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This study is a documentary research in historical domain to examine the socio-politic contexts of the physician shortage in community hospitals in Thailand and to propose new effective strategies besides the former ineffective ones used for a long time.

The results showed that Thailand has been developed to be a capitalistic state since the 1932 revolution. Past governments were not stable because of many revolutions. They paid more attention to economic policy that could benefit their capital than the public policy such as public health policy. They left government officials in the MOPH being the health policies makers. For these reasons, the health policies were directionless and incoordinate. Many National Health Development Policies were only policies to develop the MOPH. Several strategies written in the plan show incoordination, such as policy to produce the physicians and the Rural Recruitment and Training Project that was not continual although it was partially effective. The policy of allocating new physicians to rural areas did not change and the problem remained

Furthermore, the medical profession dominated in policy making and affected the direction of public health policy directly. The policies used did not interfere with their existing medical system such as using newly graduated physicians in community hospitals. Furthermore, physicians in treatment model who were specialists dominated health policies in the MOPH. This affected the structure and regulation of the MOPH that supported specialists in large health facilities more than GPs in community hospitals. The MOPH supported an insensible brain drain from community hospitals by setting a quota for residency training for all physicians yearly. By undistinguished MOPH rules for incentive payment, the gap between community hospitals and large hospitals was more widened. These led to migration of rural physicians to urban areas and made a shortage in rural areas.

The most important factors were domination of medical professions all over the state and the MOPH policies. The medical associations could debate and direct state and MOPH policies such as production of junior doctors, establishment of new medical schools, promotion of specialist training. The medical associations also affected most physicians' favored specialists. They wanted to be specialists, not GPs to practice in community hospitals and this led to rural physician shortage.

All these factors show that the medical profession had dominated the health policies for a long time and had to be changed. The domination of medical professions must be overturned to balance the medical system and solve maldistribution of physicians in rural areas and community hospitals.