

Innovation and participation for healthy public policy: the first National Health Assembly in Thailand

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Abstract

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Aim This paper aims to describe and disseminate the process and initial outcomes of the first National Health Assembly (NHA) in Thailand, as an innovative example of health policy making.

Setting The first NHA, held in December 2008 in Bangkok, brought together over 1500 people from government agencies, academia, civil society, health professionals and the private sector to discuss key health issues and produce resolutions to guide policy making. It adapted the approach used at the World Health Assembly of the World Health Organization.

Method Findings are derived from a literature review, document analysis, and the views and experiences of the authors, two of whom contributed to the organization of the NHA and two of whom were invited external observers.

Results Fourteen agenda items were discussed and resolutions passed. Potential early impacts on policy making have included an increase in the 2010 public budget for Thailand's universal health coverage scheme as total public expenditure has decreased; cabinet endorsement of proposed Strategies for Universal Access to Medicines for Thai People; and establishment of National Commissions on Health Impact Assessment and Trade and Health.

Discussion The NHA was successful in bringing together various actors and sectors involved in the social production of health, including groups often marginalized in policy making. It provides an innovative model of how governments may be able to increase public participation and intersectoral collaboration that could be adapted in other contexts. Significant challenges remain in ensuring full participation of interested groups and in implementing, and monitoring the impact of, the resolutions passed.

Introduction

Intersectoral collaboration and community participation were recognized in the 1978 Declaration of Alma Ata as essential in the drive towards health for all.¹ This was based on an understanding that the whole of society impacted on health, not just health services and health professionals. Soon after, analysis of the impressive health progress of low-income countries such as Costa Rica, China and Kerala state in India identified 'community participation in decision-making processes' and 'intersectoral linkages for health' as key common features explaining their success.² The 1986 Ottawa Charter for Health Promotion built on Alma Ata's legacy by calling for 'healthy public policy'.³ This implied that government decision making at all levels should aim to improve the conditions in which people live and support their ability to protect and improve their health, with the 'healthiness' of public policy measurable by its impact on population health.⁴

However, implementing intersectoral collaboration and increasing public participation in decision making has proved difficult in many contexts, paralleling poor progress on health inequities. Recent developments have thus reasserted the dependence of health equity on intersectoral action and participation. The Commission on Social Determinants of Health identified the cause of health inequities as policy failure and prescribed intersectoral action and increased participation in decision making to improve daily living conditions and tackle the inequitable distribution of money, power and resources.⁵ Similarly, the recent renewal of primary health care has highlighted the importance of public policy reform. It has also emphasized the need for leadership reform, promoting participation and negotiation, and co-ordinating all stakeholders to improve health and health equity.⁶ Both of these movements have advocated placing 'health in all policies'.⁷

This paper describes a recent social innovation in Thailand – the first National Health Assembly (NHA) that was held from December 11th to 13th, 2008 in Bangkok. The NHA

explicitly seeks to improve intersectoral collaboration and public participation to develop healthy public policy, ultimately aimed at improving health and health equity. This paper reviews the Thai context and the process and mechanisms of the NHA and discusses initial outcomes, potential implications for public policy in Thailand and lessons for other countries. The findings are derived from a literature review, document analysis, and the views and experiences of the authors, two of whom contributed to the organization of the NHA and two of whom were invited external observers. The paper aims to facilitate a rapid dissemination of the process of the NHA. Fuller evaluations of the impact of the NHA process are planned.

The context and history of healthy public policy in Thailand

Thailand has had a strong movement to build healthy public policy since the mid-1980s through the Basic Minimum Needs and Quality of Life approach. However, this has been mainly government driven. Improvements in participation and intersectoral action in health began with political reform in the mid-1990s with the new 1997 Thai constitution emphasizing participatory democracy and decentralization. Other related drivers for health systems reform in Thailand included persisting unequal access to essential health care services and fragmentation of the health care system with a focus on health facility-based curative care, neglecting health promotion, disease prevention and intersectoral action.⁸ The establishment of the Thai Health Promotion Fund in 2002, funded by a 2% additional levy on excise of tobacco and alcoholic beverages, has resulted in increased public resources to strengthen the role of civil society and the community in intersectoral action, health promotion and healthy public policy in Thailand. The Fund has actively sponsored civil society groups to build capacity for health promotion activities.

The National Health Systems Reform Committee convened its first national health assem-

bly in 2001, with the aim of establishing a clear mechanism to promote active multi-sectoral involvement in the formulation of healthy public policy. Five further assemblies were convened by 2006. The assemblies were successful in mobilizing strong civil society participation, but other state actors such as government agencies and the private sector were not actively engaged, partly because of the absence of a strong legal mandate and infrastructure. These assemblies also lacked systematic processes of preparation (such as technical analysis using available evidence) to underpin policy discussion and to help build consensus.

The assemblies contributed to the enactment of a new National Health Act in 2007, which mandated the establishment of the National Health Commission and Office and the convening of an annual NHA. The National Health Commission, chaired by the Prime Minister, has 39 members, evenly divided between and nominated from government, academia and health professionals, and civil society organizations, corresponding to the political, knowledge and social vertices of Professor Prawase Wasi's 'triangle that moves the mountain' strategy (see Fig. 1).^{9,10}

The new Act defines health broadly as 'a holistic system that is interrelated in all dimensions – physical, mental, social, and spiritual – holistically in balance'.¹¹ The Act also calls for moving beyond a narrow health system focus

and establishes mechanisms that aim to mobilize active multi-sectoral involvement and ownership. The Act identifies health assemblies as a key mechanism for the development of participatory healthy public policies in Thailand. There are three types of interrelated health assemblies – area-based health assemblies; issue-based health assemblies; and the NHA.

The National Health Assembly in Thailand: process and mechanisms

The NHA is an attempt at participatory policy making, as opposed to the more common rationalist ('expert') or stakeholder model.¹² The NHA's approach derives from the concept of the 'triangle that moves the mountain' and aims to bring together the vertices of the triangle to effect change and combine 'top-down' and 'bottom-up' approaches to achieve progress towards improved health and health equity.¹³ The approach of the NHA has been adapted to the Thai context from the annual World Health Assembly of the World Health Organization, although aiming for less bureaucracy, more flexibility and greater inclusiveness. An overview of the process of the NHA is shown in Fig. 2.

Like resolutions at the World Health Assembly, NHA resolutions are not binding on policy makers and service providers and instead aim to achieve influence and compliance by setting

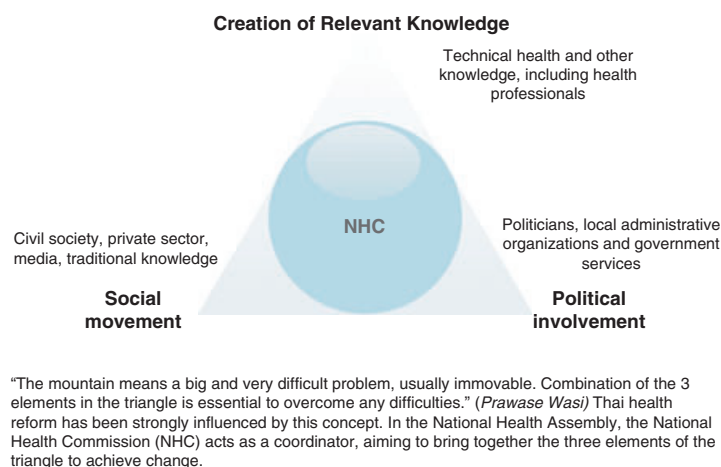


Figure 1 The 'triangle that moves the mountain' strategy.⁹

norms that derive legitimacy from the process and range of actors involved in their formulation. However, resolutions that require stronger political support can be submitted by the Prime Minister as chair of the National Health Commission for cabinet action.

The National Health Commission annually appoints only the chair of the NHA Organizing Committee. The chair has the mandate, in consultation with the Secretary General of the National Health Commission Office, to appoint the other members of the Organizing Committee. This Committee, charged with overseeing

the entire process of the NHA, is stipulated by the National Health Act to have not less than 60% of its members from outside government agencies and also aims to have its composition reflect the 'triangle that moves the mountain'.

The NHA Organizing Committee undertakes work in provinces to encourage engagement with the Assembly and raise awareness about how to participate, including regional workshops. Potential participants in the NHA need to join a constituency that has the right to attend the NHA. The constituencies correspond to country delegations at the World Health

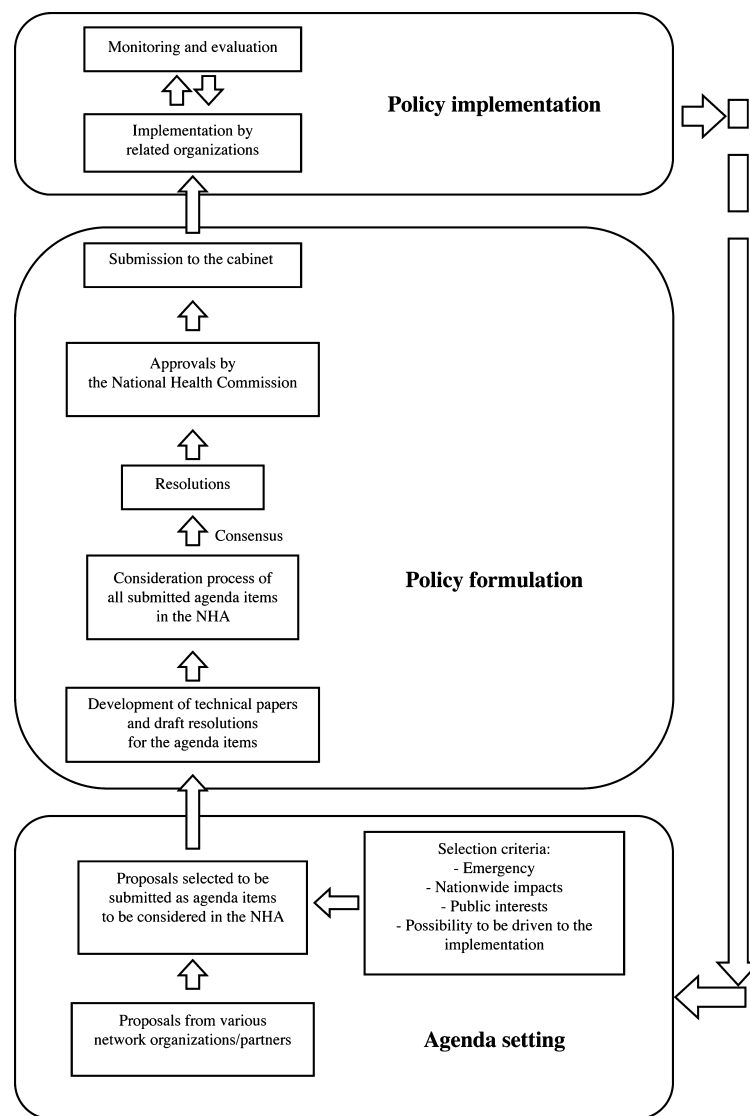


Figure 2 The process of Thailand's National Health Assembly.

Assembly. One thousand five hundred people attended the first NHA, from 178 constituencies in total.

Seventy-six of the constituencies were area-based constituencies from each of the provinces, including Bangkok. The composition of these constituencies was determined by a systematic selection process to achieve representation according to the three corners of the 'triangle'. Therefore, these constituencies were diverse, consisting of representatives from government sectors, health services, academia, civil society and the private sector.

The remainder of the constituencies were distributed to reflect equally the three corners of the 'triangle'. There were 34 constituencies from the private sector and civil society, 24 constituencies from professional associations and academia and 44 political and government agency constituencies. The latter category included representatives from political parties, all ministries and high-level organizations officially established either independently by government or under the Office of the Prime Minister. The non-area-based constituencies combined groups of similar interests, rather than being composed only of a single organization or agency. Each constituency organized its own consultation process to select its representatives to raise their concerns in the NHA.

Public health agencies, such as the Ministry of Public Health, participate through the government constituencies. However, they do not have a privileged role in the process when compared to any other constituency. The aim of the NHA is not to undermine their role in policy making on health issues, but rather to complement it by seeking views from other sectors.

Only Thai citizens are able to participate. However, efforts were made to reflect the voice of stateless persons and non-Thai migrants who reside in Thailand. There was also representation from groups often marginalized in policy making, including ethnic and religious minorities, and young people. In addition, there were representatives from a Thai non-governmental organization working with displaced persons without Thai citizenship. Guests from United

Nations agencies, embassies and international non-governmental organizations were invited as observers, with simultaneous interpretation and translated documents in English. There was also a panel discussion in the plenary during which foreign participants were asked to comment on the event.

All constituencies are entitled to submit proposals to the NHA Organizing Committee for agenda items to be discussed. For the first NHA, 68 proposals were received from 45 constituencies. The NHA Organizing Committee then reviewed the proposals according to pre-determined criteria: the public health importance of the issue in Thailand, public interest in the issue and potential for policy development and implementation. Twelve issues were selected for the NHA agenda, with some similar proposals combined into single items. There is also the possibility for urgent topics, co-sponsored by at least 10 constituencies and approved by the Assembly, to be added to the agenda at the first session of the NHA. For the first NHA, two urgent topics were proposed and accepted in this manner, one on the 'Financial Crisis and Health' and the other on the 'Relationship between Patients and Health Care Providers'. The final agenda for the NHA is shown in Table 1.

Once the NHA Organizing Committee has decided on the agenda items for discussion, it commissions a technical background paper and a draft resolution for each agenda item. These are similar to the papers produced by the World Health Organization Secretariat or Executive Board on agenda items for the World Health Assembly. These papers are made available to all constituencies, as well as published on the NHA website, to inform discussions before and during the NHA.

All constituencies at the NHA have equal speaking rights. After the initial plenaries, the agenda items are discussed at two separate concurrent subcommittees, similar to the World Health Assembly Committees A and B. As there is no financial and administrative agenda to be discussed (unlike the World Health Assembly), the two subcommittees share the technical items in the agenda. New or revised resolutions can be

Table 1 Fourteen agenda items considered at the National Health Assembly 2008

| | |
|-----|---|
| 1. | Statute on the National Health System |
| 2. | Universal Access to Medicines |
| 3. | National Policy for Health System Development in Multicultural Areas in Southern Border Provinces |
| 4. | Participation of the People's Sector in Free Trade Agreement Policies |
| 5. | Agriculture and Food in the Era of Crisis |
| 6. | Strategies for Dealing with the Alcoholic Beverage Consumption Issue |
| 7. | The Role of Local Administration Organizations in the Management of Natural Health Resources and the Environment |
| 8. | Equal Access to Basic Public Health Services |
| 9. | Creating Safe and Creative Media for Youth and Family |
| 10. | Sexual Health: Sexual Violence, Unplanned Pregnancy and Issues relating to HIV/AIDS and other Sexually Transmitted Diseases |
| 11. | The System and Mechanism for Health Impact Assessment in Thai Society |
| 12. | Public Policy for the Wellbeing of Informal Sector Workers |
| 13. | Promotion of Effective Relations between Patients and their Relatives and Medical Personnel |
| 14. | Economic Crisis and Health Protection for Thai People |

proposed and can be passed only by consensus. If consensus cannot be reached, the chair of the subcommittee may establish a working group to allow further discussion and possible modification of the resolution to gain consensus. There were two agenda items for which this was necessary in the first NHA – the ‘Strategic Plan for Universal Access to Medicines’ and the resolution on ‘Health System Development in Southern Border Provinces’. Unlike the World Health Assembly, there is no provision for voting on a resolution if consensus cannot be reached. If this occurs, the item must be deferred to the next NHA to allow more time for consultation and consensus-building.

There are also opportunities for constituencies to deliver ‘five-minute’ keynote addresses on specifically identified topics at the plenary session, similar to ministerial speeches at the World Health Assembly. In the first NHA, there were 86 such speeches. The NHA also has sessions similar to the technical briefings at the World Health Assembly. These are parallel lunch or pre-dinner

technical sessions where constituencies are able to present, share experiences and discuss issues, which may not be on the agenda of the current assembly. In the first NHA, nine such parallel technical sessions were convened. To extend the reach of the NHA further and allow sharing of experiences beyond the assembly itself, there is a public television broadcast of the first half day and all sessions in all rooms are transmitted live on nationwide community radio networks.

To fulfil the mandate of the National Health Act, the process and convening of the NHA is funded from the annual budget of the National Health Commission Office. The total cost for the entire preparatory process during the year, and the event itself, was approximately 35 million baht (1 million US dollars).

Policy impacts, successes and challenges of the National Health Assembly

The NHA has already had an impact on public policy making in Thailand. Discussions on the 14 agenda items all resulted in resolutions, of which the Cabinet has taken note. Potential policy impacts from five of the resolutions of the NHA are described in Table 2. As with all policy formulation, there are multiple contributing factors to the outcomes observed. Given the limited time that has elapsed since the NHA, it is difficult to determine how much the NHA has contributed to concrete outcomes like the increase in the health budget. Its contribution to process outcomes like the convening of the commissions on trade and health impact assessment is clearer. Despite these reservations, the strong correlation between the text of the resolutions and the outcomes presented in Table 2 suggest that the NHA has realized some of its aims for policy change. Further evaluation will be required to conclusively determine the degree of this impact.

The NHA was successful in enabling participation of a broad array of ‘actors’, including those outside of the health sector. For some agenda items, ‘non-health’ actors even dominated some discussions. The item on food security was notable for its focus on sustainable

Table 2 Policy outcomes of the 2008 National Health Assembly

| Agenda /resolution | Policy-making impacts |
|---|--|
| <p><i>Statute on the National Health System</i>¹⁵</p> <ul style="list-style-type: none"> Resolution urges all stakeholders to use 'Statute as a framework and guidelines for health policy, strategies and activities at the national and local levels'. | <ul style="list-style-type: none"> A subdistrict in Songkhla Province has used the Statute as a social reference point for drafting its own Charter, the first subdistrict health charter, to guide development of the local health system. |
| <p><i>Economic Crisis and Health Protection for Thai People</i>¹⁶</p> <ul style="list-style-type: none"> Resolution urges government 'to implement social protection measures, to provide in particular increased budgetary support sufficient for the management of the universal health coverage'. Resolution urges agencies 'to update and develop the health information system to be accurate, timely and comprehensive for use in surveillance, including early warning before an undesirable incident occurs; and synthesize lessons and experiences learnt during the current economic crisis'. Resolution calls for establishment of 'Units for surveillance and monitoring of the impacts of the economic crisis on Thai health'. | <ul style="list-style-type: none"> 700 000 laid-off workers (a result of the economic crisis) formerly covered by Social Health Insurance are now fully covered by the Universal Coverage scheme with a harmonized benefit package across the two schemes. The government health budget for 2010 has increased the UC budget by 10% even as overall public spending has been reduced by 13%. Mechanisms for monitoring health impacts of the economic crisis have been established by the Ministry of Public Health. Thai Health Promotion Foundation has endorsed a Strategic Guideline (with 6 strategies) for Preparedness on Health Impacts from Economic Crisis. The Subcommittee implementing this guideline has proposed a plan of action. |
| <p><i>Universal Access to Medicines</i>¹⁷</p> <ul style="list-style-type: none"> Resolution calls upon National Health Commission to 'submit the Strategies for Universal Access to Medicines for Thai People to the Cabinet for approval and for further instructions to implement the Strategies'. | <ul style="list-style-type: none"> The Cabinet has approved the proposed 'Strategies for Universal Access to Medicines for Thai People' and requested an operational plan for implementation be drafted by a committee made up of all three elements of the 'triangle'. A Committee has been appointed and met twice, with a 5-year operational plan to be ready for implementation by June 2010. |
| <p><i>The System and Mechanism of Health Impact Assessment in Thai Society</i>¹⁸</p> <ul style="list-style-type: none"> Resolution calls for the appointment of a committee to 'promote and support the development of a system, mechanism, form, organization, principle, and technique of health impact assessment and of guidelines to protect against impacts on health' and 'promote and support the work of networks on health impact assessment at all levels'. | <ul style="list-style-type: none"> The National Health Commission has approved the Commission on Health Impact Assessment (HIA). The first HIA Coordinating Unit in Thailand has been established working as a secretariat to the Commission. A HIA guideline has been drafted and is ready for hearings soon. In Thailand's Asia-Pacific Regional Conference on Health Impact Assessment in April 2009, it was agreed that HIA should be used as an effective mechanism among ASEAN countries for policy development. |
| <p><i>Participation of the People's Sector in Free Trade Negotiation Policies</i>¹⁹</p> <ul style="list-style-type: none"> Resolution calls for a mechanism in the form of a 'Committee to Monitor International Trade Negotiations Likely to Have Positive and Negative Impacts on Health and Health Policies' and for the promotion of a 'participatory process of the people's sector in the drafting of the law on procedures and methods for preparing international agreements'. | <ul style="list-style-type: none"> The Commission on Trade and Health has been appointed by the National Health Commission. A forum is to be held with stakeholders from state agencies, academia, professional organizations, the private sector, and civil society to discuss the law for preparing international agreements. |

agricultural production and the need to ensure soil and seed security. Issues of food safety and nutrition, which might have been expected to predominate from a health sector perspective, were secondary.

The NHA was also successful in providing a platform for civil society and provincial participation. In fact, perhaps because of their engagement in previous health assemblies in Thailand (2001–2006), these constituencies were the most active participants. Ensuring greater engagement from government constituencies and increasing the number of private sector constituencies will be important challenges for future NHAs, if they are to genuinely fulfil their intention of synergizing all the different stakeholders involved in policy making.

Ensuring the participation of all groups is essential to support the high value placed on consensus at the NHA. Any process that emphasizes consensus runs the risk of stifling dissenting voices. However, this did not seem to occur at the NHA. The working group mechanism proved successful when there were significant disagreements. For example, the working group considering access to essential drugs included civil society groups and representatives of the pharmaceutical industry, who initially had widely differing views. Not all the members of these constituencies felt they had had sufficient time prior to the NHA to contribute to the background documents for this item. Academic and civil society groups had prepared the draft document with little input from the private sector. The working group spent many hours in dialogue and negotiation to allow these differing views to be heard and considered and was also able to reconcile them. The ability to defer items to the following NHA also provides a further safety valve if consensus cannot be reached.

The NHA is not the first example of a national mechanism aimed at facilitating public participation in policy making. Brazil, for example, has had health assemblies for over 20 years, with significant impact on health policy.¹⁴ Health assemblies in Brazil are now institutionalized at all levels of policy making, from local to provincial to national. However, the

Thai NHA represents the first attempt to translate the approach and format of the World Health Assembly to a country context. By itself, any format for decision making, including that of the World Health Assembly, does not guarantee participation. The NHA has, however, put in place a range of measures to try to equalize power among constituencies, such as equal access to agenda-setting and enforced time limits on interventions. Procedural measures cannot by themselves compensate for the political economy of differential influence of the policy actors who attend the NHA. Further evaluation will therefore also be required to determine how these actors themselves view their level of participation in the NHA.

Significant challenges still exist for the NHA to achieve its goal of increased public participation in building healthy public policy and intersectoral collaboration during implementation (see Table 3). The potential of the NHA to contribute to healthier public policies and interventions to safeguard health is partly dependent on the Cabinet endorsing and formalizing resolutions passed by the Assembly. That is, the government, in determining its response to the NHA, retains the option whether to endorse the resolutions passed. The response in this regard to the first NHA has been positive, but it will be interesting to observe future NHAs, which may produce resolutions that more directly challenge government policies.

The effectiveness of the NHA in achieving its aims cannot be separated from the general political context in Thailand. There was marked political instability at the time of the first NHA, including demonstrations, closure of the international airport in Bangkok and a change in government. The calm and tolerant atmosphere of the discussions at the NHA was therefore remarkable. However, the political climate will have a crucial impact on whether greater participation in policy making through the NHA can be sustainably institutionalized. It cannot be assumed that the NHA will not be susceptible to co-option as a platform by particular political factions or private sector interests, although the

Table 3 Three challenges facing the National Health Assembly

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1. Does the representation of groups and networks who attend adequately reflect the real health needs of the country?
 2. How does the National Health Assembly ensure the implementation of its resolutions?
 3. How to develop networks and build capacity in the health assembly process, especially in the process of developing recommendations, considering resolutions and advocating their implementation?
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experience of the first NHA in a time of crisis is encouraging.

Another key question is how existing policy actors who currently have privileged positions in policy making for health will react to the NHA and its resolutions. It remains to be seen, for example, how the Ministry of Public Health will react to a policy-making forum, which it cannot dominate, and to which it is not bound to defer. Similarly, it is not known yet how ministries outside of the health sector related to key determinants of health, such as finance, industry, agriculture and education, will integrate recommendations of the NHA into their policies and work programmes. Unless intersectoral instruments and mechanisms are developed within government to engage with and respond to the processes and social demands of the NHA, progress is likely to be difficult.

There is also a continuing need to develop the capacity of all participants, especially civil society, to contribute to the NHA in an informed way. Many civil society groups came to the first NHA with extensive and impressive preparation. However, once positions had been stated, it was sometimes difficult to move dialogue beyond superficial points to substantive discussions. Facilitating access to evidence and meaningful analysis of that evidence, beyond just government and academia, is an important task to strengthen participation at the NHA. Related to this, an agenda providing for discussion of 14 items was perhaps ambitious, and future NHAs may benefit from fewer items with more time for deliberation and fewer resolutions, especially if the event is to last only 3 days and occur only once annually. The need for future NHAs to also

consider the implementation of resolutions from previous years will place an even greater premium on time for discussion of new agenda items.

Conclusion

The first NHA should be seen in the context of the broader movement in Thailand over the past 30 years aiming to increase public participation in decision-making processes. Efforts have been put in place to document and evaluate the process and impact of the NHA, to improve the process and enhance its ability to influence policy. Issues such as the true needs of groups and networks reflected by their representatives in the NHA, the under representation of the private sector and the variable engagement of government authorities have been identified for improvement in future NHAs.

What then can other countries learn from this experience? There are certainly many aspects that are specific to Thailand – a history of assemblies and a capable and engaged civil society, a tradition of dialogue and consensus, and government bodies that aim to increase public participation and strengthen capacity for healthy public policy. The level of technical capacity present in Thailand (aided by experience at the World Health Assembly) to create background papers and strategy documents may also not be readily replicable in other contexts. However, beyond these attributes, the Thai NHA provides an example of how governments can innovate to increase public participation and facilitate engagement between different sectors and the community in driving health gain. Its process and mechanisms could be adapted and trialed in other contexts and countries, which aim to improve health and health equity through inclusive, multi-sectoral, evidence-based participatory dialogue and consensus-building in the development of public policy.

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Disclaimer

The views expressed are those of the authors and should not be ascribed to their institutions.

Competing interests

TP and VT contributed to the organisation of the National Health Assembly. KR and MB attended as invited observers.

Authors' contributions

KR and TP wrote the first draft of the manuscript. MB and VT critically revised the manuscript for important intellectual content. All authors approved the final version.

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