Chapter I
Introduction

1.1 Background

Economic crisis have been more frequent in different regions of the world during 1990s while their intervals are shortening. A few years after Mexico Economic crisis a more horrible crisis paved Thailand, Indonesia, Philippine, Malaysia and before its impacts ended, it developed to south Korea and Japan, the Second powerful economy of the world and after developing to Russia it returned to Latin America again to damage Brazil. So it seems the economic crisis have not been occasional may be due to globalization, of course going beyond causes of crisis is not at the scope of this research but it seems there have been some similarities between factors are called now diagnosis of the economic crisis in IMF 1998 Report as current account deficit, dealing with capital inflows, fiscal and monetary policies the exchange rate policy, financial sector weaknesses and the role of foreign market players, that a combination of them were present before many of economic crisis of 1990s. As risk is polling and create unexpected crisis all over the world may a more effective international finance system be needed for risk sharing and avoid impact of crisis. But at present health sector while has lost some of its traditional resources during health care reforms, hyper inflation has diminished its purchasing power and is suffering deficit market of health, should response to increasing demand of more malnutritions that due to the crisis have lost their income.

1.2 Impact of Economic Crisis on Health Status

Before presenting any empirical evidence connecting the worsened economic situation to changes in health status, it may be useful to consider theoretically what connections may exist and what determines whether they will be manifested. This is particularly important in view of the paucity of data on most aspects of the relation. Most of what it would be useful to know has not been documented, either because the crisis has yet to affect health status visibly or because information at the right level of detail has not been collected.

Two basic distinctions should be made at the outset: the first between long-run and short-run effects, and the second between direct and indirect effects. As to the former, there is a wealth of evidence showing that in the long run, health status tends to improve as income increases: infant mortality declines, mortality from certain diseases almost disappears, and life expectancy increases makedly. These health benefits are among the principal gains from economic development. It is this same long-run effect that shows up in cross-sectional comparisons of countries at different levels of income and development. Even if each country is studied at only one point in time, the differences among countries reflect, in part, differences in their advancement along a common path of development. That does not mean that a given country's future development must exactly repeat that of currently richer countries, because both medical technology and the content of economic development keep changing . It does mean, however, that neither long-term temporal comparisons within countries nor one-time comparisons across countries necessarily say anything about what will happen to health when income falls abruptly after a long period of increase. This is because most of the connection between income and health depends not on current economic flows but on the stock of capital-including medical capital as well as safe water supplies and sanitation-accumulated from past incomes. Unless incomes decline and stay so low for so long that capital is allowed to deteriorate, an economic recession does not mean returning down the path that a country followed while growth was proceeding. Even if there is no deliberate effort to compensate for the income decline, the existing stock of knowledge, medical personnel, and facilities continues to be used. It is, therefore, not surprising that in the very short-run, infant mortality or life expectancy or other national indicators of health status may not show sudden downturns despite economic deterioration.

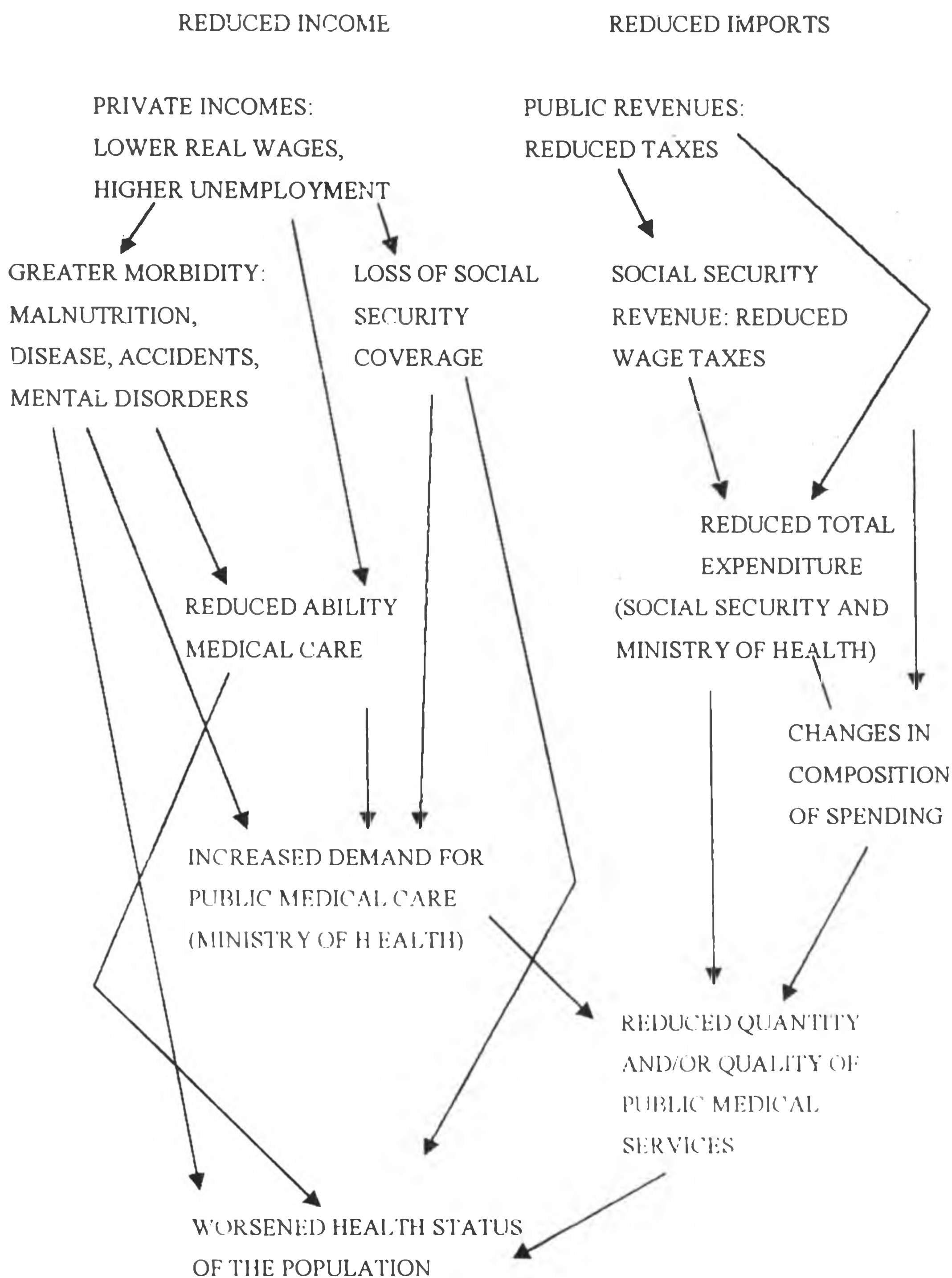
Two further observations on this point are in order. First, while income may exert a powerful effect on health status, even taking account of other factors such as safe water supply or the availability and use of medical services, the effect is unlikely to be linear: it will be concentrated at low incomes. Second, and as a direct consequence of the first observation, the health effect of a given total decline in

losses may have significant consequences for health if they hurt primarily the poor, whereas greater income losses will have little impact if they are more equitably shared or affect mostly the nonpoor.

As to the second distinction, that between direct and indirect effects, economic regression can worsen people's health status by either or both of two mechanisms: (a) by making them sicker, so that they require more medical attention; and (b) by making it more difficult for them to get whatever degree of care they need. This indirect effect through the medical care system can be further divided according to the different institutions from which people seek health care: the ministry of health and related public institutions, the social security system, and private providers.

These direct and indirect connections are illustrated schematically in Figure 1.1 In keeping with the emphasis on the short run, only two dimensions of the economic recession are considered: the reduction in income and the reduction in imports required as part of a country's external adjustment. In the short run, the sharp decline in investment has little effect, although if it continues, it will add both to the loss of employment and income and to the reduced ability of the health care system to meet the demands placed on it. In the diagram, all effects can be considered to operate through reductions in current consumption, whether private or public. Several further complicating factors are also omitted from the Figure, for simplicity. No account is taken of inflation's possible role in affecting the composition of public health care spending and output, for example, not are any adjustments shown between resources directed to private and public medical care by practitioners as demand changes. The diagram, of course, shows how the economic crisis can worsen health status, without implying that it must do so.

Figure 1.1 Schematic View of the Direct and Indirect Effects of Economic Crisis on Health Status.



Source : P. Musgrove The Economic Crisis in Latin America and the Caribean, 1987.

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Two elements of the Figure 1.1 deserve further explanation. First, the connection from economic deprivation (unemployment or reduced income) to increased morbidity or mortality varies greatly for different conditions. Being made poorer will probably have no effect on cancer or cardiovascular disease, or on the likelihood of contracting any of the vaccine-preventable diseases. It is possible that reduced economic activity will decrease the number of industrial and vehicular accidents, although accident rates could rise, if drivers or workers are more likely to be suffering from stress or alcohol use. And for several health problems, economic deprivation is virtually certain to increase morbidity and, presumably, mortality. Malnutrition is probably the most immediately sensitive condition, since it depends on current consumption, and large numbers of people were eating barely adequate diets even before the current crisis began. Economic deprivation can be expected to increase the severity, if not the prevalence, of intestinal and respiratory diseases for this reason, with increased infant and child mortality a likely result. The loss of employment and income is also likely to increase a variety of mental disorders, and, partly in consequence, assaults, homicides, and suicides. These distributional effects, in which some medical conditions vary much more than others in response to recession-and therefore some population groups are much more affected than others-are not necessarily mirrored by what happens to medical services. Depending on which medical resources and programs are protected and which are sacrificed, the indirect effects on health status can be in the same direction as or opposite direction to the direct effects. For example, a reduction of immunization efforts would create greater morbidity, even though there is probably no direct connection from economic hardship to the prevalence of immunopreventable diseases.

The second observation on Figure 1.1 is that the outcome in health status is not simply a function of what happens to total public health care spending, or of how that expenditure changes in the face of increased demand by patients who formerly paid for their own private medical care or were covered by social security medical services. Much also depends on whether public institutions become more, or less, efficient when total resources are reduced. This is largely a matter of what happens to the balance among different medical inputs, which-for constant prices-is reflected

in the composition of expenditure on health. Observing some similarities between impact of previous economic crisis on health sector and the health sector in Thailand resulted to adapting Figure 1.1 by MOPH. Such events bring this thought to mind to search for a common methodology encompassing a monitoring tool be adapted to show the impact of Economic crisis on health sector in other countries. (Musgrove, P., 1987)

1.3 Research Questions

How is the health sector affected by the economic crisis? How different financing schemes responsed to the crisis And what were the changes in their financial sustainability and efficiency?

1.4 Objectives

1) To Construct a monitoring tool consisting a set of indexes, indicators and criteria to follow up the impact of the Economic crisis before and during its occurrence
2) To develop a logical analytical framework to Evaluate Health Sector performance
3) To apply an existing tool to assess health sector performance in Thailand
4) To Evaluate changes of different schemes against sustainability and efficiency indicators
5) To assess indicators against validity, reliability and interpretibility.

1.5 Scope of Study

The scope of study is health care financing for different schemes for the health sector of Thailand in 1996, 1997 and 1998.

1.6 Expected Benefits

It is expected that methodology of this study be used to assess different health insurance schemes, that an appropriate mix of them along with convenient payment mechanisms will be the base of health policies.