Health system reform in Thailand: the role of the Health Systems Research Institute

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Alliance for Health Policy and Systems Research
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Executive summary

The Thai economy has evolved over the last four decades from an agrarian society into a newly industrialized country, with considerable changes in people’s lifestyles. Health is among the most rapidly growing sectors, as shown both by the expanded health care infrastructure throughout the country and by the improvement in health status. However, this improvement and the failure to evaluate apparently successful health programmes over the last two decades have masked failures in health system performance.

Thailand’s political reform coincided with the countrywide economic crisis beginning in 1997. It provoked a strong demand for a complete restructuring of society, which finally began to create change in the health system. Health systems research has been essential in order to reveal the hidden crisis in the health of the nation and design a strategy for a new system. A triangular process of symbiotic interaction between academic activities, social action and political commitment was a key strategy in this mission.

The move towards health system reform was enthusiastically welcomed and led to greater political commitment, culminating in plans to draft a National Health Act. This has given research institutes even greater opportunities to contribute their efforts and serve social demand.

Thailand’s Health Systems Research Institute (HSRI) was entrusted with the stewardship of the reform. Researchers and academics worked together to provide the knowledge required for creative change. Clear and critical illustrations of the need for holistic health system reform were profiled through a series of academic analyses. These were then publicized and disseminated. Four major points of crisis were uncovered: the uncontrolled rise in health expenditure, deterioration in health status due to unbalanced economic development, dependence on imported health technology and the need for political and social reform. The Thai Government expressed its support for civic movements which would enable Thai society to redesign its health system.

Thai society has now redefined health and the health system in a way which envisions a holistic scope for the health system. The drafting of the National Health Act is the first step in a long-term reform which is making use of reliable knowledge to back up public policy. A learning society inspired with the desire for a healthy lifestyle is both the means and the end of health system reform.
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<td>GDP</td>
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<td>health impact analysis</td>
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Prologue

The aim of the Alliance for Health Policy and Systems Research (AHPSR) is to contribute to health development and the efficiency and equity of health systems through research on and for health policy. Its objectives are as follows:

- to promote capacity for health policy and systems research (HPSR) on national and international issues
- to collect information for policy decisions in the health sector and other sectors influencing health
- to stimulate the generation of knowledge which facilitates policy analysis and improves understanding of health systems and the policy-making process
- to strengthen international research collaboration, information exchange and learning across countries
- to identify global-level influences on health systems and promote appropriate research.

As we pursue these objectives, we have realized that we do not know enough about how research actually affects policy in lower-income countries.

- How are research topics identified and priorities set?
- How are funding and other resources mobilized to produce evidence?
- What have been the consequences of exercises in priority-setting in the past?
- What has been the impact of research on policy?
- What are the factors affecting this process?

In order to answer these questions, in early 2001 the Alliance launched two series of case-studies. The first dealt with the enabling environment, relating donors, clients, users and producers of research throughout the life of a research project. The second approach concentrated on the structure of innovative, research-based policy development institutions in relation to the external environment. Different processes were followed to produce the case-studies, although all produced working papers which were peer-reviewed.

Enabling environment

These case-studies identified relevant indicators for assessing effectiveness in the relationship between research funding, production and utilization. The studies would also be used for training in the research-to-policy process, forming part of a curriculum being developed in an international collaboration. Case-studies were prepared to encourage discussion about the processes and mechanisms which affect support for research and its impact. To achieve this, the case-studies followed the “management school” format, where specific decision situations are described. Researchers were trained to undertake and write case-studies for this purpose.

The case-studies then sought to identify challenges in the setting of research priorities, decision-makers’ support for research and the benefits they gained from the research process and its results. They investigated the interplay of institutional mechanisms which bring stakeholders together in an “enabling environment”. Attention was therefore given to the factors which bring actors together to agree on funding, support and utilization of research.
The Alliance launched a call for proposals and selected six researchers from five countries:

- C.A.K. Yesudian (Tata Institute of Social Sciences, Maharashtra, India)
- Francisco Yepes (Colombia)
- Mahmoud Abdel Latif Salem (Egypt)
- Absatou N'Diaye Soumare (Mali)
- Godfrey M. Mubyazi and Joseph Mwanga (Tanzania).

In each country, a policy issue was identified and at least one research project undertaken. Policy issues were selected according to various criteria: relevance for the health sector within countries, diversity across countries, and the researcher’s familiarity with the policy process and research in question. Within each policy and research area, researchers were given the choice of focusing narrowly on priority-setting, project financing or utilization, or covering all three aspects in a single case-study.

Particular attention was paid to describing the influences shaping project selection and the establishment of research programmes, the role of diverse mechanisms and actors, and the incentives available to increase relevance for national and local problems. The financial and human resources available to support the research-to-policy process were also described by examining resource flows for specific projects and stages of the project.

The impact of HPSR was analysed by observing research inputs and decision outputs in specific policy development situations. Research inputs would be studied from the supply side by analysing problems of HPSR dissemination, and from the demand side through an examination of the participation of researchers as part of the policy-making process. The influence of different types of knowledge — from empirical findings in data-driven design situations to broad conceptual frameworks, for example for health sector reforms — was to be explored. Case-studies would focus on policies with explicit decision points, ample choices and scope for technical design, as well as on those which operated in a more restricted or political environment.

**Research institutions**

The second series of case-studies focused much more closely on a single institution, with the primary aim of influencing the policy process through research and analysis. The main perspective was therefore the institution’s internal organization and its relations with the external environment.

Four Alliance partner institutions were selected to develop the case-studies:

- Health Systems Research Institute (HSRI), Thailand (researcher: Wiput Phoolcharoen)
- Mexican Health Foundation (Guillermo Soberon et al.)
- Health Systems Trust in South Africa (Gcinile Buthelezi)
- Colombian Health Association (ASSALUD) (Francisco Yepes).

These institutions have in common a focus on policy development based on research. Three of them are private, non-profit agencies with close links and working relationships with ministries of health and other government units, while HSRI is a public agency with a Board of Directors including non-government participants.
The terms of reference of the papers were quite broad, asking a member of the institution to describe its structure and organization as well as its relationships to decision-makers in the country concerned. More specifically, the researcher was asked to identify promising HPSR management strategies, to analyse their benefits and challenges, and to discuss the applicability of research management innovations for other developing countries and the lessons to be learned.
Introduction

The Thai economy has evolved over the last four decades from an agrarian society into a newly industrialized country, with considerable changes in people’s lifestyles. Health is among the most rapidly growing sectors, as shown both by the expanded health care infrastructure throughout the country and by the improvement in health status. However, the economic crisis at the end of the 1990s undermined the earlier health gains and led to plans for a holistic restructuring of the societal paradigm and infrastructure of the health system.

The improvement in health status and the failure to evaluate apparently successful health programmes over the last two decades masked failures in health system performance. Health policy analyses were conducted and publicized in order to raise public awareness of critical facts about the health system. Early research concentrated on showing the need for reform. Then academic review and analysis created a clear vision of the required reforms to enable all parties to have confidence in and join the reform process. Thirdly, essential mechanisms for reorienting and sustaining the health system were created and tested to show that innovation really was possible. Finally, research was conducted into the delineation of profiles and the promotion of civic involvement in the health system.

Health system reform was placed on the national agenda during a drastic evolution in political, economic and technological structures. However, the resource constraints due to the economic crisis inevitably affected policy implementation. Strategic and well-prepared research management was crucial.

The new constitution of 1997 states that health is a human right which must be protected by the State. An equal entitlement to health was introduced for a wide range of vulnerable populations, including elderly and disabled people and abandoned children. The Government’s responsibilities under the constitution also include consumer and environmental protection, public health and disease control. The principles of equity, efficiency, quality, transparency and accountability to the community must be respected. The Ministry of Public Health has had to reorient its vision and mission to meet this new demand for health and health care so that the new political philosophy can be achieved.

Under the Decentralization Act of 1999, public health activities and the hospital mandate must devolve to local government. The central Government authority has had to shift its mission from its current function of logistical administration and policy control to that of policy guidance and quality assurance in health care. At the same time, local government must be empowered to provide equitable and efficient health care that is accountable to people in their own community.

Health Systems Research Institute

The Health Systems Research Institute (HSRI), established as a Government agency by virtue of the HSRI Act of 1992, is responsible for the promotion and support of research into appropriate national health policy. The Board of Directors is the institute’s policy-making body with the Minister of Public Health as Chairman. The Permanent Secretary of the Ministry of Public Health and those of other ministries comprise the rest of the Board, together with seven experts appointed by the cabinet.
HSRI’s activities during its first decade have contributed to a soundly based health policy that is widely accepted among researchers and health development experts, both nationally and internationally. From its inception, HSRI has been designed as a small and flexible research-granting agency, mainly funded by the Government. Its core staff of 20 consists of research managers and supporting officers.

HSRI’s three-year plan for the period 1999–2001 was designed to speed up the process of health system reform, using the knowledge gained from research results and encouraging political and civic involvement. Simultaneously, better management would enhance the capabilities of researchers and research institutes and mobilize a network of health system researchers. HSRI’s vision of “creating a holistic and proactive ‘Health for All’ through ‘All for Health’ health system reforms” has provided opportunities for new actors to participate in the learning mechanism and encouraged innovative reform.

This new and ambitious campaign for holistic and comprehensive reform is intended to facilitate the transition from therapeutic care to more intensive health promotion and prevention. To achieve this aim, HSRI has divided its own financial plan into four main areas:

- research and reviews to address the failures of the existing health system and identify alternative options for reform
- establishment of, and support for, essential new infrastructure to sustain the network of health system reform, such as hospital accreditation institutes, a centre for health equity studies and area-based institutes
- research into the mobilization of civil society for a healthier life
- research to create and support social marketing alliances to foster health system reform.

HSRI concentrated on identifying failures in health system performance which exacerbated adverse health situations. Its research was integrated into a wide range of mass communication and social events, culminating in a national conference, the Health of the Nation Assembly (15-17 August 2000). The Assembly was designed to involve stakeholders in the health system in the creation of a strategic path towards health reform, and was enthusiastically welcomed by a wide range of partners.

A National Health System Reform Committee (NHSRC) was launched in August 2000 under the chairmanship of the Prime Minister. A Health System Reform Office (HSRO) established within HSRI became the secretariat for this Committee and received a three-year mandate to coordinate technical and civic support for the drafting of a comprehensive National Health Act based on scientific and evidence-based knowledge.

To respond to its current mission, HSRI has identified three areas of strategic management: commissioned research, HSRI affiliate institutes and HSRI cooperation with other institutes.

**Commissioned research programmes and projects**

In accordance with HSRI policy, research projects on reform issues have been initiated in cooperation with stakeholders and key users, in order to obtain the knowledge and information needed for health policy and health systems
development. HSRI may sponsor the entire process of research management, or collaborate with other funding agencies such as the World Bank, Asian Development Bank, World Health Organization, etc. Thus, HSRI sponsored a study to analyse health finance schemes in Thailand and draw up recommendations for universal health care coverage. The World Bank and HSRI co-funded research to assess Thailand’s willingness to pay for HIV vaccine, which would provide basic information for bargaining with vaccine manufacturers, as well as guiding policy for HIV/AIDS prevention in the future.

HSRI also acts as a broker for users such as the Comptroller-General’s Department of the Ministry of Finance, the Bureau of Health Insurance of the Ministry of Health, etc. The Comptroller-General’s Department commissioned HSRI to study the civil servants’ medical budget scheme, and used the data obtained to develop an official health finance reform scheme which has been launched nationwide.

The commissioning, monitoring, quality control, dissemination and utilization of research is coordinated by HSRI’s core staff in collaboration with the network of researchers established by HSRI and its alliances. A study package called “Health of the Nation” was conducted as a wide-ranging health situation analysis. This was a collaborative study among analysts from a wide range of disciplines and was used by HSRI to demonstrate the critical failure of health systems to the Health of the Nation Assembly in 2000.

**HSRI-affiliated institutes/offices**

Administratively autonomous agencies were established to facilitate the new system and devise sustainable health system reforms.

- HSRO coordinates the alliance undertaking the reform process. It is funded by the Government at a cost of US$1.5 million annually for the three-year mission.
- The Hospital Accreditation Institute funded by HSRI earns its own revenue from accredited services provided to all the hospitals in Thailand. The Institute aims to improve the quality of health services.
- The first prospective cohort study of Thai children, funded by the Thailand Research Fund at a cost of US$1 million annually, will follow up a cohort of 5,000 newborn babies for 25 years to monitor the psychosocial development of Thai children.
- The International Health Policy Programme is a collaborative activity between HSRI and the Ministry of Public Health to support scholarships for researchers to study international health policy.
- The Universal Coverage Information Technology Office, funded by the Comptroller-General’s Department of the Ministry of Finance with an annual budget of US$0.5 million, deals with information on the financial management of the civil servants’ medical scheme.

**HSRI cooperation with other institutes**

Links have been established with universities and research institutes with various areas of expertise:
• an area-based research network with Khon Kaen University in the north-east of the country, Chiangmai University in the north, Chulalongkorn University in the central area, and Prince of Songkla University in the south

• the Equity in Health Study Centre, in cooperation with Naresuan University, which is creating a network of researchers for evaluation and monitoring of health inequities

• a research network for drug policy study in cooperation with the Faculty of Pharmacy, Chulalongkorn University

• a research network for the study of social health and health impact assessment

• a research network of health professional groups to investigate their new role in the short term.

The need for reform

HSRI sponsored a series of studies on national health accounts, planned by researchers and users, to profile health expenditure. They were accompanied by an in-depth analysis of health status. The users were officers from the National Statistics Office, the National Economy and Social Development Board and the Bureau of Policy and Planning of the Ministry of Public Health. They participated in the identification of research issues, methodology and data collection, as well as the formulation of conclusions and their implications. Thus, the results of these studies were understood and accepted by all users as part of a mutual learning process.

HSRI undertook the analysis and dissemination to the public of a series of health policy research results showing that the existing health infrastructure is not capable of handling the emerging crises. Four major issues have emerged:

• rising health expenditure

• economic development and inequity

• dependence on imported technology

• the need for political and social reform.

Rising health expenditure

With the expansion of modern health care delivery systems in both the public and the private sector, Thais are now using more facility-based health services. National health spending in Thailand had risen by a factor of 11, from $US562 million in 1980 to $US6302 million in 1998. Per capita health expenditure increased nearly nine-fold, from $US12 to $US104, during the same period, compared with an increase in GDP of 7.0%. Thus the share of GDP spent on health nearly doubled from 3.8% in 1980 to 6.2% in 1998.

The increasing burden of health expenditure has been masked by the mistaken impression that Thailand has a modern and efficient health system. To correct this perception, a comparative study of health outcomes was publicized, covering countries such as China, Malaysia, and Sri Lanka which have lower per capita health expenditure compared with GDP and yet have improved their health
situation as quickly as, or more quickly than, Thailand. This study shocked policy-makers, who were also concerned that Thailand might be investing inefficiently. It was therefore decided that the existing health system must be completely redesigned.

HSRI also supported a package of case studies to review various health promotion models which had emerged in Thai society. These were evidence-based and emphasized the principle that investing in healthy lifestyles is both cost-effective and feasible. These examples were made into a series of documentary videos, which were disseminated at various conferences and broadcast on television.

**Economic development and inequity**

The incidence of poverty fell from 33% in 1988 to around 11% in 1996. While Thailand can take considerable satisfaction in the progress made over the past three decades, it has paid high costs in several areas:

- the unbalanced nature of much of the development, which has led to disparities among the marginalized population
- the disruption of social structures and relationships and the erosion of social and cultural capital
- unsustainable levels of environmental pollution and depletion of natural resources.

As a result of international trends in the 1980s (recession, currency realignment and capital mobility), the Government shifted its economic strategy towards promotion of exports in both service and manufacturing industries. A natural population increase, as well as a marked increase in rural-to-urban migration, caused the manufacturing labour supply to rise; the decline in agricultural growth was an additional factor.

Thailand’s health situation deteriorated, with HIV/AIDS, traffic injuries, cancer, mental stress and environmental hazards among the top 10 causes of mortality and morbidity. The mortality rate per 1000 population, which had declined from 20 in 1975 to 4.1 in 1986, went back up to 5.0 in 1997 and 5.1 in 1998. This may mean that the existing health system is not designed to cope with the new societal challenges.

Health impact assessments were developed and tested, with HSRI support, as a new way of investigating the adverse effects of unhealthy public policy. At first this did not work well. A network of multidisciplinary researchers was deployed to construct a sound and effective methodology. Assessments of the use of chemicals in agriculture, the large petrochemical industrial estate on the eastern seaboard, transport policy and road traffic injuries were undertaken. Attempts were made to involve civil society in health impact assessments. It was recognized that, in order to cope with these new societal changes, Thai society must be empowered to handle public policies at both national and community levels. The Health of the Nation Assembly in 2000 was intended to provide a trial of the infrastructure for amplifying and verifying the voice of people who are suffering as a result of public policy. This structure may be strengthened in the future in order to involve the community in the formulation of public policy from the very beginning.
Dependence on imported technology

A wide range of health technology has been researched and developed in industrialized countries, then imported by developing countries at great expense. The HIV/AIDS epidemic exemplifies the widening inequity gap: wealthier people have access to more effective drugs, while those who are financially disadvantaged are left to take their chance. HIV/AIDS evaluative research showed that, of almost 1 million people with HIV/AIDS, fewer than 5% can afford antiretroviral drugs. Most pregnant women who can obtain drug therapy to protect their infants from HIV infection cannot obtain treatment for themselves so that they can survive and bring up their children.

Cancer, the leading cause of death since 1980, is another example. Radiotherapy is expensive, requiring complicated medical equipment. But 54% of radiotherapy units are in Bangkok and the remaining units, in provincial cities, do not have enough qualified staff to carry out the treatment.

Universal health care coverage can never be achieved if the health system relies on costly imported technology. Thailand needs to create a strong foundation of health research and development in order to transfer innovative health knowledge and technology from the industrialized countries. Investment in Government health research increased from 0.2% of the public health budget between 1992 and 1996 to 0.52% in 1999. Compared with research in agriculture, industry, science and technology, which contribute directly to national economic growth, health research is not a high priority in Thailand.

Need for political and social reform

The civil society movement gained strength in the 1990s, when the need for political and social reform became increasingly apparent. It has become a potent force for change and has played a decisive role in framing a reform agenda shaped by the principles of democracy, participation and respect for basic human rights. As both an advocate and a watchdog, it is involved in activities that go beyond the traditional concepts of participation or even empowerment and is spearheading the search for a new social paradigm, based on a far-reaching process of political democratization.

One good example is a trial of a public autonomous hospital under community governance, which is a package of research sponsored by HSRI since 1999. With the promulgation of the new constitution in 1997, the nation has built a more open and democratic society in which the basic rights of the population are safeguarded. Consequently, Thais now enjoy significant new opportunities to participate in all processes of development.

The economic crisis strained Thailand’s budget system and revealed several structural weaknesses: poor links between planning, budgeting and sectoral policy; ineffective targeting of expenditure on the country’s development objectives; lack of fiscal transparency and excessive line-item expenditure controls.

The new constitution set a framework for reforming public-sector management and improving accountability, transparency and mechanisms for combating corruption. It gave more authority to the National Counter-Corruption Commission, established new organizations to monitor and improve transparency and granted civil society the legal right to participate in the policy formulation
process. A new Official Information Act provided greater access to public information and created more opportunities for public service.

**National Health Act**

Thailand’s three-year public-sector reform programme, which began in 1999, involves both central agencies and line ministries such as education and health. Both have embarked upon substantial reforms in the following areas: expenditure management; human resource management; revenue management; decentralization; cross-government accountability and transparency. The Ministry of Public Health is expected to reform budget management in provincial health authorities and hospitals.

These developments have highlighted the emerging health crisis. The new constitution places more emphasis on health, while the existing system cannot meet the increasing demand and the country cannot afford the costs of curative care. The growing health burden will present a major obstacle to society unless people begin to lead healthier lives. This will require real commitment from all stakeholders. Making health authorities accountable to society would promote local self-governance of the health system and shift the central authority’s role towards limited policy guidance and technical leadership. Local government will be responsible for redeploying staff and building capacity for administration and management.

The value which Thai society places on health was studied in various population groups. At the same time, a series of in-depth interviews with celebrities were conducted in order to portray insights and ideology for the new health system.

**Drafting of the National Health Act**

An innovative “triangular process” has been applied to the challenging task of restructuring and reforming Thailand’s cumbersome health system. This is based on a symbiotic interaction among three basic objectives: creation of knowledge through research, social movement or social learning and political involvement.

The drafting of the National Health Act is an essential means of mobilizing all stakeholders to collaborate with each other in designing a new mind-set for health. Four subcommittees were appointed under the National Health System Reform Committee (NHSRC). The first is a technical subcommittee which brings together appropriate knowledge about possible options in all types of reform. The subcommittee on partnership-building aims to involve all partners in order to seek their opinions and support. The subcommittee on public media is responsible for wider social advocacy through the media. The fourth subcommittee will draft the National Health Act. Its importance has been strongly endorsed by the current Government, which came to power in February 2001, so that “health system reform” has become the key health policy (see Annex 1 “Timetable of health system reform in Thailand”).

The NHSRC works through research, civil society mobilization and its political agenda.

**Research**

Knowledge about health systems may be obtained from a wide range of stakeholders. These may include professionals, key decision-makers, voluntary
organizations and researchers from many disciplines, including public health, law, economics, social science and political science.

HSRI facilitated the mobilization and strengthening of researchers and research institutes to support evidence-based health system reform. Its main purpose is to assist in the synthesis of knowledge essential for drafting the proposed National Health Act. Working groups of researchers were commissioned to investigate and draft responses on specific reform issues. The results were converted into a well-defined strategy map and led to pivotal proposals which have formed the foundation of the reform process. The technical reports have provided guidance for the NHSRC and a creative network of researchers, policy-makers and civic activists.

**Mobilization of civil society**

A crucial initial strategy in any restructuring of the health system is to reconcile differences among stakeholders to create an alliance of partners in the reform. This requires a basic knowledge of leadership and motivation. An exploratory survey of stakeholders in health system reform was undertaken and the resulting information was stored in databases. Policy-mapping and analysis of stakeholders was carried out in order to identify coinciding interests. The alliance on health system reform was categorized into four functional groups: public interest groups, health professional groups, profit in health-related business and community-based civil society.

HSRI organized forums and seminars in every province. Mind-mapping and focus-group discussions were employed as powerful devices to explore people’s demands. In six months, broad and comprehensive views of the health system were depicted and proposed. Recommendations from civic alliances were complemented by academic research, and then integrated into a draft of the National Health Act.

**Political agenda and commitment**

During the first general election under the new constitution at the end of 2000, a newly established party raised universal health care coverage as a major issue for reform. It turned out to be a popular policy. This party won a landslide victory, then became the most powerful government in the history of Thai democracy. The Government has strongly endorsed the policy of health system reform, which emphasizes universal coverage. However, difficulties lie ahead, since many financing mechanisms and much of the health care infrastructure and referral system has to be reconstructed. Implementation is now under way, with a considerable demand for feedback information. HSRI was entrusted with coordinating the monitoring and evaluation of the national universal coverage plan. Other reform agendas, such as public-sector reform, decentralization and national research restructuring, will be addressed in the formulation and implementation of the plan.

The new Government has now approved most of the essential issues related to new structures and functions which arose during the design of the health system: ideology of the health system, governance of the health system, health hazard control, universal coverage of health care and the draft of the National Health Act. NHSRC has been entrusted with the continuance of this work.
Changing perceptions of health

One important aspect of the National Health Act is that it is being drafted within an ideological and scientific framework endorsed by wide-ranging alliances throughout the country. Although it has yet to be finalized, the draft lays down the basic structure of the future health system. Conclusions have been drawn up and amended by the legal affairs working group to create appropriate legislation.

The proposed health system reflects a shifting paradigm among the Thai people in terms of ideology, governance and architecture.

Ideology of health and the health system

The definition of health used in Thailand is derived from the one in the WHO constitution, and reads: “a state of physical, mental, social and spiritual well-being”. This definition has been reached as a result of studies of the adverse effects of an unhealthy public policy by academics, activists, and public authorities, with the involvement of community groups and stakeholders in policy formulation.

At the individual level, the term “spiritual health” implies faith and a commitment to a healthy life. This approach has been validated by religious teachings, academics and interested groups in civil society, such as people with HIV/AIDS, disabled people, the poor, etc. At a broader societal level, the term “spiritual health” denotes a public desire for equity, leading to strategies and actions to reduce disparities in health and health care.

Various research projects are under way to investigate appropriate forms of action by the health service, ranging from individual and community health care to governance of healthy public policy. The health system has been officially redefined as follows: “all systems which are holistically interconnected and which affect the health of the people throughout the country. It includes all factors related to health, namely, personal, environmental, economic, social, physical and biological factors, as well as the health service systems”.

Governance of the health system

In order to facilitate health reform and a move towards a self-reliant health system, a new model of governance must be designed. A review was undertaken of various countries’ health policy formulation and administration as well as governance of policy in other sectors. One recommendation calls upon the National Health Council to monitor the health impact of action in any other sector. Alternative proposals for health system governance were scrutinized by civic activists.

Health system elements

A structural study of the elements comprising a health system was undertaken. A schematic causal relationship of factors influencing holistic health (healthy individual + society) has been identified. These are: external factors - the ecological and social environment; intermediate factors - social determinants which may play a prominent role in shaping human behaviour; internal factors - genetic and biogenic factors that interact with human conduct and are reflected in the well-being of individuals and society.
The external roles supporting a healthy social environment are as follows:

- health impact assessment - guaranteeing healthy public policy
- health research systems and technology development - the “brain” of the health system
- health hazard prevention and control - surveillance and technical capability for protection
- human resources for health - a network for capacity-building and policy.

The internal role is to provide the architecture for empowering the individual and society so that people can live in a healthy manner:

- a health information system using modern information technology
- a consumer empowerment mechanism run by civil society and a network of academics
- a health service system which supports a wide range of care and self care
- social services to protect vulnerable people.

In this context, the term “health system” is broader than “health care system”, being rooted in desirable values and principles, including equity in human health. Reforming just one element of the health system cannot bring about the desired improvements to the system as a whole, although a failure to improve one element may jeopardize the whole reform.

Not all the eight elements of the health system may be in place by the time the National Health Act is promulgated. Its ongoing design and reengineering may take decades. Reorienting the architecture and function of the health system is a feasible task, albeit one which demands clear vision and political drive. Knowledge generation and management throughout this process of reform has helped to create a common understanding between policy-makers and the public on every issue.

Challenges, lessons and conclusions

Challenges

The key to successful research management is to involve all stakeholders from the very beginning. HSRI identified the Government as the main user of research on health reform. The academic community and civil society are two key agents who drive the reform process. The transformation of technical knowledge into system change has been legitimized only by its endorsement by the Government. A number of challenges associated with the reform process have still to materialize.

The first challenge was to provide clear and credible information to convince society that the existing health system needed to change. The second was to establish a collaborative process to reconcile the wide range of demands from civil society, to overcome political constraints, and to ensure scientific rigour. The third was to conduct innovative research for the development of various tools and mechanisms for the new health system. Finally and crucially, there was a need to understand the diversity of the health paradigm so that the future architecture of the health system could be designed to meet people’s demands.
This is the first time in the history of Thai health care that researchers have been recruited to work side by side with political agents and civil society. Health and the health system have been redefined to enable all sectors to participate in and sustain the process of reform. Thus, health system reform has turned out to be a laboratory which Thai society can share and learn from.

Lessons and conclusions

1. The experience of Thailand shows that research can reorient demand in the health system. Within its mandate, HSRI has used existing information to create new knowledge within a given context and provided an evidence base for new and practicable health system functions and architecture. Research management strategies are designed to achieve a shared vision by all alliances.

2. Health system reform requires a holistic approach at all levels. All stakeholders must work together under the leadership of a committed government.

3. A stable political situation provides more opportunities to apply research to ensure that changes meet the real needs of society.

4. Health policy systems research encompasses the whole range of knowledge generation and management, which requires networking with all stakeholders.

5. Effective research management strategies may help researchers and institutes from many disciplines to join together in a wide-ranging network. Without a policy which offers mutual benefits, it is difficult to integrate the activities of workers and researchers, who wish their creations to be of real value to society, rather than merely publishing manuscripts. The coordination requires time, flexible long-term financing and management strategies which will enable all participants to understand the issues, analyse the situation and come up with possible solutions.

6. Health systems research also has the role of empowering all partners to contribute their experiences to enrich the reform and health system ideology and ensure their future role as an integral part of the health system. This is crucial for both managing and sustaining change.

7. The process of drafting the National Health Act is not the end, but rather the beginning of long-term reform. Thai society has become accustomed to employing reliable knowledge to increase its wisdom. Naturally, not all the innovations introduced as a result of the reform process will achieve the same expectations or be sustainable, but failure will serve as a learning experience. A learning society inspired with the desire for a healthy lifestyle is both the means and the end of health system reform.
### Annex 1

**Timetable of health system reform in Thailand**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>HSRI established (HSRI Act)</td>
</tr>
<tr>
<td>1997</td>
<td>New constitution adopted</td>
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<tr>
<td>December 1998</td>
<td>HSRI Board formulates a strategic mission to support health system reform</td>
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<tr>
<td>March 1999</td>
<td>HSRI three-year work plan approved (mainly research studies)</td>
</tr>
<tr>
<td>March 1999</td>
<td>Network of researchers, policy-makers and civil activists established</td>
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<tr>
<td>November 1999</td>
<td>HSRI Board submits a plan to draft a National Health Act and proposes a process of reform to cabinet</td>
</tr>
<tr>
<td>November 1999</td>
<td>Decentralization Act enacted; National Decentralization Committee established.</td>
</tr>
<tr>
<td>May 2000</td>
<td>Cabinet approves rationale of health system reform; NHSRC established</td>
</tr>
<tr>
<td>August 2000</td>
<td>NHSRC initiates its three-year mission. Research and analysis of the health situation by research networks to demonstrate the rationale for reform.</td>
</tr>
<tr>
<td>February 2001</td>
<td>New Government takes power</td>
</tr>
<tr>
<td>4 September 2001</td>
<td>Draft National Health Act presented at a national assembly, including the ideology and elements of the health system, National Health Council.</td>
</tr>
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</table>
Bibliography