who can assist has a moral duty to do so. This relates to the perception that every human being has intrinsic value. This is not a charge unique to health care professionals, but as their professional skills are required in specific scenarios, it is a duty more often bestowed on health care professionals.

It is also perceived that health care professionals, together with some other professional groups, have limited rights compared with other professionals regarding their right of industrial action, particularly strikes. This differentiation according to professional trait may appear as a breach of health care professionals' freedom. The problem with health care professionals striking is not their action in itself, but rather the consequences of insufficient doctors, nurses, and other essential staff to manage emergencies; which ultimately may place someone's life in jeopardy. On a larger scale, this argument is also valid for health care professionals emigrating from countries with severe shortages of human resources for health and severe health care challenges. The lack of health care professionals in both scenarios may lead to the loss of lives and disadvantage to the health and well-being of the public.

While this sentiment is compelling, it cannot be applied as a deterrent for letting health care professionals emigrate and would be a breach of basic human rights. As cited at the beginning of this chapter, Article 13 of the UDHR states: "Everyone has the right to freedom of movement and residence within the borders of each state" and "everyone has the right to leave any country, including his own, and to return to his country". Furthermore, Article 22 and Article 23 of the UDHR state that we all have the right to "just and favourable conditions of work" and "right to rest and leisure, including reasonable limitation of working hours" (United Nations 1948). While health care professionals are at times charged with saving lives and improving our health, these professional attributes do not diminish their rights to appropriate working conditions and rest. Within the specific parameters of the Thai health care system, it can be argued that the social contract between health care professionals and the general Thai public is a testament of the debt to health care professionals for both their professional services and personal sacrifices.

While the right to medical care is a basic human right embedded in the UDHR, this right cannot be at the expense of health care professionals' rights. Rather, governments must be held accountable, both by their electorate and the international community, to ensure sufficient human resources for health without jeopardising the rights of citizens of other countries to health care. The universal right to health care is not only mandated though the UDHR, but also through additional UN declarations. The International Covenant on Economic, Social and Cultural Rights reinforces the nation-states obligation towards it citizens for providing health care. Article 12i states: "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (UN 1966). This article furthermore places an obligation on the States of "prevention,

treatment and control of epidemic, endemic, occupational and other diseases" (ibid). Thailand ratified this Covenant on December 5, 1999 (UNHCHR 2004), and as such, the Thai government is not only obligated to provide health care to its citizens, but also protect its health workforce from occupational risks of attracting HIV/AIDS as well as other diseases.

The public's right to adequate medical care was recognised among research participants. There was a strong perception of an obligation to serve the health care needs of the general population. At the same time, these health care professionals acknowledged their right to migrate and saw it as an individual right. However, the potential negative effect of highly skilled health care professionals emigrating was also highlighted. A 23 year old health care student gave the following response to the open-ended question in the questionnaire survey of effects of health care professionals emigrating:

> *This is an individual's issue. It may have some effects such as it can lead to medical schools losing professors or senior lecturers to private hospitals. This will make medical students lose the opportunity of gaining valuable knowledge from these professors. In addition, most doctors prefer to work in urban areas, in the big cities which causes a lack of doctors in the rural communities. If people have unskilled treatment or health care, they may have a health problem and become disabled. This will have negative effects on the economy, and social and productivity development of the country.*

The concerns for the public, including those voiced earlier, indicate that Thai health care professionals are conscious, even concerned, over the ripple effects of health care professionals leaving the public health care system. However, some physicians indicated concern over what they perceived to be an increase in the rights of patients, or health care consumers, while there is little protection for health care professionals. Combining this with the increases in workloads resulting form health care reform, this may lead to some resentment and has the potential to undermine the social contract which retain health care professionals. A young doctor at a large metropolitan public hospital stated:

> *It is not a problem to work with real patients; people who are really sick. But in today's society many patients raise accusations against health care professionals. … Nowadays, doctors are just service providers. Their status has changed. … Some patients just come for consultation and just want to talk to a doctor. There is nothing wrong, he or she is fine, but just wants a check up and wants to use the free service. If the doctor does not provide good service, the patient will sue the doctor.*

This doctor even indicated that he was concerned when working with elderly patients; that they would not recover and this could become a problem for him. His perception was that paediatricians are placed in difficult situations because children always cry and this can upset

the parents. He believed this can make the parents concerned and lead them to believe that the doctor had not performed the job appropriately. Crying children can be viewed as an indication that the doctor did something wrong. The patients' rights are important, including the right of restitution in the case of medical malpractice. However, there is also a need for health care professionals, particularly physicians, to be protected from unfounded legal actions. This should not deter legitimate cases or concerns from patients who have not received proper attention or treatment, but measures to discourage the opportunistic pursuit of economic advancements through unfounded lawsuits must be in place. This will be a growing challenge for the Thai health care system as it is probable that there will be more legitimate claims of inadequate medical attention as a result of the overwhelming workloads for physicians as a result of health care reform, and the general population becomes enlighten of their rights. This would place greater emphasis on individual (legal) rights, rather than social and collective obligations; deteriorating the social contract, outlined in section 8.2.

It is necessary to educate the public, both of their rights, but also of their obligations to take responsibility for their own health, and not to congest the health care system by inappropriately seeking medical attention. This is a long term and continuous task in the pursuit of sustainable health care; through ensuring sustainable lifestyles and attitudes. While health care professionals will always be required to provide medical care, and the public is entitled to health care, this must be pursued through an inclusive and holistic approach. Primary health care and health education are pillars which will support the construction of sustainable heath care practices. This is not the sole responsibility of health care professionals, but requires political commitment and the social recognition that health extends beyond medical care.

8.4 A Rights-Based Approach to Health Care

Sustainable health care is only achievable through recognising the universal and fundamental human right to medical care. The pursuit of this cannot jeopardise the human resource base which is the foundation of health care. Measures to provide health care which alienates health care professionals are not sustainable, and dynamics creating an inequitable distribution of health care personnel, whether internal, regional, global, or between sectors, threatens the viability of health care systems. A rights-based approach to health care firstly recognises the right to adequate and affordable health care as stated in the UDHR. Secondly, a rights-based approach to health care pursues health and health care through inclusive and holistic

measures, embracing the WHO definition of health as "state of total physical and mental wellbeing" (WHO 2006a). This must be pursued throughout society, and not be the sole responsibility of health care professionals. Thirdly, this approach must recognise the rights of health care professionals, both as individuals and as professionals. This incorporates the responsibilities of each nation-state to provide health care for its citizens, but also provide protection of occupational risks for the health workforce, as outlined in the Covenant on Economic, Social and Cultural Rights. Finally, a rights-based approach to health care recognises every human being's right to health care, not only the citizens of countries that can afford expensive health care systems, and emphasises global equity and co-operation.

It is the responsibility of national governments to ensure the rights of their citizens, including ensuring health care facilities and the manpower at these institutions. However, as training health care professionals is costly and time-consuming, very few countries educate and train more health care professionals than can be absorbed in the nation's own health care system. With changing demographics and a general ageing of the population in Western countries, the requirement for health care professionals, particularly doctors and nurses, is increasing significantly. While there are numerous factors which influence nations' health care policies, the relatively short electoral cycles of governments and the public's demand for results to re-elect governments have impacted Western countries' health care and immigration policies, often leading to shortcuts and the recruitment of professionals from overseas.

A rights-based approach to health care does not imply that it is only the rights of the citizen of one's own country which have to be respected, but that universal equity is pursued and that the action taken does not jeopardise the availability of human resources for health, and hence the viability of health care systems, elsewhere. This may mean that governments in Western countries, in particular, need to take responsibility not to instigate health care reform and policies which rely on importing or "poaching" health care professionals from less developed countries, particularly those adversely affected by severe health care challenges such as the HIV/AIDS pandemic. While national and international codes of practice to prevent active recruitment of health care professionals from countries with severe shortages of human resources for health (Willetts and Martineau 2004), it remains necessary to enforce an international accord and protocol for monitoring to ensure that health care is available to the most vulnerable in the poorest countries in the world. While the voluntary codes of practices are useful ethical guidelines, they will not rectify the endemic and systematic disadvantages between health care systems.

It is natural that the negotiation, development, and enforcement of an international agreement and guidelines regarding recruitment and employment of health care professionals would fall into the purview of the World Health Organization. To do so, the WHO needs a clear mandate from member states. Professional groups and human rights advocates should pursue and lobby nation states as well as the WHO to set an agenda of ethical and equitable distribution and employment of health care professionals. Clear principles and quotas for employing health care professionals from LHD and MHD countries with inadequate human resources for health are required. This regime should not only limit the number of health care professionals any given country may employ from LHD and MHD countries, but also include tariffs or mechanisms of compensation to the source countries' health care systems. This would not only compensate the source counties for the cost of training health care professionals who emigrate, but also reduce the incentive for HHD countries to educate and train less health care professionals than their health care systems require. Alternatively, countries may form their own bilateral arrangements regarding the flow of health care personnel and any compensation attached to the loss of these professionals.

It is important to make the distinction that these restrictions apply to the employment of health care professionals, and they should not impose direct restrictions on health care professionals' right to migrate. This is a universal right and cannot be linked with professional traits. As such, this regime should not impede individual health care professionals' opportunities to migrate to another country outside the active recruitment regimes, as long as they obtain visas not related to their specific professional traits. This would, for example, exclude migrants who arrive on spouse or family-reunification visas or student visas from this regime, but specifically apply to migrants obtaining work permits based on professional traits. This would require reviews and amendments to immigration procedures and requirements in many HHD countries, as visas and work permits often are granted to health care professionals based on their professional attributes.

8.5 Chapter Summary

There are social hierarchies and dynamics in Thailand which encourage health care professionals to endure personal sacrifices through their professional lives to promote the health and well-being of community members. This dynamic, where health care professionals are given high social status in return for their professional contributions and personal scarifies is viewed as a social contract. This social contract has benefited the Thai health care system

and is part of a larger cultural identity. Current trends, particularly related to the political volatility and pursuit of individual gains by politicians may erode the loyalties of health care professionals towards their communities. This may also be part of a larger social and cultural shift, instigated by rapid economic development, urbanisation, globalisation, and commercialisation. This chapter has generally engaged with the perceptions and attitudes among health care professionals in Thailand. It is recognised that there are challenges, both internally in Thailand as well as within the global purview, with regards to ensuring an equitable distribution of health care professionals. Furthermore, while it is an apparent conflict of rights between individuals' right to medical care and health care professionals' right to free movement and seeking employment, a rights based approach to health care will embrace the rights of all actors and the international dimension of this dilemma.

CHAPTER 9

Ensuring Sustainable Health Care

"There is growing recognition, in both developed and developing countries, of the dangers posed by indiscriminate recruitment of skilled health professionals. Despite the awareness of the risks, little effort has been made to solve the problem. Regardless of one's point of view in the debate, the fundamental issue is the same: should skilled migration be left completely to market forces or should some form of intervention be introduced? If so, what are the possible options?" (Ahmad 2004:797).

9.0 Introduction

This research has focused on health care and human resources for health in Thailand, and the parameters specific for this setting. However, the challenges in the Thai health care system are not unique and the experiences and approaches beneficial for Thailand are applicable elsewhere. As long as appropriate measures address the differences in local, social, and cultural influences, health care systems elsewhere should benefit from the Thai experiences, both successes and setbacks. This chapter revisits the notions of sustainable health care, and the issues of health care policies and policy-makers. It presents a review of health care and health care policy specific to the Thai experience, before engaging with sustainable health care, and broadens the scope to global challenges and opportunities for cooperation. Sustainable health care cannot be pursued without consistent political commitment, ingenuity, and cooperation in addition to health care professionals' and members of civil society's vigilant and constructive commitment in the pursuit of equitable and sustainable health care.

9.1 Health Care Policy and Policy-Making

The importance of health care policies and the roles of policy-makers in ensuring sustainable health care, within a local or national setting and on the global arena, cannot be understated. The impact of health care policies, ranging from negative initiatives, indifferent, and proactive actions can have ripple effects resulting in global achievements or devastation. It must also be acknowledged that *the worst results may come from the best intentions*, and continuous vigilance is of utmost importance to ensure that policies, even when initiated and implemented

from altruistic motivations, are not having detrimental consequences and ripple effects. In the globalised world economy, health care policies, or changes to health care policies, in a local or national setting may have significant impact on other countries' health care systems. Furthermore, if related areas are not included within the frame of reference when pursuing sustainable health care, we risk creating new dilemmas and unsustainable approaches within the larger framework. An example of such unfortunate ripple effects can be seen with regards to efforts in curbing climate change and global warming through the use of bio-fuels. Although there are different views on the effect of bio-fuels in reducing greenhouse gases, and hence curbing climate change and global warming, the diversion of land from food-crops to crops for bio-fuels has contributed to the current volatility in world food prices and is adversely affecting the poorest peoples in the world.

9.2.1 Universal Health Care Coverage in Thailand

The UC, previously known as the 30 bath health care system, can be viewed as an oxymoron as this policy has become both the epitome and Achilles heel of Thailand. The UC must be perceived as a significant and commendable achievement, as it unilaterally enforces the universal human right of health care, and mandates this principle in Thai health care. However, the simple and uniform structure of this policy; previously a flat co-payment of 30 bath which has now been abolished, is also the Achilles heel, threatening to bring down the mighty structures providing health care. The financial burden on the tax system of fully financing universal health care may not be sustainable without significant and immediate measures to ensure cost-efficiency and fully financing the health care institutions providing care.

As illustrated in section 6.3, the UC has significantly changed many Thais' attitude towards health care and health care consumption. It is commendable that this policy now mandates health care for all Thais, however, if the tensions outlined in chapter six are not sufficiently addressed, this health care policy threatens to undermine not only the sustainability of this policy, but may even damage the foundation upon which health care is provided in Thailand. The workload imposed on many health care professionals in the public health system due to this policy is significant, and indications that the policy in some cases directly leads to health care professionals leaving the public health care system to work in the private sector or migrate overseas was indicated in this research. Furthermore, the increase in workloads, about fifty percent in both rural and urban public hospital departments reported by informants

in this research (section 6.3.2), impede the ability of the health care system to provide comprehensive care.

Based on current trends and more importantly the subjective perceptions among health care professionals surveyed in this research, it could be claimed that the UC is in reality not providing comprehensive health care, but rather cosmetic health care. Chapter six provided illustrations of a *mania* among Thais to seek medical advice and medication, for any ails. It was reported that people were seeking medical advice in inappropriate situations. Hospitals and other health care institutions included in the UC structure reported feeling pestered by those seeking to exploit the free service, while those in genuine need for medical advice or care, are forced to manoeuvre through this maze. This drains human and financial resources, but more adversely threatens to undermine the mechanism currently sustaining the public health care system.

What was described as a social contract giving high social status to health care professionals in Thailand in return for their professional contributions to the community and the wellbeing of its members in their professional capacities in chapter six and eight may erode as a consequence of the current changes in the health care system. This is not because the UC reinforces citizens' right to health care, but rather that community members are perceived as contradicting an essential component of this implicit arrangement. It is not that community members no longer place health care professionals in high regard, they do; but rather that these community members are undermining the premises of health care which may lead to some form of resentment among health care professionals, as illustrated in section 6.3.2. When community members in large numbers congest public health care facilities with symptoms ranging from fatigue from physical labour to the onset of a slight cold or flu, which require rest rather than medical attention, it may irk health care professionals. With a massive workload they feel they have to accommodate these individuals, who opportunistically are exercising their right to free consultation without any legitimate need for medical attention. Furthermore, although the lines for medical consultation may be long and priority is given to those most in need or with an appointment, everyone, if willing to wait long enough, will eventually get their consultation. What further disillusions health care professionals is the continuous demand for complimentary handouts at these consultations. While this may be a threat to the health care system generally, it may cause more disparities towards the most vulnerable sections, particularly mental health, prisons health, occupational health and school

health, although this research did not engage in review the impact or disparities in these areas.

Whether consultations at public health care institutions are sought based on genuine medical concerns or because the public takes advantage of this free service, the UC has led to a shift away from primary health care. Furthermore, as voiced by some health care professionals, people are increasingly demanding medications or other *free samples* from doctors and nurses, whether this is at health care centres or in community education and outreach programmes; including vitamins and dietary supplements. Community members even encourage each other to ask for such samples, by informing each other of what samples they were able to get at different places. Although such behaviour and attitudes may create resentment among health care professionals who feel that community members are exploiting the UC and creating increased workloads at health care centres and draining resources from the system, the main concern is the ripple effects these attitudes and the UC have on the more comprehensive areas of health care.

As is the case world wide, comprehensive health care, which includes surgery, other specialist procedures, and more complex and costly exercises, is generally based on referrals and characterised by long queues. The renewed funding system of health care institutions after the introduction of the UC, combined with individuals' entitlements to free health care, has led to a concentration of high cost patients at certain university hospitals which are going into debt in order to provide health care for these patients, including Thailand's oldest medical school and university hospital, Siriraj University Hospital (Khwankhom 2006). Thai health care policy, as a result of the UC, undermines the dynamics of primary health care, through the promotion of free health care services rather than education and prevention. The underfunding of tertiary care, as a result of a per capita funding without concessions for high cost patients who will register at the hospitals they know can provide the care they require, is another adverse side effect of the UC.

The political dimension of the UC and health care in general must be scrutinised if there is a genuine attempt to promote sustainable health care for Thailand. As illustrated in chapter five, despite the UC being introduced as part of the ousted Thai Rak Thai populist platform, the promotion and popularity of this policy has been entrenched as one of the major contemporary policies and it would be politically impossible for any government to survive overturning it. The interim government following the ousting of Thaksin Shinawatra and his TRT government abolished the 30 bath [*AU$1*] co-payment and increased funding to the public hospitals; based

on both prior underfunding as well as to compensate for the loss of revenue with the withdrawal of the initial 30 bath co-payment. Hence, although resource draining, there are no current prospects that the UC will be scaled back, despite the pressures this policy has on both human and financial resources. The current government, spearheaded by the PPP, is widely seen as continuing the populist agenda of the former TRT party, and as the UC was a cornerstone of the TRT platform, it is highly unlikely that the PPP will limit the scope of the UC.

9.1.2 Health Care Challenges

The Thai health care sector through research and monitoring has, continuously and vigilantly attempted to anticipate adverse health care challenges. Recent economic and social development has led to a health care transformation. As it is still in this transition phase, Thailand is arguably combating both the ails of the modernised and industrialised health care challenges, as well as health care challenges related to development and poverty. The main challenges for the Thai health care system would be to balance the responses to these new health care challenges from lifestyle and an aging population, while at the same time addressing the traditional calamities of elementary primary health care often related to poverty and environmental factors. Addressing these traditional challenges, a national and international framework is in place, namely the MDGs, and although it has been argued that Thailand has already achieved these goals and a new framework to continue this progress has been adopted (Bjorkman 2005), this does not undermine the necessity of pursuing progress in these areas. Indeed, complacency towards these areas of health care in Thailand has the potential to create devastating ripple effects and a detrimental impact on development. The same report which suggests Thailand has reached several of the MDGs in ample time prior to 2015, also suggests a possible reversal of the positive progress.

While higher expectations of the health care system are placing strains on health care providers, disease linked to lifestyle, such as diet, smoking and alcohol consumption, are become new health care challenges. In addition to lifestyle influences, increased life expectancy also increases the frequency of chronic disease, such as diabetes. In addition, advances in ARVs for people with HIV/AIDS are increasing the workload of health care professionals and causing economic strains on the health care system as life expectancy for HIV/AIDS positive individuals increase. Other health care challenges are induced by a multitude of circumstances, perhaps specific to this pivotal transition from the old traditional agrarian society to the industrialised and service oriented modern Thailand. Arguably, the

significant losses of human capital through the high number of accidents and traffic accidents are indicative of this.

Accidents are universal and may strike indiscriminately. However, the rate of accidents in Thailand is of concern with an estimated 90,000 accidents annually and 13,000 fatalities. The cost of these accidents was estimated to be 115,337 million baht or 2.3% of GDP in 2000 (Wilbulpolprasert et al. 2004b). The concern with the high degree of accidents is not limited to the loss of human lives and productivity through fatalities and temporary or permanent infirmity, but also relates specifically to the burden on the health care sector. Preventing accidents is a multidimensional task which will require a continuous government commitment to change attitudes, enforce preventive legislation, and a continuous promotion of safety procedures, including precautions for motorists. There is a national framework within which safer transportation is promoted, particularly regarding usage of helmets for motorcyclists as well as measures to prevent driving under the influence of alcohol. It needs to be acknowledged that the impact of these parameters, together with the HIV/AIDS pandemic and tobacco smoking, are the most significant risk factors and constitute a concurrent high proportion of the disease burden.

For 1999, in terms of "disability adjusted life years" the top five contributors to the disease burden were unsafe sex, specifically HIV/AIDS but include other sexually transmitted diseases with 12.7 percent; followed by smoking with 6.9 percent; alcohol consumption with 5.3 percent; hypertension, or high blood pressure, is ranked fourth with 4.8 percent; while not using helmets ranked fifth highest contributing 4.2 percent of the disease burden. Other contributors to the disease burden included high body mass with 3.7 percent, illicit drugs with 2.7 percent, and high cholesterol with 2.0 percent of the disease burden. Poor sanitation and malnutrition as well as physical inactivity both contributed with 1.0 percent (Wilbulpolprasert et al. 2004b). Although these statistics are almost a decade old, they illuminate some of the important contemporary health care challenges, as well as foreshadow what may come.

The gender differences must also be noted. Males contributed to the disease burden with 5.6 million disability adjusted life years, while females only contributed with 3.9 million disability adjusted life years. For males, the top three contributors to the disease burden were: 1) unsafe sex with 16 percent; 2) smoking with 9 percent; 3) alcohol consumption with 8 percent; 4) not using helmets with 6 percent; and 5) high body mass index which contributed 4 percent of the disease burden. This was closely followed by illicit drug use, which also contributed 4 percent to the disease burden. For females, the top five were: 1) unsafe sex with 8 percent; 2)

high body mass index with 6 percent; 3) hypertension with 5 percent; 4) smoking with 5 percent; and 5) high cholesterol with 2 percent. These were closely followed with occupational injuries, not using helmets, and physical inactivity which each contributed with 2 percent of the disease burden (ibid).

Although the disease burden induced by unsafe sex includes other diseases than HIV/AIDS, it is clear that HIV/AIDS is by far the largest contributor to the disease burden as a result of unsafe sex, and will continue to be a major health care challenge. There can be no complacency if we are to overcome this pandemic. There are several fronts in the battle against HIV/AIDS, and ensuring that skilled health care professionals with appropriate knowledge, attitudes and composure are in the public health care sector as frontline fighters is only one dimension. It will require a cultural shift with continuous education, monitoring and reapplication of new and conventional knowledge within a framework which acknowledges and respects the rights of all parties involved. This is a continuous political, social, and a humanitarian mission which has to be advocated and fought both locally and internationally. Health care policies will have to vigorously incorporate the realities of this challenge in order to effectively plan for future health care challenges incorporating the long term repercussions of all initiatives, rather than apply simplistic short term measures. As such, advances in ARV treatment and containing the spread of HIV/AIDS cannot solely be expected to lead to a lower burden on the health care system, but the long term impact of significant numbers of people with HIV/AIDS dependent on ARVs which postpone their need for extensive care must be incorporated in contemporary preparations for future health care challenges.

These health care challenges, often preventable, do not only constitute significant workloads on the health workforce, but may lead to greater attrition of health care professionals as a result of fatigue, discontent and low morale, induced by the high workloads, stress and burnout, grief, emotional distress, and fear of occupational hazards, including HIV/AIDS but also related diseases such as tuberculosis. Indications are that future health care challenges are going to become more complex and require more extensive care as the population ages, the proportion of taxpaying workers is reduced and financial pressures may sever traditional commitments of caring for elderly and infirm family members.

It is illustrative that the disease burden of poor sanitation and malnutrition as well as physical inactivity both equals 1.0 percent; the impact on the health care system from these very divergent causes is the same. The disease burdens induced by health care challenges associated with development characteristic, or poverty, is the same as that associated with

western or lifestyle induced, health care challenges. Clearly this is an oversimplification, and the complexities and associated disease burdens related to both poverty and lifestyle are broader and cannot be reduced to these two parameters, and other parameters which are associated with both lifestyle and poverty are also contributing, several to a higher degree, to the overall disease burden. This simplistic presentation, however, illustrates the dual challenges Thai health care is facing, that of development and that of becoming developed.

The health care challenges cannot be viewed in isolation and the basic human rights of all stakeholders has to be acknowledged and taken into account. The rights of people living with HIV/AIDS and efforts to limit stigmatisation and discrimination are an integral part of the challenges in combating HIV/AIDS, particularly when utilising a human rights framework. This is not the only a human right issue, but the basic human right to sustain life is also a challenge, as one percent of the disease burden in Thailand relates to poor sanitation and malnutrition. The critical challenge is to both continue to combat traditional health care challenges from the past century related to development and poverty while preparing and stemming the new health care challenges in this new century induced by lifestyle. Some prevention goals are palpable, including stemming tobacco, alcohol and illicit substance consumption, promoting a healthy diet and daily exercise as well as enhancing people's safety in the home, workplace and when travelling. These are universal precautionary measures promoting health and well-being, not unique to any country but should be part of any health care system. Measures to combat these challenges must take into account the rights of all stakeholders, including health care professionals and health care consumers.

This promotion must be a part of a comprehensive primary health care programme, together with programmes targeting nutrition, sanitation, combating the spread of HIV/AIDS, stemming diseases such as malaria or dengue, personal hygiene, as well as maternal and child health care. The concern is, as was illustrated in chapter six, that the UC has adversely shifted the attention from primary to curative health care, which may have both short term and long term detrimental ripple effects. Primary health care can significantly reduce the burden of disease in Thailand. Comprehensive, inclusive, and well focused prevention campaigns to reduce the disease burden from unsafe sex are essential. Unsafe sex contributes with 12.7 percent of the disease burden, or more than 1.2 million disability-adjusted life years (Wilbulpolprasert et al. 2004b). Even modest progress in primary health care promoting safe sex will alleviate the health care sector significantly This is also applicable to curb tobacco and alcohol

consumption, the second and third highest contributors to the disease burden, with more than 650,000 and 500,000 disability-adjusted life years, respectively (ibid).

Primary and preventive health care, related to lifestyle as well as development or poverty, is the most vital, cost-effective, and readily deployable defence against future health care challenges. The need to prevent these health care challenges are arguably universal, applicable to any country and health care system, although the importance of urgently implementing and vigorously monitoring and adapting prevention programmes is of greater concern for countries such as Thailand. Thailand, a medium sized economy, with a universal, fully tax-funded health care system is facing a potential avalanche of health care costs, particularly as it is unlikely that the UC will be reformed in the short term. Primary health care is not just promoting healthy behaviour, but must target attitudes and promote new lifestyles. It can be as simple as promoting the use of helmets, as the fifth highest contributor to the disease burden is related to motorcyclists not wearing helmets with just shy of 400,000 disability-adjusted life years (ibid). The consequences of not wearing helmets are equivalent to one-third of the impact of the HIV/AIDS pandemic, in terms of disability-adjusted life years, and are preventable through very simple means.

Health care reform for cost-efficiency and reducing benefits as a result of an ageing population with proportionately fewer taxpayers and more health care consumers is the unpopular reality of many HHD countries and larger economies. Health care costs of the magnitude that HHD countries with comprehensive health care coverage have, is not sustainable for Thailand, and unpopular policy changes or reforms are needed to ensure the vitality of the Thai health care system. The only way that the UC can survive without crippling the Thai economy is through extensive and targeted prevention strategies significantly reducing risk behaviour and hence reducing the future disease burden. Although it is highly commendable that Thais' right to health care are ensured through the UC, the attention now has to change to ensure this right and prosperity for future Thai generations. This intergenerational principle of equity must be incorporated into the notion of sustainable health care.

9.1.3 Sustainable Health Care and Sustainable Development

Sustainable health care, and sustainability generally, can be defined on different bases and these reflect the epistemology behind the definitions and the complexities of sustainability within the framework of sustainable development and global sustainability. The Bruntland Commission defines sustainable development as "development that meets the needs of the

present without compromising the ability of future generations to meet their own needs" (Brundtland 1990:87). This definition of sustainability embraces an intergenerational dimension of sustainability. However, the Brundtland Commission also states: "Sustainable development requires meeting the basic needs of all and extending to all the opportunity to satisfy their aspirations for a better life" (ibid:88). Sustainable health care, within the spirit of the Brundtland Commission's view of sustainability, not only requires an equitable intergenerational management of health care, but also meeting the basic needs, in particular health care needs, of all.

It is proposed here that sustainable health care must ensure the same standards of living, the same health care related indicators of well-being, for future generations as for the current generation. Furthermore, as development implies *progress*, sustainable development within health care implies that there must be an advancement of current health care standards. This is being achieved through medical advances and research, internationally, although the humanistic concern is for these advances to benefit those in need, and not only those who can afford it or are citizens of more affluent economies. It is possible to achieve a more equitable distribution of the benefits of medical advances, either unilaterally or multilaterally, as has been illustrated with the HIV/AIDS pandemic and international efforts in distributing ARV drugs as well as unilateral initiatives by some governments, including Thailand, to generically reproduce these vital medications.

Sustainable health care has to be pursued through a prism of global sustainability. This is not reducible to the perception that as long as the combined health care parameters globally are within sustainable standards; we have sustainable health care. Equally, within a national setting, it cannot be argued that as long as the combined national figures allude to sustainable health care; the national health care system is sustainable. Therefore, with regards to human resources for health, global sustainability does not imply that sufficient numbers of health care professionals globally equates to sustainable health care if the distribution among health care systems is not equitable. Equally, the Thai health care system, through the proposed and calculated expansion to human resources for health over the next few decades will not lead to sustainable health care despite calculations which indicate that there will be sufficient numbers of doctors and nurses within the Thai health care system, as it is acknowledged that the internal distribution of these professionals will not be equitable.

Rather than reviewing health care based on macro statistics, national parameters, or international trends, sustainable health care must be aimed at not only enhancing the overall

progress of health care, but must specifically improve the lowest denominator. Hence, with regards to human resources for health, it is insufficient to introduce new doctors and nurses into the health care system if these are centred in areas with high density of health care professionals while there are areas or hospitals with insufficient numbers of doctors and nurses. The introduction of these new health care professionals will enhance the health care system, but the system is not sustainable if the regions or institutions most urgently in need of health care professionals are not accommodated.

Globally, responsibility has to be taken by HHD countries which are educating fewer health care professionals than they require in order to meet their health care goals. It must be acknowledged that HHD countries are attracting health care professionals from countries with lower salary levels, and although this is not always done through active recruitment, many HHD countries' health care systems rely on immigrants to supplement their stock of human resources for health. It is therefore of utmost importance to implement an international accord which will ensure that at least the countries with lowest levels of human development and with significant shortages of human resources for health do not become a source of human resources for health for *western* countries. However, it is not proposed here to impose travel restrictions or otherwise impose on health care professionals' individual rights of free movement and the opportunity to migrate.

Global sustainability requires a global effort in scaling up the global stock of human resources for health. The current transfer of technological and medical advances from HHD to LHD and MHD countries, sometimes as development aid and sometimes based on significant financial reimbursements, is not an equitable trade in exchange for the flow of human resources for health from LHD and MHD countries to HHD countries. Although individual migrants' remittances to family members has collectively become a significant source of capital and foreign exchange for some economies, individuals' financial sacrifices to aid family members is not a compensation for the migrants' home countries' loss of human resources for health. There are different approaches which can compensate LHD and MHD countries' losses of human resources for health, although the aim of international cooperation towards global sustainable health care should not rely on compensation or financial transfers, but rather aim to advance health for all through ensuring sufficient and an equitable distribution of human resources for health globally.

Ethical guidelines are required to ensure global sustainable health care, just as national guidelines are required to ensure national sustainability. As stated in chapter eight this should

fall under the purview of the WHO. Alternatively, within a larger framework of skilled migration generally, the International Labour Organization needs to be involved. There is a clear and urgent need for further international development and cooperation. Unfortunately, the global attention and momentum which was present at the turn of the millennium, both as part of the MDGs and specifically regarding the HIV/AIDS pandemic appears to have shifted towards climate change and global warming. This latter cause is not inferior, but the urgency of this cause does not undermine the urgency of sustainable health care. Arguably, what is proposed here is that these are two interrelated issues which are both founded on the principle of sustainability; sustainable development and global sustainability, and both must be part of the human transformation to a sustainable value system in this new millennia.

9.2 Sustainable Health Care

On an international scale, the United Nations MDGs (see Textbox 2.1) have been prescribed as a template for development, particularly for countries with LHD. The MDGs, although articulated for development in general, directly or indirectly promote health and health care. Sustainable health care, within a global framework, should be pursued continuously through this framework, with specific benchmarks to combat both health care challenges and development challenges, which are all interrelated. When poverty is the root cause for malnutrition and inadequate access to clean drinking water, combating poverty will directly lead to improved health. Environmental degradation is a direct health concern, as unsustainable logging, mining, interference with waterways, and the depletion of natural resources create health challenges, undermine the principles of sustainability, and may reinforce the causes of endemic poverty. All the dimensions of the MDGs are interrelated and integrated with sustainable health care. In particular, global partnerships and shared responsibility is the path forward to meet these goals and continue the progress of human development.

This section will review three aspects of sustainable health care. Firstly, the issue of gender and sustainable health care takes into account the challenges of pursuing gender equality, but also the importance of this process to achieve sustainable health care. Gender has to become integrated into all health care strategies to overcome encroaching and crippling health care challenges such as the HIV/AIDS pandemic. Secondly, sustainable health care must be pursued through the concepts of global sustainability within a global framework. Health care challenges are interrelated and national and international strategies are required. An account

of Thailand's achievements and challenges, both regarding health care and human resources for health, is presented. This is followed by a section proposing international or bilateral arrangements to increase human resources for health. In particular, Thailand's infrastructure will allow an increase in the education of health care professionals at a lower cost than in HHD countries, which can be capitalised on if managed equitably.

9.2.1 Sustainable Health Care and Gender

This research has not specifically engaged in the gender issues regarding development or health care. However, the complexities and deficits regarding the lack of gender focus in health care programmes, specifically regarding HIV/AIDS, has been illustrated in chapter seven. Gender inevitably informs and influences the dynamics of health care and hence sustainable health care. Further research into these dimensions is needed. Specific gender roles have traditionally informed and shaped care and health care, and recent transitions, industrialisation, and commercialisation in Thailand challenge some of these traditional roles, both within the family units and in civil society, and will impact both how care and health care is being provided. In addition, future health care needs may significantly change if gender and caring roles change. Gender shapes and impacts health care as well as future health care provisions and needs as social perceptions attached to gender impact the division of labour and even inform individuals' educational decisions.

As indicated in section 4.2.4; the gender division among health care professionals, within most health care systems, is that more than seventy percent of physicians are males, while more than seventy percent of nurses are females (WHO 2006b). There used to be a gender imbalance among physicians in Thailand, but the ratio of male and female physicians is converging as the number of female medical graduates is similar to that of male medical graduates, as outlined earlier. However, it has been proposed that this may create difficulties in distributing physicians equitably throughout Thailand as "it is difficult for most female doctors to stay long in remote district hospitals" (Wibulpolprasert 1999). It is probable that this observation by Wibulpolprasert can be attributed to the cultural and social anticipation that females are expected to "help parents and siblings" and the attitude that daughters should live close to home, at least until they are married, (Mills 1993). If newly graduated female physicians have these social restraints, and the compulsory public service generally place newly graduated physicians in rural areas, the structure of the three year compulsory public service for newly graduated physicians pose particular strains on female physicians.

It was observed by Chomitz et al. that "compulsory service is inequitable for medical students, mostly females, who are unable to accept remote or distant postings" (cited in Wibulpolprasert 1999). This gender specific social and cultural constraint makes it difficult for female physicians to work outside the province in which their family reside, and can contribute to the high proportion of students exiting this scheme. It was argued that the exit fee for those physicians who do not complete this compulsory service should be revamped and the specific gender dimension should also be taken into account. This dynamic may also have specific repercussions for rural recruitment programmes for medical students. If females are more likely to seek employment from the area their family is located in, they are more likely to work at the local hospitals in the provinces they are recruited from. This strategy of recruiting females from rural areas may create higher compliance among physicians in the compulsory public service period as long as they are assigned to the province they were recruited from.

Socially constructed gender roles heavily inform care and health care in Thailand. Changes due to the continuous industrialisation and urbanisation of Thailand will inevitably lead to social changes in both how care and health care is perceived and carried out and will have to be included when planning for sustainable health care for the future. In particular, the ageing of the population resulting from better living standards, lower birth-rates, and improved health care, is and will continue to impact health care demands. The traditional division of labour has meant that females are the main providers of care, including for elderly family members, while current transitions and financial pressures have led to Thai women seeking paid employment outside the home. Although perceptions of traditional gender roles are still dominant, rapid urbanisation, education, development, and arguably a *westernisation*, in addition to women seeking paid employment, are contributing to a change in attitudes as well as the general workload, which may significantly impact both the health care system and the provisions of care; whether this continues to be mainly a responsibility within the family units, shifts to the public domain, or becomes commercialised into a private service.

This shift is supported by the influx of women in the workforce. In the fourth quarter of 1999, 13,866,400 women were in paid employment (NSO n.d.b). This increased to 15,972,900 by the fourth quarter of 2004, (National Statistical Office of Thailand 2005), indicating that more than 2 million additional women were in paid employment after this five year period. In contrast, the number of women not seeking employment as they were engaged in "household work" decreased slightly. In the fourth quarter of 2004, 3,849,000 Thai women stated this as their main undertaking while only 176,500 men stated the same (National Statistical Office of

Thailand 2005). During the fourth quarter of 1999, 105,100 men were not seeking employment as they were engaged in household work, while 3,627,700 women stated this (NSO n.d.b).

Despite the rise in number of women in paid employment, it is clear from the National Statistical Office of Thailand's figures that it is women who are mainly engaged in "household work" and hence perform the unpaid work in the homes. For the figures from the last quarter of 2004, more than 36 times as many women than men stated they were not seeking employment as they were engaged in "household work". This household work includes various forms of caring roles, although child caring has increasingly become part of the public and commercial sphere. It was estimated in 2002 that more than fifty percent of children aged 3 to 5 years were cared for at nurseries, day-care centres or schools, while only 28.6 percent were looked after by their parents (Wilbulpolprasert et al. 2004b). It is probable that the other children were looked after in more informal settings, by relatives and other family members, neighbours, or by carers in setting which cannot be classified as nurseries or day-care centres. Evidence which supports the proposition that parents and relatives are no longer the sole caretakers looking after children before school age is supported by the increase of 3 to 5 year olds who attend pre-elementary schooling, which rose from 39.3 percent in 1992 to 76.75 percent in 2003 (ibid).

The full scale impact of this transition, from a single breadwinner and a homemaker partnership to a two-income family, combined with lower birth rates and an ageing population has not been fully manifested yet. The changing gender roles and the need for aged care, or care in general, may significantly impact the Thai health care system and has the potential to divert human resources for health from health care to aged care facilities if a commercial aged care industry develops in line with the trends in western countries. Although social and cultural perceptions and attitudes in Asia, as well as other world regions, emphasise family responsibilities in caring for the elderly, employment commitments, economic development, and the changing gender roles may eventually lead to a shift to commercial aged care.

Currently, there are few, if any, social mechanisms which will provide care for the elderly and infirm if family members are unable or unwilling to provide the care needed. There are no government provisions directly providing care for individuals who do not have carers. Indeed, the only social safety net would be the Buddhist temples, which rely on private donations and the work by nuns and monks to provide basic education for children, offer food, and care for the ill and infirm, particularly those associated or living on the temple grounds. The role of these temples include caring for those marginalised by society, and the Wat Pra Baht Nam

Phu temple in Lopburi, 150 kilometres from Bangkok, is renowned for caring and looking after people with HIV/AIDS, referred to as the "temple of doom". Thousands of AIDS patients have died here, their unclaimed ashes stacked in "white sand bags around a giant Buddha", thousands of people are on waiting lists for a bed at the temple's hospice, although some families do not wait and abandon family members who have become victims of AIDS by the gate "like a cat or a dog" (The West Australian 2006:40).

While some persons at the terminal stages of AIDS do not have anyone to care for them, and hence rely on the charity of others and assistance at temples, particularly the Wat Pra Baht Nam Phu, others are cared for by their family. Research has shown the most common place for people with AIDS to be at the terminal stages of the disease is at their parents' home, and the most common caregiver is their mother. According to Knodel et al (cited in Knodel and VanLandingham 2003:328): "Two-thirds of adults who died of AIDS either co-resided with or lived next door to their parents." Research by Knodel and VanLandingham indicated that adults with AIDS returned to their parents at the terminals stages of the disease, more than half died within three months of return and one-fifth died within one month. The most common cited reason for retuning, according to the parents, were the need for care, particularly for those unmarried or if the spouse had left them:

> "There is a general consensus among Thai healthcare workers that persons with AIDS return to their parent's home, especially when the illness develops so one no longer are able to work" (ibid: 332).

There are numerous other dimensions to gender and sustainable health care, and it is acknowledged that this research and account is insufficient in approaching the complexities, span and importance of gender in ensuring sustainable health care. The changes in gender roles, demographics, and patterns in mode and demand of care may significantly increase the demand of health care services and human resources for health in Thailand. This interrelationship between sustainable health care, gender, and gender roles needs to be explored and accounted for further, not only limited to the aspect of gender and gender roles regarding caring, as it is equally important, if not more important, to account for the aspects of gender in the health care workforce, educating and training health care professionals, and providing health care.

9.2.2 Thai Health Care and Global Sustainability

Global sustainability within the framework of sustainable health care inevitably relates to both the inequitable global distribution of human resources for health, as well as global health care

challenges. This will require global cooperation and commitment. The most important framework for LHD and MHD countries to pursue sustainable health care is through the MDGs. The MDGs, however, are not likely to be achieved universally, although some countries such as Thailand have successfully achieved these development goals or are on schedule to reach these benchmarks in time (Bjorkman 2005). Other countries are not likely to achieve these goals by 2015 (Travis et al. 2004). The problems with achieving the MDGs are complex and will constitute a major body of research and cannot be accounted for sufficiently here. It has been observed, however, that the health related MDGs are dependent on sufficient human resources for health within the specific health care systems, and this will require targeted strategies to develop human resources for health (Wyss 2004).

As illustrated throughout this thesis, both the inequitable distribution of human resources for health and the detrimental flow of human capital from areas and countries with inadequate numbers of health care professionals to more affluent economies and health care systems have detrimental effects on health care and efforts in stemming major health care challenges such as the HIV/AIDS pandemic (see chapters two, three, six and seven). Although Thailand is better placed than those countries most severely affected by the combined calamities of insufficient human resources for health and the HIV/AIDS pandemic, particularly in sub-Saharan Africa, the challenges of ensuring sufficient human resources for health are in principle the same. However, Thailand has had reasonable success and managed to both retain health care professionals as well as effectively stem significant detrimental trends related to the HIV/AIDS pandemic.

Thailand's efforts, both the successes and challenges, have to be viewed within the explicit local setting and parameters. However, some general observations and propositions can be made, and note should be taken from the Thai experiences and strategies. There is a global shortage of human resources for health, and changing disease patterns based on lifestyle is a challenge throughout the world. The economic development and recent prosperity for some LHD and MHD countries, or emerging economies, has led to complex and uneven results in these countries, such as lifestyle changes, increased life expectancy, and dietary and leisure consumptions, including tobacco, alcohol, drugs, and casual or commercial sex. These are all components which are and will continue to dictate health and health care challenges. Changes to behaviour and consumption of alcohol, tobacco, illicit drugs, and sex (either casual or commercial) can adversely impact another health care challenge, including HIV/AIDS. Although the most adverse effects of the HIV/AIDS pandemic are apparent in

countries with LHD and MHD, this epidemic challenges mankind, not a singular country or region. Sustainable health care must be viewed and approached as a global challenge, and be acknowledged through the prism of global sustainability, aiming to promote sustainable health care for all. However, this is and must be pursued as a continuous objective.

As illustrated chapters five, six, seven and eight, both policies and changing attitudes are negatively affecting the vitality and even the sustainability of current mechanisms delivering health care in Thailand, particular with regards to the social contract outlined in section 8.2. The irreplaceable premise for any health care system, without which health care is not viable, is the human capital, the devoted professionals, who actually deliver health care. Shortages of human resources for health in HHD countries are adversely impacting health care systems globally as HHD countries entice health care professionals from all corners of the globe through higher salaries, better working conditions, and professional and perhaps social opportunities, and may exacerbate health care challenges in countries with LHD and MHD (Buchan and Sochalski 2004; Chanda 2002; Chen et al. 2004; de Castella 2003; Diallo 2004; Dussault and Franceshini 2006; Hagopian et al. 2005; Kapp 2004; Kober and Van Damme 2004; Martineau et al. 2004; Narasimhan et al. 2004; Nullis-Kapp 2005; Saravia and Miranda 2004; Task Force on Health System Research 2004; Zurn et al. 2004;). In fact, as cited in chapter two, it is not only the number of health care professionals leaving which are creating adversities, but also the loss of key professionals (Martineau, et al. 2004) which are having adverse ripple effects in health care systems globally.

Global sustainability regarding health care and human resources for health must be pursued through educating and training sufficient numbers of health care professionals, but also having an equitable global distribution of these professionals. Current market mechanisms pull health care professionals to the most developed economies and HHD countries and do not incorporate the adverse effects this may have on the source countries. While there are voluntary guidelines among some HHD countries to ensure that the recruitment of health care professionals will not systematically deplete the stock of health personnel in LHD countries, these are guidelines and more effective measures are required. Investigation into codes of practice by Willetts and Martineau (2004:16) concluded that:

> "it is currently far from clear whether codes of practice … on ethical recruitment of health professionals will actually succeed in protecting developing countries' health systems"

As outlined in Textbox 2.2 and 2.3, Ahmad (2004) proposed strategies to stem the unsustainable flow of human resources for health from LHD and MHD countries to countries

with HHD. Martineau et al. (2004) argues for acknowledging that migration of health care professionals will take place and concur with Ahmad that bilateral agreements are needed. According to Martineau et al. these agreements should allow time-limited and well regulated arrangements for health care professionals to work in HHD countries. These agreements should also facilitate employment for the migrants, to ensure that the migrants are able to get appropriate work, but also that this experience will be beneficial to the migrants' source country upon the migrants' return. To overcome the global challenge of insufficient human resources for health, which is one of the obstacles to sustainable health care, current recruitment strategies of HHD countries must not undermine other health care systems. Innovative and diverse solutions are required, in addition to ethical recruitment and global cooperation. The only long term sustainable solution is to educate and train sufficient numbers of health care professionals, globally, to meet global demands.

This research argues for a holistic approach which should not jeopardise individuals' basic right of free movement and migration. However, strict enforcement and penalties for breaking contracts of public service for newly graduated health care professionals who had educational costs subsidised by publicly funded education, is appropriate. This process must be equitable management and transparent, to enable health care professionals and students to make informed decisions. The stemming of the exodus of physicians from Thailand during the 1960's can be attributed to the combined effect of the introduction of the compulsory public service and the development of a vital domestic private sector retaining physicians in Thailand. The last decade has illustrated that increased numbers of newly graduated physicians are not completing their compulsory public service, but rather than emigrating overseas, they are working in the lucrative private Thai health care sector, as outlined in chapters three, six and eight. The success in reversing the brain drain of physicians from Thailand may have rendered policy makers complacent regarding further exodus of Thai health care professionals. Current global dynamics regarding human resources for health are not the same as during the mid twentieth century, and the consequences of a renewed brain drain of health care professionals from Thailand may be devastating. This research has not only indicated that there is a high degree of willingness among health care professionals to migrate, but that social or cultural bonds which can be interpreted to have stemmed the exodus of health care professionals is deteriorating. Furthermore, there is also evidence that active recruitment of health care professionals in Thailand is taking place, as witness through media advertisements during field visits and cited in section 6.3.4.

For the compulsory service for Thai physicians to more effectively create an equitable distribution of these professionals, a differentiated exit fee regime may be more appropriate than a flat fee independent on where the physician will find employment. For example, physicians working at rural District Hospitals for a minimum of three years, which are not the ones they would be assigned to, should be eligible to receive a discount, for example twenty-five to fifty percent. Those working at urban public hospitals should also be eligible to receive a small discount, while those working in the private sector, but do not leave Thailand, could be eligible for a symbolic discount, of perhaps five or ten percent. Clearly, these are hypothetical figures and appropriate measures to research the optimum proportion of the discount to the exit fees needs to be carried out prior to any implementation of this proposition. The application of these strategies is to retain health care professionals in Thailand and must be transparent. It is not advisable that any regime to limit the loss of human resources for health is so rigid that it is perceived to limit or breach the rights of individual health care professionals.

In addition to differentiated exit fees for those who opt out of the compulsory public service it may be possible to consider some fully funded medical scholarships together with some partly funded medical students. Such a measure can create a greater probability that these medical students will work in rural areas. This programme could also give some more flexibility to the partly funded to seek employment in the areas of their choice. For example, students recruited to work in the most remote rural areas at the time of their compulsory public service would receive fully funded scholarships. The exit fees for these students should be at least 100 percent of the cost of their education, which in 1995 was US$72,000 for physicians (Wibulpolprasert 1999). The exit fees of US$10,000-US$15,000 do not recuperate the public's cost of investment in educating and training these professionals. Students aiming to work in urban areas, particularly metropolitan Bangkok, should have to pay some of their education costs, but their exit fees should then be reduced by an equivalent amount. This programme would require central planning and coordination between teaching institutions, but after initiation this programme would be far less costly than not having an equitable distribution of physicians and other health care professionals. Proposals of raising the school fees for Thai medical students at public medical schools have previously been put forth (Wibulpolprasert 1999; Wilbulpolprasert and Pengpaibon 2003). It may also be reasonable to deny newly graduated physicians who exit the public service to be eligible to study further through

government subsidised programmes until they have completed their public service, or for example worked five years at other public hospitals.

Thailand is, particularly compared with sub-Saharan African countries, in a good position to both sustain and expand its health workforce and overcome current health care challenges. Although Martineau et al. (2004:2) stated that "increasing numbers of nurses" are emigrating from Thailand, Wibulprasert et al. (2004a) suggests that this is relatively few compared to those leaving sub-Saharan Africa as Thai nurses are not particularly skilled in foreign languages. Although shortages of human resources for health in Thailand are generated through an inequitable distribution of health care professionals, a mass exodus of health care professionals is a real threat to the sustainability of the Thai health care system. This threat, however, is not perceived internally as dominant, and the internal brain drain is viewed as the main constraint regarding human resources for health. With the rapid development which has taken place and is continuing to take place in Thailand, combined with the following *westernisation*, it is conceivable that an exodus of health care professionals from Thailand may adversely affect the health care system.

Thailand has been proactive in stemming and reversing health care challenges, and although there are evidence of some complacency and reversals of achievements regarding stemming the HIV/AIDS pandemic, the progress Thailand has made in stemming the spread of the virus, as well as providing ARVs for infected people, is remarkable. This is not the only health care achievement which is threatened to be reversed by a mass exodus of health care professionals, but the effects of a systemic lack of human resources for health with regards to this health care challenge would be devastating. These health care challenges are interrelated, as perceived risks associated with occupational hazards may influence individuals' ambitions to migrate and insufficient numbers of health care professionals leads to increased workloads and fatigue which can increase occupational risks. It is therefore of utmost importance and in the self-interest of the Thai health care system to ensure global sustainability of human resources for health. Recognising that global sustainability requires a global commitment, the following sub-section explicitly engages in the issue of planning for future health care challenges. Arguably, ensuring future human resources for health is the most important and basic health care challenge as inadequate numbers and inequitable distribution of health care professionals obstruct the delivery of health care.

9.2.3 Planning Future Human Resources for Health

Sustainable health care can be interpreted to ensuring sufficient human resources for health to maintain today's health care standards for future generations. This relates to the intergenerational principle of sustainability, as outlined in section 9.1.3. Social transitions, environmental changes, human development and ambitions are continuously altering the expectations and demands on and for health and hence health care professionals. Health care professionals are not a uniform group and predictions and generalisations regarding future trends and behaviour among health care professionals is not only difficult to predict, but may have adverse consequences. If predictions are based on flawed premises, or if these premises change, what was once good policy may become detrimental and unsustainable policy. For example, what may be an appropriate skills mix today regarding ratio of nurses to doctors in a particular setting may change, and the assumption that physicians recruited from rural areas will return to work in the area they originate from may be proven invalid with potential adverse consequences for rural health care.

The single most important measure to ensure sufficient human resources for the future is constant and vigilant monitoring of both human capital as well as other health care challenges which may alter and increase workloads and hence increase the demand for health care professionals. It is important that this monitoring also surveys attitudes and perceptions among health care professionals, not only behaviour, in order to predict and reverse adverse developments and apply new measures to changing behaviour and ambitions. The brain drain or mass exodus of health care professionals to HHD countries is an example of such an adverse development, and if precautionary action is not taken, this may have a cataclysmic effect.

Thailand has engaged in the task of reviewing future demands for health care professionals. Unfortunately, this approach may have been conducted on too narrow premise and the utilisation of this review and calculations of future demand arguably did not include current trends and predicaments as this research has revealed, and present a too optimistic prediction for the future. Hence, these efforts and calculations may actually create complacency rather than vigilance with a net negative result. However, it must be acknowledge that the measures as well as scaling up in educating and training health care professionals which Thailand has undertaken are commendable and a progressive measure. The concern is that this effort may fall short, or even undermine, the need for future heath care professionals in the context of a

global world and world economy that is the foundation for this critical review of contemporary measures and efforts in scaling up human resources for health in Thailand.

The opening of 6 new medical schools in 2004 (Wilbulpolprasert et al. 2004b) is a testament to the commitment and proactive approach in Thailand to ensure sufficient human resources for health. Prior to this there were ten public and one private medical schools in the nation educating between 1,300 and 1,500 physicians a year between 1997 and 2003, and when the first graduates from the new medical schools have completed their education and training, the capacity in educating and training physicians will increase with 600 additional new graduates annually (ibid). However, changing national and global circumstances may also impact the positive prospects and proactive measures which were taken, and continuous vigilance is required. As outlined in section 3.3.4, efforts to estimate the need for future human resources in Thailand were carried out in the late 1990's and yielded a positive prospect regarding the shortages of physicians. Sirikanokwilai et al. (1998) estimates that there "is no need for increasing the production rate of physicians at least over the next decade" based on population-to-physician ratio. It was found that the contemporary scaling up of medical education would decrease the shortages from 15-30 percent over the first decade to only 3 percent in 2020. Although Sirikanokwilai et al. emphasised the need to continuously review the adversities related to misdistribution, rather than a thorough review of all premises in their predictions, it is appropriate based on both the findings of this research as well as general trends which have taken place in the decade since their research, to re-evaluate current and future requirements for physicians in Thailand.

Firstly, some of the premises for the projections of the population-to-physician ratio estimates may have changed. The projections of Thailand's population growth in 1991, which included adjustments for deaths due to the HIV/AIDS pandemic, may no longer be accurate with the introduction of ARVs and the ready distribution of these drugs, and although the projections by Sirikanokwilai et al. utilised the medium population growth rate from the 1991 estimates, this may still underestimate the real population growth. Secondly, the introduction of the universal health care coverage and rapidly expanding health care consumption in Thailand, with anecdotal evidence from this research of an increase of up to fifty percent due to this policy as outlined in section 6.3.2, suggests that the projected requirements of physicians may no longer be appropriate or applicable.

Measures such as the three year public service for physicians educated through public medical schools and exit fees for those who break this contract were outlined in the preceding

chapter. In a global and international market place, global and multilateral policies and measures are required. Although calls and efforts in creating a global accord for the recruitment of health care professionals, particularly in LHD countries and countries with adverse and endemic health care challenges, little affirmative action in mitigating global inequitable distribution of human resources for health is evident. As postulated by the Norwegian government, it is possible to *special order* health care professionals from other countries in a fashion which can be viewed as ethical requirement of health care professionals where the health care system which educated these professionals are given a financial reimbursement for the *loss* or *cost of training* these professionals (Solvang 2007). Thailand, which perhaps is in a unique position, both regarding the capacity to educate and train health care professionals as well as due to social mechanisms stemming the external exodus of health care professionals, may benefit from bilateral agreements in the absence of an enforced multilateral global agreement. These benefits are not limited to financial gains, but if these programmes are appropriately constructed encouraging participants to eventually return and work in their source countries, they will lead to professional development of participants through their experience of different systems which will benefit all health care systems involved. This proposition of a bilateral agreement to train and educate health care professionals is explored further in the following section.

It must be acknowledged that Thailand has actively been monitoring and aimed at predicting future requirements for human resources for health. It is not only estimates regarding physician requirements which has been carried out, but estimates for requirements of professional nurses has been carried out by Srisuphan et al. (1998); a review of dental personnel was undertaken by Udompanich (1997) and estimated supply of dentists were carried out by Lexomboon and Punyashingh (2000); requirements for pharmacists and pharmacy technicians were carried out by Payanantana et al. (1998); as well as an investigation into requirements of mobile emergency medical units and emergency medical technicians by Sateanrakarn and Kangvallert (1997).

The rational behind reviewing future requirement of different health care professionals is to "in the public interest to train only those numbers considered necessary" (Hall 1998). This rational is plain, although this is not a uniform task. Educating the exact number of health care professionals as required for future demands is not likely to ensure equitable health care. As argued in chapter three and six, it is the inequitable distribution of physicians which is of concern to the Thai health care system, not an insufficient number of medical doctors.

According to The Nursing Council in Thailand, there were 113,718 registered professional nurses in 2002, but only 76,578 to 91,602 were actually working in their field (cited in Wilbulpolprasert et al. 2004b). These figures for 2002 suggest that only 67 to 81 percent of Thai nurses are working in their field.

"It is estimated that in 2015 there will be 120,197-173,321 professional nurses, whereas there will be a need for 137,997-142,366 professional nurses, i.e. the supply is close to the demand in the future" (ibid: 270). This assessment may be too optimistic: If 67 percent of these nurses are working in there field, there will be as few as 81,000 nurses working in their field in 2015, based on 67 percent of 120,000 nurses. The highest estimate would be 140,000 nurses, based on an estimate of 81 percent of 173,000 nurses. While the high estimate is within the target range of required nurses for 2015, this is the optimum scenario. Furthermore, merely sufficient numbers of professionals will not ensure an equitable distribution of these within the health care system. It is therefore of utmost importance that the health care professionals educated and trained are likely to work within their field and are willing to work in the areas they are needed. The rural recruitment strategies, outlined in section 8.3.1, can become a crucial tool to ensure human resources for health in remote areas, if monitored and implemented appropriately. It is crucial that measures such as this rural recruitment programme are continuously monitored so appropriate adjustments can be made to ensure that these health care professionals are working the areas where they are needed the most.

9.1.4 Training Health Care Professionals through Bilateral Agreements

Restricting the emigration of health care professionals from countries with LHD and MHD by denying these individuals the freedom to travel is a breach of their human rights. Rather than attempting to stem the migration of health care professionals through measures constructed to limit the freedom and opportunities for these individuals, the focus should shift to regulating and creating mutually beneficial opportunities which address HHD countries appetite for health care consumption and health care professionals, as well as MHD and LHD countries' need to retain adequate numbers of health care professionals without huge losses to their investment of training and educating these professionals. The global shortage of health care professionals has to be rectified. This research has consistently argued for a holistic approach to the dilemmas of health care challenges and insufficient human resources for health. Innovative and creative solutions to ensure sufficient numbers of health care professionals are required, taking into account the different requirements for countries at different stages of human development.

This section will propose and refine propositions of new ways to address the global shortage of health care professionals and the mechanisms which attract these individuals to HHD countries from countries with lower levels of human development. The need for bilateral agreements to regulate the flow of health care professionals has been argued by Ahmad (2004), Martineau et al. (2004), and Stilwell et al. (2004). It is argued here, that these bilateral agreements can incorporate more than just means of regulating the flow health care professionals, ensure consistent education and training, and attempt measures to compensate the host countries for the loss of these professionals. Thailand, in particular, as a result of strong health care infrastructure and significant capacity to train and educate health care professionals, can initiate bilateral agreements of mutual benefit which can specifically address the shortages of health cadres, particularly doctors and nurses, in HHD countries through measures which will eventually benefit Thai health care system.

Through bilateral agreements, Thailand can make agreements with foreign health care systems to either train Thai health care professionals to work in other countries, or admit foreign students in Thailand with the intention of returning to their country of origin, against financial remunerations. Explicit education programmes would have to be designed, including language training, to meet the specific criteria of the host countries' requirements for new health cadres, both to accommodate and enhance the Thai students' ability to work in the proposed host countries, and to accommodate the needs for foreign students to study in Thailand. In addition, specific visa requirements will have to be negotiated to accommodate the specific circumstances of these professionals, including their family members. It may even be appropriate to create specific visas for health care professionals educated through such bilateral programmes, with restrictions requiring these health care professionals to return to Thailand after serving their contracted period, rather than qualify these individuals for permanent residency upon completing their contract[25]. However, once all the requirements of all parties are fulfilled, there are no reasons for why restrictions to emigration would be placed on individuals educated through this agreement.

Optimally, if appropriately constructed, such bilateral programmes could see Thailand educating health care professionals for other countries, and after these professionals have fulfilled their contract, they may return to Thailand to seek employment in the Thai health care system. As such, the benefits for Thailand in educating health care professionals through this

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[25]Although these avenues may be abused, this contract should not close other means of getting residency, for example through marriage and family reunification, as this clearly would break common practice and perceptions of rights.

system would not only be financial gains, but also the *free* education of some health care professionals who have experiences from overseas and will bring new perspectives into the workforce. Even if a majority of these professionals enter the private health care system when they return, the benefits to the health care system and society at large are clear and exceed the financial interests. Specific arrangements between the students and governments in question could follow similar premises as proposed in section 8.3.1 for the compulsory public service for physicians, with a contracted period of professional service at specified locations or countries, with transparent exit fees for those individuals who do not complete the contracted service. It is also reasonable to assume that the financial benefits to Thailand will be similar to those of current migration flows of professionals; with remittances sent back to family members.

For overseas health care systems, which enter into partnership through such programmes, the benefits would also exceed the mere recruitment of human resources for health, or the training of their own citizens at a lower cost, but create cultural and professional bonds. An additional perk is that such a programme, of *special ordering* health care professionals, is that the skills of these professionals can be adapted to meet the specific requirements or health care challenges of the hosts, for example cadres specifically trained for aged care. It can also eliminate the strains of having overseas trained health care professionals licensed and undergoing further training to be able to work in their professions in the specific host countries if these programmes and bilateral agreements are properly managed. It is important, however, that such programmes do not undermine the professionalism or skills of those trained.

Alternatively, specific degrees or professions could be designed, although these would not be such as those in some sub-Saharan African countries which are designed to make these professionals unattractive on the international labour marked (Andersson 2004; Kober and Van Damme 2004). Rather, these would be specifically designed to cater to the needs in the overseas workforce, and become an integrated part of the new health care systems and requirements in these countries. It could be argued that such measure will make these professionals less employable in Thailand. However, with the changing demographics and rapid economic and human development of Thailand, it is reasonable to assume a niche health care sector developing in Thailand, resembling that of HHD countries, such as aged-care facilities, and these professionals may therefore become a valuable source of experience and knowledge to develop this industry upon their return.

These new cadets of health care professionals, for example specifically trained for aged care, could supplement the increasing need for nurses in HHD countries. Furthermore, bilateral, or multilateral, arrangements between health care systems may reduce the "brain waste" (Awofeso n.d.) which is often taking place in HHD countries based on lower recognition or sometimes plain prejudice regarding their qualifications. This can prevent health care professionals trained in LHD or MHD countries from being placed in junior or semi-skilled positions rather than in the positions for which they are trained, skilled, and sometimes even given migration permits for. Although there are significant hurdles to create and implement these forms of bilateral or multilateral agreements to formalise the training and flow of skilled professionals, it is of utmost importance to stem the detrimental and uncontrolled flow of health care professionals from LHD and MHD to HHD countries without impeding these individuals' right to free movement.

The rational behind training health care professionals in Thailand for these professionals to work in other countries is the greater cost-efficiency. The cost of educating a physician in Thailand was about US$72,000 in 1995 and it is estimated that this would increase to US$100,000 (Wibulpolprasert 1999), while the cost of educating a physician in Norway is NOK1.8 million (Sundar 2001), or approximately US$225,000[26]. As such, the education cost in Thailand is less than half than in a HHD country such as Norway. However, the rational is not only to train Thai health care professionals to work in HHD countries, such as Norway, but also to have students from HHD countries educated in Thailand. This is not only applicable for physicians, but should also be an incentive for more students to undertake a nursing degree, for example in HHD countries. While the whole degree, or even just one year, of nursing degrees undertaken in Thailand, which may attract with vibrant culture, tropical climate, a wide range of exotic leisure activities, and professional challenges which are rare in HHD countries, this strategy may entice more people into the health care professions. This may be an incentive for more students to take up these professions, but the lowering of education costs may also be an incentive for HHD countries to educate more health care professionals.

While this research has not engaged with the issue of medical tourism, and Thailand is a destination for medical tourists, travelling to receive medical treatment can become another component of the globalisation of health care and should be incorporated into solutions for sustainable health care. Some countries with strong public health care policies and a

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[26]A conversion rate of 8:1 for Norwegian Krone to US$ has been used in this calculation although current conversion rates the rate is less than 5.5:1 due to recent depreciation of the US currency.

complimentary private health care industry, purchase services in the private health care sector for patients in public queues to shorten the waiting period and utilise the capacity in the private sector. There is no reason for why this cannot take place across countries as well, as long as the process is transparent. This has been voiced as a possible solution to overcome health care challenges in HHD countries, and is contemplated by Norway (Solvang 2007). The challenges to such measures to overcome health care challenges in HHD countries are that these measures may have unforeseen adverse consequences on the health care systems of the countries in which these services are provided. Further research of the parameters as well as feasibility studies into the details and consequences of such arrangements needs to be carried out prior to the implementation of any such programmes.

If appropriate bilateral agreements are created, the cooperation of educating and training health care professionals can benefit both HHD countries and countries such as Thailand, which has the infrastructure to train and educate more health care professionals. The financial gains should be shared between both countries in such agreements, and the personal and professional experiences of the individuals partaking in these programmes will benefit all parties. The crucial component of such an exchange programme is political commitment and leadership to create viable and equitable bilateral agreements. It may be necessary to incorporate a greater global governance of transactions regarding human resources for health. It is natural that the World Health Organization shows leadership and engagement with such agreements, and the WHO may need to become more vocal and authoritative. Member countries must continue lobbying the WHO to initiate stronger engagement and regulation regarding the migration of health care professionals. This is a shared responsibility, and individual health care professionals should lobby their professional organisations and governments to pursue this issue, independent of whether these professionals are from or working in a LHD, MHD, or HHD country.

9.3 Chapter Summary

Thai health care has the potential to excel. Thailand is pursuing universal health care and is increasing its stock of human resources for health. At the same time there are many significant health care challenges, both current and emerging. Many of these can be prevented through targeted prevention and primary health care programmes. In particular, attitudes and behaviour has to be targeted to reduce the disease burden from preventable causes. The diversion of public policy to curative health care and the promotion of individuals'

right to health care may have an adverse impact on individual perception and attitude towards individuals' obligation to take care of their own health. A sustainable health care system must have sufficient numbers, an equitable distribution, and appropriate skill-mix of its human resources for health to accommodate current and future health care challenges and requirements. This chapter has accounted for challenges for the Thai health care system and has proposed an approach for Thailand to engage in bilateral agreements with HHD countries to cooperate in the training of health care professionals. The following chapter will summarise and conclude this research.

CHAPTER 10

Moving Towards Global Equity

"…in the end, sustainable development is not a fixed state of harmony, but rather a process of change in which the exploitation of resources, the direction of investments, the orientation of technological development, and institutional change are made consistent with future as well as present needs. We do not pretend that the process is easy or straightforward. Painful choices have to be made. Thus, in the final analysis, sustainable development must rest on political will" (World Commission on Environment and Development, in Brundtland 1990:9).

This research has reviewed Thailand's health care challenges. In particular, tensions between rural and urban areas as well as between the public and private sector are of concern. While there are no critical shortages of health care professionals in Thailand according to the WHO parameters (WHO 2006b), the internal distribution of health care professionals, particularly physicians, is inequitable (Wibulpolprasert 1999; Wilbulpolprasert and Pengpaibon 2003; Wongwatcharapaiboon et al. 1999). While measures to address these inequities have been put forth, including compulsory public service for physicians educated at public medical schools (Wibulpolprasert 1999; Wongwatcharapaiboon et al. 1999), special allowances for doctors working in the most rural areas (Wilbulpolprasert and Pengpaibon 2003), and the expansion of medical students through new medical schools (Wilbulpolprasert et al. 2004b), this research has uncovered attitudes and perceptions among health care professionals, including physicians, which are concerning and have the potential to undermine Thailand's health care achievements.

Chapter eight outlined a social contract which remunerates health care professionals for their personal sacrifices endured in their line of work through giving these professionals high social status in the community. However, several mechanisms undermines this social contract and it was indicated that health care professionals in some instances feel resentment towards the public's attitudes and people's exploitation of the new and free universal health care system. While the move to universal health care coverage is commendable, this policy is creating tensions and increased workloads for health care professionals. In certain cases, there has been a doubling in number of clients in out-patient departments in both rural and urban public hospitals. Social, political, security, and economic challenges and changes are influencing

health care professionals, their perceptions and individual ambitions. This research uncovered a high degree of concern among health care students and professionals; and a desire among these to migrate to places with lower crime levels, higher security, more political stability, and less violence. Although these attitudes were dominant at the initial stages of this research in 2005, political and security volatilities have deteriorated throughout the research process, as outlined in chapter five. Both security and political instability are areas of concern.

This situation; political instability; poor governance (elaborated on in Appendix T); and inadequate transparency and accountability among the political elite, will lead civil servants, professionals, and intellectuals to loose confidence with the Thai democracy, bureaucracy, and the progressiveness of the country. Thai health care professionals are able to obtain travel and work permits with greater ease than most Thais, and will eventually abandon Thailand when they become disillusioned with their personal situation, working conditions, the erosion of social status, and the political and security volatilities. A mass exodus of health care professionals will have a devastating effect on the Thai health care system and the continued development in the country. Current health care challenges and progress, particularly with regards to the HIV/AIDS pandemic, will be undermined if there are insufficient human resources to sustain current standards of health care for health care consumers.

It is argued here that human development is dependent on health care. Without basic medical care, the development of mankind will stagnate and even deteriorate. The pursuit of health care must be sustainable, based on the same premises as sustainable development. Thailand and the Thai health care sector are at cross-roads, where the social, economic and cultural transitions and global developments are challenging traditional values which so far have ensured sufficient numbers of health care professionals selflessly promoting the health of their fellow citizens. The erosion of these traditional values by financial pressures, personal ambitions of betterment, and the international labour market constantly looking to recruit more health care professionals to HHD countries, may threaten to undo Thailand's health care achievements. Urgent and proactive action is required to stem this threat to the sustainability of the Thai health care system. This will require political cooperation, humility, and sacrifices among all parties. Health care professionals are resilient individuals, but we are depleting our human resources for health and all national health care systems will need to accommodate this challenge.

Traditionally, the development of health care professionals is based on domestic and internal dynamics. However, in the global market and liberated world, national borders are not an

obstacle in the pursuit of individual ambitions, and national health care systems are competing internationally for the professional services of health care professionals with the required skills. This challenge is a global challenge and requires global cooperation. For individual health care systems, such as Thailand, sustainable health care has to be pursued at three levels: By addressing domestic challenges and requirements; through bilateral agreements and cooperation; and through engaging the global community and advocating for the World Health Organization to facilitate, regulate, and compensate for the flow and losses of health care professionals from countries with low and medium levels of human development to countries with higher levels of human development. It is also necessary to engage in bilateral agreements to scale up the education and training of health care professionals through cooperation rather than competition.

Continuous and vigorous monitoring of the Thai health care system is required to ensure sufficient human resources and an equitable distribution of these professionals in the health care system. This must be carried out holistically, be inclusive and include creative approaches to stem adverse trends and reverse attitudes and perceptions of concern. Clearly, a comprehensive primary health care programme is a seminal element of the health care system with the power to illuminate and alleviate major future health care challenges and concerns. Attitudes, among health care professionals, policy makers, and the public must be based on inclusive, equitable, and sustainable principles which respect the rights of all concerned. This is not isolated to a singular health care system, but must be the concern for all world citizens and the urge in developing sustainable health care holistically, locally, and globally, within the framework of sustainable development and global sustainability.

APPENDIX A

Letter of Introduction by Supervisor to Thai Universities

Faculty of Education, Language Studies & Social Work

Curtin 🏵
University of Technology

Department of Education

Department of Languages
& Intercultural Education

Department of Social Work
& Social Policy

GPO Box U1987
Perth Western Australia 6845

Telephone +61 8 9266 9266
Facsimile +61 8 9266 2547

CRICOS Provider Code 00301J

Dear Sir/Madam

This is to introduce Mr. Stian Thoresen, who is enrolled as a Master by Research student in the Department of Social Work & Social Policy at Curtin University of Technology in Perth, Western Australia.

Mr. Thoresen would like to conduct a survey by questionnaire among healthcare students and professionals in Thailand. He is investigating push-pull factors in migration decision-making processes of health care students and graduates in Thailand. His research topic is titled: "Human Rights, HIV/AIDS, and the Brain Drain: Ensuring Sustainable Healthcare in Thailand."

Should you have any queries about the research, please contact me by email A.Fielding@curtin.edu.au; or by phone +61 8 9266 7637, and I would be happy to discuss it further.

With kind regards

Dr. Angela Fielding
Senior Lecturer and HDR Coordinator
Dept of Social Work & Social Policy
Curtin University
GPO Box U1987
Perth WA 6845
Ph. +61 8 9266 7637
Fax: +61 8 9266 3192
CRICOS Provider Code 00301J

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APPENDIX B

Letter of Interlocution by Researcher to Thai Universities

Faculty of Education, Language Studies & Social Work

Curtin
University of Technology

Department of Education

Department of Languages
& Intercultural Education

Department of Social Work
& Social Policy

GPO Box U1987
Perth Western Australia 6845

Telephone +61 8 9266 9266
Facsimile +61 8 9266 2547

CRICOS Provider Code 00301J

Dear Sir/Madam.

I am a Master by research student (Master of Arts: Human Services) at Curtin University of Technology, Perth, Australia. My research is titled: "Human Rights, HIV/AIDS, and the Brain Drain: Ensuring Sustainable Healthcare in Thailand." As such I am doing a survey by questionnaire among healthcare students and professionals in Thailand, in order to understand push-pull factors in migration decision-making processes, recognising that migration of healthcare professionals may in a worst-case-scenario constitute a conflict of rights between healthcare professionals' right to migrate and the general Thai population's right to healthcare.

I will visit Thailand in order to carry out this survey from 29th August to 19th September 2005. I would appreciate your permission to carry out the questionnaire survey among some of the healthcare students at your University, as Curtin University of Technology has a Memorandum of Understanding with your University. This questionnaire should take approximately 15 minutes to complete. If you would like me to present the topic and dilemmas surrounding the issue of HIV/AIDS and migration of healthcare professionals, I am more than happy to make a short presentation to your students after students have completed the questionnaire.

This research is significant as there is little knowledge of the interrelationship between the HIV/AIDS pandemic and migration of healthcare professionals in Thailand; and as the HIV/AIDS pandemic has not been recognised as a significant migration push-factor.

This research has been approved by the Curtin University Human Research Ethics Committee (HR 87/2005). If you have any complaints, you may write to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth 6845 WA Australia, or telephone +61 8 9266 2784. Please do not hesitate to contact me if further information is needed or you have any inquiries on S.Thoresen@postgrad.curtin.edu.au or my supervisor, Dr. Angela Fielding on A.Fielding@curtin.edu.au or by telephone on +61 8 9266 7637.

Yours faithfully

Stian H Thoresen
Perth, 16 August 2005

Information Sheet: Questionnaire Survey

Dear Sir/Madam

My name is Stian H. Thoresen and I am a Master by research student at Curtin University of Technology, Perth, Australia. My research investigates the brain drain–the migration of skilled or educated persons–in Thailand. As such, I am surveying the motivations and current trends of migration from Thailand and would be very grateful if you would take the time to complete this questionnaire to the best of your abilities.

This research is important as there is a lack of studies investigating the correlation between the brain drain and the HIV/AIDS pandemic. The target group of this of this research is healthcare students and professionals and the research's main concern is to answer the question: "What impact the brain drain of health professionals is having on the battle against the HIV/AIDS pandemic in Thailand?" The research is carried out within a Human Rights paradigm, recognising that the issue of the brain drain can be labelled as a conflict of rights, between individuals' right to proper healthcare and individuals' rights to migrate. The objectives of this research are:

1. Explore what effects the brain drain has on the Thai healthcare systems – in particular with regards to the HIV/AIDS pandemic.
2. Identify motivations for exodus of Thai healthcare professionals – to what extent the HIV/AIDS pandemic is a 'push force' for migration.
3. Investigate the conflict of rights between healthcare professions' right to migrate and the remaining population's right to adequate healthcare.

The researcher will take the proper measures in order to protect anonymity for all participants. By returning this questionnaire you are giving consent to the researcher to make use of the information you provide, including publishing the final findings.

The researcher will perform interviews with volunteers at a later stage in order to better understand the motivations for migration and the effects might have had on the Thai health system. If you would like to be contacted as a participant, please fill out the consent form. (Not

all volunteers will be contacted). Please note that by completing the consent form you still maintain the right of full confidentiality, which also will be protected for all interviewees.

If you should have any concerns or questions regarding this research, please do not hesitate to contact me:

Phone number:

████████████ or

████████████

E-mail: ██████████████████████

You may also contact my research supervisor Dr. Angela Fielding (PhD)

Phone number ████████████████
E-mail: ███████████████████

Please note that you may withdraw from this research without any prejudice.

Sincerely yours
(signed)
Stian H. Thoresen

Consent Form: Questionnaire Survey

This is a Consent Form for a questionnaire survey which is part of Stian H Thoresen's research: "The HIV/AIDS Pandemic, Human Rights and the Brain Drain: Ensuring Sustainable Healthcare in Thailand". By filling out and returning this Questionnaire Survey I am giving consent for the researcher to utilise my answers in the research.

Date (day/month/year):   Signed:

_____ _____

Please note:
- This questionnaire survey is confidential and anonymous.
- The research will be carried out within the Curtin University of Technology's Ethical Guidelines.
- Participants have the opportunity to ask any questions regarding the research and its purpose.
- Participation is voluntary, and participants may withdraw from the research at any time without prejudice.
- Identifying information will be separately in a safe and locked place, and this information is accessible by the researcher and authorised individuals only.
- The information shared through the interview may be published, although no identifiable information will be used.

The researcher will at a later stage conduct interviews. If you would like be interviewed at a later stage, please fill out your personal details. Please note that this information will be kept only for the purpose of the research and that you at any time can withdraw from the research, completely or partly.

Name: Mr/Mrs/Ms (please circle the appropriate) _____

Daytime phone number: _____Evening phone number: _____

E-mail: _____

Postal address _____

Thank you very much.

Sincerely yours

(signed)

Stian H. Thoresen

Questionnaire

Please cross the most appropriate box or fill out the information below to the best of your ability.

1. Gender: ☐Male ☐Female

2. Age: _____ years

3. Marital Status:

☐Single ☐ Married ☐ Divorced ☐ Widowed ☐ Long Term Relationship

4. Children under 18 years:

☐Yes ☐No   If yes, how many children under 18 years? _____ Children

5. Residency:

A Please specify your city/province of residence: _____

Is this ☐ A Rural Area ☐ An Urban Area

B Please specify your city/province of origin: _____

Is this ☐ A Rural Area ☐ An Urban Area

A Please specify your province of residence: _____

Is this ☐ A Rural Area ☐ An Urban Area

B Please specify your city/province of origin: _____

Is this ☐ A Rural Area ☐ An Urban Area

6. Work:

A: Please cross one <u>or</u> both:

Are you ☐ A student ☐ Graduate/trained professional

B: If you are a graduate/trained professional

What is the exact name of your position?
_____

How long have you worked within this field?
_____years

7. Training and Education:

A: What is your highest/current academic qualification? _____

B: What is the exact name of your degree? (E.g. B.A., M.A., Diploma of nursing, etc.)
_____

C: How many years of University/Professional Training have you completed?__years.

For each question, please indicate the level of your agreement according to your *current situation and views* with the following statements by circling the most appropriate number where 1 represents 'I strongly disagree', and 5 representing 'I strongly agree'.

		I Strongly Disagree	I Disagree	Neutral	I Agree	I Strongly Agree
1A	I would like to work in an urban area.	1	2	3	4	5
1B	I would like to work in the private sector.	1	2	3	4	5
1C	I would like to work in a country other than Thailand.	1	2	3	4	5
2A	Receiving a high salary is a key factor when I choose where to work.	1	2	3	4	5
2B	Low level of corruption is a key factor when I choose where to work.	1	2	3	4	5
2C	High degree of political stability in the region is key factor when I choose where to work.	1	2	3	4	5
2D	High level of security is a key factor when I choose where to work.	1	2	3	4	5
2E	Low crime level is a key factor when I choose where to work.	1	2	3	4	5
3A	I would like to migrate to a developed country (such as Japan, Taiwan or Australia) if the circumstances are right.	1	2	3	4	5
3B	I would try to migrate to a developed country, even if it would mean that in the process I would have to 'bend' or break the law.	1	2	3	4	5
3C	I would like to migrate to a developed country even if it would mean I would have to work in a different field than I am educated and trained for.	1	2	3	4	5
4A	The health system in Thailand is good.	1	2	3	4	5
4B	There are high levels of HIV/AIDS infection Thailand.	1	2	3	4	5

	I Strongly Disagree	I Disagree	Neutral	I Agree	I Strongly Agree

4C The Thai health system is effectively targeting the spread of HIV/AIDS.

1	2	3	4	5

4D The Thai health system is effectively treating HIV/AIDS patients.

1	2	3	4	5

4E The Thai government is effectively creating awareness of HIV/AIDS.

1	2	3	4	5

4F The Thai government is running effective HIV/AIDS education programmes.

1	2	3	4	5

5A The education system in Thailand is good.

1	2	3	4	5

5B There are low levels of violence and crime in Thailand.

1	2	3	4	5

5C There is a high degree of political stability in Thailand.

1	2	3	4	5

5D There is a high degree of political freedom in Thailand.

1	2	3	4	5

6A I would <u>not</u> like to work in a rural area.

1	2	3	4	5

6B I would <u>not</u> like to work in the public sector.

1	2	3	4	5

6C I would <u>not</u> like to work in Thailand.

1	2	3	4	5

7A I would like to migrate to a place where I can earn more money.

1	2	3	4	5

7B I would like to migrate to a place with less corruption.

1	2	3	4	5

7C I would like to migrate to a place with more political stability.

1	2	3	4	5

7D I would like to migrate to a place with higher security.

1	2	3	4	5

7E I would like to migrate to a place with lower crime levels.

1	2	3	4	5

	I Strongly Disagree	I Disagree	Neutral	I Agree	I Strongly Agree

8A   Developed countries (such as Japan, Taiwan or Australia) have good health systems.
1   2   3   4   5

8B   Developed countries have good education systems.
1   2   3   4   5

8C   Developed countries have low levels of violence and crime.
1   2   3   4   5

8D   Developed countries have high levels of political stability.
1   2   3   4   5

8E   Developed countries have high levels of political freedom.
1   2   3   4   5

8F   Developed countries have low levels of HIV/AIDS infection.
1   2   3   4   5

8G   Developed countries have taken good measures to stem the spread of HIV/AIDS.
1   2   3   4   5

9A   I am proud to call myself Thai.
1   2   3   4   5

9B   I have an obligation of service to my country as a healthcare student/professional.
1   2   3   4   5

9C   I have the right to migrate independently on my country's need of my (future) professional services.
1   2   3   4   5

10   In your own words and according to your own experiences, could you please describe the effects migration of healthcare professionals has and has had on the Thai healthcare system?

_____

_____

_____

_____

_____

_____

_____

Thank you very much for completing this questionnaire.

Information Sheet: Interview Health Care Professionals

Dear Sir/Madam

My name is Stian H. Thoresen and I am a PhD student at Curtin University of Technology, Perth, Australia. My research project is titled "The HIV/AIDS Pandemic, Human Rights, and the Brain Drain: Ensuring Sustainable Healthcare in Thailand."

At this stage I am investigating different aspects of the Thai healthcare system and would be very grateful if you would assist me with an interview. The Thai healthcare system has undergone major reformation during the last few years, most notably the introduction of the *30 Bath Universal Healthcare Scheme*. At the same time, the healthcare system in Thailand is facing several challenges; the HIV/AIDS pandemic, disparities between services in rural and urban areas, as well as the potential threats of an avian influenza pandemic.

As the title of this research project suggests, I am concerned with ensuring a sustainable healthcare system in Thailand and would therefore like to ask you a few questions related to migration of healthcare professionals, healthcare challenges in Thailand and your own views on your rights and obligations as a healthcare professional.

Please retain this information sheet for future reference and please note that the researcher will take the proper measures in order to protect anonymity for all participants; unless anyone explicitly state that he or she would like to be identified.

Please also note that:

- Participation in this research is voluntarily.

- You have the right to withdraw fully or partially from this research at any time until the final stage of this research, estimated to June 2007.

- Excerpts of the interview may be published, although precautions will be taken to protect your identity, unless you explicitly state you wish otherwise.

- All identifiable material will be kept in a secure place and no such material will be accessed by unauthorised persons.

- All identifiable material will be used for this research only and all handling, storing and finally destruction of this material will be in accordance with Curtin University's procedures.

Please do not hesitate to ask any questions and if you should have any concerns or questions at a later stage, please do not hesitate to contact me.

E-mail: ███████████████████████

Phone in Thailand between 20/10-06 – 23/11-06, and between 9/01-07-20/02-07:

███████████

Phone number after 15 February 2007:

████████████ or

██████████████

You may also contact my research supervisor Dr. Mark Liddiard (PhD) at Curtin University of Technology.

E-mail: ██████████████████

Phone number ████████████████

Thank you very much for participating in this research and sharing your valuable knowledge. I am truly grateful for your insight and generosity.

Sincerely yours

(signed)

Stian H. Thoresen

This study has been approved by the Curtin Human Research Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics c/-Office of Research and Development, GPO Box U1987, Perth, WA 6845, Australia, or by telephoning (+61) 8 9266 2784.

APPENDIX G

Consent Form for All Interviews

This is a Consent Form for semi-structured interviews which part of Stian H Thoresen's research: "The HIV/AIDS Pandemic, Human Rights and the Brain Drain: Ensuring Sustainable Healthcare in Thailand".

Please note:

- Participation in this research is voluntarily.

- You have the right to withdraw fully or partially from this research at any time until the final stage of this research, estimated to June 2007.

- The researcher will take the proper measures in order to protect anonymity for all participants.

- The research will be carried out within the Curtin University of Technology's Ethical Guidelines.

- Excerpt of the interview may be published, although precautions will be taken to protect your identity.

- All identifiable material will be kept in a secure place and no such material will be accessed by unauthorised persons.

- All identifiable material will be used for this research only and all handling, storing and finally destruction of this material will be in accordance with Curtin University's procedures.

- Participants have the opportunity to ask any questions regarding the research and its purpose.

By signing this consent form I am giving consent for the researcher to utilise my answers given during this interview in the research.

Date (day/month/year):   Signed:

_____   _____

                                Witness:

                                _____

Thank you very much.

Sincerely yours

(signed)

Stian H. Thoresen

APPENDIX H

Fact Sheet: Interviews Health Care Professionals

Please cross the most appropriate box or fill out the information below to the best of your ability.

1. **Gender:** ☐Male ☐Female

2. **Age:** _____ years

3. **Marital Status:**

☐Single ☐ Married ☐ Divorced ☐ Widowed

4. **Children under 18 years:**

☐Yes ☐No If yes, how many children under 18 years? _____ Children

5. **Residency:**

A Please specify your city/province of residence: _____

Is this ☐ A Rural Area ☐ An Urban Area

Is this ☐ Permanently ☐ Temporary

B Please specify your city/province of origin: _____

Is this ☐ A Rural Area ☐ An Urban Area

6. **Work:**

A: Please cross one <u>or</u> both:

Are you ☐ A student ☐ Graduate/trained professional

B: If you are a graduate and/or trained professional

What is the exact name of your position? _____

How long have you worked within this field? _____Years

7. **Training and Education:**

A: What is your highest/current academic qualification? _____

B: What is the exact name of your degree? (E.g. B.A., M.A., Diploma of nursing, etc.)

_____

C: How many years of University/Professional Training have you completed?

_____ Years.

APPENDIX I

Guiding Questions: Interviews Health Care Professions

Questions related to the 30 Bath Healthcare Policy:

1. How do you view the 30 Bath Healthcare Policy?
    a. For Patients/Clients?
    b. For Healthcare Professionals?
    c. For Healthcare Institutions?
2. What are the strengths and weaknesses of the 30 Bath Healthcare Policy?
    a. For Patients/Clients?
    b. For Healthcare Professionals?
    c. For Healthcare Institutions?
3. Should this Policy continue?
    a. Is there need for any changes?
    b. Why/why not?
    c. What changes?
4. Have the services improved/declined for Patients/Clients as a result of this Policy?
5. Has the workload/responsibilities increased/decrease for Healthcare Professionals as a result of this Policy?

Questions related to the Social Security Scheme (Private Health Insurance)

1. Do you think most people who can afford Social Security Scheme chose to have it?
2. Is Social Security Scheme substantial better than the 30 Bath Healthcare Policy?
3. Is Private Healthcare Insurance reducing the workload of Healthcare Professionals working in the Public Sector?

Questions related to the Civil Servant Medical Benefit Scheme (Government Provided Insurance)

1. How do you view the Civil Servant Medical Benefit Scheme?
2. Do you think the Government's Insurance Policy is improving or declining?
3. Is the Civil Servant Medical Benefit Scheme substantial better than the 30 Bath Healthcare Policy?
4. Is Civil Servant Medical Benefit Scheme reducing the workload of Healthcare Professionals working in the Public Sector?

Questions related to HIV/AIDS

1. How do you feel Thailand is currently coping with the HIV/AIDS pandemic?
2. Some reports suggests a shift in the nature of the HIV/AIDS pandemic with increased infections related to drug abuse injections, mother to child transmissions and among teenagers and young adults. How would you describe the HIV/AIDS pandemic with regards to these issues?
3. Is the Government running effective Education Campaigns addressing the new dimensions of the HIV/AIDS pandemic?
4. Has the Government implemented effective Prevention Campaigns addressing the new dimensions of the HIV/AIDS pandemic?
5. Has the Government implemented effective Treatment Programmes addressing the new dimensions of the HIV/AIDS pandemic?

Questions related to Migration

1. Have you ever migrated during your career?
   a. Why?
   b. Where (international/urban/rural)?
   c. Permanently/temporary?
2. Do you plan to migrate?
   a. Why?
   b. Where (international/urban/rural)?
   c. Permanently/temporary?
3. Do you think you have the language skills to migration to another country?
4. If you ever emigrated from Thailand, do you think you would come back to live and/or work in Thailand later?

Questions regarding rural/urban disparities

1. Have/are you working in a rural area?
   a. How was/is it (workload/professional development/lifestyle)?
   b. How did/do you view you income level?
   c. Would you/will you continue to work in a rural area? (Permanently/temporary, why/why not)
2. Have/are you working in an urban area?
   a. How was/is it (workload/professional development/lifestyle)?
   b. How did/do you view you income level?
   c. Would you/will you continue to work in an urban area? (Permanently/temporary, why/why not)

Questions related to rights and obligations

1. How do you view your obligations towards the public as a Healthcare Professional?
   a. What kind?
   b. Do these obligations affect your life/lifestyle (how)?
2. How do you view your rights and freedoms as a Healthcare Professional?
   a. Right to choose where to work?
   b. Economic compensation for you professional responsibilities?

Note:

Only a subset of these questions will be presented during each interview, depending on the allocated time for the interview and professional and personal experiences of the interviewee. Although some probes have been prepared and are resented, additional probes may be added if appropriate.

Guiding Questions: First Five Interviews Health Care Professionals

1. How would you describe your country with regards to healthcare?
    a. Do you believe most people have access to affordable and good quality healthcare facilities?
    b. What are the greatest challenges within the healthcare system?
    c. Do you believe there is a conflict between the traditional Thai medicine and 'western medicine'?

2. How would you describe your country with regards to the HIV/AIDS pandemic?
    d. Do you believe that there is great urgency with regards to the pandemic?
    e. Do you believe that your government is doing a good job?
    f. Do you believe there is a conflict between the traditional Thai medicine and 'western medicine' for treatment of HIV/AIDS positive people?

3. I see you are (planning on becoming) a _____. How are your (prospective) working conditions?
    g. Can you give examples from your own experience, or from your colleagues' experience, of problems within the healthcare systems with regards to the HIV/AIDS pandemic?
    h. What do you believe are the reasons for this?
    i. What are the greatest challenges for Thailand with regards to the HIV/AIDS pandemic?

4. As a health professional/student, do you believe that you have special obligations towards the Thai public which you would have to consider if contemplating migration?
    j. What kinds of obligations do you believe you under?
    k. How would your emigration fit with these kinds of obligations?
    l. Do you believe you are under the same kinds of obligation with regards to potential dichotomies between rural-urban and public-private healthcare policies?

Thank you very much for participating. If you have any concerns, please do not hesitate to contact me by e-mail on ███████████████, and please know that if you whish to withdraw from the research, you can at any time.

Note:

Sub-questions (a, b, and c) are elaborative questions to be used when the answers to the main questions are short and with little substance.

Estimated time per interview: 60-100 minutes (15-25 minutes per main question).

Information Sheet: Interviews Non-Government Sector

Dear Sir/Madam

My name is Stian H. Thoresen and I am a PhD student at Curtin University of Technology, Perth, Australia. My research project is titled "The HIV/AIDS Pandemic, Human Rights, and the Brain Drain: Ensuring Sustainable Healthcare in Thailand."

At this stage I am investigating different aspects of the Thai healthcare system and would be very grateful if you would assist me with an interview. The Thai healthcare system has undergone major reformation during the last few years, most notably the introduction of the *30 Bath Universal Healthcare Scheme*. At the same time, the healthcare system in Thailand is facing several challenges; the HIV/AIDS pandemic, disparities between services in rural and urban areas, as well as the potential threats of an avian influenza pandemic.

The research process so far has revealed that the social, civil, and political factors may significantly influence both the healthcare system and healthcare professionals' attitudes. As such, I would like to ask you a few questions with regards to the current and historical social, civil, and political influences and trends in Thailand. This will aid the research project by contextualising my interviews with Thai healthcare professionals as well as shed light on the domestic dynamics and influences on the Thai healthcare system.

Please retain this information sheet for future reference and please note that the researcher will take the proper measures in order to protect anonymity for all participants; unless anyone <u>explicitly</u> state that he or she would like to be identified.

Please also note that:

- Participation in this research is voluntarily.

- You have the right to withdraw fully or partially from this research at any time until the final stage of this research, estimated to June 2007.

- Excerpts of the interview may be published, although precautions will be taken to protect your identity, unless you <u>explicitly</u> state you wish otherwise.

- All identifiable material will be kept in a secure place and no such material will be accessed by unauthorised persons.

- All identifiable material will be used for this research only and all handling, storing and finally destruction of this material will be in accordance with Curtin University's procedures.

Please do not hesitate to ask any questions and if you should have any concerns or questions at a later stage, please do not hesitate to contact me.

E-mail: ████████████████████

Phone in Thailand between 20/10-06 – 23/11-06, and between 9/01-07-20/02-07:

██████████

Phone number after 15 February 2007:

████████████ or

████████████

You may also contact my research supervisor Dr. Mark Liddiard (PhD) at Curtin University of Technology.

E-mail: ████████████████

Phone number ████████████

Thank you very much for participating in this research and sharing your valuable knowledge. I am truly grateful for your insight and generosity.

Sincerely yours

Stian H. Thoresen

This study has been approved by the Curtin Human Research Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics c/-Office of Research and Development, GPO Box U1987, Perth, WA 6845, Australia, or by telephoning (+61) 8 9266 2784.

APPENDIX L

Fact Sheet: Interviews Non-Government Sector

Please cross the most appropriate box or fill out the information below to the best of your ability.

1. Gender: ☐ Male ☐ Female

2. Age: ☐ 20 Years or Younger ☐ 21-30 Years ☐ 31-40 Years ☐ 41-50 Years

☐ 51-60 Years ☐ 61-70 Years ☐ 71 Years or Older

3. Residency:

If you are an expatriate, please indicate your nationality: _____

Please specify your city/province of residence: _____

Is this ☐ A Rural Area ☐ An Urban Area

If you are a Thai national, please specify your city/province of origin: _____

Is this ☐ A Rural Area ☐ An Urban Area

4. Work:

Please identify your NGO's area of work (e.g. Agriculture, Housing, Healthcare, or HIV/AIDS)

_____

–

Please identify your position (e.g. Programme Coordinator, Technical or Administrative Staff)

_____

Please outline your responsibilities

_____

APPENDIX M

Guiding Question: Interviews Non-Government Sector

Questions related to public services:
1. How do you regard the strength of Thai Civil Society?
    a. Are Human Rights generally protected?
    b. How is Thailand with regards to discrimination?
2. How do you view the strength of Thai Democracy?

Questions related to HIV/AIDS
1. How do you feel Thailand is currently coping with the HIV/AIDS pandemic?
2. Some reports suggests a shift in the nature of the HIV/AIDS pandemic with increased infections related to drug abuse injections, mother to child transmissions and among teenagers and young adults. How would you describe the HIV/AIDS pandemic with regards to these issues?
3. Is the Government running effective Education Campaigns addressing the new dimensions of the HIV/AIDS pandemic?
4. Has the Government implemented effective Prevention Campaigns addressing the new dimensions of the HIV/AIDS pandemic?
5. Has the government implemented effective Treatment Programmes addressing the new dimensions of the HIV/AIDS pandemic?

Questions regarding political dynamics and current tensions
1. How do you view the current political situation?
    a. What are the effects of the current situation/conflict?
    b. How can the current situation/conflict be resolved?
2. How do you view the future domestic political development?
    a. Has the current situation/conflict created a need for a revision of the Thai political structure?
    b. Has the current situation/conflict created a need for a revision of the Thai media culture?
    c. Has the current situation/conflict created a need for a revision of the Government's Economic Policies?
3. How do you view the geopolitical situation and prospects for Thailand?
    a. Economic Development/Free Trade Agreements?
    b. Strategic/Military cooperation?
    c. Bilateral Partnerships (Singapore, USA, Malaysia?)

Questions regarding the Southern Violence/Tensions
1. How do you view the current Southern violence/tensions?
2. How do you believe the Violence/Tensions can be resolved?
3. How do you believe the Thai Government should interact?
    a. With the "Rebels"?
    b. With the "Clergy"?
    c. With the Southern Civilians?
    d. With the "Thai Minority"?
    e. With "Outsiders" (Malaysia)?

4. Do you think the general Thai population has a good insight into the fundamental issues in this conflict?
5. Do you think the current situation/conflict can have a "spill-over-effect"?
6. Do you believe the Thai Government should seek advice/help from the International Community to resolve the current situation/conflict?
    a. Who?
    b. How?
    c. Why?

Note:
Only a subset of these questions will be presented during each interview, depending on the allocated time for the interview and professional and personal experiences of the interviewee. Although some probes have been prepared and are resented, additional probes may be added if appropriate.

Information Sheet: Interviews Government Officers

Dear Sir/Madam

My name is Stian H. Thoresen and I am a PhD student at Curtin University of Technology, Perth, Australia. My research project is titled "The HIV/AIDS Pandemic, Human Rights, and the Brain Drain: Ensuring Sustainable Healthcare in Thailand."

At this stage I am investigating different aspects of the Thai healthcare system and would be very grateful if you would assist me with an interview. The Thai healthcare system has undergone major reformation during the last few years, most notably the introduction of the *30 Bath Universal Healthcare Scheme*. At the same time, the healthcare system in Thailand is facing several challenges; the HIV/AIDS pandemic, disparities between services in rural and urban areas, as well as the potential threats of an avian influenza pandemic.

The research process so far has revealed that the social, civil, and political factors may significantly influence both the healthcare system and healthcare professionals' attitudes. As such, I would like to ask you a few questions with regards to the current and historical social, civil, and political influences and trends in Thailand. This will aid the research project by contextualising my interviews with Thai healthcare professionals as well as shed light on the domestic dynamics and influences on the Thai healthcare system.

Please retain this information sheet for future reference and please note that the researcher will take the proper measures in order to protect anonymity for all participants; unless anyone explicitly state that he or she would like to be identified and makes an official statement.

Please also note that:

- Participation in this research is voluntarily.

- You have the right to withdraw fully or partially from this research at any time until the final stage of this research, estimated to June 2007.

- Excerpts of the interview may be published, although precautions will be taken to protect your identity, unless you explicitly state you wish otherwise.

- All identifiable material will be kept in a secure place and no such material will be accessed by unauthorised persons.

- All identifiable material will be used for this research only and all handling, storing and finally destruction of this material will be in accordance with Curtin University's procedures.

Please do not hesitate to ask any questions and if you should have any concerns or questions at a later stage, please do not hesitate to contact me.

E-mail: ███████████████████████

Phone in Thailand between 20/10-06 – 23/11-06, and between 9/01-07-20/02-07:

████████████

Phone number after 15 February 2007:

████████████ or

████████████

You may also contact my research supervisor Dr. Mark Liddiard (PhD) at Curtin University of Technology.

E-mail: ████████████████████

Phone number ████████████████

Thank you very much for participating in this research and sharing your valuable knowledge. I am truly grateful for your insight and generosity.

Sincerely yours

(signed)

Stian H. Thoresen

This study has been approved by the Curtin Human Research Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics c/-Office of Research and Development, GPO Box U1987, Perth, WA 6845, Australia, or by telephoning (+61) 8 9266 2784.

APPENDIX O

Fact Sheet: Interviews Government Officers

Please cross the most appropriate box or fill out the information below to the best of your ability.

1. Gender: ☐ Male ☐ Female

2. Age: ☐ 20 Years or Younger ☐ 21-30 Years ☐ 31-40 Years ☐ 41-50 Years

☐ 51-60 Years ☐ 61-70 Years ☐ 71 Years or Older

3. Residency:

A Please specify your city/province of residence: _____

Is this ☐ A Rural Area ☐ An Urban Area

B Please specify your city/province of origin: _____

Is this ☐ A Rural Area ☐ An Urban Area

4. Work:

Please identify your area of work (e.g. Agriculture, Housing, Military, or Politics)

_____

What is the exact name of your position?

_____

Please outline your responsibilities

_____

Do you hold any other positions and/or titles?

_____

_____

_____

_____

Guiding Questions: Interviews Government Officers

Questions related to the 30 Bath Healthcare Policy:
1. How do you view the 30 Bath Healthcare Policy?
2. What are the strengths and weaknesses of the 30 Bath Healthcare Policy?
3. Should this policy continue?
   - I. Is there need for any changes?
   - II. Why/why not?
   - III. What changes?

Questions related to the Civil Servant Medical Benefit Scheme (Government Provided Insurance)
1. How do you view the Civil Servant Medical Benefit Scheme?
2. Do you think this policy is improving or declining?
3. Is the Civil Servant Medical Benefit Scheme substantial better than the 30 Bath Healthcare Policy?

Questions related to HIV/AIDS
1. How do you feel Thailand is currently coping with the HIV/AIDS pandemic?
2. Some reports suggests a shift in the nature of the HIV/AIDS pandemic with increased infections related to drug abuse injections, mother to child transmissions and among teenagers and young adults. How would you describe the HIV/AIDS pandemic with regards to these issues?
3. Is the Government running effective Education Campaigns addressing the new dimensions of the HIV/AIDS pandemic?
4. Has the Government implemented effective Prevention Campaigns addressing the new dimensions of the HIV/AIDS pandemic?
5. Has the government implemented effective Treatment Programmes addressing the new dimensions of the HIV/AIDS pandemic?

Questions regarding political dynamics and current tensions
4. How do you view the current political situation?
   - a. What are the effects of the current situation/conflict?
   - b. How can the current situation/conflict be resolved?
5. How do you view the future domestic political development?
   - a. Has the current situation/conflict created a need for a revision of the Thai political structure?
   - b. Has the current situation/conflict created a need for a revision of the Thai media culture?
   - c. Has the current situation/conflict created a need for a revision of the Government's Economic Policies?
6. How do you view the geopolitical situation and prospects for Thailand?
   - a. Economic development/Free trade agreements?
   - b. Strategic/military cooperation?
   - c. Partnerships (Singapore, USA, Malaysia?)

Questions regarding the Southern Violence/Tensions

1. How do you view the current Southern Violence/Tensions?
2. How do you believe the Violence/Tensions can be resolved?
3. How do you believe the Government should interact?
   a. With the "Rebels"?
   b. With the "Clergy"?
   c. With the Southern Civilians?
   d. With the "Thai minority"?
   e. With "Outsiders" (Malaysia)?
4. Do you think the general Thai population has a good insight into the fundamental issues in this conflict?
5. Do you think the current situation/conflict can have a "spill-over-effect"?
6. Do you believe the Thai Government should seek advice/help from the International Community to resolve the current situation/conflict?
   a. Who?
   b. How?
   c. Why?

Note:

Only a subset of these questions will be presented during each interview, depending on the allocated time for the interview and professional and personal experiences of the interviewee. Although some probes have been prepared and are resented, additional probes may be added if appropriate.

Information Sheet: Interviews Southern Key Informants

Dear Sir/Madam

My name is Stian H. Thoresen and I am a PhD student at Curtin University of Technology, Perth, Australia. My research project is titled "The HIV/AIDS Pandemic, Human Rights, and the Brain Drain: Ensuring Sustainable Healthcare in Thailand."

At this stage I am investigating different aspects of the Thai healthcare system and would be very grateful if you would assist me with an interview. The Thai healthcare system has undergone major reformation during the last few years, most notably the introduction of the *30 Bath Universal Healthcare Scheme*. At the same time, the healthcare system in Thailand is facing several challenges; the HIV/AIDS pandemic, disparities between services in rural and urban areas, as well as the potential threats of an avian influenza pandemic.

The research process so far has revealed that the social, civil, and political factors may significantly influence both the healthcare system and healthcare professionals' attitudes. As social, civil, and political factors in the Southern Provinces currently, and historically, have differed from the rest of Thailand, I would be very grateful for an interview, which will help me better understand the current situation and repercussions of the "Southern Violence" or "Southern Problem", as it has been referred to in the Thai press.

Please retain this information sheet for future reference and please note that the researcher will take the proper measures in order to protect anonymity for all participants; unless anyone <u>explicitly</u> state that he or she would like to be identified.

Please also note that:

- Participation in this research is voluntarily.

- You have the right to withdraw fully or partially from this research at any time until the final stage of this research, estimated to June 2007.

- Excerpts of the interview may be published, although precautions will be taken to protect your identity, unless you <u>explicitly</u> state you wish otherwise.

- All identifiable material will be kept in a secure place and no such material will be accessed by unauthorised persons.

- All identifiable material will be used for this research only and all handling, storing and finally destruction of this material will be in accordance with Curtin University's procedures.

Please do not hesitate to ask any questions and if you should have any concerns or questions at a later stage, please do not hesitate to contact me.

E-mail: ███████████████████████

Phone in Thailand between 20/10-06 – 23/11-06, and between 9/01-07-20/02-07:

████████████

Phone number after 15 February 2007:

███████████ or

████████████

You may also contact my research supervisor Dr. Mark Liddiard (PhD) at Curtin University of Technology.

E-mail: ████████████████████

Phone number ███████████████

Thank you very much for participating in this research and sharing your valuable knowledge. I am truly grateful for your insight and generosity.

Sincerely yours

(signeed)

Stian H. Thoresen

This study has been approved by the Curtin Human Research Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics c/-Office of Research and Development, GPO Box U1987, Perth, WA 6845, Australia, or by telephoning (+61) 8 9266 2784.

Fact Sheet: Interviews Southern Key Informants

Please cross the most appropriate box or fill out the information below to the best of your ability.

1. Gender: ☐ Male ☐ Female

2. Age: ☐ 20 Years or Younger ☐ 21-30 Years ☐ 31-40 Years ☐ 41-50 Years

☐ 51-60 Years ☐ 61-70 Years ☐ 71 Years or Older

3. Residency:

A Please specify your city/province of residence: _____

Is this ☐ A Rural Area ☐ An Urban Area

Is this ☐ Permanently ☐ Temporary

B Please specify your city/province of origin: _____

Is this ☐ A Rural Area ☐ An Urban Area

4. Do you have family in the South?

☐ Spouse

☐ Parents

☐ Children

☐ Other, please specify: _____

5. Work:

Please cross one <u>or</u> both:

Are you ☐ A student ☐ Graduate/trained professional

Please identify your area of work and/or study (e.g. Agriculture, Business, Military, or Politics)

_____

APPENDIX S

Guiding Questions: Interviews Southern Key Informants

Questions related to Migration
1. Do you plan/wish to migrate?
    a. Why?
    b. Where (Away from the South/urban/rural/international)?
    c. Permanently/temporary?
2. Has the current situation/conflict any impact on your wishes/plans to migrate?
3. If you ever emigrated from the South, do you think you would come back to live and/or work if the situation changed?

Questions regarding the Southern Violence/Tensions
1. How do you view the current Southern Violence/Tensions?
2. How do you believe the Violence/Tensions can be resolved?
3. How do you believe the Thai Government should interact?
    a. With the "Rebels"?
    b. With the "Clergy"?
    c. With the Southern Civilians?
    d. With the "Thai minority"?
    e. With "Outsiders" (Malaysia)?
4. Do you think the general Thai population has a good insight into the fundamental issues in this conflict?
5. Do you think the current situation/conflict can have a "spill-over-effect"?
6. Do you believe the Thai government should seek advice/help from the international community to resolve the current situation/conflict?
    a. Who?
    b. How?
    c. Why?

Note:
Only a subset of these questions will be presented during each interview, depending on the allocated time for the interview and professional and personal experiences of the interviewee. Although some probes have been prepared and are resented, additional probes may be added if appropriate.

APPENDIX T

Corruption Allegations towards Thaksin Shinawatra

The corruption allegations towards ousted Prime Minister Thaksin Shinawatra are manifold and severe. The case which has caused greatest outrage relates to the sale in January 2006 of 49 percent of his family company Shin Corp., a telecommunication cooperation to Thameasek, a Singaporean company, which was viewed as controversial for several reasons: Firstly this took place immediately after Thaksin had a bill passed in parliament which increased the proportion of Thai companies which could be owned by foreigners or foreign companies from 25 percent to 49 percent. Secondly, some security analysts viewed this as a potential threat to national security, as this sale also saw the transfer of Thailand's only satellite into the control of a foreign company (Pollard 2007). Thirdly, and more significantly, the sale of Shin Corp., which is the highest transaction in Thai stock history as it exceeded 73 billion Thai bath, or AU$2.4 billion, caused outrage as no tax was levied. Thailand does not levy any capital gains tax (Chantanusornsiri 2006), which allowed the Shinawatras to sell the family company without sharing their profits with the Thai general public.

The sale was not a singular transaction, but it was revealed that it comprised of several stages leading to substantial financial gains for Thaksin and his family. The most controversial part relates to Ample Rich, a company registered in the British Virgin Islands, which on January 20 2006 sold 164.6 million shares of Shin Corp. shares for only 1 bath per share to Thanksin's son and daughter. Three days later, on January 23, Thaksin's children sold these shares to Thameasek at 49.25 bath a share (Post Reporters 2006d), suggesting insider trading or blatant corruption. The complete 73 billion bath sale was carried out without any tax levied, as the there is a tax waiver of capital gains on the Stock Exchange of Thailand. Although not being charged any capital gains tax on this transaction was legitimate, the sale of shares to Thaksin's children for well below market price only days before Thameasek bought 49 percent of Shin Corp. Furthermore, the sales of Shin Corp. shares from Ample Rich to Thaksin's children was not reported as required (Srisukkasem and Chaitrong 2006). If this had been reported on the stock exchange, it is probable that the market would have reacted; anticipating further moves or takeover speculation. The irony of the controversy over the Shin Corp. sale is that one of the stated motivations for Prime Minister at the time to sell this company was to avoid conflict of interests.

The saga regarding the Shinawatras' tax evasion took another turn when Thaksin's wife, her brother and secretary were found guilty of evading 546 million bath (*18.2 million AUD*) in taxes on share transactions. Thaksin's wife and brother-in-law were sentenced to three years jail (Minder 2008). Despite the conviction, Thaksin and his wife were allowed to travel to the Beijing Olympics, and instead of returning to Thailand, the couple "skipped bail" and "fled to London", leading to speculations that the couple had been given leeway in order to ease the political stand-off (The Economist 2008).

Other allegations of improper conduct benefiting the ousted Prime Minister and his family include their free and casual use of government property. One incident which became controversial was regarding Thaksin Shinawatra's sister, Monthathip Komutcharoenkul, and the use of a military aircraft to transport guests to her birthday party in Chiang Mai. The media mogul Sondhi Limthongku[27], a stark critic of Thaksin personally spearheaded the mass protests and grassroots movements, the People's Alliance for Democracy (PAD), in the lead-up to the failed elections in early 2006. Sondhi's public and stark opposition to Thaksin cost him his television broadcast on national television, although he continued broadcasting criticism of Thaksin through his private satellite station and instigated mass protests against Thaksin and the government, frequently revealing corruption allegations. One of many issues which Sondhi raised when criticising Thaksin was the incident involving the use of a military aircraft as private transportation. Sondhi revealed that the account of this event portrayed by Air Force Chief-of-Staff was not true, and that "authorities lied to protect Prime Minister Thaksin Shinawatra and his younger sister Monthathip Komutcharoenkul Shinawatra" (Thip-Osod and Kamnodnae 2005:1). The use of this military aircraft had been approved by the Air Force Chief-of-Staff–a former classmate of both Thaksin and his sister (Nanuam and Ruangdit 2005). Sondhi had managed to get hold of the flight schedule and claimed that the flight to Chiang Mai carrying Thaksin's sister's guests had been booked explicitly for this purpose. An indication of this was that the aircraft's 20 canvass seats had been taken out and replaced by VIP seats (ibid).

This section has only covered two of the controversial dealings benefiting Thaksin and his family. There are numerous other dealings which could also have been included. These range from his first post as Minister of Foreign Affairs in 1994 which only lasted 101 days due to controversies over his share holdings (Vejjajiva 2008), military concerns dealing with Singapore after becoming Prime Minister; including the leasing of an army training site to

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[27]Sondhi Limthongkul should not be confused with the military coup leader Gen Sonthi Boonyaratglin.

Singapore (Nanuam et al. 2007); controversies over sub-standard work and materials allegedly caused by siphoning off funds at the new Bangkok International Airport, Suvarnabhumi[28] and government land sales around the airport; netting Thanksin's family and his close political allies high profits (Glahan and Santimetanedol 2006). Despite the severe allegation of corruption towards Thaksin and his family, corruption by politicians is neither new nor unique for Thailand. Thaksin's first TRT government from 2001 to 2005 was the first Thai government to serve its full term, as all previous democratic elected governments were toppled by coups and corruption scandals (Winichakul 2008). Thaksin and TRT were re-elected in a landslide in February 2005 (McCargo 2007b).

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[28] Common alternative spelling includes: Suvarnapom Airport

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