The Movement of Thailand's Health System Reform
A Paradigm Shift

National Health Commission Office

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Foreword

In the midst of a drastic evolutionary shift in political, societal, economical and technological environments in the last few decades, Thai people were confronting a challenge to reshape their health entity. A process to reform a comprehensive and holistic health system was inescapable. Research and mutual learning endeavors became essential knowledge in uncovering a camouflaged crisis on the health of the nation as well as a premise of strategy to redesign health systems.

Thailand's political reform coincided with a country wide economic crisis in 1997. It raised a strong demand for extended societal restructuring, which finally triggered a paradigm shift in health. Political commitment, in coordinating with a wide range of civil society groups to work with academics, was demonstrated as a crucial leverage to lead an envisioned and systematic reform. The "Triangle that Moves the Mountain" process - a symbiotic interaction among academic activities, social movement and political involvement - was employed as a key strategy to pursue the mission. Movements towards health system reform were enthusiastically welcomed as they could culminate into a stronger political commitment –

legislation of the National Health Act. This had extended opportunities for research institutes to contribute their efforts to serve social demands.

Finally, Thai society had redefined health and the health system, which led to a capability to envision a holistic scope of the health system. A "Regulation of the Office of the Prime Minister on National Health System Reform" was published in the Government Gazette on the 31st July 2000, and the National Health System Reform Committee as well as the National Health System Reform Office were appointed to launch a "Health System Reform Movement." As a result, the National Health Act was finally enacted on 20th March 2007. This initiated the utilization of sound knowledge to arm public policy towards health concern.

This book focuses on the initiation of Thailand's movement towards health system reform started a decade ago, when a "Paradigm Shift" took place. Information in this book was mainly from two booklets – "Triangle That Moves The Mountain and Health Systems Reform Movement in Thailand" of Prof.Dr.Prawase Wasi and "Thailand's Health System Reform" of Dr.Wiput Phoolcharoen. Main ideas and key messages from the two booklets were combined together and revised aiming to introduce a background as well as strategy and process implemented during the first period of the movement, before the National Health Act 2007 was enacted.

The NHCO is most grateful to thank Prof.Dr.Prawase Wasi and Dr.Wiput Phoolcharoen for their comprehensive information clearly presented in the two booklets. Such information is very fruitful and is among the best sources

depicting clearly the starting period of Thailand's movement on health system reform.

The NHCO hopes that readers will find this book very useful and informative to elaborate steps and initiatives towards a paradigm shift and movement to the health system reform in Thailand, which is a process leading to an implementation of the National Health Act 2007, the first law focusing on the holistic well-being of Thai people.

National Health Commission Office
October 2008

Background

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The first research initiative was a quest to shift health paradigm as well as to inspire willingness to reform.

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Background

Back to 1990s, Thailand had economically evolved from an agrarian society four decades ago to a newly industrialized country with a great leap in societal and people's lifestyle. Health was among the most rapidly growing sectors reflected in both the expanded health care infrastructure throughout the country and improvements in the health status of the Thai people.

However, because of the unexpected emergence of new health determinants, the immense health gains in the last few decades decelerated. An unprecedented catastrophic social anomie resulted in increased mortality and morbidity in the last few years. At the end of 1990s, the economic crisis had a broad and negative impact on the country. It had also driven Thai society to rethink the holistic structuring of its societal paradigm and infrastructure.

Betterment of health status and the illusion of admired successful health programs without sound evaluation in the last two decades had camouflaged the failure of the country's health system performance. To raise the awareness of the public on the critical facts of the health system, a series of analyses on health policies and health ideologies that had emerged in Thai society was

conducted and publicized. The first research initiative was a quest to shift health paradigm as well as to inspire willingness to reform. Secondly, packages of academic review and synthesis were undertaken to provide a clear vision for all parties to trust so that they would join the reform process. Thirdly, essential devices and mechanisms to reorient and sustain the health system were created and tried in order to confirm the possibility of innovative performances. And finally, research to delineate profiles and the competence of civic involvement in the health system was conducted in order to propel the reform synergistically.

Thailand's health system reform was raised as a national agenda in the midst of a drastic evolution in political, economic, and technological structures. However, the constraint of resources as a result of the economic crisis inevitably affected this reform so that policy implementation for transition had to be undertaken with deliberative and insightful movements.

1. The Constitution B.E.2540 (1997): Reorientation for Thailand's Health Demand

The Constitution B.E. 2540 (1997) established enormous opportunities for further progress in restructuring the relationships between the state and civil society for further democratizing the development process; and for creating new institutions and mechanisms that provide greater accountability, transparency, representation, and participation. Initiatives in these areas were rooted in law and guided by far-reaching principals

pertaining to basic human rights. It was of utmost importance that these opportunities be seized to the fullest and remain central issues in the policy and reform agenda. Their full and effective utilization would allow civil society organizations to further flourish and to serve as a positive force for change as well as enable them to serve more effectively as a countervailing force against the negative impacts of globalization.

> ***"The Constitution provided a crucial reorientation for the health of the Thai people; health was stipulated as a human right, which had to be protected by the state."***

An egalitarian standpoint was emphasized in the context of health for the first time in Thailand's political philosophy. An equal entitlement to health was introduced for a wide range of vulnerable people; i.e., the elderly, the disabled, abandoned children and so forth. Consumer and environment protection, particularly for the sake of health, was another area that had been mandated.

Under a section on the fundamental roles of the state, the government was responsible to efficiently provide public health services to all people at the same standard. Disease control was also a state obligation to be pursued free of charge. In order to comply with these missions, devolution of various services upon local governments was conducted urgently. Health services under the Constitution was under the state of equity, efficiency, quality, as well as transparency and accountability to the community.

Political reform, thus called for a re-examination of the health sector's role and approach, which concerned for social capital as well as for financial capital. The health sector had to re-orient its own vision and mission to meet this new demand for health and health care so that the Constitutional mandate could be achieved. Leadership for collective movement through collaboration of all societal sectors had been pivotal to meet these constitutional demands.

2. Decentralization

The Decentralization Act became effective in November 1999. This Act defined the roles and responsibilities of the National Decentralization Committee (NDC). A primary responsibility of the NDC was to formulate a Decentralization Plan that would be executed by the government. This plan had defined the relationships and functional responsibilities between the central and local governments as well as among local governments. It defined local revenue sources and identified the means to improve local tax and revenue mobilization. The plan outlined the stages and means to transfer functions from the central government to local governments. It recommended the means to coordinate the transfer of public officials from the central government to local governments and state enterprises that had been related to the new assignments of functions and resources.

According to the Decentralization Act, the public health mission and hospital mandate had to be devolved to local governments. Thus, a crucial re-orientation campaign needed to be undertaken by both the central government's officers and local governments' authorities. The central authority had to shift its mission from the current function of logistic administration and policy control to that of policy guideline and quality assurance of health care in the future. At the same time, local governments had to be empowered so that they would be capable of providing equitable and efficient health care, which would be accountable to the people in their own community.

3. Key Demands to Reform

The health status of the Thai people had immensely improved in the last decades of the millennium. However, evidences indicating failures of the health system's performance were tacitly demonstrated. A series of health policy research issues were analyzed and indicated that emerging crises could never be handled by the existing health infrastructure. Five major critical issues were depicted as key messages that demanded structural reconstruction in health systems. The issues included: higher cost of health expenditure, unbalanced economic development, rapid technological evolution, political and social reform, and government sector reform.

3.1 Higher Cost of Health Expenditure: Paradigm towards Health Care

Thailand had a relatively good health care service infrastructure with hospitals in all its 76 provinces and over 700 districts, and health stations in all its 7,000 sub-districts or tambons. It did well in communicable disease control; plague, small pox, cholera, leprosy, diphtheria, pertussis, yaws, poliomyelitis had disappeared or were very much reduced in prevalence. However, if looked at a system dimension, the Thai health system was running into crisis.

With the expansion of modern health care delivery systems in both the public and the private sector, the Thais were moving towards using more facility-based health services. National health spending in Thailand rose eleven times from USD562.5 million in 1980 to USD6,301.7 million in 1998. The per capita health expense rose nearly 9-fold from USD12.1 to USD103.6 during the same period. This was higher than the per capita average annual gross domestic product (GDP) growth of 7.0%. Thus, the share of GDP taken by health nearly doubled from 3.82% in 1980 to 6.21% in 1998. In addition, access and quality of health care were not good enough, the people were not satisfied, while the health personnel were over-worked. If no any measure taken, the country at that time would run out of money for an inefficient health investment. Therefore, the health system was in need of a reform.

3.2 Unbalanced Economic Development: Social Pathology

It seemed to be good that the poverty incidence fell from 33% in 1988 to about 11% in 1996. While Thailand drew considerable satisfaction from its development over the past three decades, it paid high costs in several areas: i) the unbalanced nature of much of the development causing disparities among the marginalized population; ii) the disruption of social structures and relationships as well as the erosion of social and cultural capital; and iii) unsustainable levels of natural resource because of resource depletion and environmental pollution.

As a result of international recession, currency realignment, and capital mobility in the 1980's, the government shifted its economic strategy towards the promotion of exports in both services and manu¬facturing industries. Both natural increase and marked increase in rural to urban migration contributed to the manufacturing labor supply, the decline in agricultural growth, and the closing of the agrarian frontier.

This deterioration in its social ecology altered Thailand's health situation with the emergence of HIV/AIDS, traffic injuries, cancer, mental stress, and environmental hazards among the top-ten causes of mortality and morbidity. The mortality rate, which had declined from 20 in 1975 to 4.1 in 1986, rebounded to 5.0 in 1997 and 5.1 in 1998. This might have signified that the existing health system was not well designed to cope with the new societal challenges.

3.3 Rapid Technological Evolution: Reliance on Imported Technology

A wide spectrum of health technology had been researched and developed in industrialized countries then imported by developing countries at high cost. The HIV/AIDS epidemic exemplified the widening gap of inequity with the accessibility of more efficacious drugs to wealthier people with HIV while leaving those who were financially disadvantaged to suffer on their own.

Cancer, the leading cause of death since 1980, was another example, radiotherapy was expensive, requiring complicated medical equipment to effectively cure cancer patients. In addition, 54% of radiotherapy units were installed in Bangkok, while the other 46% were in provincial cities. They had a shortage of qualified manpower to provide the treatment.

> ***"The policy proposing universal coverage of health care could never be achieved if the health systems continued to rely on the importation of costly evolved technology."***

Thailand, therefore, needed to create and orientate a strong foundation on health research and development to be able to transfer novel health knowledge and technology from industrialized to developing countries. Investment in government health research increased from 0.2% of the public health budget between 1992-1996 to 0.52% in 1999. Compared to research in agriculture, industry, science and technology, which contributed

directly to national economic growth, the health research was not a top priority in Thailand.

3.4 Political and Social Reform: Demand for a Reoriented Government Sector

Civil society's movement gained strength in the 1990's, when the need for political and social reforms became increasingly apparent. They became a potent force for change and played a decisive role in framing a reform agenda shaped by the principles of democracy, participation and respect for basic human rights. As both advocates and watchdogs, they were involved in activities that went beyond the traditional concepts of participation and even empowerment. They were spearheading the search for a new social paradigm based on a far-reaching process of political democratization.

With the promulgation of the Constitution in 1997, the nation built a more open and democratic society in which the basic rights of the population were safeguarded. Consequently, the Thais were provided with significant new opportunities to participate in all processes of development.

3.5 Government Sector Reform: Demand for Structural Adjustment

The Constitution set a framework for reforming government sector management and improving accountability, transparency and mechanisms for combating corruption. It provided the National Counter Corruption Commission with more authority, established new organization to monitor and improve transparency, and granted legal rights for civil society to participate in the policy formulation process.

> ***"A new Official Information Act provided greater access to government related information and created greater opportunities for people to be involved in government services."***

Thailand's three-year Government Sector Reform Program that commenced in 1999 involved both central agencies and line ministries such as education and health. Both embarked upon substantial reforms in these areas: i) expenditure management, ii) human resource management, iii) revenue management, iv) decentralization, and v) cross-government accountability and transparency.

The Ministry of Public Health expected to reform its budget management for provincial health authorities and provincial hospitals. The Comptroller General's Office and the Fiscal Policy Office had analyzed the issue of fiscal transparency. A new accounting system was being developed aiming to acknowledge the cost of care.

The Office of the Civil Service Commission (OCSC) oversaw the program on human resource management reform by encouraging the civil officers to achieve the highest levels of efficiency, quality and integrity. One of the strategies involved downsizing the civil officers with early retirement being the first phase.

4. Movements to Reform

4.1 The World Health Organization

Thailand's involvement with WHO in various capacities caused a lot of inspiration that has led to a variety of health research and development activities in Thailand. The non-smoking campaign, health economics capacity building, and the idea for health systems reform, for example, are all traceable to WHO-led inspiration. The greatest strength of WHO lies in it being highly prestigious and its unlimited access to expertise around the world.

The WHO Headquarter (HQ) and the Regional Offices (ROs) have generated and collected a lot of concepts and methods aiming for the health and well-being of mankind around the world, but the most difficult part is implementing those concepts and methods in member countries. If knowledge-based health development could not be implemented successfully in member countries, there would be bottleneck in the otherwise very good WHO System. The concepts and methods developed at the HQ and ROs would become congested, untested by real practices in member countries and thus provide no appropriate feedback to the System. The System would not be as interactive and as vibrant as expected. Thus more attention should be focused on the member countries.

> ***"How they could implement knowledge-based health development successfully is the crucial issue."***

4.2 Research and Development

Health research capability building is most crucial for making health systems reform possible. In the last two decades or so health research capability had strengthened through different means. These included Thailand Development Research Institute Foundation (TDRI)'s research strengthening program, Rockefeller Foundation's the Great Neglected Diseases of Mankind program, Centers for Disease Control and Prevention (CDC)'s collaborated Field Epidemiology Training program, the Rockefeller Foundation's INCLEN (The International Clinical Epidemiology Network), and establishment of the College of Public Health at Chulalongkorn University under the leadership of Dr.Charas Suwanwela and Dr.Chitr Sithi-amorn as well as other Thai academic leaders' involvement with the international health research movement. The Health Care Reform project under the leadership of Dr.Sanguan Nitayarumphong, supported by EU, had pioneered research and development in health care system reform in Thailand.

> ***"The chronic problem in most developing countries was the lack of good research management mechanisms."***

To overcome this deficit, the Thai government established two effective national research institutes in 1992, as promoting and funding agencies, namely the Thailand Research Fund (TRF) and the Health Systems Research Institute (HSRI). The HSRI was

established with an intention to be a tool for health system reform. Under the able leadership of its two successive directors, Dr. Somsak Chunharas and Dr.Wiput Phoolcharoen, the institute had mobilized the creation of much health system knowledge. Although the knowledge was not yet complete, it was adequate to support a health system reform movement.

It should be pointed out here that both the TRF and the HSRI have been especially designed to be effective in research management. Both agencies were established by special Acts that allowed them to use the government budget but remain independent. They are not bureaucratic organizations, and governed by independent boards. Even though independent by law, in practice, as in many developing countries, the organizations in the past had suffered from creeping in bureaucratic politics and politically motivated politics. Having senior academics respected by politicians, bureaucrats and media was very crucial in helping the organizations to steer through such scenario.

4.3 Health System Reform: As a National Agenda

Although the reform policy seemed to be chaotic in coordinating control, it did provide a challenging opportunity for a bold movement toward health care reform. The issue of constitutional rights raised more concern over health, while the existing system could not meet the increasing demand, nor could the country afford the increasing cost of curative care within the prevailing state of infirmity. The growing health burden to society became an inevitable hurdle, unless the causes of illness and death

diminished with people living a healthier life. This had demanded the real involvement of all stakeholders to cooperate in the health system. Societal accountability of the health authority promoted local and community self-governance of the health system as well as shifted central health function towards limited policy guidance and technical leadership. Local government urged societal empowerment by redeploying manpower and capacity building for administration and management. It also demanded the new health system be redressed within the evolving insights and ideology of health in Thai society.

The passive "ill-health-oriented" system had to be reformed to a proactive "good-health-oriented" system. For this, the health promotion campaign needed to be fully developed and the disease control and prevention system needed to be reformed to be fully efficient. Health care finance needed to be developed to guarantee access to adequate and quality health care for all. Consumers had to be adequately protected and empowered. Health personnel development, as well as technology, information and research systems needed to be reformed.

> ***"In the reformed health systems, responsibility for good health would not solely lie with the Ministry of Public Health, but with all sectors of society -- All For Health."***

Thus there was a need for a body to coordinate health policies for all sectors, and the National Health Act was needed.

In response, the Royal Thai Government had undertaken widespread health system reforms. The Cabinet approved a national agenda for Health Systems Reform on 9th May 2000. It entrusted the HSRI to establish the National Health System Reform Office (HSRO) as a Secretariat Office for the National Health System Reform Committee (NHSRC) under the chairmanship of the Prime Minister. Roles of the NHSRC were to scrutinize and approve most of the essential issues related to new structure and functions that had evolved in the design of the health system, such as principles of the health system, the governance mechanism of the health system, health hazard control, the Universal Coverage of Health Care Plan, and the National Health Act.

The Prime Minister Office's Regulation on National Health System Reform was published in the Government Gazette on 31st July 2000 (see Annex 1). This regulation ensured high-level political support and continuity of the movement. The regulation had two main goals: (1) the knowledge-based social movement to support health system reform; and (2) to enact within three years, the National Health Act as the principal mechanism for future health system reform.

The next session will entail the strategy and process to reform.

Strategy

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An innovative strategic approach called *Triangle that Moves the Mountain* had been introduced.

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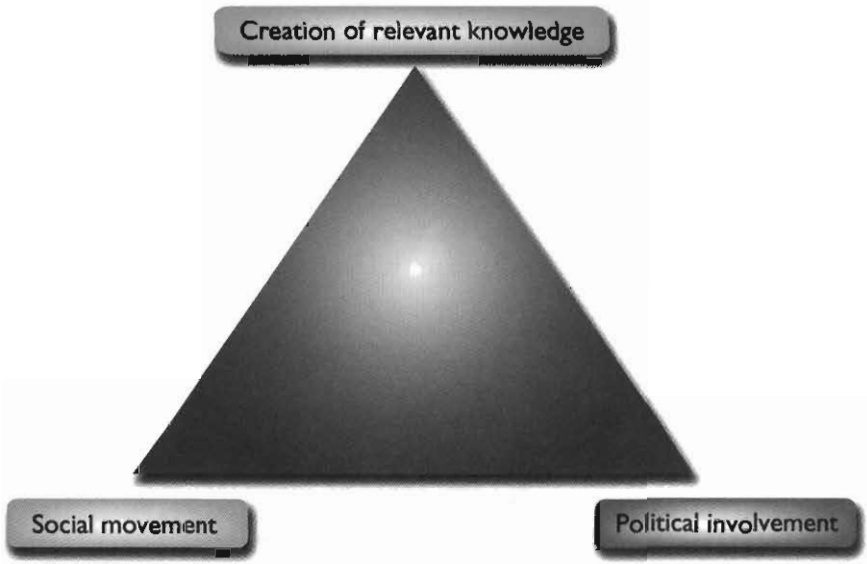
Strategy

As mentioned previously, Thailand, as many other countries, had faced extremely difficult problems -- political, economic, cultural, and environmental -- culminating in the phenomenon of social crisis, severely affecting health and the national health system. The problems had been inter-connected, complex and extremely difficult to solve. Therefore, for a better health system of the country, it needed a strategy to encounter these obstacles.

5. A Strategy to Reform: The Triangle that Moves the Mountain

Although the problems were complicated that some felt they were too big and too difficult and beyond imagination to solve, strategic means had to be found for getting out of the crisis in order to be able to move forward positively. In Thailand, an innovative strategic approach called "Triangle that Moves the Mountain" had been introduced.

Triangle that Moves the Mountain Strategy



According to the strategy, the mountain means a big and very difficult problem, usually immovable. The triangle consists of (1) Creation of relevant knowledge through research (2) Social movement or social learning and (3) Political involvement. A combination of these three elements is aimed to overcome the difficulties.

This strategy had been applied to restructure and reform Thailand's cumbersome health system, another mountain to be moved. In this case, drafting of the National Health Act using a symbiotic interaction among the three elements in the triangle was a mean to solicitation, perspective modification, brainstorming, visualization, commitment, and, finally, a common creation of desirable health systems. It heralded the health agenda of the

society and outlined systems and fundamental structures. Thereafter, it was conductive to a systematic and discernible health system reform.

5.1 Creation of Relevant Knowledge

Knowledge of health systems was not the preserve of any one disciplinary group. Instead, it drew on the experience and expertise of a wide range of stakeholders who were involved throughout the system. These included professionals with knowledge relevant to the issues being addressed, key decision-makers and relevant voluntary organizations, and researchers from broad disciplines, which included public health, law, economics, social science as well as political science.

As a national agenda, it was legitimate for HSRI to facilitate the mobilization and strengthening of a wide range of related researchers and research institutes in support of evidence-based health system reform. The main purpose was to support the synthesis of essential knowledge on a contextual basis for drafting the National Health Act. This entailed an ongoing set of strategically planned and coordinated action that involved a range of different actors who cut across a number of different disciplines and sectors. It was not a typical health research project or even limited to action in the public health domain.

Working groups of researchers were contracted to deliberate and synthesize on particular reform issues, which were hypothetically defined as strategic in direction.

> ***"These research results culminated into pivotal proposals and served as a foundation to design a reform process."***

They yielded not only recommendations to be reported to technically guide the NHSRC, but also a creative network of researchers, policy-makers and civic activists who contributed their wills to forward the health system reform.

5.2 Social Movement

Stakeholders in restructuring the health system had their own varied interests. An emotional response to changing processes varied in a broad range -- from affirmative support through confusion or frustration to another extreme of a sense of rejection. Thus, reconciliation of differences among stakeholders so that most of them could be allied as partners in the reform was a crucial initial strategy. To do this, basic knowledge on leadership and civil movement of the potential stakeholders was studied. In the first few months, the stakeholders for national health systems reform were explored. Information on these stakeholders including responsibilities, contact persons, and addresses were collected and organized, and finally computerized as a database. Policy mapping and analysis of stakeholders within a framework of health related movements were verified in order to align their issues of interest. The alliances on health system reform were categorized into four functional groups, namely: public interest groups, health professional groups, profit-in-health related businesses, and community based civil society.

The HSRO encouraged and empowered all partners to express their interests and vision, and to be involved in the process of deliberating the National Health Act. Forums and seminars were facilitated in every province to solicit those potentials groups to join their own mutual learning process of the existing health systems. Mind Mapping and Focus Group Discussions were employed as powerful devices to explore the imaginary demands of people. In six months, broad and comprehensive views of the health system were depicted and proposed.

> ***"Recommendations from civic alliances had been complemented by academic work, and integrated into the draft of the National Health Act."***

5.3 Political Involvement

The HSRI proposed a conceptual framework for health system reform to the Government through Parliament and the Cabinet. Consequently, in 2000, the senate sub-commission on health recommended to the Cabinet to reform the health system. The HSRI formulated a plan and architecture for undertaking a process to draft the National Health Act as an essential device to mobilize the reform. This was endorsed and approved by the Cabinet, which committed to launch the national agenda to health system reform.

The government's engagement was crucial to guarantee that legitimate, legislative, and cooperative devices as well as financial, human, and public communication resources were provided to mobilize the reform. In the midst of a political rally in the first general election under the Constitution 1997 at the end of 2000, universal health care coverage -- a principal issue for reform -- was raised by a newly established political party. It turned out to be a popular policy. This party won a landslide victory in the election, and became the most powerful Cabinet in the history of Thailand's democracy.

> ***"The Cabinet had strongly endorsed the policy of health system reform, which emphasized the universal coverage."***

However, difficulties lay ahead; financing mechanisms as well as a wide range of health care infrastructures and referral systems were waiting to be constructed. A myriad of actors had to be engaged to move the whole system. Implementation was underway with a serious demand for feedback information, in which HSRI had been entrusted to coordinate the monitoring and evaluation of the nation's universal coverage plan. Other items in the reform agenda - such as demands for restructuring of the health sector; decentralization which aimed at empowerment of local governments; and civil societies and establishment of a national research structure which strengthened and orientated the function of science and technology in development - were addressed in its formulation and implementation.

National Health Act

A Societal Paradigm Shift

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According to the
proposed draft Act,...
It reflected a shifting paradigm
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many ways: principles of health
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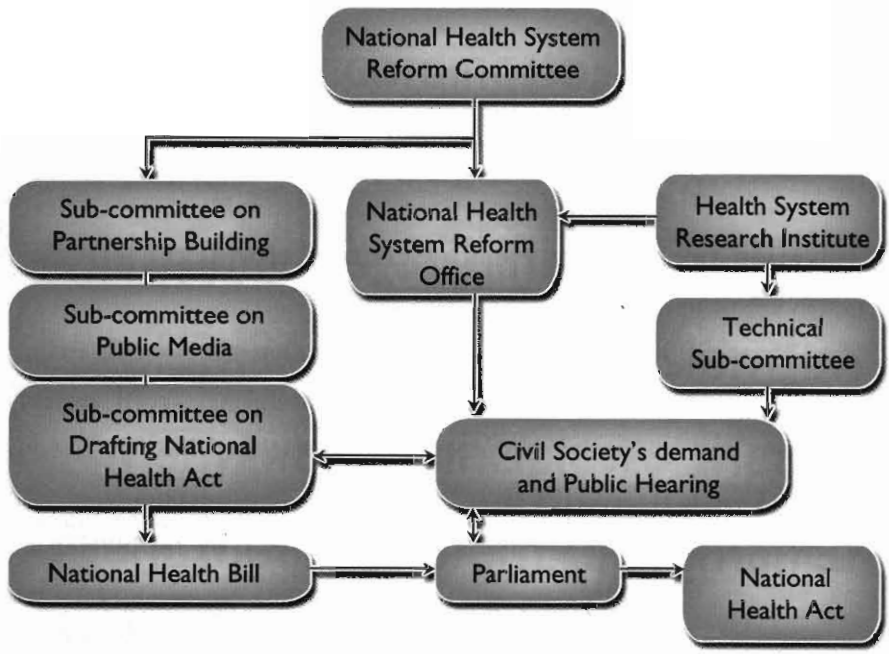
National Health Act: A Societal Paradigm Shift

After the announcement of the Prime Minister Office's Regulation on National Health System Reform, the National Health System Reform Committee (NHSRC) was established on 9th August 2000. The Committee was chaired by the Prime Minister with the board consisted of 31 members from various disciplines and ministries (Annex 2). The National Health System Reform Office (HSRO) was established as the secretary of the NHSRC. Drafting of the National Health Act by mobilizing all stakeholders to collaborate with each other in redesigning a new mind set for their health was among important mandates of the NHSRC.

The National Health System Reform Committee (NHSRC)



Four sub-committees under NHSRC were appointed and worked in parallel: (1) Technical Sub-committee to synthesize the appropriate knowledge and to draw up options for all issues of reform; (2) Sub-committee on Partnership Building to interact with and to involve all partners in order to seek their opinions and support; (3) Sub-committee on Public Media responsible for wider social advocacy and movement through public media; and (4) Sub-committee on drafting the National Health Act.

According to the proposed draft Act, it was conceptualized according to an ideological and scientific frame, which had been collated from a wide range of reform alliances' deliberations. It reflected a shifting paradigm of Thailand's health system in many ways: principles of health and health system, governance of the health system, and health system elements.

6. Principles of Health and Health System

New Definition of Health

Health had been redefined as "a state of well-being that is physical, mental, social and spiritual" which was modified from the conventional definition in WHO's constitution. The phrase "not merely the absence of disease and infirmity" was deleted in order to be responsible for a broader dynamic of human well-being related to sex, age, genetics, including consequences of various health hazards.

Another remarked term was "spiritual health", which was a strong sense developed into a crucial foundation for health at both individual and society levels. At the individual level it implied belief, faith, and sound commitment to a healthy life. This was verified and validated from the ultimate sense of various religious preaching through the pragmatic experience of scholars, then, to the realistic practice of broader civil society, which was exposed to sufferings such as those of people with HIV/AIDS, disabled groups, poverty stricken groups, and so on.

At a broader societal level, it connoted a public will to equity which entailed strategy and actions that led to real and sustained change in reducing unfair disparities in health and health care. This was worked out by reviews of sufferings from unhealthy public policy at broader terms of strategic, program and project level. The studies were conducted with the collaboration of academics, activists, and public authorities engaged with the policy as well as the involvement of community groups and stakeholders in policy formulation.

The health system's legitimate intervention according to this new definition was underway as various research projects.

They ranged from individual and community health care to governance of healthy public policy.

> ***"Thus, the health system had been officially redefined as all the system which are holistically interconnected and which affect the health of the people throughout the country."***

The health system included all factors related to health, namely, personal, environmental, economic, social, physical biological factors as well as the health service systems.

This meant that health system reform seemed to be very broad, but all of these factors were mutually interrelated. Intervention on just a single well-focused issue could not reshape the health system or might have caused a failed reform. Thus, holistic reform to redesign and integrate all of these issues would enable broader collaborations from all paces of life to clarify their destination.

7. Governance of the Health System

Culminating from deliberations towards health system reform, healthy public policy had been recognized as a strategic foundation to create a healthy pace for all life. Evidence from the experience of civic movements from grass roots level, through local level, and up to national level demonstrated a more effective

and knowledgeable involvement with public policy. Most of the civic interventions had engaged with health based on a broad definition of ongoing reform. However, chaotic alignment within the existing government authority had prevailed since a centralized command structure still dominated the scene. In order to facilitate the change to a self-reliant health system, a new model of governance had to be designed.

Various countries' health policy formulation and administration, as well as governance of other sectors involved with policy formulation in Thailand were studied. This was concluded and synthesized to form recommendations for the National Health Council to oversee all the health impacts affected by any policies. Alternative drafts of architecture of the health system's governance were studied and scrutinized by civic activists as the basis of a real struggle for practical actions in their own fields.

8. Health System Elements

Based on a structural study of whole elements comprising of health systems, a holistic approach of interrelated elements was identified. Not all of these had been synthesized to a final real architecture or organization, but mutually related functions had been depicted in order to articulate with broader related actors and expand the mission so that furthering the redesign of the system could be undertaken.

A schematic causal relationship of factors influencing holistic health had been realized. The factors were composed of: External factors – consisting of the ecological and social environment that were dominated by anthropogenic determinants with some natural impact; Intermediate factors – consisting of social determinants that played a prominent role in shaping human behavior; and Inner factors – consisting of genetic and biogenetic factors that interacted with human conduct and reflected the well being of individuals and society.

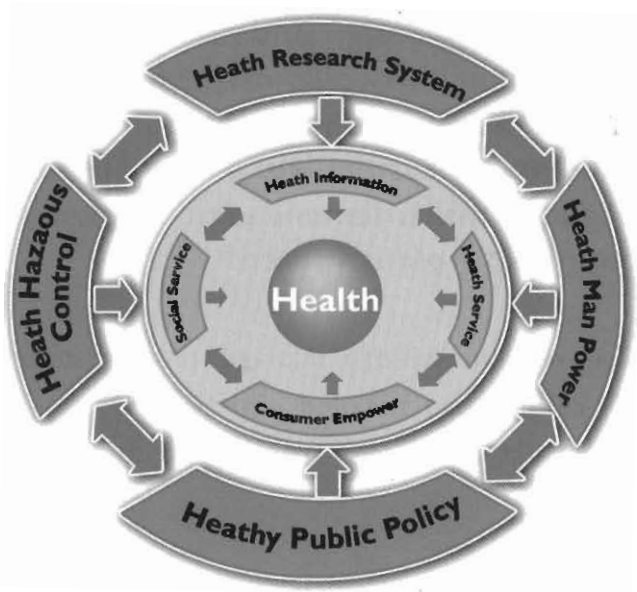
Health System Elements

With this conceptual framework of healthy individual and society, a new interrelated set of elements comprising a health system was depicted to support a healthy environment for society. The external roles included:

1. To guarantee healthy public policy – health impact assessment, structure, and function;
2. To be the brain of the health system – health research system and technology development;
3. To prevent and control health hazards – surveillance and technical capability for protection;
4. To provide health related human resources – a network for manpower capacity and policy.

The inner circumstance of elements would be the architecture for empowering the individual and society so that they could cope with the situation in a healthy manner. These included:

1. Health information system - new information technology would be employed to enrich individual and society knowledge;
2. Consumer empowerment mechanism - the participation of civil society and a network of academic would be focused;
3. Health service system - a wide range of care as well as self care would be supported;
4. Social service system – people would be protected from being vulnerable.



According to this context, the proposed health system was broader than a health care system. It was rooted in desirable values and principles, including equity in the health of people. Elements included in the health system were mutually interactive and interrelated. To reform one single element would not improve the health system to the refined destination. On the other hand, it might have complicated or jeopardized the reform.

All of these eight elements of health system might not have been in place by the time of promulgation of the National Health Act.

> ***"The ongoing design and re-engineering of these mechanisms would last for decades after that. Reorienting the architecture and function of the health system was a surmountable obligation, which demanded clear visions and committed political force."***

However, knowledge manage¬ment throughout this process of reform had entailed efforts to create a common understanding between policy-makers and the public on each specific issue.

Conclusion and Recommendations

Conclusion and Recommendations

1. Concepts and methods for health developed at the global and international levels are important, but focus should be at real actions in the countries.

The results from real actions in the countries and emerging needs for more knowledge will provide a feedback into the global system, thus making the international networks for health research and development actively interacting in a most creative manner.

2. In the countries special attention should be paid to creation of functionally effective research promotion and funding mechanisms.

The Thailand Research Fund (TRF) can be an example. To generate health systems knowledge necessary for health system reform a research institute such as the Health Systems Research

Institute (HSRI) may be necessary. The international health research promotion networks should give political support in creation of effective health research management mechanisms in member countries, if they do not exist.

3. Research is fun, but research should not just create more research and go on without end.

Research should lead to development and development lead to more research relevant to development needs. Research should not be floating or 'go to the shelf' but tested and receive feedback from real applications.

4. Health development in the countries is extremely difficult.

It depends on complex interactions between knowledge, culture, politics, bureaucracy, media, society, etc. Expertise leaders with systems perspectives, and management skills with strong commitment and charisma, are rare, if not lacking, in many societies.

5. It is recommended to the international health research and development circles to pay more attention in finding and developing health policy leaders who can mobilize resources for health development in the countries, whether it is to be labeled health systems reform or not. Regional or international courses in health policy leadership should be considered to provide opportunities for interactive learning through action and network building.

With this, it is hoped that health research and development will really take place in the countries. Interaction between the countries and the international health research forum will form a vibrant global network with knowledge generation, learning and development to benefit the health and well being of mankind around the world.


ขอประกาศปฏิรูประบบสุขภาพ
ระบบสุขภาพที่คนไทยต้องการ

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Annexes

Annex I

Regulation of the Office of the Prime Minister on National Health System Reform, B.E. 2543 (2000)

Whereas the current national health system has inadequately contributed to the achievement of good health and quality of life of the people, evidenced by an upward trend of several diseases and hazards, lack of efficiency and thoroughness of health management systems, which is inconsistent with the spirit of the Constitution of the Kingdom of Thailand, it is expedient to initiate health systems reform to build up standardized, good quality and equitable health systems as well as put forward a law on national health as a master legislation for the reform of health systems.

By virtue of the provisions of section 11 (8) of the Organization of State Administration Act, B.E. 2534 (1991), the Prime Minister, with the advice of the Council of Ministers, Proclaims this Regulation as follows:

Clause 1. This Regulation is called the "Regulation of the Office of the Prime Minister on National Health System Reform, B.E. 2543" (2000).

Clause 2. This Regulation shall come into force as from the day following the date of its publication in the Government Gazette.

Clause 3. In this Regulation:

'National health system' means all the systems which are holistically interconnected and affect health of the people throughout the country. It includes all factors related to health, namely, personal, environmental, economic, social, physical and biological factors as well as the health service systems;

'National health system reform' means all processes which lead to changes in the management of the national health system to achieve the systems which are aimed at good physical, mental, social and spiritual conditions of the people, as well as those aimed at the accessibility to good quality health services in an efficient and equitable manner.

'Committee' means the National Health System Reform Committee;

'Office' means the National Health System Reform Office;

'Director' means the Director of the National Health System Reform Office.

Clause 4. There shall be a Committee called the National Health System Reform Committee, briefly called 'HSRC' which consists of:

(1) Prime Minister _____ as Chairman;

(2) Minister of Public Health _____ as Vice Chairman;

(3) Minister to the Office of the Prime Minister as entrusted by the Prime Minister _____ as Vice Chairman;

(4) One qualified person appointed by the Prime Minister from qualified members under (18)_____as Vice Chairman;

(5) Permanent Secretary of the Ministry of Finance _____as member;

(6) Permanent Secretary of the Ministry of Commerce _____as member;

(7) Permanent Secretary of the Ministry of Interior _____as member;

(8) Permanent Secretary of the Ministry of Labor and Social Welfare _____as member;

(9) Permanent Secretary of the Ministry of Science, Technology and Environment_____as member;

(10) Permanent Secretary of the Ministry of Education _____as member;

(11) Permanent Secretary of the Ministry of Public Health _____as member;

(12) Permanent Secretary of the Ministry of University Affairs _____as member;

(13) Secretary-General of the Council of State _____as member;

(14) Secretary-General of the Civil Service Commission _____as member;

(15) Secretary-General of the National Economic and Social Development Board_____as member;

(16) Director of the Bureau of the Budget _____as member;

(17) Director of the Health Systems Research Institute _____as member;

(18) Not more than fourteen qualified persons, appointed by the Prime Minister, in the field of education, public health, administration, mass communications, community development, law, economics, development of specific population groups _____ as member;

(19) Director of the National Health System Reform Office _____ as member and secretary

(20) Not more than two officials of the National Health System Reform Office appointed by the Prime Minister _____ as assistant secretaries

Clause 5. A qualified member may serve for only one term and shall hold office for the same term of office as that of the Committee.

In the case where the qualified member vacates office before the expiration of the term or in the case where an additional qualified member is appointed while the qualified members already appointed remain in office, the person appointed to fill the vacancy or additionally appointed shall be in office for the remaining term of the qualified members already appointed.

In the case where the qualified member vacates office before the expiration of the term, the remaining members shall, while appointment of a new member to fill the vacancy has not yet been made, continue their performance within the powers and duties of the Committee.

Clause 6. In addition to vacating office at the expiration of the term, the qualified member shall vacate office upon:

(1) death;
(2) resignation;
(3) being removed by the Prime Minister;
(4) being an incompetent or quasi-incompetent person;
(5) being bankrupt;
(6) being sentenced to imprisonment by a final judgment except for an offence committed through negligence or a petty offence;

Clause 7. At a meeting of the Committee, the presence of not less than one-half of the number of existing members is required to constitute a quorum.

At a meeting of the Committee, if the Chairman is not present or is unable to perform the duty, the Vice Chairman shall preside over the meeting, and, if the Chairman and the Vice Chairman are not present or are unable to perform the duty, the meeting shall elect one member to preside over the meeting.

The decision of the meeting shall be by a majority of votes. In casting votes, each member shall have one vote. In the case of a tie vote, the presiding Chairman shall have an additional vote as the deciding vote.

Clause 8. The Committee shall have the powers and duties as follows:

(1) to give recommendations and advice to the Council of Ministers with regard to the national health system reform;

(2) to recommend revision of policies, work structures, work systems or budgetary systems relevant to the national health system reform, provided that reference shall be made to the State Administration Systems Reform Plan and regard shall be made to resolutions of the Civil Service Commission in connection with directions, emphases and adjustment of roles and affairs of the Ministry of Public Health;

(3) to prepare draft legislation on national health in order for such legislation to enter into force within three years as from the date of the Committee's first meeting;

(4) to give recommendations to the Council of Ministers for revision of relevant laws, rules, regulations or resolutions of the Council of Ministers so as to be in line with the national heath system reform;

(5) to make available information and public relations for enabling public awareness and understanding of, and participation in, the national heath system reform;

(6) to organize seminars, meetings, public hearings or any other activity aimed at enabling the public, agencies and interest groups which will be affected by the national heath system reform to have wide participation in presenting opinions, information and suggestions with respect to the national health system reform;

(7) to arrange for studies, analyses and research for the purpose of framing directions, strategies and measures for the national health system reform and for the purpose of

putting forward a law on national health;

(8) to support the development of policies or the revision of structures or systems of work which may be taken as an essential component of the health system reform; to co-ordinate work and solve problems and obstacles in carrying out the national health systems reform;

(9) to co-ordinate work and solve problems and obstacles in carrying out the national health systems reform;

(10) to perform other acts as entrusted by the Prime Minister or the Council of Ministers.

Clause 9. The Committee has the power to appoint sub-committees or working groups for performing any particular tasks as entrusted by the Committee.

Clause 7 shall apply mutatis mutandis to a meeting of the sub-committees or working groups.

In the performance of duties, a sub-committee or working group has the power to require a State agency or State official to furnish documents or information or give explanations for the purpose of consideration as necessary.

Clause 10. The National Health System Reform Office shall be established as an internal agency of the Health Systems Research Institute for the purposes of serving as the secretariat of the Committee and acting as a focal point for the administration and management of work in accordance with the affairs entrusted by the Committee.

Clause 11. The Office shall have the powers and duties as follows:

(1) to be responsible for the administrative affairs, technical affairs, meeting affairs, public relations affairs and secretarial affairs of the Committee, sub-committees and working groups;

(2) to be responsible for the administration of operations, finance, personnel and procurement as determined by the Committee;

(3) to monitor situations, study and gather information related to the work of the Committee, sub - committees and working groups;

(4) to provide co-ordination for, and give recommendations to, the Committee with regard to the national health system reform;

(5) to perform any other work or take any other action as entrusted by the Committee.

Clause 12. The Health Systems Research Institute Board shall act as a technical adviser to the Committee in the performance of work in connection with the national health system reform.

Clause 13. The Committee and the Office shall be dissolved upon the entry into force of the law on national health, which shall take place not later than three years from the date of the Committee's first meeting.

Clause 14. Subject to the law, for the purpose of the administration of work of the Office, the Prime Minister may order a Government official of a Government agency, or the Office may request the Council of Ministers to pass a resolution requiring an official or employee of a State enterprise or other State agency, to assist in the performance of work in the capacity as an official of the Office, provided that it shall be deemed as his or her normal performance of official service or work, whether on a full-time or part-time basis or outside official hours.

Clause 15. Other Committees concerned and State agencies and State officials concerned shall give co-operation and support to the performance of work of the Committee and the Office.

Clause 16. The provisions of the law on the Health Systems Research Institute, and rules, regulations and resolutions of the Health Systems Research Institute Board shall apply to the administration of the Office mutatis mutandis.

Clause 17. The Prime Minister shall have charge and control of the execution of this Regulation.

Given on the 27th Day of July, B.E. 2543 (2000)

H.E. Chuan Leekphai

Prime Minister

NB. This regulation was published in the Government Gazette, general announcement issue, 117 special part 75 Ngor., on 31st July 2000.

Annex II

The National Health System Reform Committee

Chairman

Prime Minister

Vice Chairman

Minister of Public Health

Minister to the Office of the Prime Minister as entrusted by the Prime Minister Qualified Person (Dr. Pirot Ningsanon)

Members

By Position	**Qualified Person**
Permanent Secretary of the:	
Ministry of Finance	Mrs.Kasama Varavaran
Ministry of Commerce	Prof.Kasem Suwanakul
Ministry of Interior	Prof.Charas Suwanwela
Ministry of Labor and Social Welfare	Mr.Narong Patibatsarakich
Ministry of Science, Technology and Environment	Assoc.Prof.Tassana Boontong
Ministry of Education	Banrool Siriphanich
Ministry of Public Health	Prof.Borwornsak Uwanno
Ministry of University Affairs	Prof.Prawase Wasi
Secretary-General of the:	
Council of State	Prof. Pakdee Pothisiri
Civil Service Commission	Nun Sansanee Sthirasut
National Economic and Social Development Board	Mr.Somchai Krusounsombat
Director of the Bureau of the Budget	Prof.Ammar Siamwalla
Director of the Health Systems - Research Institute	Prof.Aree Valyasevi

Member and secretary

(Amphon Jindawatthana: Director of the National Health System Reform Office)

Assistant secretary

(Suwit Wibulpolprasert)

"The passive 'ill-health-oriented' system had to be reformed to a proactive 'good-health-oriented' system... the health promotion campaign needed to be fully developed and the disease control and prevention system needed to be reformed to be fully efficient. Health care finance needed to be developed to guarantee access to adequate and quality health care for all. Consumers had to be adequately protected and empowered. Health personnel development, as well as technology, information and research systems needed to be reform[illegible]"