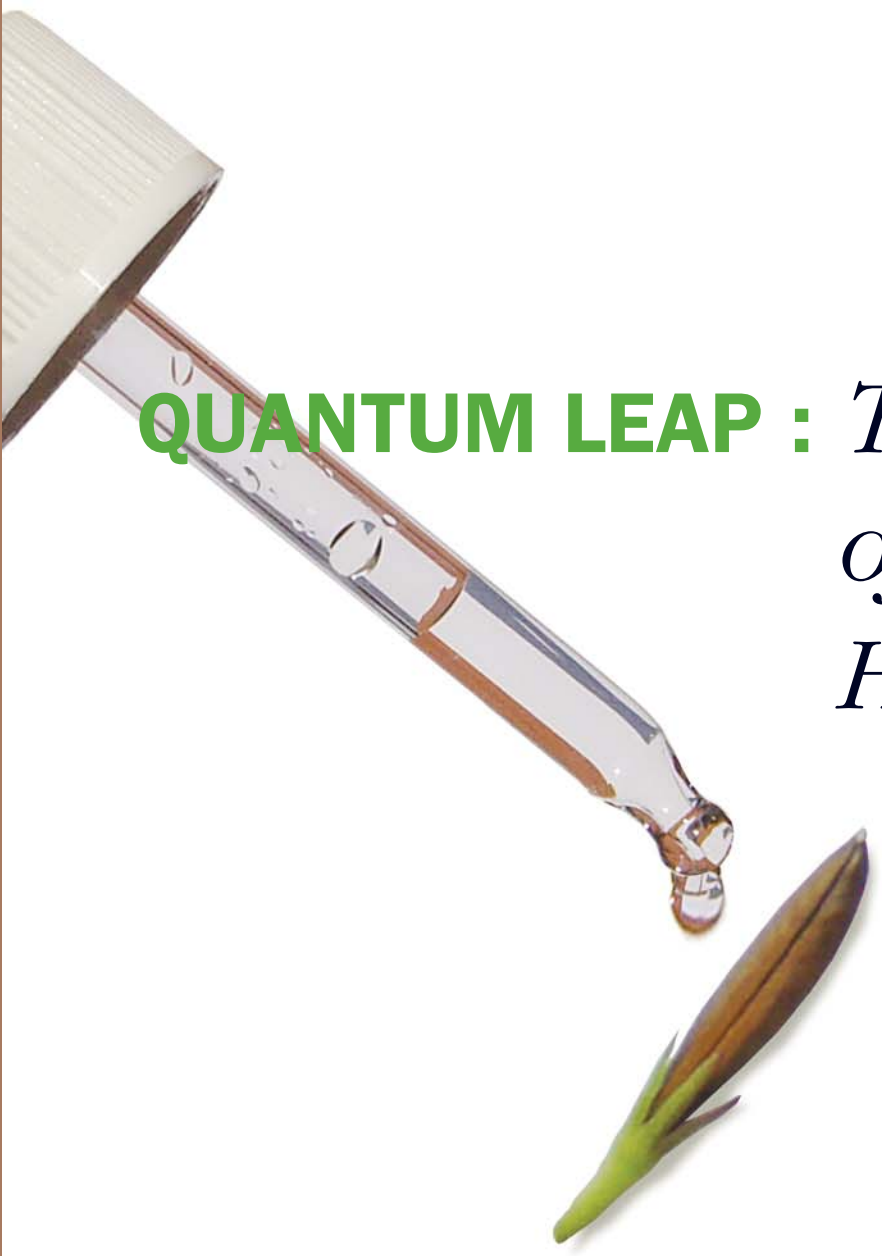

QUANTUM LEAP : *The Reform of Thailand's Health System*

By

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Just as a drop of water on a tropical plant induces the sudden spread of seeds, the health reform process is pushing the evolving health system forward at a rate never seen before.

Preface

In 2000, Thailand embarked on a journey to construct a visionary health system and entered the new millennium with hopes of obtaining a better quality of life for its constituents. The holistic health policy has now become a key concern of individuals as well as the general public rather than a restricted attempt to achieve wealth as a result of economic development in the first three quarters of the last century. Even as the health system evolved at an increasingly accelerated rate, health performances were far from the expectations set forth in 1997 constitution, which was developed from decades of rapid social and political reform. The general public seemed to be driving health demand far beyond the capacity of health system development. This, therefore, is a strong rationale to support a deliberative means to develop the health system at the fastest pace and to the farthest point ever seen or "*quantum leap*" in order to meet the demands of the Thai society.

Although drastic changes in Thailand's health system had occurred many times in the past, the authoritative propulsion played a major role in facilitating health infrastructure development. A critical renewal of the health system was ignited and supported by western technology in 1880's. The Rockefeller Foundation contributed consultative and technical support to place Thailand's first medical school in the modern medicine era. This initiated a critical change in the health care system. It was the turning point in which Thai health care jumped from being based on tradition and self reliance to using modern medical care and a public health system. The new approach gradually expanded to encompass the whole country. There were, of course, a few more crucial junctures after that, but most of these changes were either straight-line adjustments in the infrastructure and facilities or modifications of the Ministry of Public Health's authority. Since there was no solid profile of a health system to be used as a foundation, the input contributed from the growing number of stakeholders and the constituency could not be systematically synergized effectively.

Whereas, the health system reform called for by the Royal Thai Government since 2000 intends to redress two main crucial roles. The reform movement is being shaped by a shift in standards set by the government, the private sector and the general public on health and the health system. This, in turn, will then serve as a firm foundation to design and engineer the architecture, roles and functions of the novel elements and partners of the visionary health system. This initiative process of the health system reform demands cooperative endeavors, which involves ownerships, ideas and trust from a broad array of stakeholders, particularly networks of researchers.

The purpose of this book is to provide three major perspectives learnt over the last three years during the intensive study conducted by alliances of the health system reform. They are the following:

1) To describe the initiative process impelled transitional approaches of the health system reform at the beginning of the new millennium

This policy process has been supported by the government but driven by a consensus of demands and inspirations from the broad participation of individuals and sectors. As the movement progressed along this path, a firm foundation of the health system became clearly envisioned.

2) To identify the essential role and function of the health policy and system research in contributing to the health system reform

Research has changed its role from following up the policy implementation and recommendations of researchers to being assertive in the construction of policy and strategy obtained through the collaboration of policymakers, stakeholders, constituencies and researchers. This has led to the socialization of the research culture among the policymakers, administrators and community activists.

3) To reveal the discovery of research management as a principal tool in initiating research alliances and networks, so that these types of human resources can galvanize and sustain the ongoing engineering and management of the reform process

This managerial process has gone beyond just identifying research questions and facilitating the mobilization of resources to becoming responsible for actual research performance. It has become a critical means for fostering a deliberative identification of essential research areas or a theoretical framework that are lacking and thus are pitfalls in setting forth visionary systems.

Even though public apprehension in the health system may be diverted from what was depicted as existing in the mainstream, the draft of the "National Health Act", annexed in this book, uncovers the potential value Thais place on ideas or approaches responsible for their future wellbeing. Even though the National Health Act is the strategic outcome of a monumental learning endeavor, the draft's statements may be far too vague to guide plausible actions and resource allocation decisions. Nevertheless, it has been used as a principal framework for further studies and research under a mandate given to the Health Systems Research Institute (HSRI). This kind of research mapping will provide invaluable guidance for the researchers as well as for policymakers, administrators, stakeholders and community activists to work together in concerted research projects and the development of the policy and health system research through future decades.

Wiput Phoolcharoen

May, 2004

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Contents

Summary

Health system and policy research was a key element in the drafting of Thailand's National Health Act and it has led to significant advances in understanding the philosophy, architecture and alignment of the evolving health system's alliances.

Political commitment has played a vital role in facilitating the holistic health system reform and has allowed Thai society to be turned into an interdisciplinary and comprehensive laboratory for health policy research. Partnerships in health system reform were essential in generating knowledge, which in turn could then be translated into public health benefits. The governance and administrative mechanisms of the visionary health system were developed through the collaborative research process. This has led to the development of the trend of ongoing policy reform based on demands and innovations coming from participatory research carried out by a broad array of partners.

The National Health System Reform Committee set up four subcommittees - social mobilization, technical, law drafting and public communication - comprised of researchers, the civil network, policymakers and members of the mass media whose objective was to design the blueprint of the new health system. After three years of extensive collaborative research, it was decided (with the consensus of all participants) that the health system should be made up of eight components - health governance, health promotion, health hazard control, health services, health research, health information, consumer empowerment and health manpower.

Health research has thus been recognized as one of the creative components of the health system. It has also been granted legislative power by virtue of it being incorporated into the National Health Act, which is about to be submitted to the Thai Parliament. Moreover, all of the other components of the health system are heavily dependent on health policy and system research because they are, by definition, evolving evidence-based systems.

Health research has played a pivotal role not only in the drafting of the National Health Act but also in the detailed design, implementation and evaluation of each of the eight components of the new health system. Only research can unify the differing needs and demands of policymakers and the civil society. To carry out the required research as effectively as possible, multisectoral research alliances are being created for each of the subsystems. The alliances are deemed essential to the successful implementation of Thailand's visionary health system.

Health research management is the essential link between researchers and users of research. Research managers will build and sustain the required alliances and coalitions, oversee the research projects, manage funding and resource mobilization and monitor and evaluate research. The management of health research will ensure that all research is relevant to all the related parties.

In conclusion, health research, its coordination and its management are the foundation and driving force behind the proof of the need to reform the health system in Thailand. The findings of health research is an integral part in drafting the National Health Act. Health research has proven to be even more important in probing, implementing, monitoring and evaluating the new health system. Thus, it has been recognized as the motivating force for health system reform.

Healthcare is
a basic ***right*** *not a social welfare.*

1) Rationale for Health System Reform

Thailand's Health system reform is defined as -

"A process that leads a transitional management of the national health system to a capable system aimed at good physical, mental, social, and spiritual wellbeing of the people, as well as people's accessibility to health services that are of good quality, efficient and equitable."

This quotation was taken from "Regulation of the Office of the Prime Minister on National Health System reform" promulgated in 2000. It affirms the Royal Thai Government's political commitment to literally facilitate a drastic and systematic revolution of the health system and provides for the change in the health system to extend beyond health care. The timing of the statement, the last year of the millennium, seemed to be contrary to the public's perception of medical services in which the trend of modernization was pervasive in the society in general.

Even though, on record, Thailand's overall health status has improved immensely in the last two decades, some evidence of failure in the health system's performance has gradually unfolded. The lack of a sound evaluation of past policy had obscured these drawbacks in the system. In conclusion, four major critical issues were listed as key factors to address in the reconstructing of the health system. These underlying problems are higher cost of health expenditure, health deterioration from unbalanced economic development, rapid technological evolution with increasing inequity and political and social reform.

1.1) Escalating Cost of Inefficient Health Spending

The health system in Thailand has evolved from self-reliance in the past, using local wisdom for health promotion and curative care, to the current system, which depends on modern medical and health technology. The public sector has extended its role in the system to the point that it is the main service provider while the private for profit and not-for-profit sectors participate actively in all types of health services. Thais in general have tended to use more health facility-based services in line with the expansion of modern health care delivery systems both in the public and private sector.

The majority of the people are accustomed to the conventional health system, which is designed and developed under state authority and relies on state bodies to formulate policy. Under this situation, illness and death are considered on an individual basis instead of as a matter of concern for all members of society. The fact that people cannot take control in solving their own health problems may be due to their inability to

thoroughly assess health problems in general and associate them to factors related to their environment. This has gradually led to the public's increased dependence on health care institutions which in turn has set a trend towards the commercialization of medical care and the exploitation of its users.

Evidence of this was shown by the significant rise in health spending in Thailand during the past decade from US$562.5 million in 1980 to US$6,301.7 million in 1998, an 11-fold increase at current prices. The per capita health expense had risen nearly nine-fold from US$12.1 to US$103.6 during the same period. This was a 9.1 % per annum increase in real terms, higher than the per capita average annual gross domestic product (GDP) growth of 7.0 %. Thus, the amount of health expenditure as a proportion of GDP increased from 3.82 % in 1980 to 6.21 % in 1998.

The general view that Thailand has a modern and highly efficient health system has masked the increased burden of health expenditure. A comparative study with other Asian countries showed that Malaysia, China and Sri Lanka, have lower health spending related to their GDP than Thailand but their country's general health situation has improved at the same or at an even better rate. This evidence has sent a warning to policymakers that Thailand needs to invest more efficiently in health as well as methodically redesign the system.

1.2) Health Deterioration from Unbalanced Economic Development

Economic growth and increased spending in the social sector have been two key mutually reinforcing factors for social and economic development. High economic growth boosted disposable incomes while a strong commitment to investments in sectors such as health and education was instrumental in reducing poverty and opening up opportunities for the general public. The poverty incidence, defined as the percentage of the population living below a predetermined poverty line, gradually fell from 33 % in 1988 to about 11 % in 1996.

Development in Thailand has progressed at a very good rate over the past three decades but it has also led to some widely recognized scars on society in three areas. First of all, the unbalanced nature of much of the economic development has left the marginalized population further behind. They still cannot obtain access to social services and infrastructure. Secondly, a disruption of social structures and relationships, as well as the erosion of social and cultural capital has been observed. Thirdly, there have been unsustainable levels of natural resource depletion and environmental pollution

The acceleration of urban growth, particularly during the spectacular boom which began in the 1980's was the result of a global recovery from a recession, currency realignment and capital mobility. The government shifted its economic strategy towards the promotion of exports in both the service and manufacturing industries. Total employment in the manufacturing sector increased by one million workers, from 1.3 million in 1980 to 2.3 million in 1990. However, this growing proportion of workers was concentrated in large firms. By the end of the 1980's, around one million workers (40% of all workers in the manufacturing sector) were employed in firms with 100 or more workers.

The natural increase as well as rural immigration contributed to the labor supply. During that time, there was a distinct increase in rural to urban migration. Around four million people dropped out of the agricultural labor force in the off - season by the early 1990's, and around one million people found other work, mainly in the manufacturing and construction sector. With the decline in agricultural growth and the closing of the agrarian frontier, Thais in the rural areas moved to the cities at a more rapid rate and on a more permanent basis.

The deteriorating social conditions has altered Thailand's health situation. HIV/AIDS, traffic injuries, cancer, mental stress and environmental hazards, all of which had not been factors in the public health perspective 30 years ago, have become among the top ten causes of mortality in the country. Thailand's mortality rate (per 1,000 population), which declined from 20 in 1975 to 4.1 in 1986, climbed to 5.0 in 1997 and 5.1 in 1998. Age specific mortality-rate in the labor age population has been increasing due to the epidemic of HIV/AIDS and traffic accidents. This is an indication that the existing health system was not designed to cope with the new societal challenges.

1.3) Rapidly Changing Technology caused Increased Disparity

Inequities in the health status of Thais have grown in the recent decades despite substantial gains in the general health of the public. Primary health care under the strategy of "Health for All" was launched throughout the country more than two decades ago. But as of yet, it not ensured equitable health care for the whole population.

Evidence from the biannual National Socio-economic surveys from 1992 to 1998 showed that the poor spent a higher percentage of their household income on health care than the rich. In 1992, the poorest quintile spent 8.17 % of their income on health, while the richest quintile spent 1.27 %, a 6.4 fold difference. The Index for Fairness of Financial contribution calculated for Thailand in the World Health Report 2000, was 0.913. It was ranked 128 out of 130 countries.

The infant mortality rate (IMR) is also a good indicator of health status differences in various population groups, i.e., the IMR in non-municipal areas is 1.85 times higher than that in municipal areas. Although the IMR has dropped by half in the past 20 years, the urban-rural difference has been widening. Primary health care has done well with modest technology-related health care. However, this alone cannot eradicate the prevailing and increasing disparity in health resource allocations between urban and rural areas or between regions.

Health systems are currently challenged with rapid changes in advances in biomedical science and other technology developments as well as by national and international politics, demographic and epidemiological transitions, environmental degradation, globalization, trade liberalization and other development policies that affect health. Industrial countries are researching and developing a wide spectrum of health technology - from knowledge for professional health providers, medical equipment, medicine, vaccine, and information technology and then exporting it to developing countries at a high cost. The world has further accelerated its research in health through the new era of genome and molecular approach, where novel and efficacious health technology will ultimately emerge at a rapid pace.

The HIV/AIDS epidemic exemplifies the wide gap of accessibility to treatment after a decade of competitive advancements in anti-retroviral drug research. Now, more efficacious drugs are available to wealthier people with HIV while poorer victims are left to suffer with their own fate. The rapid emergence in technology has widened the inequity between the "haves" and the "have-nots".

The misdistribution of radiotherapy as a cure for cancer is another example of inequities in Thai health care. Since the 1980's, cancer has been a leading cause of death. Radiotherapy is expensive, requiring complicated medical equipment to effectively cure the patients. A total of 54 % of the radiotherapy units were installed in Bangkok. The other 46% of the units are in provincial cities, which lack qualified manpower to operate the units.

To mitigate such a gap in equity based on technological reliance, Thailand needs to create a strong foundation on health research and development which is reoriented to be able to transfer new health knowledge and technology from industrialized countries. The government expenditures for all branches of research in 1996 were only 0.13 % of GDP. In 1999, investment in governmental health research increased from 0.2% of the public health budget during 1992 - 1996 to 0.52 %, still very low compared to other fields of research. This implies that health research is not a top priority in Thailand, while agricultural research, industrial research, science and technological industry are major concerns since they would directly contribute to the economic growth of the country.

1.4) Political and Social Reform: Need for Reoriented Public Sector

Thailand's recent societal development has moved in the direction of improving governance. This reached its climax in 1997, with the implementation of a new constitution. The nation has built a more open and democratic society in which the basic rights of the population are safeguarded. Consequently, the general public has been provided with significant new opportunities to participate in all processes of development. The political reform has been driven by activism from members of the civil society. It gained strength in the 1990's, when the need for political and social reforms became increasingly apparent. Civil society organizations have become a potent force for change and have played a decisive role in framing a reform agenda, which was shaped by the principles of democracy and the respect for basic human rights. As both advocates and watchdogs, they are involved in activities that go beyond the traditional concepts of participation and even empowerment. They are spearheading the search for a new social paradigm based on a far-reaching process of political democratization.

The new constitution (1997) has established an enormous opportunity for further progress in restructuring the relationships between the state and civil society; in making the development process more democratic; and in creating new institutions and mechanisms that provide greater accountability, transparency, representation and participation. Initiatives in these areas take their roots from the laws and are guided by far-reaching principles pertaining to basic human rights. It is of utmost importance that these opportunities are fully exploited and remain central issues in the policy and reform agenda. The complete and effective utilization of them would allow civil society organizations to continue to flourish and serve as a positive force for change as well as enable them to function more effectively to counter the negative effects of globalization.

The new constitution has paved the way for the re-orientation of health and its relation to the general public. It stipulated that health is a human right, which must be protected by the state. This is the first time that an egalitarian view towards health has been expressed in Thai political philosophy. More specifically, health entitlement has been introduced for a wide range of the disadvantage members of the population, i.e., the elderly, the disabled and abandoned children. Consumer and environment protection, particularly for the sake of health, is another area that is mandated.

In a section which defines the fundamental policy of the state, the government is required to provide public health services of the same standards to all of the population. Disease control is also a state obligation which must be provided free of charge. In order to comply with these directives, various services in the local governments must be urgently restructured. Health services under the new constitution must be of good quality, provided efficiently and equitably distributed as well as be transparent and accountable to the community.

Political reform, therefore, calls for a re-examination of the health sector's role and way of operating, with concern for social capital as well as financial capital. To achieve the requirements stipulated in the new constition, the public sectors have to re-orient their visions and missions to comply with this new demand on health and health care.

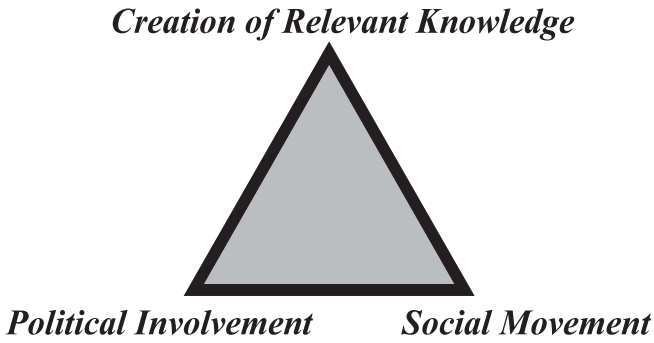
Based on hardcore evidence of the need for change, the Royal Thai Government (RTG) opted to set forth on the complex mission of incorporating whole sectors of Thai society into the monumental civil reform process instead of just addressing issues of some government programs. This initiative public process has been ongoing for such a long time that a majority of the reform alliances envisioned that the result would lead to the establishment of a health system that would effectively serve Thai society in the new millennium. It would serve as a conduit for researchers to link up with alliances in the policy process to design and engineer the new structure, role and functions of the revolutionary health system. In conclusion, the critical two intrinsic aims of the reform process are to clarify the new ideology of the health system and to identify as well as develop new infrastructures and mechanisms that would lead to the sustainable wellbeing of the citizens of Thailand.

Society must be part of the initiative in buidling a sustainable health system.

2) Opportunity and Methodology pertaining to the Study of Health System Reform

The objective of the Health Systems Research Institute (HSRI) is to support research and academic activities for the restructuring of the health system as part of the ongoing reform process in Thailand. Health policy and system research has proven to be an effective tool in providing an insightful perspective for directing the transitional management of the reform process. However, due to the strong forces against drastic change in the democratic era, to carry out the process, strong political commitment and social acceptance is needed.

Based on the concept **"the triangle moves the mountain[1]"**, the creation of knowledge through research has proven to play a key role in the reform of the country's political system in the last decade. This is now being used in applying the framework for establishing the academic role in the health system reform. For the process to be effective, the Royal Thai Government had to be politically committed to health system



[1] A well-known approach structure in Thailand. The mountain is seen as a big and very difficult problem, often unmovable while the triangle consists of the creation of relevant knowledge through research, social movement or social learning and political involvement. The creation of relevant knowledge is vital but inadequate by itself. So, it must interact with social movement or social learning. In turn, without relevant knowledge, social movements cannot gather momentum or may even deviate. Knowledge derived from research must be relayed in a way that it can empower the general public. Politicians prodded by political involvement completes the triangle in that though they may be shunned by academicians, they often control the purse strings as well as have the power to change laws. Without poltical involvement the structure is not complete and without knowledge or social activity and political involvement will not come into play.

reform as it served as the coordinator of putting together researchers, policymakers and the civil network to work as a team towards finding innovative ways to restructure the health system. Only through the common bond of research and knowledge could the different demands between policymakers and the civil network be ironed out, especially in times of conflicting changes in which no one party has clearly envisioned the evolving holistic system. Health system research, therefore, is a powerful function of the ongoing reform process.

In 1998, the HSRI's board of directors officially stated that the health system must be restructured in order to keep up with new demands stemming from the changes in the society and the political environment. They envisioned that the inevitable reform of the health system must conform with new demands from the society in general and be set capable to keep up with the rapid changes of health science in the upcoming millennium. The HSRI's research plan from 1999 to 2001, thus, contributed to a comprehensive mission to push for health system reform. The agency wrote a series of research packages and academic papers which addressed the necessity to reform Thailand's health system. They were well preceived by both the government ministries and parliamentarians. As a consequence, the Senator's Commission for Health also reviewed the documents issued by the HSRI and then submitted them to the cabinet in the form of a suggestive memorandum urging health system reform.

In November,1999, the HSRI proposed that the government deem the drafting of the National Health Act as a strategic movement with the objective to restructure the country's health system to meet the demands of the rapidly changing society. To bring together the broad array of groups that are directly affected by the health system to participate in the drafting process, the government would also take on the role as the main coordinator of the operation. The HSRI also submitted an operating plan to get the process in motion. The cabinet officially endorsed the process on May 9, 2000 and the National Health System Reform Committee (NHSRC) chaired by the prime minister was then set up with the role as coordinator for the drafting of the National Health Act. A timeframe of three years was set for the draft to be written and submitted to the government for approval. The HSRI was directed to set up the Health System Reform Office (HSRO) with the role to serve as the secretariat office and mobilize members of the government sector, civil network and private sector to provide input in the drafting of the plan for a visionary health system. The RTG has allocated about 60 million baht (US$1.4 million) annually to finance the drafting process of a National Health Act.

Even though the health system reform is a state issue under the guidance of the Royal Thai Government, participation in the reform process was actively sought from the international research community. The HSRI wrote a proposal for financial support from the Global Forum for Health Research, which had funds allocated for research in developing countries. The funds granted would be used to partly subsidize the study and academic activities related to the reform process. Consequently, the Rockefeller Foundation at the Global Forum for Health Research (Forum IV) Conference held in Bangkok in 2000 awarded the HSRI with a grant. The objective of the contribution was to empower the research community to work in unison and create an academic power base that would drive the ongoing reform of the health system. The objectives of the grant were broadly outlined and this has enabled the HSRI to flexibly implement it own methodology in handling the academeic activities related to the reform process.

In the beginning, the academic activities supported by the award focused on a review and situation analysis of the following health issues:

a) Healthy public policy which was essentially derived from the health promotion concept and devised by the tools and framework of the Health Impact Assessment.

b) Health information system which was derived from demand to support the governance, administration, service and accountablity of the health system.

c) Health hazard control where was partly derived from disease control together with environmental health.

d) Health research system which was designated as the visionary center of the health system

e) Health care system which was comprised of health care management, quality system, financing system, and health manpower development.

f) Consumer empowerment in the health system which evolved around community responsibility rather than the conventional authoritarian approach of consumer protection

g) The academic review includes the thoughts, and inspiration from elite members of the Thai society so that the direction for reform would be concluded. This would be laid out as a powerful initiative for the health system reform.

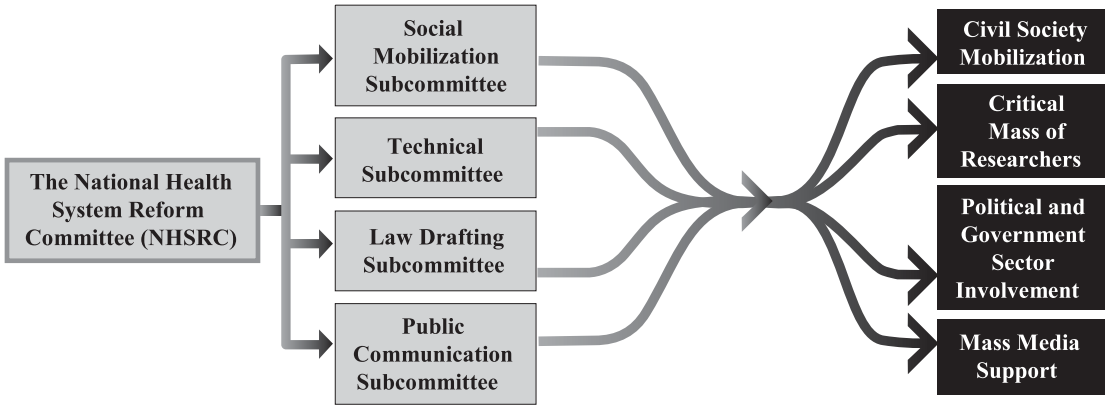
The reform was marked as the first law drafting process that would be derived from seeking information, perspective modification, brainstorming, visualization, commitment, and the common drive to build a desirable health system. Consequently, a broad range of civil activists, government officers, politicians and academics from many different fields were deployed to join the mutual learning process for three years. The National Health Act was mandated to herald a new health agenda for the society and outline the system and fundamental structures that are needed to achieve discernible health system reform. Four principal subcommittees were set up to facilitate the collaboration of the participants in the process in four different roles. The research and academic activities were systematically designed and managed to respond to the demands of the reform process in three principal ways:

a) To generate essential knowledge shared by all the parties involved for the gradual formation of the roles, functions, and architecture of the visionary health system.

b) To create and develop innovative tools and mechanisms essential for building a pragmatic health system in Thailand

c) To foster the development of health system research so that the alliances of academics can continue to support the health system in its long term and continually work on projects that evolve.

As the concepts and tools used for developing the health system are mutually interdependent and interactive, the aforementioned three core functions have been interlinked with each other in the research managerial process. The HSRO performed a key function in supporting the open forum as an opportunity for all effected parties of the health system to join in the process. In the meantime, the HSRI focused on its mission to be the mobilizing force to gather the essential knowledge needed for driving the reform process. In addition, these academic activities have been integrated into the NHSRC's active mission in order to facilitate collaboration and mutual learning among academics, policymakers and the community.



These four subcommittees were engaged to the following missions.

2.1) Social Mobilization Subcommittee

The social mobilization subcommittee organized meetings among diverse community groups to voice their foreseen demands in health issues as well as their expectations of the health system. From 2001 - 2002, more than one hundred thousand people in total participated in hundreds of sessions held in every corner of the country. The sessions' objectives were to collect a range of opinions and to inspire full commitment to health system reform from the grassroots communities and public interest groups. Simultaneously, networks of social researchers from various institutes have incorporated as alliances to study as a basic thesis of the ongoing civil society formation and movement. This was done in recognition of the crucial role set for civil society members in contributing to the health systems.

On August 2001, a **"Health Exposition"** ***(Talad Nad Sukaparb)*** was held to draw inspiration and guidance for the health system. At the event, 200,000 people from all over the country were assembled under the coordination of the HSRO to offer their input. The visionary and creative demands were then shared with the technical and law-drafting subcommittees to validate their scientific and legal merit and feasibility. The input was seen as essential for the law-drafting subcommittee and by the end of 2001, the first draft of the National Health Act was drawn up and endorsed by the NHSRC.

In 2002, civil groups in every province of Thailand met in what was called a Provincial Health Assembly to the discuss the Act. Debates on the proposals in the Act were noted and submitted to the subcommittees for reconsideration. Small task forces made up of key members of the subcommittee and opponents of the proposals at stake met to resolve the major disagreements and come up compromised resolutions. Once this was the complete, the second draft was drawn and affirmed by NHSRC.

In August 2002, the National Health Assembly was held to amend and endorse the draft of National Health Act. The amended draft was submitted directly to the prime minister at the end of the conference. The forum was also an exercise for the alliances in the health system reform to constructively work together towards creating an efficient public health policy. The Provincial Health Assembly and National Health Assembly were viewed as constructive mechanisms and more of each were held in 2003 as way to nurture civil involvement in the health policy process. The NHSRC continued to raise policy issues and implementation plans openly with relevant government sectors in order to keep communications running on a regular basis. At the same time, civil organizations and grassroot communities have set up their own initiatives to report on progress in the health reform process to targeted areas and the population in general.

2.2) Technical Subcommittee

The technical subcommittee's preliminary task was to commission various groups of researchers to review and clarify the concepts and definitions of the health system that had been collected from a broad array of Thailand's elite members of society. An initial study was conducted in 2000 with the conclusions put forward to a broader group of alliances. More than 2,500 participants from diverse walks of life, took part in the third HSRI's academic biannual conference in 2000 held to begin the process of reforming the health system. An informative framework was set and then endorsed by the NHSRC as holding the key elements of the new health system. The draft framework of the health system was then divided into eight sub-systems for further research. These were healthy public policy, health promotion, health hazard control, health care, health research system, health manpower development, health information system, and consumer protection.

Various groups of different types of researchers were then given the task to conduct eight packages of evaluative studies of these sub-systems and to do a comparative study of Thailand's systems with similar ones in a selected group of countries. The results of the studies were reviewed by related government sectors and relevant civil activists. The studies were then reformatted into optional models for developing efficient health systems. After debating certain issues, the technical subcommittee under the guidance of stakeholders came up with a finalized subsystem which was then submitted to the NHSRC for endorsement. The concluded study of visionary system was sent to the law-drafting sub-committee for modification into legislative terms for inclusion in Act.

The proposed draft of the national health act was distributed to a number of civil society groups as well as to district, provincial, and national health assemblies. Points of disagreements with some of the key concepts and structures were relayed to the technical subcommittee for review. The subcommittee then sought to resolve any of the points of contention with the help of specified academics and stakeholders. Alternative recommendations were considered and appropriate changes were made. The proposal was submitted to the law drafting subcommittee to be formatted into legal terms. These activities were reciprocated among subcommittees in 2001. This process enabled the alliances of researchers to extend their networks to include a more broad range of government sectors and the civil network in providing input for the design of

the essential role and the functions of the health systems as an experimental research of imposed innovative tools and mechanisms in real situations. Some of the researchers started to focus on engineering a particular subsystem, giving them expertise in undertaking specific mechanisms of the evolving systems. This learning process, through actions, will ensure that the health research alliances will be able to handle the transitional management of the health system.

2.3) Law Drafting Subcommittee

At the start of the process, the law drafting subcommittee had a study done on health-related laws in Thailand and some selected countries in order to review the legal issues related to the health systems. It then commissioned groups of law researchers to study existing laws in the country related to the eight dimensions of the health system proposed for reconstruction by the technical subcommittee. The subcommittee reviewed the results of the studies and issued a list of critical issues related to the drawing up of the principal structure of the National Health Act. These were in turn relayed to other subcommittees of the NHSRC by the end of 2001.

The subcommittee also reviewed demands and political issues raised during sessions with the civic network as well as the recommendations from the research process. After a year of legislative research, the National Health Act Draft was drawn up and then presented at health assemblies for modification. These assemblies were conducted through seminars and conferences in 500 districts and the draft was put together by 76 provincial assemblies. The end result was the draft of the National Health Act which went before the National Health Assembly in August 2002 for approval. This process which included the participation of a broad spectrum of society served as a strong foundation for new laws related to the constitution.

2.4) Public Communication Subcommittee

The public communication subcommittee had the key task of preparing members of the mass media for the coming changes. Before the media could accurately report on health system reform they first had to understand its background. Since the beginning of the process in 2000, print journalists and radio and television producers have been invited to attend learning sessions on the need for health reform. The entire transitional management phase of the health system reform was communicated to the media. The subcommittee has gone to great lengths to gain the public's participation in and support for the reform process. Numerous public events were held in both Bangkok and in all the provinces and a variety of educational materials were produced and disseminated. Public communication researchers were commissioned to find the most appropriate avenues for communicating the new health system to the general public. The ability to effectively communicate with diverse groups of people will be a key factor of success for the future health assembly to serve as an effective body in handling the governance of the health system.

A key activity for indoctrinating the reform system into society has been the establishment of a platform for sharing past experiences and skills among the civil network and communities. Monthly journals as well as radio and television program were used to disseminate information on the variety health issues among different

communities. The newsletters were sent to all the people who participated in the reform process. By the end of 2002, they had over 50,000 subscribers from a wide range of fields and different walks of life. The marketing strategy of the health system reform has achieved its goal of instilling the concern of health to the general public. The motto of the health system reform - **"Look after your health rather than wait for a problem to arise"** ***(Srang Nam Sorm)*** has become widely known. It has been used in different types of advertisements and widely displayed at a variety of events.

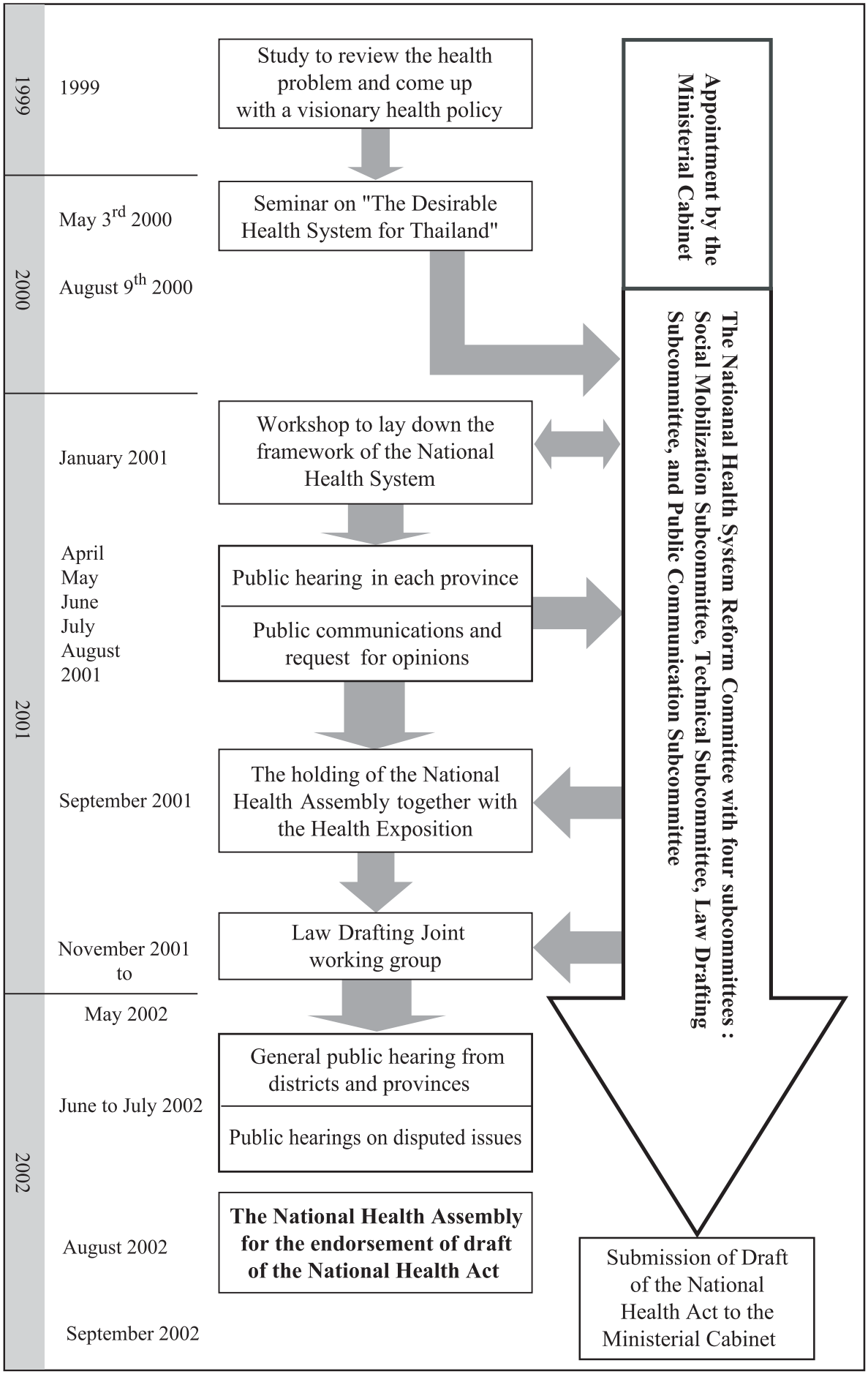
The health system reform activities and health system research process were a combination of the alliances' demands. The draft of the National Health Act was result of the combined efforts of researchers, policymakers and different stakeholders. The reform process has allowed broad array of stakeholders in Thai society to participate in initiative of sustainable health system.

A large cross section of the civil society *participates in rallies held throughout the country to hail the health constitution.*

3) Process and Intermediate Output of the Health System Reform

Over the last three years, the health system reform process has opened up the opportunity for mutual learning in the Thai society. The active discourses and informative public hearings were integral parts of the reform process, bringing knowledge and innovative ideas with a visionary perspective to the expected health system. The process of reform in itself simultaneously produced results that has enlightened the media about paradigm shifts in the general view of health.

Information from a series of reviews from HSRI on the health problems facing Thailand and the study of a visionary health system among elite members of Thai society were used as the basis for a national seminar on "The Desirable Health System for Thailand". This event triggered off the brainstorm process of the health system reform on May 3rd, 2000. Among the participants at the seminar were 150 public leaders from various sectors including policymakers, legislators, civil activists, government officers, community workers and religious leaders. The views from this seminar were then shared at six other seminars held in six different regions of Thailand. The results were then put into background paper to be framework used by the NHSRC.


1999
2000
2001
2002
1999
Study to review the health problem and come up with a visionary health policy
May 3rd 2000
Seminar on "The Desirable Health System for Thailand"
August 9th 2000
January 2001
Workshop to lay down the framework of the National Health System
April
May
June
July
August
2001
Public hearing in each province
Public communications and request for opinions
September 2001
The holding of the National Health Assembly together with the Health Exposition
November 2001
to
May 2002
Law Drafting Joint working group
June to July 2002
General public hearing from districts and provinces
Public hearings on disputed issues
August 2002
The National Health Assembly for the endorsement of draft of the National Health Act
September 2002
Appointment by the Ministerial Cabinet
The Natioanal Health System Reform Committee with four subcommittees : Social Mobilization Subcommittee, Technical Subcommittee, Law Drafting Subcommittee, and Public Communication Subcommittee
Submission of Draft of the National Health Act to the Ministerial Cabinet

The first meeting of the Health System Reform Committee (NHSRC) held on August 9, 2000 marked the official foothold in the reform process. The committee implemented a series of activities with an aim to develop a comprehensive plan in three years. It appointed members to four subcommittees - technical subcommittee, social mobilization subcommittee, law drafting subcommittee and public communication subcommittee - which were set up to provide specialized input for the health system for use in the development of alternative models of performance. The proposed models were reviewed and endorsed by the NHSRC.

After five months, In January 2001, the members of the four subcommittees met with the NHSRC to lay down the principle framework of the national health system. From April to August 2001, the framework was then presented to the public through two main channels.

a) The HSRO held public hearing forums attended by over 35,000 people from more than 1,800 organizational networks which were hosted by local civil groups and government organizations in every province of the country.

b) The HSRO disclosed the main points of the framework in newspapers, pamphlets and through radio and television broadcasts. Comments and suggestions were then fielded through boxes located in grocery stores in major cities. It received more than 100,000 notes of feedback.

The feedback on the framework of the health system was reviewed by a joint working group composed of representatives from the four subcommittees. On September 3-5 in 2001, an assembly made up of more than 1,500 representatives from provincial networks was held to discuss the major issues of the health system. A draft of the National Health Act under the supervision of the law drafting subcommittee was drawn up.

The first draft of the national health act was then discussed at two types of public hearings.

a) General public hearings for groups in 500 districts. Among the participants were 40,000 activists from the grassroots communities.

b) Some 20 public hearings on specific issues raised in the drafting process were held before people affected by the reform, specialists related to the issues and government authorities. More than 1,100 people took part in these sessions.

A comprehensive summation of the hearings was presented to provincial health assemblies in 76 provinces for further discussion. Over 40,000 people attended the provincial health assemblies held in June and July of 2002. These events also served as an exercise in dealing with the differing views found at health assemblies at the provincial level. According to the researchers, a broad range of health activists attended many of the provincial health assemblies while at some, government officers were the main attendees. The alliances did an excellent job in organizing the meetings and presenting the complicated issues but were seen weak in terms of taking an active role in the policy process. Most of the alliances from the grassroots communities were familiar with the problematic issues raised and offered some solutions. Policy researchers and academics gave their viewpoints on critical issues based on their general knowledge, background information and political context. Nevertheless, there were still gaps in how to proceed between the academics and social activists. This presented a challenge going forward.

After the NHSRC and subcommittees had reviewed all of the conclusions from the provincial assemblies, a final draft of the National Health Act was drawn up and submitted for endorsement to the National Health Assembly on August 8-9, 2002. Some 4,000 representatives from communities nationwide and academics met to review the draft. They then submitted it to the prime minister at the end of their meeting. Although the real version was amended and finalized on September 19, 2002, the official submission to the ministerial cabinet was made on September 24, 2002.

The prime minister has assigned a legislative working group led by a vice prime minister, who is a legal expert, to review in detail the draft, taking into account related laws and all stakeholders. Even though many years were spent on the detailed study, the trial and learning about the health governance is an ongoing process. The second National Health Assembly was held August 7-8, 2003. It was the result of provincial assemblies where six key issues that needed to be dealt with were raised. They were:

a) A health-oriented agriculture policy was proposed which called for a reduction in chemical use in cultivation of and on agricultural products and to increase production at organic farms.
b) A sustainable food safety program was recommended to protect the food chain process (cultivation, production, distribution, and consumption) to benefit the general population.
c) A public policy for a clean environment was proposed to protect the health of the common citizen by applying a Health Impact Assessment as a learning process.
d) Use of traditional health methods was suggested to complement the health care system in each community.
e) Holistic health care was raised as an issue to be integrated in the society as a whole.
f) Health manpower management by locality was addressed as essential for further studies in primary health care in individual communities.

New approaches for the National Health Assembly have been used on a trial and error basis as a means to widen the scope of the policy process among different groups and issues. Consequently, the National Health Assembly has addressed the policy issues and at different phases of the proposal process, the health system alliances have honed their skills while wading through the policy process. The six issues raised for establishing a healthy public policy were submitted for consideration to the NHSRC. They which in turn, were passed on to a working group which was directed to further study the issues and apply them to the implementation of the health system.

The NHSRC and the NHSRO were supposed to be terminated on August 9, 2003. But, as the ministerial cabinet viewed that more time was needed to scrutinize and amend the draft of the National Health Act to fit legislative protocol, the renewal and continuation of their missions were consequently endorsed. The new mandate specified continued support for generating information and applying specific expertise to the process of drawing up the National Health Act so that the related legislative organizations and the other stakeholders would continue to be part of the ongoing process. Furthermore, the NHSRC may become part of the governance body of the National Health System in a prelude to the start of the National Health Committee stipulated in the National Health Act. Then, the lessons learnt from health policy intervention would be utilized and be beneficial toward the establishment of a functional health system.

The events which unfolded in the last three year have elucidated to the general public the need to change its mindset on health and the health system in order to adapt to the constant changes in society and technology. The knowledge and skill generated has been a firm basis for a sustainable revolutionary health system. Alliances among the researchers and stakeholders have crystallized all the lessons yielded from these experiences. A new approach for implementing a health policy and system research has been realized. This has shifted from the notion of an evaluative study and situation analysis to proactively noting policy implications or policy options through the input provide from all of the stakeholders and then conducting a series of research experiments to come up with an appropriate solution.

The new health constitution receives an ***enthusiastic*** *endorsement from Prime Minister Thaksin Shinawatra.*

4) Preliminary Result: Architecture of the Visionary Health System

The National Health Act submitted to the cabinet was drafted within an ideological and scientific framework that had been endorsed by a wide range of alliances throughout the country. Although it has yet to be amended and finalized in the ministerial cabinet and parliamentary process, the draft lays down the basic infrastructure of the future health system. The proposed health system reflects a shifting paradigm among Thais in terms of ideology, governance, elements and architecture and provides a basic roadmap for a long-term constantly evolving process.

The draft of the National Health Act conveys the philosophical ideal of the 1997 constitution which states that health is a dignified human right which all people are entitled to. Furthermore, the draft defines health as physical, mental, social and spiritual wellbeing. This new, broader definition provides a challenge to administrators of the health system because it involves engaging all sectors of the Thai society. The health system now legitimately transcends beyond individual and community health care. It has been placed in the center of multisectoral development and governance of all public policy related to health. **"Health system"** has been defined in the draft as: **"All the systems, which are holistically interconnected and affect the health of the people throughout the country. It includes all factors related to health, namely personal, environmental, economic, social, physical and biological, as well as the health service systems."** In this context, the term "health system" is broader than " health care system". It is based on desirable values and principles, including equity in human health. Thus, reforming just one element of the health system cannot bring about the desired improvements to the system as a whole, whereas failing to improve one element may jeopardize the entire reform initiative.

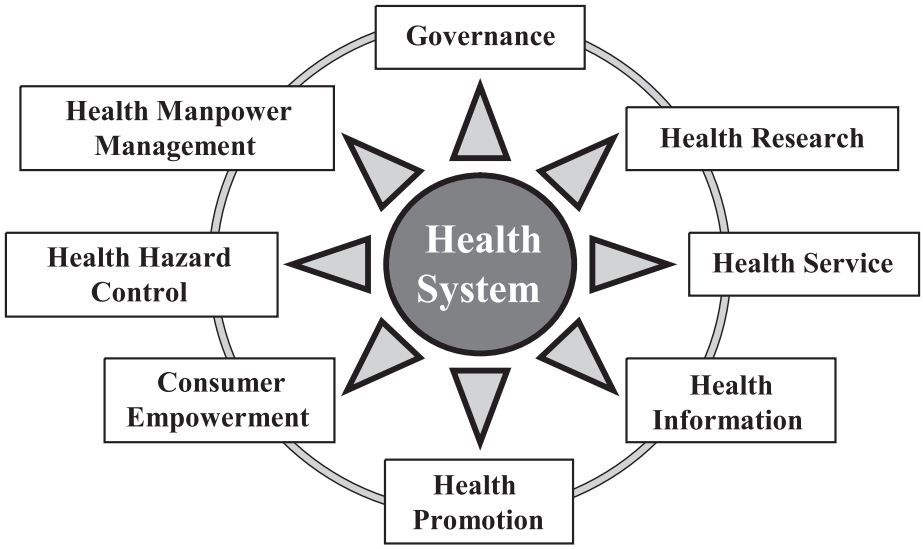
Furthermore, the HSRI has set the draft of the National Health Act to be a visionary framework set by a collaboration of research and stakeholders for the process of changing the health system.

The draft of the National Health Act outlines eight components of the health system:

4.1) Health Governance System will be the principal governing body of the health system. The National Health Assembly (NHA) will carry out government policy to meet the diverse needs of society. It will ensure that policy, strategic directions and investments are tailored to meet the demands of each community. This requires a realignment of the health system's partnerships and the involvement among civil society so that a more effective information and knowledge network is in place that would foster sustainable health development.

4.2) Health Promotion System will work towards getting the various agencies and civil society to work together in creating a holistic healthy public policy. Health Impact Assessment (HIA) will be made and used as the principal tool in setting the framework for developing a comprehensive health system that takes into account societal, environmental and political factors affecting all levels of Thai society.

4.3) Health Hazard Control System will function as a surveillance network for monitoring a broad range of conditions known to be harmful to human health. This will serve as an early warning system to protect citizens from exposure to health hazards such as contagious microbes, drug-resistant organisms, industrial toxic substances, radioactive substances, genetically modified products, addiction, violence and sexual perversion. The system will track emerging health hazards and respond at the national, provincial and local level.



4.4) Health Service System will be a network of health-care providers and facilities supported by adequate financing to ensure that all Thais have equal access to high quality health care. This will require community involvement, transparency and establishment of a non-profit administration. The system will also accommodate a patient's right to choose alternative health care, including traditional Thai medicine.

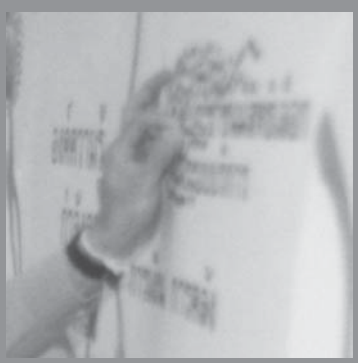
4.5) Health Research System will function as the knowledge generating center of the health system. It will set policy for national health research and ensure that research projects are appropriate, effective and sufficiently funded. Strengthening research management skills will be one of its core functions. Research institutes will be empowered to create and transfer health technology, which is a key factor in the country's goal to become self-reliant.

4.6) Consumer Empowerment System will be a mechanism set up to provide support to community and knowledge-based consumer protection organizations in all areas of the country. The system and the consumer protection network will be independent. In cases involving adverse drug effects or ill effects from health products and health-related equipment, a compensation fund will be set up to provide immediate financial assistance or compensation while negotiations and/or possible legal actions run their course according to the law.

4.7) Health Information System will be set up to keep the public informed on essential health information. It will disseminate timely health information to communities, using all the various types of media available. As modern information and communication technologies have made it easier for people to access health information, the system will develop the means for the public to access the information and work toward the goal of sustainable self-care.

4.8) Health Manpower Management System will be responsible for the essential personnel in health services and administration. It will work with various training and educational authorities to increase the number of skilled managers in the community and at every level of the health governing system. The system will be required to make sure that the distribution of health manpower meets the needs of each community, even in remote areas.

Collaboration among alliances of researchers and those directly involved in health services must take place for the eight visionary health systems to function effectively. Group learning through action is a necessary process for setting up the systems. While the legal framework will be the basis for the systems, the roles and functions have to come from a collaborative effort in order to be effective.

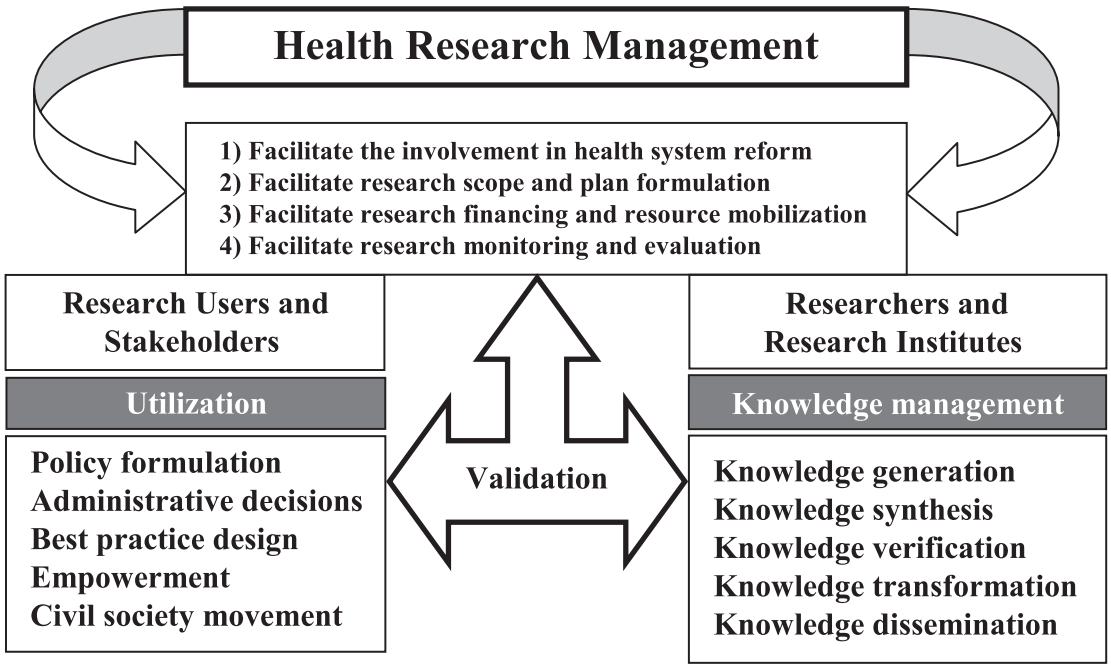


All sectors of society are providing input in the drafing of the new health system.

5) Findings: Pivotal Manifestation for Research Management to Align Alliances

Health system reform in Thailand has shown that collaborative knowledge among stakeholders is necessary in order to create insightful models of systematic roles and functions. Partnerships among users and researchers have to be fostered and nurtured in the development process so that the inner workings of the plan effectively drive the health system. The objective of getting this broad range of people to work together is a very challenging task and consequently, enormous research management skills have been deployed to meet this challenge.

Although research management has long been recognized as an important and pivotal role in any health research, it has been largely done by "trial and error" with no guiding principles or sets of "best practice". Effective management of research is critical to ensure that the information and knowledge derived from research is utilized effectively by linking researchers with users of research. Development along this path will simultaneously nurture and strengthen the research culture among policymakers, health care providers and community leaders.



Based on the experience gained thus far in the reform process, the principal roles of health research management may be summed up in four major functions:

5.1) Facilitate Research Involvement among Researchers and Stakeholders in the Health System

The research management process has been used to interweave coalitions among a broad array of researchers and those directly involved in the health system. Their commitment to work together to develop new roles, functions and mechanisms of the evolving framework is essential to health policy and systems research. The high profile of the health system reform, which is on the government's national agenda and has the support of the majority of civil society, and the view that the research findings would be an integral part of the visionary health system have prompted many researchers to become involved in groups set up in the reform process.

5.2) Facilitate Formulation of Research Scope and Plan

Research managers are responsible for facilitating discourses, dialogues, and discussions among the users and related researchers of each research theme so that its scope can be delineated and clarified. The research theme may include concerned constructive questions to be mutually solved among interdisciplinary partners. Parties involved in the health system have shared their experiences and knowledge in this group effort which encompasses both knowledge generation and knowledge utilization. This procedure ensures that all partners participate in the research and development process through the whole process.

5.3) Facilitate Research Financing and Resource Mobilization

Financing and resource mobilization to foster research is a fundamental role of a research manager. In this case, however, managerial responsibility extends beyond just funding the research. Even though the government and other concerned parties have provided the initial financial support, more resources are needed in terms of financial investment, human resources and technology. Thus, principal users (the Ministry of Public Health, the Ministry of Labor and Welfare, the Ministry of Finance, the National Research Council, etc.) have been persuaded to provide funds and become partners in or owners of the research. Research institutes and universities have lent human, technology and capital resources to these collaborative studies. The civil network has also contributed to the effort. The research manager's role is to coordinate these resources and encourage continued support from all the partners to sustain and accomplish the objectives of the process.

5.4) Facilitate Research Monitoring and Evaluation

Monitoring and evaluation is an essential mechanism to clarify what is involved in the process of research management. Each research project goes through a review process periodically and feedback is to be given to the respective research partners and managers. If necessary, they will reshape and redirect their collaborative effort to keep it in line with the desired goals. In addition, in the evaluation of research management, a mandate is given to persuade partners to mutually learn from each other and share their experiences. The skill and experience in the monitoring and evaluation of research management is still very rare, but under current conditions, the health system reform process has been providing an opportunity for allied research managers to learn on the job and gain practical hands-on experience.

Through the efforts of research management, research users and health systems' participants can share their perceived demands with researchers and assist them in constructing relevant research questions. This will help ensure that research users and stakeholders contribute to the research process. Any study undertaken will, of course, have to respond to the visionary framework of the health system reform.

Policymakers can use the information obtained through the research process in formulating related strategies and policy. As well, amendments to and the redirection of the health policy may be the result of the ongoing studies. The sharing of information between policymakers and research alliances will be continuous and serve as an interactive learning process. At the implementation level, administrative officers will have access to the information generated from the research to help them keep their frame of mind in line with the latest developments. Some health care providers have volunteered to conduct research. Best practices derived from research involving all participating parties can provide invaluable input into the decision-making process concerning policies and strategies that will improve the health system.

Research institutes have been enthusiastically embracing the revolutionary mandate and seeking closer collaboration with other related parties in the health system. This may be in part because of the constitutionally inspired education reforms, which are aimed at freeing universities from bureaucratic red tape. Research excellence and community service has to be strengthened and integrated into the primary role of education.

Research management is a key support factor for the process involved in reforming the health system. It provides partnership advocacy, strategic advice and capacity building for alliances. This is the means to recruit and extend the research networks to cover all the elements within the health system.

Thousands of people from all walks of life participate in a run staged to herald *the drafting of the National Health Act.*

6) Achievements of Sustainable Reform: Research Alliances to Guide the System

The health system reform is far from being completed. Even though the parliamentary process may be finalized within a few years, defining the roles and functions of the new health system, including ensuring that capable human resources are in place, is an effort that will go on for decades. A critical mass of interdisciplinary health researchers has to be enlisted in order to ensure that the health system stays on the innovative path set forth by the revolutionary health system. This is the only way that the new paradigms of health and health system will be practical and effective.

Since 2002, the HSRI has been committed to the implementation of its evolved strategic plan to mobilize research management as an integral part in developing the health system based on the context in the draft of the National Health Act. The research proposals for 2002 - 2004 include seven principal research schemes respective of eight key elements involved in the drafting of the health system. Only, the issue on health manpower development was included as an integral part of the health care system.

Initial financial contributions for these research proposals will come from the Health Systems Research Institute (HSRI). Alliances and other members of the health community will later share the responsibility of sponsorships for new research proposals. The integrated mission of research and reform will encourage users to be accountable for the results from the research. The following research schemes will ensure that the mechanisms, roles and functions of the health system will adjust to changes in policy:

6.1) Research Schemes Leading to Good Governance of the Health System

The rethinking of the health governance concept and procedure is very complex and demands closed and continued collaboration among a broad range of parties. As well, research alliances have to undertake the study of governance development of the health system at the national, local, community and hospital levels. Constructive learning through practical action is one aspect involved in ensuring governance at all levels of the health system, and this will form the cornerstone for mutual learning among alliances. Thus, health intelligence networks have been aligned to construct a creative information system set up as the health system's foundation pertaining to accountability, financing, monitoring and evaluating the health systems. They will also provide essential health information and knowledge at the national,

provincial, and community level. A center for health equity is also being supported to facilitate the assessment of the health situation and to serve as an evaluative tool for directing the whole governance level's health policy.

6.1.1 Public Commitment to the Reform of Health Governance

A health governance system for the national, provincial and district levels was proposed in the draft of the National Health Act. The proposal was finalized at the National Health Assembly and Provincial Health Assembly as a forum held to mediate the diverse demands of various interest groups and then spread the information on public policy through various policymakers. Though the National Health Act draft has not yet passed through the whole legislative process; some of the activities proposed at the health assemblies within the last three years have been put into action. In fact, the 1997 constitution mandated for this type of approach.

Another explicit commitment to create an innovative health governance system is the government's policy under the mandate of the Decentralization Plan and the Public Sector Reform. These are efforts aimed at reducing the government's bureaucratic structure and empowering local and community authorities to service the demands within their own jurisdictions. According to the plan, the local health service policy would be handled at the local government level by a committee made up of government officers, local government representatives and community members. This reform plan needs to be finished by the end of fiscal year 2003.

A plan to corporatize public hospitals became government policy in 1999. The first example was "the Decree of Ban Paew Hospital" which turned a district hospital into an autonomous hospital[2] in 2000. Next, a new financing scheme for the universal coverage of the health care was implemented with hospitals in accounting terms moving from being classified on the supply side to being placed on the demand side as a per capita payment. These changes have provided fertile ground for research to develop good governance at public hospitals.

6.1.2 Research Mapping in Health Governance

The HSRI has set up a roadmap for researchers and other parties involved in the health system in order to keep them directed on their main objectives. The research scheme would yield expertise in three principal dimensions.

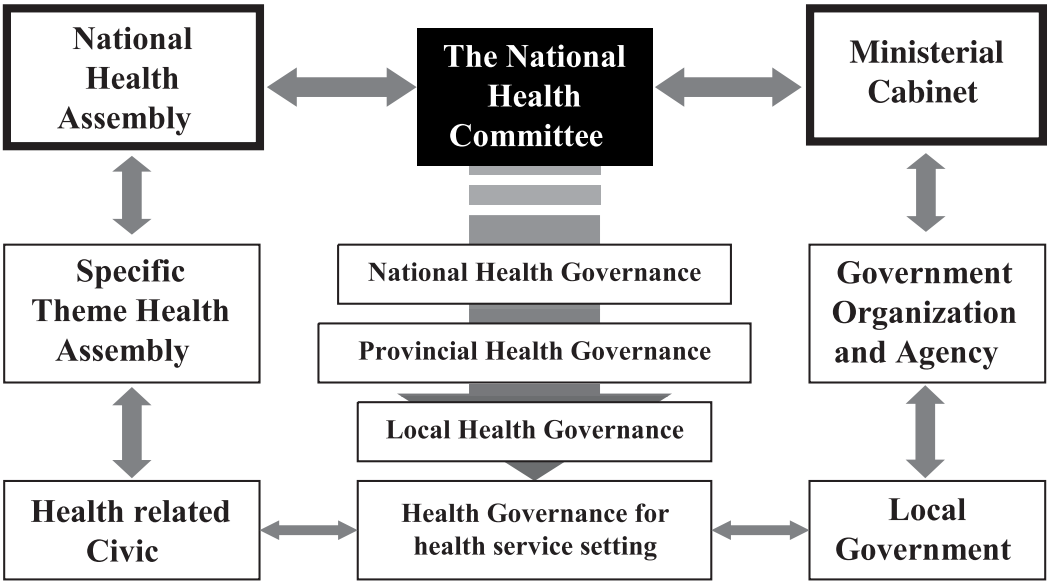
a) Research on the process to formulate and implement health policy at the national, provincial and local level as well as policy and strategic management of the hospital.

b) Research on information and intelligence devises for health policy development at all levels.

c) Research on social and anthropological aspects of the civil process and public sphere to influence society in general.

[2] A state-funded hospital run by an independent board of directors but accountable to community, local government, provincial government bodies and the Ministry of Public Health.

Research mapping of health governance system



These three principal research areas have been laid out to support the main strategy of research management, which was designed to collaboratively work as an integral part of the ongoing reform mandated.

The Health System Reform Office (HSRO) has changed its function from acting as the secretariat for the National Health System Reform Committee (NHSRC) to taking on the role of the National Health Committee (NHC) as drawn up in the draft of National Health Act. Accordingly, the HSRI has enlisted multidisciplinary researchers affiliated with each level of the health governance to conduct research and continually provide feedback to be used in setting policy.

6.1.3 Research in Health Governance

The following are studies being conducted to provide backup for the three-year reform movement:

a) The study of governance methodology as an innovation to support the National Health Assembly

b) The study to monitor and evaluate the structural reform of the Ministry of Public Health

c) The study of provincial and district health assemblies to collect the information and use it for developing alternative models

d) The study of evolving roles and functions of the Provincial Authority, Municipality and Tambon Authority with respect to the trend to decentralize government authority

e) The study of the governance and administrative system for autonomous hospitals

These studies were launched before the end of 2002, and will be completed over the next three years. The information obtained from them will be utilized to benefit the health system.

6.2) Research Schemes for Healthy Public Policy and Health Impact Assessment

The draft of the National Health Act has insightfully placed "Health" as a cross-cutting concern of all the development sectors. Consequently, the whole reform process will be developed under the pretext of the direct impact it may have on the health of the population. "Healthy Public Policy" describes a broad process that recognizes most factors influencing health outside the health sector. It is characterized by an explicit concern for health and equity in all areas of policy development and implementation. In addition, the consequences of actions falling outside the health sector, such as housing, environment, income and leisure activities are also recognized politically as having an effect on the overall health of the population.

There is compelling evidence that the health of the population has less to do with health care spending than with other social, economic and environmental factors. A country that overspends on health care may under invest in the primary wealth-creating sectors and social policies that ensure access to key determinants of health. In the formulation of a healthy public policy, health is seen as both a fundamental human right and a sound social investment. There is also explicit recognition that inequalities in health services are the result of inequities in the society. Accordingly, "Health Impact Assessment (HIA)" has played a strategic role in supporting a participatory learning process among different types on parties involved in the health system in the development of a new policy for the country. However, HIA, under a new mandate, is a new innovation in Thai society which previously had been obscured by its limited function within the environmental impact assessment (EIA).

However, the existing and widening gap between well - trained technocrats and average citizens has adversely affected both the development of the country and unity within a community. Authoritarian masterminds have seen these pluralistic approaches of policy decision as an unmanageable process. Thus, constructive and incorporate mechanisms must be created to mediate the demands of the diverse groups involved in the health system for any public policy to take fold.

Based on this critical pitfall, HIA alliances have been formed to search for the means and methodologies to guarantee a practical and sustainable healthy public policy and health impact assessment in Thailand. A workable governing framework, based on cooperation between the government and the community at large and supported by continuous research, must be established and developed to ensure that a healthy life is plausible and feasible to all Thais.

6.2.1 Commitment to a Healthy Public Policy and Health Impact Assessment

The HSRI's support of the research scheme for a healthy public policy, which began in 2001, has led to the establishment of six networks that function as coordinating bodies for related sectors. They are:

a) Public policy on industry and energy

b) Public policy on agriculture and rural development

c) Public policy on transportation and urban development

d) Public policy on water resource management

e) Public policy on international trade

f) Public policy on natural resource management

These networks provide the academic framework for their particular function and incorporate related research and civil activities into the ongoing policy process. An amendment in 2002, which requires that the existing Environment Act includes a more effective HIA with broad-based participation from different segments of society exemplified the networks coordinating functions.

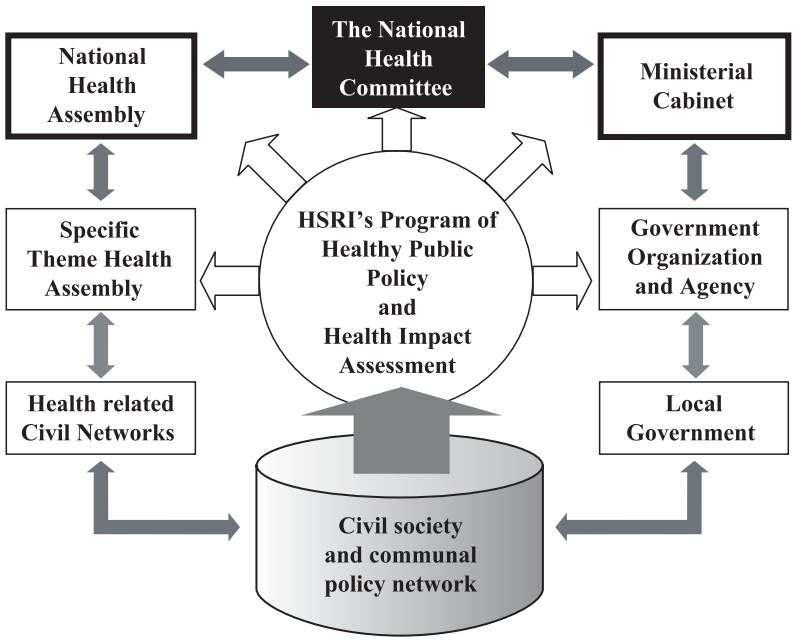
During the preparatory phase of the National Health Assembly in 2003, the policy agenda of healthy agriculture was deemed as a very beneficial and promising movement. The healthy agriculture network has proposed two key alternatives as policy issues. The first one is to restrict the importation of agricultural chemicals such as fertilizers and pesticides, which contaminate the soil and water and ultimately hurt both farmers and consumers. The second policy is to promote a sustainable agriculture, which encourages small farmers to use organic agents and educates consumers about the value of untainted agricultural products. Both the Ministry of Agriculture and Ministry of Public Health have endorsed these policies and the plan of action has been developed by the NHSRC's task force, which will reinforce the government policy of developing a learning process that involves the community.

Another notable change in the Ministry of Public Health was the establishment of a new agency called "Bureau of Environmental Health and Health Impact Assessment" in 2002. This has been seen as instrument in the innovative move to place "Health" as the central concern for all development sectors. This organization is actively involved in the implementation of HIA.

6.2.2 Strategic Map to Integrate the Existing Policy Process

The legal framework for the National Health Assembly still needs to be set up even though the mandate for its existence has been drafted. An application for the HIA to get support communities involved in the state-led policy process needs to pass through various development sectors. The networks of researchers supported by the HSRI have expanded their efforts to work with diverse government agencies. For example, they provided support to research projects of the Ministry of Agriculture. In another area, which pertained to the amendment to the Environmental Impact Assessment (EIA) Act,

Research mapping of healthy public policy and health impact assessment



researchers provided information and expertise to the Ministry of Natural Resource and Environment. This led to the understanding that the health impact assessment is an integral part of EIA. These examples put light on how practical the healthy public policy and health impact assessment stands to be.

The aim of the research network is mainly to create and maintain the civil society and communal activities' involvement in public policy. This is seen as an empowering process where the evidence-based policy can be implemented as a legitimate strategy through real life participation.

6.2.3 Research in Healthy Public Policy and Health Impact Assessment

Essential research infrastructure has been established as a platform to enable academics, researchers, civil society organizations and community leaders to work together. The following are ongoing parts of the research project:

a) The study of alternative power sources to complement different sources of electric power supply to optimize the health of Thai residents

b) The study for the policy of healthy and sustainable agriculture policy

c) The study of urbanization and transportation policy in the cities

d) The study of water resource management policy and watershed resource management

e) The study of resource based policy in affiliation with the National Commission for Human Rights

These ongoing studies have been jointly planned with the officers responsible in related sectors and representatives from the community and business sectors. The HPP and HIA program is led by a board of directors appointed by the HSRI. The board members consist of academic experts, civil society representatives and stakeholders. Networks for six research areas have been enlisted to undertake field studies.

6.3) Research Scheme for Health Hazard Control

Health hazard control has shifted the notion of health protection far beyond just disease control, giving a new role and function for monitoring and preventing hazardous elements. For disease control, hospitals and public health authorities are the key centers for disseminating and gathering information as preventive measures of epidemics. But, for protection from health hazardous elements, surveillance and monitoring devises are under the responsibility of a variety of entities, some of which are not in the health sector. The purpose of this is to prevent people from being afflicted by hazardous agents or conditions, and to protect them from overexposure.

Since, the ideal principle of health hazardous control overlaps with the principle of disease control, it is difficult to find researchers who clearly envisage the necessity to create tools and mechanism for this area. In the health sector, there are plenty of epidemiologists who contribute to studies on disease prevention and control while at the same time, those in the environmental and industrial sector may assist in the effort to reduce hazardous agent levels to international standards of practice. As well, those who are responsible for legal aspects of the field may focus on criminal suppression and prevention. The interrelated and coherent measures to protect human beings from diverse threatening conditions has never been interwoven between different sectors, making the implementation and measures for health hazard control far from being efficient.

The draft of the National Health Act calls for the coordination of the different authorities involved in the detection of conditions which may be threatening to human beings. The HSRI has categorized three hazardous sources.

a) Bio hazard focuses on biological agents that cause disease and disability. Viral and bacterial transgenic mutants and recombinants have recently raised scientific concerns of emerging diseases and drug resistant diseases. Since the transmitter may be human, livestock, insect or environment, work involved with the detection of emerging virulent strains has to be extended to cover the relevant authority.

b) Chemical and physical hazard include chemical and physical agents used in production and processing as well as in industrial waste, transportation, agriculture and generating energy. The relevant authorities should coordinate activities in controlling hazardous agent contamination.

c) Psycho-social hazard is a reflection of the interplay between threatening behaviors such as violence, sexuality or addiction with psychological interaction in stressful society. The social anomaly which has been exacerbated by deteriorating family values has had a large impact on public health. The social research network was set up to provide insight into this phenomenon.

These have provided a rough framework for research formulation, which allows researchers concerned in these areas to join the future movement.

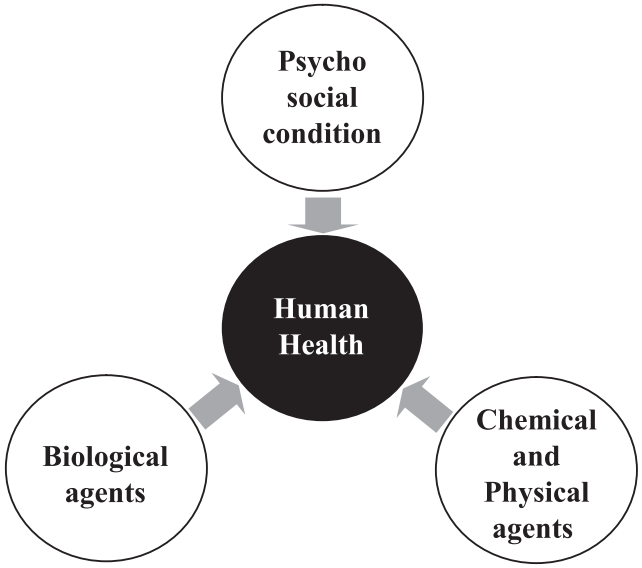
6.3.1 Commitment to Health Hazard Control

The government recently became committed to health hazardous control. This is the result of the restructuring of the Ministry of Public Health, in which the Disease Control Department was placed with the principal mission of handling health hazard control. However, the operational missions have just focused on disease control, which, includes monitoring and surveillance of both communicable and non communicable diseases; enforcement of some laws such as the Contagious Disease Act and the Tobacco Control Act; logistic support for disease prevention with control of such things as vaccine supplies, the distribution of condoms and insecticide supplies and the setting of standard guidelines for disease prevention and control. The task of grouping all the authorities responsible for detecting and monitoring different health hazardous agents or conditions has never been undertaken.

6.3.2 Strategic Map for Health Hazard Control

The conceptual framework for health hazard control is derived from the epidemiological basis for disease prevention, which focuses on the associations among host, agents and the environment. Currently, the sense of environment has been broadened to cover complicated social and economic circumstances. The natural environment has declined as an influencing factor in the health of human beings when compared to social and human-created circumstances.

Research mapping of health hazard control



The research results for the draft of the National Health Act focused on these three determinants. However, each area still need alliances to draw up realistic scope and detailed elements related to existing infrastructure.

6.3.3 Research in Health Hazard Control

The following are initiatives to prepare networks of researchers in four particular areas:

a) The study of domestic violence and preventive measures

b) The study of addiction and addict substance dynamism

c) The study of toxic substances related to industry and environment

d) The study of a surveillance system for prevention of narsocomial infection in hospital

The area of psycho - social hazard is in the process of enlisting social scientists to its research team.

6.4) Research Schemes for Health Care System

Over the past two decades, Thailand's health care system has been based on primary health care. The policy has emphasized community engagement with the public health service, mainly provided by the Ministry of Public Health, while the health service under the primary health care policy aimed to use volunteers from the community to rapidly extend health services to cover every corner of the country. This policy has resulted in an inadequate health service system with the advancement in technology held back by the limited resources provided by the government and the need for it to be user-friendly to the general public.

At the end of the millennium, unanticipated health problems rapidly emerged with health technology advancing at a fast rate and the local communities participating in providing health care unable to meet the demands of the constituents. The pressure on the system is even greater under the present constitutional mandate to ensure that the general public has equal access to health care services. In addition, the accelerated advancement of health technology combined with rising costs of health care would certainly widen the gap of accessibility to health care between the rich and the poor.

Since 2000, the HSRI has sponsored a research task group to review the financial situation of the health care system and come up with a feasible model for financing health care in Thailand. This research effort coincided with the first general election held under the new constitution, making health care coverage for all Thais a popular campaign issue due to strong political pressure. Under the new ministerial cabinet appointed in January 2001, the government actively pursued a policy to sponsor health insurance. So, the research task force had to modify its research results to fit with the policy process as set in a road map towards universal coverage of health care as proposed to the prime minister in March 2001.

6.4.1 Government Commitment to Universal Coverage of Health Care

The government policy of health care coverage is in line with the requirement in the constitution that all people have to access to health care. Momentum from this decree has led to the "30 baht coverage for all diseases" program. Its implementation has shown rapid results with 95% of the population in 2002 covered under health insurance compared to 70% in 1998. In addition, the National Health Insurance Act was enacted to ensure public financing for health care. As mandated in the law, the National Health Security Office was set up to handle the implementation of the policy and strategy for universal coverage of health care.

Nonetheless, there are still many obstacles to providing good quality health care with updated technology that meets constantly changing demands. Primary and traditional care has been developed as a basic part of the health care system but the function of secondary and tertiary care as a referral system has not been put in place. The government's financing of the 30- baht scheme has focused on primary care. So far, there is no well-designed financing scheme for the maintenance of emergency medical services, intensive care units or long-term chronic care, as well as for costly care for catastrophic health problems. The existing health care benefit package is based on the per capita of the people registered to the authority for primary care while the task of making sure that the health care infrastructure was sufficient was left to a team of multidisciplinary research networks.

Over the past few years, some key developments in health care have evolved from the partnerships set up to utilize system research in formulating health policy. The HSRI launched a research program that became the "Hospital Accreditation Institute". Since 1999, the Ministry of Public Health and the National Health Security Office have supported the institute in taking on the role of supervising all the hospitals. This is an academic body which is made up of many types of professionals and primarily focuses on quality health care.

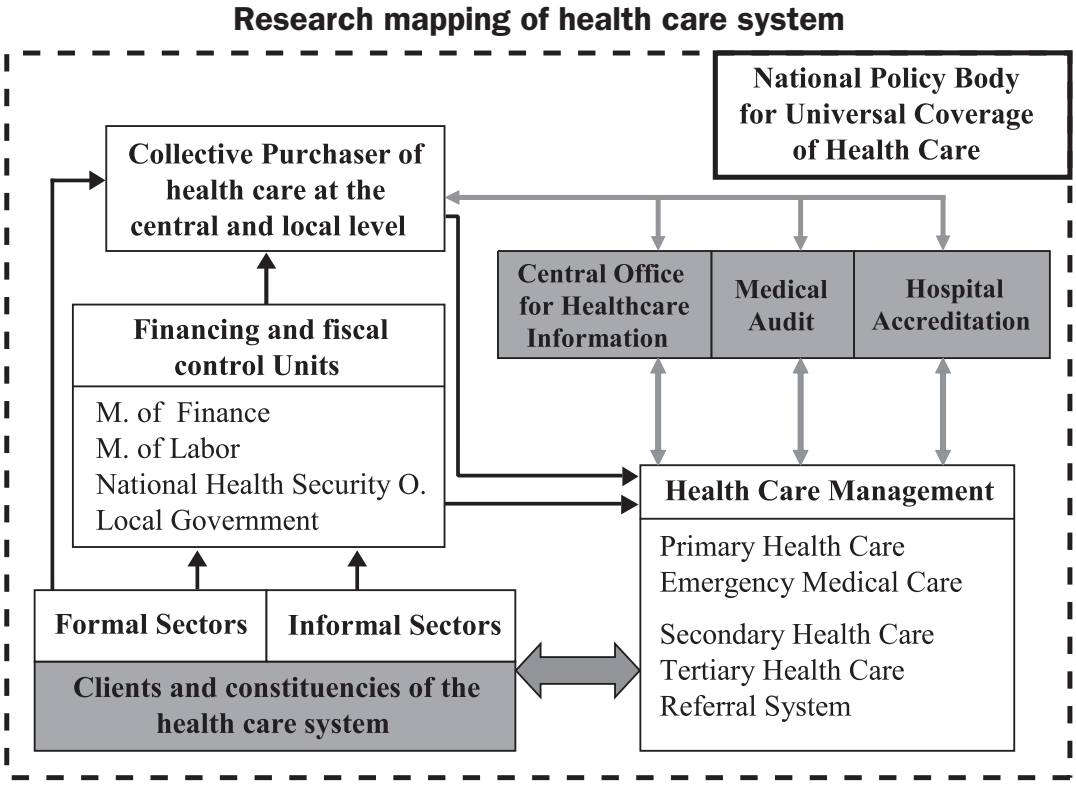
In 2001, the Ministry of Finance contracted the HSRI to establish an agency called the "Central Office for Healthcare Information" for processing and verifying data submitted from the hospitals for reimbursement of inpatient charges. This agency plays a leading role in paving the way for revolutionary change in the health system as it serves as a critical extension of the organizational research and development. It is comprised of a medical audit unit to detect fraud and unintentional false medical care and a unit that studies patient care costs for chronic cases so that in the future, case management costs may be scheduled. The Ministry of Finance's contract also called for a study on a pharmacy benefit package and a drug price mechanism for cost containment. These tasks resulted in an innovative model utilized by researchers and of benefit to end-users. Of significance, research has resulted in the development of a culture set in the health policy that requires legitimacy and rationale with sound evidence in the operations of the system.

On the view that health care should be developed with the input from many different types of professionals, the HSRI has supported the research from faculty of nursing, medicine, dentistry, pharmacy, physiotherapists etc, in developing an education curriculum that conforms with community needs and the evolving social and political reform. Some newly innovated programs were implemented in the last few years, such as an additional option for local communities to work with the faculty of nurses in opening up places for nursing students from the community. The faculty of nurses at Khon Kaen University, initiated this program in 2002, under the plan communities sponsor local students to take training courses and in return the students be back to their hometown to work as nurses when they have finished their studies. Health manpower development may be a fundamental strategy for strengthening future primary health care.

The involvement of users in health system research from the beginning has led to an innovative research management. Furthermore, collaborative alliances composed of a balanced mix of policymakers and administrative users, related parties and constituents and researchers has churned out relevant information pertaining to the transitional management of the health care reform.

6.4.2 Strategic Map in Health Care

Most researchers in the past decade have just focused on the financing and economic perspective of health care despite enthusiasm over reforming the system. The Ministry of Public Health has set a design for primary health care so that it could be available in all parts of the country. However, the uneven distribution of health manpower and high technological equipment has critically hindered the possibility of providing equitable health services. The existing hospital-based health care may not be efficient or effective enough to provide primary care to all of the population. Additionally, academics have sought for more efficient approaches, such as a public/private mix of health care providers, health care privatization and a freelance support system for health care.



The research alliance for health care is made up of researchers with health professional backgrounds and with expertise in social and economic issues. Based on the framework of research mapping designed to complement the health care system, the HSRI worked with principal beneficiaries to come up with three key agencies. The first agency - Central Office for Healthcare Information - is currently responsible for the accounting involved in the handling of inpatients and reimbursements under the health financing program. The second one - Medical Audit - is to audit the medical records in order to guarantee that correct clinical practice guidelines are performed. The last one - Hospital Accreditation - is in charge of ensuring that the good quality standards are maintained in the hospitals as well as the setting up of an accreditation system for evaluating and improvement of the quality.

6.4.3 Research in Health Care

The HSRI has coordinated studies among multidisciplinary health professions to evaluate the scope of the research in health care management as a substitute for the lack of a clearly articulated program on health care facilities and health manpower. The principal research packages will deal with the following:

a) The operational research on primary health care in diverse communities
b) The study of medical anthropology as a tool for primary health care
c) The study of the role of each health professional in primary health care
d) The evaluative study of the transitional management toward the universal coverage of health care
e) The study of chronic case management and costs
f) The study of the emergency medical service
g) The study of the health manpower development in response to the health care reform

These ongoing studies will fill holes in the evolving health care system and will provide a challenging platform to get related researchers to join the efforts.

6.5) Research Schemes to Innovate Health Research System

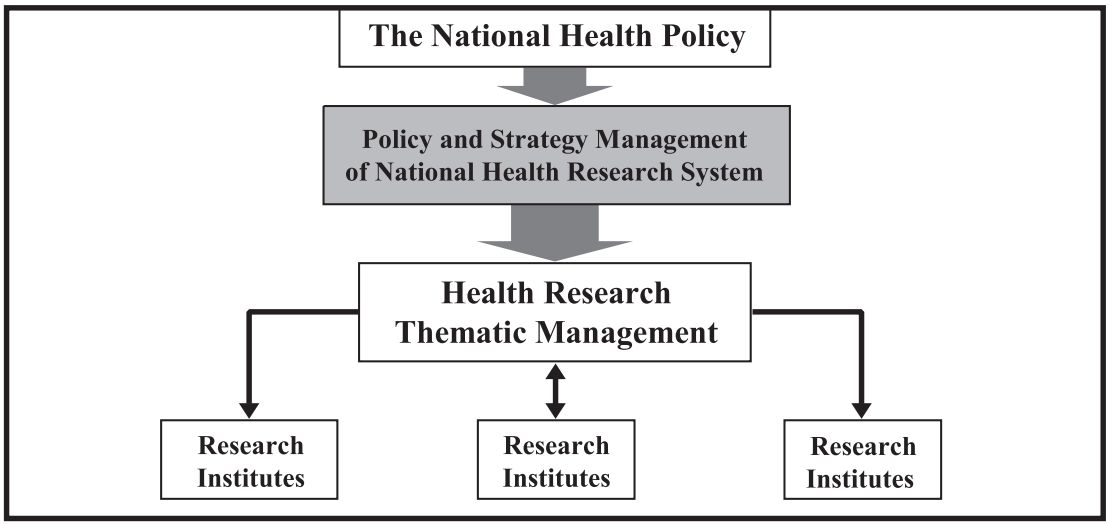
In the beginning of the health system reform process, the technical subcommittee took the view that the national health research system would be an essential element of the health system. A series of assessments and reviews were consequently conducted to verify the necessity to facilitate systematic management of health research. In the process to elucidate a feasible structure, role and function of the health research system, two movements that occurred simultaneously influenced the direction of the mission.

(1) Concept Development of the Health Research System

While the NHSRC was reviewing the health research system for Thailand, a global movement enriched the process. In an address entitled “The National Health Research System” at the Global Forum for Health Research Conference (Forum IV) in November 2000, a policy advocating a systematic approach of health research at the country level was recommended. The World Health Organization (WHO) followed the suggestion. Consequently, international forums were held to review, assess and clarify the policy on national health research systems. This in turn led to ongoing discourses that have pushed forward better designs for the evolving system. The technical subcommittee finally submitted a three-parts framework for development of the national health research system.

According to the proposed framework, the first part is the managerial process to provide national health research policy and strategy. This body will coordinate the health policy of the country and relevant research sectors to address the essential health research issues related to the current health problems as well as take a visionary view of what may be in store in the future both from a circumstantial and technological viewpoint. The research issues will be mapped out, depicting the situation analysis, state of the arts of technology related to issues, availability of researchers and research technology and the return of the research investment. Then, the second part will take over the process by estimating budget and managerial demands and then mobilizing the resources to facilitate the research task by the organization responsible for this area of research.

Research mapping of health research system in 2001



The underlying assumption of this approach is that the research policy management should operate separately from research thematic management so that conflict of interests may be avoided. The monitoring and evaluation, thus, will be handled by the body that guides policy and strategy as feedback to reshape and redress research policy. Research thematic management units would carry out four main functions. These include facilitating participation among researchers and stakeholders to come up with the scope and plan of the research schemes. The units have to be initially financed by the government then later can be co-financed by the stakeholders that stand to benefit from the research. The monitoring and evaluation of each research project must be conducted by the thematic management authority. The themes of the research issues may deal with health systems research, health equity or health threatening diseases such as HIV/AIDS or Dengue Hemorrhagic fever, or future technology such as work with stem cells, nanotechnology, or critical measures for affordable health care such as herbal medicine, medical informatics, etc.

The individual research thematic management units do not have the mandate to conduct their own research. Instead, this task is placed upon specialized research institutes which also handle matters dealing with development and education. The research institutes can combine their expertise with the state-of-the-arts technology to develop advanced centers which may be based in universities, private companies or with nonprofit organizations. The research centers affiliated with the universities can also be used as a way to attract students to participate in the health research system.

The Clinical Research Collaborative Network (CRCN) was set up as a consortium of medical schools aimed at establishing multicenter study programs in university hospitals. The Rockefeller award to set up the coordinating body for the research in six areas of disease and anesthetic operations is funding the program. The research involves seven colleges and organizations that deal with these seven subjects. This program is expected to provide strong evidence for the need to develop a clinical practice guideline in Thailand.

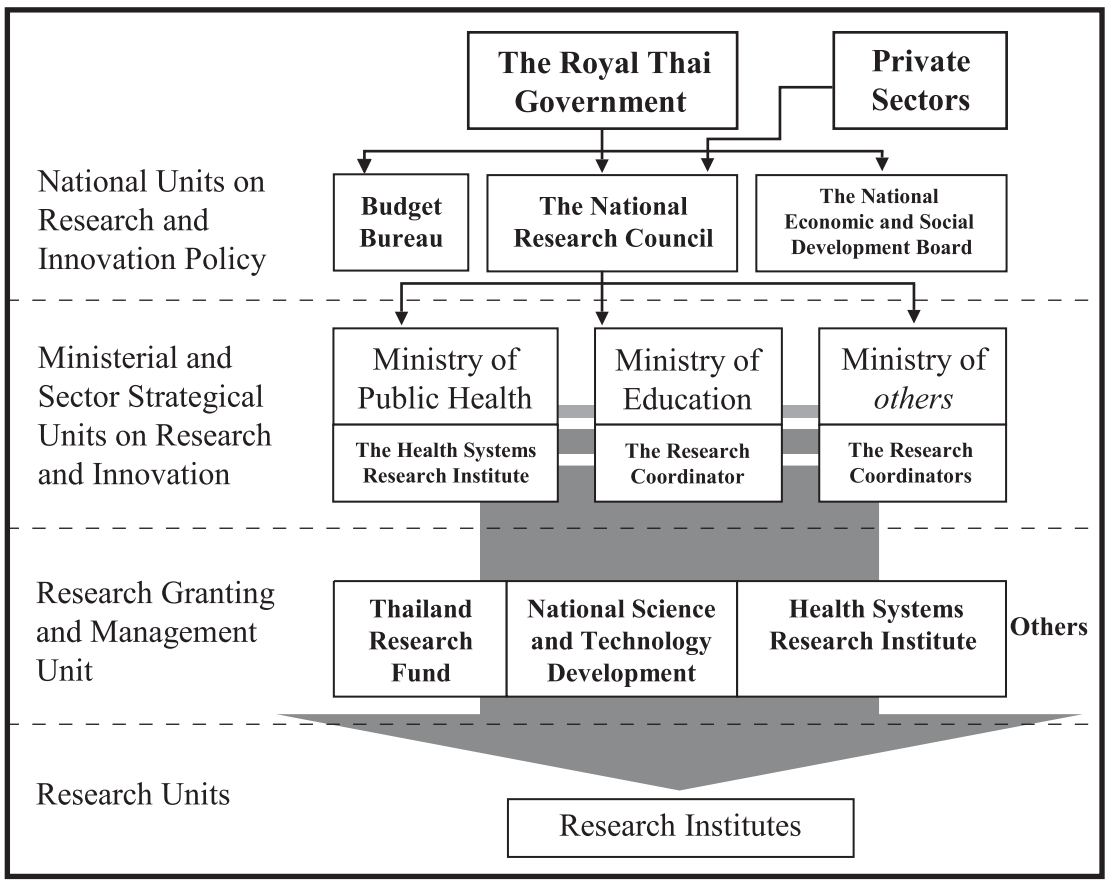
Since Thailand's research community has been seriously concerned about the researchers' initiatives, breakthrough thinking that may provide an advancement opportunity in the scientific arena may be ignored in this top-down approach. This trend tends to suppress the creative and proactive efforts of brilliant researchers. To rectify this, a research fund for projects proposed by researchers should be set up. Also, the forum for management of research policy and strategy and thematic research needs to employ the top researchers and strongly justify the reasoning behind any project. This is essential in getting researchers of science to provide productive support to the country's academic environment.

At the National Health Assembly in 2003, the grassroots communities as well as local governments were called upon to participate more in area-based research as way for the average person to better understand and utilize the guidance offered.

(2) Thailand's Agenda toward the National Research System

The move on the political front by the Royal Thai Government to establish a national research policy was the second most influential change in the reform system process. This began in 2001 when the Thailand Research Fund (TRF), the largest

Framwork of Thailand's research system



research granting agency in the country, was contracted to do a study on the system. A framework for the national research system culminated from the review. On December 17, 2002, the ministerial cabinet endorsed the fiscal and managerial framework of the national research system entitled the "Policy for National Research and Innovation". The RTG instructed all government sectors to redress their organization's research management.

As part of the reform of the financing structure of the research system, the Ministry of Public Health (MOPH) has entrusted the HSRI with the role of being the ministerial unit for research and innovation. The unit's main function was to coordinate research among the MOPH's departments and then consolidate the results into packages based on fields relevant to the government's health and research policy. The assignment was a rush task, delegated in February 2002 and required to be ready for submission to the Budget Bureau a month later. Consequently the fiscal plan 2003 has not been integrated into the overall ministerial research plan. This mandate, however, has helped facilitate the HSRI's task of collecting the health research requests from every department. The Health Research Committee chaired by the permanent secretariat for public health was appointed the role to coordinate and consolidate the research plan into an integrated research program. The HSRI's director has served as secretariat of the committee.

6.5.1 Commitment to Health Research System

The draft of the National Health Act states that the country's health research system is an integral part of the health system. The NHSRC has proposed that the health research system serve as the "brain" of the health system. The research process, as a guiding factor for health system reform, has also instilled in academics and researchers from every university in the country, the necessity of the health research system. Currently, there are six affiliated centers for health systems research set up by universities that cover every region of the country. This reflects the academic concern and commitment to work in partnerships in matters related to the national health research system.

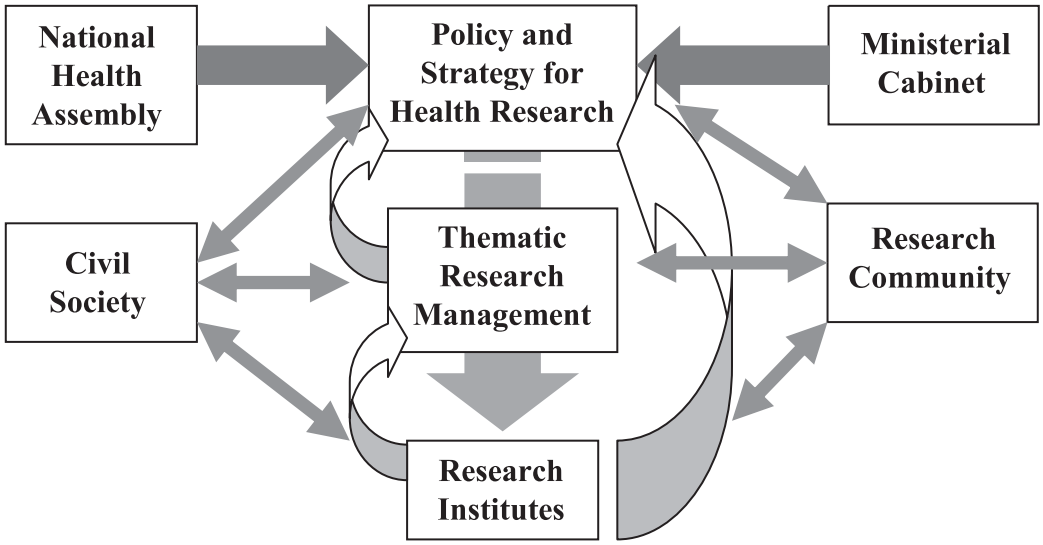
Some health research schemes have let activists in communities conduct their own community research. For instance, the consortium for the health impact assessment recruited citizens, who were affected by the construction of Pak-Moon dam in the northeastern province, to conduct a study on the fishery livelihood in the river after the dam gate was opened. The project ended up being a creative tool which enabled citizens to debate with technocrats and government officers. Another example is the case of people in the eastern seaboard who were given a mandate to conduct a study of suffering afflicted on their community due to air and water pollution caused by the recent establishment of an industrial estate. This led to peaceful negotiations over measures to protect the people from pollutants and compensation. These are examples of learning through action for the grassroots community and how research can help serve in the goal of sustaining a healthy life.

The reorientation of the ministerial health research system needs to account for an expanding research community.

6.5.2 Strategic Map of the Health Research System

The structural design of the health research system has already been laid out. However capacity building among relevant policymakers, administrative staff, research administrators, researchers and a broad array of parties effected by the system needs to take place under the realistic conditions for financing research set in 2003.

Research mapping of health research system after national research system reform



Even research themes and topics proposed by the Ministry of Public Health need input from researchers in other sectors as the research community, which conduct health related research, may have expertise that is complementary. For example, some basic research is handled by the Ministry of Science and Technology such as molecular biology, genetic engineer, nanotechnology etc. or the agricultural research may contribute to the production of herbal plants so that the research in herbal medicine will be systematically integrated with other research projects.

Some non-profit organizations and the national and provincial health assembly have contributed to health research, primarily in the form of operational research and action research, which involved these groups. They may also be involved in the health research system from the process of policy and planning through the thematic management or even through the participation with research institutes.

According to government policy, the Budget Bureau would initially finance the research. However, the users of the research results should participate in the research process from the beginning and later help fund it.

6.5.3 Ongoing Plan of Study in Health Research System

Alliances to design and construct new structural functions have been categorized into three main dimensions:

a) The research policy alliance will group together policymakers in all sectors to create a multidisciplinary research spirit. This will create a firm foundation for formulating the role of policy management for the health research system. Members will consist of policymakers in principal health-related sectors, executives of existing research funding agencies and executives of university research institutes. A process for policy development within the national health research system will be an essential outcome of their work.

b) Thematic research management groups will oversee the research issues that are deemed as vital for the health system. The fundamental research coordination being used on a trial basis for learning the process of research management are as follows:

- Clinical Research Coordination Network (CRCN)
- HIV/AIDS Research
- Prospective Cohort Studies of Thai Children
- Area-based Research Network
- Center for Health Equity Monitoring .

c) Health research institute management was set up as a network of research institutes which are to evaluate the roles and functions of the research units in universities and other organizations. Its aim is to build a network of researchers, increase research capacity and strengthen the research institute's ability to meet the expected demands of the health system in the future.

Through effective networking and identification of specific roles and functions, these health research alliances will eventually integrate their efforts to become the foundation of Thailand's health research system.

6.6) Research Schemes for Health Information System

The health information system has been the main provider of diagnostic evidence of hidden problems that undermine the health system. According to the National Health Act, the information system is viewed as an intelligent mechanism to monitor, control and direct the policy and strategy of the health system. The intelligence gained from the analysis and the gathering of information would be used as a powerful tool in steering the ongoing reform process.

The networks studying health information have expanded to cover academics from many different fields, such as epidemiologist, demographic researchers, statisticians, economists, computer scientists and sociologists. As well, the source of demand in health information has shifted from academic and policymakers' interests to taking in account interests of the common citizen. Telecommunication and computer technology has drastically changed the means and channels for communicating the information throughout the country. To date, over 95% of the villages in Thailand have radio and television receivers and have access to telephones and the Internet. Even though the dissemination of health information and knowledge has broadly covered most of population, there are still wide differences in the level of perceiving and understanding it.

6.6.1 Commitment to Health Information System

Two principles were applied in developing the health information system. Firstly, the constitution of 1997 set that public service be transparent and accessible to the general population. Secondly, the draft of the National Health Act emphasizes that the health information system should seek active participation from all levels of health policymakers and health care providers as well as the general public. This policy should help in overcoming three main constraints currently plaguing the undertaking.

First of all, the advancement in information technology makes it necessary that a new line of scientists work on this mission. With globalization and computer technology behind the rapid development of cyberspace, the communication of health related information has shifted. Health professionals and academics will never be able to adequately accumulate all of the knowledge to meet the requests of the diverse users. So, the novel architecture of the information services must be constructed and installed to be compatible with the emerging demands and also to be in synch with evolving information technology.

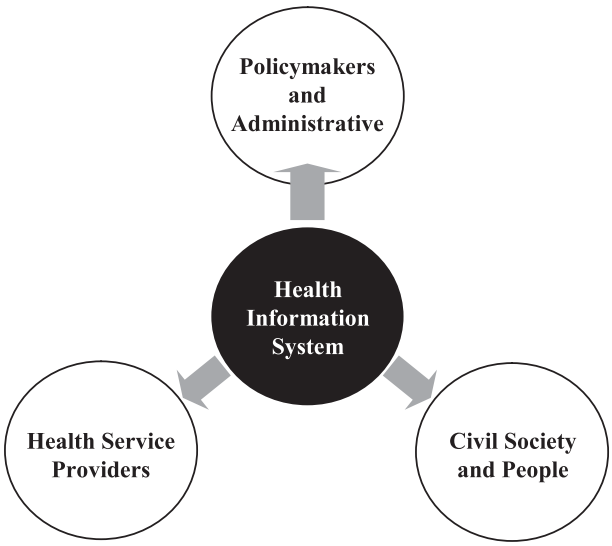
Secondly, new demands in public sector reform calls for management to be more focused on strategy with the funding of the system based on results instead of execution of authorized health services and logistic support. The performance indicators will be based on outcome and the policy's impact rather than the input activities and the immediate results. The mandate in the constitution of equity and transparency as good governance of the health system must be reflected in all areas of the new information system.

Thirdly, audit requirements are required for all health financing schemes in order to make health care providers accountable to the purchasing agents and their clients. A large amount of researchers from varying fields such as clinical science, computer science, system analysis, and pharmacy needs to be recruited to develop the framework for the system. Of note, the information systems must be flexible enough to be able to adapt to the constant changes in health care technology while at the same time be able to effectively carry out its main duties of maintaining costs, providing efficient care and being accessible to all members of society.

6.6.2 Strategic Map in Health Information System

The information system has been categorized into three principal areas for research and alliances. The first area is the information for policymakers and administrative staff in different levels. Particularly, with political reform and decentralization being an ongoing progress, the information must be used for decision making and evaluative purposes with regard to policy implementation. The users of the system are in the central health related system, provincial health authority, and local government.

Research mapping of health information system



The health service providers demand that the system accommodate feedback information for assessments of their achievement in terms of quality, equity and efficiency of care. The constitutional mandate and government policy to ensure the accessibility of essential health care is a driving force behind the construction of the health service information system. The collective purchaser mechanisms have invested in the HSRI's program to feed the processed intelligence as a financing control system. At the same time, hospitals can be evaluated in terms of the effectiveness and efficiency of the services provided. The system also is able to segregate macroeconomic intelligence data to make clear that the health service is equitable.

As we are now well entrenched in the information era, people need to weed through a mass amount of information offered on a growing amount of channels to find what is relevant and take stock in it as way to achieve a proper lifestyle toward living a healthy life.

6.6.3 Research in Health Information System

The HSRI has supported three major research schemes to strengthen the health information system.

a) Information system to guide the policy and strategy for health at all levels

b) Information system for a health care that is efficient, equitable and of good quality

c) Information system that serves the general public by providing a guideline for a healthy life

All of these schemes were implemented through the joint work efforts of a diverse group of researchers. Financial support for the information research for the policy and strategic dimension has come from the Ministry of Public Health and the Thai Health Promotion Foundation. The latter, set up upon the suggestion of the HSRI in 2000, is in charge of allocating the proceeds of the 2 % sin tax on alcohol and tobacco consumption. The information system serving health care was funded by the Ministry of Finance and the National Health Security Office, a newly established agency as part of the health system reform process which is directed to put into motion toward the universal coverage of health care.

6.7) Research Schemes to Strengthen the Rights of Health Consumers

The huge rise in the consumption of health products and health services is the result of the growing trend toward good health and beauty. Globalization and new technology has led to a plethora of health products and services that in turn has played on the unrelenting consumerism in Thai society. Rampant amounts of false advertisements for health-related goods have misguided people into over consuming some products or services.

Previously, consumer protection was handled by government sectors, which were believed to be technically competent and equipped with legal and regulatory resources for enforcement purposes. However, these sectors are now overwhelmed due to the expansion of the free marketing public policy which fostered the promotion of products and services in more seductive ways though complex communication channels.

Strengthening consumer rights as a civic virtue has emerged in recent decades but little work has been done in the area of consumer protection. An increasing number of civil organizations responsible for consumer rights at the national level have been set up and drives to educate the consumer at the community level have also been undertaken. The activities included legislation advocacy, investigative roles, serving as watchdogs, promoting appropriate consumption levels, capacity building at grassroots organizations to monitor for defected products and services and handling consumer grievances for future litigation. These groups have tended to work independently instead of jointly despite their common interests. Therefore, research to come up with a model for a consumer protection task force at the community level needs to be done.

6.7.1 Commitment to Health Consumer Empowerment

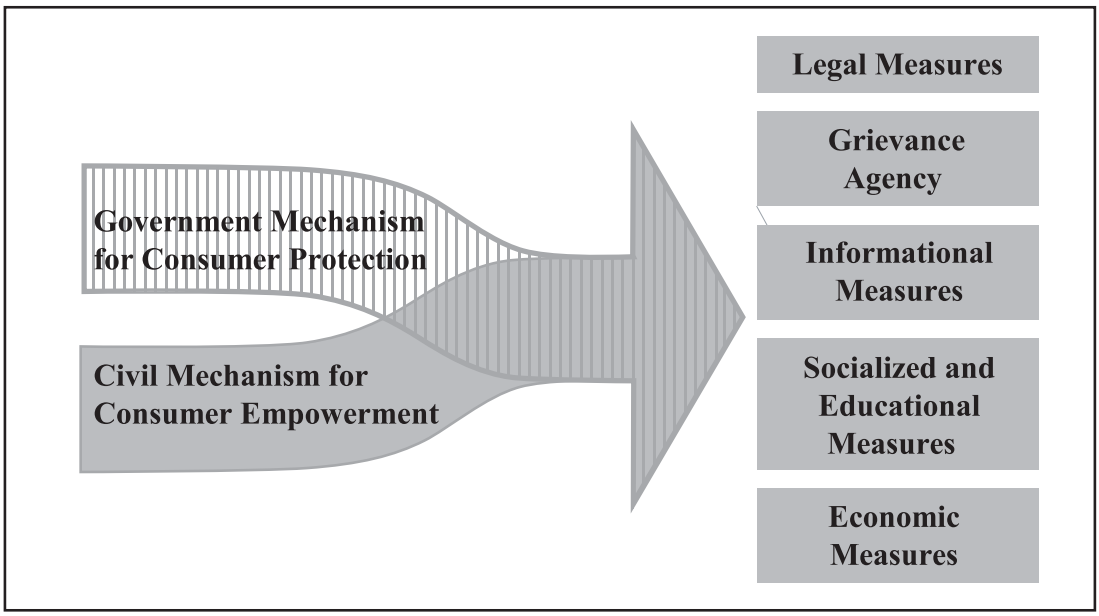
Article 59 of the constitution states that consumer protection against deceptive advertising of health products and services is a basic right. This has led to the formation of civil organizations in each community. Their main duty is to verify information from service providers or goods traders. The civil groups may expand their role to providing support for the consumption of healthy products.

However, the law which would facilitate this civic mission has not been enacted yet. The government and civil society are now working on the legal framework for this mandate. Despite legal pitfalls, the process of health system reform has enlisted consumer activists from every province to share their experiences and help put in use the right kind of technology for the each community.

6.7.2 Strategic Map for Health Consumer Empowerment

Both the government authority and civil organizations have contributed to the development of the framework for the management of research in the area of consumer protection. Consequently, members of the academic community and researchers may also serve as intermediaries over some discordant issues with key stakeholders. As well, participation from all key players is required in the designing of the framework.

Research mapping of health consumer empowerment



There are five keys areas that must be considered in the development of a system that will actively serve the consumer. Legal measures must be set up in a way that the government and civil groups can easily seek recourse for misdeeds and a grievance board and guidance for using the legal system also needs to be established. These measures are especially important at the community level. Ensuring that information on health products and services is efficiently disseminated to the general public for the reasons of safety and protection are essential. A study of the database and information flow for this purpose is now in a preliminary stage. Social- and education- related measures have been set up in different areas of the country. It is critical that a process be developed where activists work together and share their experiences and expertise and then pass them on to researchers. Finally, economic measures need to be promoted through academic work by pushing for a policy that protects the consumer.

6.7.3 Research in Health Consumer Protection

Researchers will work with consumer groups on developing ways to get consumers to use health products and services efficiently. They will support community volunteers in creating and sustaining models for non-government organizations that deal with consumer protection issues as mandated in the constitution. Communities will be equipped with appropriate information systems which will give them access to up-to-date information about the possible adverse side effects coming from new products.

The strategic research alliances consist of multidisciplinary professionals. They need to be nurtured in a way that will be able to take on the responsibility of continuously monitoring and managing changes in the ongoing health system reform. Therefore, selected essential reform alliances have been established through contractual agreements along with commissioned research to formulate critical solutions for the visionary health system. Facilitation of the research alliances is vital for success in implementing Thailand's new health system. Since, this is the only way to allow the knowledge generated among those policymakers, administrative and member of civil society to interplay and exchange with acadamics and researchers. Thus, application and utilization of evolving knowledge in transitional management of health system reform will turn into pragmatic action.

7) Conclusion

Thailand's health system has made great strides in the last century. Health care development was heavily pushed and investments were made to expand services to cover most areas of the country. However, the overall status of the general public's health took a step backward in the last decade due to an imbalance in the economic development of the country. Also, escalation in health costs had increasingly burdened the country and the new constitution called for an equitable health system, a goal which would be very difficult to achieve under the current health system.

The challenge of setting up a new health system was officially launched in 2000. It marked a systematic reform process, which applies the use of research management to serve as a learning vehicle for both policymakers and stakeholders to join the monumental change. The National Health System Reform Committee (NHSRC) had planned to use the drafting process of the National Health Act as powerful political leverage in driving the revolutionary mission, which has already accomplished two principal objectives. First of all, the research has become a significant influencing factor in the civil process within a timeframe of three years. Thai society is now looking at health determinants, health context, and the profile of the health system. This would be a firm model from which to expand the system. Secondly, the shifted paradigm of the health and health system has spurred academics within the reform alliance to come up with the framework for building a practical system. The alliance aims to use research as the main tool in the process of reforming the evidence-based health system.

The health policy and system research have been utilized as a creative devise to support the process of the health system reform. The collaboration among the policy and implementation sectors, the broad array of people directly affected by the health system and the communities of researchers have come up with many key features for use in the reform process.

7.1) Initiative Role in the Health System Reform

The health policy and system research has not just galvanized the health system reform process, but it has also played an innovative role of getting research management to sustain the interactive and creative power between the knowledge generation and policy process. This has brought the ever-fragmented process - policy implementation and research mission - to complement each other and work constructively in the areas of problem identification, determinant verification, policy decision, strategic management and implementation.

7.2) Developing a Role for the Community

The civil network and communal activists have participated in the health reform process by contributing their expertise. This has averted their alienation to research methodology and given them exposure to the process of learning through research. The activists are now more at ease about sharing their experiences and evidence-based knowledge in forums related to the policy process. Provincial Health Assembly and National Health Assembly have served as new venues for peaceful and constructive debates about a healthy public policy. The research culture is now deeply rooted in the democratic society.

7.3) Cohesive Role for Multi-disciplined Research Teams

The Royal Thai Government's strong commitment to the health system reform has led to the enthusiastic involvement of a diverse group of researchers to literally work together as a team to contribute to the effort. The multi-disciplined research teams are currently undertaking the complex research tasks needed to carry on the drive for a radical change in Thailand's health system.

7.4) Research Management to Align Health Research Alliances

The research management has become a key process in facilitating the collaboration among researchers and the research users. The collateral utilization of each study has to be anticipated by all parties involved from the beginning through to setting the framework for the research and the implementation. The research manager has to ensure that resources are available and that there are enough funds to cover the project. The availability of the resources for research throughout the project enables users to take ownership of the study. With the clear role of research management emerging, the research community has undertaken the role as the cornerstone for the complex and long-lasting research.

7.5) Strategic Roadmap for Ongoing Reform

The hard work done in the last three years toward achieving the goal of reforming the health system will serve as a gateway for the process over the next few decades. Thus, the draft of the National Health Act has become the desired roadmap for Thailand in its effort to achieve a healthy life for all of its citizens. Total involvement has moved from just a narrow framework in the health sector to encompass whole sectors which are involved in aspects regarding the health of the general public. The framework of the system is not completed yet but Thais now can get a general idea of what is to come based on the blueprint.

7.6) Research Mapping as Guidance for Complex Research Schemes

The researchers have become a critical partnership in the transitional management of developing the framework of the health system. It is necessary to lay out a research plan that is agreeable to other related parties, particularly, where the requisition of resources and technology are the basis of the research tasks. The research mapping would include the expected return of the research within a specified timeframe, state of the arts and necessary technology for research, availability of capable researchers and the required budget. This will enable the policymakers and stakeholders to invest funds in the projects accordingly.

7.7) Experiences and Lesson Learnt for International Sharing

The ongoing health system reform process has provided insight for revolutionary change as well as for the transitional role and infrastructure of the process. The researchers, policymakers, government officers, civil activists and those from the business sector have mutually gained experience and knowledge from the valuable learning process applied over the last three years. Further investments must be made to share the lessons learnt with global academics and public health practitioners so that it will be of benefit for international health-related agencies. Since health reform in any country has to be supported through a learning process, the understanding of one's own social and cultural context serves as a critical framework for revolutionary change rather than a fashionable change with generic recommendations.

The process so far has proven that research can effectively address the needs and demands of the health system but that health policy and system research, as integral parts of health systems, must do more. To respond to rapid changes in the society and political circumstances, research must not exist in isolation. All other parties involved must recognize it as a key factor for health systems. Thus, management of the research process has been found to play a vital role in ensuring that scientific knowledge and societal involvement are combined into a powerful vision for health system reform.

Health system reform needs a holistic approach at all levels of a country and a have the unified support of all stakeholders. Clear and firm leadership from the government has proven to be an essential element in ensuring that the process goes forward. As well, the setting of a stable political environment opens up the opportunity to apply research and manage the changes in accordance with real societal demands. Health policy and system research encompasses the entire spectrum of the knowledge management - coordinating research, empowering stakeholders, encouraging policymakers to be involved in the change process and publishing research results in layman's terms. Therefore, the grouping of all parties involved in the reform process into a collaborative network serves as the foundation for the research management.

Health research management involves having researchers and institutes join multi-disciplinary networks in order to undertake the enlightened complex mission of reforming the health system. But without a promising and committed policy, the reform cannot be accomplished. This affirms the fact that most academics would prefer to contribute their insightful work to benefit society a whole rather than just solely publishing manuscripts. Coordination of researchers from different disciplines requires developing mutual understanding of the issues, analyzing situations collectively and coming up with alternative options and policies. Finding researchers who are willing to focus their efforts on a common issue in the health system and work as a team is very time-consuming. A committed financing plan for a reasonable amount of time which is under a flexible contract and allows the research teams to handle the project with dynamism is required. All of this makes it obligatory that the research users and stakeholders work together and deeply realize that research applications are behind the development of a pragmatic and efficient policy.

Annex

THE DRAFT LAW ON NATIONAL HEALTH AS A THAIS' HEALTH CONSTITUTION (REVISED EDITION: SEPTEMBER 24, 2002)

NATIONAL HEALTH SYSTEM REFORM COMMITTEE

Foreword

An Act is, in general, presumed to be the general law provided to enforce upon the public by the State without public participation in its legislation; however, the "National Health Act" or "Thais' Health Constitution" is not a general law and not even the public health law. It is required to be the public law which is the health constitution of Thai society for stipulating the directions, the philosophy, the principles, the tools / mechanisms, the measures and the prime conditions of health systems.

This Law on National Health is drafted for being the typical law on health, which may be called "Building Before Repairing" health constitution is not enacted by the Government as a tool for the administration of the country, but such law is the public law of the people, by the people and for the people. The knowledge is promoted alongside with learning by sharing in the process of drafting this Law. The exchange of public opinions and recommendations has broadly been made throughout the process.

At present, the draft Law on National Health has been completed with the embroided process of wisdom and intellectual forces of all social sectors. The people concerned have put the great efforts in working together with the spirits of hardships and comforts share and not to abandon each other. From now on, Thai people could, therefore, utilize it as a tool in building "well-being" for All.

Acknowledgements

This draft Law on National Health have been completed with the jointly independent and creative collaboration from all social sectors.

The National Health System Reform Office would like to express the appreciation for the National Health System Reform Committee, chaired by the Prime Minister, of which functions are to be the interconnected mechanisms at the national level. The Committee manages through four Sub-Committees, i.e. the Technical Sub-Committee, chaired by Prof. Dr. Kasem Watanachai; the Social Collaboration Sub-Committee, chaired by Prof. Dr. Prawase Wasi; the Public Medias Sub-Committee, chaired by the Minister to the Prime Minister's Office and the Sub-Committee on Drafting the National Health Law, chaired by Dr. Pirot Ningsanon. Many thanks are also given to the Working Group on Drafting the National Health Law.

It is most grateful to Dr. Tanomwong Lamyodmakpol (Ph.D), Chairman, the Association of Translators and Interpreters, and Mrs. Nantavan Petchwathana for translating this draft Law; and to Prof. Dr. Vithoon Eungprabhanth and Ms. Suttikarn Chunsuttiwat for checking the accuracy of substantial issues and the terminology.

Finally, the National Health System Reform Office would also like to thank all of those who take part in preparing this draft Law, yet their names cannot entirely be mentioned herein.

Introduction
(in the first revision)

By the linkage among the forces of academic, people and political sectors, in accordance with the Triangle that Moves the Mountain Strategy for creating the complicated but good deeds, the social movement was embroidered in consequence (under the management of the Prime Minister's Office Regulation on National Health System Reform, B.E. 2543) until the draft Law on **National Health** or **the draft Law on Building Before Repairing** was attained as the current **"Thais' Health Constitution"**.

Various fields of technical knowledge were strongly built up by the wisdom-based energetic synthesis.

More than 1,000 forums were opened, during the years 2000-2001, for public hearing and recommendations from various groups of people: laymen; academicians; professionals; officials; politicians; the disabled; farmers; local intellectuals; the women, children and youths network; network for the poor, mass media, volunteers and private bodies, etc. The networks, agencies, organizations and over 2,000 civil societies, a total of more than 100,000 participants attended therein.

The national health assembly demonstration forums were opened, during September 1-5, 2001, in the health fair. A total of over 5,000 representatives from the agencies, organizations and various civil societies expressed their opinions; and over 150,000 persons joined the health fair activities.

A number of over 550 forums was opened, at the beginning of the year 2002, for a second-round additional public hearing at district level countrywide; a total of almost half of 100,000 participants attended the forums.

The provincial health assembly forums were opened, during May-July, 2002 in all provinces nationwide, approximately 50,000 participants attended the forums.

The 2002 national health assembly forum was opened during August 8-9, 2002, a number of 4,000 participants from over 3,000 civil societies nationwide attended and expressed their opinions therein, and the channels for public hearing were done through various public medias.

The conceptual framework of the academic-based idealistic national health systems, was compiled with the viewpoints collected from one to two, three, four and so on, and formed into collective ideas. Such ideas became the draft of substantial issues of the national health systems and the draft Law on National Health or the draft Law on Building Before Repairing which is regarded as the Thais' Health Constitution. Today, **eventhough it has not yet been the most-complete final constitution because there will be an adjustment in the administrative and legislative procedures,** it takes into account that the preparation of the constitution or the draft of introductory law has been broadly participated by the people.

The whole process has been carried on to make an actual **Health Constitution of Thais, by Thais and for Thais.**

Days to come, whether the draft Law on National Health could irrespectively pass the legislative procedure, whether it will become as the original, or, more or less amended; that is all the future and the process of which all social sectors still have duties to supervise, push for and share their responsibilities.

But today, the Thai people sectors have agreed upon the substantial principles of the draft Law on National Health as **"Thais' Health Constitution,"** so that it could be utilized as a tool for formulating the directive principles, directions, strategies, measures and guidelines for the continuing enthusiastic establishment of health or healthy condition of Thai people and Thai society.

National Health System Reform Partnership
September 24, 2002

National Health Act:
Thais' Health Constitution

- The scope of health concept is expanded to reach a state of interrelated and complete well-being in all aspects: the physical, mental, social and intellectual dimensions, not just the matter of diseases and its treatment.
- The health systems are complex and interconnected with the social systems and the way of life. The systems belong to everyone in the society, not monopolized by any particular sector.
- Healthiness is the national ideology. All development directions must therefore consider the state of complete well-being, not the money, as an ultimate goal.
- The health systems must focus on the building before repairing concept with the adequacy suffifficiency base.
- The health systems must respect the human dignity and human value which are the basic moral of the society.
- The State shall follow the policies implemented in line with the Constitution, to establish the health status to all Thai people and Thai society, not for the benefits of any specific group.
- Anything that benefits on health status or so-called health security must be promoted, protected, nurtured to maintain and highly developed. Anything that threatens and is harmful to health status must be carefully rectified for the sake of the people's and society's healthiness.
- The health systems must have the concrete mechanisms that open the space for people to be informed, to consider, to take actions, to push, to follow and to inspect in all aspects and at all levels; directing all sectors to be aware of the intersectoral responsibility for health systems, in accordance with the intention of the Constitution, B.E. 2540 that bases on the participatory democracy. The forums of the area-pecific health assembly, the issue-specific health assembly, the national health assembly and the National Health Committee, as well as many more measures and guidelines, will serve as tools for the realistic and dynamic participation of all sectors.
- The subsystems of the main health systems are considered complete. However, the continual development and improvement must be implemented through a participatory mechanism with knowledge based working, merging with the friendly opinions from all sectors, for the establishment of common health status.

Contents

The draft Law on National Health B.E. .....

Memorandum on Principles and Reasons

Constituting the Draft Law on National Health
B.E. .....

Principles

The National Health Law shall be provided.

Reasons

Whereas, in the past, the health systems have mostly intended as the curative service. It required high cost with low results on health, and with uncontrollable expense. In the meantime the diseases and the health threatening factors were rapidly and complicatedly changing. The usual systems, modes and body of knowledge were unable to solve the problems. To conform with the Constitution of the Kingdom of Thailand, B.E.2540 which provided that a person should have the rights and freedom, in terms of health, to receive the standard, sufficient and efficient public health service, the local administrative authorities and the public should participate in such promotion. Any action that enhances healthiness shall be protected. Therefore, the health constitution should be provided for stipulating the principles, the directions, the measures, the tools, and the prime conditions of health systems which could strengthen the health and solve the health problems in accordance with the continually changing problems. In addition, the Prime Minister's Office Regulation on National Health System Reform, B.E.2543 Clause 8 (3) shall stipulate the appointment of the National Health System Reform Committee, of which duty is to draft the National Health Law. This assignment shall be effective within a period of three years, as from the first day of the board meeting (August 9, 2000), this Act is, therefore, required to be enacted.

The draft Law on National Health

B.E. .....

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As of the National Health Law should be provided.

This Act has some provisions on the restriction of rights and freedom of a person which Section 29 including Section 50 of the Constitution of the Kingdom of Thailand shall permit by virtue of provisions of the law.

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Section 1 This Act shall be "The National Health Act, B.E....."

Section 2 This Act shall come into force after the date of its publication in the Goverment Gazette.

Section 3 In this Act

"Health" means the complete health status holistically interrelated in the physical, mental, social and intellectual balances.*

"Health systems" means all of the interconnected management that enhance healthiness and factors relevant to health aspects, such as: individual

factors; the environments in terms of physical and biological factors; economic, social, political, educational, legal, religious, cultural and traditional factors; scientific and technology factors; as well as the factors on public health and public health service.

"Health service" means the services with the objectives on health development, including the public health service.

"Public health service" means the management for health promotion service; the prevention and control over the health threatening factors; the diagnosis and treatment for illness conditions; and the rehabilitation of persons, families and communities.

"Health check-up" means the process of searching for the causes and risk factors that may threaten health, in order to reach the enviro-behavioral improvement and other fostering factors conducive to health.

"Health promotion" means any act that intends to promote and support the personal behaviors and the socio environmental conditions in order to build health status and good quality of life for persons, families and communities.

"Healthy public policy" means the progressive guideline that intends to establish the socio-physical environment facilitating to health and enabling people to approach the choices conducive to health.

* The joint conclusion is in process for any of the most communicable and understandable words, i.e. in wisdom dimension, in religious approaches, or else.

"Health threatening factors means various things harmful to health.

"Health security" means the provision of coverage insurance and protection for sustainable health status.

"Local wisdom on health" means the body of knowledge, concepts, beliefs and expertise in health care accumulated from the exercises in life experiences, and passed on to the society and culture of the group of people, i.e. traditional health care, traditional food, traditional medical wisdom and Thai traditional medical care.

"Traditional medical wisdom" means that people in the community utilize traditional health care among each other until it has become a part of their way of life. Such concept concerns with the beliefs, rites, cultures, customs and different resources in each locality, and is acceptable by those communities.

"Thai traditional medical care" means the health care drawn from Thai traditional medical wisdom which has been conserved and developed up to the present, including the applied Thai traditional medical care

"Health personnel" means the health professionals and other persons who provide public health service.

"Collective financing" means the financing of which people participate according to their financial ability in line with a principle of hardships and comforts share. The fund collected in advance shall be utilized for necessary public health service and survival of everyone.

"Health assembly" means the sitting process which all sectors could intellectually and harmoniously participate and exchange their knowledge and experiences, through a systematic and participatory management, to reach the state of well-being.

"Committee member" means the members of the National Health Committee.

"Selection committee" means the committee for selecting members of the National Health Committee.

"Secretary-General" means the Secretary-General of the National Health Committee.

"Office" means the National Health Committee Office.

"Executive member" means the executive member of the National Health Committee Office.

"Minister" means the Minister who is in charge of the execution of this Act.

Section 4 The Prime Minister and the Minister of the Ministry of Public Health shall be in charge of the execution of this Act, and shall have the authorities to issue the ministerial orders, regulations and notifications for the asexecution of this Act.

Those ministerial orders, regulations and notifications shall come into force after the date of its publication in the Government Gazette.

Chapter 1
Aims and Principles

Section 5 Healthiness is the human dignity in accordance with the provision of the Constitution.

Section 6 Healthiness is the ultimate goal of the community and the society. It is the national ideology and the coverage insurance of security.

Section 7 The health systems should aim atcreating health for all, and all sectoral participation should be enhanced therein for health promotion with the continual potential building process of persons, families, communities and socio-environmental conditions for reciprocal benefits of living together.

The health systems under paragraph one must be desirable as follows:-

(1) consisting of morals, virtue and ethics.

(2) respecting the human right, human value and dignity, and leading to equality.

(3) comprising of a complete structure, and working together by integration.

(4) consisting of quality and efficiency, cost containment and accountability, and sharing responsibility in harmony.

(5) comprising of wisdom background, being able to learn and develop continually in conformity with the way of life and the society, as well as the appropriately sustainable self-reliance.

Chapter 2
Rights, Duties and Security on Health

Part 1
Rights to Health

Section 8 A person shall have the right to survive in the environment and the environmental conditions beneficial to health.

A person shall have the right to participate with the State and the community in generating an adequate environment and the environmental conditions which are appropriate, balance, safe, quality and meet the standard for continuous normal living in good health with good quality of life.

Section 9 The health of women that means the sexual health and the women's health of reproductive system, which are specific, complex, and influential to the women's health through their lives, must be strengthened and protected consistently and appropriately.

The health of the children, the disabled, the elderly, the underprivileged in the society, and the groups of people with specific health characteristics must also be strengthened and protected consistently and appropriately.

Section 10 A person shall have the right to be protected in keeping secret of his/her health personal information.

The disclosure of such information under paragraph one is prohibited, except receiving permission from the information owner, or as provided by law of that act .

Section 11 A person shall have the right to exercise religious precepts or to worship in accordance with his/her belief, but not threatening the health of the others or the public.

Section 12 A person shall have the right to unite and manage the health service for sustainable self-reliance in the community.

Section 13 A person shall have an equal right to receive the public health service without unjust discrimination on the grounds of difference in his/her origin, race, language, gender, age, health condition, personal status, economic or social standing, religious belief, education, training or political attitude.

A person shall have the right to receive the safe, quality, standard and efficient public health service.

Section 14 A person shall have an equal right to receive, from the State, an adequate public health service that is essential to his/her health and survival.

The poor shall have the right to receive, from the State, free public health service that is essential to their health and survival.

A person shall have the right to receive, from the State, without charge, a prompt prevention and eradication against the health threatening factors that are seriously hazardous.

A person of over sixty years of age, a underprivileged, a disabled and a person who should be helped by the society shall have the right to receive the health welfare from the State.

The right under paragraphs two, three and four shall be in compliance with the law provided.

A person shall have the right to receive the health check-up in an appropriate time, by the useful means which enhance his/her health in accordance with rules, procedures and conditions promulgated by the Minister.

Section 15 The children, youths and family members shall have the right to be protected against violence and health threatening treatment.

Section 16 A person shall have the right to be protected in health products consumption and to receive the safe, quality and standard public health service; to receive the accurate and adequate information; and shall have a freedom to choose and to use health products and public health service. The State should give and create the opportunities for the consumers to choose the health products and the public health service of the same category or those with varieties in the same group.

The right to be protected under paragraph one, shall be provided with the quality assurance system; the service provision and distribution control system; the equity in making contracts on health consumption; as well as having the right to claim for the damage compensation when suffered by the act or the negligence that is hazardous or threatening his/her health.

Section 17 A person shall have the right to be informed and get access to an accurate and adequate data/information on health from the radio, television and other public medias.

Section 18 A person shall have the right to receive, from the health personnel or the health care unit, an accurate, complete and adequate information on health for his/her dicision-making to receive or refuse any public health service, or to receive or refuse any specific category of the services, except the emergency assistance necessary for life-saving.

A person shall have the right to choose to consult on his/her health with an expert or health personnel rather than from his/her provider, as well as shall have the right to request for a change of provider and health care unit.

A person shall have the right to receive an accurate, complete and adequate information before making his/her decision to participate in or withdraw from being a subject in an experimental research processed by the health personnel.

Section 19 A person shall have the right to receive an urgent assistance from the health personnel immediately as needed in the case that such person is in a hazardous situation, regardless of whether he/she requests for such assistance or not.

Section 20 A person or group of persons shall have the right to be informed and get access to information possessed by the official units, State agencies, State enterprises, or local official authorities, other State sectors, or public sectors, which may affect his/her health and the community; all this as provided by law on that act.

Seciton 21 A person or group of persons shall have the right to request for the assessment of and the participation in the process of health impact assessment from the public policy.

A person or group of persons shall have the right to be informed of the information, explanation and reasons from the official units, State agencies, State enterprises, local administrative authorities, or other State sectors before the permission of any project or activity, which may affect the health of a person or the community is given, and shall have the right to express opinions on such matters.

Section 22 A person or group of persons shall have the right to participate in the decision-making process of the State officers in the administrative functions, in the case affecting or may affect health.

As provided by law, a person or group of persons shall have the right to sue the official units, State agencies, State enterprises, local administrative authorities or other State sectors to be responsible for the act or the negligence made by their officials, officers or employees, which has a harmful effect or threatens his/her health.

Section 23 A person shall have the right to be protected in terms of education, research and academic performance, as well as to improve the body of knowledge on health by means that does not infringe upon the others, and is not harmful to the public.

Section 24 A person shall have the right to express his/her intention to refuse any curative treatment held only for prolonging the death in final period of his/her life, so that such person could die in peace and with human dignity.

The expression of such intention under paragraph one shall be in accordance with the rules, procedures and conditions stimulated in the ministerial orders.

Part 2
Duties for Health

Section 25 A person, family and community shall enhance his/her own health and the community members, and must be responsible for his/her act that causes the health threatening factors.

A person, family, community and State shall be cooperatively conserve, revive and nurture the customs, traditions, local wisdom, natural resources, environment and environmental conditions beneficial to health.

The State shall support the people to participate, preserve, maintain and balancely utilize natural resources and biological diversity, and protect the environment quality in accordance with the sustainable development principle, as well as control and eradicate the health threatening factors.

The State shall carry out activities to create the opportunities, protect, and promote health for the people, and give the importance to healthy public policy. The State must also be responsible for the eradication of the health threatening factors caused by the public policy or by the performance of the State or other organizations.

To perform under paragraph one, there shall be a process of health impact assessment from the public policy, in order to prevent and control over the health threatening factors, and to carry out the health impact assessment from the public policy, with a close public participation in the whole process.

Section 28 The State shall support the organization of the system and the process of justice, the political development and the public participation in order to create beneficial impact on health promotion, as well as the decentralization of authorities to localities for the purpose of self-reliance in health promotion and in health service provision.

Section 29 The State shall protect and develop the children, youths and family members to be free from health threatening behaviors; and encourage and support the health development of persons, in order to build up strong family and strong community.

Section 30 The State shall provide and promote the health service provision and the public health service everywhere, with the same standard, safe, efficient and fair for everyone. The people could make their own choices. The supervision shall be made in compliance with the desirable health systems under Section 7.

Section 31 The State shall implement the fair distribution of incomes, organize an appropriate system of the holding and use of land, promote employment, protect the labour especially child and woman labour, develop the educational field and create the fair opportunities for education, improve the environmental conditions, dwellings and other factors, so that the people would have occupation, income and fundamental factors essential to their health and sustainable self-reliance survival.

Part 3
Health Security

Section 32 The State, local official authorities, community, family and a person shall cooperatively support and protect the health security, as well as rectify, reduce and eradicate the conditions harmful to health security.

Section 33 The health security shall at least cover these following aspects:-

(1) social security implies that the people maintain their happy lives; they have long life with quality, warm family, strong community, peaceful society, safety in their lives and properties; and they help and support each other without discrimination.

(2) economic security implies that the people have a secure occupation, sufficient income for survival with adequate fundamental factors for self-reliance. The gap between the rich and the poor shall be reduced as well.

(3) infrastructure security implies the appropriate education system, health service system, communication and transportation systems, public utilities system, mass telecommunication system, city planning system, energy system and other appropriate systems.

(4) security in resources and environments implies to having the conservation, development, protection, and nurturing of natural resources and environments in order to utilize together with merits and endurement.

(5) security in accessing and receiving the public health service essential to health and survival.

(6) political security implies the exercise of State authorities, the policy formulation, the country administration and the healthy public policy with the people participation on a fair, honest, transparent and accountable basis.

(7) justice security implies an efficient and rapid justice administration system for creating an equal justice for all.

(8) security in research and in applying the body of knowledge and technology on health implies the performance which does not affect the health of people, community and society. Such performance should be carried on ethically and be done for public benefits.

(9) security in beliefs, religions, traditions and cultures implies the respect for the difference in terms of right and freedom of a person and a local community on beliefs, religions traditions and cultures.

Chapter 3
National Health Committee

Section 34 There shall be the National Health Committee, abbreviated as "NHC". Such Committee includes:-

(1) the Prime Minister as Chairman of the Committee;

(2) six Ministers of the Ministries assigned by the Prime Minister as committee members;

(3) the Chairman of the National Economic and Social Council as committee member;

(4) the representatives of local administrative authorities who select among themselves to be four in number as committee members;

(5) the representatives of health professional organizations certified by law, who select among themselves to be five in number as committee members;

(6) the distinguished experts on the following aspects: religion, art and culture, education, community and environment development, public health, administration or law, mass medias, economics, specific target community development and local wisdom, who select among themselves to be six in number as committee members;

(7) the representatives of non-profit people sector organizations working upon health, and not registered as juristic persons, who select among themselves to be thirteen in number as committee members;

(8) the representatives of NGOs working upon health, and registered as juristic persons who select among themselves to be two in number as committee members. The Secretary-General shall be committee member and Secretary, and he/she shall appoint the officers of the Office, not more than two in number, as Assistant Secretary.

Section 35 The committee members under Section 34 (4) (5) (6) (7) and (8) shall have the qualifications, and shall not be under any prohibition as follows:-

(1) Thai nationality;

(2) not less than twenty years of age;

(3) not being a person of mental abnormality which is an obstacle to work;

(4) not addicted to drugs;

(5) not being a bankrupt;

(6) have never been fired, dismissed or removed from the official services, State agencies or State enterprises, or from private agencies, by an order or a final judgement of the Labour Court.

Section 36 A selection of committee members under Section 34 (4) (5) (6) (7) and (8) shall be proceeded as follows:-

(1) in a selection of committee members under Section 34 (4), the subdistrict administrative authorities, provincial administrative authorities, municipalities and the Bangkok Metropolitan Authority or similar local administrative authorities in different names shall select among themselves to be one in number in each group.

(2) in a selection of committee members under Section 34 (5), each of health professional organizations shall send one representative for selection, and all representatives of the mentioned organizations shall select among themselves to be five in number.

(3) in a selection of committee members under Section 34 (6), the Selection Committee shall prepare the name-lists of distinguished experts not more than five in each field, and they shall select among themselves to be six in number, provided that the selected persons shall be from the different name-lists. The proportion of distinguished experts from local regions should also be considered.

(4) in a selection of committee members under Section 34 (7), the Selection Committee shall prepare the classified category-lists of public sector organizations by the types of activities relevant to health. The organizations conducting the same category of activities, with an apparent achievement not less than one year, shall send their representatives to apply for selection among themselves to be one in number for one category. The organization's representatives in each category shall select among themselves one representative from one province. After that the representatives of each province shall select among themselves to be one in number from one area.

The areas shall be determined by the Selection Committee.

(5) in a selection of committee members under Section 34 (8), the Selection Committee shall prepare the classified category-lists of NGOs by the types of activities relevant to health. The NGOs conducting the same category of activities with an apparent achievement not less than one year, shall send their representatives to apply for selection among themselves to be two in number.

The selection of committee members under this Section shall also regard to the proportion of men and women.

Section 37 There shall be the Selectio Committee appointed by the NHC. Such Committee includes:-

(1) one of the committee members under Section 34 (5) or (6) or (7) or (8) as Chairman of the Selection Committee

(2) the representatives of the official units, health professional organizations, academicians, mass medias and public sector organizations relevant to health, provided that one representative from one group as members of the Selection Committee.

(3) the Secretary-General shall be Secretary of the Selection Committee.

Section 38 The Selection Committee shall have the following authorities and duties:-

(1) to formulate the rules and prodecures, as well as the regulations in selecting the committee members, and to proceed as mentioned in Section 36.

(2) to appoint the sub-committees to carry on the duties assigned by the Selection Committee.

Chapter 39 The committee members under Section 34 (4) (5) (6) (7) and (8) shall hold office for a term of four years, but shall not serve for more than two consecutive terms.

The committee members who vacate office upon the expiration of the term shall remain in office to perform their duties until the committee members to be selected on their behalf take office, but not longer than sixty days as from the date of the vacation of office upon the expiration of the term.

In the case that the committee members under paragraph one vacate office upon the expiration of the term, the selection for committee members of the same category shall be proceeded within sixty days.

In the case that the committee members under paragraph one vacate office prior to the expiration of the term, the selection for committee members of the same category shall be proceeded within sixty days as from the date of the vacancy of office of those committee members, and the selected persons shall serve only for the remainder of the term of the replaced committee members.

In the case that the term of committee members who vacate office prior to the expiration of the term remains less than ninety days, the selection for vacancy replacement may not be proceeded, and in such case the NHC shall consist of the remainders of the committee members.

Chapter 40 In addition to the vacation of office upon the expiration of term, the committee members under Section 34 (5) (6) (7) and (8) vacate office upon:-

(1) death;

(2) resignation;

(3) being a bankrupt;

(4) being an incompetent or quasi-incompetent;

(5) being sentenced to imprisonment by a final judgement, except for an offence committed through negligence or a petty offence;

(6) the NHC with not less than two-thirds of the total existing number of the committee members has the resolution to remove, due to his/her deficiency to duties, degenerate behaviors or lack of ability;

(7) being disqualified or being under any of the prohibitions under Section 35.

Section 41 At a sitting of the NHC, the presence of not less than one-half of the total number of the committee members is required to constitute a quorum.

The NHC Chairman shall be the Chairman of the sitting. In the case that the NHC Chairman is not present or unable to perform his/her duties, the attending committee members shall select one of them to preside over such sitting.

The judgement of the sitting shall be made by a majority of votes. In casting a vote, each committee member has one vote. In case of an equality of votes, the Chairman shall make a casting vote.

In such sitting if there is the consideration in the matter of any interested committee member, that committee member shall have the right to explain the facts and to express his/her opinions on such matter, but shall have no right to attend the sitting and to vote.

The procedure of the sitting and the performance of the NHC shall be in accordance with the regulations stipulated by the NHC.

Section 42 The NHC shall have the following authorities and duties :

(1) to propose and give advice to the Cabinet and the Parliament with regard to the formation on health policies and strategies.

(2) to propose and give advice to the Cabinet and the Parliament with regard to the provision or the revision of laws, regulations for action or measures in compliance with the health policies and stretegies as referred in (1).

(3) to propose and give advice on issuance of the ministerial rules, regulations or notifications with regard to this Act.

(4) to propose and give advice to the organizations of both government and private sectors in the part of health aspect, or the performance in accordance with the health policies and strategies, as referred in (1).

(5) to monitor and assess the national health systems, both at a policy level and at an implementation level of health policies and strategies, as referred in (1), as well as to encourage and support the health impact assessment caused by the public policy.

(6) to formulate the measures for the purpose of strengthening the co-operation and co-ordination among the political sectors, official units, State enterprises, private sectors, people and organizations on health.

(7) to support and encourage the mechanism management for education, research, distribution, application and organisation of health knowledge network.

(8) to provide the specific mechanism with participation from all sectors to work on the development of health policies and strategies as referred in Sections 68, 74, 77 and 85 or other significant matters.

(9) to provide the national health assembly at least once a year, and support the appropriate provision of area specific health assembly or issue-specific health assembly.

(10) to receive the opinions or recommendations from the health assemblies for the consideration to appropriately construct the health policies and strategies.

(11) to provide the analytic report on the situations of health systems at least once a year, and submit it to the Cabinet, the Parliament, the National Economic and Social Council and the National Health Assembly, and distribute to the public.

(12) to formulate policy, control and supervise the performance of the Executive Committee and the Office.

(13) to appoint the sub-committees or the task forces to work as assigned by the NHC.

(14) to perform other duties as provided in this Act, or other laws, or as assigned by the Cabinet, or in compliance with the proposals from the National Health Assembly.

In performing the above-mentioned duties, the NHC may assign the Office to practice or to prepare the proposal for the NHC for further consideration of action.

Section 43 In performing the duties according to this Act, the NHC or the sub-committees, depending on cases, may invite the officials, officers or employees of the official units, State agencies, State enterprises, public sectors, or local official authorities, or any relevant person to give statements of fact or express their opinions, or send the documents of evidence or information comprising for an appropriate consideration.

The officials, officers or employees of the official units, State agencies, State enterprises, public sectors or local official authorities or any relevant person shall cooperate with the NHC and the sub-committees appointed by the NHC.

Section 44 The committee members, members of the sub-committees or practitioners shall receive the sitting allowances, travelling expenses and other expenditures in performing the duties stipulated by the Committee upon the approval of the Cabinet.

Chapter 4
National Health Committee Office

Section 45 There shall be an Office as a State agency of juristic person status, not being an official unit or a State enterprise in compliance with the Law on Budgetary Procedure or other laws.

The activities of the Office shall not be subject to the Law on Labour Protection, the Law on Labour Relations, the Law on Social Insurance and the Law on Compensation, provided that the officers and the employees of the Office must gain the remuneration not less than that provided in the Law on Labour Protection, the Law on Social Insurance and the Law on Compensation.

Section 46 The Office shall have the following authorities and duties:-

(1) to be responsible for the general affairs of the NHC, the Executive Committee and the sub-committees.

(2) to coordinate with the government units on policies and strategies and with other agencies of both government and private sectors whose performance are relevant to health, and to perform for the purpose of joint working at the levels of health policy, strategy and planning.

(3) to survey, follow up, study, gather and analyse the information, as well as the situations of health systems for the purpose of preparing a report or for the benefits of performing as referred in this Act.

(4) to be the secretariat in organizing the national health assembly, and support the organizing of the area specific health assembly and the issue-specific health assembly as appropriate.

(5) to hold the proprietary right, to have the right of possession and the property rights, including the right establishment, and to handle any legal contract or agreement relevant to the assets.

(6) to employ or assign other sectors or other persons to handle the duties authorized by the Office.

(7) to perform other duties as provided in this Act, or other laws, or as assigned by the NHC.

Section 47 The funds and assets for managing the Office are consisted of:-

(1) the capital provided by the Government.

(2) the annual general allowance allocated by the Government as appropriate.

(3) the donated money or assets.

(4) the money or other assets dissolved on the Office.

(5) the interests acquired by money or income from the assets of the Office.

Section 48 All incomes of the Office shall not be delivered to the Ministry of Finance, in compliance with the Law on Treasury Balance and the Law on Budgetary Procedure.

The assets of the Office shall not be admitted its guilt of suit enforcement.

All real properties which the Office obtained by donation, or by purchasing or exchanging by spending the Office's income shall be the proprietary right of the Office.

The Office shall have the authorities in the administration, supervision, maintenance, custody, payment and procurement for benefits from the assets of the Office.

Section 49 The financial custody and payment of the Office shall be in compliance with the regulations promulgated by the Executive Committee.

As for the accounting of the Office, the universal account system shall be prepared in line with the forms and the rules provided by the Executive Committee, and the regular internal audit shall be made at least once a year.

The Office shall prepare the balance account, the settle account of financing and accounting and submit them to the auditor within one hundred and twenty days as from the date of the end of accounting year of every year, and the State Auditor Office or a person appointed by the Executive Committee upon the approval of the State Auditor Office shall be an auditor of the Office in every year. Such auditor prepares the report of the results and submit them to the NHC.

The Office shall prepare an annual report and submit it to the Executive Committee to be further submitted to the NHC and to the Minister who is in charge of the execution of this Act, provided that the output, the balance account, the settle account of financing and accounting in the past year guaranteed the accuracy by the auditor shall be demonstrated together with the report from the auditor.

Section 50 The Secretary-General shall be the person responsible for the administration of the Office. His/her duties are to supervise the general work of the Office and to command the officers and employees in the Office, provided that there may be the Deputy Secretary-General in number assigned by the Executive Committee to be his/her assistant. He/she also commands and carries out the jobs as assigned by the Secretary-General.

The qualifications of the Secretary-General and the Deputy Secretary-General shall be stipulated by the Executive Committee upon the approval of the NHC.

The appointment and the removal of the Secretary General shall be in accordance with the regulations, rules and procedures stipulated by the Executive Committee upon the approval of the NHC, and when the Executive Committee has selected a person suitable to be the Secretary-General, the resolution shall be submitted to be approved by the NHC before submitting to the Prime Minister for an appointment.

The Secretary-General shall appoint the Deputy Secretary-General upon the approval of the Executive Committee.

Section 51 The Secretary-General shall hold office for a term of four years, and may be appointed again, but shall not serve for more than two consecutive terms.

Whenever the Secretary-General vacates office, the Deputy Secretary-General shall vacate office accordingly.

When the position of Secretary-General becomes vacant and the new Secretary-General has not yet been appointed, the Executive Committee shall appoint an Executive Member to act for the Secretary-General.

In the case that the Secretary-General is unable to perform his/her duties, the Deputy Secretary-General shall act for the Secretary-General, if there is no Deputy Secretary-General, or the Deputy Secretary-General is unable to perform, the Secretary-General shall appoint an officer of the Office to act for the Secretary-General.

Section 52 In addition to the vacation of office upon the expiration of term, the Secretary-General terminates upon:-

(1) death;

(2) resignation;

(3) being a bankrupt;

(4) being an incompetent or quasi - incompetent;

(5) being sentenced to imprisonment by a final judgement, except for an offence committed through negligence or a petty offence;

(6) The Executive Committee with not less than two-thirds of the total existing number of the Executive Members, upon the approval of the NHC, has the resolution to remove due to his/her deficiency to duties, or degenerate behaviors or lack of ability.

Section 53 The Secretary-General shall have the following authorities and duties:-

(1) to administer the Office's business in accordance with the laws, policies and resolutions of the NHC, and with the regulations, rules and notifications of the Executive Committee.

(2) to command the officers and employees in all positions of the Office.

(3) to recruit, appoint, elavate the salary or the stipend, reduce the salary or the stipend level, cut down the salary or the stipend, prescribe the disciplinary penalty against the officers and the employees, as well as to remove the officers or the employees from the positions, in accordance with the rules provided by the Executive Committee.

(4) to set up the rules on the management of the Office, provided that it is not contrary to or inconsistent with the policies, resolutions, regulations,

(5) to perform other duties as assigned by the NHC and the Executive Committee.

Section 54 The Secretary-General and the Deputy Secretary-General shall receive the salary and other remuneration in compliance with the rules provided by the Executive Committee upon the approval of the NHC.

Section 55 The Secretary-General shall be the representative of the Office in carrying out the activities of the Office relevant to the outsiders. The Secretary-General may assign any person to perform in any matter on his/her behalf, provided that it shall be in compliance with the rules provided by the Executive Committee.

Section 56 The Executive Committee shall be appointed by the NHC. Such Committee includes:-

(1) an Executive Member as Chairman of the Executive Committee.

(2) one representative of the Ministry of Public Health as Executive Member.

(3) the distinguished experts, not more than seven in number, provided that there shall be those distinguished experts in administration or law, public health, environment and community development, mass communication, and economics at least one person in one field as Executive Members.

Those distinguished experts as referred to (3) should have qualifications in compliance with the rules provided by the NHC.

The Secretary-General shall be Executive Member and Secretary, and the Secretary-General shall have the authorities to appoint the Assistant Secretary not more than two in number.

Section 57 The provisions of Section 39 paragraph one, paragraph four and paragraph five and Section 40 (1) (2) (3) (4) (5) and (6) shall apply to the holding of office and the vacation of office of the distinguished Executive Members in compliance with the Section 56 (3) mutatis mutandis, and the provision of Section 41 shall apply to the sitting and the performance of the Executive Committee mutatis mutandis.

Section 58 The Executive Committee shall have the following authorities and duties:-

(1) to formulate policies, support and supervise the performance of the Office, with its authorities and duties in order to have efficient management and efficiency enabling to achieve the objectives.

(2) to determine the qualifications of the Secretary General and the Deputy Secretary-General, regulations, rules and procedures as to the appointment and the removal of the Secretary-General for the approval of the NHC, and to proceed in selecting the Secretary-General.

(3) to approve a principle plan, an implementation plan, an annual budgeting and financing plan of the Office.

(4) sto issue the rules, regulations or notifications relevant to the general administration, personnel administration, budgeting, financing and assets, and other conducts of activities of the Office.

(5) to co-ordinate the performance between the NHC and the Office, as well as among the agencies and the organizations for the supreme benefits.

(6) to provide an assessment and inspection of the performance of the Office, at least once a year.

(7) to appoint the sub-committees to perform the duties as assigned by the Executive Committee.

(8) to provide the report on the operational output of the Executive Committee and of the Office to the NHC, at least once a year.

(9) to perform other duties as provided in this Act, or as assigned by the NHC.

Chapter 5
Health Assemblies

Part 1
Area-Specific Health Assembly and Issue-Specific Health Assembly

Section 59 The people shall be able to unite for the preparation of the area-specific health assembly or issue-specific health assembly or to propose for the provision of the area-specific health assembly or issue specific health assembly, provided that an appropriate support should be given by the NHC and the Office.

The opinions or recommendations from the health assemblies under paragraph one, official units, State agencies, State enterprises, local administrative authorities, other sectors of the State in related localities, should also be taken into consideration by the NHC, the Executive Committee, the Office and the Sub-Committee for an Arrangement of the National Health Assembly, constituting for the performance of their authorities and duties, and for the arrangement of the national health assembly.

Part 2
National Health Assembly

Section 60 There shall be an arrangement of the national health assembly at least once a year.

The members of the national health assembly under paragraph one should consist of the public sectors not less than sixty percent of the total assembly members.

Section 61 The NHC occasionally appoints a Sub Committee for an Arrangement of the National Health Assembly.

The Sub-Committee for an Arrangement of the National Health Assembly under paragraph one comprises of the sub-committee members from the State and political sectors, the academic and professional sectors and the people sectors in the proportion of one to three.

The Sub-Committee for an Arrangement of the National Health Assembly shall have the authorities to formulate the rules and the procedures of the sitting and other rules related to the performance.

Section 62 The members of the National Health Assembly comprise of the persons being the representatives from the different groups and the people who intend to participate.

Any person who intends to participate in the national health assembly shall occasionally apply for a registration to the Sub-Committee for an Arrangement of the National Health Assembly, in compliance with Section 61.

The selection for the members of the national health assembly who apply for a registration shall be in compliance with the rules and the procedures as provided by the Sub Committee for an Arrangement of the National Health Assembly.

Section 63 The Office shall perform the secretarial works in an arrangement of the health national assembly.

The Office shall report the opinions or recommendations derived from the national health assembly to the NHC for its consideration of action in compliance with its authorities and duties. Such report shall also be submitted to the Government, official units, State agencies, State enterprises, local administrative authorities and other related sectors of the State to be considered in exercising their authorities and duties.

Chapter 6
Health Policies and Strategies

Section 64 The NHC shall submit the health policies and strategies to the Cabinet for consideration and approval, and shall also inform the Parliament.

The health policies and strategies as provided by the NHC under paragraph one shall have the principles, the objectives, the guidelines, the measures and the mechanisms as provided in this Chapter.

The health policies and strategies as provided by the NHC under paragraph one may come from the proposal of the NHC, or from the recommendations of the area-specific health assembly, the issue-specific health assembly or the national health assembly.

Section 65 The health policies and strategies under Section 64 which approved by the Cabinet shall be taken into action by the related State agencies in compliance with their authorities and duties, to attain the objectives. In the case of need for provision or amendment of any law, there shall be made in compliance with that act.

Part 1
Health Promotion

Section 66 The health promotion shall be for the purpose of facilitating all over the state to be well-being; reducing illness, deformity and premature deaths; as well as cost containment on health. Such management shall be carried out at the levels of policy, society, community and individual.

Section 67 The health promotion in compliance with Section 66 shall have the following guidelines and measures:-

(1) to establish the healthy public policy and the process of the health impact assessment from the public policy, aimed at joint learning of all sectors in the society, through the sufficient academic utilization, with the transparent and accountable mechanism. The people could also participate in accessing the information, suggesting, performing, using the assessment outputs and making decision on the approval and permission of the policy implementation and the crucial projects that may have an impact on health.

(2) to create environment and environmental conditions conducive to health promotion, such as supporting or assigning the communities, local administrative authorities, State agencies and organizations to equip their workplaces to be beneficial to health conditions of the members and of other persons, and to arrange for the healthy communities.

(3) to support the process of exchanging knowledge and experiences of the people and of the communities, for the purpose of enhancing knowledge and improving personal skills and community strength, for self-care on health and self-reliance of the community.

(4) to utilize local wisdom in line with the community's way of life, cultures, traditions and customs, for the purpose of strengthening and nourishing each other's health among people in the community.

(5) to support and increase the potential of communities, local administrative authorities, State agencies, and other organizations at all levels to participate and share their responsibilities in health promotion.

(6) to utilize the measures on taxation, budgeting, academic aspects, social aspects, education, law or other aspects for increasing the efficient contribution of health promotion.

(7) to support the contribution of community welfare systems and various health funds for the incentive and the strengthening of the holistic health promotion.

(8) to support the health promotion activities emphasizing on the sustainable health, the avoidance or reduction of preventable illness, deformity and death.

(9) to support an adequate distribution of medicine and medical equipments necessary for self-care and self-reliance on health thoroughly.

(10) to encourage the non-chemical agricultural development and to control over the chemical utilization by all sectors.

(11) to control over the behaviours hazardous to own and others' health, such as smoking in the public, narcotic addiction and prostitution.

(12) to support and push for the reorientation of public health service at all levels, and in all areas, in accordance with Sections 71 and 72.

(13) other appropriate guidelines and measures.

Section 68 The NHC shall provide the mechanism to follow up the important policy implementation on health promotion and the mechanism of health impact assessment from the public policy in compliance with Section 67 (1).

Part 2
Prevention and Control over
Health Threatening Factors

Section 69 The prevention and control over the health threatening factors shall be intended to eradicate, restrain and control over the factors or states that cause or may cause the damages to health.

Section 70 The prevention and control over the health threatening factors shall have the following guidelines and measures:-

(1) to create and improve the process of establishing the body of knowledge, surveillance, investigation, standard determination, performance and monitoring an assessment which emphasizes on the principles of participation, transparency and accountability, worthwhile and suitable for the problems, environment and community's way of life of each locality, as well as to provide an intersectoral action at the local, regional, national and international levels.

(2) to utilize the efficient legal measures for prevention and control over the health threatening factors, such as genetic diseases or abnormality, harmful communicable diseases, hazardous chemical usage, various contingencies and personal behaviors that are harmful to oneself or the others.

(3) to support and increase the potential of communities, local administrative authorities, State agencies and other organizations at all levels to participate and share their responsibilities in prevention and control over the health threatening factors.

(4) to utilize effectively the measures on taxation, budgeting, academic aspect, education, social aspect or other aspects for prevention and control over the health threatening factors.

(5) to assign the agencies or organizations of both State and private sectors whose activities caused the health threatening factors, or may cause health threats in the future, to cooperate in inspecting and to give information to the agencies responsible to the prevention and control over the health threatening factors, for the purpose of prompt prevention, control and problem solving. Those responsible agencies should disclose such information and results of inspection to the public.

(6) to establish and improve the systems that supervise, assist and are responsible for the damages caused by various health threatening factors, as well as by the deficiencies in preventing and controlling over the health threatening factors, with regard to the right, health security and harmonious living in the society.

(7) other appropriate guidelines and measures.

Part 3
Public Health Service and Quality Assurance

Section 71 The public health service shall be in line with the desirable health systems under Section 7, and shall not be for profit business.

Section 72 There shall be the support of the public health service which puts an emphasis on the people's continuous health care with the people participation. The importance of human and social dimensions shall be given with the holistic concept, and the public health services shall be interconnected for the purpose of sharing responsibilities alongside with an emphasis on supporting the self reliance on health of people.

Section 73 The public health service under Sections 71 and 72 shall have the following guidelines and measures:-

(1) to support and increase the potential of communities, local administrative authorities, and other organizations at all levels to participate and share their responsibilities in the public health service.

(2) to utilize the measures on taxation, budgeting, academic aspect, social aspect, education, law and other aspects for the continual reorientation and improvement of public health service, in compliance with the desirable health systems.

(3) to establish the system of the health technology assessment conducive to public health service and health aspects for the purpose of an appropriate technology utilization and cost containment.

(4) to support the development process and quality assurance on public health service, for the purpose of developing the quality and standard of the service and of the consumer protection.

(5) to establish the people participation process at the clinical and local levels, for the purpose of inducing responsibility and harmony between the people and the health personnel.

(6) to support the development of the public health service for crucial and essential specific issues, such as the emergency medical service.

(7) other appropriate guidelines and measures.

Section 74 The NHC shall specifically provide a mechanism of the policy development and the development strategy of the public health service and a mechanism of the health technology assessment, in accordance with Section 73 (3).

There shall be an independent mechanism for the purpose of supervising the system of the development and quality guaranty of public health service, as provided by law.

Part 4
Local Wisdom on Health

Section 75 The support for the usage and development of local wisdom on health shall be in compliance with the community's way of life, customs, traditions, and local cultures to support and strengthen a self-reliance principle on health, and to increase various options of public health service.

Section 76 The support for the usage and development of local wisdom on health under Section 75 shall have the following guidelines and measures:

(1) to support the utilization, the restoration and the passing on to conserve local wisdom on health, the acknowledgement system management as well as to develop the body of knowledge and standard, including the establishment of the organization which could take care of each other, with regard to consumer protection alongside.

(2) to support and increase the potential of communities, local administrative authorities, State agencies and other organizations at all levels to participate in the development of local wisdom on health.

(3) to utilize the measures on taxation, budgeting, academic aspect, social aspect, education, law and other aspects to support the utilization and development of local wisdom on health.

(4) other appropriate guidelines and measures.

Section 77 The NHC shall specifically provide a development mechanism of the policies and strategies for local wisdom on health.

Part 5
Consumer Protection on Health

Section 78 The consumer protection on health shall be to protect all people equally so that they shall be safe in consuming health products and receiving public health service.

Section 79 The consumer protection on health in compliance with Section 78 shall have the following guidelines and measures:-

(1) to assure the quality and to inspect the health products and public health service in an efficient manner. To give an accurate and adequate information and knowledge on health products and public health service, as well as to create the opportunities for people to have a right to choose safety health products and public health service.

(2) to insure the damages from using health products and public health service, with regard to the right of people, health security and living together in harmony.

(3) to assign the agencies and organizations of both State and private sectors whose activities caused or may cause the damages to health, to cooperate promptly in supplying complete information to the legally registered consumer protection organizations, for the purpose of inspecting for the consumer protection.

(4) to propose the Government and local administrative authorities for budget allocation, not less than one percent of the budget on health. The budget is allocated for supportive assistance to the people sector consumer organizations in different areas, in carrying out their energetic protection activities for the consumers themselves, alongside with the performance of the State sectors.

(5) to utilize the measures on taxation, budgeting, academic aspect, social aspect, education, law and other aspects for the purpose of inducing an efficient consumer protection on health.

(6) other appropriate guidelines and measures.

Part 6
Body of Knowledge and Information on Health

Section 80 The body of knowledge and information on health are considered as crucial fundamental factors of the national health systems. They should be sufficiently constructed and developed, and the opportunities should be easily opened for the public to access.

Section 81 The development of the body of knowledge and information on health under Section 80 shall have the following guidelines and measures:

(1) to support the persons, people and communities to participate in the investment of the establishment and management of the body of knowledge and information on health, and to arrange the appropriate mechanisms and measures for utilizing the body of knowledge and information on health for public interest.

(2) to propose the Government for budget allocation not less than three percent of the health budget for health research investment in order to gain the body of knowledge sufficient to the continual development of health potential and health systems.

(3) to establish a mechanism of which functions are to determine and manage the health research policy. This mechanism shall be separated from the research mechanism unit.

(4) to construct and support the network of health research organizations at the local, national and international levels in order to construct the body of knowledge for formulating the important policies and strategies on health, and supporting the community-level research with close people participation.

(5) to support the channels and the mechanisms of distribution and inspection of the information on health for the benefits of health promotion, potential increase and people protection.

(6) oher appropriate guidelines and measures.

Section 82 There shall be a mechanism of which functions are to determine the research direction and policy in order to construct sufficient body of knowledge for health development and for developing health systems, to administer the research policy on health, to manage the provision of research funds on health, to support the establishment of research network on health, to supervise, monitor and evaluate the outcome from research system on health, to support and manage for a mechanism network on health, to distribute the information on health to the public, and others. This mechanism shall not do the research by itself.

Part 7
Health Personnel

Section 83 The health personnel is considered the important fundamental factor of health systems. The development of health personnel shall be in compliance with the desirable health systems under Section 7.

Section 84 The development of health personnel under Section 7 shall have the following guidelines and measures:-

(1) to formulate the policies, strategies and planning on health personnel at all levels, in compliance with the directions of desirable health systems under Section 7.

(2) to support the resources sufficient for producing, developing and maintaining the health personnel with regard to the utmost benefits for public and to an equal distribution of these personnel.

(3) to support the personnel production systems which enable the persons from different local communities to receive educational opportunities and to be trained to be the health personnel for working in his/her locality.

(4) to support the establishment of health professional organizations in different academic fields which shall be certified by law. To support the intersectoral working process among the health professional organizations by opening the channels for people participation.

(5) other appropriate guidelines and measures.

Section 85 The NHC shall specifically provide a development mechanism of the policies and strategies for health personnel.

Part 8
Financing for Public Health Service

Section 86 The financing for public health service shall be for the purpose of having the services in conformity with the desirable health systems under Section 7.

Section 87 The financing for public health service essential to health potential and survival shall have the following guidelines and measures:-

(1) there shall be a close-ended collective financing that the limitation of expenditure is apparently made in advance for the cost containment.

(2) the collective financing as referred in (1) may include the management of various funds to increase the options available to people. However, for the equity to all, all funds shall have the same basic principle, and a person insured under the same fund shall receive an equal right for health benefits.

(3) there shall be a separation between the mechanism that supervises the collective financial payment and the mechanism that is responsible for public health service management, with a view of enhancing transparency, accountability and efficiency.

(4) other appropriate guidelines and measures.

Section 88 The management of collective financing system to ensure the accessibility and to receive the public health service essential to health and the survival for all people shall be in conformity with the law provided.

Transitory Provisions

Section 89 All of the business, assets, rights, debts and budget of the Health Systems Research Institute on the part of the National Health System Reform Office shall be transferred to be those of the Office, in compliance with this Act as from the effective date of this Act.

Section 90 The NHC Chairman shall appoint a suitable person acting as the Secretary-General until the Secretary-General is appointed by the NHC in accordance with this Act, not longer than one hundred and eighty days as from the effective date of this Act.

Section 91 At the first selection of the committee members when this Act is effective, the NHC Chairman shall appoint the Selection Committee comprising of a distinguished expert who was one of the committee members in the National Health System Reform Committee as Chairman, one representative from the Ministry of Public Health, one representative from health professional organizations, one representative from mass medias and not more than two representatives from public sector organizations whose activities are relevant to health as committee members. The person who is the acting Secretary-General in compliance with Section 90 as Secretary. The duty of the Selection Committee is to select the committee members in compliance with Section 34 (4) (5) (6) (7) and (8) provided that the process shall be done within one hundred and eigthy days as from the effective date of this Act.

Section 92 At the beginning period, at the end of the period of two years as from the date the selected committee members under Section 91 hold office, one-half of the committee members of each category under Section 34 (4) (6) and (8) shall vacate office by lot, and the committee members under Section 34 (5) and (7) two and six in sequence shall vacate office by lot. It shall be deem that such vacation of office by lot is the vacation of office upon the expiration of the term.

The committee members who vacate office under paragraph one shall remain in office to perform their duties until the committee members to be selected on their behalf take office, but not longer than sixty days as from the date of the vacation of office.

While there is no mechanism acting in accordance with Section 82, the Executive Committee of the Health Systems Research Institute shall act temporarily, and the Act on the Health Systems Research Institute, B.E. 2535 shall be improved for within a period of not longer than three years, as from the effective date of this Act, for acting in accordance with Section 82.

Countersigned by

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Prime Minister

(The draft is revised on September 24, 2002)