Thai Health 2017

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Institute for Population and Social Research, Mahidol University
999 Phuttamonthon Sai 4, Salaya, Phuttamonthon, Nakhon Pathom 73170, Thailand.
Telephone +66 2 441 0201, +66 2 441 9666 ext. 219. Fax +66 2 441 9333
website: http://www.population.mahidol.ac.th

Thai Health Promotion Foundation (Thai Health)
979, SM Tower (Floor 34), Phaholyothin Road, Samsen, Phayathai
Bangkok 10400, Thailand. Telephone +66 2 298 0500. Fax +66 2 298 0501
Website: http://www.thaihealth.or.th/en

The National Health Commission Offce
88/39 3th Floor, Building North of Health Park (Sataranasuk 6 Lane), Ministry of Public Health Complex,
Tiwanon Rd., Mueng District, Nonthaburi 11000 Thailand
Tel:+66 2 590 2304 Fax: +66 2 590 2311
Website: http://www.nationalhealth.or.th/eng/

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Institute for Population and Social Research, Mahidol.ac.th
Thai Health Promotion Foundation
The National Health Commission Office

Empowering Vulnerable Populations

Creating an Inclusive Society

11 Indicators on Thai Health and the Sustainable Development Goals

10 Outstanding Situations in the Year 2017

4 Good Works on Thai Health

Thai Health 2017

Preface

At the end of the Millennium Development Goals (MDGs) Sustainable Development Goals (SDGs) began to be adopted as an important and guiding concept under the leadership of the United Nations. The report on Thai Health would like to take this opportunity to use the SDG as the unit of measurement and specifically for Goal 3: Ensure healthy lives and promote wellbeing for all at all ages. We intend to do this by presenting 11 indicators under the title of: The Health of Thais and the Goal of Sustainable Development. We will present data that reflect various levels of challenges in order for Thailand to achieve the sustainable development goals. This will be a very challenging task seen in the rate of mother's mortality that remains high in certain areas of the country, non-communicable chronic diseases that have caused unnecessary deaths, accidents that still remain one of the highest in the region, the Universal Health Care Scheme which still encounters obstacles to providing equal and quality access to its services. In addition there is also drug addiction and the environment that remain as continuing challenges.

The second part of this report will look at 10 important or prominent health issues that have occurred during the year one of those of which is the holding of a referendum for Thailand's 20 year strategy that was passed allowing this Health Act to be passed into law. The birth of the 2nd Health Charter including a new HIA: Towards the Health of Thai's. A draft Act was also undertaken to protect people who received health

services from the state, the registration of low income persons, measures to assist the elderly in preparation for an ageing population, bringing in foreign labor, an MoU on the special economic development zones and the challenge of low prices for rice. Four successful outputs in this year include the provision of the Gold Health Care card for all disabled persons, free education for children from nursery level to grade 6, Thailand reported as being the country that has the lowest level of need (poverty) and efforts to use the Gold Card universal health care scheme as a model for other Asian countries.

In every society there exists differences and variation and even in small groups such as the family, its members are all different from one another. What is of importance though is how a society enables people of different nature and background to live harmoniously together without conflict or neglect that may result in a fragile or weakening of this part of society. A special section of this report on Thai Health 2017 invites you to reflect on the issue "Empowering Vulnerable Populations: Creating an Inclusive Society", that will allow the reader to better understand the dimensions of fragility, the reasons that make persons become fragile and the characteristics of fragility of each group including the impact that fragility has upon these groups as well as what can be done about it so that persons in these groups can escape from this predicament and become fully fledged members of society with dignity, equal to others and with equal opportunity and access to resources in the community.

This report on Thai Health 2017 would like to thank all our readers that have continued to follow us in all our yearly reports and have used the information presented in this report in their work. This and other reports can be downloaded from www.thaihealthreport.com

Working Group on Thai Health
November 2017

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King Bhumibhol Adulyadej

and Thai Health

Introduction

When King Rama 8, Ananda Mahidol passed away on 9 June of 1946 King Bhumibhol was the only remaining brother with the title of Somdej Pra Chao Nong Ya Teau Bhumibhol Adulyadej. At that time Khig Bhumibhol was 18 years 6 months and 4 days old and had not come of age and was visiting Thailand from his studies in Switzerland. The Thai government and parliament at the time were in overwhelming consensus in paying homage to King Bhumibhol and requested that he take the throne on that day.[1]

Before his return to complete his studies in Switzerland King Bhumibhol bode farewell to the people through the radio:

> *It is necessary for me to depart Thailand and all of you to continue my studies and further my knowledge.*

On the day of King Bhumibhol's departure from Thailand there was an occurrence that demonstrated the love and admiration from the people of Thailand towards the King. This occurrence molded the populace and the King into one. King Bhumibhol was to remark in his diary on that day that:

> *On Rajdamnern Avenue people came very close to the car that I was sitting in. I was afraid that the car would run over someone's leg. The car continued very slowly amongst the large crowd. When we passed Wat Benchamabophit we were able to move slightly faster. As we continued I could hear someone call out: "Don't leave us". I wanted to go down and shout back that "If you do not forsake me how in the world would I forsake you". But the car was moving further and further away.*

If you do not
forsake me how
in the world would
I forsake you.
But the car was
moving further
and further away.

> *When I entered the airplane I could still see and hear many people cheering and wishing me well. When the pilot began to start one and then another engine the roar of the engines silenced the cheering of the people. At 12:00 noon we departed and the plane circled three times above the city. I could still see many people looking up towards the plane from many streets of the city."* [2]

At the end of 1947 King Bhumibhol turned 18 years while studying in Switzerland and celebrated his birthday in a quite manner. He made up his mind that he would not return to Thailand until the funeral ceremony of his brother King Ananda Mahidol which was to be held on 1948. However, the funeral ceremony of King Ananda Mahidol at the Sanam Luang grounds was not held until 29 March of 1950. It was not till then that King Bhumibhol returned to Thailand. After the funeral ceremony King Bhumibhol married to M.R. Sirikit Kitiyakorn on 28 April at Sraprathum Palace which was the same place that his father married his mother and also where his father passed away. As per tradition, both the bride and groom registered their marriage and paid a fee of 10 Baht as was the normal fee for all commoners. He filled in the marriage registration without entering his occupation. Incorrect rumors held that he filed his occupation as King of the Land. [3]

Soon after was held the coronation at the Amarin Hall on 5 May 1950. A title was given to the Queen as Somdej Phra Nangchao Sirikit Phra Boromarachinee. The Royal couple then returned to Switzerland temporarily to finally return to Thailand permanently in time for the King Bhurmibhol's 24th birthday on the 5th of December 1951.

Even though the first five years of his reign was spent overseas in Switzerland, the King had already begun his official duties for the people of Thailand well before that. In actual fact the King's work on Thai health had already begun before his coronation.

A Public Health Family

King Bhumibhol was the youngest son of Prince Phra Borom Ratchanok and Princess Phra Sri Nakrintara and was born on 5 December 1927 at Cambridge hospital which later changed its name to Mt. Auburn hospital in Cambridge Massachusetts, USA. His father Prince Phra Borom Ratchanok was enlisted in the navy and later became responsible for public health matters.

Prince Phra Borom Ratchanok spent 12 years studying public health and received a degree in public health and medicine from Harvard University. Soon after he donated his personal funds to build a hospital as well as provide scholarships for many aspiring students. He was also responsible for negotiating with the Rockefeller Foundation to improve and develop the School of Medicine in Thailand equal to international standards. His work and his speeches were important in molding the values, principles and direction of the development of medicine and public health in Thailand such that the medical profession bestowed upon him the title of the Father of Thai Modern Medicine.

The many writings of Phra Borom Ratchanok on medicine and public health have been regularly cited. A selected phrase is inscribed on his statue that is now displayed at the Ministry of Public Health. It is in his handwriting and was written to Dr. Sawat Dangsawang that states:

> *Please view your personal benefit as secondary in importance. Benefits to your fellow humans must come first. Fortune and wealth and fame will come to you if you stay true and steadfast to the teachings of the profession.*[4]

Please view your personal benefit as secondary in importance. Benefits to your fellow humans must come first. Fortune and wealth and fame will come to you if you stay true and steadfast to the teachings of the profession.

The Princess Mother, Somdej Phra Srinagarindra Borommaratchachonnani, came from a commoner family with her father passing away when she was very young. And her mother passed away when she was at a very young age of nine years. Her mother was the only one in their very large family who could read and write and saw the benefits of this for her daughter. The Princess Mother went to school but received intermittent education. The first school she enrolled in closed after only a few years. Later she enrolled in Suksanari primary school for a little more than a month but had to leave as the family did not have enough funds to support her. She had the good fortune of becoming a personal attendant of a Princess (Chao Fa Walaialongkorn Krom Luang Petchaburi Raja Sirindhorn). Because the Princess Mother was not of royal blood she became only a second level attendant. The Princess Mother was able to complete grade three education and then enrolled to the midwifery and nursing school of Siriraj hospital. After graduation the Princess Mother received a scholarship from Princess Somdej Pra Phan Vassa Ayika Chao to study in the United States.[5]

It was there that she met her future husband Prince Mahidol Adulyadej Phra Borom Ratchanok. When Bhumibhol's father Chao Pha Mahidol planned to marry with Miss Sangwan Thalapath (the Princess Mother) the King at the time, His Royal Highness Phra Mongkut Klao Chao Yu Hua was greatly troubled. ***A prince is going against tradition and desires to marry a commoner.*** In the end however, the King capitulated and gave his permission. Prince Mahidol was to explain to his mother, the Queen, in writing to request her permission.

> *Miss Sangwal is an orphan, after she marries she will use my name. I did not choose a wife by her status that she has to be born from this or that family line. One cannot choose how to be born. I simply chose a good person.*[6]

A Fine Example of the King and his Royal Family in the Area of Medicine and Public Health

Modern medicine entered Thailand at about the same time as the spread of religion by missionaries during the reign of King Rama the Third. The first Thai monarch that layed the foundations for modern medicine in Thailand was Kind Rama V (Phra Bat Somdej Phra Chula Chomklao Chao Yu Hua). This began when the first government hospital on modern medicine was established. At that time one of the sons of King Rama V was seriously ill. The son (Somdej Phra Chao Lukyateau Chao Fa Siriraj Kakuttapan) died of dysentery at a young age of one year six months and four days. Dysentery caused tremendous pain and suffering to his son from continuous and bloody bowel movements. It was recorded at the time that his son had 42-52 bowel movements in a 24-hour period. The King was present throughout this ordeal and observed the pain and suffering of his son first hand. King Rama V was to write at the time to the hospital development committee:

> *I have provided so much care and support to my son yet he was in so much pain and suffering. What about the poor people in our land, how much more pain and suffering would they have to endure? This has made my desire to build a hospital even more urgent."* [7]

These events made King Rama V determined to build a modern hospital to alleviate the pain and suffering of his people. The plan was to be developed in an organized fashion. The lumber that was left over from the funeral of his son, held along with the funeral of four other royalty was used to build the hospital. The King confided with the Queen that the assets of their son of 700 Chang (56,000 Baht) would also contribute to the building of the hospital. This hospital was named after his son as Rong Siriraj Payaban, however, the people fondly called it just Siriraj Hospital. The hospital construction began in 1886 and was opened in 1888.

In addition to hospitals King Rama V also established the Department of Health (Krom Payabaan) under the Ministry of Education in 1887 and the School of Medicine and Midwifery School at Siriraj Hospital. The first modern medical publication in Thailand soon followed as well as a pilot program on Sanitation Administration health in Samut Prakarn province.

In addition to a hospital to care for the health of the people some of the public sent relatives with psychiatric issues to the hospital for care. Siriraj hospital was not equipped to deal with this. Doctors also felt it inappropriate to turn these patients away which would be in conflict with the principles of public health care. It was decided that a psychiatric hospital be established whereby the Committee presented to the King a request for a government building that was to be refurbished and developed into this. In all, five additional hospitals were established:

At the residence of Phya Pakdee Pattarakon situated in Klong San where a Mental Disorders hospital was established.

At the Arkorn Ta building on the banks of Pranakorn klong (city canal). In Burapa Phirom where a general hospital was established named Burapa hospital.

At a government building at the top of Silom road adjacent to Charoen Krung road where Dr. Hays received permission to care for foreign westerners called the Nursing Home that was transferred to be under the Department of Health.

Another hospital was built at Thanon Luang road opposite from Thepsirin temple by using an old two-floor wooden building that was granted during the funeral of Somdej Chao Fa Siriraj Kakuttaphan as the administrative building as well as building an additional wooden structure in that vicinity to care for patients similar to Siriraj hospital, this was called Thepsirin Hospital.[8]

In the year 1893 a crisis occurred when Thailand and France clashed at the eastern border of the country. This resulted in numerous casualties requiring changes in some royalty. It was requested that an organization be established to assist in the casualties and this became the establishment of the Thai Red Cross to the present day, to assist and care for

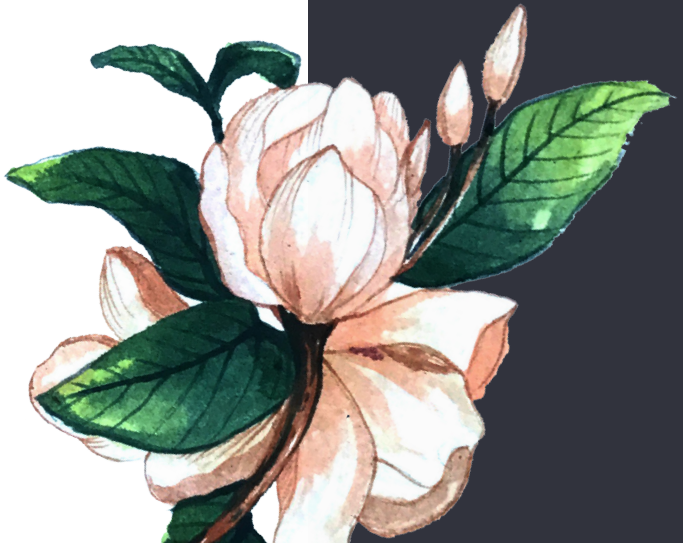
the many soldiers injured. After receiving permission, the Thai Red Cross began its work in earnest. The first representative was Princess Somdej Phra Punwasa Ayika Chao, King Bhumibhol's grandmother who became its First Funding Member. Princess Phra Sri Pacharintara Boromrachineenaat (the first Queen of King Rama V) became the President. Later in 1918 the Thai Red Cross registered as a non-profit organization and Princess Somdej Phra Punwasa Ayika Chao became its first Extraordinary Member member and Her Majesty Queen Sri Prcharintara Borommarachineenaat became its President until 1920 when she passed away at which time Princess Somdej Phra Punwasa Ayika Chao became the President until her death in 1955.[9]

During the reign of King Rama VI he used his personal funds to build Chulalongkorn hospital as part of the Thai Red Cross. Soon after the Pasteur Institute was established, known as the Sathan Saowapha and then the Army Medical Assistant College and Vachira hospital. The Department of Health and responsible health agencies from various ministries together combined to create the Public Health Department which then opened Medical Dispensary throughout the nation.[11,12,13] The first law on medical practice was also enacted in the year 1923.[14]

Princess Somdej Phra Phan Vassa Ayika Chao, King Bhumiphol's grandmother, in addition to supporting the Thai Red Cross and the building of many schools in Bangkok and the provinces, while recuperating in Sri Racha of Chonburi province also established a health care facility there to care for royal staff in that area. When King Rama V went to visit her in 1902 he designated a name for this hospital as Somdej hospital at Sri Racha. Currently it is called the Somdej Boromaratchathevee at Sri Racha hospital. In the beginning the princess looked after the hospital administration personally and donated her land for the building of the hospital as well as her own funds to manage the hospital for royal staff and the general public in the area.

At Sri Racha hospital, the Princess initiated a mobile medical unit to provide care for the people living in outlying areas. In those days the medical mobile unit used ox carts to travel to carry medicine and medical equipment. It went out to care for the ill and prevention of disease. It can be said that this was the beginning of the medical mobile unit.

Health Status of the Thais during the early reign of King Rama 9



When King Bhumibol took to the throne on 9 June 1946 Thailand was still a very underdeveloped country and was devastated from World War II. Even though this was not as devastating as the countries of Japan and Germany or countries that experienced a direct impact from the war. Roads and infrastructure were still very crude, people were ill and many died from illnesses that could have been prevented from vaccines, there was widespread communicable diseases and malnutrition. Even though modern health services were available since the reign of King Rama V , it was still very underdeveloped and more importantly only concentrated in the capital and large cities in few outlying provinces.

At the time the maternal mortality rate was higher than 400 per one hundred thousand population. The infant mortality rate was still in the hundreds per 1000 births even though the official statistics reported were below 100. Diphtheria, whooping cough, tetanus was widely found. In the children's ward of hospitals many children could be found with their throats punctured to treat diphtheria. Whooping cough, that can have severe symptoms and last as long as 100 days before its recovering became known by the people as the 100 day cough. In the villages one could hear the coughing of young children from the beginning to the end of the village. Cholera was also became an epidemic and caused common and widespread deaths. Tuberculosis was commonly found and when occurred could also cause death. Popular novelists began to call this the lover's disease because it affected the chest of the patients as one famous novelist , "Jacob " or Choti Praepan, also died of Tuberculosis. Chronic diseases also became a major challenge for public health such as yaws, and later measles, where currently vaccine have prevented this with vaccinations for children that has been prevalent for many decades. In the past it was accepted that all children would have measles even though the symptoms and various side effects could cause death such as pneumonia, that could cause death or the inability to walk such that the child may have to learn how to walk all over again.[16]

The First Initiative

King Bhumibhol returned to Thailand along with his elder brother King Ananda on 5 December 1945 the very day of his birthday. He was to say later that:

> *I left Thailand for almost seven years and almost could not picture in my mind how Thailand and its people may have changed.*

While in Switzerland King Bhumibhol also studied music and began to compose music through the advice of Mom Chao Chakrapun Pensiri. His elder brother Ananda and the Princess Mother were of the opinion that their younger brother should try to compose a Blues type song first because the chord structure is rather straightforward. King Bhumibhol began to compose. Mom Chao Chakrapun informed King Bhumibhol that if the King should finish this composition he would write the lyrics for it. The first song that the King completed was in April of 1946 called Sangtien(Candlelight Blues) which was in the Blues format of New Orleans. After the completion of this song other songs followed such as the second and third song, that of Yarmyen (Love at Sundown) and Saifon (Falling Rain). Mom Chao Chakrapun provided the lyrics to all three songs. [17]

Yarmyen or Love at Sundown was the first song that was publicly aired by a full orchestra at a charity event to fight tuberculosis by the Tuberculosis Control Association of Thailand under the King's royal patronage. The King also donated a wooden model of his own making of the Royal battleship Sri Ayudhaya for auction at the event on May 1946. He also donated his own funds to the Association and continued to do so on a regular basis.[18]

In the month of July 1949 while King Bhumihol was studying law in Switzerland he donated his own funds of 300,000 Baht for the building of the Mahidol Wongsanusorn building for the Thai Red Cross to be used as a laboratory for the production of the BCG vaccine to combat tuberculosis. Later, the World Health Organization (WHO) accredited this vaccine produced in Thailand to be used by the United Nations International Children's Energency Fund or UNICEF in many other countries.

While in Switzerland King Bhumibhol continued to look for additional ways to treat people with tuberculosis. He ordered the purchase of Para-aminosalicylic acid or PAS that was the first second drug and was at the time not widely used. He ordered this drug to treat people with tuberculosis in Thailand. Later, further research found that if this new drug was combined with the streptomycin injectable, that was the first drug for tuberculosis, it was able to further reduce the resistance of tuberculosis to treatment. [19,20] In 1975, the King became ill with a lung illness due to a mycoplasma infection. This was the first time that this type of illness was diagnosed in Thailand. People began to ask what kind of bacteria caused this illness when news of the first diagnosis in Thailand became public. The King decided that both the medical community and the general public should know. The results of this diagnosis was published in the Royal Thai Medical Journal. As professional ethics required, no identification of the patient was made. This publication was sent to the National Library of the United States and was widely disseminated internationally for continued study. Because of the King's continued work in promoting health, prevention of illness and the treatment of lung infections to the Thai people and its impact upon people generally, the American College of Chest Physicians awarded him with the Partnering of World Health Award that was the first to be awarded to a foreign person on 12 November 1996.

Rajapracha Samasai

One epidemic that brought tremendous pain and suffering to the patient and the family for thousands of years is that of leprosy because it can cause severe bloating of the ear and eyes and open wounds around the body with pus. This created fear and disgust amongst the wider population. In later life leprosy could also cause disfigurement of limbs and nose. Many Thai people fell under this fate.

In the year 1954 King Bhumibhol decided that a movie of his experiences should be shown at the Chalerm Krung Theatre with all the funds to go toward the building of the Ananda Mahidol building in Siriraj hospital. This building was to be built in honor of his brother King Ananda Mahidol. Funds raised came to 444,600.50 Baht that was still not enough for the construction of the building. The King donated his own funds as well received many other personal donations for this effort. The funds raised for the building, the beds, equipment and electricity totaled 1,558,561.00 Baht. The building was used to care for children ill with communicable diseases. The King opened the Ananda Mahidol building on 9 June 1965.

After the completion of the building for treatment of communicable diseases, it was found that a sum of money remained of 175,064.75 Baht. This initial amount was used to contribute to the building of a training institute for research into leprosy at Prapradang hospital in Samut Prakarn Province which cost approximately one million Baht. The King donated the initial sum to begin the construction along with the other individual donations.

The building continued according to the plan by constructing one building at a time depending upon the available budget. 1. The building for instruction and training of personnel that was completed on 2 June 1959, the cost of construction of 299,300.00 Baht. 2. The research building for leprosy completed on 17 March of 1959, the cost of construction of 478,000.00 Baht. 3. The physical therapy building and radiology completed on 4 April 1959 the construction cost of 198,800.00 Baht. 4. A dormitory for personnel and trainees that was completed on 7 May 1959, the construction cost of 260,500.00 Baht.

The total construction cost of the four buildings amounted to 1,236,600.00 Baht. The King named this building as the Rajapracha Samasai meaning the King (Raj), the people (pracha) depend on each other (Samasai).

On 16 June 1959 the King donated the sum of 100,000 Baht to the Lampang Leprosy Foundation.

After deduction of the construction cost and donations to the Lampang Leprosy Foundation the remaining funds from the Ananda Mahidol were 271,452.05 Baht and on the opening of the Rajapracha Samasai Foundation on 16 January 1960 the King donated a part of this sum for the Foundation for use in the promotion of its activities.

The funds for the Lampang Leprosy Foundation was also later used to establish the Rajapracha Samasai Foundation under royal patronage.

On 1 February 1961 the King took Princess Lilian Derate the consort of Prince Leopold, former King of Belgium to visit the hospital and the Rajapracha Samasai Institute.

In addition, the King donated equipment and television and three radio transmitters to the division for leprosy control for their use for patients that were receiving care in the facility. [22]

In addition to donating funds for research and prevention of leprosy, the King was also an important force in changing the attitudes towards people with leprosy such as when he visited the center to not only talk to those with leprosy but also receive garlands that patients presented to him. Dr. Teera

> ... the King touched patients, talked to them and smiled at them. The visit to the patients was very important. The King showed that he did not discriminate against people with leprosy and the people saw this and most importantly the doctors saw this as even doctors were afraid of people with leprosy.

Ramasuta, an expert in the treatment of leprosy and who gave his career to research on leprosy was to state that:

The King was to say in 1997 that *When visiting people in the provinces, (Narathiwat on 25 March 1959) he was to see one person with leprosy that was sitting with other people in the crowd. The doctor said that this person had 'that disease' and did not say that it was leprosy. The King walked towards him and asked him where he came from and how he was doing. The doctor with the King was surprised meaning that the doctor even did not know that it was difficult to contract leprosy.*

Dr. Teera continued:
Discrimination during those days was worse than the discrimination towards people with AIDS that we see nowadays. Even the healthy relatives of the people with leprosy, many times were not allowed to go to school because it was feared that they would spread the disease in the school.

Dr. Teera recalled what the King said to the staff of the Foundation

I*n the care of patients one must first create understanding. One must be able to enter their minds not just of the illness and symptoms. One must see that leprosy can be treated. The King advised that the benefits in providing moral support are of two methods.*

It enables them to want to come to the hospital and accept treatment. Before they would shy away from coming to the hospital, they would run away whenever they could and refuse to have the doctor treat them. Which is a very dangerous thing[23]

Ultimately the world was able to triumph over leprosy when the WHO advised the use of three combination medicines. The target was not just to control or prevent leprosy but to move towards eradication of this disease similar to that of eradicating smallpox many decades earlier.

Ananda Mahidol Foundation

On presiding over the graduation ceremony for doctors and nurses at Siriraj hospital on April 1946 King Bhumibol stated to all that he desired there would be more doctors to care for the people of Thailand, that resulted in the creation of the Faculty of Medicine at Chulalongkorn hospital.

In honor of his late brother King Ananda, King Bhumibhol gave his permission to establish the Ananda Mahidol Foundation with the objective of promoting and supporting able students to study overseas for a higher degree and to return to Thailand to practice their work. As his father Somdej Phra Boromratchanok had studied medicine and supported students to study overseas to return and become well known doctors, King Bhumibhol provided scholarships for medical students as an initial step [24], on 3 April 1959. Afterwards scholarships were provided for other academic disciplines such as.

- **Science**
  25 September 1959
- **Agriculture**
  9 October 1961
- **Political Science**
  5 February 1963
- **Liberal Arts**
  26 October 1963
- **Dentistry**
  25 September 1992
- **Veterinary**
  20 July 1994
- **Engineering**
  19 May 1998

Eliminating Cholera

King Bhumibhol also wanted to eliminate cholera that was spreading at the time in 1958-1959. His support in this work was widespread such as:

Establishing a fund to eliminate cholera as well as allowing the population to contribute to this fund.

Donating a water purification machine for producing saline solution for Phra Mongkut Klao hospital of one machine and one machine for the Government Pharmaceutical Organization.

Donating saline solution and funds to purchase equipment and medical supplies and saline machinery for the Department of Health .

Donating funds to families whose members died from cholera to support their continued occupation.

Establishing a cholera vaccine unit for the population situated in Chitrlada palace and Hua Hin in Prachuab Kirikhan province as well as establishing a vaccine unit that travelled with him to the South .

On 19 October 1959 he allowed the Minister of Public Health to visit him in Chitrlada palace. There the Minister received 409,017.50 Baht for the development of a psychiatric buildingl in the vicinity of Somdej Chao Phraya hospital. On this occasion he stated that there is a cholera epidemic in Pakistan and 500 people were infected every week. That this epidemic may spread to Thailand and that the ministry should have a prevention program. The King also stated various strategies to eliminate cholera that should be considered.

In addition to this, the King supported research on the spread of cholera in Thailand in order to develop a strategy to eliminate cholera as soon as possible. The Advisory Committee for research on cholera of SEATO traveled to Thailand to survey the cholera situation and on August 1959 they visited the King. [25]

Supporting the Construction of Hospitals

The Construction of
the Ratchasatit
Special in-patient Building
at Somdej Chaophraya Hosptial

King Bhumbhol donated funds raised from the showing of the documentary of his to the South of 409,071.50 Baht for a special in-patient building at Somdej Chaophraya hospital in Thonburi. The building was named Ratchasatit. Additional funds were also raised through private donations. In total the funds raised amounted to 500,000 Baht. The Princess Mother presided over the opening on 27 June 1960. The modern Ratchasatit building allowed for the special care for psychiatric patients. [26]

Neurological Hospital at

Phaya Thai

King Bhumibhol was concerned of the increasing number of neurological disorders in the country and donated funds from the showing of the documentary film of his trip to Vietnam, Indonesia and Myanmar of 850,000 Baht to the Neurological hospital at Phya Thai for the improvement and expansion of the hospital. The funds were to improve the treatment, care and prevention of neurological illnesses including a research unit. The Ministry of Public Health used the royal donations and other private donations along with government funds which in all totaled 2 million Baht to construct the building. The building was five stories high consisting of three floors for operations and research and two floors for patients. King Bhumibhol and Queen Sirikit presided over the foundation stone laying of the building on 21 July 1961.

Provincial Hospital

Prakpok Klao

Chanthaburi Hospital

King Bhumibhol and Queen Sirikit presided over the opening ceremony of the Prapok Klao Chanthaburi hospital as well as the Prachatipok building on 17 November 1956.

Donation of funds from the showing of the film of his trip to the North including funds collected by Phrae hospital allowed the construction of one inpatient building at Phrae hospital on 1959.

With the showing of his documentary film of his visit to Vietnam, Indonesia and Myanmar, a merit making ceremony was held for Nongkhai provincial hospital in 1959.

With funds from the screening of his foreign royal visits the king donated an additional sum of 147,231.00 Baht combined with the savings of the Prachinburi hospital of 56,679.00 Baht to construct an inpatient building in 1962 and named the building Rajprachanusorn.

With funds from additional screenings of royal foreign visits to Vietnam, Indonesia and Myanmar combined with donations from private businesses as well as savings from the Buriram hospital a combined total of 150,135.00 Baht was raised to construct the 25-bed pediatric ward at Buriram hospital. The hospital was named Ratchathai hospital. Senior privy counselors of the King presided over the opening ceremony on 4 January 1962.

Construction of a statue of King Chao Fa Mahidol Adulyadej was erected in front of the administrative building of Songklha hospital along with a donation of 10,000 Baht as part contribution to its construction.[28]

Royal Mobile Medical Units Established

There were eight Royal Medical Units that were established.

The Royal Doctor Mobile Medical Unit in 1967

The program on Royal Doctors in 1969

The Royal Dental Unit in 1969

The Royal Specialist Doctor Unit in 1974

The Program on Surgeon Volunteer of
The Royal College of Surgeons of Thailand on 1975

The Royal Program on Ear, Throat, Nose, and Allergies on 1979

The Royal Village Doctor Training Programs, as when necessary.
The first program was conducted at Wang district
in Narathiwat province on 1974.

The Training on basic emergency medical care and emergency births
for police that first conducted on 6 September 1973.

Floating Medical Unit

The King had stated that there were many people that lived along the banks of rivers and canals. Some houses were isolated with no road connections to the provincial capital. Even though the villages were connected by water they were still far away from the provincial hospital. When people got ill they were treated with traditional medicine which was not effective for many illnesses. With the King's personal funds he arranged with the Bangkok Shipyard Ltd. to begin constructing boat that were donated to the Thai Red Cross to be used as a floating medical unit for people along the waterways naming this program as *Wechapa*. The King presided over the opening ceremony for the *Wechapa* floating medical unit on 19 January 1955 at 12 noon at Thawasukree port in Bangkok. Immediately after the ceremony the boat went straight into service in Nonthaburi province.

The *Wechapa* boat was a two-story boat with a width of 3.81m a length of 15.69m and height of 3.75m. Taking in water of 0.85m with a diesel engine of 100hp. It could carry a crew and passengers of 30 at a speed of 12 knots per hour.

The Division of Health and Relief (as it was known at the time) used the *Wechapa* boat for mobile medical purposes on a regular basis for people living along rivers and canals since 19 January 1955 several times a year in various durations of time depending on the need.

During the years of operation health checkups and minor surgeries were conducted, dental care, dressing wounds, injections, medicine distribution

including the rest and sleep of all the staff were conducted solely on the boat. Later more and more people came to receive services. Increasing types of service began to be provided such as health education and mobile library services, which later had to be moved on to land at temple buildings, boat landings and schools. The distribution of medicines however, continued to be done on board the boat. Upon entry onto the boat people would observe the sign on the side of the boat that states:

King Bhumibhol Adulyadej provided this boat in 1955 for people's come and relief with no charge.

Wechapa boat first operated during on 19 January-13 February 1955 at Nonthaburi province and most recently on 22-29 November 2007 in Angthong province a total service of 137 times in 18 provinces has been provided in the following provinces: Nonthaburi, Suphanburi, Nakhon Sawan, Bangkok, Samut Sakhon, Chachoengsao, Phra Nakon Sri Ayudhaya, Prachinburi, Chainat, Singburi, Kanchanaburi, Lopburi, Angthong, Ratchburi, Pathumthani, Samut Songkram, Nakhon Pathom, Uthai Thani. A total of 317,984 persons received services.

The Traditional Medicine School at Watprachetupon (Wat Pho)

Traditional Thai medicine and traditional massage has been a part of the Thai nation ever since recorded history. In the distant past knowledge of treatment and massage was taught from teacher to pupil. This knowledge that was passed on from generation to generation may have increased or disappeared and changed somewhat due to the abilities of the teacher or student to pass on the knowledge. In the Rattanakosin dynasty, King Pra Buddha Yod Fa Chulalok (Rama I) proclaimed Wat Pho as the center of these teachings and that all manuals on traditional medicine and massage were to be gathered for cumulative knowledge that could be later disseminated to the people. Later in 1832 King Phra Nangklao (Rama III) renovated Wat Pho. He ordered the construction of a metallic statue of a wise hermit and the collection of books on massage and traditional medicine to be inscribed in Wat Pho in order for dissemination to the people to study and use the knowledge for beneficial purposes. Later, during the era of King Pra Piyamaharat (Rama V), he ordered that the royal doctors should reform and translate the traditional medicine journals from pali and sanscrit texts into the Thai language. This became known as the Thai Royal Text on medicine. In this Text massage was distinguished massage as the science of hands. In the year 1923 the law on medical practice was separated into two area of Modern Medical Practice and Traditional Medical Practice. Later traditional

medical practice was separated into four disciplines of traditional medicine for basic treatment, traditional pharmacy, traditional mid-wife and traditional massage and when the new law came into enactment in 1936 traditional massage was removed. Later in 1955, soon after the 17th Supreme Patriarch (the 17th) established the association of traditional medicine and a school for traditional medicine (Wat Pho) whereby the school taught traditional medicine in the three disciplines as the law at the time allowed.

In the year 1961 King Bhumibhol visited Wat Pho whereby teachers of Traditional Thai Medicine School at the the temple gave him the school's texts. The King was to ask, is there any teaching on traditional massage. From this remark a collection of knowledge on traditional massage was developed into a curriculum. This curriculum was first taught on 15 May 1962. The school at Wat Pho now had the complete four curriculum being taught until the present day. The teachings of Thai traditional massage continued to develop until it has become well known internationally. Ultimately, the Minister of the Public Health announced that Thai traditional massage is now part of the discipline of Thai traditional medicine on 1 February 2001. Later, trainings for the first traditional massage cohort received their diploma and the graduation ceremony for traditional Thai medicine was held at the main hall of Wat Pho on 29 September 2005.[29]

Compassion and Forgiveness Cannot be Forced

On 9 September 1954 there was a large fire in a market in Ban Pong district of Ratchburi province that covered an area of 100,000 square wah (one square wah equals four meters square). A total of 832 houses had to be evacuated and three persons lost their lives with 5,904 persons affected. The loss totaled 61,524,254.36 Baht. On the 13th of September King Bhumibhol and Queen Sirikit privately travelled to Ban Pong along with a small number of palace staff. The King and Queen donated clothes, food and medicine and money of 100,000 Baht to alleviate the suffering of the people.

Later, newspapers reported on this visit as follows.

Sarn Seree
Newspaper
14 September 1954

Private royal visit,

police did not know.

Because of his desire to visit the market that was devastatingly burnt down on the 9th of this month and to visit the people of the market that were affected first hand, the King left the Amporn palace traveling to Ban Pong at approximately 9 a.m. today (12th)without knowledge of the police.

Only after his departure from the palace did security police became aware of this and quickly telephoned the Bangkok metropolitan police and the policed director general and the palace security police immediately followed.

The metropolitan police immediately set out to maintain security along the route in preparation for his return to the city and also a set out for Ban Pong.

Phim Thai
Newspaper

16 September 1954

Royal Activity

The King and Queen made a private visit to people affected in Ban Pong of Ratchburi province on the 13th of this month. The people in Ban Pong were greatly heartened because of the royal couple's travel by personal car, quietly from the palace without any ceremony and even without the knowledge of the police who were to provide security and convenience. According to the reports, the police knew of this only after the royal couple left the palace for quite some time. The royal police only reached the couple in Nakhon Pathom province.

On this quiet royal visit it can be determined that it was to personally visit the people that were affected by the disaster of the fire. After arriving at the scene of the disaster the King observed the entire area and gave moral support to the people and donated a sum of money to assist the government of 100,000 Baht as well as having the royal treasury collect donations to assist in the recovery.

These actions of good will were greatly appreciated by the people. It demonstrated the compassion that the King has towards the people under a democracy as the King is the highest leader of the land. Even though our King does not directly rule he has demonstrated a great ability to lead.

Siam Rath
Newspaper
16 September 1954

The people of Ban Pong are deeply heartened by the visit of the King.

The King and Queen traveled by car to Ban Pong in Ratchburi province on the 13th of this month to visit the people affected by the terrible fire.

Additional reports stated that there a small contingent accompanied him without informal official staff because he did not want any large preparation for his visit. The King's vehicle arrived at Nakhon Pathom province at 12:00 noon and had lunch at the Chaleeborom Asna palace. After lunch he travelled to Ban Pong market. There he was met by the acting governor of region 7. They drove their vehicle to survey the devastation, talked to those affected and expressed their sorrow and provided moral support to the people affected.

The people of Ban Pong deeply appreciate the compassion and support provided by the King.

Instilling Righteousness

In addition to the King's numerous qualities he also was determined to instill righteousness to the people of Thailand by translating novels, one of which was titled Nai In Phu Pid thong Larng Phra (A man named In who always placed the gold leaf on the back of the Buddha). The King wanted Thai people to know and see the value of working for the country as best to one's knowledge and ability without expecting any return or reward to come to him such as praise. Based on this principle he also wrote a song titled Kwam Fund Un Soong Sud (The Highest Dream) that has the phrase I will place the gold leaf on the back of the Buddha.

King Bhumibhol also instilled the value of persistence by authoring the novel Phra Mahachanok in the style of a tale which later was produced into a comic book so that it could be read and watched by young people.

The numerous songs composed by the King not only demonstrated his talent in music but the lyrics of the songs also instilled the values of righteousness to the Thai people.

On the occasion of 60 years of his reign on 9 June 2006 the King stated the four ways of righteousness

This [four principles] is the basis of unity and compassion towards one another that unites the people and national development for its progress into the future. The proclamations were appropriate for the context of the time amidst widespread internal conflict and strife.

The First

That everyone thinks, speaks with compassion, furthering good, furthering prosperity towards each other.

The Second

That everyone assists others and depend on each other, combine your work and your benefits so that this work becomes successful both for oneself, for others and for the country.

The Third

That all persons are truthful and within rules and act towards each other as equals.

The Fourth

That everyone endeavors to think with correctness, accuracy and with reason.

Many years before, the King had also spoke about the four virtues that included, Sacca (honest and sincerity to one another), dama (controlling one's mind, mindfulness and discipline) khanti (to endure) and jaga (sacrifice, generosity sharing) meaning karawastum si as taught in Buddhism. That the King did not refer to Buddhism as such may have been because even these are the teachings of all religions such as that said by King Asoka Maharat that even though he was a Buddhist his statements are general statements applicable to the teaching of all religions.

In the area of Thai language, the King's abilities became well known when he presided over and spoke about The Problems of the Use of Thai Language together with other professionals in the Conference on The Meeting Group on Thai Language at the Faculty of Arts of Chulalongkorn University. He demonstrated his abilities and interests and concern for the Thai language. The meeting on that day of 29 July 1962 was later announced by the government as National Thai Language Day in 1999.

The King's abilities in the Thai language became widely known since that time and later his views became used widely in the Thai vocabulary and accepted such as the word Kamling (cheek of the monkey, referring to a run-out reservoir). Another word included

Saasn (letter or note) (with the second s silent) that state linguists say must be written as Saasn (with the n as silent). These disagreements by linguists on how to spell certain words continued for some time among until the Thai National Dictionary kept that original Saasn (with the second s as silent).

The Kings views on Self Sufficiency Economy was also embraced by the Thai people as a way of life.

On the occasion of 25 years of reign a ceremony the Rachada Piseksompoj was held. On this occasion the government wished to build a monument to in praise of the King. King Bhumibhol however, suggested that a ring road be built circling Bangkok instead. The King was to state that

Please do not built a monument just yet, it is better to build a road. A ring road, because it has been a dream of mine for a long time.

Today the Thai people thus have the Ratchadapisek road for use in transportation across the city, this road continues to expand. And after 50 years of reign the Thai people also received the Kanchanapisek road, this is larger than any monument that could ever be built. The Thai people should be grateful for the Kings foresightedness and give thanks to this as an example that should be learnt from.

Moreover, the King's actions, related to his work as the King was full of thoughtfulness, sincerity and complete compassion. This has always been seen on how he cares for all in his royal family especially his love and katunyu (deep sense of obligation) to the Princess Mother. This is a picture that all Thais are deeply impressed with and have taught our children to treat their mother's as such.

The King's royal activities throughout his reign are numerous and varied and obviously cannot be documented fully in a report as limited as this. The Royal programs alone number 4,000. We can only provide a very brief summary as shown in this report.

Bravery

In addition to the virtuous behavior or way of life displayed by the King (these include the teachings of giving, good behavior, donating, honesty, compassion, persistence, calmness, not imposing, enduring and steadfastness), another was bravery.

Throughout his life King Bhumibhol has had to endure endless danger but has endured through this with bravery.

Upon King Bhumibhol's reign the world was in the midst of a long cold war which regularly erupted into a hot war with full military conflict in many regions including Southeast Asia. Thailand was also caught in the situation of conflict for many decades that increased in its seriousness through the use of major weapons of warfare. In 1969 the Governor of Chiangrai province along with Colonel Jamnien of Army Region 3 and Colonel Sridej were assassinated [(31)]. Later Mom Chao Viphawadi Rangsit's, (a key royal aide) was shot dead in a helicopter while she was transporting the injured to Wiangsa district hospital in Surat Thani province. [(32)]

Accidents also occurred when a police and army helicopter collided in mid-air on 30 October 1973 at Rom Klao school, in Nong Kan village, Dongluang sub-district, Na Kae district of Nakhon Phanom province where the governor of Nakhon Phanom lost his life.

During incidents such as this the King was ever present in the front lines.

The events that demonstrate the virtuous behavior and bravery of the King was during the bombing of the Islamic Po Noh award ceremony and the award ceremony of the Village Scouts at Chang Puek ceremonial hall in Yala province of the deep South on 22 September 1978. The first bomb went off approximately 55 meters from where the King was sitting, the second bomb went off further away of 110 meters, forty seven people were injured and everyone scattered in fear. However, the King was of stable mind and after the chaos settled down somewhat, which caused a temporary delay in the ceremony after people were sent to the hospital, he stated to those that came to the ceremony that:

I would like everybody to be strong, do not be excited because of this occurrence. Open your eyes and ears and you can eliminate this danger. Thai people, in whatever region you live in have similar minds, that of maintaining peace. Whoever creates turmoil must we all have to prevent. Let me praise the Village Scouts effective training in dealing with this situation here.

May all of you have strength, maintain steadfastness, be safe and successful in your endeavors.[34]

After the completion of the ceremony the palace police requested that the King return to the Taksinrachaniwet palace for his safety. The King however, wanted to visit the people injured at the hospital, the police requested that:

> *Please do not visit the hospital, it is not safe because on the way back if in the evening it would be very dangerous. They might use rocket propelled grenades and we should return before dark. The King remained determined and said 'no'. 'The people came here and were injured because I came to meet with them, they came to see me and I have to go visit them.'*

Queen Sirikit was later to provide an interview to reporters on this matter:

> *There were reports that not many were injured. I was reaffirmed that there were only minor scratches and minor treatment would be given and the people could return home.*
>
> *I believe that in other countries where the monarch fell from reign is they were told just like this and did not visit the injured.*

The King stated that even if it was minor scratches and wounds he would still visit the people but the royal cavalcade continued back to the palace. The King then ordered his car to immediately turn around.

> *I want to go to the hospital.*

Queen Sirikit continued:

> *The driver of the car turned back to the hospital and when we arrived we were shocked because there was so much blood. There was one young girl around 17-19 years that could not breathe as a part of her chest had collapsed. If we were not there she would not have been helped and would have died. One other young girl may have been blinded by the blast. There were many people lying down all over the place and I could only see blood. When that young girl saw us she began crying and said "please sir, it hurts so much I cannot breathe it hurts. My mother and father are not here, can you please help me.* [(35)]

Maintaining Good Health

The King has always maintained good health though some reports state he was ill at times. He engaged in many royal activities throughout the year in all regions of the country, especially in rural areas, both during the day and at night. This was clearly seen by the public and with those that have been fortunate enough to accompany him.

Not only climbing mountains and going down streams without showing any tiredness such that those that followed with him had to maintain their fitness to keep up. As well as presiding of ceremonies of long duration and engagements such as graduation ceremonies at universities he maintains a straight and grand posture for hours on end without any change in his seating. When he plays music one can see that he does not move or get up from the early evening till the morning while other musicians had to excuse themselves to go to the toilet regularly. These are scenes that were seen regularly by the public for decades.

King Bhumibhol is able to do this because he regularly exercises, whether while in the city or in the provinces as well practicing meditation to maintain steadfastness in order to maintain his posture for several hours at a time. Focusing on precisely on the activity he is doing at the time allows him not to dwell on pain or numbness of the body. Pain or numbness does come but the body accepts it and releases it by nature as if the body overcomes it. [36]

Lon Klao Pao Thai

Many Thais are familiar with the song Sadudee Maharaja (Praise to the King) composed by Chalee Intrawijit and Surat Pukawej in 1966 with lyrics by Saman Kanjanapalin that debuted in the movie *Lom Nao* (Cold Win) that is sung in the contemporary style. This song is widely sung by Thais with great passion. Another song that reflects Thai feelings is the country style song *Lon Klao Phao* Thai composed by Cholathee Tarntong, a nationally renowned dramatic composer of the National Cultural Committee on 1999.

Cholathee Tarntong's real name was Somnuek Tongma and who composed the song with Charnchai Buabungsorn, national artist of the year (2007) responsible for choir arrangement. Popular country singer Sayan Sanya (real name Sayan Deesamur) sang this song in 1976. The lyrics are as follows:

His Majesty King of Thailand
The Center for Thai People
I want to pay respect to you, His Majesty King Bhumibol
When citizen facing poverty.
(He) concerns, worries. Like rain on the ground.

Even the forest, (he) still goes.
Even his body is dirty, the weather is not nice
Share the happiness, share the sufferings
Have mercy on citizen

The love of Thai people
Guardian for all
Everyone knows
I am proud of His Majesty King of Chakri (Dynasty)

What's more, the Thai love him very much
What's more, he cares when Thai is suffering
Thai people love him more than life
If anyone hurt you, I am willing to sacrifice my life

His Majesty King of Thailand
The Center for Thai People
I want to pay respect to you, His Majesty King Bhumibol
When citizen facing poverty.
(He) concerns, worries. Like rain on the ground.

Even the forest, (he) still goes.
Even his body is dirty, the weather is not nice
Share the happiness, share the sufferings
Have mercy on citizen

What's more, the Thai love him very much
What's more, he cares when Thai is suffering
Thai people love him more than life
If anyone hurt you, I am willing to sacrifice my life [37]

Songs such as these any many
more reflect the true feeling of the
Thai people towards and the gratitude they
have towards King Bhumibhol.

Able Intelligence Recognized Internationally

King Bhumibhol's ability was recognized not only in Thailand but internationally as well. Such as his ability in music when visiting several countries around the world. During his visit to the United States and the Philippines he played with their national symphonies when invited without any previous preparation. During his visit to Austria in 1964 a symphony presentation was provided in the concert hall by the Vienna Symphony Orchestra. There the symphony played the song *Manora, Falling Rain, Love at Sundown, March Nawikayothin* (march of the marines) as well as *March Rachawanlop* (Royal Guards March). The King played in the orchestra with great applause from the audience. The Austrian government broadcast the songs and the event was covered by all television stations for the next two days. The Academy Die Akademie fur Musik und Darstellende Khunst in Wien presented a diploma of the highest order and gave him the honorary member number 23 and his name was inscribed in granite at the Institute. King Bhumibhol was the first Asian to be a member of this very prestigious Institute at the young age of 37 years. [38]

King Bhumibhol was also an able speaker. One could see this in his speeches on numerous occasions since he became king not only impressing Thais but foreigners as well. While visiting the United States on 1960 he spoke to the US Congress and received a standing ovation from those present. There was laughter and cheering and as one noted observer stated, the audience applauded 17 times, something never heard before ending in a standing ovation of over a minute. On his visit to Canada and the United States in 1967, Princess Viphawadi Rangsit, who accompanied him on that visit, stated that he had 27 speaking engagements in Thai, English and French with some speeches unprepared as they were not in the planned schedule. [39]

The King's accomplishments has resulted in international recognition seen in the Institute of Road Engineering of the United Kingdom who presented him with the honorary engineering award in the year 2000. The United Nations Environment program awarded him with the honourary Gold Medal in environment in 2001, the Food and Agriculture Organization awarded him with the Agricola Medal in 2006. Kofi Anan, the Secretary General of the United Nations awarded the King with the United Nation's First Human Development Lifetime Achievement Award to celebrate the human development of the Thai nation throughout his reign of 60 years and Time magazine praised the King as one of the heroes of Asia in the last 60 years on the occasion of the magazine's 60 years of operation. [40]

In the area of public health, numerous recognition was received, one's that can be briefly mentioned include the World Health Organization's Gold Medal award on Health For All in 1992. The International Committee on Iodine Deficiency Gold Medal award in praise of his ideas and direction in the expanded access to iodine and the Franklin Delano Roosevelt Institute FDR International Disability Award in 2001 for progress in Thailand based on the international plan for disability as set by the United Nations.[41]

These achievements that have been recognized nationally and internationally reflect the writings of King Praputhayodfa Chulaloke Rama I that stated:

> *The grandeur throughout this land*
>
> *Splendid king of enormous independence*
>
> *Supporting the continuity of both the sea and land*
>
> *From the lowly to the highly pay respect to* [42]

The Grandeur
throughout this land

Splendid king of
enormous independence

Supporting the continuity
of both the sea and land

From the lowly to the
highly pay respect to

Analysis

Though King Bhumibhol was not born as a direct heir to throne there were also many other limitations. He lost his father at a young age of one year 9 months and 19 days. The country at the time had been in conflict and crisis for many years. The change on 24 June 1932 from an absolute monarchy to a constitutional democracy directly impacted the royal family. The conflict reached such a serious stage that King Phra Pokklao Rama VII stepped down from his throne on 2 March 1934.

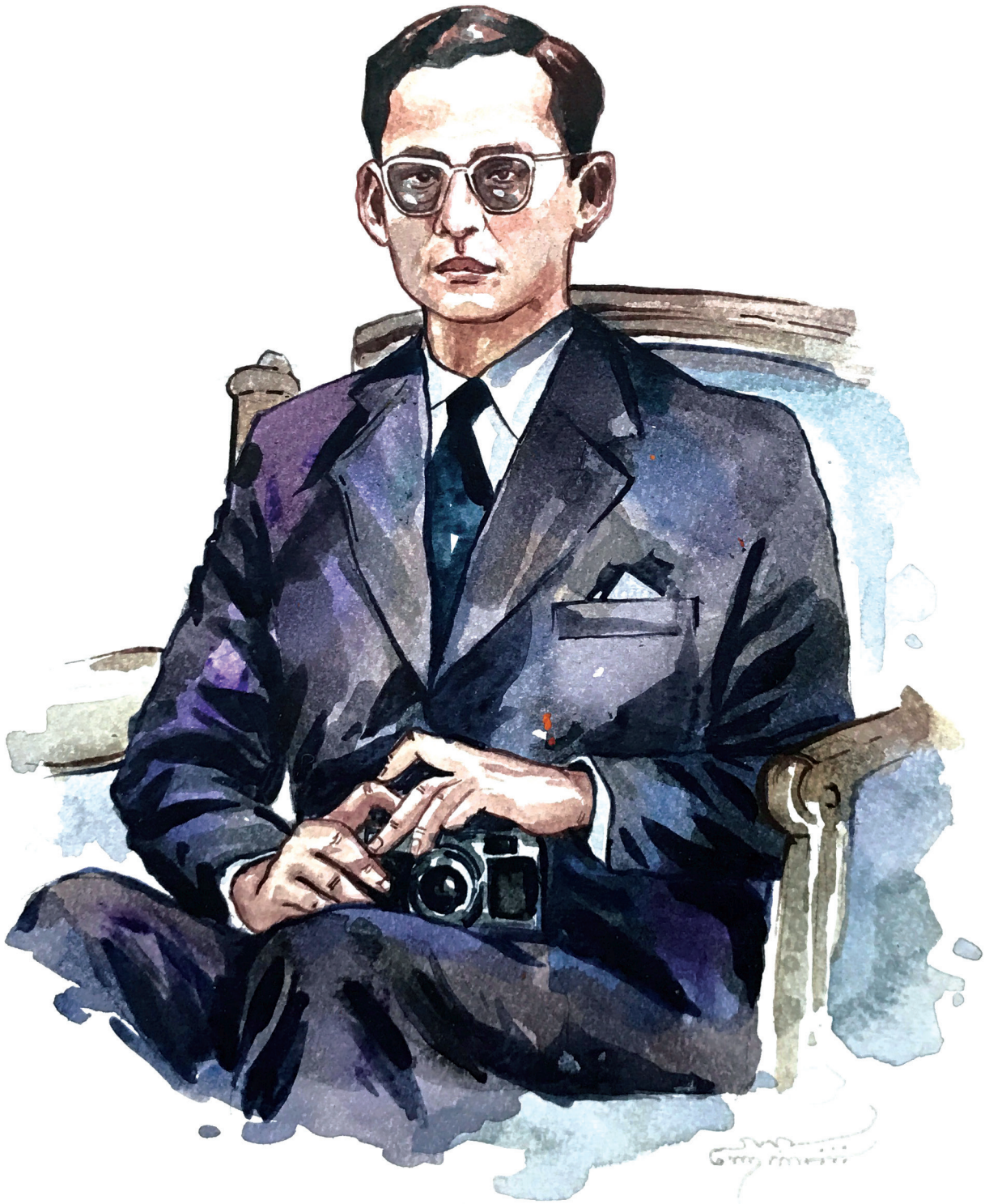
The Thai government and parliament resolved that they request Ananda Mahidol (Bhumibhol's brother) at the young age of 8 years 5 months and 11 days to take to the throne.

A great crisis occurred in the death of King Ananda on 9 June 1946 requiring that King Bhumibhol take to the throne at the age of 18 years 6 months and 4 days.

King Bhumibhol was to experience a serious car accident that caused the permanent loss of his right eyesight on 4 October 1948 when his vehicle hit a truck whilst he was traveling from his home in Lausanne to attend a jazz concert in Geneva.

Amidst the personal crisis and political conflict in the country it is remarkable that King Bhurmibhol was able to conduct his duties with such great success. To achieve such high acceptance from the Thai people for such a long period. After the passing-away of King Bhumibhol, the United Nations called a special meeting to mark his passing.

The reasons and factors in his success could be summarized as follows



1

A Brilliant Mother

When King Rama VII stepped down from the throne and the government and parliament requested that King Ananda Mahidol to take the throne, the Princess Mother desired that her son should continue to live his life in Switzerland in a normal manner. She wrote to the Princess Grandmother, Somdej Phra Phan Vassa Ayika Chao as to her son taking the throne:

20 March 1934

Your Highness

You may be rather distressed that Ananda will have to become king. I am not pleased as well but as this cannot be avoided I will have to do my best.

Chao Phya Sri has come to see me on the 17th. As I write now we are living in Lausanne and we discussed to continue to live here. I stated that we would like to live in incognito so that Ananda will live a normal child's life as much as can be possible. Chao Phya Sri was of the opinion that on this issue the government most likely would agree. However, a house should be found that is an improvement, one with a garden of our own so it is more presentable. As to people that will come and reside with us the government will send Luang Siriraj Maitree to stay with us and I agree with this. I also mentioned that if they were to force us to stay in luxury as a full king this would certainly not be good at all for our children and they would not be happy and would not like to be king. We want to live a modest life and this certainly would not offend the throne and Chao Phya Sri was in agreement.

I wish you the best and hope you are not too concerned. When I am distressed about this issue I also think that Ananda can help the country indirectly. If they were to designate another person to be king it will certainly be more conflicting, this puts my mind at ease.

The children and myself think of you always.

Sangwal.

You are so wise and full of insight and patience. Your responses to Phya Sri Tamathibet are so wonderfully sharp. It is my merit that I have a daughter in law like you and the good luck that my grandsons have a mother like you.[43]

The Princess Grandmother complimented the Princess Mother.

> *You are so wise and full of insight and patience. Your responses to Phya Sri Tamathibet are so wonderfully sharp. It is my merit that I have a daughter in law like you and the good luck that my grandsons have a mother like you.*[43]

The Princess Mother came from a commoner family and can well understand the life of common folk. When King Bhumibhol's father Prince Boromratchanok passed away on 1929 during the era of absolute monarchy. Before he died he told his mother that if he should die one day to please place some of his remains in the public temple of Wat Pathumwanaram in the hope that his wife (the Princess Mother, who at the time was not a princess) who was a commoner could pay her respects to him .[44]

That the Princess Mother requested that her son Ananda , who was a youth king at the time, be able to live a simple life and grow up as other common children had an important impact to the future king.

Living a simple common life was a good opportunity and the brothers also had a good teacher as Cléon Séraïdaris that came to their house on a daily basis. Teacher Cléon took the young brothers out cycling, row boating, swimming and building toy trains. Teacher Cléon was well trained in the arts and taught the young brothers the skill of boat and airplane building, building various engines as well as a radio transmitter. Cléon was also a skilled carpenter and imparted these skills to his students. That is why Thai people have seen pictures of the King building sail boats to race.

Later on the King began to learn music and was able to play many musical instruments and played saxophone with the school band even though he only learnt to play the saxophone formally for nine months. King Bhumibhol continued to developed these skills to extent that he composed 47 songs in total for the Thai people.[45, 46]

2

A Noble Father

In addition to donating his personal funds to build hospitals and scholarships for many students as well as contributing greatly to developing the medical studies up to and equal to international standards, Prince Boromratchanok was a prime example of living life in a self -sufficient way. There were interesting anecdotes such as that by one Thai student who was preparing to enter university. This student visited the Prince and was staying with the prince temporarily. While entering the room he took off his shoes thinking that a royal page would come to clean the shoes. It turned out that the Prince did not have a royal page as the young student had thought because he wanted to economize and use that money to help others that were less fortunate. The student learnt of this only the next morning and was shocked because the person who polished his shoes was the Prince himself. [47] One scholarship student who the prince visited and stayed a night with him in the dormitory found in the morning that the prince had mended his torn socks in the garbage can for him to keep using.

When the prince took the students to visit various places in London he liked to walk a lot and when some students became tired he would allow them to use other forms of transport but not cars but rather the underground subway.

Being very thrifty in this way was because he was well aware that all the assets he had come from the sweat of the backs of his own people. He would economize to use those savings for the benefit of the people.[48]

These activities, not experienced by the young prince brothers because of their father's passing away when they were young, were known to them and absorbed either directly or indirectly by them, as seen in stories that were told by Lady Puaw Anurakrachamontian that:

When King Bhumibhol was still a young boy and returned to Thailand for the first time along with his elder brother Ananda Mahidol he was only 12 years old. *He bought an electric car or someone gave this to him as a present I cannot remember but he was very fond of it. He drove this car all around Chitrlada palace. When visitors came to the palace to see the Princess Mother and he happened to know them he would ask them to get into the car and would ask for a fee of five satang at the door of the car and would drive them to the front of the palace door. Some visitors did not have five satang for the fee and gave him 10 satang and did not ask for change in return and stated that the remaining five satang was a present. King Bhumibhol quickly returned five satang and said to that person that 'with five satang one can set oneself up in life.' The visitor asked how, in what way?' King Bhumibhol replied 'you can use this money to buy bean seeds, plant them for sale and have money'*.[49]

3

A Noble Queen

As the well-known phrase in the song to praise the King and Queen known as Sadudee Maharaja *"...the noble queen with immense merit of the Chakri dynasty..'* the queen travelled widely to distant and difficult places with the King as we have seen for many decades. Queen Sirikit also began much work to assist the people and complement the work of the King such as the Silpacheep foundation for special persons that is well known internationally.

For those not fortunate enough to experience the travels of the Queen and King they may not know of the difficult terrain encountered in their travels as mentioned in the book *Dern Tham roy tao Po* or Following in the footsteps of my Father that Princess Prathep Rattana Rachasuda who travelled with the King wrote in her book:

I walked following the footsteps of
my father without stopping

Passing into the huge forest, it was very scary and
thick and seemed to go on forever

There was a very large tree that looked like a strong
and powerful tower

Dear father I am so hungry, I am so tired

Look! There is blood coming out from both my feet

I am afraid of snakes, tigers and wild dogs

Father, when will we arrive at our destination?

My daughter...In this world there is no place
that is pleasant and comfortable for you

Our path is not laid with beautiful flowers

Please walk on forward though it may be
very painful to your heart

I see that the thorns have pricked your feet

Your blood is like ruby on the blades of
grass near the lake

Your tears that are falling on the green shrubbery
are like a diamond reflecting its highest brightness

Humankind, you should not reduce your bravery

Confronted with pain and difficulty one must be brave
and persistent and be thankful that
one have chosen a path of great value

Come with me ...if you want to walk
in the footsteps of your father.

4

An Example of A Great King

During the reign of King Pra Nangklao (Rama III) war in Myanmar began to die down when they came under the rule of the British and colonialism became a start reality. In the reign of King Phra Jomklao Chaoyuhua (Rama IV) the country continued to be confronted with this danger. It was the good luck of Thailand that King Rama IV had enough time of 27 years to prepare for this while his was in the monkhood before he took reign. Upon his taking to the throne be began a new tradition, that of announcing that:

> *I will reign with just and fairness for the benefit and happiness of the people of Siam.*

He was able to succeed in this proclamation.

King Phra Chulajomklao (Rama V) though, began his reign at only 15 years and 10 days, but showed great ability in maintaining the independence of the country and to develop the country in all facets. He was loved by the people so that he became known by the people as Phra Piya Maharaj (The Great King that is loved by all the people).

When King Bhumibhol was coronated he announced the same phrase as that of King Rama IV

> *I will reign with just and fairness for the benefit and happiness of the people of Siam.*

Later the King returned to Thailand permanently and fully immersed himself in his duties that were carried out excellently according to the ten principles of just law and religious principles, the Dasaphit Rajadham. This was important in steering the country pass numerous conflicts due to his sharp acumen, especially during the cold war era and internal conflicts. He always positioned himself as a neutral but fair party, a true center of the heart of the country, caring for the people both in the cities and the provinces near and far, in the mountains, the valleys, in the forest and the countryside. In travels to foreign lands the practice/manners /behavior and wisdom he showed garnered much praise in all the countries that he visited. The result is the benefit and happiness of the Siamese people.

In addition, the importance given to development of public health was because he saw that in the development of the country to achieve self-dependence the people must first have good health. If the people cannot get access to public health services each generation would be caught in a cycle of ill health and poverty that will impede the country's development and progress. [52]

Dr. Sumet Tuntiwechakul, Secretary General of the Chai Pattana Foundation believes that the reason that many Royal programs in the early years focused on public health was most likely because it did not involve a lot of field work as travel during throughout the country at the time of 1950 was rather limited. Much research had also yet to be conducted for several more years before positive results could be confirmed. Health programs that were established at the time were those that provided treatment and programs that were already proven to have positive results even if it was still new to the country. Though the Ministry of Public Health and other agencies in the health field and medical field where the main responsible agency for the creation of the national health program, including the expansion of medical services, the royal health programs of the King filled a large gap in the program, promoted the work of public health staff and created public support from the population.[53]

5

The Love and Affection that People have for the King

In the diary of the King which noted the voices of the people shouting don't leave the people' and his desire to shout back if you won't forsake me how would I ever forsake the people' shows the love and attachment between the King and the Thai people. There have been many examples of this even before the words were written in the King's diary and throughout King Bhumibhol's reign.

Admiral Mom Chao Kalawanadhit, the former Chief Aide de-Camp General once gave an interview saying that:

> *The casket of King Rama VIII was in the Dusit Mahaprasat Hall and King Bhumibhol went to pay his respects every day.*
>
> *One day there were many people paying respect to King Rama VIII that filled the grounds of the hall at the same time King Bhumibhol was there to pay respect to his brother. When he saw the people in the grounds he said he wanted to go down, be closer to them, greet them and thank them.*
>
> *I was surprised at the statement because in the crowd there may be some people that were on the opposite side as the King that it may be dangerous. I told the King that he should not go down to meet the crowd and should remain on the platform but the King refused my request and went down because he was of the opinion that the people were his people and being closer together was very important at that time.*

> *When he went down to greet the people. The aides on that day, of which there were only four tried to hold hands in front of the King for his protection but could not due to the number of people, everyone tried to get as close as possible to the King causing us to almost fall over but the King was not concerned at all and stayed with the people for a long time.*[54]

Professor Sanya Thammsak, former Chief Privy Counselor, former Chief Supreme Court and former Prime Minister also gave his thoughts.

> *The King was most concerned of the welfare and happiness of the people and how they make a living. An example of when he visited Bang Pa-In recently. He went out to visit the people to observe how they made their living in many districts in Ayuthaya province. After his return he stated that there is a problem here. The rice in the Central region has a good harvest but why is the kernel so small, it must be because of the heavy flooding last time that may have washed the fertilizer away. He began to think of how to solve this problem.*
>
> *Two to three days later he visited Chainat province and took with him an officer from the irrigation department to see how to get the fertilizer that ran off into the river back into the paddy field. The King always dwelled on the wellbeing of the population, the safety, justice and contentedness of all groups of people, especially farmers and people in distant rural areas.*
>
> *The people are always in the mind of the King. He is thinking of everyone. All the challenges that are in his mind will target the wellbeing of the people of the land.*
>
> *Now he is going to Chiangmai again. Don't think that he is going just to relax. Everywhere he goes he will visit the people look at the crop fields and how the grains are growing, provide his advice and give assistance, almost every day without omission.* [55]

I will rule the land with
just and fairness for
the benefit and happiness
of the people of Siam

6

Remarkable Talents

Professor Sanya Thammasak once stated that

> *I believe that our king is truly remarkable in all facets. I am not just saying this to be kind, I believe that he is truly competent. Speaking in plain language he is intelligently sharp and can overcome problems swiftly. He can see the problem and the solution at its core. Even difficult problems can be solved and he does this in such a tactful and instantaneous way. Some of these problems were solved so seamlessly.* [(51)]

When the incident of 14 October 1973 sent the country into great turmoil the King came out to stop the incident resulting in the problem being resolved instantly, it certainly seemed like a miracle and was greatly appreciated by the Thai people throughout the country. It was a remarkable turn of events as seen also around the world. Later when the May incident of 1992 occurred the King again was able to 'hault the army' of both sides resulting in peace in another remarkable turn of events.

Afterwards when conflicts arose that have led to violence people would call out for the King to come out to stop the conflict and so he did, at the appropriate time and manner, with neutrality and wisdom that was universally appreciated and praised by all Thai people.

7

Surrounded by Loyal and Trusted Persons that are Willing to Sacrifice their Lives

Other than the Princess Mother and the Queen that have stood beside the King he has selected persons that have given their lives to serve and be loyal that include royal aides, royal police as well as army, police that have protected him in the front lines. These individual are willing to sacrifice their lives, put themselves in danger amongst those that wish harm and natural disasters that may occur during his visits. One such occurrence was when a helicopter that was part of the royal procession of Queen Sirikit crashed into a mountainside of Lijau and fell into the thick forest at Baan Ayepakoh of Phukaothong sub-district of Sukirin district of Narathiwat province on 19 September 1997 that resulted in the deaths of 14 royal trusted persons and flight crew.

- Lady Suprapada Kasemsan Na Ayudhaya,
  Her Majesty's Private Secretary
- Lady Tawee Maneenuch,
  Her Royal Highness Princess Chulabhorn Walailak's nanny
- Lady Viyada Kridakorn, Lady-in-waiting
- Lady Tadsamai Sawatseranee, Lady-in-waiting
- VAdm. Wathinna Puingprakiat
- Ms. Chaychan Boonluepun
- Ms. Piyanart Nilubol
- Lt.Col.Dr.Pakorn Phavichitr
- Senior Col.Anon Yangpattana
- Col.Yingyot Sricharoen
- Col.Udom Krajangsut
- Wg.Cdr.Uaychai Sinnak, Pilot
- Sg.Ldr.Sutin Kongnian, Co-pilot
- Flt.Lt.Nirut Donpanat[57]

Conclusion

Though King Bhumibhol was only the son of a prince he also had many other limitations. He lost his father at the tender age of 2 years and experienced life and national crisis on numerous occasions. His purity of mind and wisdom and divine grace as that of a bodhisattva allowed him to rule the country under democratic rule under the constitution with great excellence. He rose above conflicts to fulfill his duties at great stress to his physical comfort to reduce the pain and suffering of his people and to build happiness for the nation far and wide in a sustainable manner. He was the center that unite the spirit, the love, the unity of the people of the nation. He ruled in a just manner for the true benefit and happiness of the people. The countless works on health of Thais has created not only strength in body, mind and society of the people but also allowed them to be the power that builds a nation, to develop and progress in a sustainable way. King Bhumibhol has achieved his greatest desire.

> *I will rule this land with just and fairness for the benefit and happiness of the people of Siam*

Most worldly statesmen are concerned with how history will remember them. But the King remains above statesmen such as when he celebrated his birthday of 2523 and spoke to those who came to wish him a happy birthday at Dusit palace:

Many years ago when I visited the United States
a television station came to interview me and asked.
In your reign what do you want, what is your objective?
How would you like to be remembered in history.
I answered that my desire is
I do not want this reign to be remembered.
The interviewer was surprised
but all of you here are most likely not surprised
because I have already explained that if there is peace
and quiet in the nation that is not history.
I do not want to be a part of history.
Whenever there is war, turmoil and conflict
that has always been a part of history.
Thus, what I want is Thailand to be at peace,
nothing exciting, no fame or fortune.

Remarks of the King make clear he is more than just
a statesman but rather a Great Statesman.

Citation:

Thai Health Project. 2017. Title of article. In Thai Health Report. (page number). Nakorn Pathom: Institute for Population and Social Research, Mahidol University.

Citation Example

Thai Health Project. 2017. 11 Indicators on Thai Health and the Sustainable Development Goals. In Thai Health 2017. (page 78-79). Nakorn Pathom: Institute for Population and Social Research, Mahidol University.

11

11 Indicators on Thai Health and the Sustainable Development Goals

11 Indicators on Thai Health and the Sustainable Development Goals

The Post -2015 Development Agenda began upon completion of the monitoring and implementation of the Millennium Development Goals (MDGs). A new paradigm has emerged known as the Sustainable Development Goals (SDGs). This began to be used as the important framework under the leadership of the United Nations at their consultation meeting with heads of state around the world. Working together with organizational representatives and numerous working groups resulted in determining the SDGs that consist of 17 goals on development as well as targets and indicators to monitor the progress, results and desired achievements by the year 2030 of 230 indicators.

All of the 17 Goals of the SDG are inter-related in the areas of social, economic and environmental development, which include also the aspect of management process in dealing with the issue. They cover various development agenda - that were seen as important gaps during the period of the MDGs - under the 5Ps principle of People, Planet, Prosperity, Peace and Partnership. The SDGs place increased importance in participation and promoting cooperation of all stakeholders at all levels from the national to the global level. It emphasizes long term results and sustainable development through distribution of equality and justice to all groups of the population.

SDG1: End poverty in all its forms everywhere
SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture
SDG 3: Ensure healthy lives and promote well-being for all at all ages
SDG 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
SDG 5: Achieve gender equality and empower all women and girls
SDG 6: Ensure availability and sustainable management of water and sanitation for all
SDG 7: Ensure access to affordable, reliable, sustainable and modern energy for all
SDG 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all
SDG 9: Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation
SDG 10: Reduce inequality within and among countries
SDG 11: Make cities and human settlements inclusive, safe, resilient and sustainable
SDG 12: Ensure sustainable consumption and production patterns
SDG 13: Take urgent action to combat climate change and its impacts
SDG 14: Conserve and sustainably use the oceans, seas and marine resources for sustainable development
SDG 15: Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
SDG 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
SDG 17: Strengthen the means of implementation and revitalize the Global Partnership for sustainable development

For Thailand, a reference of data that reflects the baseline status that can be used to monitor the progress in achieving success according to the SDG framework of sustainable development is of vital importance. This Thai Health 2017 Report, thus, presents 11 indicators on Thai Health and the Sustainable Development Goals that focus mainly on the area of health in various dimensions, mostly under the SDG3. "Ensure healthy lives and promote well-being for all at all ages". Other health indictors presented in this report fall into other SDG targets as well.

In the area of maternal and child health, children under 5 years and maternal mortality in Thailand in general has already met the SDG targets. The challenging task however, is the inequality in health of mothers and children that exists between various population groups. Data collection and its reliability, especially on source of death statistics are still of varying quality and needs to be improved. In the area of HIV/AIDS, the situation has improved with a continuing trend of lower numbers of transmission. Similarly, Malaria shows a reduction in incidence while in Tuberculosis there still remains difficulty in accessing to treatment of people with the disease.

Non-Communicable Diseases (NCDs), however, has become a major health problem that shows no significant improvement. Economic and social losses occur as a result of premature deaths and illness from NCDs which results in a high cost to the country. The same can be said for substance abuse including drug addiction and dangerous levels of alcohol consumption. Data show that Thailand has a lot of work to be done on various fronts, especially working to prevent and promote better access to treatment, care and therapy services.

Injuries and deaths from road and traffic accidents have been reported as one of the highest in the world. To overcome this, major challenge depends on the success of raising awareness on road safety and reducing risky behaviors of people, as well as higher and more appropriate investment in the development of rail transport so that all people have access to this as an alternative and safer option.

Sexual and reproductive health as part of health development is another agenda item under the SDG3. For Thailand, the main population group of focus is adolescents and youth, especially in managing the challenge of unwanted pregnancies, abortion and sexually transmitted diseases. The impact on health from water contamination and pollution has also increased globally and Thailand is not exempted. This occurs partly as a consequence of development of a country and partly due to a lack of standards for management and appropriate controls. The promotion of access to clean water and safe sanitation services for all the people is necessary to counter this.

Thailand can be considered as a success story in achieving Universal Health Coverage (the UHC) where all Thais have rights to access needed health services and necessary medicines with the financial protection from major health care expenses. However, achieving sufficient sustainability, fairness and efficiency of the management process and system of the UHC, especially in health financing, is still an important goal to strive for. The same can be said for the distribution of health personnel that has continued to improve. However, there still exist inequities and large differences between regions and areas of the country. Efforts need to be undertaken to appropriately distribute human resources in health in both numbers and its quality.

In the last section, there is a discussion on the overall picture of the SDGs on health. Though some of Thailand's indicators are better or meet the SDGs' global targets, there are still many areas that the indicators, including those not under SDG3, such as the impact on health from disasters, unclean source of drinking water and interpersonal violence remain a problem and are far from the global target. It is the duty of all stakeholders and the people in general that must be aware of this challenge and work together to overcome it.

SDG 3 Ensure healthy lives and promote well-being for all at all ages

Health targets to be achieved by 2030	Indicators
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1 Maternal mortality ratio (per 100,000 live births) 3.1.2 Proportion of births attended by skilled health personnel
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.	3.2.1 Under-five mortality rate (per 1,000 live births) 3.2.2 Neonatal mortality rate (per 1,000 live births)
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.	3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations 3.3.2 Tuberculosis incidence per 1,000 population. 3.3.3 Malaria incidence per 1,000 population 3.3.4 Hepatitis B incidence per 100,000 population 3.3.5 Number of people requiring interventions against neglected tropical diseases
3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease 3.4.2 Suicide mortality rate
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.	3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders 3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol
3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents.	3.6.1 Death rate due to road traffic injuries
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programs.	3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods 3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, quality, and affordable essential medicines and vaccines for all.	3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population) 3.8.2 Number of people covered by health insurance or a public health scheme per 1,000 population

Health targets to be achieved by 2030	Indicators
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemical and air, water, and soil pollution and contamination.	3.9.1 Mortality rate attributed to household and ambient air pollution 3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services) 3.9.3 Mortality rate attributed to unintentional poisoning
3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older
3.b Support research and development of vaccines and other drugs including health technology on communicable and non-communicable diseases that have an effect on health of the population in developing countries to enable greater access to essential medicines and vaccines at affordable prices according to the DOHA Declaration of TRIPS Agreement and Public Health.	3.b.1 Proportion of the population with access to affordable medicines and vaccines on a sustainable basis 3.b.2 Total net official development assistance to medical research and basic health sectors
3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.	3.c.1 Health worker density and distribution
3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.	3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness

Source: The United Nations' Website: Official List of SDG Indicators

In addition to the health indicators under SDG3, there are also other goals of the SDGs that contain indicators related-to-health such as the prevalence of undernourishment, stunting, wasting and overweight among children (SDG2), violence against women and children (SDG5), access to clean and safe drinking water and sanitation services (SDG6), occupational and health disabilities (SDG8), deaths, missing persons and persons affected by disaster (SDG11 and 13) and death rates due to various categories of violence (SDG16).

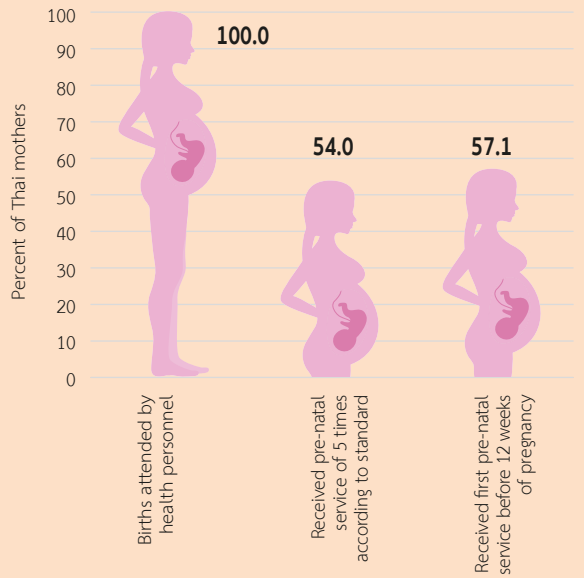
This Thai Health 2017 Report attempt to present all the main indicators under SDG3 (where these indicators will be presented in the background color). However, due to the limitations of data, available source of information and definition used; some indicators are not presented in this report and some presented might be defined differently from the SDG indicator's official definition.

1 Maternal Health

The target for Thailand is to reduce the maternal mortality ratio from 24.6 down to 15 per 100,000 live births.

Though the maternal mortality ratio in Thailand is already below the international SDG target (70 per 100,000 live births), it is still considerably higher than the national target. There are also differences that reflect maternal health inequality across regions of the country.

Births attended by health personnel and receiving of pre-natal service by Thai mothers, 2015

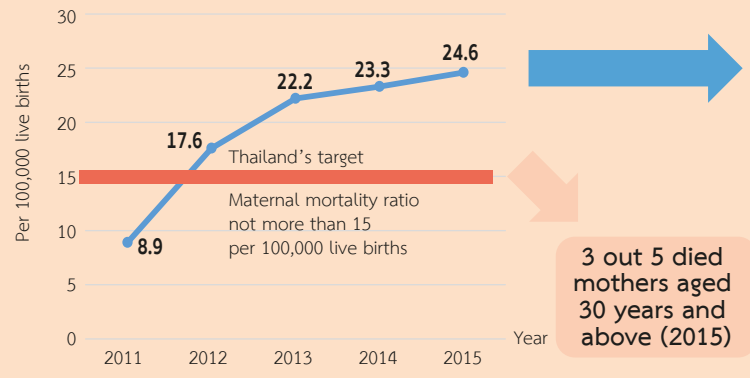


Source: Supervision Report Tor.Kor.2 Form, Office of the Permanent Secretary, Ministry of Public Health, 2015.

Presently, almost all births in Thailand are undertaken by skilled health personnel which prevents complications that may occur during birth including post-natal services for both the mother and the child. The challenging task however is in the area of receiving pre-natal services. In the year 2015, there were mothers who received pre-natal service before 12 weeks of pregnancy with continuing service of 5 months, according to standards, of only 57.1 and 54.0 percent, respectively.

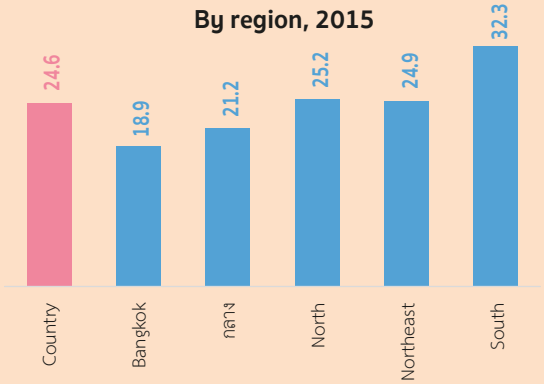
In the year 2016, under the Strategy of Health Development for Specific-Age Groups, the Ministry of Public Heath set the goal for the maternal mortality ratio in the country at not more than 15 persons per 100,000 live births. While data from available sources and most research show a higher number. Statistics from the Bureau of Policy and Strategy of the Ministry of Public Health report Thai

Maternal mortality ratio and trends, 2011-2015



3 out 5 died mothers aged 30 years and above (2015)

By region, 2015



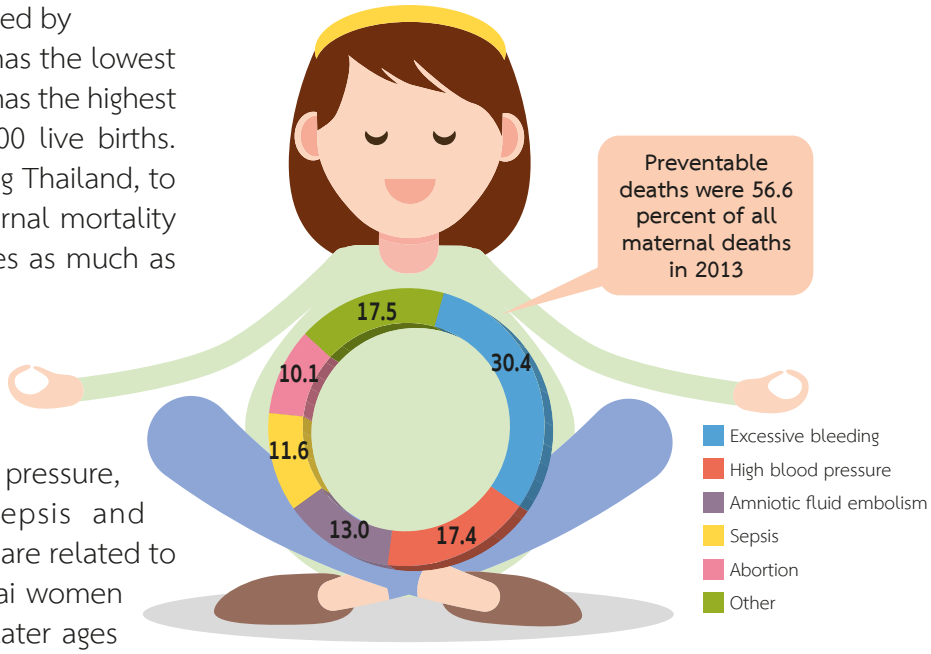
Source: Public Health Statistics A.D. 2015

Note: Since the year 2006 onwards, data on maternal mortality ratio in Thailand by the Bureau of Policy and Strategy, Ministry of Public Health was revised and re-calculated to be more precise by using the civil registration data together with analyzing data on cause of death in the death registration data. The revision and recalculation result in limitations in comparing of mortality ratios by year. This is one of the explaining reason for the increasing trends of maternal mortality ratio in 2011-2015.

maternal mortality ratio at 24.6 persons in the year 2015. When categorized by region, it is found that Bangkok has the lowest at 18.9 persons while the South has the highest rate of 32.3 persons per 100,000 live births. This is the major challenge facing Thailand, to reduce the overall rate of maternal mortality as well as reduce the differences as much as possible.

Considering the causes of maternal deaths more than half are preventable, especially excessive bleeding, high blood pressure, amniotic fluid embolism, sepsis and abortion. These factors possibly are related to the increasing frequency for Thai women to marry and have children at later ages (more than 60 percent of maternal deaths in the year 2015 are among mothers aged 30 years and over), including late and discontinuing pre-natal services received that still remain high.

Preventable deaths of Thai mothers by causes, 2013



Source: Sarawud Boonsuk and Nongluck Roongsupsin, 2015

There is discrepancy in maternal mortality data - depending on source of data and method of calculation used - making comparisons and references limited.

Maternal mortality ratio per 100,000 live births from various data sources and studies

Year	Public Health Statistics	(1)	(2)	(3)
2006	11.7	44.1		24.0
2007	12.2		33.6	24.0
2008	11.3		42.5	24.0
2009	10.8		39.9	23.0
2010	10.2		39.1	23.0
2011	8.9		31.2	22.0
2012	17.6		30.7	22.0
2013	22.2	31.2	34.8	21.0
2014	23.3		31.8	21.0
2015	24.6	22.7		20.0

(1) A survey conducted by the Bureau of Health Promotion, Department of Health. Data on deaths of women in reproductive ages from death certificates of the Ministry of Interior linked with data of the Bureau of Policy and Strategy, Office of the Permanent Secretary of the Ministry of Public Health and data from the National Health and Security Office.

(2) Chandoevwit et al. 2016. Data from national civil registration, data as reported by the Ministry of Public Health and data from in-patients of the Civil Servant Medical Benefit Scheme and the Universal Health Coverage Scheme.

(3) WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Estimation of maternal mortality ratio by statistical modeling.

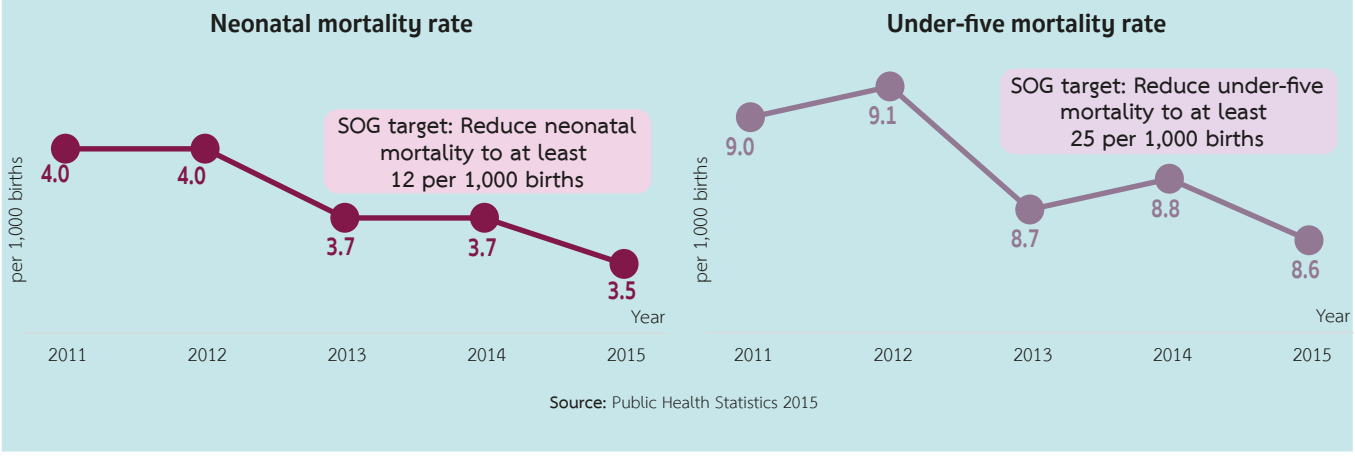
Source: (1) Government Inspection Report Form at Provincial Level, Fiscal Year 2016
(2) Chandoevwit et al. 2016. "Improving the measurement of maternal mortality in Thailand using multiple data sources". Population Health Metrics (2016) 14:16
(3) Trends in Maternal Mortality: 1990 to 2015; Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division

2 Births and Quality of Children

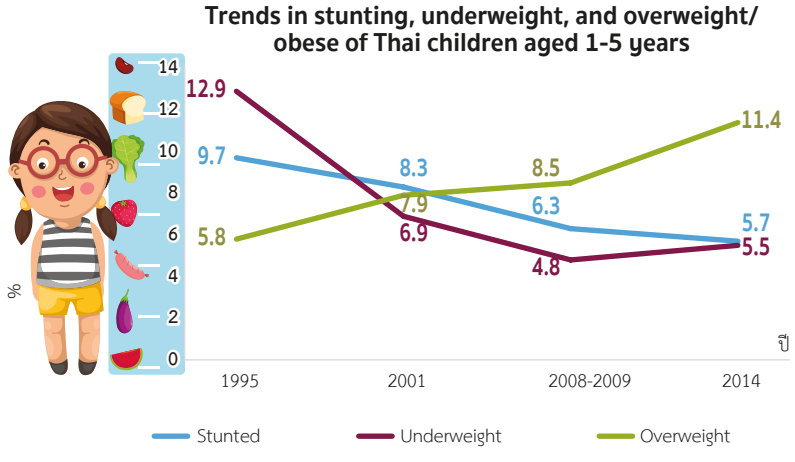
The neonatal mortality rate for Thailand is 3.5 per 1,000 live births and the under-five mortality rate is 8.6 per 1,000 live births. These rates are already lower than the goals set by the SDGs.

Thailand has surpassed the SDG goal in reducing the neonatal mortality rate and the under-five mortality rate. However, there are still challenges in the health inequity and the quality of children.

High quality birth is the starting point for a high quality population. All children should be given the chance of good health and good development appropriate for their age. Currently, the under-five mortality is no longer a problem for Thailand, but the quality of health and development of the child still have room for improvement. In the area of child health Thailand has seen a reduction in malnutrition where fewer children are stunted and underweight. On the contrary, we have seen in Thai children an emerging problem of obesity in recent years, where there is a higher tendency of children 1-5 years of age to be overweight or obese, which has almost doubled in the past 20 years.



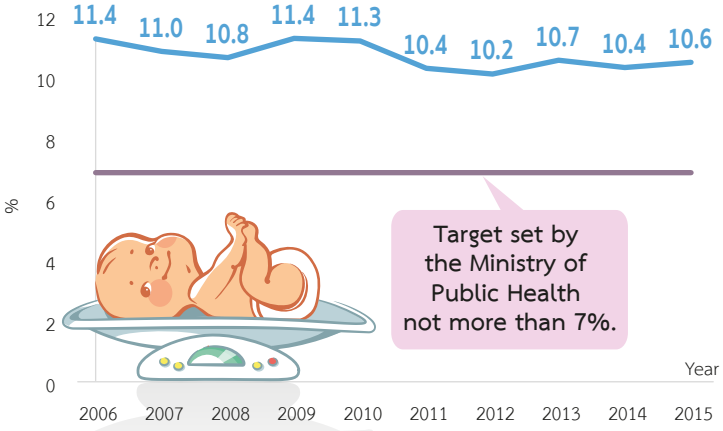
Source: Public Health Statistics 2015



Source: - The 2nd, 4th and 5th National Health Examination Survey.
- Holistic Development of Thai Children Project, 2011

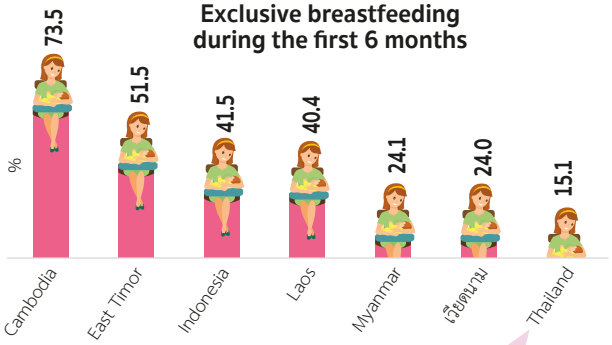
Data on neonatal mortality rate and under-five mortality rate in Thailand differ depending of the source of data and method of measurement. Other data sources besides the MOPH's Public Health Statistics include estimations of the UN Inter-agency Group for Child Mortality Estimation and The Global Burden of Diseases 2015 Study.

Low birth weight of less than 2,500 grams



Source: Public Health Statistics 2006-2015.

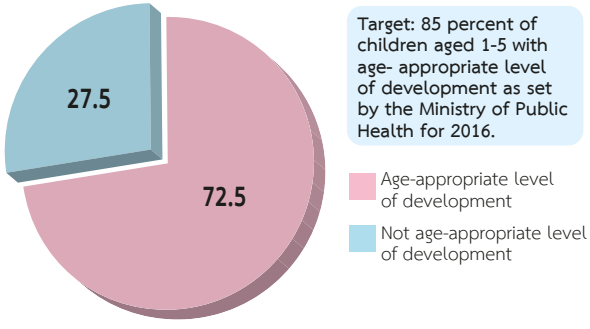
Exclusive breastfeeding during the first 6 months



Source: Walters et al, 2016

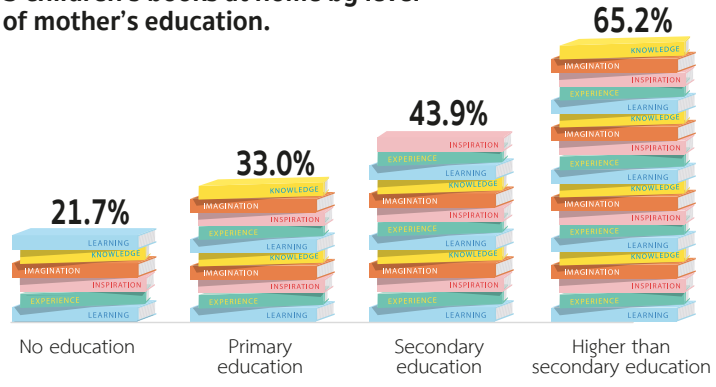
It has been estimated that there is a cognitive loss of 192.6 million us dollars and an increase in health expenditures of 7.65 million us dollars a year from not exclusively breastfeeding for the first 6 months of birth.

Percent of children 0-5 years that have age-appropriate level of development



Source: Department of Health, Ministry of Public Health,2014

Children under 5 years of age with at least 3 children's books at home by level of mother's education.



Source: Multiple Indicator Cluster Survey, 2012

For children in the first six months of life, mother's milk is the best source of nutrition. Mother's milk promotes the physical, mental and emotional development of the child and also assists in protection against various diseases such as diarrhea and pneumonia. It is for this reason, the WHO recommends exclusive breastfeeding for the first six months of life. In any case, Thailand still ranks low in breastfeeding of only 15 percent, which results in major costs from public health expenditures and cognitive loss.

Promoting child development in the first five years of life is important in laying the foundation of life. It is still found that 27.5 percent of children 0-5 years of age in Thailand in the year 2014 have a low level of childhood development. Promoting childhood development in Thailand is thus a priority that will result in higher quality birth and children and lead to sustainable development.

3 AIDS, Tuberculosis and Malaria

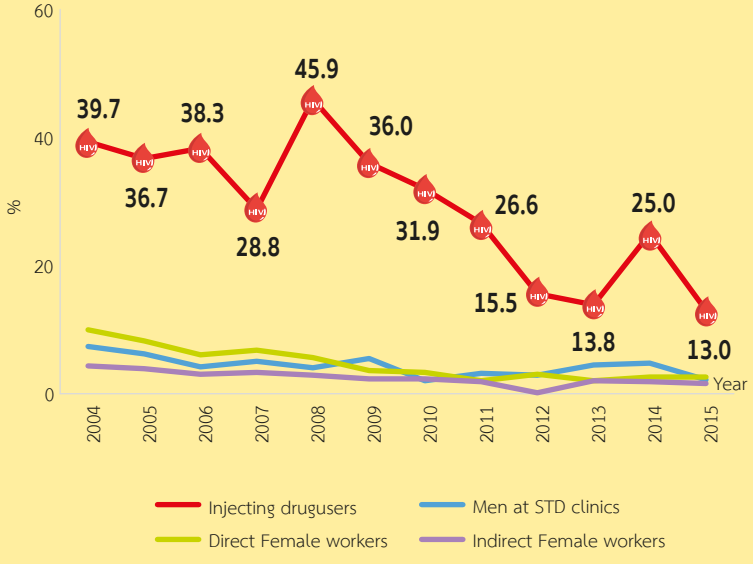
Situation of AIDS and Malaria shows an improved trend, while still more than half of the Tuberculosis patients do not access treatment.

The projection of new HIV infections show that it will reduce to 3,736 cases in the year 2030. The reductions are seen in all age groups. The policy of "Ending AIDS" should be able to be achieved without too much difficulty. However, in the policy of "End TB", there is much more work to be done if the goal is to be achieved.

Thailand has achieved success in the comprehensive control of the spread of HIV transmission in the past ten years but the monitoring of most at risk populations need to be continued, especially in the group of injecting drug users or IDUs that is found to have higher level of HIV infection than other groups. HIV infected persons in Thailand are mostly in the working-age group of 30-34 years which is the most productive age groups and of importance to the country. While the migrant population that could replace this population, it is found that they can only access VCT (Voluntary Counseling and Testing) services of only 6 percent. Related agencies should place higher importance on the health of migrant populations as this is a group that has high movement and have a high chance is spreading HIV to other groups.

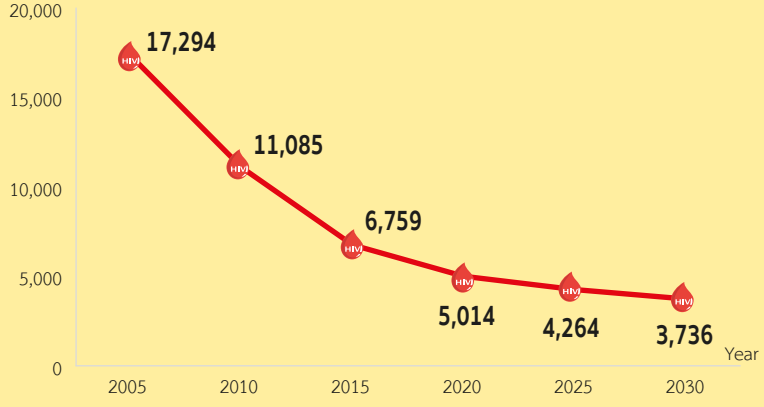
"The Institute for Population and Social Research, Mahidol University found that migrant populations, that are a substitute population in Thailand that is lacking in labor, can access VCT service at a very low level of 6 percent. (The Survey of PHAMIT Project, Year 2015)."

Sentinel surveillance of HIV infection in most at risk populations

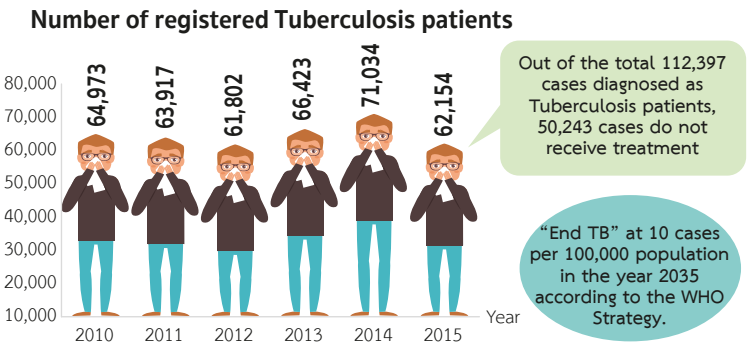


Source: Bureau of Epidemiology, Department of Disease Control, Ministry of Public Health, 2016.

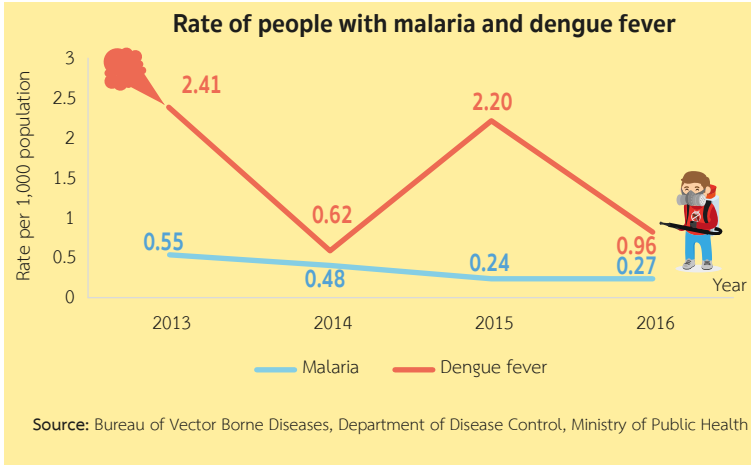
Projection of new HIV infections aged 15 years and above



Source: Bureau of Epidemiology, Department of Disease Control, Ministry of Public Health, 2016.



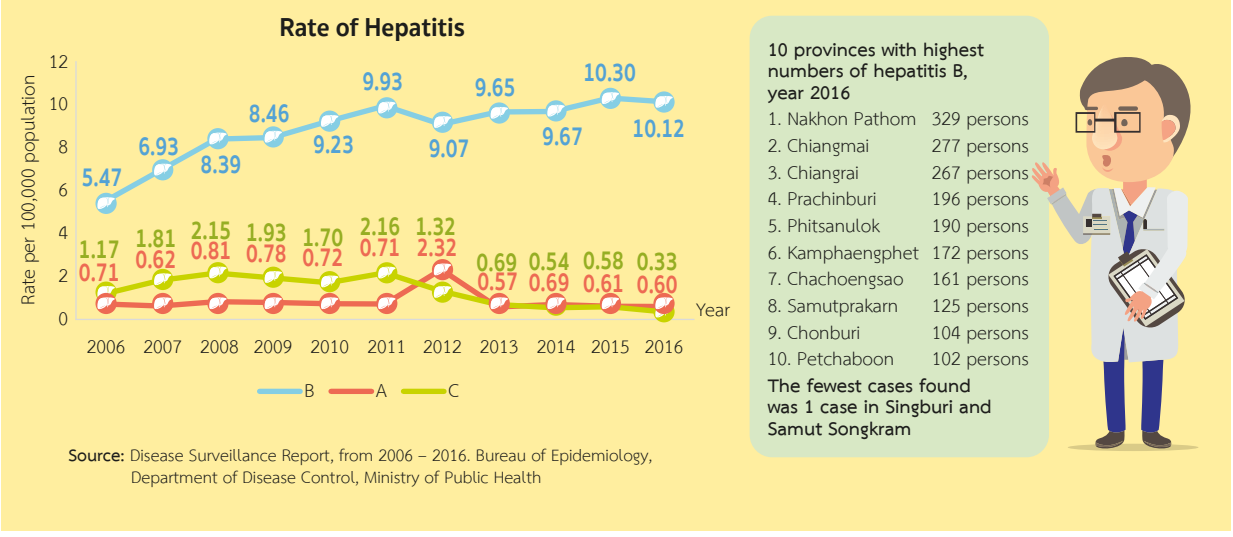
Source: Bureau of Tuberculosis, Department of Disease Control, Ministry of Public Health



Source: Bureau of Vector Borne Diseases, Department of Disease Control, Ministry of Public Health

Considering the situation of Tuberculosis, access to treatment continues to be an important issue. In 2015, the proportion of patients that registered and received treatment are only 55.3 percent indicating that almost half of the TB patients have not been treated even though the disease can be cured. The goal of reducing incidence down to 10 per 100,000 persons in the year 2035 according to the strategy of "End TB" that the WHO has set is a major challenge for Thailand.

In the area of preventing Malaria, the situation has improved. It is found that the reported case has reduced two fold from 0.55 per 1,000 population in the year 2013 down to 0.27 in the year 2016. At the same time, Dengue fever shows an erratic up and down trend where in the year 2016 it was found that Dengue fever was almost three times higher. Prevention work on Dengue fever must be increased and continued.



Source: Disease Surveillance Report, from 2006 – 2016. Bureau of Epidemiology, Department of Disease Control, Ministry of Public Health

Another communicable disease that cannot be overlooked is Hepatitis B that is more dangerous than other form of Hepatitis. Persons with Hepatitis B may have a long illness that could lead to liver cancer. More dangerous is that some patients do not show any symptoms and do not know they have the illness and that it may be transmitted to other persons. For Thailand, even though there has been a vaccine for several years, it was found that the cost remains high so that the rate of Hepatitis B continues to rise in the last ten years. Hepatitis B is thus another disease that is an indicator of the SDG that cannot be overlooked.

4 Non-Communicable Diseases

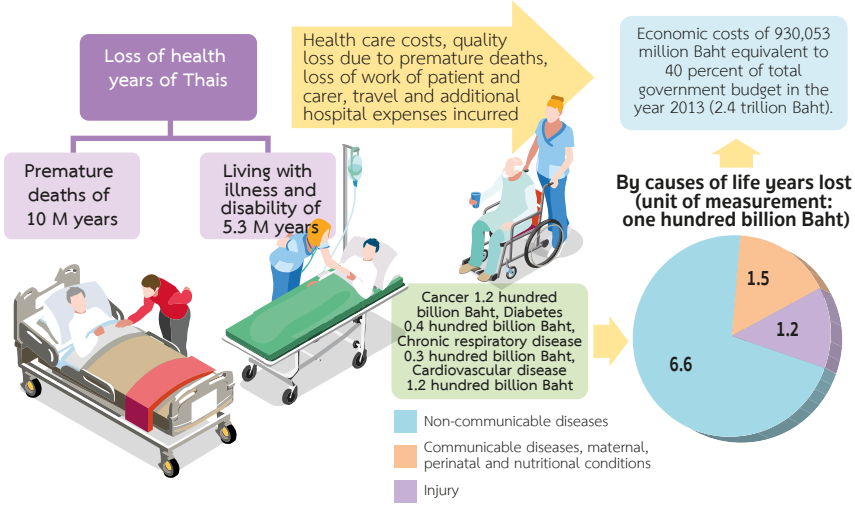
Premature deaths and disabilities of Thais were estimated to cost 9.3 hundred billion Baht in 2013. Almost 3 out of 4 causes have been from non-communicable diseases.

Illness and death from non-communicable diseases of Thais shows an increasing and continuing trend. This runs in the opposite direction of global goals of reducing premature deaths from non-communicable diseases of 25 percent by the year 2025. Managing health systems for increased effectiveness in preventing non-communicable diseases including risky behavioral factors is an urgent agenda for the country.

"Non-communicable diseases" is an important health problem that many countries are confronted with. A study on burden of diseases and injuries of the Thai population shows that in the year 2013 the country has lost up to 15.3 million healthy life years of its population where two out of three are due to premature deaths. When estimating the economic costs, this is considered very high or approximately 40 percent of the country's GDP in that year. The main causes of loss of healthy life years is due directly to non-communicable diseases, especially the four important diseases of cancer, diabetes, chronic respiratory disease and cardiovascular disease.

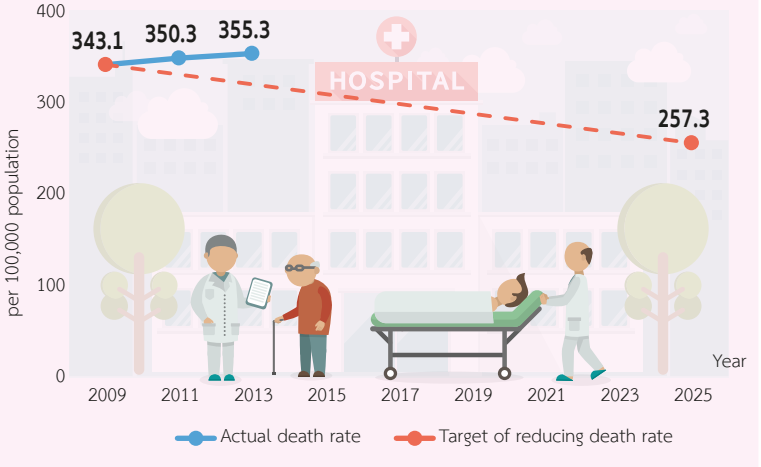
If we use the year 2009 as a base year for the Global NCDs Targets, the rate of premature deaths for non-communicable diseases in Thailand must reduce from 343.1 cases per hundred thousand persons down to 257.3 persons by the year 2025. The recent trends, however, do not support this happening. The death rate continues to increase while the prevalence of illness and risk behavior for non-communicable diseases of Thais in many facets shows no

Years of life lost and economic value of premature deaths and illness of the Thai population (Year 2013)



Source: Report on Burden of Diseases and Injuries of the Thai Population, Year 2013

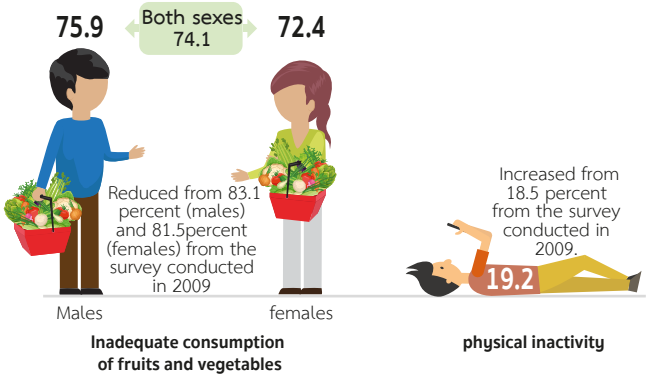
Mortality rate of population aged 30-70 years by 4 major non- communicable diseases



Note: Four major non-communicable diseases include heart and cardiovascular disease, cancer, diabetes and chronic respiratory disease; The target of reducing death rate down 25 percent according to the 9 Global NCDs Target.
Source: Office of the International Health Policy Development (2016), report on NCDs: Kick off to the Goals 2nd publication.

tendency in reduction. The 5th National Health Examination Survey for Thais in 2014 show that the proportion of Thais aged 15 years and above have high blood pressure and diabetes of 24.7 and 8.9 percent, respectively, which is an increase compared to the 4th survey in 2009. As well, the prevalence of being overweight and obese also show a continuing increase of 37.5 and 10.9 percent, respectively. This can be explained by unhealthy food consumption behaviors compound with an increase in physical inactivity of the Thais.

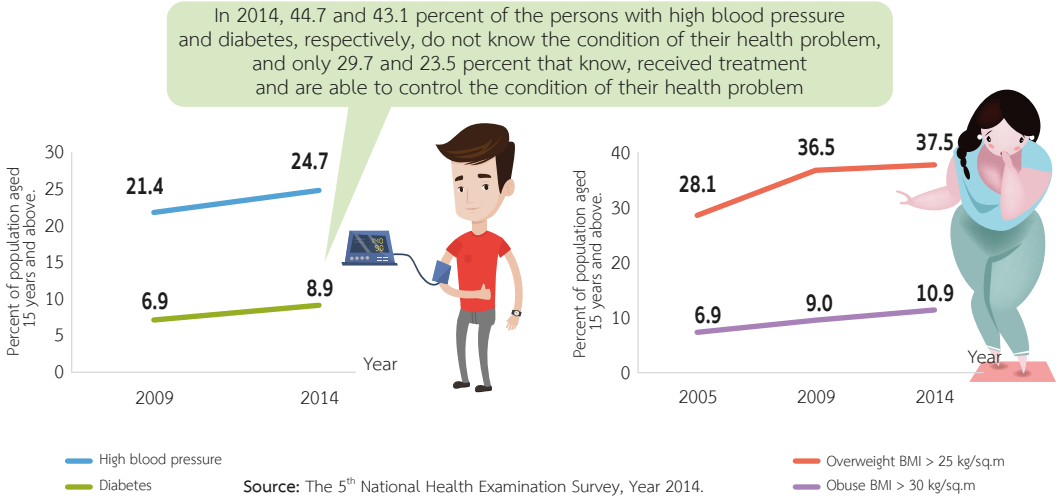
Inadequate consumption of fruits and vegetables, and physical inactivity, 2014



Note: Percent of population aged 15 years and above
Source: The 5th National Health Examination Survey, Year 2014.

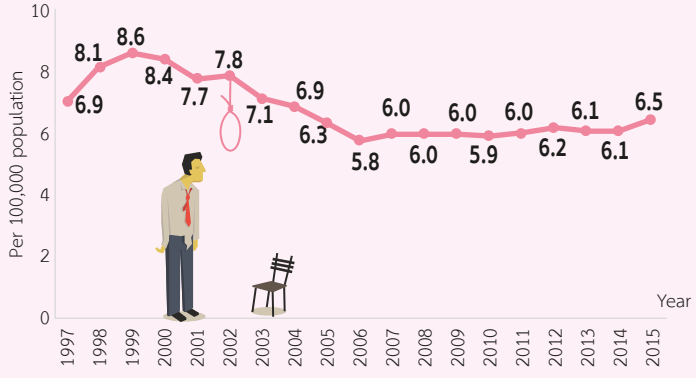
In the attempt to reduce premature deaths of Thais, the challenge of reducing numbers of suicide is another issue that cannot be overlooked because the trend has been increasing in the past 4-5 years where the rate of 6.5 per hundred thousand persons in the year 2015 was an increase from 5.9 persons in the year 2010 reflecting the need and the importance in support of prevention and care programs, and also the promotion of psychological health of Thais..

Prevalence of risk factors and non-communicable diseases in the Thai population, year 2014



Source: The 5th National Health Examination Survey, Year 2014.

Suicide mortality rate year 1997-2015



Source: Department of Mental Health, Ministry of Public Health, 2017

9 Global NCD Target for 2025 for Thailand

Mortality and illness	Premature from mortality from NCDs 25 percent reduction					
Health system management	Drug therapy and counseling (to prevent heart disease/heart attacks and strokes) 50 percentcoverage	Essential NCD medicines and technologies 80 percent coverage				
Biological and behavioral risk factors	Harmful use of alcohol 10 percent reduction	Physical inactivity 10 percent reduction	Salt/ Sodium intake 30 percent reduction	Tobac-couse 30 percent reduction	Raised blood pressure 25 percent reduction	Diabetes / obesity 0 percent increase

Note: Year of reference for these targets of 2009-2011.
Source: International Health Policy Program (2016). The 2nd Report on the Situation of NCDs: Kick off to the goals.

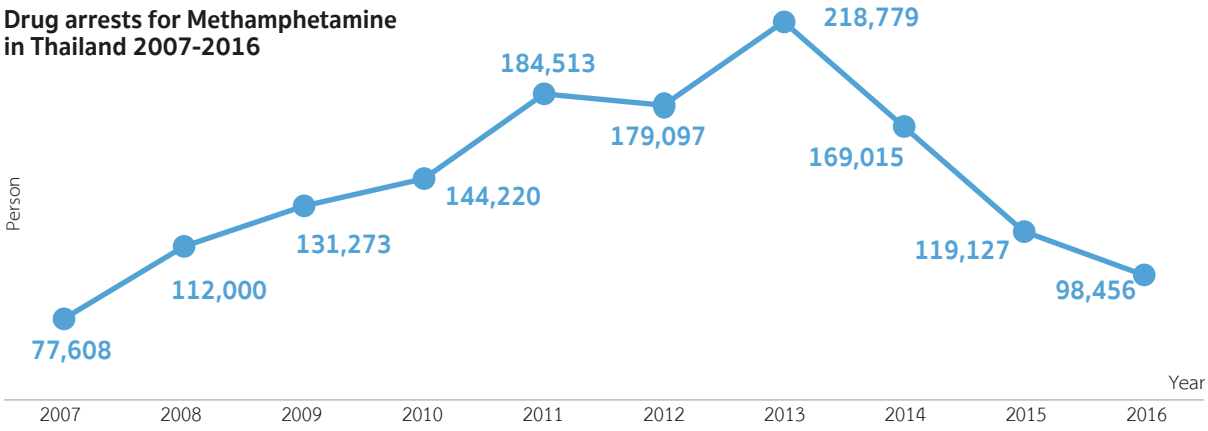
5 Substance Abuse

Alcohol consumption in the Thai population aged over 15 years in the year 2015 averaged 6.9 liters per person per year, which is higher than the world average of 6.3 liters.[1]

Prevention and treatment of substance abuse and harmful use of alcohol is one SDG goal that will lead to an improved quality of life in society. Thailand is still confronted with major challenges, in both demand and supply with regard to addictive substances, and the Thai population continues to consume alcohol at harmful levels.

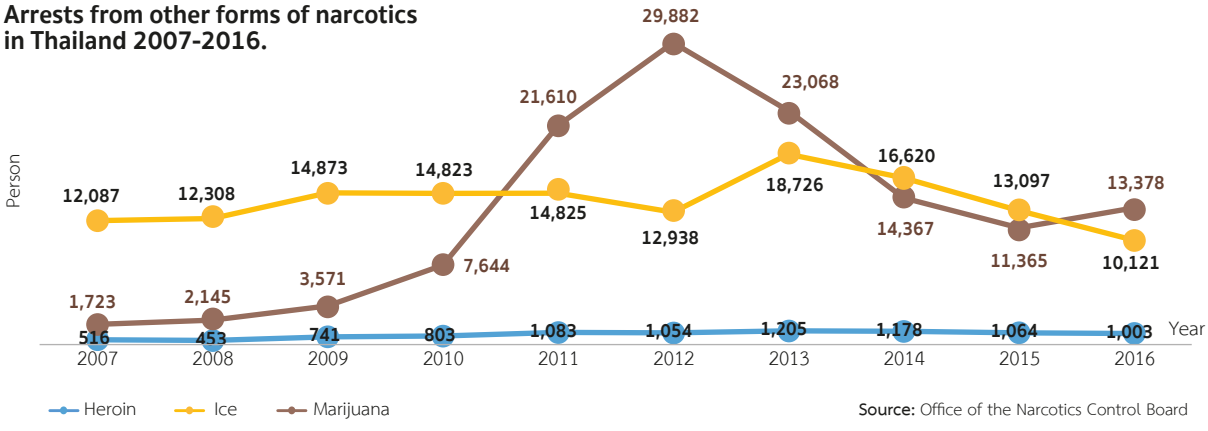
The problem of narcotic drug abuse is one issue that has always been of interest in society. Addictive drugs that are most widespread in Thailand are Methamphetamines or what is commonly known as 'Ya ba'. In the year 2013 there were 218,779 arrests for 'Ya ba'. Other arrests for addictive drugs include 'Kratom' and 'Kratom' fluid, whereas 'Ice' is an addictive drug that is becoming popular only in the last 5-6 years. Between the years 2011-2013, 'Ice' was the second highest arrests after 'Ya ba'. In the year 2010, 36 percent of IDUs in Bangkok stated that they were able to access Ice within

Drug arrests for Methamphetamine in Thailand 2007-2016



Source: Office of the Narcotics Control Board

Arrests from other forms of narcotics in Thailand 2007-2016.

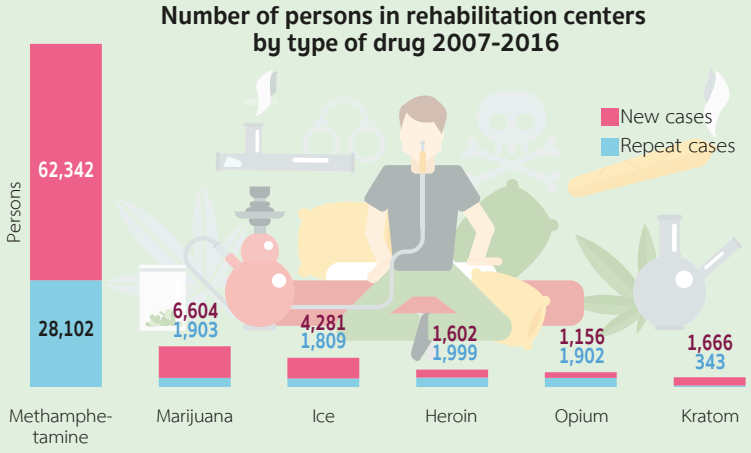


Source: Office of the Narcotics Control Board

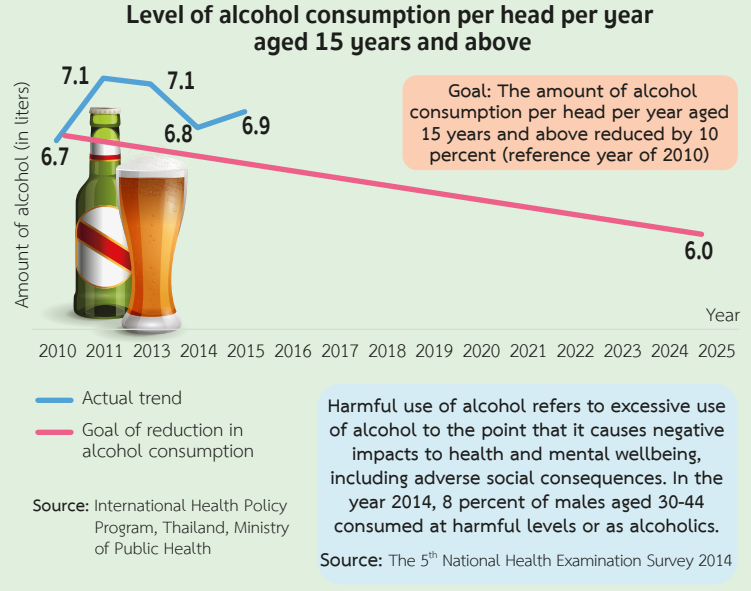
[1] World Health Statistics 2016

10 minutes, reflecting the wide spread arailability of addictive drugs in Thailand. Treatment for addictive drugs in Thailand is generally compulsory. Data from the Office of the Narcotics Control Board in 2016 found that more than half of those who were treated for opium and heroin were repeat cases that had been treated before, reflecting the challenge for the treatment process. Taking into account the user's perspective if they are unable or unwilling to stop the use of substances, harm reduction policies should be introduced, such as needle distribution to prevent HIV transmission.

In the area of alcohol consumption Thailand has set the goal of reducing consumption per head down to 6.03 liters by the end of year 2025 which from the trends seen since the year 2010 onwards, alcohol consumption of the Thai population has not reduced. Similarly, tobacco consumption of the population has remained stable. This is a challenging task for Thailand in the future (according to SDG 3a: Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate).



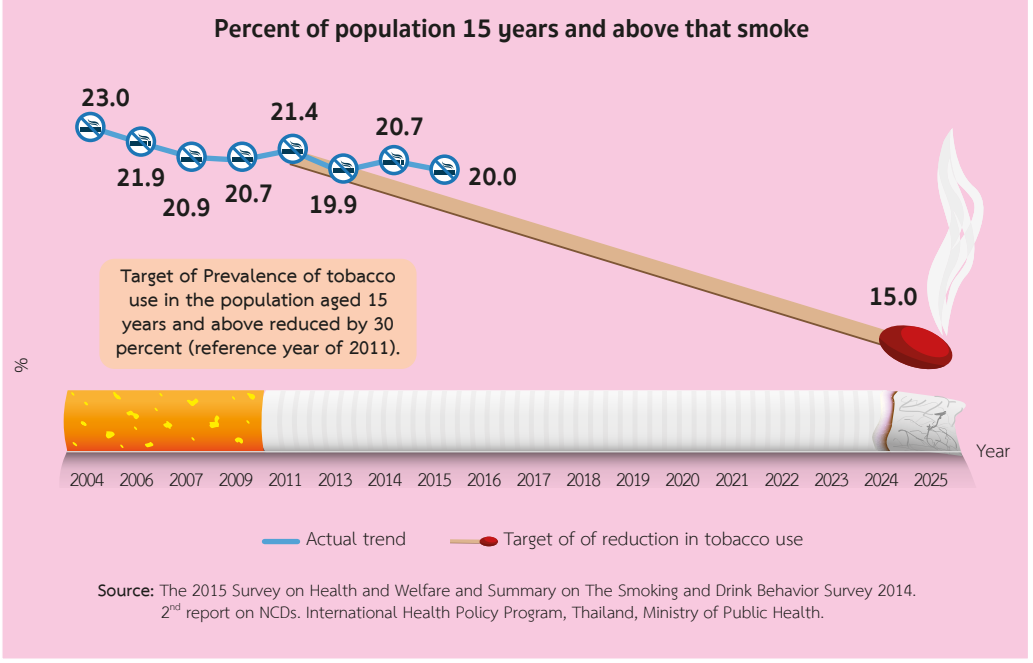
Source: Office of the Narcotics Control Board



Source: International Health Policy Program, Thailand, Ministry of Public Health

Harmful use of alcohol refers to excessive use of alcohol to the point that it causes negative impacts to health and mental wellbeing, including adverse social consequences. In the year 2014, 8 percent of males aged 30-44 consumed at harmful levels or as alcoholics.

Source: The 5th National Health Examination Survey 2014



Source: The 2015 Survey on Health and Welfare and Summary on The Smoking and Drink Behavior Survey 2014. 2nd report on NCDs. International Health Policy Program, Thailand, Ministry of Public Health.

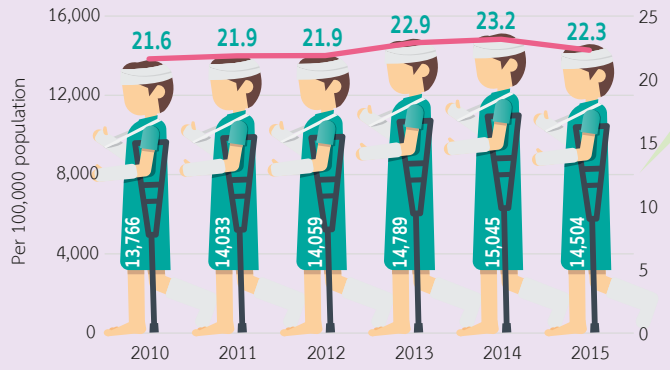
Reducing the harmful use of drugs is one policy or measure that emphasizes harm reduction in the use of addictive drugs for those that unable or refuse to stop. Examples of this measure of harm reduction include: needle and syringe distribution, replacement drugs such methadone and knowledge dissemination on health and drugs.

6 Road Traffic Accidents

Thais die from road traffic accidents of 14,000-15,000 persons a year or an average of 40 persons a day.

The number one cause of loss of life years of the adolescent population for both men and women (aged 15-29) is accidents on roads. Such premature deaths and injuries can be prevented from improvement of behavior of driving of Thais to development of the transport system of the country.

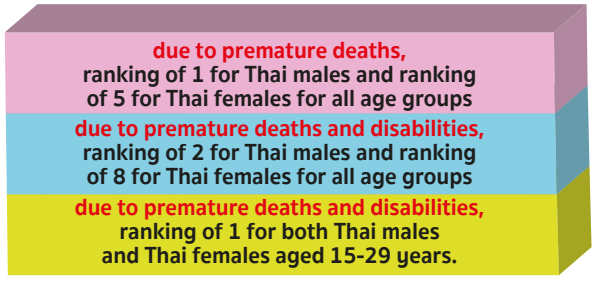
Number and rate of deaths from road traffic accidents (per one hundred thousand population), 2010-2015.



The WHO estimated the number and rate of deaths that are due to road traffic accidents in Thailand higher than the figures in this report of 1.6 times at 24,237 persons per year or 36.2 cases per one hundred thousand population. (2013).

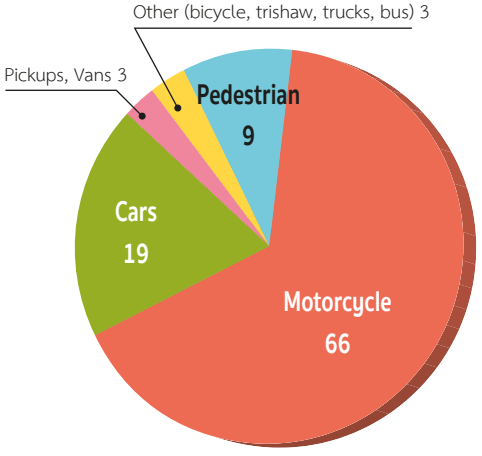
Source: Data 2010-2014 from the Annual Report of 2015, Bureau of Non-communicable Disease, Department of Disease Control; Data 2015 from the Cluster of Road Traffic Injuries Prevention, Bureau of Non-communicable Disease

Road traffic accidents" are the cause of loss of life years,



Source: Report on Burden of Diseases and Injuries of the Thai Population, Year 2013

Percent of deaths from road traffic accidents by type of vehicle used, 2014

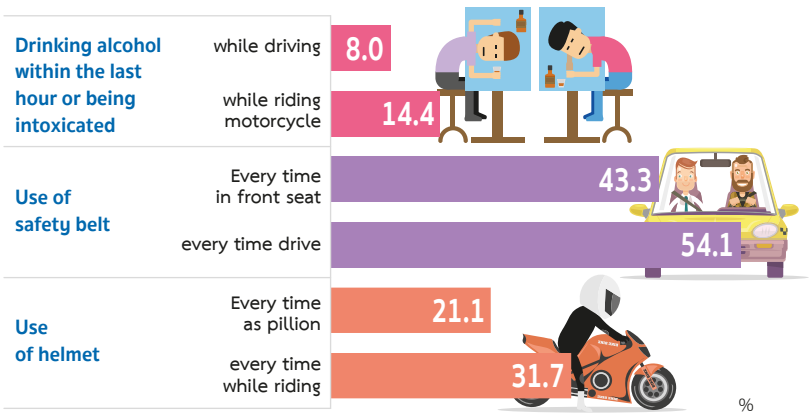


Source: Annual Report of 2015, Bureau of Non-communicable Disease, Department of Disease Control

The SDGs, have determined the goal in reducing deaths and injuries from road traffic accidents worldwide by halving this number by the year 2020. This is a major challenge for Thailand because the Global Status Report on Road Safety 2015 of the WHO estimated the rate of death from road accidents of Thailand as the highest in ASEAN countries and the second highest in the world. Data on trends in the past 5-6 years show that the situation has improved somewhat. Data on deaths are still high at approximately 14,000-15,000 persons per year. In the year 2015 it was found that the highest accidents two thirds of all deaths were motorcycle riders.

The main reason for accidents in Thailand are due to inappropriate traffic behavior and road manners in the sharing of roads with other users of Thais, and low compliance with the traffic laws. Thais still insufficiently see the importance of this, especially in the area of safety. The survey on risky behavior of non-communicable diseases and injuries in the year 2015 (The BRFSS: Behavioral Risk Factor Surveillance System) found that Thai people drive while always using seat belts of only 54.1 percent and ride motorcycles while always using helmets of less than one third or 31.7 percent. Another risky behavior that is worrying is driving while intoxicated or after drinking alcohol. It was found that there were still many 'drinkers' that still do this.

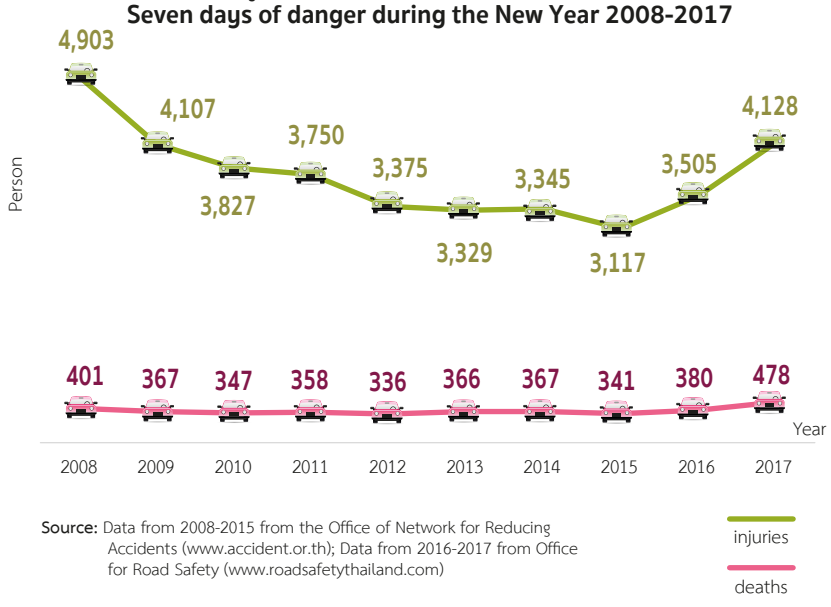
Risky Behavior of Road Users, 2015



Source: The BRFSS: Behavioral Risk Factor Surveillance System, 2015 (By Health Area)

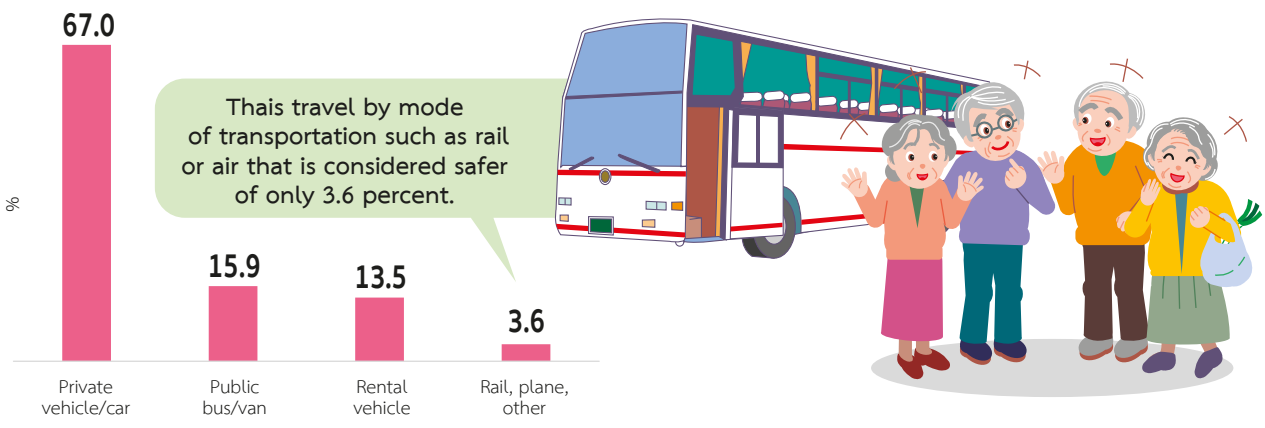
In addition to behavior change that is needed, there is urgent need for development of transport systems as a safer alternative to driving on public roads. An expanded rail transport and linkages will make travel more convenient and is one alternative that the country should invest in. If this can be done, during public holidays or festive seasons such as the New Year and Songkran, where many Thais travel back home, we may see the figures of injuries and death due to road traffic accidents decrease..

Number of injuries and deaths from road traffic accidents, Seven days of danger during the New Year 2008-2017



Source: Data from 2008-2015 from the Office of Network for Reducing Accidents (www.accident.or.th); Data from 2016-2017 from Office for Road Safety (www.roadsafetythailand.com)

Type of vehicles used during vacation of Thais, 2015



Source: The 2016 Survey on Transportation and Travel Behavior of Thai People, National Statistical Office.

7 Reproductive Health

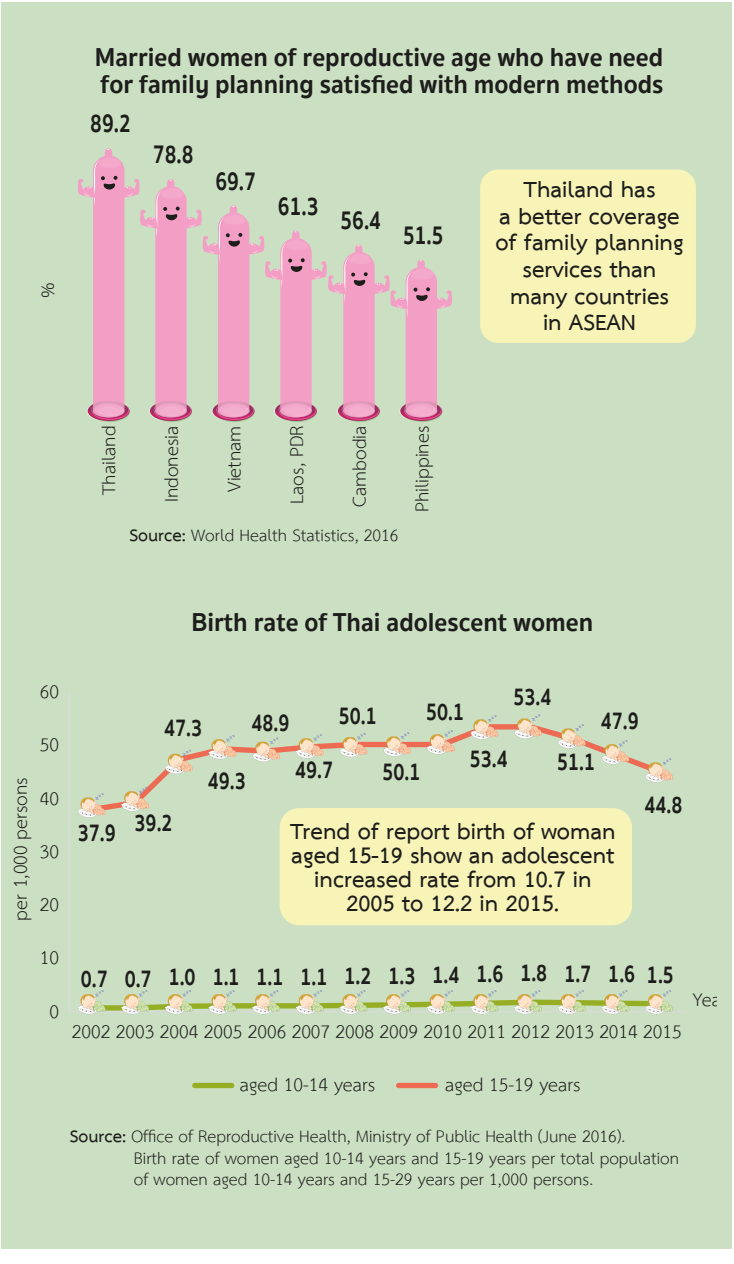
Teen pregnancy shows a reduced trend but abortions and sexually transmitted diseases cannot be overlooked.

Adolescent pregnancy leads to various reproductive health problems, from illegal abortion and complications of bleeding after delivery, premature births, low birth weight... 'fewer birth but must not with low quality' continues to be a challenge for Thailand.

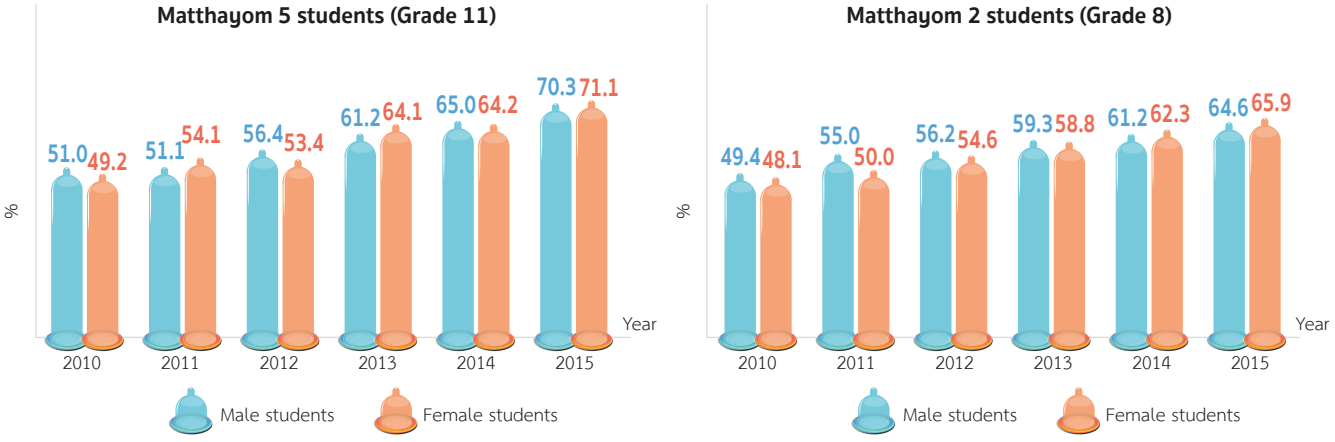
At the present, women in reproductive ages aged under 20 years are able to access contraceptive service such as injectable and IUD without charge, at all health facilities under the Universal Health Coverage program. In general, Thai women in the reproductive ages have access to and are satisfied with modern methods of family planning at a rather high proportion compared to many other countries in the ASEAN. Nevertheless, reproductive health among adolescents must still be given importance.

In the years 2014-2015, the adolescent birth rate of women aged 15-19 years in Thailand was lower than the target set by the Ministry of Public Health of not more than 50 cases per 1,000 population. But the repeat birth rate remains high and may partly be due to a lack of knowledge and correct understanding on preventing pregnancy including preventing risk to communicable diseases that may occur from sex. Even though the situation of condom use during sex for the first time amongst junior and senior high school students show a continuing and marked improvement during 2010-2015, morbidity rate, however, from sexually transmitted diseases of adolescents show an increase.

When faced with unintended or unplanned pregnancies, the decision is

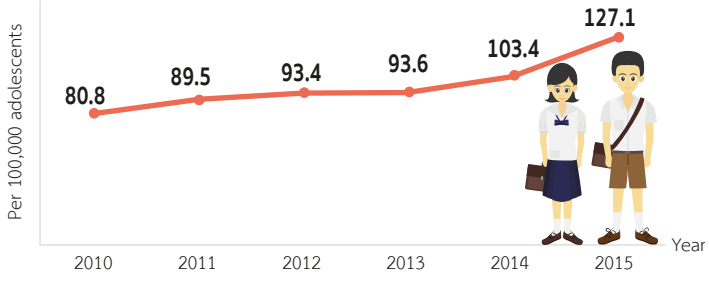


Condoms use at first sex of high school students



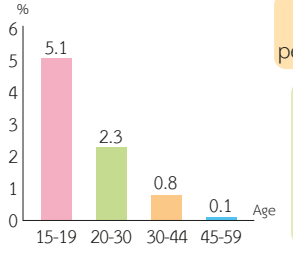
Source: Bureau of Epidemiology, Department of Disease Control, Ministry of Public Health, 2015

Rate of sexually transmitted diseases aged 15-24 years.



Source: Bureau of Epidemiology, Department of Disease Control, Ministry of Public Health, 2015

Percent of women who experienced abortion in the past years



For adolescent women who experienced abortion, 19.2 percent was "induced abortion".

For all age-groups, about reasons for induced abortion, half state that they were not prepared to have children. Of those who received abortions, 9.1 percent did not use services of modern medical personnel.

Source: The 5th National Health Examination Survey, 2014.

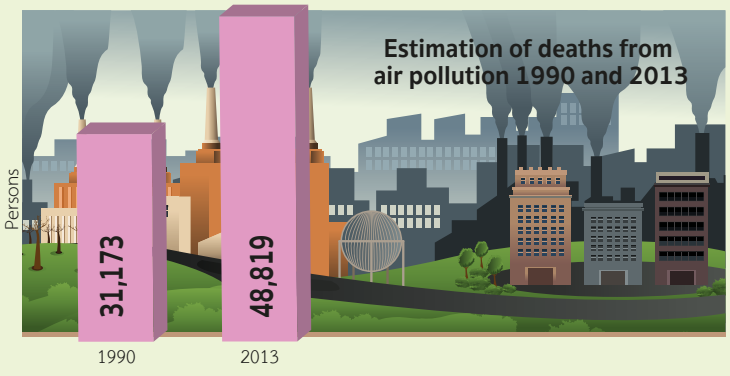
sometimes made to have an abortion where most abortions are not undertaken by medical personnel and are illegal and considered in Thailand as a criminal offence. Presently, there are various options for undertaking an abortion but that must be done under the supervision of a doctor by using medication to terminate the pregnancy in pregnancies of less than 9 weeks which can be done safely. This medication is registered with the Food and Drug Administration (FDA) and is also listed under the National List of Essential Medicines. For women that have unintended pregnancies and choose this option, they should educate themselves on the side effects before making a decision and this must be done under the supervision of a doctor. Nevertheless, developing awareness and providing knowledge in preventing an unintended pregnancy or unplanned pregnancy is more important and must be promoted.

What is of interest is that the National Legislative Assembly has supported and approved the Prevention and Solution of the Adolescent Pregnancy Problem Act B.E. 2559 on 31 March 2016, giving the right for adolescents and the authority of the related agencies responsible to undertake an abortion. It remains to be seen if this law will overcome this problem or not.

8 Pollution

The expansion in industrial production brings with it an increase in dangerous waste. In the year 2003-2015 dangerous waste from industry doubled in size.

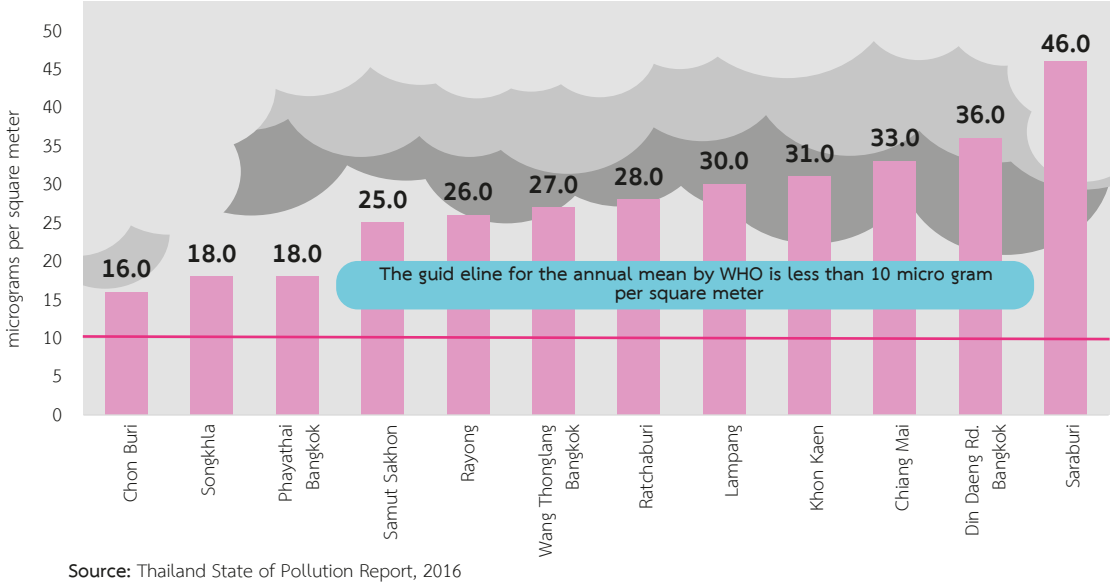
One outcome that arises from rapid economic development is the problem of pollution and dangerous chemicals. If there are no measures to adequately manage and control, there will be negative impacts to the health of the population. The SDG goal is to substantially reduce the number of deaths and injuries from hazardous chemicals and air, water, and soil pollution and contamination by the year 2030.



Source: The World Bank and Institute for Health Metrics and Evaluation, University of Washington

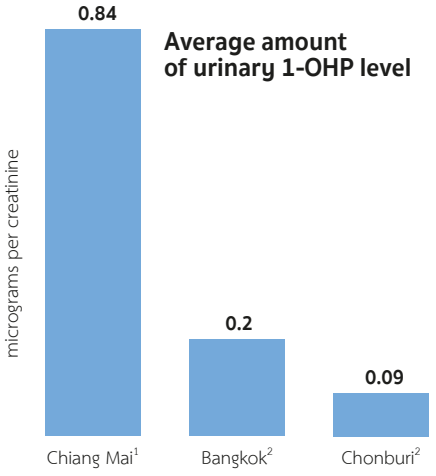
In developing countries pollution is one reason that contributes to illness and premature deaths. In Thailand, air pollution is one reason contributing to many deaths of people. The trend in deaths from air pollution in Thailand increased from approximately 30,000 persons in 1990 to almost 50,000 persons in the year 2013. One indicator for air quality is the amount of fine particles in the air. Fine particles with a PM 2.5 are minute particles that can enter in the respiratory tract and increase the chances of death from respiratory diseases, lung cancer, and ischaemic heart disease. Data from the Pollution Control Department show that all large cities in Thailand that were surveyed contained

Mean of fine particles not more than 2.5 micron (PM 2.5) 2015

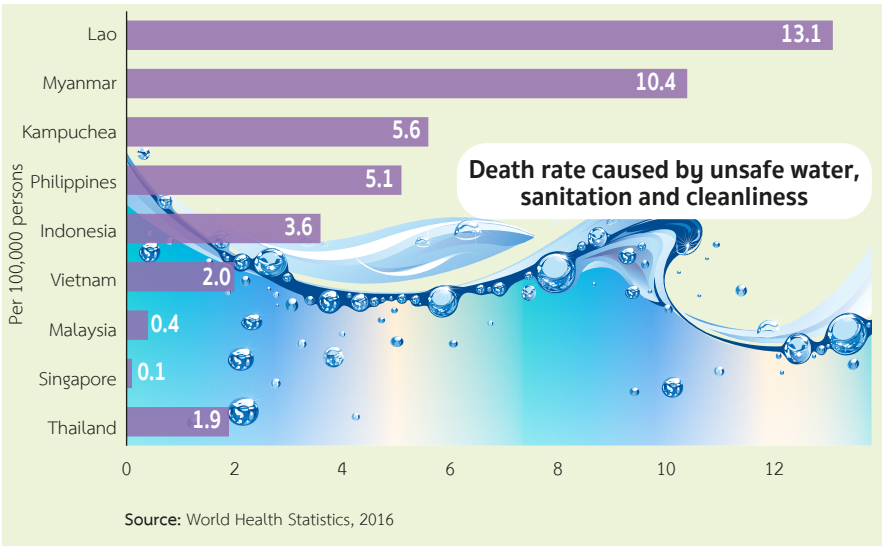


Source: Thailand State of Pollution Report, 2016

[1] The guideline for Thailand was set at 25 micrograms per square meter per year which is higher than the WHO guideline



Note 1: Study of school students aged 9-12 years in Omkoi and Mae Cham Districts, Chiangmai province
Note 2: Study done with School aged 10-12 years
Source: Naksen et. Al. (2016) and Ruchirawat et. al (2007)



Source: World Health Statistics, 2016

Source: Report on waste in Thailand 2016, Pollution Control Department

Source: Thailand State of Pollution Report 2546-2558 Pollution Control Department

fine particles with a PM of 2.5 that is above the WHO guideline of no more than 10 micrograms per square meter per year (footnote 1).

Air pollution can originate from industrial production, traffic congestion, construction and biomass burning. In the North there exists a smoke haze episode that causes an impact on the health of the people around the month of March of every year. The urinary 1-OHP is an important biomarker indicating PAH exposure, which may link to cancer. The urinary 1-OHP levels of children in the Omkoi and Mae Cham districts who experienced high levels of smoke during the smoke haze period in March 2015 were four times higher than those of Bangkok children.

Wastes also remain a growing problem for Thailand. Even though a higher proportion of waste is destroyed appropriately and recycled, the remaining wastes in the year 2016 of 11.68 million tons is still considerable. In addition to household wastes, eliminating industrial waste is still inefficient leading to dumping which leads to further health consequences of the population in the long run.

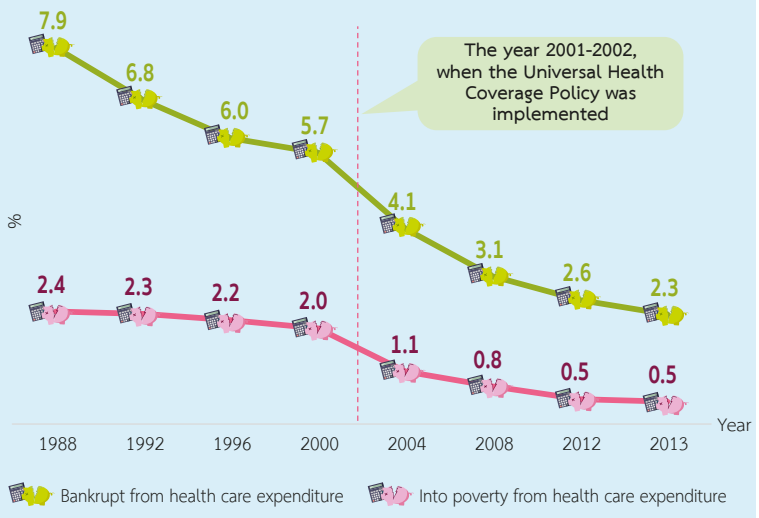
9 Universal Health Coverage

The chances of going bankrupt and falling into poverty of Thais from health care expenditure have continually reduced. However, the sustainability of national health security system remains a challenge.

That all Thais are protected from the high health care costs, able to access quality basic health services that are safe and efficient including essential medicines and vaccines is the basis of achieving universal health coverage in Thailand.

Thailand began its universal health coverage policy in 2001-2002. Currently, this basic right of accessing universal health care covers all people through three health care schemes. These are the Universal Health Coverage Scheme or the Gold Card Scheme (73.7 percent), the Social Security Scheme (17.2 percent) and the Civil Servant Medical Benefit Scheme (7.4 percent). For the past 15 years, Thai people have been better protected from the risk of high health care cost reflected by reduced percent of households that have gone bankrupt and fell into poverty as caused by the burden of health care costs of from 5.7 percent and 2.0 percent in the year 2000 down to 2.3 percent and 0.5 percent, respectively, in the year 2013. Several studies report that access to basic health care has seen an improvement, especially in groups that are vulnerable and living close to the poverty level such as labor in the informal sector, the elderly and people with disabilities.

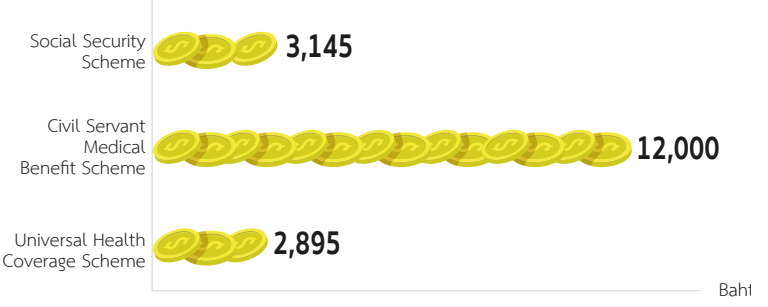
Percent of households that fall into poverty and go bankrupt from the health care expenditure (1988-2013)



Source: Analysis results in the Health Financing Recommendations for Sustainability of the National Health Security System (goals, indicators and targets)

Nevertheless, the use of these rights by the people and the costs that are incurred have increased continuously (in one sense is seen as good that people have improved access to services and, partly, may be due to illness from non-communicable diseases that have increased including the aging of the population of the country where the number of the elderly have increased along with a high rate of illness). Thus, the sustainability of the universal

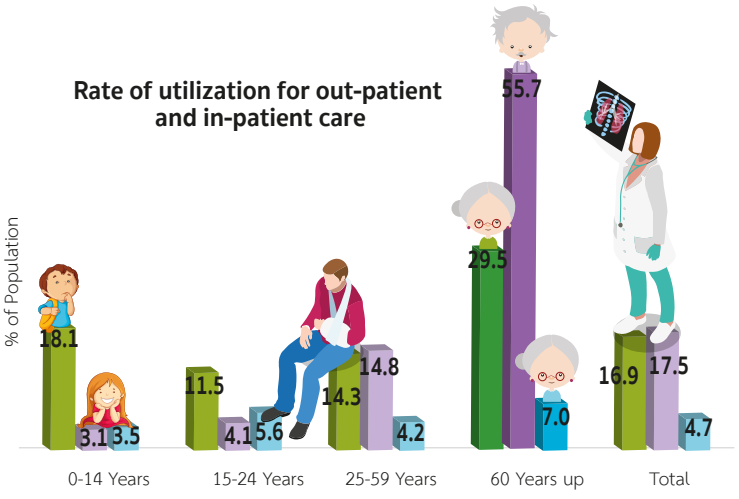
Per capita health care expenditure (age-adjusted) of the 3 main health schemes (2015)



Source: Policy Brief: Health Systems in Transition. The Public Health System of Thailand Success and Challenges, International Health Policy Program (IHPP).

health coverage system with the question of whether there is a sufficient health financing have become a large challenge. The same can be said in harmonizing the inequities of the 3 health schemes in both the area of co-payment and the coverage of benefit package that are still unequal in many aspects.

The Health Financing Recommendations for Sustainability of the National Health Security System have stipulated the identification of 4 clear objectives of SAFE or S-sustainability, A-Adequacy, F-fairness and E-efficiency, including the 11 indicators as a monitoring framework in the health financing management that will enhance sustainability of the health security system for Thai people in the long run.



Source: National Statistical Office

11 Indicators and Goals of the Recommendation on Financing for Sustainability (Sustainability, Adequacy, Fairness, Efficiency: SAFE)

Goal 1 Sustainability	1. Total Health Expenditure (THE) not more than 5% of the GDP 2. General Government Health Expenditure (GGHE) not more than 20% of General Government Expenditure (GGE)
Goal 2 Adequacy	3. Total Health Expenditure (THE) not less than current level (4.6 percent of GDP, in 2013) 4. General Government Health Expenditure (GGHE) not less than current level (17 percent of General Government Expenditure (GGE), in 2013) 5. Private Health Expenditure (PriHE) not more than 20% of THE, where household health expenditure not more than current level (11.3 percent of THE, in 2013) 6. Incidence of households bankrupt from catastrophic health care expenditure not more than current level (2.3 percent of all households, in 2013) 7. Incidence of households in poverty from health care expenditure not more than current level (0.47% of all households, in 2013)
Goal 3 Fairness	8. Improve fairness in contribution system of the Social Security Scheme (SSS), by increasing ceiling of monthly payment calculation of the beneficiaries' contribution to 7 times of the minimum wage 9. Achieve fairness in pre-payment and co-payment system 9.1 Consider 2 options for pre-payment: Everyone must pay or no one must pay 9.2 Raise more funds from co-payment at point of service. 10. Achieve fairness in care provider payment system 10.1 Age-adjusted per capita expenditure of all public schemes are +/- 10% of the average 10.2 Standard rate of payment for all public schemes
Goal 4 Efficiency	11. Increase efficiency – using closed-end budget system for all public schemes, efficient reimbursement and price monitoring and controlling system, using collective purchasing power and appropriate government interventions

Situation as of year 2013
- THE at 4.6% of GDP
- GGHE at 17% of GGE
- PriHE at 11.3% of THE
- Incidence of households bankrupt from catastrophic health care expenditure equal to 2.3%
- Incidence of households in poverty from health care expenditure equal to 0.47%

Source: Summarized from Health Financing Recommendations for Sustainability of the National Health Security System (goals, indicators and targets)

10 Health Workforce

The distribution of health personnel in Thailand show an improving trend. The differences in the proportion of doctors per population between Bangkok and the Northeast have reduced from approximately 8 times in 2004 down to approximately 4 times in 2015.

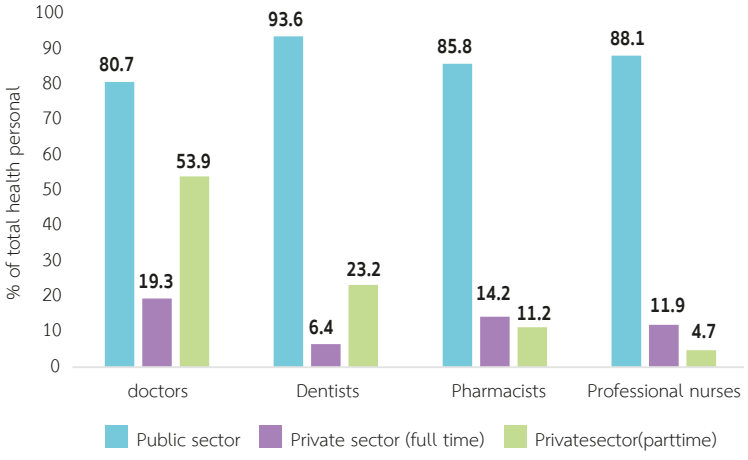
The current production of health personnel show that Thailand should have adequate doctors for its future needs. However, there is still need for better distribution of doctors for a more equitable access to services for all Thai people.

Health personnel are the heart of any health system as they are the key in providing health services, such as diagnosis, treatment, consultation and advice. Thus, the goal of good health cannot be achieved if there is no development in both the quantity and quality of health personnel. Efforts must be made to ensure the adequacy, dispersion and coverage such that all people have equal access and receive a good standard of service.

The distribution of health personnel in Thailand has improved. Data on the numbers of health personnel at various levels of service outlets show that community hospitals have more health personnel than provincial hospitals and regional hospitals. This shows that Thailand has distributed its health workforce to all regions, and places importance more at the community level.

Nevertheless, the number of doctors per population is only one aspect that reflects equity in the access to medical services. Though Bangkok has the highest proportion of doctors per population, more than half are in the private sector full time which limits access for some group of the population. The need for health personnel in Thailand in the future is a challenging task particularly when Thailand enters into an aging society and non-communicable diseases become more common. The production of personnel must change and adapt to suit the changing needs of the future. The sub-committee on planning for

Proportion of health personnel in public and private sectors



Source: Report on Public Health Resource,Bureau of Policies and Strategy.
Note: Number of doctors = 31,959, Dentists = 6,953, Pharmacists = 12,231 and Professional nurses = 149,183

Number of health personnel at various facilities under the Ministry of Public Health

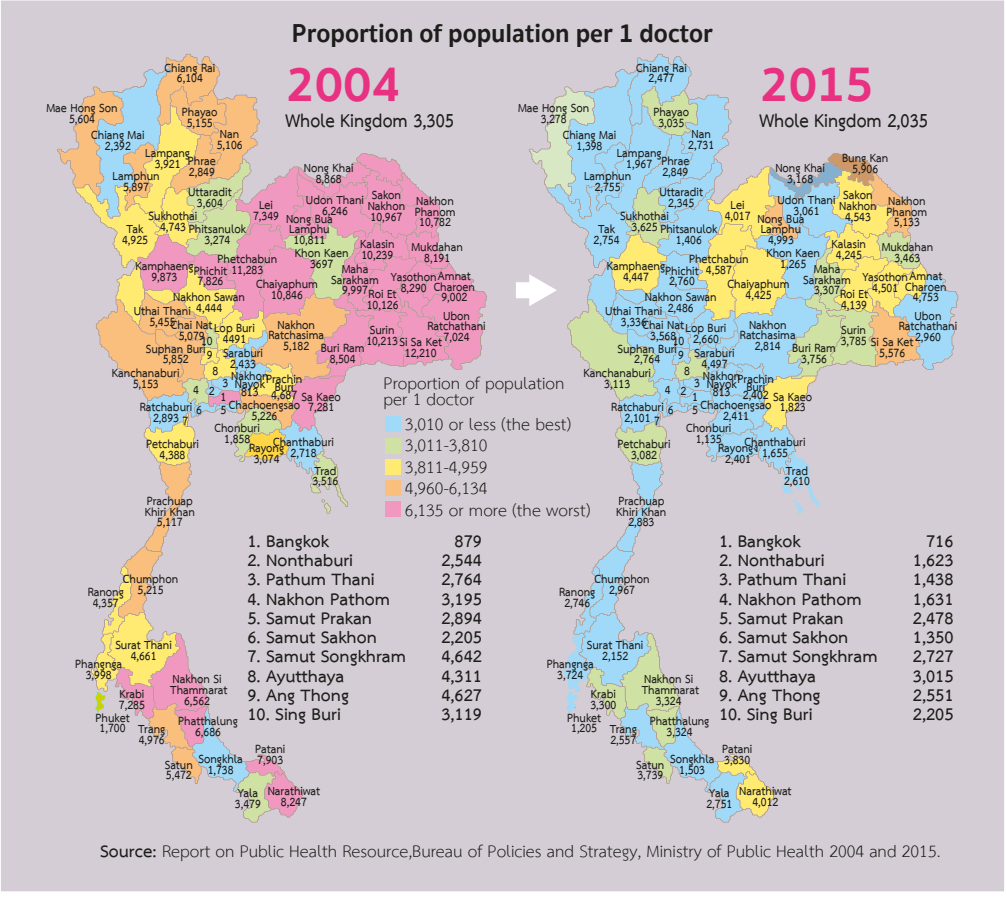
	Regional Hospital	General Hospital	Community Hospital	District Health Promotion hospitals
Doctors	4,543	3,915	7,539	
Dentists	525	939	3,109	
Pharmacists	1,272	1,788	3,778	
Professional nurses	19,856	24,300	37,342	10,114
Technical nurses	645	737	419	
Total	**26,841**	**31,679**	**52,187**	**10,114**

Source: Report on Public Health Resource,Bureau of Policies and Strategy.

10 Provinces with the best proportion of medical doctors per population 2015 (number of population per one doctor)	
Bangkok	716
Nakhon Nayok	813
Chonburi	1,135
Phuket	1,205
Khon Kaen	1,265
Samut Sakhon	1,350
Chiangmai	1,398
Phitsanulok	1,406
Pathum thani	1,438
Songklha	1,503

10 provinces with the worst proportion of medical doctors per population (number of population per one doctor)	
Bungkan	5,906
Sri Sakate	5,576
Nakhon Panom	5,133
Nongbualumpoo	4,993
Amnart Charoen	4,753
Petchabun	4,587
Sakhon Nakhon	4,543
Yasothorn	4,501
Sa Kaew	4,497
Kamphanphet	4,447

Source: Report on Public Health Resource, Bureau of Policies and Strategy,



Source: Report on Public Health Resource,Bureau of Policies and Strategy, Ministry of Public Health 2004 and 2015.

manpower in health in the next decade, under the national committee for manpower in health have estimated the demand for health personnel in the year 2026. According to the estimates, it is recommended to maintain the rate of doctor and dentist production but increase the number of professional nurses and pharmacists. In addition, an increased enrollment of students from rural areas is suggested so that they return to their place of origin after graduation. In this way the rural population will have an adequate number of personnel for their needs. This will create more equity in the access to quality health and medical services in the coming future.

Estimation on the demand and Supply of human resources for health in the year 2026

	Estimated demand in 2026			Estimated supply in 2026
	Method 1	Method 2	Method 3	
1. Doctors	30,610-37,620	34,913-41,437		62,779
2. Nurses	194,205-237,870	215,565		180,992[1]-193,048[2]
3. Dentists	16,457-20,546	19,677- 20,955	16,557	17,415 (18,675)
4. Pharmacists	14,020-17,135	47,786-64,700	-	39,913[3]

Source: sub-committee on manpower planning on health in the next decade under the National Committee on Manpower on Health, 2016. Policy recommendation on planning for manpower in health in the next ten years (2017-2026).

Note:
Doctors
Method 1 Health demand by using Service Utilization and estimation into the future by using the change in population that is age adjusted.
Method 2 at the primary care level using the number of doctors of 6,500 persons according to the Primary Care Cluster that was designated where number of doctors at the primary level is equal to 1:10,000
Nurses
Method 1 Health demand
Method 2 Using health demand and service target for elderly patients bed ridden at home and community
1. Using the scenario that nurses have an average working year of 22 years
2. Using the scenario that nurses have an average working year of 25 years
Dentists
Method 1 Using health demand
Method 2 Mixed method using health demand with determining a service target Method 3 Using the modified population rati

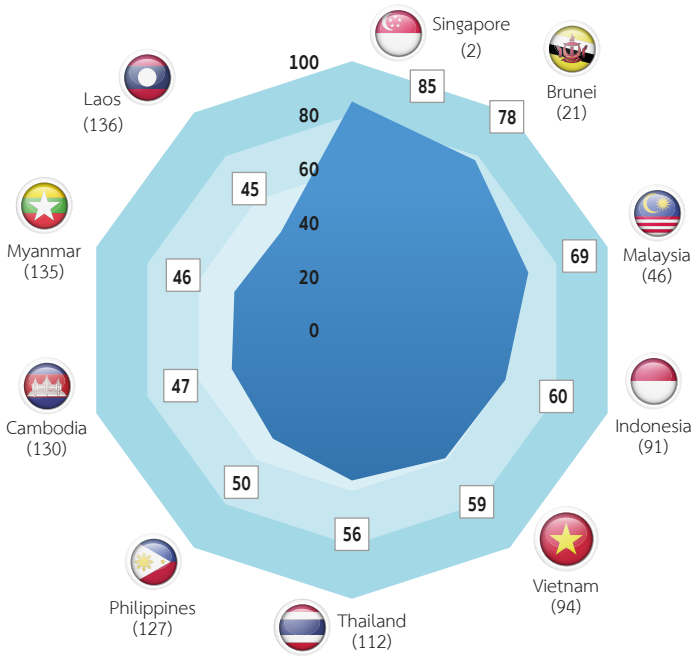
11 Overall Health-related SDG

Thailand still follows behind other countries in achieving the overall health-related SDGs, where its ranking is 112 from a total of 188 countries.

In addition to the indicators on sustainability under the SDG: Goal 3 that relate to health there are also many other targets where Thailand is in a situation of unpreparedness and cannot yet achieve its goals such as the impact and loss due to natural disasters, sanitation and water resource consumption safety and personal violence.

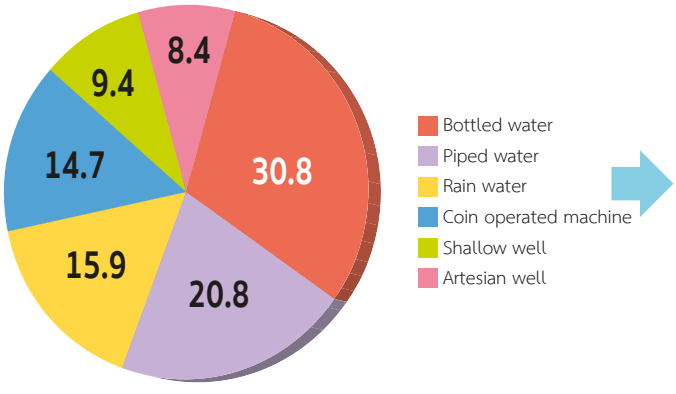
The Global Burden of Disease (GBD) Collaborators have developed a Health-related SGD Index to measure the status and progress of the 188 countries related to health in various aspects of 33 indicators. Most of these are under SDG3 and others are in other SDG goals. The results show that Thailand's index was at 56 points (from a total of 100) ranked 112 - according to the highest down to the lowest - which is in the latter half of the world ranking behind other countries in ASEAN such as Singapore, Brunei, Malaysia, Indonesia and Vietnam.

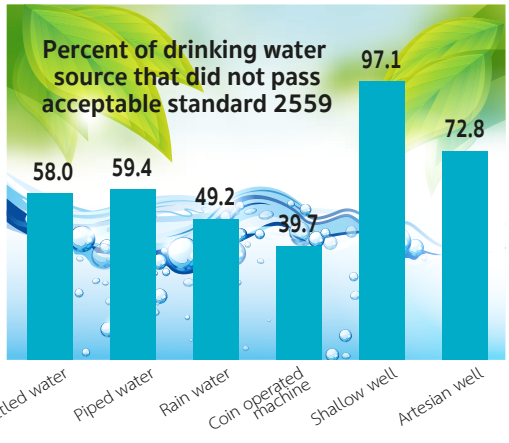
Scores and Ranking of Health-related SDG Index of countries in ASEAN (of the total 188 countries around the world).



Source: GBD 2015 SDG Collaborators. Measuring the health-related Sustainable Development Goals in 188 countries: a baseline analysis from the the Global Burden of Disease Study 2015. Lancet 2016; published online Sept 21. http://dx.-doi.org/10.1016/S0140-6736(16)31467-2

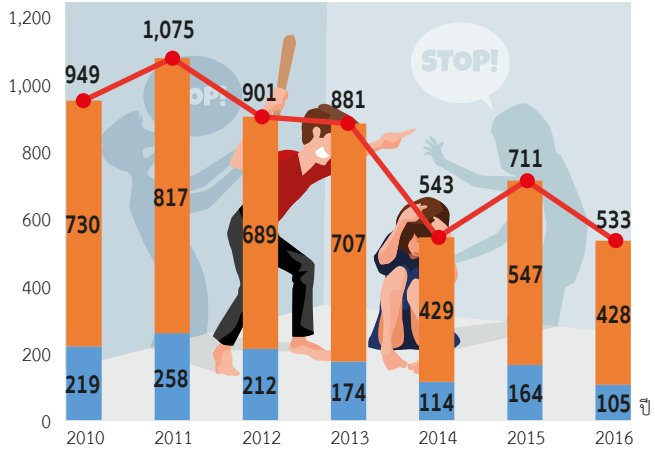
Percent of source of drinking water in Thai households, 2014





Source: Situation Report on Quality of Water for Consumption in Thailand Year 2008-2016, Bureau of Food and Water Sanitation, Department of Health

Number of domestic violence, year 2010-2016



The affected in the predicament where they could officially report incident

The affected in the predicament where they could not officially report incident

Total number of incidents

Source: Data collected from the Operation Center for Prevention of Domestic Violence, Ministry of Social Development and Human Security

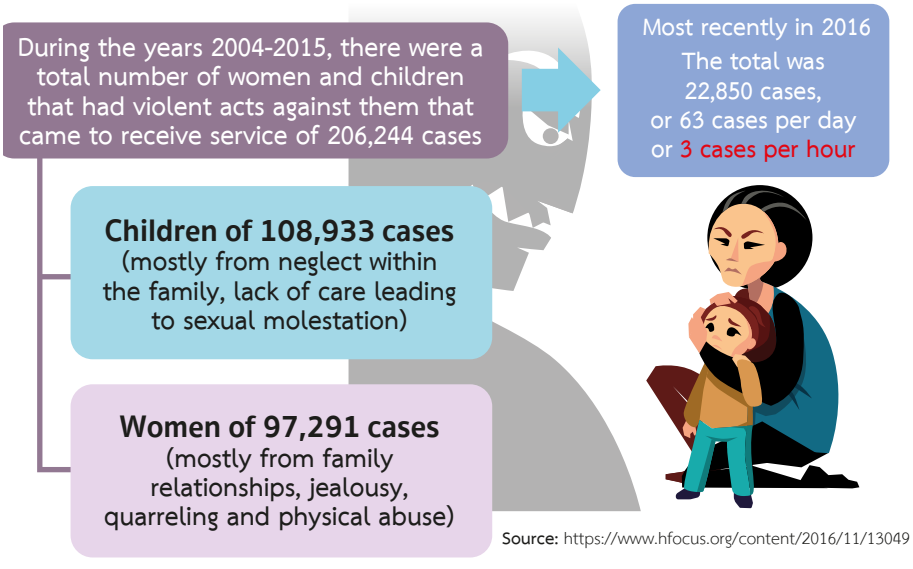
Accumulated number of deaths and affected from disasters in ASEAN countries from 2006-2015

	Accumulated deaths	Accumulated affected
Cambodia	947	3,977,465
Indonesia	14,826	10,587,329
Lao PDR	179	1,423,020
Malaysia	600	2,856,160
Myanmar	139,608	12,335,552
Philippines	20,078	107,230,842
Thailand	2,235	62,800,658*
Vietnam	2,825	18,708,726

Note: Disaster under this definition consists of two categories. Natural disasters (such as earthquakes, volcanic eruption, drought and heat wave, flooding, storms, snow storms) and technological disasters (such as chemical disasters from industry (leaking, exploding), transport and communication).

Source: World Disasters Report 2016 Resilience: Saving lives today, investing for tomorrow

Number of women and children exposed to violence from the data of the One-Stop Crisis Service (OSCC)



Source: https://www.hfocus.org/content/2016/11/13049

The indicators outside of SDG3, where Thailand has a low figure, is in the issue of "disaster". Referring to the World Disaster Report 2016, even though the accumulated deaths of Thais from disasters is not dangerously high when compared to other countries but the number of affected in the past 10 years, is as high as 62.8 million persons, some of this due to the numbers of people affected by flooding during the 2011. Next issue is "source of water", especially for consumption purposes which found that Thai household's consume a large amount of bottled water ranked 1 followed by piped water, rain water and water from coin operated dispensers. According to the nationwide survey by the Department of Health, the results show that many of sources of water in the country have a quality that do not pass standards; for example, bottled water and piped water where almost 60 percent did not pass the drinking water standards.

Another health-related indicator that is a major challenging task is "interpersonal violence". In 2016, there were 533 cases of domestic violence in the country. Data from the One-Stop Crisis Center (OSCC) report that every hour there are three children and women that have acts of violence done against them. These numbers are worrying because they may not include many other incidents of violence and those affected that are not reported.

Citation:

Thai Health Project.2017. Title of article. In *Thai Health 2017*. (page number). Nakorn Pathom: Institute for Population and Social Research, Mahidol University.

Example:

Thai Health Project.2017. Thai Referendum Approves the New Constitution, Paving the Way for the General Election. In *Thai Health 2017*. (page 106-109). Nakorn Pathom: Institute for Population and Social Research, Mahidol University.

10

Outstanding Situations

1 Thai Referendum Approves the New Constitution, Paving the Way for the General Election

What has to be documented as an historical event for Thailand is the national referendum on the draft constitution on 7 August 2016. In this event, the people voted in support of the draft constitution, the highest law of the land. They also voted in favor of the supplementary question that enables the senate to vote along with members of parliament, the choosing of the Prime Minister during the first five years after the constitution comes into use. Following the referendum, the government will move forward by enacting various laws related to the general election. It is estimated that the next general election will be held in late 2018 after King Bhumibhol's royal funeral.

As a matter of fact, the National Council for Peace and Order (NCPO) had drafted its first constitution under the direction of Professor Bowornsuk Uwano, as the Chair of the Drafting Committee. This first draft was completed in 2015 but the National Reform Council did not pass this, leading to another round of constitution drafting process. The NCPO then appointed a new Constitutional Drafting Committee of 21 persons designating Meechai Ruchupun as the Chair of this Committee. The drafting timeframe was designated as 6 months from November 2015 to April 2016. After completion of the draft, it will then be presented to the people for a referendum. From then the draft will be sent to the King for his royal signature and then announced as the highest law of the country.

This Meechai draft constitution consists of 279 sections and 16 categories including transitional provisions. Issues of importance to the public include "the choosing of the Prime Minister" that opens the way for an outsider to become Prime Minister or who is not a Member of Parliament (MP). There will be 250 senators, some of whom are selected by the committee of the NCPO and another from their official positions such as permanent secretary of the Ministry of Interior, commander of all armed forces, Army Commander in Chief, Navy Commander in Chief, Air Force Commander in Chief and Commander in Chief of the Police. There will be a total number 500 Members of Parliament (MPs) chosen by proportion using one election ballot and calculating the number of MPs per election district for the number of MPs in the party list. Another important issue of interest to the public is the mechanism to prevent corruption by politicians. In this Meechai draft constitution, persons will not be allowed to become an MP, senator or minister if they have been sentenced by the court for corruption and dishonesty, or committing dishonesty actions during elections. In addition, it is stipulated that the national reform should be undertaken in 7 major areas of: politics, management of national affairs by the government, justice, laws, education, the economy and others.

Nevertheless, this Meechai draft constitution and the provisions within it make it more difficult to amend. The process of amendment, according to section 253 of this draft, stipulates that the amendment requires a majority from parliament, and under the condition that there must be support from no less than 10 percent of every political party and 1 in 3 approval from senators. This is different from the 1997 and 2007 constitution that only required a majority vote from the parliament. Thus in this Meechai draft constitution, an amendment is possible only if it wins support from powerful groups in parliament. But if a group or groups have little bargaining power, there will be no chance whatsoever of an amendment. Even more than that, there is also an additional stipulation for an amendment where in these cases a national referendum must be held for sections in the general category, on the monarchy, and on the power and authority of independent organizations. Such that, before the national referendum on 7 August of 2015 there was a major debate on the possible impact if the draft constitution did not pass the national referendum. Many people were concerned that the failure to pass the constitution may affect the legitimacy and stability of the NCPO, and various political groups may take this opportunity to raise popular discontent against the government.

Public health rights of the people under the Meechai constitution

Issues related to public health in the draft constitution of 2015 are found in category 3 on rights and independence of the people of Thailand section 47-48.

Section 47: "Individuals have the right to receive public health services from the government. Individuals who are in poverty have the right to receive public health services from the government without cost according to the law. Individuals have the right to receive prevention and protection from dangerous communicable diseases by the state without cost."

Section 48: "The rights of the mother both before and after birth is protected and support as the law stipulates. Individuals with an age over 60 years and do not have a sufficient income to maintain their lives and individuals who are living in poverty have the right to receive appropriate assistance from the state as the law stipulates."

In addition to this, it is also written in category 5 that the duty of the state in Section 55 that "the state must implement for the people to receive uninterrupted public health service that is efficient and has good coverage, promote and develop people to have basic knowledge on the health and prevention of disease and support the development of knowledge on traditional Thai medicine for the highest benefit."

Also, the public health service must cover the promotion of health, the control and prevention of disease, treatment and rehabilitation. The government must develop the public health services to be of an acceptable and continually improved standard.

On the issue of rights to public health, there were several comments from civil society that the draft constitution is a step backwards compared to past constitutions. Nimit Tienudom, former member of the National Health and Social Security Office, stated that the rights to services in this draft has less benefits compared to the 1997 and 2007 constitution because it uses the normal social welfare concept[1]. The rural doctors network also voiced a similar concern by Dr. Supat Hasuwannakij, member of the Rural Doctors Group and Director of the Jana hospital, Songkhla province, who viewed that the change in rights could reduce the welfare as the rights to health was an equal benefit for all persons in the past, whether they are impoverished, disabled, young or old. Thus, Section 47 in this new constitution could be interpreted as opening the way for people, over and above these 4 groups to have to "co-pay" because the state views that the health security scheme is a burden[2]. Nevertheless, Dr. Vichai Chokewiwat, member of the NHSO and senior fellow on health promotion states that these views of the state omitting rights on equality is a misunderstanding because this is already acknowledged in Section 4-2, such that the constitutional draft committee has reiterated that the content in the draft constitution does not omit any benefits to the people but quite the opposite; it increases rights including rights from the Gold Card catered for needy people.

Direction of reform in Thai Public Health

Meechai Ruchupun (member of the Consitutional Drafting Committee) gave a special presentation on "the constitution and reform in public health" and stated that the draft constitution has included the universal health care scheme in its content so that there will be quality and efficiency, where the people will receive more benefits and assure that this mechanism becomes sustainable. It did not abort the 30 Baht Scheme for all diseases that many people are concerned about. Not only this, what was added in this constitution that other constitutions did not have is the care of the people that covers them from birth to death. It is a holistic health approach covering health knowledge, prevention, care and rehabilitation, and the promotion for a family doctor through general practitioner and various specialist doctors[3]. What Mechai Ruchupun stated is stipulated in the category on national reform Section 258 point (4) that the state must accordingly re-structure the social security scheme mechanism so that the people receive benefits from improved management and services of high quality, convenience and equality to all, and (5) to improve primary care system with a general practitioner.

Whereas Pattara Kumpitake (member of the constitution drafting committee) reaffirmed that the content in the draft stipulates that the various Funds must be reorganized and improved in order to bring better benefits whereby the 3 Schemes currently in use—the civil servant welfare and benefits, the social security scheme and the Gold Card— must adjust its rights and benefits, its management, and access to services for quality, convenience and equality. In addition, the people will receive better care from the state that is also stipulated in Section 55 that "the state must undertake procedures so that the people will receive public health services that is of efficient and has good coverage" such that it is a service that is fully integrated[4].

The draft constitution passes the referendum easily at 61:39

The national referendum was held on 7 August 2016 with the approval of 16,820,402 votes or 61.35%, whereas 10,598,037 votes or 38.65% rejecting it. While the referendum on the supplemental question on: "do you approve or not for the governing of the country to be uninterrupted according to the national strategy that there should be a clause in the constitution transitional provision that in the ensuing 5 years from the day of the opening of the parliament, the combined meeting of parliament will

consider and select the prime minister". The vote on this question was approved with 15,132,050 votes or 58.07%, and the rejection rate of 41.93% or 10,926,648 votes.

As for 50,071,589 eligible voters, 59.4% or 29,740,677 persons cast their votes. A high rate of 96.85% of all votes were correctly done. If we compare this with the referendum of the draft constitution in the year 2007, in the year 2016 there were more people who voted than in 2007 where there were 25.9 million persons from total eligible persons of 45 million or 57.61%. Of this, the Northeast and the three lower southern provinces of Yala, Pattani and Narathiwat generally voted not to accept the draft constitution. The provinces with the highest vote of approval included Chumporn, Nakhon Srithammarat, Phuket, Suratthani and Ranong.

The general election is scheduled after the royal funeral

After the passing of the national referendum on the draft constitution, the road map towards the national election has become clearer as Prime Minister Prayuth Chan-ocha announced that everything is moving along as planned[5]. After the referendum, the draft constitution will be sent to the Constitutional Court for the finalization before presenting it to His Majesty the King for the royal approval. The time period for this process should take no longer than three months.

The prime minister stated that after the royal approval and announcement of the new constitution, the temporary constitution of 2014 will cease and will be replaced by the new constitution. The Constitutional Drafting Committee will then finalize ten supportive laws such as the election of MPs, the selection of senators, the setting up of the election commission, and the law related to political parties. The subsequent step is to present this to the national assembly for consideration. It is expected that the new constitution will commence no later than the middle of 2017. The Election Committee will later organize the general election within 150 days after relevant laws have been finalized.

Nevertheless, soon after the constitutional drafting committee began working on supportive laws, a tragic event occurred that caused great sorrow for the Thai people. King Bhumibhol Adulyadej passed away on 13 October 2016. At first, the government re-affirmed that the transition of the monarchy would not affect the general election planned in 2017. On 10 January 2017, Prime Minister Prayuth Chan-ocha announced that the Office of the Royal Secretary sent a message to the government that there were some issues that had to be amended in the draft constitution the sections related to the monarchy and the successor or Regent to the King all of this as per according to the authority of the King[6]. Afterwards, the government presented the revised draft constitution to the National Assembly. The Prime Minister stated that the process of amending the draft constitution would not take more than 3 months, and that the national election would take place after the royal funeral. Dr. Wisanu Kruangarm, Deputy Prime Minister reaffirmed that an announcement will be done in due course as to the new date for the election to allow. Political parties will then be allowed to conduct their activities, organize meetings, and begin their political campaign[7].

Conclusion

After the draft constitution has been approved by the national referendum in 2016, the government began drafting supporting laws that will lead to the general election and return Thailand to the democratic system. This constitution has indicated that the universal health care services will be provided, and that a family doctor system will be set up in Thailand. Civil society groups expect that the various benefits on public health care will be in an equal and fair manner. When the new constitution comes into use, related agencies running the social security and the universal health care or gold card will have to streamline their operations for equitable service delivery and care, and the standardization of their services for the benefits of all people.

2 The 20-Year National Strategic Plan

In the era of the National Council for Peace and Order (NCPO), some observers have mentioned the term national strategy numerous times. Many are curious as to what this national strategy, that has been stated on numerous occasions, mean and how has this national strategy been determined. When the public have come to learn that the country is developing a 20-year national strategy on development many have questioned whether this determination to have a strategy so far into the future is appropriate or not. Will the next government that comes to power have enough independence to govern and determine its own policies? In addition, what will be the role of the national economic and social development plan that already has a 5-year plan and what relationship will it have with the 20-year strategic plan. This chapter will discuss the 20-year national strategic plan and the impact on future health mechanisms of the people.

The national strategic plan is a national development goal

The draft constitution that passed the national referendum on 7 August 2016 designated that there will be a national strategic plan to lay the long term goals and process in the development of the country for the next 20 years. This began in earnest on 30 June 2015 with a cabinet resolution approving the recommendation of its Secretariat to develop a 20 year national strategic plan for 2017-2036. Approval was given for the establishment of a committee to develop this national plan with the Secretariat as the Chair to move the country towards a **Secure, Prosperous and Sustainable** future[1].

The draft constitution of Thailand has highlighted the national strategy in numerous sections such as in Section 65: The state must develop a national strategy as a goal for sustainable national development according to good governance principles. This can then be used as a framework for various plans that are to be coordinated and integrated and act as a powerful force towards the ultimate goal. This will involve setting goals and a timeframe to achieve the goals to be implemented under procedures that will be set by laws.

Section 142: In the presentation of the draft Act on the annual budget it should state the amount of the budget as well as the expected income, estimated results or benefits from the

expense and its interrelationship with the national strategy and various development plans using legal guidelines and financial discipline.

Section 162: The Cabinet that comes into power must announce its policy to parliament and this policy must be related to its duty as the government, the policy direction of the government and its overall strategy...

As detailed above, after the new constitution comes into use, the national strategy will come into effect as a framework for the management and planning of the government and its various departments including budget planning. Such that, the contents and issues that will be contained in the national strategic plan must be under the laws that govern it.

Why must there be a National Strategy?

In the past, the country has set a goal and strategy for development under the National Economic and Social Development Board (NESDB). Each plan covers only 5 years but in practice each government that comes into power places higher importance on its party's policies and campaign promises. When there is a change in government, there often is a change in many economic and social policies, resulting in a break in the continuity of work. Thus, in order to reform national development strategy, and to ensure that all governments that come into power are committed to the larger goal that have already been set, the country should have a long term national goal or National Strategy.

Diagram 1: The Vision of the 20-year National Strategy

"Security, Prosperity, Sustainability" in accordance with the principles of Sufficiency-Economy Philosophy.		
Security	**Prosperity**	**Sustainability**
• **Secure and Safe** from natural disasters and changes from within the country and outside the country at all levels including at the national, social, community, family and individual level and to be secure and safe in all dimensions of both economic, social, environmental and political. • **Nation** to be secure in its independent sovereignty, to have a national institution, religion, monarchy that is strong and at the center that is depended upon and trusted by the people. A political structure that is secure and leads to continuous management of the country with transparency according to the principles of good governance. • **Society** to have reconciliation and unity, able to unite and strengthen national, community and family development. • **People** to have a secure life. To have a secure work and income adequate to maintain one's life. To have a place to live and to have safety in one's life and assets. • **Natural resources and the environment** to have security in food, energy and water.	• **The country continues to have economic expansion** and raise its level to a high income country. To reduce unequal development. The population to receive the benefits of development in more equal proportions. • **The economy is more competitive** and able to create income from both within and outside the country. To create an economic and social base for the future that is an important link within the region in both communication, transport, production, trade, investment and business. To have an important role in the region and globally arising from its economic relationship and trade with others. • **Financial completeness enabling creation and continuation of development** that includes human capital, knowledge, financial, industrial machinery, social and natural resources and the environment.	• **Development that leads to progress** in income and quality of life of the people continue to increase, which is due to the progress and development of the economy that does not overuse its natural resource, not overly create pollution to the environment and promote environmental preservation. • **Production and consumption that is friendly to the environment** and is linked to the regulations accepted by the world community of the abundance of natural resources and the improvement of the environment. For people to have responsibility to the environment, have compassion to one another and show sacrifice for the greater benefit. • **Move towards sustainability for the greater benefit** that places importance in participation of the people from all sectors for development in all facets equally in a stable and sustained manner. • **People in all sectors of society** adhere to the philosophy of sufficiency economy.

Diagram 2:
20-year National Strategic Framework

This view has been well supported by numerous groups such as the National Reform Council and academics. A government that comes into power will then determine policies leading to the major goal and can then set a framework for determining its policies along the longer term direction with greater integrity. This will lead to the effective allocation of resources and result in a more coordinated move towards the shared goal.

The Thai National Strategy

The government of General Prayuth Chan-o-cha established a National Strategic Committee with General Wilas Arunsri, Secretariat of the Prime Minister, as Chair[2] on 30 June to draft the 20-year national strategy 2015 as a first draft according to the Constitution. Up till the beginning of 2017, the National Strategy Committee developed the draft 20-year national strategy by articulating feedback and recommendations from its members that came from various areas including government officials, the private sector, politicians and academics, the National Reform Council, and civil society. The 20 year Strategic Plan consists of:

Goal: So that Thailand can raise its level of development from a middle income country to a high income country by the year 2036.

Vision: For Thailand to be prosperous, secure and sustained. A country that is developed according to the philosophy of sufficiency economy that has been expanded in its meaning to include secure, prosperous and sustained as shown in Diagram 1.

It can be seen that the national strategy has set the goal, vision and path for the development that each successive government should give importance to. Successive governments can then set their policies in a coordinated manner and in the same direction in order to set the budget in an efficient and integrated manner. However, the incoming governments will be able to determine its policies, plans and projects suitable to the situation in the future.

The National Strategy and Thai Health Systems

The 20-year national strategy has some clauses related to the health system in two strategies. The first strategy is on development and supporting capacity of people—the creation of improved capacity for people to have good health. The second strategy is on the creation of equality and equity in society. It will focus on developing mechanisms for service provision and the management of health.

Due to the nature of the 20-year strategic plan that has a long term goal, it is necessary to set various time periods for implementation. Currently there is the use of the National Economic and Social Development Board (NESDB) as the mechanism to move the national strategy into short and medium term goals for five years[3]. The 20-year national strategy (2017-2036) will then be carried out by the 5-year NESDB in its 12th to 15th publications.

For the 12th NESDB (2017-2022), the first NESDB that will come under the 20-year national strategic plan, its goal aims to promote good health for Thai people by setting various indicators such as: population aged 15-79 years that are overweight must be reduced; deaths from road accidents are below 18 persons per 100,000 population, total health expenditure to be not more than 5% of the national GDP; and the elderly living at home with an appropriate environment to increase to 20%.

Moreover, the strategy in the first 5 years emphasizes behavior change in health and reduction of risk factors that may affect health. It includes improving health knowledge on good health, promoting health fitness appropriate for each age, using legal action and taxes in controlling consumption that is negative to health, the creation of an environment that is supportive to good health, and overcoming problems of deaths from road accidents. This 12th 5 year plan also places importance in the promotion of a culture of safety through mass media to change behavior and reduce accidents, and the setting up of mechanisms to manage risk from road accidents.

20-Year National Strategy of the Ministry of Public Health

The Ministry of Public Health has developed the 20-year national strategy by determining 3 goals for good health of the population: The people are in good health, officials are content and the health structure is sustained[4]. The goal has a Strategy of Excellence in 4 areas with 16 plans and 8 projects that include:

1. Promotion and Prevention of health and disease (PP Excellence Strategies) that include 4 plans of: 1.1 Development of the quality of life of Thai people in all age groups. 1.2 Prevention and control of disease and health dangers. 1.3 Food safety. 1.4 management of the environment and development of service centers.

2. Service Excellence Strategies include 4 plans. 2.1 Development of Royal wishes. 2.2 Development of primary medicine. 2.3 Development of public health systems and 2.4. Thailand 4.0 in the area of public health, medical health and technology, legal aspects of health in special economic zones and access to services in the southern border areas.

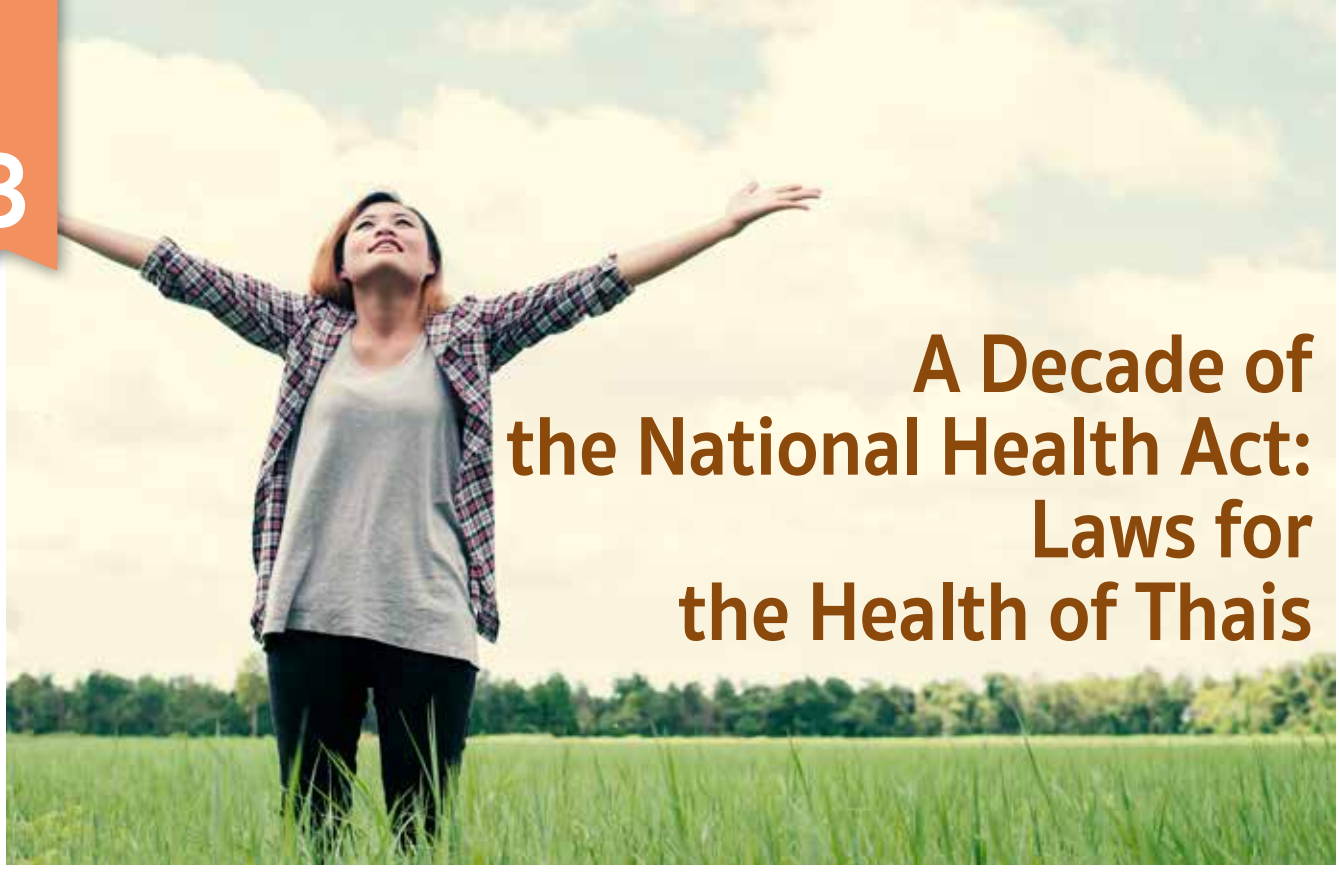
3. People Excellence strategy includes 4 plans: 3.1 Planning for manpower in health. 3.2 Developing and producing manpower. 3.3 Development of management mechanisms in manpower and 3.4 Manpower in health and network partners.

4. Governance Excellence Strategy include 4 plans: 4.1 Data management systems/ health laws. 4.2 Universal health care scheme. 4.3 Security in pharmaceuticals and drugs and consumer protection and 4.4 Good governance principles in research.

Summary

Thailand, in the era of the National Council for Peace and Order (NCPO), has launched the 20-year National Strategic Plan that has set the long-term strategy for national development. The Ministry of Public Health has used this national strategy to determine its own 20-year strategy that consists of excellence in health promotion and prevention of disease, service excellence, excellence in personnel and excellence in management with good governance. From this, the 12th NESDB will be the first plan that will implement this overall national strategy by setting targets to promote good health for Thai people. From the present to the next 20 years, it is expected Thailand will develop with the goal of good health with sustainable public health systems.

3



A Decade of the National Health Act: Laws for the Health of Thais

In 2016, Thailand launched the second charter on national health systems as the framework that determines the direction of the health system of the nation. The aim is for the people to be in good health following the use of the first Health Act of 2007. The 1st Health Act of 2007 led to the creation of many laws including[1] the health impact assessment, the law on the prevention and control of adolescent births of 2016, the draft law on protection of people from the impact of public health services, and the draft law on the control of marketing of food products for children.

The National Health Act of 2007 and the Charter on National Health Systems

The National Health Act of 2007 is a kind of "social engineer" that has designed the ideal public health system of Thailand. This law demonstrates the health concepts of 4 dimensions that include the wellbeing of one's health, mind, knowledge and society that are all linked[2] to achieve real results and change in the society. This is considered an innovation of society because this law is a change in the thinking on public health from the previous thinking, where it has been the responsibility of the government. This law opened an arena for the people to participate in the government's policy and management of the health system as a healthy society "is not the responsibility of any particular person but is the responsibility of everyone in society that must be created together"[3]. By using 'health' as a goal a society must strive towards it together and creatively develop policies on public policy with participation and shared knowledge.

The tools in the creative development of public policy with participation according to the Public Health Act 2007 consists of 4 major paths of the rights and responsibility in the areas of health, the charter on health systems, health assembly and the participatory health impact assessment as follows:

1. The rights and responsibilities in health

The National Health law 2007 stipulated the rights and responsibility in section 5-12 whereby rights on health is divided into 7 areas of: Section 5 paragraph 1: The right to maintaining one's life under an environment that is of benefit to one's health. Section 6: The right to health of women and children, the disabled, the elderly, the disadvantaged in society and various groups that are in need of protection that is appropriate and related. Section 7: The right to information on health of the individual. Section 88: The right to information when receiving public health service. Section 9: The right to have information when participating in a research program. Section 10-11: The right in the request for an evaluation and participation in the process of the impact on health from a public policy. Section 12: The right to express in writing the decision not to receive public health service in the last stage of one's life and another role on health is Section 5, paragraph 2, the role together with the state in working towards an environment and social environment that promotes good health, whereby the various rights and responsibilities are to be developed into specific laws and related laws as well as improving existing laws.

For example, Section 5 and 6 are used as the foundation in the development of the law on prevention and overcoming the problem of pregnancy among adolescents. In 2016 the draft law on occupational disease and environment and the draft law controlling the promotion of infant and child food industry have been developed. Currently the latter draft law is in the stages of tremendous debate between supporters of the mother and the infant food industry. In addition, there is the development of the draft law to protect individual information according to section 7, and the draft law on research on human subjects in section 9.

With the ministry regulation according to section 12, paragraph 2, there arose a new idea for the development of various laws and policies of the state to promote and support a good death, such as amending the law of illegal drug use that allows easier access to the use of morphine in the care of patients at home. Efforts are also made to develop and improve care regulations on finance of health to support care at home, to develop standards of health and medical personnel, and assistance in the provision of care.

2. The Charter on health systems

The charter on the national health system is a framework and pathway to determine policy, strategy and implementation of health in the country so that people are in good health. Though the charter on health systems is not compulsory by law, the national health law of 2007 had already laid the mechanisms that bind government agencies to implement the Charter.

The first Charter on national health system 2009 led to the use of Thai traditional medicine in the hospital for primary care, and initiatives for the family doctor. Since the first charter on national health systems came into use, it has created the extension of the charter into the community level. Communities began to set up local health systems in accordance with the national Charter. To date, 100 local charter sites are operating in conjunction with strategic partners such as the Office of the Universal Care scheme regional offices and Office of primary education regional zones.

Later, the Cabinet approved the second charter on national health systems on 9 August 2016. This second charter has been approved by the Review Committee of the 2007 National Health System, and passed the public referendum in all regions with a total participation of 1,115 persons from around the country, including the public referendum of the national health refer-

endum on 8 May 2015, and with feedback from almost 100 agencies. The charter will be reviewed every 5 years after its implementation.

The second charter reflects a picture of the future national health system in the next 10 years, and designates challenges on health risks such as emerging diseases, communicable diseases, non-communicable diseases, the ageing population and the impact of the urban environment. The second charter is an integral part of the draft 20-year national strategy of 2017-2036 by the government, where the health system is one part that will ensure the security in life and support human development, knowledge investment, natural resource investment and the environment that creates prosperity, and the development in all facets with equality, equity and sustainability, in accordance with the philosophy of sufficiency economy. At the same time, it is also in line with the 12th NESDB, not only just in health, but also the health dimensions of the self, the wisdom and the society[4].

3. Health Assembly

The Health Assembly is the process where the people and government agencies concerned come together to exchange ideas and learn together through a consensus building process that lead to recommendations on public health policy through a participatory manner. There are 3 types of health assembly of assembly in specific areas, health assembly on specific issues and the national health assembly.

Organizing the assembly as explained above is a social innovation that creates learning together through consensus building based on knowledge data. The assembly is not an academic meeting or a seminar but is a process that is creative and attempts to have learning together on economics and social issues, and from various disciplines, leading to the conclusion for all sides.

From the year 2008 to the present, there have been 9 Assemblies on Health with a total of 77 resolutions presented to the National Health Committee. The resolutions from the national health assembly, the National Office of the Committee on Health and various partner networks have resulted in numerous concrete actions. The Health Minister is tasked to take action on the resolutions by the Health Assembly and to monitor the progress of these actions. Such actions include the push for the law on preventing and overcoming the challenge of adolescent pregnancies 2015[5] and development of the draft law on protecting people affected by public health services[6], the draft law controlling the market promotion of food industry for children[7], the draft law on occupational diseases and the environment[8], the draft law on the prohibition of sale of alcohol in industrial areas[9], the improvement of the law on psychological health (2009)[10] and the improvement of the draft law on non-communicable diseases (2015)[11].

In addition to the development of various laws, there is also the use of the national health assembly resolutions to develop government policies that have an impact on society such as the resolution of 1.2 on access to medicine for all Thais, Resolution 1.4 Participation of the people in determining the free trade negotiation. Resolution 1.11 Structure and mechanism on the impact on health in Thai society. Resolution 2.88, Managing overweight and obesity. Resolution 3.1 Measures for Thailand to be free of asbestos. Resolution 3.6 Measure to control risk factors to tobacco. Resolution 3.88 on overcoming the challenge of adolescent unwanted pregnancies. Resolution 4.1 on food safety in the management of use of old cooking oil. Resolution 5.1 on managing the infrastructure to promote walking and use of bicycles in daily life. Resolution 5.4 on managing excessive smoke and Resolution 7.4 on managing improper steroid use.

4. Health Impact Assessment

Health Impact Assessment (HIA) is a process that was developed as one tool for health policy development. It looks at the impact of the activities of projects, plans and various policies on the health of the population. The decision making process will consider factors that impact on health of the people. The data acquired from this assessment is beneficial for policy makers at all levels to take decisions on policy that are most beneficial to the people.

The HIA has been used in many large projects such as the building of bio-electricity plants, waste disposal sites, and licensing of gold mines. As a result, the Central Administrative Court has ordered a temporary restraint to 76 projects with a value of 400,000,000 million baht in Map Ta Phut Industrial Estate, Rayong province in 2009. This was done to protect the community and the environment of the area. Since then, the HIA has been used in many other areas around the country.

Recently, the 2016 constitution of Thailand[12] requires the HIA in projects which may have an impact on natural resources, the environment, health and sanitation, and the quality of life of the people[13]. It requires compulsory measures from agencies involved, or else responsible officials will be relieved from their positions[14].

New Laws and the National Health Service

The partnership networks of the government, private sector and civil society have used the national health assembly process, initiated by the national health law 2007, to develop various laws that help to improve the Thai health service system such as:

1. The law on the protection and overcoming problems of adolescent pregnancies 2016

Currently, Thailand has experienced a large number of unwanted pregnancies, and ranked as one of the highest rate of unwanted pregnancies in the world. Partner networks and academics have used the national health assembly as one avenue in the push for this issue to become a national agenda, and proposed for a new law on this issue. This led to the drafting of a law on preventing and overcoming the problem of unwanted adolescent pregnancies of 2016. This law designates the role of the education system, workplaces, care centers and local administrative organizations to have the key role in the support and promotion, prevention and overcoming the problem of adolescent pregnancies.

2. The draft law on protecting people affected from public health services ...

Conflicts between those who receive services and those who provide services is one important problem in the service provision of

health in Thailand. In the past, there had been several charges made against public health services and hospitals. These conflicts have increased over the years as seen in the media. These conflicts reduce the spirit of service providers in their duty, and create negative feelings for the general public. Therefore, a recommendation has been made for a draft law that would protect those affected from public health services. The National Assembly is still working on this project.

3. Draft law to control the promotion of marketing of food products for children

The industry on supplementary food and milk powder for children and infants in Thailand is valued at around twenty thousand million baht[15]. Milk product companies and supplementary food companies have marketed their products inappropriately such as paying service providers to advertise their milk products, and providing free lunches and gifts to health personnel to promote their products, etc. These actions are against ethics of the occupation as it promotes powder milk products for young children and infants to replace the mother's milk, resulting in negative effects to infants in the long run. Such consumption also incur more unnecessary expenses to the mother and her family. Civil society, academics and government agencies thus have used the national health assembly to discuss this issue, and propose for a law to control the marketing of milk powder and supplementary health products by private companies, and the sale of these products by health personnel and hospitals.

4. The draft law on occupational health diseases and safety...

Overcoming health challenges of occupational health and safety originally was the responsibility of the Ministry of Labor and related agencies. Local health agencies have very little input on the issue despite the fact that occupational health and safety is very complicated. This draft law would empower the Department of Disease Control and health personnel in the provinces in the promotion, prevention, treatment and rehabilitation of those affected from occupation illness. It also places high importance on the environmental problem and health and safety issues. Presently, this draft law is under review by the Royal Decree Committee.

The Next Steps

The National Health Act of 2007 is a law that arose from the joint effort of Thai society to push for the development of a law that would improve Thailand's health system. This led to the announcement of the first and second charters on the national health system. In addition, the network partners of the government, civil society and academics have used the national health assembly as a platform to present views and work together on various health issues to develop public health policies and laws. Whether the efforts will become successful depends on the support from various networks, and joint efforts to pushing forward their goal, guided by the principle that "good health is not for sale, but one has to do it for oneself."

4 The 2nd Charter on National Health System: Towards the Future Development of Thai Health Services

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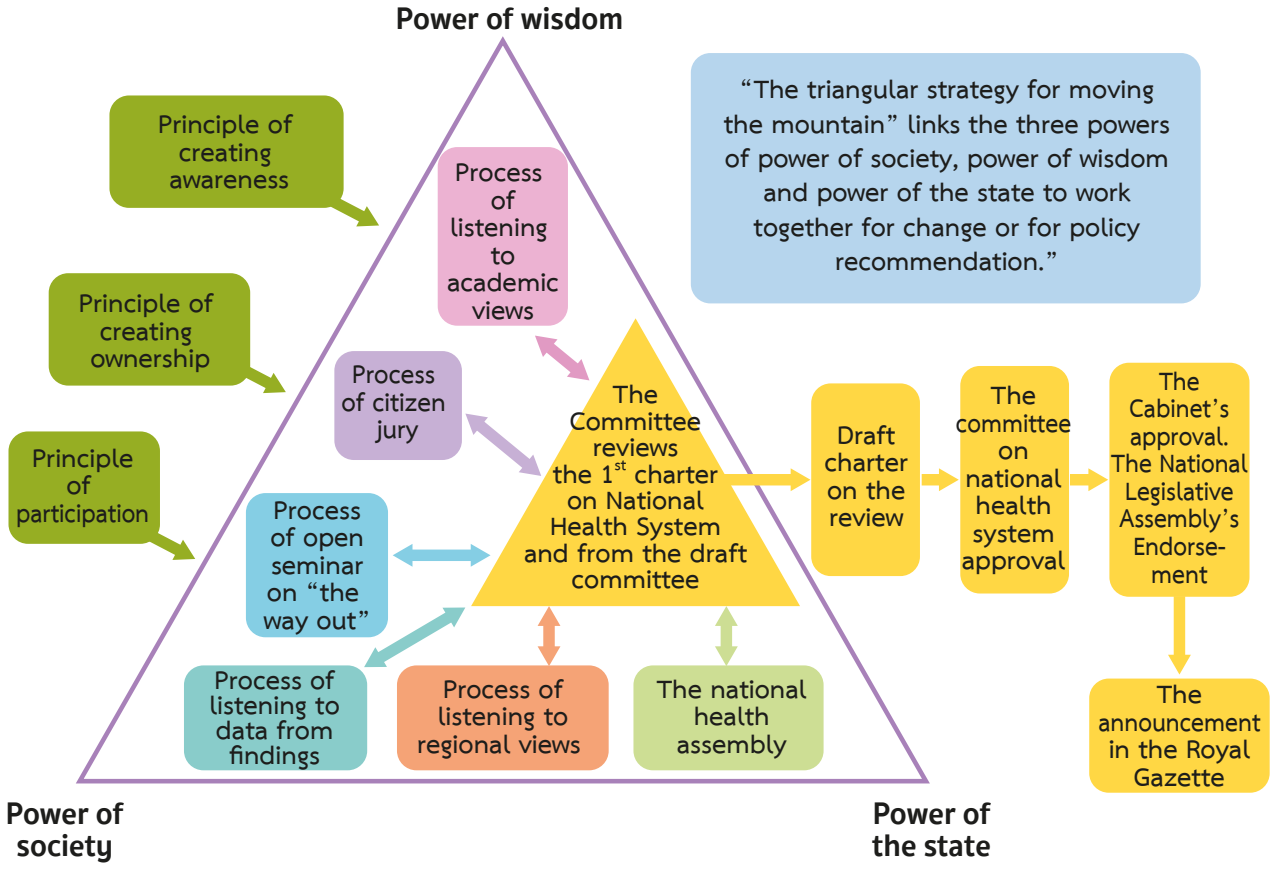
Thailand's new charter on the national health system was passed by the cabinet and the National Legislative Assembly, and was announced in the government gazette on 7 December 2016. This charter will be used as a blueprint for health strategy and policy development in the next 10 years. It emphasizes the concept of health as a basic human right where all national policies must take into account this principle. The charter was carried out by public participation in the drafting process and public referendum in all 4 regions of the country, before being submitted for hearing at the national health assembly on 8 May 2015. This article will summarize the main contents of the charter and its future health impacts.

Background of the 2nd Charter on National Health System

The National Health Act 2007 section 25[1] and section 46 established the Committee on National Health to be responsible for the development of the Charter on National Health System. This charter will be used as a framework for health strategy and policy development of the country. Section 48 states that after the approval of the cabinet, it is incumbent for government agencies and other related agencies to implement the Charter on National Health System. According to section 46 paragraph 4, the Charter will be reviewed at least every 5 years. The first Charter on National Health System came into use on 2 December 2009. Therefore, the review process of the first Charter took place in 2014 when the office of the Committee on National Health System set up a

Diagram 1

Process of Review of the 1st Charter on National Health System



review committee on 28 November 2014, headed by Dr. Narongsuk Angkhasuwpla[1]. The establishment of this committee was announced in the government gazette on 7 December 2016.

The review process of the committee was based on academic findings and health data. It gave importance to the participation process, and the feedback from all sectors according to the triangular strategy—the awareness and learning by the society, public participation, and creating ownership. The review process can be summarized as follows:

1. The process before the draft charter: A seminar was held in 5 venues to 'seek a way out' in order to listen to views of the public (organized in 4 regions and 1 central gathering with a total number of 500 participants). A meeting of public jurors of one event in order to hear views on systems for care in the long term for the elderly (jurors were sampled from the population in the North, Northeast, Central, South and Bangkok of 12 persons each) and work by the committee on academic research to study and compile data from various issues. The academic committee also received feedback and opinions from various stakeholders.

2. Process while developing the draft charter.

The secretariat and academics presented their data to the Committee. The Committee used the data in the drafting of the Charter and presented their progress on regular intervals.

3. Process after the completion of the draft charter: The process consists of (1) Public Hearing of the draft Charter at hearing venues in 4 regions with 1,115 participants. Hearing

venues at the 8th national health assembly on 8 May 2015 (430 persons participated) and hearing by written means (99 written replies from experts and government agencies, academic institutions, occupational groups, and the private sector) and (2) editing the draft charter and presenting it to the Committee on National Health System, the Cabinet and the National Legislative Assembly before announcing it in the Royal Gazette.

Comparing the 1st and 2nd National Health System Charters

1. The 2nd Charter on National Health System 2016 added information on health trends that may have an impact on health in the next 10 years.

2. Improvements and additions on new definitions in the 2nd Charter.

3. Five additional contents that include: a section on rights and responsibilities in health, section on psychological health, mental health, specialized health areas and a section on local charters. The process of review found that these issues are related to the changing dynamics of the country, and are expected to be important issues for Thai health systems in the future.

4. Reorganized the structure of contents of each section to have a section on " important principles" and "desired outcome". The implementation was not specified because of various possible ways that could be used and adapted to implement the Charter.

5. Added the intent of use, and explanation in each section of the charter, by bullet point in order for the reader and the user to better understand its meaning.

The 2nd Charter on National Health System and its impacts

The 2nd Charter specifies that health is a basic right of people at levels of individual, family, community and society. The word "health" defined by the national health Act of 2007 is rather broad and covers both legal, mind, knowledge and social aspects. Thus, the 2nd charter has added sections on psychological health and health of the mind, and rights and responsibilities, so that the society can better understand what their rights are and what their roles should be. Its intent is that all sectors take this path of "Health in all Policies" by creating policies that are in support of good health, whereby the state and all sectors must work as partners in networks and support participation of all sectors at all levels. They must have in their minds the social determinants of health[2].

Presently, government agencies such as the office of the Committee for the National Economic and Social Development Board (NESDB) and the Ministry of Public Health place importance in using this Charter in the development of the 12th National Economic and Social Development Plan (NESDB) during 2017-2022. It will serve as a basis for the 20-year National Development Strategy (2017-2036) with the goal of achieving the country's sustainable development. In addition, the Board of Investment (BOI) has begun using the Charter to set HIA standards for investment promotion in private hospitals.

Past Achievements of the 1st Charter on National Health System 2009

The first Charter on National Health System has led to the development of Thai health systems in many ways as follows[3].

1) Its use as a reference in the development of the national strategic plan:

- The 11th National Economic and Social Development Plan (11th NESDB) and the 12th plan for health development has placed importance in the promotion of health, reduced risk factors to health, promoted greater participation in the development of public health policies, developed health service delivery system, developed data base on health, developed public health personnel, and used

financial measures for health efficiency and sustainability.

- Strategy on the development of universal health care system (2012-2016) with the vision of "every person that resides on Thai soil to receive protection on universal health care", which is accordance with Charter section 3 and the Charter part 3, 6 and 12.

- Strategic plan for the Institute for Health Systems Research Institute (2011-2016) on "Knowledge management towards a system that is just and sustained". This uses the Charter part 1 point 7 and section 9 as the basis for its development.

2) Example of concrete references and implementation related to the charter in various parts include:

- Part 3: To insure and protect health. The Cabinet and the National Health Security Office (NHSO) supports health insurance for stateless people, migrant populations and informal workers.

-Part 5: Prevention of diseases and the control of health risks. (1) The announcement of eligibility guidelines and methods of assessment of the impact on health (HIA) (2) Support for HIA in the community. (3) BOI will not promote investment in private hospitals which do not follow the Charter.

- Part 7: Wisdom. (1) Support the first Thai traditional medicine hospital in Sakhon Nakhon province. (2) Promote Thai traditional medicine and traditional doctors in the universal health care scheme. (3) Develop national strategic plan for the development of local wisdom and traditional Thai health (2012-2016).

- Part 8: Consumer protection. The establishment of the committee to support education and monitoring the negotiation in trade agreements which might affect public health, and to present recommendations to the government.

- Part 10: Dissemination of information on health through the national health information committee.

- Part 11: Creation and development of health personnel. Recommendation on relationship management between doctors and patients. Increasing doctors to serve rural population.

- Part 12: Finance for health services. The establishment of the committee for development of financial mechanisms on health.

3) The use of the 2007 Charter as a reference tool in the development of local health charters, leading to more than 400 local health charters around the country.

The 2nd Charter and Health Impact Assessment

Health impact assessment is the process of learning together by the society so that the people, the community, government agencies, the private sector, and academics to analyze and forecast the impacts on health that might occur from certain policies and projects. This is done by applying various tools through a process of appropriate participation in order to come up with decisions suitable for the health of people in the short and long term.

HIA consists of 6 steps of: (1) Filtering of policies, plans, projects or activities by public screening. (2) Determining study zones and methods of assessment of health impact by Public Scoping. (3) Assessment of impact on health. (4) Review of reports on and analysis of impact on health or public review. (5) The push into the process of decision making or influencing. (6) Public monitoring and evaluation.

Section 25 (5) of the National Health Act 2007 designated that the Committee on Health set the guidelines and procedures for monitoring and evaluating the national health system and its impact on health that may arise from public health policies in its 1st report. But due to policies, projects and development activities that have changed rapidly, the National Committee on Health had the resolution on 19 May 2559 to review and improve its criteria and methods

of follow-up related to national health systems, and health impacts, to be more up to date[4]. The task was completed on 2 May 2016, and announced in the Royal Gazette on 6 September 2016.

The objective of developing the criteria in the 2nd Charter[5] is not only to create criteria, the implementation procedure, and strict regulations, but also the intention to promote public participation in the process, according to the intent of the Act on National Health Act 2007. These criteria can be adapted and used in more specific purposes depending on local issues and contexts. However, this must be done according to the 4 steps of (1) Proactive HIA. (2) Ongoing HIA. (3) Conflict and Complaint Resolution and (4) Sustainable HIA.

In addition to this criteria, the 2nd Charter specifies clearly that the assessment on health should proceed according to democratic principles, just and fairness, an appropriate use of evidence, an appropriateness of practice, the principle of participation, the principle of health inclusion and the principle of sustainability.

Towards Sustainable Health

The Charter on the National Health System is a framework and pathway to determine policy, strategy and implementation for the country's health system that would helps all sectors to better understand health from a broad perspective. It is health lens that incorporate the rights and roles in health as well as an awareness that all policies should take into account health aspects. It states that HIA be used as a tool for policy making so that good health could be sustained by Thai society. In the future, the health system of Thailand should be based on the 2nd Charter on National Health System, which has been much praised by its inclusive and participatory process.

5 The Draft Act on Patient Protection from Public Health Services

Public health services are about the quality of life. It is one of the four requisites of clothing, food, housing and medicine that humans cannot live without. When health and medical care alleviates or cures an illness, it creates wellbeing for the patient and his/her family. On some occasions, however, there are incidents when medical treatment causes injury and death, creating great financial loss for the cost of care and the legal expense involving court cases.

http://www.thairath.co.th/media/NjpUs24nCQKx5e1DGjstPIMsgn7TxCzBNQ1auQwO4Zs.jpg

In the year 2002, WHO had a program on Patient for Patient Safety[1] to encourage the disclosure of information on mistakes made by physicians in order to develop mechanisms to prevent damage and to save patients' lives. In Thailand, the system that prevents such damages is weak. Patients and their relatives thus jointly set up the Thai Medical Error Network (TMEN) in 2002 to demand for justice for affected patients, and to push for a mechanism to compensate them, in an effort to reduce legal cases. This led to the drafting of an Act to protect those who have been injured by public health services to reduce court cases between doctors and patients.

TMEN and the Medical Council[2]

In general, TMEN presented their cases to the Medical Council as follows:

1. The deliberation of petitions made by injured patients and their relatives takes a very long time (from 3 to 10 years).
2. Most deliberations have an outcome that states that the "case has no evidence", leading to no compensation for affected patients.
3. Health personal, as defenders, have better knowledge and good support on legal matters than patients and relatives who fight their cases to demand for justice
4. Witnesses are often trained by physicians before testifying in the court, whereas patients and relatives have less information and knowledge on medical affairs to fight their cases.

5. The medical networks usually seek cooperation and assistance from state agencies such as the national police during the investigation. Such practice could influence the deliberation of the cases in favour of the defender.

The problem of arbitration

In addition to the failure to achieve success in petitioning to the medical council, victims of medical mistakes also face obstacles in the arbitration as follows:

- The agency at origin does not have a special budget on compensation
- If the compensation is inevitable, public health agencies usually shift the burden to the hospital of origin
- The ceiling of compensation is not high enough to alleviate damages in the long term.
- Patients and relatives feel that the arbitration usually leads to the status quo and take no action.
- The hospital in the arbitrated case usually does not provide medical equipment or supplies to assist disabled patients to recover.

The problem of suing and taking the case to court

When arbitration does not work and the case is taken to court, the affected patients and relatives have to confront prolonged legal battle and suffering as the followings:

- Patients and relatives will most likely lose their cases because it is an uneven fight between common villagers and a large and well-funded medical networks.
- Deliberating the case can take a long time of 10-12 years.
- The affected patients find it difficult to find a medical witness. As the burden of proof rests on the patients or relatives, fighting the case is an uphill battle.
- Medical records are the only evidence in any incident, but they are in the hands of the health facility. Therefore, the patient may not get the information needed, or the information risks being tampered with by the defender.
- Fighting the case can be very expensive for patients and relatives.
- When the case is taken to court, conflict between the doctor and patient increases and the relationship between the two is harmed.

Lessons learnt from a case study

Incidents of conflict between receivers and providers of medical services have increased tremendously. A classic example of such cases was an appendix operation in 2002. Mrs. Somkuan Kaewkongjun[3] received an appendix operation at Ronpibul hospital in Nakhon Si Thammarat province. But an error took place when the doctor gave a spinal cord injection to Mrs. Somkuan, resulting in a complication that caused the life of Mrs. Somkuan. The children of Mrs. Somkuan took the case to court as a criminal case. The court of Thungsong province gave a verdict of imprisoning the doctor for 3 years without suspension of the sentence. This case created huge conflicts between the medical network and the people's network, leading to the closing of operating rooms in all community hospitals around the country as a protest.

In addition to the criminal case, the incident also involved a civil court case as the children of Mrs. Somkuan asked for compensation from the Office of the Permanent Secretary of the Ministry of Public Health. This case had prolonged for many years until 11 May 2016 when the Supreme Court gave the verdict that the Ministry of Public Health compensate 1.2 million baht with an interest of 7.5 percent per year to Mrs. Somkuan's family (in this case, the court of first instance gave a similar verdict, but later the court of appeal reversed the verdict)[4].

The problem of receiving initial compensation according to Section 41 of the National Health Commission

Even though the National Health Act of 2002 protects the health service receiver from the medical mistake by providing an initial financial assistance, according to Section 41, but in practice there are still problems in requesting for the initial assistance as follows:

- This financial assistance covers only patients under the Gold card and does not cover patients in other schemes.
- The ceiling for the assistance is not more than 400,000 baht, and not all cases will reach this ceiling.
- The initial financial assistance is to alleviate the initial problem only, and cannot be a long term solution.
- The standards of the committee in each province differ, resulting in no national standards.
- In cases where assistance is not approved or does not reach the ceiling, there is an appeal to the administrative court. This is not the intent of Section 41 that has the objective to assist patients without proving right or wrong.

Draft Act on protection of persons affected from public health services: A new path to reduce conflicts

During the years 2002-2006, there was a crisis in the relationship between medical personnel and relatives of injured patients[5]. As there was an increase in the number of court cases, two patients were shot and killed and two doctors were imprisoned. Many relatives of injured patients were also jailed for stealing medical records from the hospital. At the end of 2006, the Minister of Public Health at the time, Dr. Monkol Na Songklha gave the order to draft a law to protect those affected from public health services. Representatives from all sectors came together to draft this law, using the Swedish law as a model.

The intent of the draft law was to protect persons affected from health services in order to reduce the number of patients suing doctors. The main principle was to have a compensation fund with a standing committee that deliberates compensation that is efficient and just. The process would take no more than 1 year to reach decision. The advantage was that it would reduce the number of cases going to court. The patients and relatives would not waste their time, money and ill will. Importantly, it would bring back good relationships between doctors and patients. Money was to be acquired from the universal health care of 2008, the social security scheme, the civil servant fund, and private hospitals.

Disagreements between doctors and the TMEN

At the end of 2010, the draft Act on the protection of those affected from public health services passed deliberations from the Council of State after 11 months, and was included in the agenda to be discussed in parliament. However, private hospitals together with many elements in the medical council did not want to make contribution to the compensation fund. They thus incited doctors around the country to wear black to pressure the government to suspend the draft Act, resulting in the delay of deliberations of this law.

The network of affected persons later campaigned for the public to send letters to the Prime Minister and House Speaker to support the law to go ahead. When the government did not take any action, the network gathered support from the media. Finally, the cabinet approved the draft Act, but the medical council still objected it. The medical council requested that the initial compensation fund be extended further instead of passing a new law that would require more contribution from various parties.

The NCPO gave the green light to the New Law

During the era of the NCPO under Prime Minister Prayuth Chan-o-cha, there were attempts to solve the issue of people affected from medical services again. The Committee on Legal Reform began a new draft law to cover only patients in the three health funds—the Gold Card, the Social Security and Civil servant fund. Private hospitals could join on a voluntary basis. The TMEN once again campaigned via Change.org[6] to urge the NCPO to push forward the draft Act through a collection of 22 thousand signatures[7]. Later the Commission for Protection of Consumers of the Council for National Reform drafted a new law called "Draft Act to Protect Those Affected from Public Health Services". The Council for National Reform later passed the draft Act with a vote of 148 to 13, no vote of 18, and presented this draft Act to the cabinet on 29 July 2015 for consideration. Later, the Ministry of Public Health worked on the draft Act that covers only the three funds. Professor Dr. Piyasakol Sakonsatayatorn, the Minister of Public Health presented this draft to the Cabinet in June 2016, but the cabinet sent it back for the revision.

Later, General Chusak Santiworawuth, Chair of the sub-committee on Consumer Protection, Commission on National Social Reform, the Council on National Reform presented the case to the Extraordinary Committee and finally received approval to include this draft Act in the parliament deliberations on 16 January 2016. In this session, among 151 persons in attendance, 48 persons voted yes for the draft Act, 26 persons voted no, and 77 abstained from the vote. Since the supporters of the draft Act were less than abstained voters, the meeting requested for later consideration of the draft Act in the future meeting[8].

The Draft Act on Protection of Those Affected from Public Health Services

The main point of the draft Act is the establishment of compensation fund for both providers and receivers of public health services in order to reduce the number of court cases. General Chusak Sunthiworawuth stated that this Act has the mediation process that is just and has a compensation fund without the need to determine wrongdoings. Even though there is a mediation process, the affected parties still able to take their cases to the court. The compensation fund consists of 1% from the three health funds, according to section 41 of the universal health care of Thailand.

Not all members of the National Reform Council supports the draft Act. Assoc. Prof. Kitti Pitaknitinun is of the opinion that the rights to this protection should cover all persons, and all service organizations, in both government and the private sector. It should provide details of exemptions that are not covered in the compensation. Kasit Bhirom wanted more specifics from the Commission on whether this law actually gives benefits to those that actually make mistakes in both the hospital as well as pharmacies, and pushes the burden of responsibility to tax payers in the establishing of the compensation fund[9].

Transitioning into the future

The Draft Act to Protect Those Affected from Public Health Services is a long struggle between the network of persons affected from public health services and the network of medical service providers that lasted for many governments. From the first calls for justice by patient groups to the draft law, and then placed on the back burner, until it became alive again, it took a total of 15 years for the struggle to have this law in place. The Council on National Reform has re-ignited new hopes that the law would soon materialize, and that conflicts between the providers and receivers of medical services could be resolved.

6 Registration of Low-Income Persons: Reducing Inequality and Improving the Quality of Life

Back in June 2016, the Thai government initiated a policy to compile the list of low-income earners, those whose income are not more than 100,000 baht per year, in order to plan for welfare benefits suitable for them. The Finance Ministry was in charge of implementation of the project called “Registration for State Welfare”. Qualified persons were asked to register at 3 Thai banks and wait for the proof of their validity by government agencies. At first, it was not yet clear as to what benefits they would receive. However, the policy was aimed at improving the quality of life of low-income earners, and reducing social and economic inequality in Thailand[1].

Challenges of the poor in Thailand

"Poverty" is one problem that has arisen in Thai society for some time, causing health deterioration and affecting the daily life of many people. The poverty in Thailand has increased over the years and undermined national development and the quality of life of millions of people. The root causes of poverty in Thailand include:

1. Internal factors. Lack of opportunities and limited capacities to earn incomes such as poor infrastructure, lack of negotiation power, little knowledge, etc.

2. External factors. The economic system which is a mixed economic system between capitalism and socialism. But in practice, capitalism in Thailand led to the exploitation of natural resources at the expense of the local community. As income distribution deteriorates, poverty has increased.

The main causes of death among Thai population are cancer and heart disease, which affect more low-income people than other groups. Therefore, the reduction of poverty will not only solve the economic problem, but it will also lessen the health problem as well. It will certainly boost the quality of life of the majority of people in the country.

Registration of low-income persons

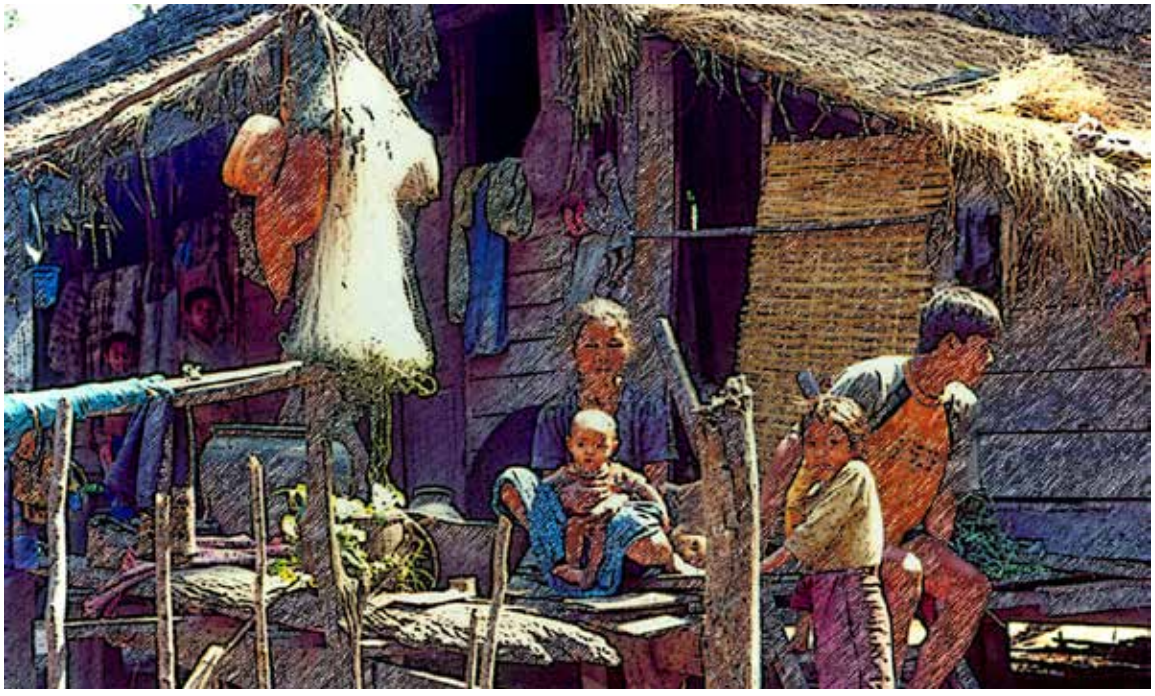
In order to solve the problem of income distribution in Thai society, the government of General Prayuth Chan-O-cha has initiated a policy to register low-income people between 15 July-15 August of 2016 to update the government's data base of the level of poverty in Thailand, and to develop state welfares for them. On 22 November 2016, the Cabinet approved the policy initiative. The "low-income person" according to the criteria set by the government is a person that is of Thai nationality, aged over 18 years on 15 August 2016 (or born before 16 August 1998) and is not employed, or those whose income are not more than 100,000 baht in the year 2015[2].

Those who wish to register must provide information on the status of their assets. The assets that have to be declared are:

- Income proof, which includes monthly income, savings in the bank, bond holdings, etc.
- Assets such as land, buildings, vehicles such as car and motorcycle.
- Debts that include loans from banks, informal loans, credit card debts, agricultural debts, business debts, education debt, consumption debt, land purchase debt. etc.

State welfare is separated into two categories: cash assistance of 3,000 baht for persons with an income of not more than 30,000 baht per year; and cash assistance of 1,500 baht

In 2016, it was found that there were 5.4 million[3] applicants who were not farmers. Among them, 3.1 million applicants earned not more than 30,000 baht per annum, and 2.3 million others earned 300,001-100,000 baht per annum. The total welfare subsidy amounted to 12,750 million baht.



for persons with an income between 30,001-100,000 baht per year. Financial payment will be done by bank transfer through the Bank for Agricultural Cooperative or the Government Savings Bank.

After the first stage of the registration, the government had decided to extend the program by opening another round of registration in April 2016[4] to allow those who missed the first round of registration to join the program. Details of the benefits include the followings:

- An identity card for low income persons to receive benefits from the government in the future such as reduction in water and electricity costs, free ride for public buses and trains.
- Life insurance for low income persons with a premium of 99 baht per year that covers 50-60 thousand baht insurance for accidents and illness.
- Subsistence allowance for the elderly with low income. In the case of elderly with a higher income, they can also use this benefit to replace their elderly allowance.

Those who desire to register can go the website of the Revenue Department and register. The steps of registration can be done in two ways:

1. Filling in the form at the bank under the project.
2. Download the form from the website of the Ministry of Finance or banks under the project, fill out the form, and take it to the bank under the project.

Past programs and Comments

As a matter of fact, the project is nothing new in Thailand as previous governments also introduced similar policies. For example, the Thaksin government launched the program of "registration of poor people" where 7 million people registered. During the Abhisit government, there was a measure called "checks to help the nation" where checks of 2,000 baht were given to low-income people in 3 groups of[5]:

1. People who contribute to the social security fund with an income of less than 15,000 baht, and those who have been laid off, or resigned from work and are waiting their unemployment compensation. There were 8.1 million persons.

2. Pensioners of 2.3 hundred thousand.

3. Government personnel of 1.4 million persons

Later, the Yingluck government adopted two policies to help low income persons[6]:

1. The policy on increasing the minimum wage to 300 baht per day.

2. The policy on the minimum salary of whose who obtain a bachelor degree of 15,000 baht a month.

Though each government had good intentions in raising the quality of life of people, however, there are different views among social critiques on these programs. Major debates on the policy of the current government are as follows:

General Sunsern Kaewkumnerd, the spokesperson attached to the Prime Minister's Office, viewed that the government policy would boost consumption in the country, increase income distribution, and reduce debts of the poor. In addition, the registration of low income persons would help improve the database that will be useful for targeted measures. However, the persons who received the benefits must also make efforts to help themselves.

Krisdika Jeenawijarn Director of the Fiscal Policy Office stated that the registration policy would support economic growth as it would increase internal dynamism. The asistance of "disadvantage groups" was necessary for the country.

But Pichai Naripthappun, former Minister of Energy under the Yingluck government had a different opinion. He stated that the policy would not create any benefit in boosting the economy because in reality the entire economy dis not depend on the financial hand-out to one group only.

Dr. Nonrit Bisalbutra, an academic attached to Thailand Development Research Institute (TDRI), gave an interview to the Isara News Agency that the assistance would boost the economy as it was the distribution of money to the populations who would use it for consumption purposes. But when asked if this was a good policy or not, he was quoted as saying: "as an academic it is very worrying because policies such as this are not farsighted while Thailand has a far more important problem of indebtedness. That is, the people are still not able to manage their own debt. If we give out money and do this without trying to change the behavior of the people, the situation will not change. The burden of debt will never change like water draining out of a sandy pitch. Thus, whatever policy that comes out, it must be very careful because we are using tax payer's money". Dr. Nonrit stated that we must first solve the problem of household debt, though not easy and may take some time, it was essential that we change the spending behavior of the Thai people[7].

Conclusion

The program on the registration of low-income people to receive government welfare is one program that has the objective of raising the quality of life of the Thai people. In the first stage of the program, some people were not able to access the program, and the registration figure was lower than was first estimated. This resulted in the expansion of the program as well as the benefits designed for them. Although the government has a policy to assist as many people as possible, the people themselves should rely on themselves and develop their own capacity, work hard, have financial discipline, and increase their savings in order to raise their quality of life in the long run.

7 Measures to Assist the Elderly in Ageing Society

It is auspicious that the cabinet approved measures to help the elderly as presented by the Ministry of Finance in November 2016 to prepare Thailand for an ageing society. The measures consist of promoting employment for the elderly, building residences for the elderly, reversed mortgages for the elderly, and the integration of pension schemes. These measures will help to strengthen the security of the elderly by increasing their income generation, savings and home ownership.

Thailand and the elderly

Thailand passed the threshold of an ageing society in 2005 (the aging society takes pace when the population aged 60 and above are more than 10 percent of the total population). From that point on, the proportion of the aged population increased to 10.8 percent or 17% of the total population, according to the National Economic and Social Development Board (NESDB, 2013)[1]. Thailand will become a fully-aged society when the proportion of population aged 60 and above reaches 20 percent in 2021. In 2031, Thailand will become a super-aged society when the population aged 60 and above reaches 28 percent of the total population.

This occurrence is likely to affect the development of the economy and society at the individual level, family level, community level and the national level, and dramatically change the picture of Thai society. The Thai

population will age at a very fast rate as the workforce will have a lower proportion. As the household size reduces, the way elderly live will also change. The government must therefore come up with policies and measures to prepare for an ageing society.

Measures to help the elderly

Measures to help the elderly in the past emphasized the security of income by paying out subsistence allowance for the elderly. But it is still not sufficient to maintain a high quality of life for the elderly. The government also promotes good health through the dissemination of health knowledge so that the elderly can maintain good health both physically and mentally when they get old.

Currently, the issue of employment of the elderly has gained strong interests in Thailand. Research studies and seminars have promoted longer work life for the elderly in order that they maintain the quality of living with similar standards to what they have before retirement. Active ageing would also promote psychological and social health of the elderly. This thinking is a positive sign that the Thai society is aware of the ageing society and make efforts to support the elderly. The new government measures are as follows:

1. Measures to employ the elderly

For any organization that employs a person aged 60 years and above, the salary paid to the elderly can be tax-deducted at a high rate (when a salary of the elderly is not more than 15,000 baht per month). The employer can use this right up to 10% of total employed workers. The employee, however, cannot hold any shares in the organization, and is not a board director or senior manager of the organization[2].

This measure can be considered as a form of income security for the elderly so that they can take care of themselves in the long run[3]. It is a change from the previous view of the elderly "as a burden" to "a value" in the society. Although income from children is still dominant, there is a tendency that this traditional income source will decline in the future as Thai people have fewer children[4]. Promoting longer working life and active ageing for the elderly is an important issue not only for income generation, but also for mental and social health reasons.

2. Measures to build residences for the elderly

This measure promotes the building of homes designed for the elderly in order to improve their quality of life and to secure home ownership. Chonburi, Nakhonnayok, Chiangrai and Chiangmai provinces are chosen as sites for the new elderly residences to be built by the National Housing Authority and the Institute for Community Development[5]. This measure will also give the first right to children who are care providers for parents. It reflects the culture of Thai society that children are expected to look after their parents. For those elderly residing in their original homes, they will not require a new place of residence. But there is a tendency that they will be living alone or will be living with

their spouse in the future. This measure will thus include the improvement of original homes of the elderly to suit them, rather than moving them to the elderly residence complex.

3. Reversed Mortgage for the elderly

Home mortgage means a long term loan from a financial institution or bank to purchase or build a residence, whereby that residence is used as a collateral for mortgage to the bank or the financial institution[6]. This particular measure, however, is to provide a loan to the elderly aged 60 years and above who already have a residence that is free from any debt, so that the elderly can use this residence to generate an allowance, where the amount of the loan will depend upon the age of the person, the value of the house and the interest rates. The elderly can choose to receive payment as a lump sum or in installments until their death or until the end of the loan contract. On their death, their residences will be owned by the bank[7]. The person taking out the reverse mortgage does not have to prove their income, nor do they have to undergo a health check-up. Only the house and land that is free from debt is sufficient for the scheme. This measure is already in use in the United States and South Korea[8]. In Thailand, some banks have agreed to join the government scheme such as the Government Savings Bank[9]. This measure aims to help the elderly who are not civil servant pensioners, and those who do not have sufficient savings, or children to care for them. The number of elderly in this group shows a tendency to increase every year.

4. Integration of the pension systems

This measure supports compulsory savings in order to create income security when one gets old. A survey of the savings of the elderly[10] found that the Thai elderly have a very low level of savings; 65 percent of persons aged 60 years and above do not have any savings at all. It means that Thai elderly do not have any income security after their retirement, especially those in the informal labor sector, or those who do not belong to any provident fund.

This measure requires the set-up of a national committee on the provident fund under the chairmanship of the Prime Minister. It is tasked to set a policy and direction to develop the national provident fund that is to be "compulsory provident fund" that covers private sector employees, temporary employees of the government, government staff and state enterprise employees aged 15-60 years, who are not members of any previous provident fund. The money to support this will come from two sources: the employees and the employers. The employee will receive a pension in a lump sum or monthly basis when they reach 60 years of age, so that they will have a sufficient income after retirement. It requires that the fund be open for membership in the year 2018 onwards. Employees and employers will each contribute to the fund at 3% percent of the salary, but not more than 1,800 baht a month, and gradually the rate will increase to 10% in the tenth year. But employees with a salary of less than 10,000 baht do not have to contribute to the fund, whereas the employer will have to make contribution still[11].

The survey on the informal labor sector of the National Statistical Office 2015[12] found that there were 38.3 million persons employed in Thailand, of which 16.9 million were in the formal sector (41.1%), and 21.4 million (55.9%) were in the informal sector. Of the 16.9 million persons in the formal sector, a high proportion was not members of any provident fund. They include employees in the private sector, temporary employees in the government sector, government and state enterprise staff. This measure will help to increase savings of informal labour after retirement by up to 50% from the current number of 19%. It will also urge labor in the formal sector to save more for their retirement. It is estimated that this measure will increase the level of savings of the country by 68,000 million baht[13].

The step forward

The acknowledgement of the rapid increase of older persons by the government and various stakeholders has led to the implementation of four measures to help the elderly. These measures will help the elderly to have more security in their income and to secure income savings for their retirement. Moreover, it will also reduce the burden of care of the elderly by the government and society as they will be able to take care of themselves better. Importantly, the elderly should be viewed as an active agent in society, and that they should have a good quality of life in their later lives, both physically and mentally.

8 Thai Migration Policies: Preference for Labour Import via the MoU Channel

On 23 February 2016, the Thai Cabinet approved the resolution to regulations for two major groups of foreign labor that hold the alien card (pink card), and those that hold the ID card from their country of origin, to stay and work in Thailand for two more years ending on 31 March 2018. Foreign labor in both groups must report and register with the Thai authorities, and request permission to work and obtain a foreign identity card (pink card) during 1 April- 29 July 2016. This resolution was expected to reduce irregular migrant workers in a more organized manner. This move also signaled the policy preference of direct labour imports from the country of origin via the MoU channel. Whether this policy to solve irregular labour migration will be successful or not remains to be seen. In 2016, the number of foreign labor registered totaled 1,178,678 persons, whereas it was estimated that there were more than 4 million migrant workers in the country[1].

The management of foreign labor from the past to the present

Thai immigration policy concerning foreign labor was to reduce the problem of irregular migrant workers. Its policy in the past 20 years focused on modifying immigration and employment regulations to allow foreign labor to reside and work temporarily in the country. From 2005 onwards, the Thai policy of foreign labor management has been more institutionalized, and Thailand has collaborated with its neighboring countries by signing Memorandum

of Understandings (MoUs) on legal employment of foreign labor in two aspects:

One: Allowing foreign labor to reside and work in the country while waiting for the proof of their identity with the country of origin. This led to the issuance of temporary passports or official substitute papers for migrant workers in Thailand.

Two: Direct labor imports through legal employment agencies according to the Memorandum of Understanding on the Employment of Workers between Thailand and neighboring countries including Cambodia, Myanmar, Laos and later Vietnam.

In the year 2015, the number of foreign labor allowed to live and work in Thailand while waiting for identity check was approximately 1 million persons, and those with proven identity numbered 989,374 persons. Meanwhile, foreign labor who came through the MoU system accounted for 279,311 persons a steady increase from 9,877 persons in 2006, 100,000 in 2013, and over 200,000 in 2014. Nevertheless foreign labor who went through the MoU process still constitutes a much smaller proportion compared with irregular labor (see Table 1).

Table 1 Number of foreign labor of three nationalities (Myanmar, Lao and Cambodia) from 2005-2015)

Year	Proven identity	MoU Channel
2005	1,681	0
2006	49,214	9,877
2007	72,096	14,150
2008	71,017	17,059
2009	77,914	27,447
2010	228,411	43,032
2011	505,238	72,356
2012	733,603	93,265
2013	847,130	174,042
2014	971,461	206,168
2015	989,374	279,311

Source: Data from the Office of Foreign Labor Management: http://www.doe.go.th/alien

In addition, Thailand has allowed cross-border employment as seen in Section 15 of the Foreign Employment Act of 2008.

Thai Migration Policy on foreign labor in 2016: Great confusion in the registration process

The Thai Cabinet agreed to the registration of two foreign labor groups, those with the foreign permit (pink card), and those with the identity card provided by their country of origin, from 1 April -29 July 2016. The employment permission will end on 31 March 2018. Afterwards, these two groups must undergo another registration and request for a new work permit. This policy led to the registration of 1,178,678 foreign migrant workers, despite the fact that close to 3 million migrant workers were estimated to live in Thailand[2].

The network on foreign labor stated that although this policy was intended to relax employment regulations for foreign labour, but it might cause negative consequences for those with proven identity, because it would turn them into irregular migrant workers who needed to register and wait for another identity check. As a result, the policy will lead to a vicious cycle of irregular migration again[3].

Long-term policy emphasis on the MoU Channel

Aung San Suu Kyi Chi, in her capacity as adviser to the President of Myanmar and Foreign Minister, made an official visit to Thailand on 23-25 June 2016. During her visit, a signing

ceremony on three new MoUs between Thailand and Myanmar took place. The MoUs which emphasized the care and protection of foreign labor was seen as a positive development of Thailand's policy on foreign labour management.

1. The first MoU was on cooperation i n foreign labor that specified the development of relationship and support in both countries that will be the basis of foreign labor skill development, protection of foreign labor and social insurance.

2. The second MoU is on employment of labor that determines a process of training for preparation of foreign labor before they travel to outside by the country of origin. The country of origin is to develop a clear employment contract, determine the role and responsibility of the private employment agency and change the conditions of work from originally that set "foreign labor able to work in the country of destination of no more than 2 years per time for two inclusive time periods (or a total of not more than 4 years) and then to return back before to the country of origin for 3 years before they can then return back to work again" changed to " when work is 4 years completed foreign labor must return back to the country of origin for 30 days and then return back to work" (after the completion of both MoUs with Myanmar Thailand developed a similar agreement with Vietnam on 23 July 2015 and with Kamphuchea on 19 December 2015 and with Lao on 7 July 2016.)

3. MoU on Border crossing between 2 countries. In this agreement, there is a section on cross-border migration to support the special border economic zones in Thailand.

In addition, the cabinet resolution on 25 October 2016 approvve the Strategy on Management of Foreign Labor 2560-2564 that consists of a 5 areas as follows:

Strategy 1- Mechanism to reduce dependency of foreign labor

Strategy 2- Control, direct and care of foreign labor

Strategy 3- Determining standards of employment of foreign labor according to international practices

Strategy 4- Efficient management of foreign labor

Strategy 5- Monitoring and evaluation

Table 2. Foreign labor statistics, November 2016

Type/nationality	Myanmar	Cambodia	Laos	Total
Nationality verified	754,037	99,030	63,025	916,09
MoU	188,979	149,485	43,502	381,966
Extended permit	723,360	385,829	69,489	1,178,678
Fishermen	27,224	21,730	1,038	49,992
Seafood Processing	100,870	35,632	4,408	140,550
Border employment	596	6,436	-	7,032
Total	**1,795,066**	**698,142**	**181,102**	**2,674,310**

Source: Foreign Workers Administration Office: November 2016

Strengthening management of foreign labour

In addition to the MoUs, the Ministry of Labor suggested that there should be a new royal decree to regulate the employment of foreign labor in 2016 to reduce irregular migrant workers. This decree passed on 16 August 2016 has the objective of controlling the recruitment and employment of foreign labor and preventing the illegal migration of foreign labor. This decree sets two major conditions for the recruitment of foreign labour:

1. The employer who brings in foreign labor by themselves must place insurance money to the authorities.

2. The employment agency that has a license must place insurance money not less than 5 million baht.

This decree made it clear that employment expense must be paid by employers, not employees. Also, if an employment agency violates the agreement, the insurance money they placed with the Department of Employment will be given to employers. Moreover, it requires that the recruitment agency and the employer be responsible for foreign labor that they bring in to the country. These measures will protect foreign workers and employers as well as to improve the control of employment agencies in Thailand[4].

Also, the cabinet resolution on 26 July 2016 established 3 service centers for foreign labor in Tak, Sakaew and Nongkhai provinces to provide advice on labor laws, and the coordination with employers after the completion of employment contract[5]. This arrangement will assist foreign labor who come in through the MoU process.

Obstacles in bringing in foreign labor via the MoU Channel

Though the Thai government and the Ministry of Labor have plans to increase the import of foreign labor through the MoU channel, there are still concerns to the success of this policy. Looking at the statistics, the number of labour import from the three neighboring countries of Cambodia, Laos and Myanmar through the MoU channel was around 200,000 persons, compared to the total number of foreign workers at 4 million plus (see Table 1).

The main obstacles to bring in foreign labor through the MoU process are the complicated procedures involved, high expenses, and the long waiting period. On this issue, Dr. Nuttanan Vijitaksorn, researcher attached to Thailand Development Research Institute, commented that "the tendency for the number of foreign labor (via the MoU channel) to increase or decrease depends on the active implementation of this law. One problem is the long procedure for the national verification of prospective migrant workers. I would recommend the government to develop new regulations and amend certain parts of the MoU to be less complicated, to reduce expenses to be suit the income of the labor, to expand or set the time period for the registration to be more appropriate with the types of work, and to allow workers to change employers"[6].

Concerning the MoU with Vietnam, it was found that from 23 July 2015 until 31 December 2015 there had been no import of foreign labor from Vietnam. One reason was that Thailand set conditions that Vietnam labour can only work in two occupations of fishing and construction industries, whereas the demand for Vietnamese labour was in other occupations such as retailed sales and restaurant services.

Another challenge to manage foreign labor is the cross-border migration of labor in the special economic zones along the Thai borders. Because, illegal travel across borders can be done easily, the possibility of solving illegal employment is difficult.

As the population structure of Thailand is becoming an aging society, the need for foreign labor is likely to increase in the long-run because of the declining Thai workforce. Dr. Thanapong Podhipud's research on "The need for foreign labor in an aging society" projected that at least 6.4 million foreign workers will be required in 2030. But if Thailand wants to maintain stable GDP growth, it will need a total amount of 9.14 million foreign workers[7]. If the government wants to control labour import by focusing on the MoU channel only, there would be a great bottleneck in labour imports.

Future Steps

The recent management of foreign labor in Thailand was not much different from the past as it emphasized the regularization of foreign labour in the country to reduce the number of irregular migrants, coupled with the encouragement of foreign labour imports through the MoU channel. However, the new royal decree which aims to better regulate labour imports and employment conditions for migrant workers should be able to improve labour management in Thailand. However, the inefficient MoU process requires the Thai government to negotiate with the origin countries to speed up the process and reduce its related expense. Thailand should try to reduce obstacles in the MoU channel in order to increase regular migration and reduce the number of irregular migrants in the future.

9

Special Economic Zones: Precaution Is Better Than Cure

In early November 2016, the Love Maesot Locality Network and 60 local representatives of the North filed a lawsuit with the Administrative Court in Phitsanulok province to oppose the Treasury Department's plan to turn its land into special economic zone areas. These areas are in Maesot District of Tak province. Representatives of the local areas affected stated that they did not object to the development policy, but they demanded justice as villagers who lived in the areas should be protected, and they should be given an alternative to make a living.

Sumitchai Hathasaarn, lawyer from the Center to Protect and Revive Localities, stated that this lawsuit arose from the announcement of the head of the NCPO of 17/2015 that led to the Treasury Department's land reclamation of 2,183 rai to set up the special economic zone in that area. Villagers filed the lawsuit to the Land Office, leading to the Land Office's order to investigate property ownership of villagers. Later the Land Office specified that the Treasury Department had the rights to own the land. However, the law allows villagers to send this matter to the Administrative Court for consideration. This case is still pending the court's decision[1].

Before this incident, there were also moves to request the government to review its policy on the special economic zones in many provinces. On 16 August 2016, civil society groups in 13 districts of Narathiwat province met the Deputy Governor of the province and representatives of the southern border province administrative center region 4 in order to present their view, to be forwarded to the Prime Minister. Villagers were concerned that their culture, the way of life, and identity would be harmed as a result of this development. They also want to participate in the mechanism to establish the special economic zone in the area. This result in the declaration of 18 points to be

submitted to the government to take into account the way of life of the people, natural resources and the environment[2].

The events above reflect the viewpoint of the community in border areas towards the policy on special economic zones. This chapter will discuss the background of the policy, their impact, and local movements of the civil society on the policy.

Thailand's policy on special economic zones

The government under the NCPO has introduced a policy to set up special economic zones along border areas in many provinces. Its objective is to raise the level of economic development, trade and investment by "linking economies in the ASEAN region and expand cooperation in the Greater Mekong Sub-region which is part of the agreement in cooperation between the Ayeyawady- Chao Phraya - Mekong Economic Cooperation Strategy (ACMECS)"[3].

The government focuses on the development of trade and investment zones the gates to support regional linkages that will arise through the special economic zones. These zones have been established by special laws that promote, support and provide special conveniences and privileges to of businesses that will be of benefit to the economy.

From 2014 onwards the government set the policy to develop special economic zones in many areas. The implementation of the first phase began in 2015 in border areas which showed high potential including Tak, Srakaew, Songkhla, Mukdahan and Trat provinces. The second stage began in 2016 in Nongkhai, Narathiwat, Chiangrai, Nakhon Phanom and Kanchanaburi provinces. Section 44 of the temporary Constitution of 2014, which gave special power to the Prime Minister, was used to demarcate the area for special economic zones, resulting in the change of land use. This policy was opposed by local people in many border areas as people's participation in the decision making was non-existent. Locals wanted the government to uphold sustainable development by protecting fertile areas, natural resources, and coastal areas to secure sustainable life of the people.

The view of the government

The concept of special economic zones has the main objective of spreading development to various areas so that the prosperity will not be concentrated only in large cities. In addition to the development of specific areas such as special economic zones, it hopes to raise the standard of living of local people in the surrounding area as well[4]. The policy committee on the special economic zones has a strategy to: 1) develop new special economic sites in border areas to increase benefits from the link with neighboring countries; 2) to support Thai SMEs to invest continually in the neighboring countries; 3) to manage the border area properly, to solve the issue of irregular migrants and smuggling of agricultural products from neighboring countries.

In each zone, there will be different activities depending on the potential of the area and local need. Activities are grouped into 13 industrial categories and 62 activities such as industrial ceramic production, precious stones and jewelry, and tourism industry (see Table 1). Later, the government added 10 other target activities, according to the announcement of the Policy Committee on investment 12-16/2015 on 10 January 2016 (see Table 2)[5]. The special economic zone is seen as a strategy to improve comparative advantages of the Thai economy.

Though the government has clearly announced the plan to establish special economic zones in 10 border provinces, but the

progress has been slow[6]. Investment is below expectation as investors are not yet fully confident in the project. They are concerned about future Thai politics after the next election. Moreover, special economic zones in many areas are troubled by protests and the land use issue[7].

Impacts on the local community

In 2015, the policy committee on the development of special economic zones began a feasibility study in the first 5 zones (Tak, Songkhla, Mukdahan, Trat and Sakaew). It studied both the physical and financial aspects of the projects such as architectural, engineering, investment, cost-benefit issues. Management and marketing issues are also covered. In 2016, the committee began a study on the environmental impact assessment (EIA) and carried out public forum for stakeholders and the local community.

The civil society has both positive and negative views on the establishment of special economic zones. Positive impacts are that people will live better lives, their children will find it easier to find jobs near homes, new

Table 1: Target industries in the areas

13 Industries (62 types of business)	Tak	Sakaew	Trat	Mukdahan	Songkhla	Chiangrai	Nongkhai	Nakon Phanom	Kanchanaburi	Nara-thiwat
1. Agriculture, fishing and related activities	✓	✓	✓	✓	✓	✓	✓	✓	✓	The Board of Investment issues BOI Announcement No. 4/2557 and the list of targeted industries being promoted in the Special Economic Development Zones, in accordance with the Announcements of the Board of Investment Nos. 1/2558, 2/2558, 3/2558, 4/2558, 5/2558.
2. Ceramics	✓							✓	✓	
3. Weaving, clothing and leather	✓	✓			✓	✓	✓	✓	✓	
4. Household products	✓	✓			✓	✓		✓	✓	
5. Precious stones and jewelry	✓	✓				✓		✓	✓	
6. Medical equipment	✓	✓				✓		✓	✓	
7. Automotive, machinery and parts	✓	✓						✓	✓	
8. Electrical and electronics	✓	✓		✓				✓	✓	
9. Plastics	✓	✓				✓		✓	✓	
10. Pharmaceuticals	✓	✓				✓		✓	✓	
11. Logistics	✓	✓	✓	✓	✓	✓	✓	✓	✓	
12. Industrial parks	✓	✓	✓	✓	✓	✓	✓	✓	✓	
13. Tourism	✓	✓	✓	✓	✓	✓	✓	✓	✓	

Table 2: Types of business

Business	Tak	Sakaew	Trat	Mukdahan	Songkhla	Chiangrai	Nongkhai	Nakon Phanom	Kanchanaburi
1. Grains and silos	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Ceramics	✓	✓	✓	✓	✓	✓	✓	✓	✓
3. Weaving, clothing and leather	✓	✓		✓	✓	✓	✓	✓	✓
4. Household equipment	✓	✓	✓	✓	✓	✓	✓	✓	✓
5. Precious stones and jewelry	✓	✓	✓	✓	✓	✓	✓	✓	✓
6. Medical equipment	✓	✓	✓	✓	✓	✓	✓	✓	✓
7. Automotive, machinery and parts	✓	✓	✓	✓	✓	✓	✓	✓	✓
8. Electrical and electronics	✓	✓	✓	✓	✓	✓	✓	✓	✓
9. Plastics	✓	✓		✓	✓	✓	✓	✓	✓
10. Pharmaceuticals	✓	✓	✓	✓	✓	✓	✓	✓	✓

businesses will emerge, and skill development will improve. Moreover, business opportunities will increase in the areas of trade, homestays, accommodation, petrol stations and infrastructure development[8].

On the other hand, negative impacts include: 1) The power and rights of local people to management natural resources and the environment will be affected, whether it is the ownership of land, water resource management, management of forests, for example. 2) The structure of the community, economy, the way of life of local people, and original communities may be affected. 3) Economic inequalities may increase as a few groups of people who owners the resources may benefit whereas local people may be just wage earners Employers may also employ foreign labor at lower costs. 4) Migrant workers may replace local people due to their lower labor costs, resulting in unemployment and the lack of access to resources in the local area[9].

The movement of civil society

Because the community has faced uncertainties and possible negative impacts from the special economic zones, the stakeholders of both the private sector and civil society held public forum in many provinces to gather opinions on the establishment of the special economic zones. The results from the various stages can be summarized as follows:

1) Tak: There may be economic inequalities in the area and between the areas of Maesot in Thailand and Myawaddy in Myanmar, leading to unequal in development. There will be differences in laws and regulations between the two countries, causing difficulties for investors and traders. As most of the western part of the province is protected national forest, it is difficult to develop basic infrastructure for economic development.

2) Sakaew: Impacts will be felt due to differences in economic development between the two areas of each country, including laws and regulations. Political uncertainties may result in a lack of confidence for investors. Business activities and transport that arise without efficient planning will complicate cross-border problems such as illicit drugs, criminal activities, human trafficking, and log poaching.

3) Songkhla: Violence in Sadao district may impact trade, investment and tourism.

4) Mukdahan: Industries may cause air and water pollution and affect agricultural areas and the community's food chain. Existing problems like drug, illegal immigration in border areas, animal poaching and human trafficking could get worse from the increasing cross-border flows[10].

In addition, the special economic zones have created a lot of concern at health assembly networks in many border provinces. They are concerned about issues of cross-border migration, communicable diseases, water management, environment, logistics and public health services. In the meeting of the 8th National Health Assembly titled "Creating a Healthy Society in the Special Economic Zone" on 22 July 2015, these issues were discussed. There are also concerns on the safety of local people from the increasing traffic, the way of life of the community, water resource management,, waste accumulation, and the delivery of public health services.

Conclusion

The policy to set up special economic zones was intended to opening new economic areas to connect with Thailand's neighboring countries. As the ASEAN Community has emerged, there are opportunities to spread development to many local regions to reduce inequalities and improve the quality of life of the people. But the success of the program has yet to be seen as investors still adopt the wait-and-see attitude towards the program. Local communities, meanwhile, are concerned on the management of natural resources, economic inequalities, income distribution, and problems of crimes, drugs, traffic, and pollution. The future success of special economic zones is still a long way as many issues have yet to be resolved.

10

Fall of Rice Prices: A Chronic Problem for Thailand

http://nizeetrading.com/

In 2016, the fall of rice price topped the headline news for weeks as the price of Thai rice fell to its lowest in the last few years. A major reason for this was the global market price reduction due to the oversupply of rice as many rice-growing countries increased their production to a very high level[1]. This was a nightmare for the Thai government as it had a direct severe impact on Thai farmers, a major population of the country. The government, the private sector and Thai society had worked together to find measures to relieve the hardship of Thai farmers, while at the same time more and more farmers adjusted themselves by selling their rice directly to consumers without passing through the middlemen to gain a higher price margin.

Introduction

"Rice" is one important global agricultural product which is consumed by most people in Asia. Rice is also the main food traded in Asia. Thailand is a major producer and exporter of rice so much so that it is known as "the kitchen of the world". During 2008-2009, a global food crisis caused the price of unhusked rice to rise. Thai farmers saw this as an opportunity to increase their income and began to grow more rice and the rice stock grew to 19 million tons. When the price of rice began to fall, Thailand faced with a problem and could not export

much of their rice anymore due to the global surplus. However, the country was lucky again in 2010-2011 when major rice exporting countries had a severe drought and rice production dropped. As a result, Thailand was able to export a large amount of rice and reduce its stockpile[2]. Later, when rice prices became very volatile and then came down again, Thailand introduced the rice subsidy scheme, causing the stockpile of rice to rise to millions of tons once again. In 2014, Thailand was in yet caught in another price war of the global rice trade. Nibhon Wongthrngan, former Chair of the Rice Millers Association of Thailand, stated that Thai rice prices had been lower than in 2013 due to the mistakes in the rice subsidy scheme, the high production cost, and the large production of substitute food staple such as wheat and corn[3].

A Record low price in 2016

Although the problem of low rice prices has been a frequent crisis for Thailand, in 2016 Thai farmers had to experience their largest challenge for many years when the price of unhusked *Hom Mali* rice dropped sharply from 12,090 baht per ton in September 2016 to only 10,500 baht per ton in late October. To understand the reasons of the price drop, one must first realize that the current rice price is calculated based on the forecast of demand of consumers and future supply in the coming season. Such projection will form a basis of purchasing price during the harvest season[4]. But due to the volatility in supply and demand in 2016, there was a mistake in the calculation of rice prices during the harvest season in 2016, resulting in the sharp drop in purchasing price, when the global rice trade remained stable. The speculation of supply and demand that was so volatile can be explained as follows:

1) In 2015 and early 2016, the country was affected by El Nino which caused long drought and the reduction in agricultural output. Many businessmen expected that the rice price would rise and began stockpiling rice. But in mid-2016, the El Nino effect reduced and rain began to fall in most of the rice-growing regions. Businessmen thus had the accumulated stock of unhusked rice that was likely to increase as the new rice crop was ready to be harvested. With the large stockpile of rice waiting to be sold, millers and traders had the liquidity problem and could not purchase the new crop. Rice prices then began to plummet when the new harvest came out.

2) Thailand lacks a system to forecast rice supply based on the real data of national rice stocks of both the government and the private sector. The lack of accurate data led to the mistake in calculating the demand and supply of rice in the country. When the exact amount is not known, some businessmen would do their own surveys by collecting data from rice mills and traders. This leads to the calculation of purchasing price that could be distorted from the real market.

Another problem—the tarnished image of Thai rice

In addition to the low prices, the Thai rice image was also tarnished in 2016, causing its popularity to decline in the global market. An American woman took Thai *Hom Mali* rice and stir fried it and it caught fire and turned black. She then posted this on the internet and stated that there was plastic mixed with the rice, this news had gone viral[5], and shook the consumers' confidence of Thai rice. The real facts came out later that *Hom Mali* rice from Thailand was pure and not contaminated. However, Thai rice had lost its credibility, and importers began imposing additional measures to check the quality of Thai rice, adding to the higher cost of Thai rice exports.

Immediate responses to help Thai farmers

The low price of rice led to widespread calls for the government to help Thai rice farmers. In the beginning, the Policy Committee on Rice Management implemented "the subsidy for granary storage *(Jumnum Yungcharng)*" by providing money to farmers to the amount of 9,500 baht per ton of rice plus the storage cost of 1,500 baht a ton, and the cost for harvesting of 2,000 baht per ton. In total, the value of 13,000 baht per ton of rice was allocated[6]. The Ministry of Commerce together with the private sector also promoted the sale of rice both on line and in regular markets. Farmers were allowed to sell their own rice online without the need for e-commerce registration. The Federation of Thai Industries also coordinated with its provincial offices to find the machinery to harvest the rice of farmers at low costs, and to find markets for farmers.

Meanwhile, state enterprises such as the Petroleum Authority of Thailand (PTT) Ltd. arranged a program called "the united power to buy rice from farmers" to sell rice at petrol stations without any charge. PTT also bought rice from farmers and gave them as gifts to people during the New Year. At the same time, Bangchak Petroleum Ltd. bought high quality *Hom Mali* rice from farmers and sold them at special low prices. It also launched a campaign for credit card holders to earn more points when they bought *Hom Mali* rice. Other private companies such as Tesco Lotus also helped by selling *Hom Mali* rice in their branches locally and internationally in more than 6,900 stores. This would not only help Thai farmers but also promote *Hom Mali* Thai rice to the world.

Farmers became traders

The problem of low rice prices urged many farmers to solve the problem by themselves by searching for new markets through social media so they could bypass the middlemen. Many farmers were able to reduce their stocks significantly. Farms such as *Farm Bahn Chud Jane* in Phichit province began selling chemical-free rice with a high price on Facebook. The Facebook page of Sirimnee Maneetapote also began selling *Riceberry* and brown rice *Homnim* with great success. There was also the ThaiRice website developed by Pijarn Chaengsawang to allow farmers to sell their own rice for free, with their own price offers.

These methods are well supported by the views of Dr. Dechrud Sukgumnerg, Head of Agricultural Economics and Resource of the Department of Economics, Kasetsart University, who advised the children of farmers to help their parents to sell rice. The children are the ones who can sell rice better as they can connect farming parents directly with urban consumers and know how to use online technology[7].

Future solution

Stakeholders have shown some major ideas how to solve the problem of low rice prices. Dr. Suthikorn Kingkaew, Director of Center for National Advisory on Development and Management, Thammasat University, recommended that the government should plan for the appropriate level of supply and demand for rice and determine the amount to be produced, the amount to be sold, and the types of rice to be sold. The coordination between farmers, the government, universities and the people could be done by integrating the knowledge and

ตัวอย่างราคาข้าวในท้องตลาด

information as well as the management system of rice production[8]. Assoc. Professor Somporn Asawilanon, recommended that rice production should be targeted at specific markets. The improvement of rice standard and its added value should be the priority for farmers and relevant agencies in the era of intense competition from free trade[9]. The rice subsidy was not the only option. Other policy options that would help to improve rice prices included the effective storage of rice, increasing exports, and reducing rice stockpiles[10].

Conclusion

It can be said that the low price of rice in Thailand is a major problem damaging the farmers and the economy. Working to solve the problem requires good cooperation from the government, state enterprises, the private sector, and farmers themselves. Marketing strategies of all parties to reduce rice stockpiles had alleviated the problem. As rice is a major staple of the Thai people, and rice production is a way of life of Thailand, people are sympathetic to the plight of Thai farmers and unite together to help them. But to solve the problem in the long-run, there must be a major policy change to improve the efficiency in rice production and land management. Other strategies to raise income and improve the quality of life of farmers include improved irrigation, reducing the use of chemicals, producing agricultural products demanded by consumers, developing market channels for farmers, and creating added value for their agricultural products.

4 Good Works on Thai Health

The disabled are eligible for the Gold Card

The NCPO, authorized by Section 44 of the constitution, made an order that disabled people on the social security scheme be eligible for public health services equal to that provided by the Gold Card. In this regard, the Social Security Office will cover the costs that may incur to enable the disabled (employed and on the social security scheme) to use the services. Due to the fact that the Gold Card already covers the health care cost of the disabled (who have no security of any kind) at state hospitals, the social security scheme will have to co-pay for the services provided to the disabled. The Social Security Office will also transfer the data of all disabled patients that are on the social security scheme (of 28,000 persons) to the National Health and Security Office (NHSO), and provide a memo to employers to inform them that their employees are now eligible for the Gold Card, and can receive treatments at any state hospital from 15 October 2016 onwards.

Approval of 15-year free education to all

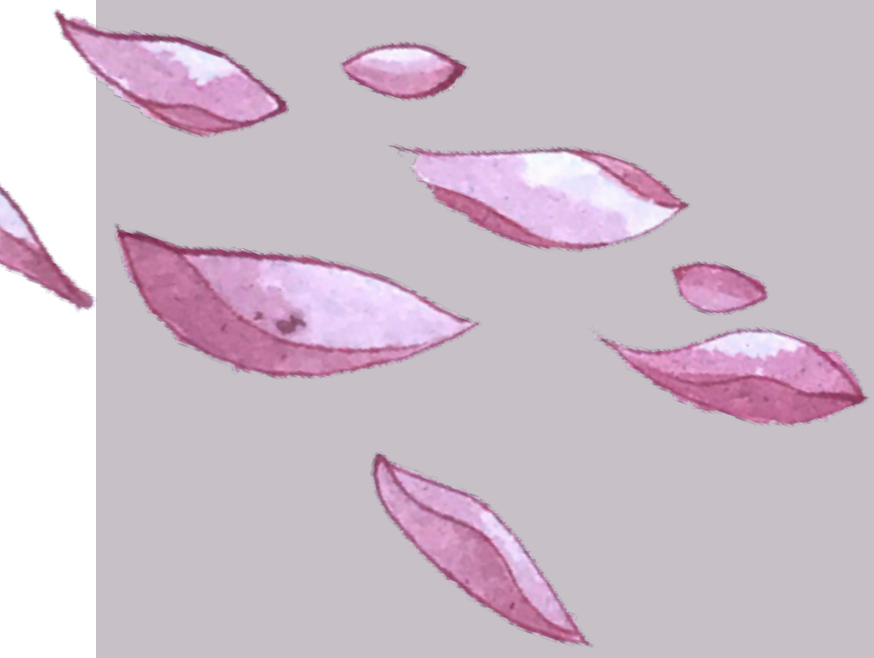
The NCPO, authorized by Section 44 of the constitution, made an order that free education of 15 years be eligible for all people in Thailand at public schools. On 15 June 2016, the government set the budget for the universal education of 15 years for children in Thailand from the nursery level to high school and vocational education (including special education and social welfare education). The costs of such education include all tools for learning, uniforms, activities to promote learning, as well as other expenses (such as sports equipment, sports fields, teacher costs and English by foreign teachers). All schools are required to prepare for the care of their students and to develop their health, mind, temperament and knowledge to improve education standard. The government also asked relevant agencies to amend the national education law to be in line with this Order. Although past governments also had policies of 15-year universal education, they were only government policies without any legal commitment.

Thailand ranks well on the Misery Index

Bloomberg news reported on their Misery Index 2016 that Thailand was the country that had the lowest Misery index in the world, when compared with 74 other countries. They reported that the economic data consisted of unemployment rates, inflation, the standard of living and the strength of the labor market. The report stated that Thailand had a low unemployment rate and low inflation when compared with other countries, causing the Misery Index to be low. Whereas the second and third country that also had a low misery index was Singapore and Japan, respectively. In the opposite direction, the countries which had the Highest Misery index was Venezuela because the tumbled petrol price reduced its export income, the high unemployment rate, the economic crisis, and a shortage of food and medicine. The second and third country with the highest misery index were Bosnia and Herzegovina and South Africa, respectively. Bloomberg news also reported that 15 countries with the happiest economies in the world were Thailand followed by Singapore, Switzerland, Japan, South Korea, Taiwan, Denmark, China, United States, Norway, United Kingdom, Austria, New Zealand, Iceland, Malaysia and Germany, respectively.

Thailand's Gold Card praised as a model for Asia

The Voice of America reported that Prof. Michael Gideon Marmot, expert on public health policy and Chair of the World Medical Association, applauded Thailand for its Universal Health Care scheme (Gold Card). The Gold Card was seen as a model for emerging economies in Asia to provide heal care services that cover most of their population, whereas most people in Asia such as India had to pay for their own health care costs. Thailand's Gold Card began in 2001 when it started to provide services for people who did not have health insurance of around 18 million persons. It also provided partial services to another 29 million persons. The universal health care scheme arose from the idea that there needs to be health care of high quality that is sufficient for all people, as "Health for All" is the target announced at the World Health Assembly in 1977 to raise the level of health of all people in the world. "Health for All" will allow people to live a life freely and not be a burden to the society. The target of health for all works to reduce the gap in health between developed, developing and underdeveloped countries, leading to the equality and justice in health care in all societies.



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Empowering Vulnerable Populations

Creating an Inclusive Society

http://www.thairath.co.th/media/NjpUs24nCQKx5e1A7JZ4qmb78eFoZMTaXCWAPXPUQUP.jpg

Empowering Vulnerable Populations - Creating an Inclusive Society

1. Introduction

If a society is regarded as a large family with members from all over the country, then a strong society is comparable to a family that is warm and comforting.

In a warm and comforting family, all its members grow together and no one is left behind. Everyone, the stronger and the weaker, shares the pain and the joy. Similarly, in a strong society where no one group is left behind regardless of their difference in physical strengths, knowledge, capability, social status, color or ethnicity, individuals and all groups have their places that may not necessarily be the same but are equal and just. All have rights and opportunities to live their lives with dignity.

A strong society is one where all groups of people move forward together and no one group is left behind.

The statement above may seem ideal. But in reality a family where its members do not leave anyone behind is not just a dream or imagination that cannot be realized. In fact, it can be achieved in the real world; it does exist though not all families are like this. Similarly, a society that leaves no one behind is possible; indeed it does exist in many countries such as Sweden, Denmark, Finland, Norway and Switzerland.

Difference are human nature. It is common in all societies where many individuals and groups live together. It is also common even in a small

family. However, regardless of differences, everyone in society should have opportunities and access to the basic necessities of life - food, a secure place to live, healthcare, decent sanitation and environment, education, and participation in public activities without discrimination. All this constitutes the basis of human rights globally regarded as the goal of development.

From the past up to the present, development under the capitalist ideology is driven by the market system based on free competition. This system often favors stronger individuals and groups at the expense of those who are weaker not only in terms of physical strengths and health but also in knowledge, ability, economic and social capital, rights, opportunities, power and dignity. These weaker groups are unable to keep up with others on the path of development. Intentionally or not, they are left behind. Being 'left behind', for whatever reason, makes these groups of population vulnerable; they are at risk to various difficulties and confronted with undesirable situations in many aspects of their lives.

Vulnerability is deeply rooted in inequality. A society that has many vulnerable groups is often a society with inequalities, economically or otherwise. The more inequalities there are, the higher the chances that more vulnerable groups will increase. What follows is conflict in society. Several empirical studies have shown that societies with high level of inequality experience high level of conflict between groups and social classes. Such societies also experience more health problems compared to those with low level of inequality.

For the past several decades, Thailand has succeeded in various aspects of development. Yet, it cannot be denied that the largest share of the development has so far been in the hands of a small group, those that are at an overall advantage compared to others. The concrete examples of inequality can be seen in the economic, social and health aspects. Such inequality has expanded even more and at times has led to conflict and violence that is still present in Thai society today.

Social conflict in Thai society has been viewed as a political issue (which is mostly correct) but many analyses have shown that deeper down the conflict in Thailand has its deep-seated roots in the problem of inequalities among groups. A large number of weaker people feel that they are taken advantage of, neglected and left behind on the path of development. Most of these people have a lower quality of life, are discriminated against and have poor access to basic necessary services in maintaining their existence; they have become 'marginalized'.

This type of development, no matter how much resources have been invested, can hardly achieve sustainability. Successful and sustainable development can be possible only when no individuals or groups in society are left behind. That is, it must lead to a society where all move forward together. The important agenda of development must be to reduce the factors that make certain individuals and groups vulnerable.

2. What is considered Vulnerable?

2.1 Vulnerability

For a concrete object or entity the term vulnerability can easily be understood and is not complicated. It means a state of fragility, not strong and durable and cannot take a strong impact.

For a person this can also be the same even though it may be more complicated. To understand vulnerability in persons, it is necessary to consider at least two factors: one is the internal factor such as physical and mental attributes of an individual, the other is the external factor involving the total

environment that includes physical, economic, social, cultural and political setting within which in individuals and groups live.

Whether it is of a person or of a group, vulnerability is the condition that makes people so weak that they are unable to withstand the impact of the problems or foresee and plan for effective management of a problem when needed. When affected, the vulnerable people become unbalanced and, if fall, are less able to "get up" and return to normal life.

Viewed internally in terms of the individual characteristics, vulnerability is the state where a person is not ready or unprepared due to health problems or lack of knowledge, experience, resources and social capital – all are a result of being subordinated in terms of rights, opportunities, power and dignity. Because of these reasons, vulnerable people are unable to handle problems by themselves, whether they are natural catastrophes or social and economic hardship.

But vulnerability is also due to external factors. This means that vulnerability also depends on the context. By itself a person's attributes alone may not be enough to determine that he or she is vulnerable. Take for instance a physical disability such as weak lower limbs that makes a person unable to walk and must use a wheelchair. Such a physical impairment would normally be regarded as a vulnerability because it limits the person's ability to move around by himself/herself. But it is not under the context where physical infrastructure (such as roads, buildings and transport networks) and existing public services are favorable for the disabled to move or travel independently. Similarly, in a society with a high cost of living, poor basic welfare, poor social capital and unjust social structure, a lower income person may be vulnerable because under such a circumstance they are at risk to various impacts. In addition, when such persons are impacted it will be more difficult for them to return to their normal life. On the contrary, in a society that has a strong welfare system, adequate social capital and a just social structure that supports equality for all, lower income may not cause vulnerability.

From the perspective of external factors, vulnerability is to be understood in relative terms. A similar condition may be a vulnerability in one environment but in a different environment it may not be.

2.2 What makes people vulnerable?

Although several things can make individuals or groups of people vulnerable, what is discussed below are key factors of vulnerability. But to what degree the people with these factors become vulnerable depends upon the social and environmental context within which they live.:

1) *Natural and physical characteristics*: In many instances, vulnerability is a natural attribute of life that one cannot avoid, or is difficult to avoid. Thus, a person may be vulnerable simply because of age (children or the elderly), sex (women, LGBT groups), or a situation such as an accident or an illness that causes a physical or mental impairment or causes stigma (such as HIV infection). People with these attributes are more likely to be vulnerable compared to people with other natural characteristics.
2) *Ethnic minority and stateless persons*: In Thailand, hill tribes, sea gypsies, immigrants, refugees, stateless people, and citizens with no legal personal status are likely to be viewed as "others" by the majority population. Similarly, foreign workers, especially undocumented workers, and displaced groups are another type of vulnerable people who are often segregated and discriminated against.
3) *Limited freedom and imprisonment*: In all societies, Thailand included, there are

women and men, children and adults whose freedom are limited, or they are imprisoned because of the crimes they committed. Being imprisoned may result in loss of freedom, rights and opportunity to access services that are available to others. They are often segregated.

4) *Poverty*: Poverty is an important reason that makes many persons vulnerable because poverty is the primary cause of being in a subordinated condition. A poor family usually lives in deteriorated conditions. Children born into poor families usually have little education, less opportunities for skill development, work in harsh conditions and are at higher risk of ill health and lower incomes. They have a greater chance of being poor like their parents. Just as poverty can be 'passed on' from one generation to the next, so is the vulnerability that often comes with poverty; it can be passed on from generation to generation. In Thailand, poor people are the largest vulnerable group.
5) *An unjust social structure*: The social structure can be simply understood here as a base that supports everything in society. This base consists of many important parts related to making a living (the economy), interrelationships of people (laws, traditions, customs, norms), healthcare provision, education, and many others. Each part in the structure, if unjust, can cause tremendous impact; the most important is: it gives certain groups more advantages in everything than others. For instance, with an unjust economic system, the largest share of development invested by the public tends to fall in the hands of the advantageous group. The same is true for the unjust education system which makes it difficult to access by the groups with disadvantage that are at the bottom of the social ladder. Consequently, the bottom group that are disadvantaged, and mostly the poor, become vulnerable.

As there are several factors that cause vulnerability, there are also several groups of people who are vulnerable - children, the elderly, women, HIV-infected persons, street children and the homeless, LGBT, the physically and mentally disabled, persons with behavioral and learning disabilities, ethnic minorities, stateless and displaced persons, refugees, inmates, the poor and foreign workers. However, the discussion below will focus on four groups only: the poor, the disabled, minority groups including stateless persons, and foreign workers. These 4 groups are selected because together they constitute a large population with vulnerability and their problems have significant policy implications.

3. The poor

3.1 Poverty and how to measure it

In common sense, anyone can tell what poverty (being poor) is. However, in analytical sense this is a rather complicated issue due to its various dimensions. To say who is poor and who is not, we need to take into account various factors.

There are many approaches to understanding of poverty. One could view that poverty is the condition whereby there is a lack of resources as the World Bank has defined it: *"Poverty is about the lack of resources that makes a person vulnerable and sensitive to situations such as illness, death of a household member, or loss of occupation and wealth. Poverty makes a person subordinated in power to negotiate politically, socially and economically both at the community and national levels"*.

But one may also view poverty as a state of a low quality of life. This view is taken by the UNDP which states: *"Poverty is a situation where one has no opportunities and no alternatives that will lead to a good life with good health, independence, dignity and respect for oneself and for others"*.

We could also view poverty as a direct effect of one's capacity. In this view, poverty is a situation that hinders capacity development and the inability to use one's existing capacity to the fullest as suggested by the Nobel Laureate economist, Amartya Sen: *"Poverty is a condition where one has no opportunities to use one's abilities to the fullest resulting in not being able to conduct one's duty as it should be. Such condition makes a person's life less than desirable and lack freedom to do and have in what can be done or what can be obtained as all humans should"*.

Whatever views on poverty, it is clear that it has many dimensions and not just in the level of income or material possessions only. Equally important are the nonmaterial aspects such as health, education and learning, community and social participation, access to basic public services, security in life, freedom and human dignity. All these have sometimes been referred to as structural factors of poverty.

Nevertheless, most people would say that income is the most important indicator that determines who is poor and who is not. Generally, we understand that poor people are those who have low income or whose income is not enough to live on, which is not necessarily incorrect. However, it becomes complicated when people are not in total agreement on what level of income is considered low and how low the income is considered as poor. For some, a monthly income in the tens of thousands (of Baht) may be considered a low income because it is insufficient for their monthly expenses. But for others, an income of a few thousand Baht per month may be substantial because not only is it adequate for their personal expenses but it is possible for them to save part of it. Obviously, poverty taken in terms of the amount of income as it is commonly understood has a limitation because there is no one standard.

Source: http://oknation.nationtv.tv/blog/ya-jok/2010/08/25/entry-1

The National Economic and Social Development Board, the Thai development planning body, has created a poverty indicator for use in evaluating national development success, particularly with regard to poverty reduction. This indicator is called the "poverty line" which is measured as the average of consumption expenditure per capita per month. This is the lowest possible amount considered sufficient for a person. It includes all types of expenditure in-cash and in-kind (converted to cash) that a person spends or receives from all sources. People whose average monthly income expenditure falls below this poverty line are considered poor.

Due to the fact that consumption expenditure differs in different levels - the country, region and province; it changes as the cost of living changes. This means that the number and proportion of the poor people also change accordingly. For instance, in 2006, the national level poverty line was at 1,934 Baht per person per month. In that year, nearly 14 million persons (21.9% of the total population) lived below the poverty line; they were poor people. In 2015, the poverty line increased to 2,644 Baht per person per month and there were nearly 5 million persons (7.2% of the total population) living in poverty. Out of these, 2.2% were classified as "extremely poor[1], and about 5% not so poor[2].

Table 1. Poverty Line, (Baht/person/month) Number (in thousands) and percent of poor people in Thailand, 2006-2015

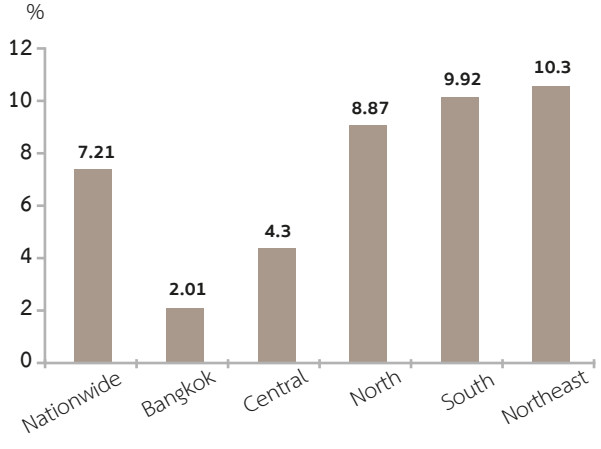
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Poverty line (Baht/ person/month	1,934	2,006	2,172	2,174	2,285	2,415	2,492	2,572	2,647	2,644
Number of the poor (in thousands)	13,779.7	12,718.3	13,116.3	11,623.9	10,800.7	8,751.9	8,402.1	7,305.1	7,057.4	4,847.2
Percent of total population	21.9	20.0	20.4	17.9	16.4	13.2	12.6	10.9	10.5	7.2

Source: National Economic and Social Development Board, based on the data from the Household Social and Economic Survey, National Statistical Office.

In addition to these, there was a group of 8.4% that was "near poverty"[3], i.e. considered to be at risk of being poor. If all the groups are combined, they account for 15.6% of the total Thai population (Data not shown in the Table).

Over the period of the past 10 years (2006-2015), the number and proportion of poor people in Thailand have reduced substantially as shown in Table 1. It is worth noting that in 2015 the region with the most poor person was the Northeast with 10.3% of the population in the region, followed by the South (9.9%), North (8.9%), Central (4.3%) and Bangkok (2.0), respectively as shown in Figure 1.

Figure 1: Percent of poor persons per population in each region



Source: National Economic and Social Development Board, 2015

3.2 Causes of poverty

Poverty has many dimensions. However, it is clear from the above discussion that it concerns disadvantages in various aspects including income, opportunity, negotiating power, education, rights, access to public services, and dignity. But the question is: What are the causes of these disadvantages? What are the reasons behind many people living in conditions of lacking? Why are so many people poor?

The answer that poverty is an individual problem may sound reasonable. It is unquestionable that some people are poor because they do not work hard enough, do not save, and spend more than they earn or gamble their money away. Yet, there are many people who work hard, consume moderately and are not involved in vice and temptations but still cannot make ends meet. Thus, the explanation that poverty is individually determined carries but much weight.

If we look deeper, we can find that the reason many people are in poverty and lack of resources is because of social inequality. This inequality is a state where some people have more opportunities and advantages than others with regard to access to necessary resources to maintain their lives with quality. The more inequalities that exist in society, the higher the level of poverty and

[1] Group that has consumption costs of more than 20% below the Poverty Line.
[2] Group that has consumption costs of less than 20% lower than the Poverty Line.
[3] Group that has consumption costs of not more than 20% higher than the Poverty Line.

the larger the number of poor people. This is so because under the unequal system all the good things – wealth (money, assets), resources (both natural resources, knowledge and technology) including the opportunity to access the good things in life - are controlled by a smaller number of people who are stronger and have much better odds in everyday competition. Most of the people that have much lesser opportunities and are not able to compete will receive their share of development and economic growth in much smaller proportions and become poor in both income, assets and access to various services.

If we delve further into this, we can find that inequalities have deep-seated roots in the unjust social structure. The social structure is not something that is fixed but changes in time under changing circumstances. This means that a social structure that is just and fair at a certain time, may become unjust and unfair as time goes by and conditions change. Another cause of inequality is the practice of double standard that still remains in many public services.

One can see an example of structural inequality in the case of the land ownership and land tax system currently in use in Thailand. At present, there is no legal limit to land ownership by individuals or legal entities, and the taxation does not favor land distribution. In practice, this situation favors groups that have large funds and more power to own land without a limit. Thus, we can see some wealthy families or legal entities that hold tens of thousands of *rai* of land[4]. In addition, a study has shown that the top 20% of the land owners possess 80% of all the land with title deeds in the country. This leaves only a small share of land (20%) to the large majority of people with less capital (especially small farmers and the poor). Access to land for these people is extremely difficult. The structure that favors certain people and groups like this is common in nearly all aspects and in all sectors of society including the education, labor, health service, and justice system. (See Box 1).

In summary, the true origin of poverty is the social structure that is not just and fair and results in inequality in various aspects.

In analogy, all of this is like a tree. That is, the social structure, the true origin of poverty, is comparable with the tree's roots, the important part that functions in sending nutrients to all parts of the tree. Inequality which is the intermediate factor of poverty is like the tree trunk through which the nutrients pass from the roots to all branches and leaves. And finally, poverty, the outcome of the unjust social structure, is comparable with unhealthy branches and leaves of the tree. Note that poverty has a very high chance of repeating itself, i.e. being passed from one generation to another in a repetitive cycle. This is like the fruits of the tree that fall to the ground and then grow into the same kind of tree as their parent. Hence, poverty can be 'repeatedly reproduced' from generation to generation as long as the base social structure remains unjust. (See Figure 2).

[4] A research by Duangmanee Laowakul (2557) based on the land-ownership data from the Department of Lands reveals that land owners from one single family have 631,263 rai of land (6.25 rai = 1 ha). This land area is equal to 1,010 square kilometers and is a bit larger than Samut Prakan, a province in the lower Chao Phrya Delta.

Box 1: Some dimensions of inequality in Thai society

Income

- The top 20% of the households with the highest income hold 44.6% of the total income in the country while the bottom 20% of the households hold only 7.0% of total income (data in 2015).
- There are 111,517 bank savings accounts with 10 million Baht or more each (0.1% of total bank accounts). Altogether these accounts have nearly half (49.2%) of total savings where the remaining accounts of 84 million (99.9%) have a total amount of only 50.8% (data in 2015).

Landholding

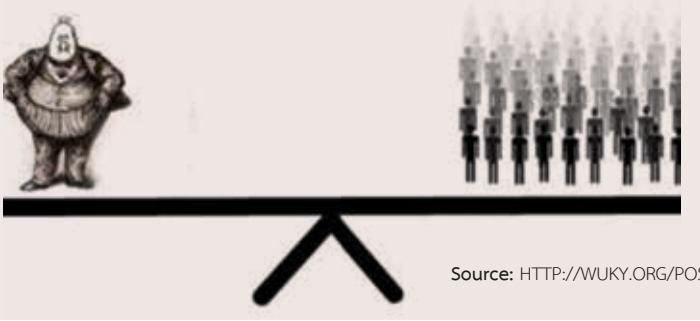
- The top 10% (decile 10) of the landholders own 61.5% of the total land while the rest 90% (deciles 1-9) of landholders hold 38.5% of land (Duangmanee Laowakul, 2014).
- There are 4,613 landowners (individuals or legal entities) in the country who own 100 rai and more of land. Of these owners, 121 cases own 500-999 rai each and another 113 cases own 1,000+ rai each (6.25 rai = 1 ha).
- About 1.2 million agricultural households are landless who have to rent land or are laborers (Social and Economic Survey, 2011).

Education

About 67% of all college students are from the top 10% of the population with the highest income, while only about 4% are from the bottom 10% of the population with the lowest income.

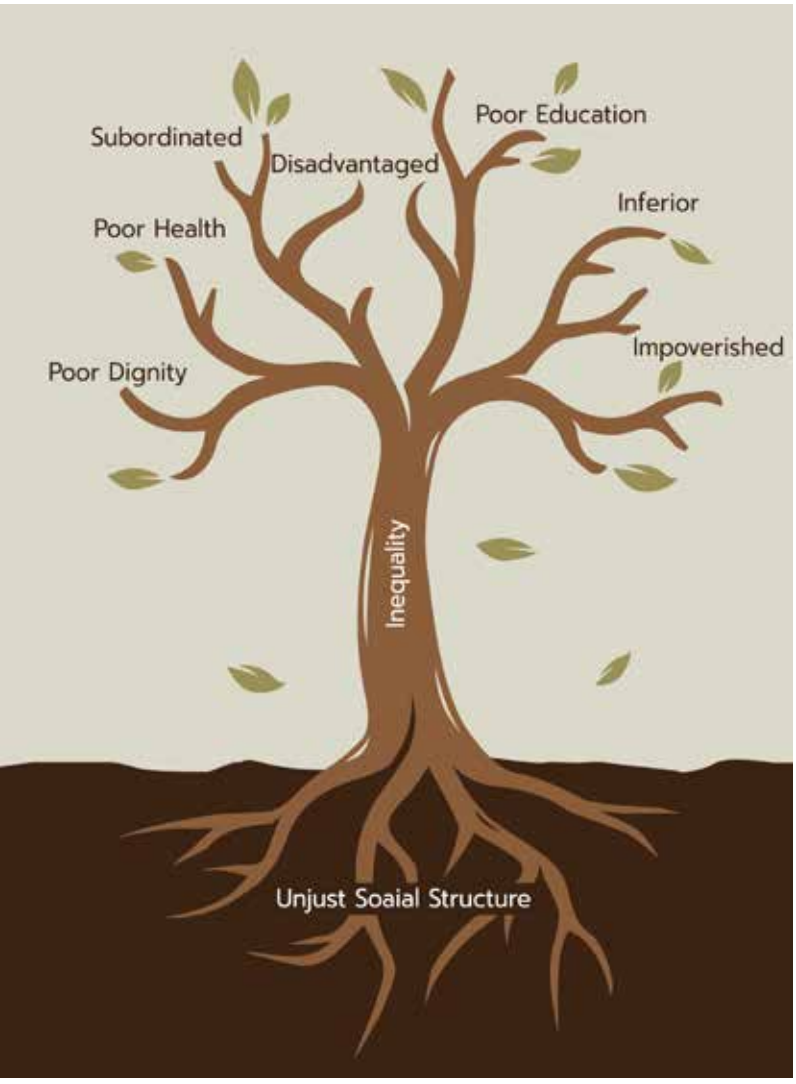
Health

- Bangkok which has the highest income per capita in the country has a doctor-population ratio of 1:1,057 while the same ratio for the Northeast is 1:3,528, a difference of 2.5 times. This large difference means, among other things, great difference in quality of service (Report on Analysis of Poverty and Inequality Situation in Thailand 2015).



Source: HTTP://WUKY.ORG/POST/UK-HOLD-CONFERENCE-ECONOMIC-POLITICAL-INEQUALITY#STREAM/0

Figure 2: The poverty tree



Credit: Koonpol Podhisita

3.3 Who are the poor?

Past studies have revealed the important characteristics of poor people in Thai society. By and large, they are the people with the following characteristics:

- *Living in rural areas*: The Report on Analysis of Poverty and Inequality in Thailand in 2015 shows that nearly 2 out 3 (62%) of the poor reside in rural areas with the rest living in slum areas of large cities (urban poor).
- *Low education*: The same report cited above found that 82.3% of poor people have only a primary or lower level of education. Those with higher but not more than college education constitute only 17% of the total population of poor people.
- *Agriculturalists*: Most poor are agriculturalists or laborers in the non-formal sector.
- *Have a large household with many children*. Studies on Thai households show that most poor people live in large households with 4 or more family members, i.e. larger than the national average of 3 persons per household. In addition, it was also found that old-person-only households and those consisting of the elderly and young children (aged below 15), so-called skipped-generation households, are more likely to be poor.

3.4 Vulnerability of the poor

Poverty can lead to weaknesses in all dimensions of people's lives - whether it is poor economy, low education, poor health, or even in lack of justice. The poor are at a higher risk of these undesirable outcomes. It should be noted, however, that the real problem is not that the poor do not have any rights to access to services. In modern society, every citizen regardless of economic status has equal rights to access to basic and necessary services in life, especially those provided by the state. But the problem for the poor is whether they can actually access those services in the quantity and quality that is reasonable. In many instances, the services they receive are of low quality and not nearly adequate for them to maintain a reasonable quality of life. Another way of saying this is that the poor "have rights but inadequate opportunities" to exercise them. It is probably for this reason that some people refer to the poor as "the disadvantaged".

Education is a good example of this. The rights of poor people are the same as the rights of all Thais but in reality most of the poor have the opportunity for an education that differs in both quantity and quality from what the wealthy people receive. Children of the poor have the right to free basic education that the state provides (15 years from pre-school to high school level), i.e. the same as children of the wealthy group. But the number of children from poor families and from wealthy families who actually receive an education at these levels are widely different. The 2015 analysis on poverty and inequality in Thailand reveals interesting difference. Only 39% of the bottom 10% of the population (i.e. the poorest group) had an opportunity to study up to the high school level or equivalent while 70% of the top10% of the population (i.e. the richest) had this opportunity. Needless to say, the standard and quality of the education that these two groups received were obviously different.

Similarly, the poor and the better-off have the right to health care provided by the state, but services provided to these groups are much different. Three health care schemes exist in Thailand: the National Health Security (so-called 'Universal Health Coverage Scheme') for the low-income self-employed workers – mainly farmers; the Social Security Scheme for employees in the private sector who have to also contribute part of the premium; and Health Benefit Schemes for government officials and state enterprise employees who are generally better-off. Of these, the costs of service per head for the first two schemes are estimated to be 4 times less than that for the third one. It is observed that this gap in the costs per capita has been widening over the past 10 year period. Although, virtually everyone in Thailand is under one or another public health scheme, the service quality and standards are obviously not the same.

Access to justice is no different. The poor have the rights to access to justice no different from other groups but their chance of receiving justice is much less. Documents from the Reform Committee disseminated in 2011 showed that 90% of the 240,000 inmates in prison were poor persons. Of this number, more than 50,000 cases were imprisoned before their cases were decided by the court because they did not have the money for bail while their cases awaited the court decision. There are also many more cases where the court ruled that they be fined but did not have the money and so they were imprisoned instead. This is like a double standard in the justice system, which makes some people believe that "prisons are but for the poor".

As such, vulnerability of the poor is linked to inequality in society that has deep-seated roots in the unjust social structure.

4. Disabled persons

4.1 Disability

We may have seen disabled persons but one must ask: what is a disability? Many people may have difficulty in defining who is a person with disability and how can disability make one vulnerable. It must first be clear at the outset what is meant by "disability".

If we use the definition provided by WHO in the 2011 *International Classification of Functioning, Disability and Health - ICF*, disability is a rather complicated issue with many dimensions. What determines what is or is not a disability is in the activities that include physical functioning and participation in society. Under this definition, an individual should not be considered a person with

a disability if he/she can function normally in daily life and can participate in society as other people. In view of the ICF, the person's ability or inability to engage in the above activities involves 3 interrelated factors:

1) *Physical disability:* Is the person with or without physical impairment - whether the person is blind, deaf, or with strong legs and hands with which he/she can move around?
2) *Functional limitations:* Can the person engaged in daily activities or not - such as walk, eat, wash, dress, and communicate with others?
3) *Limitation in social participation:* In addition to the limitations above, does the person have obstacles that prevent him/her from participating in social activities as other people? This involves an attitude of segregation or discrimination that deprives the person's rights to travel, work, or receive equal pay for equal work as others do.

In these three factors, the first two are related to the individual's physical body and mind while the third concerns the environment, both natural and social.

Professionals usually rely on the medical and environmental perspective in defining disability. This perspective views *disability as an outcome of the interaction between individual and environmental factors. In other words, disability is the condition in which a person's ability is limited with regard to functioning in daily life activities and participating in social activities*. Such limitation may be many, but in summary there are 2 of them: one is the limitation stemming from the individuals themselves, the other is the limitation from the environment within which the individuals live.

In addition to physical and mental disabilities, individuals' limitation also includes personal motivation and self-esteem that have a significant influence for them to "step out" to engage or not engage in various personal and social activities. The environmental limitation, on the other hand, is partly due to the natural conditions, but more importantly involves things that humans create such as roads, public transportation, buildings and other facilities. Also included in environmental limitation are the public's attitudes towards the disabled and existing social policies. The environment, therefore, could support or hinder the activities of individuals with different personal characteristics and hence place them in a varying degree of disability or no disability.

4.2 Who are the disabled?

The ICF gives a holistic view of disability. Although it provides a comprehensive understanding, there are some limitations in determining who is the disabled and who is not. In many instances, it is not possible to clearly give a 'Yes/No' distinction because disability and non-disability is not a matter of 'black or white' but a continuum ranging from the very least (not disabled) to the very most (disabled). Thus, in the ICF classification it is difficult to determine who are disabled and how many of them need state welfare.

Not only that, even if it is possible to clearly determine to a certain degree, in practice there are still problems. Being disabled has different and varied conditions so much so that we cannot simply assume that they are all the same. It is certainly inaccurate to say that all the disabled are in the same category and encounter the same challenges and hence should receive the same benefits. In reality, persons with disabilities of each type face challenges and needs that require attention from society in different ways. Disabled persons who cannot see are different from those that cannot hear or communicate and different from the physically disabled. Ultimately, even those with the same type of disability but are of different personal characteristics have different problems and needs. As such, a female teen with

disability in seeing has different vulnerability from an elderly male who has the same disability. This is because the age and sex difference often requires different needs.

Because of its complexities and the need to clearly determine who the disabled persons are for the practical purpose of the policy, a law was established to determine 'disabled persons'. Article 4 of the Empowerment of Persons with Disabilities Act, B.E. 2550 (2007), amended on 2 May 2013, defines disability and disabled persons as follows:

Disabled person means a person who has limitations in carrying out activities in daily life or participating in society due to the disabilities in seeing, hearing, moving, communicating, mental condition, emotion, behavior, aptitude, learning or other capabilities that, with existing obstacles, put individuals in special needs which require assistance in one form or another to enable them to engage in daily activities or participate in society as others in general. The types and criteria of disability is to be announced by the Minister of the Social Development and Human Security.

Naturally, disability is a dynamic condition; it changes as a person ages. As a person gets older and becomes elderly, various parts of the body are weaker and cannot function properly. Many become disabled in this way. Because of this, the rate of disability is relatively higher among older people than among the younger ones. And for this same reason, countries with a large share of old population are likely to have a large proportion of the disabled.

The Ministry of Social Development and Human Security issued an announcement on types and criteria of disability in 2012, based on Article 4 of the Empowerment of Persons with Disabilities Act, B.E. 2550 (2007). According to the announcement, there are 7 types of disability:

(1) Seeing disability
(2) Hearing disability
(3) Moving or body disability
(4) Emotional or behavioral disability
(5) Mental disability
(6) Learning disability
(7) Autism

According to Thai law, if a person has one or more conditions as designated above, he/she has a disability. But another problem still remains, that is, if clarity is needed as to who is disabled or not, this has to be checked by technical experts because disability of almost all types cannot be identified just by looking. Accurate identification is necessary for a person to be eligible for state benefits. Thus, the Announcement of the Ministry, as detailed above, determined the specific characteristics of each type of disability. This is summarized in Box 2.

In 1974, the National Statistical Office conducted the first survey on the disabled and disability as part of the Health and Welfare Survey which has been carried out every 2 years. Since 2002, the disability survey has been conducted independently every 5 years. Data from this survey show that during the period from 1974 to 2012 the proportion of the disabled in Thailand, though not a large number, continued to increase from 0.5% of the total population in 1974 to 2.9% in 2007. However, in 2012, it reduced slightly to 2.2% or 1.5 million disabled persons.

In the future, it is estimated that both the numbers and proportion of the disabled will increase due to the existing demographic and development trends that will occur in the time to come. Demographically, the important factor is the increasing longevity and the consequent rise in the number and proportion of old persons. In general, old persons are at higher risk to being disabled compared to the younger people. Development can also lead to disability because the way of life of people will be changing with more work involving use of machinery, and transport becoming more technologically dependent thus increasing the chances of accidents. Moreover, if development also brings with it greater inequality in society, it will create poverty and more poor people.

Source: http://www.stou.ac.th/study/sumrit/1-58(500)/page2-1-58(500).html

Box 2 Summary Characteristics of Disability by Type

There are 7 types of disability. All of them are to be determined by technical professionals:

1. Disability in seeing refers to (i) complete blindness, or (ii) partial blindness.
2. Disability in hearing refers to (i) completely or partly deaf, or (ii) disability in communicating thoughts due to being mute or unable to say meaningful words understandable to others.
3. Disability in movement is defined as (i) lack or loss of ability of limbs in movement due to various reasons, or (ii) a problem or abnormality of the head, face, body and external appearance of the body.
4. Disability in emotions or behavior is defined as limitations that are a result of abnormalities of the brain that affect a person's consciousness, emotions and thinking.
5. Disability in mentality or in the mind refers to limitations caused by retarded development observed before the age of 18.
6. Disability in learning is defined as limitations due to problems in the brain causing difficulties in reading, writing and calculating in the process of basic learning.

As such, the person's learning ability is below an average level based on age. Autism is defined as a problem in development of social skills, language, communication, behavior and emotion due to abnormalities in the brain which can be clearly detected before the age of 2 years. This includes Asperger autism.

Source: Summarized from the Announcement of the Ministry of Social Development and Human Security (Nos. 1 and 2, 2009 and 2012).

Amartya Sen, the Nobel Laureate in economics, has pointed out that poverty and disability are interrelated; disability has a tendency to cause poverty and at the same time poverty makes a person at risk to accidents or illness that may end up in disability.

In 2016, total persons with disability was 1,525,834. More than half of these (794,648 persons) were disabled in movement. Around 1 in 5 (300,265) were disabled in hearing, followed by the disabled in seeing (175,692), in emotions and behavior (120,785), mentally disabled (117,887), autism (9,125) and learning (7,432) respectively. (See Figure 3)

In 2012, 98.4% of the disabled received benefits in treatment and care, largely through the Universal Health Care Scheme (so-called 'Gold Card' scheme). As for allowance for the disabled, the report on Analysis of Poverty and Inequality, 2015 reveals that 55.8% of the disabled received the allowance of 500 Baht per month (to be increased to 800 in October of 2017 onwards). To be eligible for this allowance, disabled persons have to register in the area where they reside.

Data in Table 2 show the overall picture of the disabled in 2015. In summary, the proportion of the disabled is highest in old age (60+) and among women more than men. More disabled persons are in rural areas than in urban areas, and in the North and Northeast more than in other regions. Most disabled have no education; for those that do, the largest majority have education up to the primary level only. About 3 out of 4 disabled persons are not working.

4.3 The vulnerability of disabled persons

The vulnerability of disabled persons involves two related problems. One is the problem to individuals and the other is the problem to society. Both problems are intertwined and cannot be separated like different sides of the same coin.

In terms of the problem to individuals, disability is something that reduces "immunity"

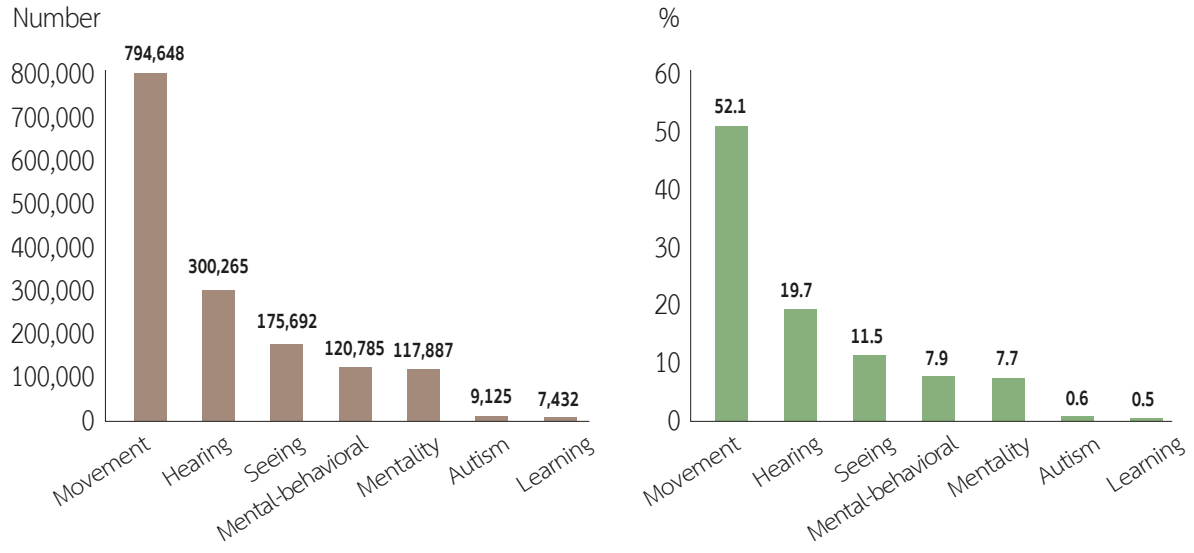
Table 2: Percentage of disabled persons, by personal characteristics, 2007, 2012

Characteristics	2007	2012
Whole country	2.9	2.2
Age		
0-14	0.4	0.3
15-24	0.9	0.8
25-59	2.0	1.4
60+	15.3	9.8
Sex		
Male	2.7	2.1
Female	3.0	2.3
Place of residence		
Urban	1.6	1.5
Rural	3.4	2.5
Region		
Central (Bangkok included)	1.7	1.3
North	4.4	2.9
Northeast	3.5	2.8
South	2.2	1.8
Education		
No education	*	22.4
Below primary level	*	57.6
Primary education	*	10.4
High school	*	7.8
More than high school	*	1.8
Working status		
Not working	*	74.3
Working	*	25.7

* No data

Source: Compiled from summary of important findings from the Survey of Disability, 2012 by the National Statistical Office

Figure 3: Number and percentage of disabled persons, by type, 2016



Source: Department of Empowerment of Persons with Disability, 2016

and therefore puts the person at risk of being affected by several problems more easily and more seriously than in the case of general people. In a simple analogy, this is similar to a person with immune deficiency who is weaker and more likely to getting ill than a person who has a strong immunity. This is so because disability limits the functional ability of the person in doing daily activities and other important things such as health care, work, or participating in social activities with dignity. When compared to people in general, the disabled are vulnerable in such aspects as health, economic wellbeing and social life. These individual challenges alone are enough reason that disabled persons should have the right to receive appropriate attention and support both from people around them and society.

In terms of the problems to society, there are two related issues. The first is that the disabled should receive assistance and appropriate care, not only from people in their family but also from society and the state. On this issue, providing assistance and care for the disabled should be the direct responsibility of the society. The second concerns human rights. The fact is: disability and disabled persons are the human rights issues. As a human, a person with disability should have the right to receive equal treatment as others without discrimination in access to basic and necessary services in their lives such as education, health, travel, work and pay that is just and fair.

Take for instance a disability in hearing. Having a problem in hearing (deaf) does not mean that the persons have no chance to communicate with others for their entire life but it means that society must give them the right to communicate with others by providing sign language skills and services to allow for communication among themselves and with other people. Similarly, having a problem in movement (cannot walk) does not mean that the persons have no rights to get around by themselves but it is the responsibility of society to allow them to have these rights, as other people do, by providing appropriate infrastructures such as transport and public services that facilitate their movement. These various services must aim to integrate disabled persons with others in society so that they do not feel like "second class citizens".

5. Ethnic minorities and people with personal status problems

Thailand's reports submitted to the Committee on the Elimination of Racial Discrimination, United Nations International Convention on the Elimination of All Forms of Racial Discrimination, distributed on 5 October 2011, specify 4 categories of persons that may be at risk of losing their rights, having their rights neglected or their human rights violated. These four groups are vulnerable in the true sense of the term we use here. They are:

1. Ethnic minorities
2. Displaced Thais
3. Unregistered persons
4. Alien population

For convenience here, categories 1-3 will be referred to as "ethnic minority groups and persons with problems of personal status". Although being a minority person and having a problem of personal status are not the same, in many instances they often exist in the same person. Persons of ethnic minority and those with a problem of personal status share a common problem of risk of having their rights neglected or violated. The fourth category (alien population) are persons who have migrated or moved into Thailand and may have been allowed to reside temporarily or permanently. This category also includes undocumented foreign workers. Foreign workers, who constitute the largest group of alien population in the country now, will be discussed separately in the next section (See section 6 on foreign labor).

5.1 Ethnic minority groups

Many people tend to think of ethnic minorities in Thailand as "hill tribe populations" that mostly reside in the highlands in the northern and western regions of the country. Such understanding is only partly correct and not accurate. *Minority group refers to any group of population with a unique race that lives side by side with other groups or races that are numerically larger.* Viewed as a group of population with a unique race, language, culture, religious belief and way of life, a "minority group" is an "ethnic group". Yet, not all ethnic groups are minorities since large ethnic groups also exist. The study by researchers at the Institute of Language and Culture for Rural Development (now the Institute of Language and Asian Culture), Mahidol University in 2004 found that there are more than 60 ethnic groups in Thailand. These include large ethic groups such as Thaineau (Northern Thai), Thai Isan (Northeastern Thai), Thai Klang (Central Thai) and Thai Tai (Southern Thai), and smaller ethnic groups (tribes) such as Karen, Hmong, Puthai, Kui, Song, and Chao Lay or sea gypsies.

Thailand's reports to the UN International Convention on the Elimination of All Forms of Racial Discrimination mentioned above identified 4 minority groups that are considered at risk of vulnerability.

1) *Minority groups in the highlands of the North and the West*: These are 10 ethnic groups of Karen, Hmong, Mien, Akha, Lahu, Lisu, Lua, Kamu, Mlabri and Tin. Also included in these groups are other minorities and some Tai groups that reside in the mountains. These hill tribes have a total population of approximately 1.2 million.

[5] Unless stated otherwise, number of the population of this group and that of the others referred to in this section are the numbers specified in the Thailand's First and Third Reports to UN International Convention on the Elimination of All Forms of Racial Discrimination, disseminated in October 2011. These numbers may have changed. More accurate and up-to-date statistics on this is not available for our purpose.

2) *Chao Lay (Sea Gypsies)*: These consist of 3 small ethnic of groups of Mokan or Moken, Moglan and Uraklawoey (Urang Laut) that reside in the small and large islands in Ranong, Phangna, Phuket, Krabi and Satul provinces. The Chao Lay build their houses along coastal areas. Currently, there are many Chao Lay persons who do not have any documents of their personal status. Although the government has initiated a policy to register Chao Lay people for many years, the implementation has not covered all. The Chao Lay's traditional way of life does not recognize land ownership. This becomes a chance for other people to take advantage of them by encroaching on the land and sea they use to make a living. There are approximately 13,000 Chao Lay persons. (data from Chumchon Thai Foundation - http://chumchonthai.or.th/)
3) *Thais in the lower south provinces (Satul, Yala, Pattani, Narathiwat)*: These include Muslim Thais of Malay origin, Buddhist Thais who migrated from Kelantan State in Malaysia, Chinese immigrants and other smaller indigenous groups such as Sakai or Orang Asli (or Mani as they refer to themselves). The largest group are Muslim Thais of Malay origin which account for about 1.4 million persons.
4) *Smaller ethnic groups that live in the plains*: In all parts of the country, there are small pockets of populations with unique language, culture and way of life. Examples of these small groups include Thai Korat, Phuthai, Khmer and Kui in the Northeast.

5.2 People with a problem of personal status

The problem of personal status here refers to a state of being a "nationality-less" or "stateless" person. Being "nationality-less" means the persons do not have their nationality recognized by any country in the world. If no country grants them residence, their problem becomes more severe. In such case, persons with a nationality-less status automatically become stateless.

There are two reasons that make the person to be nationality-less and stateless. The first is the absence of trustworthy evidence or documents that can prove the person's legal connection to any state in the world, thus his/her nationality cannot be determined, and he/she becomes a person without nationality. The second is when some people, even though they were born in the country, claim their Thai citizenship but there is no evidence to convince the concerned authorities; as a result, they are not granted Thai nationality. At present, it is difficult to specify the number of persons with a problem of personal status.

According to Thailand's reports mentioned above, Thais who have this personal status problem can be categorized into two groups: displaced Thais and unregistered persons.

a) Displaced Thais: According to the Nationality Act, B.E. 2555 (2012) (5th amendment), displaced Thais refer to *"those Thais who became residents of neighboring countries due to changes in borders in the past. They do not hold nationality of another country and have migrated to reside in Thailand for a certain time period and have a way of life as Thais, have been surveyed and registered according to the Thai law under the principles and criteria set by the Cabinet, or have other similar characteristics as specified in the ministerial regulations."*

Being displaced Thais is a consequence of historical events and international politics during the colonial time around the late 19th to early 20th century. The colonial powers in Southeast Asia at the time (France and England) demarcated the borders of Thailand and its neighbors using geographical marks as the criteria without taking into account the population or race. This caused

a number of Thais in the lands once belonging to Thailand to become displaced in the lands of neighboring countries. They may or may not receive nationality of the country they live in. As long as they do not move into the country, this group is not a problem for Thailand. The problem is with the group that moved into Thailand any time after demarcation of the borders. It is a problem because people in this group do not have personal status according to the Thai law. Even though later on the state had a policy of proving them nationality and citizenship, the actual implementation of the policy has not been straightforward. The complication is not only in finding reliable evidence to prove that they have Thai race but also in the complex process of providing nationality which is often related to the sensitive issue of national security. In addition, there is also the problem of discrimination by some officials. As a result, a large number of such people are residing in Thailand as stateless persons.

b) Unregistered persons: Whatever the reasons, the incomplete population registration coupled with discriminatory practices due in part to some officials has caused many Thais, who were born and have lived in the country all their lives, to have their names unrecorded in the registration system. Such unregistered persons do not have any documents to support their request for a Thai nationality and consequently become people with a legal problem of personal status. They are not granted ID cards with 13-digit personal numbers and therefore have no right of citizenship to access public welfare and services as other Thais in general do. These unregistered persons are of 4 categories.

(1) *Thai persons with no personal documents:* These persons were born and have lived in Thailand all their lives but do not have a birth certificate and did not request to be included in the household registration system. For some, their names may have been left out or erased from the household registration for unknown reasons. These cases have occurred in both large cities and in rural areas. A substantial number of these unregistered people are hill tribe persons. There are about 300,000 people in this category as stated in Thailand's reports to the UN cited above.

(2) *Undocumented immigrants:* These are the persons who have migrated in from outside and lived in Thailand for a long time but were never registered, such as Vietnamese immigrants and former Chinese nationalist soldiers. There are around 180,000 persons in this category.

(3) *Migrants who cannot return to their countries:* Persons who have migrated into Thailand but are not able to return to their home countries for various reasons. Their number is unknown. This category also includes about 60,000 persons who moved to Thailand for study in various levels and have not return to their countries.

(4) *Rootless persons:* This is a group of persons whose origin cannot be identified, or they have no clear connecting point. They are without parents or ancestors or have been abandoned since childhood, no document of their birth registration can be traced; their names are not registered in the household registration system, and hence no ID card. Some persons in this group were born in Thailand but there is no evidence of their birth due to negligence of their parents or whatever reasons. Others were born in other countries but moved into Thailand a long time ago; they have no documents to prove their identity or where they came from. Although these rootless persons have lived in Thailand, they have no status as citizens and thus have no rights to access public welfare and services as other people do. The number of these persons cannot be estimated because there has not been any complete survey of them.

Box 3: The Chao Lay of Rawai Beach

The Chao Lay of Rawai Beach in Phuket province, around 2,000 persons, is one example of a vulnerable ethnic minority in Thai society. The group has lived in this area for many generations, fishing in their traditional way, building houses and living together in a public area on the beach where their boats are moored and repaired. They live a very simple life, are a peaceful people and most cannot read or write.

As the country becomes more developed, many laws have been enacted especially laws on landholding. As a result, the public land that this group had lived in and used collectively for generations was taken over by a private owner, understandably with the help of state officials. The Chao Lay, therefore, lost the land they were living in; they had to live in very poor and deteriorated conditions. This was because government authorities could not enter and provide public services such as running water, electricity, sanitation, and waste management, simply because that land now belongs to a private owner. This is so despite the fact that they have lived on this land for many generations. There are proofs such as coconut trees of over 50 years old that were grown by the Chao Lay themselves and the DNA of their ancestors from the burial under their houses. All these prove that the land has long been occupied by the group. Yet, the Chao Lay lost.

The quality of life of the Chao Lay now is very poor; they do not have access to basic public services of any type. Worse still, they are taken to court to be removed from the land that once was considered public land and used as such for a long time. Roads leading to the area have been blocked and the areas where their fishing boats are moored and equipment maintained have been slowly closed off, including areas where they worship. All this is because the owner has now claimed the legal rights over their land.

To date, the government agencies have not been able to solve this problem or alleviate the situation. Thus, the Chao Lay continue to be a vulnerable population.

Photo credit: Above: http://www.bangkokbiznews.com/news/detail/729941; Below: Arunothai et al. 2012

Though the government has a policy to have the people with a problem of personal status legally registered, the process takes a long time as it requires trusted evidence. Many persons in this category end up still living without personal status and not receiving any basic rights at all.

5.3 Vulnerability of ethnic minorities and people without personal status

The attitude that views ethnic minorities as "others" is an important reason why these groups are at risk to vulnerability in many ways. Because of such attitude, ethnic minorities face the problem of rights, discrimination, or unjust treatments. The case of Chao Lay and Uraklawoey ethnic minorities in the South is an example here. The state has proclaimed the areas where these minorities lived and worked for generations to be the areas of natural resource conservation; this automatically has made them the encroachers. Fishing along the coastal areas that they had relied on for generations is prohibited. Anyone who fishes in the conservation areas faces legal penalty and his boat and fishing equipment will be confiscated. All of this does not include the opportunistic investors who claim the land of the Chao Lay and turn it into resorts simply because they do not have the documents to prove their rights to the land they have lived on for such a long time since their parent's generation. In addition, some groups of Chao Lay do not have Thai citizenship because they have no evidence such as a household registration or personal identity card (See Box 3).

A human rights expert of Thammasat University, Assoc. Prof. Pantip Kanchanachitra-Saisunthorn, said that "Being an ethnic minority in a state will likely make a person disadvantaged and weak in his rights in that state, even though in the present time human rights is not just a moral right any more, it has been widely accepted as a legal right". This human rights expert also stated, "A phenomenon like this can be observed not only in Thailand but also in the world community".

For people who have a personal status problem, the difficult thing is to fight for their legal right of personal status. At first glance this does not seem to be a difficult task, especially if the person is born and has lived in the country from birth, but in practice it is a complicated process that could take years in addition to a large amount of money and patience. The most important thing is finding trustworthy documents which, for most cases, are lost. Some have given up the effort while others failed simply because they are not able to produce any reliable evidence or witnesses that the authorities can accept. Even those who are successful have had to endure a life without nationality and rights for a long period during which their access to basic public services such as health care was not possible. Some are stigmatized as an 'outlaw' because they have no legal document, particularly an ID card, to prove their personal status. Even to open a bank account is not possible without such document.

An example may be seen in the case of a middle aged man in the northern province of Lampang. For unknown reasons, this man's name was erased from the household registration and substituted with another person's name. He became aware of this years later, but the process took many years before he could get his name back into the registration system so that he could have an ID card.

In the case of immigrants from other countries who are allowed to live in Thailand (groups 2 and 3 of "unregistered" persons discussed above), the important problem is in the request for Thai nationality that depends on the policy of the government towards certain immigrant groups. As long as the government does not have a policy, these people will have to wait and this might have to be a very long wait, sometimes for generations (from parents to children and grandchildren) as in the case of Vietnamese refugees who fled from war with the French and came to live in Thailand during

1945-1946. At first, the Thai policy on Vietnamese refugees was not to give them nationality, but after 40 years Thailand granted the second and third generations who were born in Thailand to have Thai nationality and at the same time relaxed the criteria for the first generation to also have the same.

6. Foreign workers

6.1 The in-flow of foreign workers

Since the past 3 decades until today the growing economy, associated with the fact that many Thais are reluctant to do hard labor that pays low wage, has caused increasing shortage of unskilled workers in the lower sector of employment. At the same time, the manufacturing sector has tried to maintain competitiveness by keeping wages low as it has a direct effect on production costs and exports. Such circumstance opened opportunities for workers from neighboring countries, especially Myanmar, Cambodia and Laos, to work in Thailand. Since 1987, most foreign workers who have come in to work and reside in Thailand were undocumented. Around 1992, the Thai government began a policy to "relax the rule" and allow illegal workers from neighboring countries to request work permits. This was done with reference to Article 7 of the Working of Alien Act, B.E. 2521 (1978) and Article 7 of the Immigration Act, B.E. 2522 (1979). The purpose is to reduce the problem of labor shortage at the lower level employment and at the same time to strengthen the Thai economy.

In 1996, with the Cabinet approval, registration of foreign workers started. The registered workers were allowed to work temporarily while awaiting to be sent back to their countries of origin. However, because of labor shortage, the approval of a temporary stay continued to be extended time and again.

Foreign workers from Myanmar, Cambodia and Laos (sometimes called 'migrant workers') may be categorized into 4 groups based on how they entered the country and their work status:

1) *The 'relaxed and extended' group:* These are foreign workers who are registered and received approval to reside temporarily and hold a 13-digit ID card that begins with '00'. These workers must go through a physical check-up before requesting a work permit from the Ministry of Labor and Social Welfare. They need to have 3 necessary documents: an approval letter for temporary residence, a health insurance card and a work permit.
2) *The group with 'proved nationality':* Proving nationality for this group is done according to the government policy to change their illegal status to a legal one. Workers from Cambodia and Laos began this process in 2004 whereas those from Myanmar began in 2009. Foreign workers with proved nationality are able to travel freely around the country but if they leave the country and want to return for work again, they have to request approval from the Immigration Office. While in the country, this group has to report to the Immigration Office every 90 days. They are allowed to work for only 4 years; after that they have to return to their country for 3 years before they are eligible to apply to return for work again.
3) *Imported foreign workers:* Workers in this group have come in through the MOU signed during 2002-2003 between Thailand and each of the three neighboring countries. The MOU set a framework for foreign unskilled workers from the 3 countries to work legally. They have rights to social welfare, health care and other public services similar to Thai workers and those with proved nationality. Thailand began import of workers from Cambodia and

Laos in 2005 and from Myanmar in 2010. Workers in this group can extend their work for not more than 4 years and, if they return to their countries, they have to wait 3 years before they can request to reenter for work again as in the case of those with a proved nationality (group 2 above).

4) *Unregistered foreign workers:* Workers in this group, sometimes referred to as 'underground labor', work without any formal approval whether it is a temporary residence permit or any other documents. These workers are in a predicament of constant fear of being arrested and sent back to their country; they are obviously under stress and sometimes are threatened or taken advantage of during their stay in Thailand.

6.2 How many foreign workers are there?

It is rather difficult to accurately estimate the number of foreign workers in the country because sources of data have different objectives and different time frames. There are two official large data sources: the Ministry of Interior that focuses mainly on the issues of national security, and the Ministry of Labor and Social Welfare that is interested in work status of the workers. In addition, the difficulties also arise from the complex and dynamic nature of the foreign workers who change their work status and come in and out of the country on a continual basis.

According to the January 2017 report on statistics of current foreign workers with work permit compiled by the Foreign Workers Administration Office, Department of Labor, Ministry of Labor and Social Welfare, there were a total of 1,470,225 workers from all countries. Among these, 1,280,991 workers (87% of the total) are from Myanmar, Cambodia and Laos. This figure does not include about 11,675 workers who commute on a daily basis or seasonal workers in the border areas of some provinces such as Tak in the North and Sakeaw in the East. It is believed that these reported numbers are less than the actual number which is very likely to be much larger.

Published data from the Ministry of Interior's website (reference date was not provided but assumed to be around the middle of 2015 or not much later) reveals the number of 2,337,905 workers from the three neighboring countries (i.e. more than the figure reported above). This figure is close to that reported by the T-News Agency on 30 June 2014 which gives the number of 2,223,015 workers from these neighboring countries. Yet, the numbers reported by both sources seems to be lower than what is believed to be actual because they do not include unregistered workers (group 4 above). Not only that, there are also persons who accompanied these workers (spouses, children and the elderly); whose exact number is unknown.

The T-News Agency report cited an estimate of unregistered foreign workers in 2014 given by the Secretary General of the National Security Council at the time. The number of unregistered workers, according to this source, was more than twice as many as registered workers. If the two groups are combined, there should be at least 4 million workers from Myanmar, Cambodia and Laos. This seems to be in agreement with the estimate by the Institute for Population and Social Research, Mahidol University, based on multiple data sources, which gives the number of workers from the three neighboring countries at the end of 2015 to be 4.55 million, out of which 3.52 million are workers and 1.03 million are accompanying persons (spouses, children and the elderly).

In summary, foreign workers from Myanmar, Cambodia and Laos currently in Thailand are believed to be more than the official report of 2.2-2.3 million. The number of more than 4 million workers estimated by researchers is likely to be more accurate.

6.3 The vulnerability of foreign workers

The vulnerability of foreign workers arises from many risks that they face in their lives which include:

1) *Risk of human trafficking:* As noted above, a large number of workers from three neighboring countries come to work in Thailand illegally. Some enter Thailand without a travel document, others are "brought in" by some groups that may or may not be licensed or have connection with local authorities. All of them are at risk of being victims of human trafficking. In the worst instance, some of the victims die on the way while being taken into the country.
2) *Risk of being taken advantaged of:* Once in the country, a large number of the workers are at risk of not getting employment as promised before entering into Thailand. Even those who get employment, they often receive unfair wage and little or no welfare services. Most foreign workers are in the lower employment sector with hard work, low wage and no legal protection. Although there is no discrimination in the laws with regard to labor protection, in reality most foreign workers are not given justice in both their wages and benefits. The case of fishing boat workers, reported many times in the past years, is probably the worst case of discrimination and extreme oppression that foreign workers received.
3) *Risk of not getting access to existing public services:* So far the government policy is to provide foreign workers access to health service and education while working in the country, but in reality their access to these services is limited. For instance, although registered foreign workers are eligible to health care service under the Universal Health Coverage Scheme or the Social Security System, most of them do not have such access because they have to pay from their own budget. A research study found that only 1 in 3 workers in this group reported having at least one type of public health insurance. Among unregistered workers, use of health services in the government outlets is believed to be very little, if at all, as they are afraid of being arrested. Similarly, although the state has a policy to provide free basic education to all children of school age regardless of their legal and nationality status, in reality a relatively small number of foreign workers' children get this opportunity. For instance, in Samut Sakhon province, where there is a very large (if not the largest) number of foreign workers, it is found that only 20% of children of school age from foreign worker families are in school. This is believed to be related to family as well as social problems.

7. Social impact of vulnerability

Having some vulnerable groups in society is not something unusual and not a serious problem if they are not discriminated or neglected. But with a large number of vulnerable people left behind while a smaller number have moved ahead there will certainly be many problems for both the vulnerable groups and society as a whole. We have already pointed out some of the problems for the vulnerable groups above. Here we want to highlight only one important problem for society, that is, the health problem. The fact is: a society with a large number of vulnerable people is usually the same society with a high level of inequality that in turn has significant impact on the people's health. Therefore, a society that has many vulnerable persons is a society that has a health problem.

A study based on data from around the world by Richard Wilkinson and Kate Pickett in 2009 revealed that inequality not only strongly impacts physical and psychological health, but also impedes cooperation and trust that people have to one another leading to stress, fear, insecurity and lack of safety for all in society. In the United States, for example, the rate of untimely death is found to be higher in the states with a high level of inequality. The same study also found that, in 2000, more than 60% of low-income women who live in a state with high inequality have been diagnosed as depressed; 80% of these women have poor health when compared with those in a state with low inequality. Within the same state, those who have low income and live in a community with low inequality have significantly lower death rate than those who have high income and live in a community with high inequality. People's health is thus associated with inequality.

Inequality also has a strong impact on education, a key determinant of improved quality of life and through which the vulnerable groups can escape from poverty. Even though basic education is a right for all children, most children from poor families are not able to receive good education up to a high enough level that enables them to get a job with sufficient pay. Disabled children have even more limitations when compared to those from poor households. Children with a personal status problem and those of foreign workers have the least opportunity for education, even though their right to education is legally recognized. It is because of inequality and limited education that persons of vulnerable groups are unable to develop individual capacities to the fullest of their potentials. And as a result, they are unable to achieve a standard of living that they aspire to. With a large number of people falling behind other groups in education, it is very difficult for a society to develop and become strong.

8. What has been done for the vulnerable groups?

There are many things that the government has done for the benefit of all people including the vulnerable groups. The question is whether they are effective and sustainable. Briefly discussed below are some examples of the programs implemented by the government for the benefit of the 4 vulnerable groups included in this article.

For the poor: Past and present governments have had many programs that aimed to provide benefits for low income groups regarding health, economic wellbeing and education. In terms of health, the state has provided a health care program for the general population over and above the services already provided for civil servants and state enterprise employees (that also include their

family members). The attempt was first initiated in 1975 when Kukrit Pramoj was the Prime Minister. His government had a policy to provide free health care for the general population. However, due to the short duration of the government, the policy was not implemented. In 1983, the Health Card Program was developed for voluntary participation of the people by buying services on a yearly basis. This Program continued until 2001 when it evolved into the current Universal Health Care scheme, so-called "30 Baht for all treatments program" but now widely known as the "Gold Card Program". This is the state-run health insurance program that provides free treatment of all health problems and for all people who are not covered under other state-run health plans, namely, the health benefit schemes for the government and state enterprise workers and the social security program for all workers in the private sector. The Universal Health Care scheme is the best public-run health program in Thailand that has been applauded by WHO, the World Bank and health communities across the world.

In the economic aspect, important programs implemented for the farmers' benefits by the past governments include the Paddy Rice Price Insurance scheme and the Paddy Rice Pledging scheme. Both have now been terminated due to political reasons; they have been replaced by the current program known as the Barn Insurance scheme which aims for much of the same thing as the previous two schemes.

For workers in the private sector, a minimum daily wage of 300 Baht was set into practice by the Yingluck Shinawatra government. With regard to education, the state provides free basic education for 15 years (up to the high school level) in the state-run schools. At higher levels, there is the educational loan fund from which students can borrow on a voluntary basis. Nevertheless, empirical data have indicated that there is still marked difference in the quality and quantity of these services that people of the vulnerable groups receive.

For disabled Persons: The Empowerment of Persons with Disabilities Act, B.E. 2550 (2007)

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aims to empower the disabled so that they are independent as much as possible rather than just giving them basic welfare. To achieve the goal, this Act stipulates that a committee responsible for development of the quality of life of the disabled be organized, unjust discrimination towards the disabled be prohibited, and registration of disabled persons be implemented. The Act also clearly specifies the rights of disabled persons including their access to public welfare and services especially disability allowances. A fund to support the development of the quality of life of the disabled was also set up under the law. The law also requires that private and public agencies employ disabled persons in appropriate proportion to their employees.

Despite the fact that this law has been effective for 10 years, there is no clear evidence as to how much the quality of life of the disabled has improved. Most public places such as parks and buildings have not been changed or improved in ways that disabled persons can have convenient access. A major obstacle may be in the public attitudes towards disabled persons. In the view of some disabled persons from the Independent Living Center of the Disabled, Phuthamonthon district, Nakhon Pathom province, public attitudes are very important for social participation of the disabled. As long as society continues to view the disabled as a group that awaits welfare, opportunities for them to participate in such important activities as education and work will continue to be a challenge.

For ethnic minority and stateless persons: Thailand has laws concerning the status of ethnic minorities and stateless persons. These include: (1) The Nationality Act, B.E. 2508 (1965) amended in 2012, (2) The Immigration Act, B.E. 2522 (1979) amended in 1999, and (3) The Civil Registration Act, B.E. 2534 (1991). These laws set the criteria for acquiring nationality by various groups of people including displaced Thais and aliens living in Thailand. In addition, the government has also set policies, strategies and procedures for specific issues. For example, in 2005, the government announced the Strategy on Managing the Problem of Status and Rights of Individuals, under the new concept of security management. This strategy takes into account balancing of basic human rights and national security by various possible means, such as: placing importance on values and diversity in the way of life and culture of the people, human equality and dignity, basic rights and positive attitudes toward each other, accepting the fact that some groups of people cannot return to their country, creating balance between the principle of human rights, human security and national security, using all stakeholders and international civil societies to overcome the challenge.

Based on this strategy, groups of people that should receive benefits include stateless people and ethnic minorities that currently do not have any legal status as Thais. Nevertheless, due to the slow nature of action and discrimination, hundreds of thousands of such people continue to remain in a state of vulnerability.

For Foreign Workers: This group of people are similar to ethnic minority and stateless persons because their presence in Thailand concerns national security and the economy. In terms of national security, there is the Immigration Law that handles this while in the economic sphere there is the law on foreign workers that first came into use in 1978 and was later replaced by the Foreign Labor Act, B.E. 2551 (2008). In addition to this, there are ministerial regulations and several cabinet resolutions; all of them aim to manage foreign workers. However, the issue of foreign workers is complex and has accumulated over time, especially with regard to human rights and human trafficking. This has made Thailand the target of close watch by developed countries such as the United States and the EU. Despite efforts made by the present government that took control of the country in May of 2014, Thailand's credit on human rights issues was reduced by the United States to Tier 3 (20 June 2014). Thailand was considered a country that did not meet the lowest standard of protection for victims of human trafficking and with no clear attempts to solve the problem until 30 June 2016 when the US revised its position and put it in Tier 2. Nevertheless, at the Tier 2 level the country is still in the watch list regarding the standards in solving the problem of human rights and human trafficking.

Although attempts have been made by the state through numerous policies, laws and many regulations that aim to provide benefits, directly and indirectly, to vulnerable groups (as to the population of all groups), the problem for vulnerable groups does not seem to have substantially reduced. This may be due to the size and complexity of the problem associated with slow implementation and discrimination that remain. Thus, it is difficult to assess whether what has been done and what is under implementation can be sustained and continued. Even what has been proved to have highly positive benefits for all – particularly the vulnerable groups – such as the Universal Health Coverage scheme is sometimes questionable: whether it can survive the current circumstance despite its survival during the past seven governments. This is because the distinction between social benefits and the people is a very difficult concept for those in power who have no connection to the people and are used to only the system of giving in the form of succor.

9. Towards an inclusive society

Though the vulnerable groups that are discussed in this report have different characteristics, all of them have a common problem of being unable to keep up with other groups on the path of development. This is not only a problem for each of the vulnerable groups but also a problem for society as a whole. A society where a large population is left far behind is weak and lacks power. This is the reason why we must create a society that leaves no one behind.

The key strategy to be an inclusive society is in reducing the opportunity that may cause inequality. Experience from the past of many countries shows that economic development brings with it not only prosperity but also undesirable social effects such as inequality. Inequality is like a disease that harms the society's health and makes a large number of people vulnerable.

One measure to reduce inequality that many developed countries have used successfully is taxation. For Thailand, the most important seems to be the land tax. Many experts believe that, if appropriately managed, the land tax will help redistribute land ownership, particularly the ownership for speculation. It could be an effective way to enable the poor (farmers particularly) to have access to land. Although there have been discussions on restructuring the land tax system by nearly every government for more than two decades, the present government as well, it has not gone far enough to implementation. As for the new inheritance tax law which has already come into effect in early 2016, it is not clear how it could reduce inequality.

Tax measures should be implemented along with development in the social welfare system, especially the national retirement fund that will help reduce inequality for the elderly to some extent. So far, measures to achieve this goal have been delayed or put on hold. Many people just hope it will not end in the same way as the land tax that has kept postponing.

Inequality will reduce only when all people have equal rights to access the economic and social opportunities. In most modern societies, including Thailand, the issue of rights is hardly a problem for legal citizens, but it is very much so for stateless


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people who may have lived in the country since birth or may have entered to work and live in the country for a long time. To facilitate the rights for these people, measures based purely on the interest of national security may not be the answer because what is equally important is human beings and basic human rights.

For foreign workers who are in a different status, the most important measure is to prevent them from becoming victims of human trafficking, being taken advantaged of and oppressed. After all, these are the people who contribute to the country's economy; they should deserve the same basic rights and benefits as Thai labor.

Empowering vulnerable groups so that they can develop their capacities to the best of their ability should be seriously considered. The goal is for the vulnerable groups to have a life of independence just like other groups of people. It should be emphasized here that, without opportunity properly provided, rights per se may not be sufficient for vulnerable people to be independent. Therefore, it is important to not only provide rights, but also empowering them so that they are not left behind in the development process. Thai society today must increase this effort.

A society consists of people of many groups and can be compared with a human body that is made up of many interrelated and interdependent organs that function to maintain the whole. A strong and healthy society is no different from a strong and healthy body. Just as a healthy body is free from all forms of illness, so is a healthy society; it is without any 'social pathology' that makes certain groups vulnerable in all circumstances.

If the desirable goal of development is to allow all groups to move forward together with no one group left behind, reducing inequality by empowering the vulnerable groups must be the top agenda for development.

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Empowering Vulnerable Populations and Creating an Inclusive Society

Personal resources

Assoc. Prof. Pantip Kanchanachitra Saisunthorn, a law lecturer at Thammasat University,

Thongpoon Buasri, Foundation for the better life of children

The Independent Living Center of Phutthamonthon Disability People

Mr. Santi Rungnasuan

Mr. Athiphan Wongwai

Mr. Jumpee Sawaskham

Mr. Piyawat Sawaschu

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The Process of Producing the "Thai Health Report 2017"

Health Indicators

Process

- Select interesting and important issues to be included in the health indicators through a series of meetings of the Steering Committee
- Identify experts to be contacted, then hold meetings to plan each section
- Assign an expert to each approved section to prepare a draft
- Brainstorm the draft papers, considering suitability, content, coverage, data quality, and possible overlaps
- Meetings with experts responsible for each section, to review the draft papers and outline key message for each section
- Broad review of the draft papers by experts, followed by revisions of the papers

Guidelines for health indicator contents

- Find a key message for each section to shape its contents
- Find relevant statistics, particularly annual statistics and recent surveys to reflect recent developments
- Select a format, contents and language suitable for diverse readers

The 10 Health Issues, and Four Outstanding Accomplishment for Health

Criteria for selecting the health issues

- Occurred in 2016
- Have a significant impact on health, safety, and security, broadly defined
- Include public policies with effects on health during 2016
- Are new or emerging
- Recurred during the year

4 Four Outstanding

Four Outstanding Achievements are success stories in innovation, advances in health technologies, and new findings that positively affected health in general.

Procedur/e for ranking the issues

- A survey was conducted using a questionnaire listing significant issues in 2016 before the survey date. The situations obtained from the survey were ranked using a Likert scale with three levels: high (3 points), medium (2 points), and low (1 point).
- The ranking data were analyzed using the SPSS statistics package. Issues with high mean scores were given high priority.

The special Issue

There are two types of special topics: target group oriented and issue oriented. The types alternate each year. The topic is sometimes selected from the 10 health issues.

Important criteria in selecting the special topic include:

- Political significance
- Public benefits
- The existence of diverse views and dimensions

Working process

- The Steering Committee met to select the topic
- The working group outlined a conceptual framework for the report
- Experts were contacted to act as academic advisors
- The working group compiled and synthesized the contents. The contents were thoroughly checked for accuracy by academics and experts.
- The report was revised in line with reviewers' suggestions.

Names of Steering Committee 2016

คณะกรรมการชี้ทิศทาง

Dr.Amphon Jindawattana	National Health Commission Office of Thailand	Committee Chair
Dr.Choochai Supawong	National Health Foundation	Committee
Dr.Pongpisut Jongudomsuk	National Health Security Office	Committee
Parichart Siwaraksa	Freelance Academician	Committee
Orapan Srisookwatana	National Health Commission Office of Thailand	Committee
Dr.Perapon Sutthivisatsunk	Health Systems Research Institute	Committee
Surin Kitnitchi Klongkanomjeen	Community, Sena District, Ayutthaya Province	Committee
Suriyon Thankitchanukit	Office of the National Economic and Social Development Board	Committee
Dr.Vichai Chokevivat	Institute for the Development of Human Resource Protections	Committee
Yuwadee Kardkarnklai	Future Urban Development	Committee
Director of Health System	Thai Health Foundation Promotion	Committee

Development Section

Director Statistical Forecasting Bureau	National Statistical Office	Committee

Names of Experts

Reviewers

Dr.Suwit Wibulpolprasert

Dr.Vichai Chokevivat

Parichart Siwaraksa

Reviewers for Empowering Vulnerable Populations Creating an Inclusive Society

Dr.Amphon Jindawattana

The Writers “His Majesty King Bhumibhol Adulyadej and Thai Health”

Dr.Vichai Chokevivat

Personal resources “Empowering Vulnerable Populations and Creating an Inclusive Society”

Assoc. Prof. Pantip Kanchanachitra Saisunthorn, a law lecturer atThammasat University,

Thongpoon Buasri, Foundation for the better life of children

The Independent Living Center of Phutthamonthon Disability People

Mr. Santi Rungnasuan

Mr. Athiphan Wongwai

Mr. Jumpee Sawaskham

Mr. Piyawat Sawaschu

The Writers 10 Health Issues Team

Chairith Yonpiam

Abhisuk Vevisid

Asst. Prof. Sutthida Chuanwan, Ph.D

Pharm.D. Tipicha Posayanon

Pisit Sriakkapokin

Preeyanan Lorsermvatta

Adisorn Keadmongkol

Asst. Prof. Anlaya Smuseneeto, Ph.D

Napaschon Thongsomjit

The Thai Health Report Team

Institute for Population and Social research Mahidol University

Main Editor

Associate Professor Churnrurtai Kanchanachitra, Ph.D.

Editor A Good Death: Alternative Option

Associate Professor Chai Podhisita, Ph.D.

Assistant Professor Kanchana Tangchontip, Ph.D.

Kanyapat Suttikasem

Editor “10 Outstanding Situations in the Year 2016” and “Four Outstanding Accomplishments for Health”

Sakkarin Niyomsilpa, Ph.D.

Kanchana Thianlai

Editor “11 Indicators on Thai Health and the Sustainability Development Goals”

Assistant Professor Chalermpol Chamchan , Ph.D.

Assistant Professor Manasigan Kanchanachitra, Ph.D.

Kanya Apipornchaisakul

His Majesty King Bhumibhol Adulyadej and Thai Health

Suporn Jaratsit

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