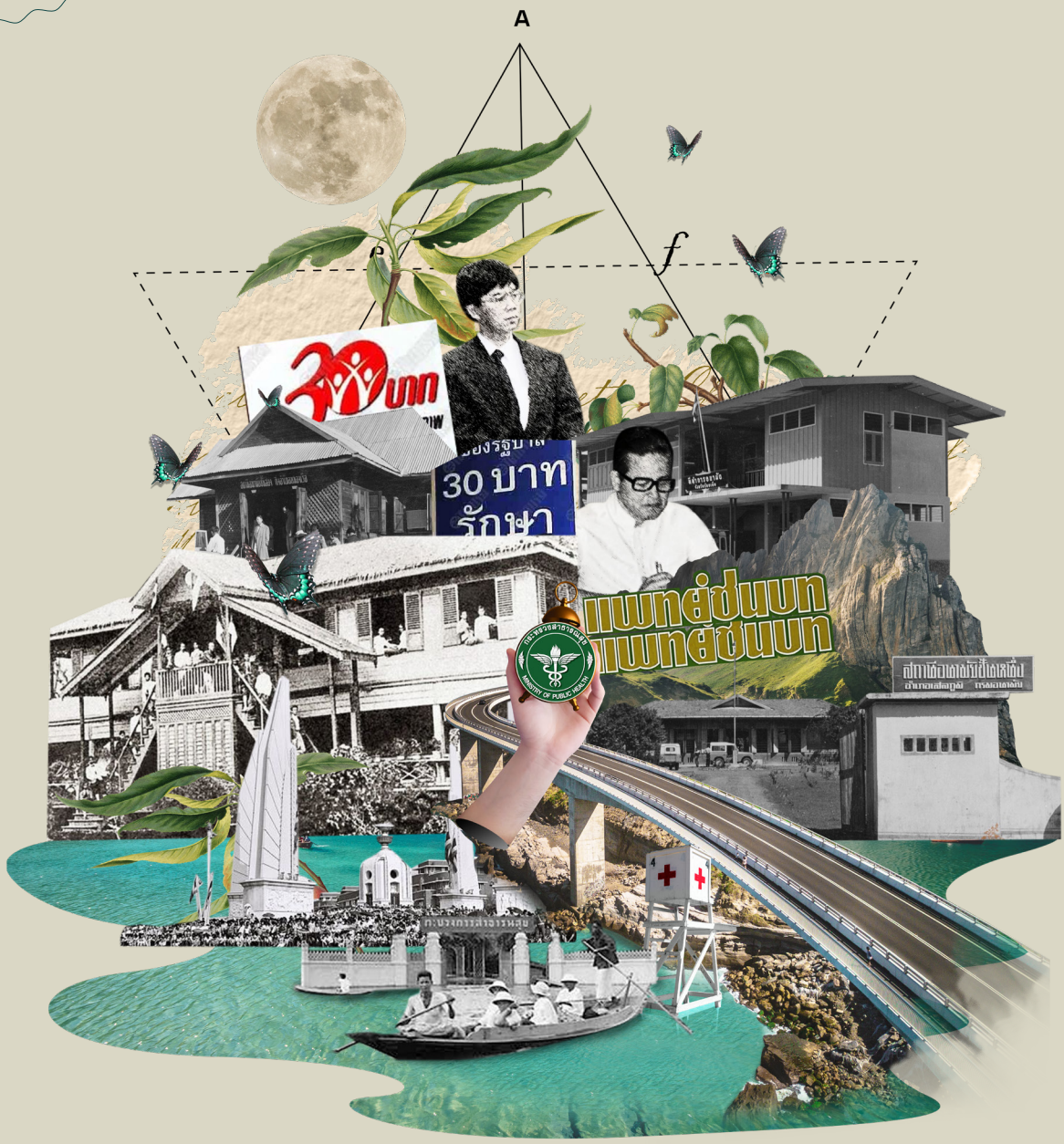
When streams converge, Universal Health Coverage was born, c.1868-2002



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Finally, the authors acknowledge that due to the constraints of time and decisions in selecting topics, certain viewpoints of scholars or other key individuals might be inadvertently disregarded or challenged. The authors sincerely apologize for any shortcomings, and humbly accept any errors that may have occurred. Moreover, considering the limitations of paper space, some topics of interest had to be excluded. If readers desire more comprehensive details, they are encouraged to explore this topic further in "*The Art of Establishing Universal Health Coverage in Thailand: From the Past to the Present (1868-2002),*" which presents the complete version of this work.

Nattanee Satchanawakul
Napaphat Satchanawakul

Preface

The book "*When streams converge, Universal Health Coverage was born, c.1868-2002*" that you are currently holding is the result of the authors' intention as an "outsider" to the public health field. The authors were interested in the development of the healthcare system and the establishment of comprehensive health coverage in Thailand. This volume offers a historical and political perspective on the conditions and pathways of economic, social, political, and cultural changes in the country. This book serves as a condensed rendition, aiming to encapsulate and summarize the content from the book " *The Art of Establishing the Universal Health Coverage in Thailand: From Past to Present, c.1868-2002"* for readers who have an interest but limited time.

Although the authors might not have extensive experiences, based on their recollection from a young age to the present, there has not been any state policy that has endured and brought about as much change and benefit to the Thai people as this policy. Up until now, no policy has shifted the state's perspective on public service provision from "charity-based" to "rights-based" as clearly as this policy.

While many might perceive policies like the "*30 Baht Treats All Diseases*" or the "*Gold Card*," as political platforms to gain votes, ultimately this policy has been acknowledged widely as not just a politically-motivated one, but something that has gone well beyond politics. It has made a difference for people beyond borders, whether they are well-off or struggling, so that they do not have to succumb to illness as they used to.

The authors firmly believe that, regardless of who the readers are, whether they work or live in any part of Thai society, at least one person they know—whether it is a family member, relative, friend, or acquaintance—must have been a beneficiary of this policy and enjoyed its rights, as it has permeated society at large.

This volume is yet another historical narrative presented through the perspective of early-career scholars outside the public health domain. We, with genuine interest and fortunate opportunities, have engaged in learning and understanding the journey of creating Thailand's Universal Health Coverage policy. We have achieved this by listening to and delving into the accounts of significant figures who can be regarded as the "players" of this historical path, both those still living and those who have passed on. Additionally, we have meticulously read, analyzed, and interpreted numerous documents that have surfaced. Our aspiration is that this book will serve as another record of this captivating story, aimed at providing the younger generation, who might have never had the chance to know, with an understanding of how the roots and origins of such a beneficial policy could emerge, take shape, and progress through the passage of time.

The content of this book will narrate the history of creating Thailand's Universal Health Coverage using the "6 x 3" framework. This framework comprises six components derived from the "6 Building Blocks of a Health System," namely: approach and information, health workforce, service delivery, financing, structure and governance, and medical products and technologies. Additionally, it considers another three components following the "Triangle that Moves the Mountain" strategy, which constitutes the core strategies for the development of this policy by the progressive doctors' group. These components include knowledge creation, social movement, and political will. Together, these components aim to enhance the reader's understanding of the origins and trajectory of the phrase "*When Streams Converge*."

However, it must be understood that the intention of this volume is to provide an overview of the path to establishing Universal Health Coverage (UHC) in Thailand. As such, it encompasses various health security systems that have been established and developed in the country. However, the primary focus will be on the "Universal Coverage Scheme" (UCS), often referred to as the "Gold Card," which is a pivotal element in the creation of universall health coverage. This scheme serves as a cornerstone and manages the rights and healthcare services for the largest portion of the country's population.

The authors made a concerted effort to present concise and targeted content, emphasizing the core knowledge believed to be beneficial for policymakers, practitioners, and the general public interested in the origins of universal health coverage. Due to the limitations of paper space, the authors unavoidably had to "select" certain topics to present while "sacrificing" other intriguing subjects. If readers are interested in the details of specific aspects, they can explore and read further in "*The Art of Establishing the Universal Health Coverage in Thailand: From Past to Present, c.1868-2002"),"* which is the comprehensive version of this work.

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Profile Sketch of the Authors

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completed her undergraduate and master's degrees from the Faculty of Liberal Arts, Thammasat University, before receiving a government scholarship to pursue further studies in History at the School of Oriental and African Studies, University of London, United Kingdom, at both the master's and doctoral levels. Currently, Nattanee is a faculty member at the Faculty of Liberal Arts, Mahidol University.

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completed his bachelor's degree in Political Science from the Faculty of Political Science, Thammasat University, and a master's degree in Gender and Development Studies from the Asian Institute of Technology, before receiving a government scholarship to further study at the master's and doctoral levels in Public Policy in the United Kingdom, firstly at the University of Bristol and then at King's College London. Formerly, Napaphat worked as a faculty member at the Institute for Population and Social Research, Mahidol University, and currently serves as a Social Affairs Officer at the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP).

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Universal Coverage Scheme: The heart of Thailand's Universal Health Coverage today

For me, I am a person
who finds happiness in my work,
even though it may be tiring and stressful.
However, coincidentally, the job that is my dream,
and that I want to achieve success
in is quite a significant task.
That is, I aspire to see a situation
where every Thai person can have comprehensive
access to the healthcare system,
and the received services must be of high quality;
not second-rate services.

Dr. Sanguan Nitayarumphong
considered to be the “Father” of Thailand’s Universal Health Coverage
(Chatree Charoencheewakul and Opiwan Nitayarumphong, 2011, p. 75)

Fundamental rights principle: The core of Universal Health Coverage

Before 2001, 29 per cent of Thais did not have any form of health security. Falling ill sometimes led to financial crisis due to health-related issues. The establishment of the Universal Coverage Scheme, or UCS, in 2001 changed this scenario. It granted the previously uninsured Thai population the "*right to health for themselves*." With all Thai citizens across the country under one form of health security or another, universal health coverage (UHC) was truly established in Thailand. Therefore, to understand the history of establishing UHC in Thailand, it is essential to discuss the inception of the UCS alongside it.

The recent period leading up to 2021 marked the twenty-year anniversary of the inception of the UCS (also known as the familiar "Gold Card"). This has been a significant milestone that has enriched rights and enabled all Thai people nationwide to access UHC. Additionally, in 2022, the two-decade milestone of the operation of the National Health Security Office, known by its acronym "NHSO" was reached. This organization has been responsible for overseeing and managing the UCS system since 2002.

The establishment of the UCS and the NHSO is the outcome of a significant healthcare system reform that has transformed and elevated the health and quality of life of the Thai population across various dimensions.

The establishment of the UCS also emphasizes that health is an "*urgent necessity*" and a "*government responsibility*" in providing essential services that all citizens can easily access as a "*fundamental right*" of the Thai people (Working Group for UHC Policy Development of the Health Systems Research Institute, 2001). For this reason, Thailand became one of the pioneering developing countries capable of successfully creating a UHC, offering opportunities for all Thais, regardless of their socio-economic status, to access essential healthcare services more extensively, without worrying about service costs (Isranews, 2016) or falling into poverty due to healthcare out-of-pocket expenditure. The achievements of the UCS and the role of the NHSO have resulted in more than 48 million Thais, or approximately 75 per cent of the total population, receiving necessary health services. These services encompass promotion, prevention, treatment, recovery, and long-term care over the past two decades (NHSO, 2021). Therefore, when mentioning the "Gold Card," it often entails referencing the "NHSO's role" as the essential pillar of joint administration and management (Wichai Chokwiwat, 2015, p. 43; Atthaporn Limpanyalert, 2020, p. 46).

Role of the NHSO in managing the benefits package

Currently, there are various types of registered healthcare units within the UCS. These include regional hospitals, general hospitals, community hospitals, sub-district health promoting hospitals, health centers, public health service centers, and community clinics in Bangkok. These facilities are established to provide essential healthcare services and are funded by the UCS. Additionally, the following measures have been implemented:

(1) The "Universal Coverage for Emergency Patients (UCEP)" program ensures that emergency patients can receive services at the nearest healthcare unit within the first 72 hours of an emergency without incurring any costs until they stabilize.

(2) Provision of the "Right to No-Fault Compensation for Initial Assistance in Case of Harm Resulting from Medical Treatment (according to Article 41 of the National Health Security Act of 2002)."

(3) Activities have been organized to promote preventive and proactive health initiatives. NHSO collaborates with local governments through the "Sub-district Health Fund" to offer comprehensive preventive services to eligible citizens at an average cost of 45 baht per person. These activities include the development of proactive health services for mothers and children, older persons, persons with disabilities, high-risk occupations, chronic patients, early childhood development centers, aged and disabled care centers, etc. The fund covers the entire population of 65 million, regardless of their entitlement.

Taken together, these measures are collectively aimed at enhancing health, disease prevention, and long-term care services, ensuring comprehensive and necessary care for all citizens.

Currently, beneficiary covered by the UCS can access a wide range of health promotion and disease prevention services, general diagnostic examinations, comprehensive disease treatment, management of chronic diseases/conditions, and treatment for specific high-cost illnesses. This includes services for common conditions like childbirth, neonatal care, cancer, chronic kidney disease, heart disease, diabetes, high blood pressure, HIV/AIDS, tuberculosis, and more. This coverage extends to dental care, traditional Thai medicine or alternative medicine services, as well as physical and mental rehabilitation for specific groups (as specified by NHSO criteria). It also covers palliative care and end-of-life care, as well as long-term care. The healthcare access includes the entire treatment process, room and board during hospitalization, medication, medical supplies, prosthetics, and medical equipment listed in the essential drug list. The service extends to referrals to other healthcare facilities if necessary.

All of this is truly remarkable. It took a significant paradigm shift for the Thai state to invest in comprehensive financial support for healthcare services for the majority of the population. This makes it even more intriguing to understand how Thailand's UHC was built and how it has evolved.

A full understanding the path of constructing Thailand's UHC requires looking back at the history of medicine and public health, especially events during the decade from 1967-1976, which had a substantial impact on molding the leaders in the healthcare sector of the country. These leaders came from diverse fields, including groups of progressive-minded physicians, forward-thinking medical students, nurses, dentists, pharmacists, public health professionals, and other individuals who immersed themselves in the rural experience, as well as professors and students from various disciplines. Volunteer enthusiasts and intellectuals from contemporary groups also became significant forces in propelling and driving UHC forward. They all played a crucial role in advocating for UHC and were involved in shaping the direction of the UCS and the operational stance of the NHSO, and continue to do so up until the present day.

However, this vision of the operations of the health reform movement did not arise solely from theoretical research or references to global health governance textbooks. Instead, it was a body of knowledge that emerged from the experiences of the rural medical movement when key individuals ventured into Thailand's remote rural areas (Suwit Wibulpolprasert, 2003). These experiences allowed them to experiment with prototypes and methodologies to assist the

impoverished and those with low incomes who lacked access to health knowledge and care services (Nopphanat Anuphongphat et al., 2013; Suwit Wibulpolprasert, 2003). It was a period of germination of ideas and social networks that gradually evolved into essential tools supporting the vision of creating UHC. This evolution extended to the management and administration of the UCS and the NHSO.

The period during 2001-02 can be considered a crucial turning point for the group of reformist physicians and stakeholders who were behind the push for the establishment of the UCS and the formal creation of the NHSO organization, institutionally supported by the National Health Security Act of 2002. Undeniably, that period marked a significant convergence of readiness in terms of knowledge, social dynamics, and political power to form a dynamic synergy. It was a time when environmental factors, foundational structures, service systems, institutional frameworks (such as the Constitution of 1997), and the history of various healthcare schemes all contributed to the emergence of a successful creation of the UHC. This transformation shifted the paradigm for both service providers and recipients, changing the perspective from "*charity*" to "*right entitlement*." Therefore, we now indulge the reader to rewind time and gain an understanding of the history of UHC creation in a concise manner, starting from the inception of the first healthcare service facility in Thailand.

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Healthcare facilities in Thailand: From the first day to today

In the midst of the decade from 1977-86, it was discovered that large hospitals in Bangkok and provincial hospitals were not being considered for budget allocations to expand their bed capacity. Instead, the focus was directed towards community hospitals by allocating a significant budget to rural areas. The ‘freeze mechanism’ meant that the budget was not allocated as extensively to large hospitals in Bangkok and provinces. That policy emphasized a shift toward primary care rather than secondary/tertiary care. We urged the Ministry of Public Health to adjust the budget to be in line with the government’s policy.

Komol Chobchurnchom
former Deputy Secretary-General of the National Economic and Social Development Board
(Interview with Komol Chobchurnchom, 15 May 2022)

Getting to the point in time when Thailand had its first hospital or healthcare facility was not an easy matter. However, once established, it raised the ongoing question of whether the quantity of healthcare facilities was sufficient to provide services or not. Moreover, there was a challenge to expand the number of healthcare facilities to a level that could cover a larger population adequately while maintaining a quality that was sufficient. In any case, without even having healthcare facilities that are widely distributed across the country, universal health coverage could not come into existence.

Siam's first hospital

Since the introduction of modern scientific knowledge and medical technology from the Western world to Siam, or present-day Thailand, a significant impact can be observed on the enhancement of modern-era public health knowledge. Specifically, the application of scientific knowledge has played a crucial role in reducing the rates of illness and death caused by epidemic diseases and contagious ailments. This has led to remarkable outcomes, such as a decrease in mortality rates among citizens and, subsequently, an increase in a strong and healthy labor force, contributing to the overall growth of the nation's economy. The integration of medical scientific advancements encompassed various levels, including individual health, well-being, societal advancement, and even governmental progress.

Indeed, preventing premature death was not a new concept in Siamese society at that time. Credit should be given to the various missionary groups that provided modern medical services along with spreading their religious beliefs. Key missionaries who entered Thailand, such as Dr. Dan Beach Bradley, Dr. Samuel Reynolds House, and others, played an essential role in introducing Western medicine to Siam.

Dan Beach Bradley

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was part of the third missionary group to Siam, and arrived in 1835. He established a pharmacy to provide medication for treating diseases, as well as distributing free medicines to the public. Subsequently, in 1838, an epidemic of small pox broke out in Bangkok. Dr. Bradley initiated the practice of cultivating preventive measures against pathogens to prevent diseases. This effort later expanded to nationwide initiatives in the field of preventive medicine.

Samuel Reynolds House

...

was another significant medical missionary who arrived in Bangkok about 12 years after Dr. Bradley. He introduced the use of anesthetic ether for the first time in surgical procedures on a female patient aged 84 years (circa 1848) effectively sedating her. The successful surgery led to House, also known as "Dr. Hao," becoming a renowned foreign doctor in that era.

The country's embrace of knowledge from the West led to significant changes in Siam's medical and public health landscape. This transformation affected treatment methods, technology utilization, medical tools, and the adoption of Western medicinal practices. Eventually, the concept of Western-style hospitals was introduced, with the first government-initiated hospital of this kind marking a turning point in health care.

The first state hospital in Siam was established in the central area of the capital, encompassing both the Phra Nakhon and Thonburi sides. It was officially opened in 1888. At that time, it was known as the "Wang Na Hospital" or the "Grand Wang Lang Hospital." Some may recognize it by the name "Siriraj Hospital." Initially, its purpose was to provide medical treatment to the sick without any charges (Royal Thai Government Gazette, 1887). According to historical documents, the inauguration of Siam's first state hospital is described as *"a part of the royal charity, where funds were generously provided by His Majesty the King to establish the hospital for the treatment and prevention of various diseases among the people"* (Royal Thai Government Gazette, 1888).

This initiative stemmed from the benevolence of His Majesty King Chulalongkorn, who donated materials and resources from the royal barges, buildings, and various belongings of his son, Prince Siriraj Kakuttaphan. These were used to construct the Wang Na Hospital, alongside a royal donation of 200 *chang* (a unit of measurement) of money, equivalent to around 16,000 baht (where 1 chang was worth 80 baht). This act became the origin of the hospital's name and is considered the first step towards the official development of Western-style medicine in Thai society.

After the establishment of Siriraj Hospital, several other healthcare facilities emerged, both developed by the government and the private sector. However, in the early stages, the expansion of healthcare services was relatively slow and primarily concentrated within the Bangkok metropolitan area. Meanwhile, the "up-country" regions remained relatively underserved. The government began to establish "*Osot Sala,"* which were distribution centers or dispensaries for medicines in certain areas.

The *"Provincial City Hospital"* and *"Osot Sala"* were the initial starting points for medical services in regional areas

Originally, providing medical care in remote areas through Western-style medicine was a task undertaken by private individuals. Many philanthropists established hospitals or medical service outposts by collecting donations from members of the royal family, government officials, merchants, and charitable local residents. The state might contribute partially to the funding, but fundraising was often a more straightforward approach than relying entirely on the government to build new facilities (Pensri Kaweewongprasert, 1985, pp. 67-68). In some wealthier areas where revenue was generated from business taxes, communities could establish hospitals independently without repeatedly seeking government funding. This confirmed that the government had not yet seriously committed to establishing hospitals in areas outside of Bangkok. If hospitals were established in provincial capital cities, they were primarily intended for charitable purposes rather than being seen as a government duty (Royal Thai Government Gazette, 1927).

Around 1895, the government promoted the establishment of "*Osot Sala*" to distribute medicines for treating fever. Osot Sala gradually transformed into the most significant medical service institution in the provinces during this era (Pensri Kawiwongprasert, 1985, p. 99). In these regional areas, the Department of Nursing was responsible for providing physicians, while local municipalities under the Ministry of Interior took charge of finding locations and allocating budgets for construction. However, in the initial stages, the operation of Osot Sala faced financial challenges and gradually closed down. In 1902, the government supported the reopening of Osot Sala with a similar nature to sell a broader range of medicines. It was renamed "*Osot Sapha*," with Prince Prawitwatthanodhom (HRH Krom Luang Prachin Kitibodee) serving as the chairperson to purchase medicines from abroad. There is a record of the establishment of the Osotspa. "Nowadays, medicines that are good medicines have many benefits. But if those medicines are not yet widely spread to the people living in remote areas and sickness in those areas, which could lead to significant dangers...Therefore, the Osot Spha was established..." (Royal Thai Government Gazette, 1902). This initiative led to the distribution of Western medicines, including quinine for treating malaria, chloroquine for treating cholera, fever reducers, pain relievers, and more, in various provincial capitals (Pensri Kaweewongprasert, 1985, pp. 75-77). However, the expansion of Osot Sapha was slow, and by 1921, there were only 43 branches nationwide (Apichat Satitniramai and Isakul Unahakate, 2021, p. 276). Nevertheless, Osot Sapha remained crucial in providing healthcare support to people in different regions.

Later, when the political landscape shifted rapidly from an absolute monarchy to a democracy with the King becoming a constitutional monarch in 1932, this seismic event was the catalyst for a sudden change in the healthcare sector to align with the new political paradigm.

Flagship policy: Building hospitals in rural areas

After the seismic events of the Siamese Revolution of 1932, a new constitution was established under the framework of a democratic system, with the king serving as a unifying figure. This constitution laid down the directive for the government to have the responsibility to care for all citizens. This directive elevated the significance of public health activities to a level comparable to other duties. Despite the absence of a comprehensive systematic development plan, these efforts progressed gradually in response to individual circumstances. Nevertheless, the government indicated a clear intention to expand health services to the population in the up-country areas. During the era of Prime Minister Field Marshal Plaek Phibunsongkhram (first term, 1938-1944), the government recognized that public health initiatives could contribute to a larger workforce, supporting the nation's economy and industries. These efforts also served as a cultural instrument, demonstrating that Thailand was a civilized nation, an international entity, and a united community. (Kongsakon Kawinraweekun, 2002, pp. 72–73; Plaek Phibunsongkhram, 1940, pp. 26-27). These initiatives also served as a means to proudly showcase the nation's achievements to the Western world. (Nopphanat Anuphongphat et al, 2013, p. 240;

Six categories of health service facilities defined in 1935

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1. First-class hospital with approximately 200 beds.
2. Second-class hospital with approximately 100 beds.
3. Third-class hospital with approximately 50 beds located in urban or municipal areas without the aforementioned two types of hospitals.
4. First-class health center with at least 1 physician, situated in a remote area from the hospital.
5. Second-class health center without a resident physician but with 1 assistant physician, established in an area without a first-floor health station.
6. Mobile Health Unit.

Source: "National Archives, (2) SR0201.27/9, Subject: Report of the Committee Meeting for Public Health and Medicine (6 December 1935 - 12 April 1937).

Weerasak Chansongsaeng, 2011, pp. 2–7). The prominently outstanding public health policy of this era is referred to as the "Flagship Policy" or the project to establish hospitals and second-class health centers in all provinces of the regional areas.

The "Flagship Hospitals" became a reflection of the establishment of Thailand's healthcare service system during a period when Thai nationalism was flourishing. This was particularly notable as it primarily focused on constructing healthcare facilities in the Thai border regions adjacent to French Indochina (present-day Lao People's Democratic Republic) in order to present an image of Thailand's progress to its neighbors. Some of the provinces included in this initiative were Ubon Ratchathani, Nong Khai, Nakhon Phanom, and Chiang Rai, among others. However, due to the state's financial constraints, it was not feasible to successfully establish hospitals in all provinces as initially intended.

As Thailand transitioned into the post-World War II era, a policy of revitalization emerged, leading to the revival of the initiative to construct hospitals in every province. This effort was undertaken under the name "Hospital and Health Center Establishment Project of the Ministry of Public Health -1946." The focus was on creating new medium-sized hospitals in each province. Smaller hospitals were established only in densely populated districts. Concurrently, efforts were made to expand existing first and second-class health centers into smaller hospitals, accompanying the construction of new hospitals. However, progress in hospital construction still faced challenges, as budgetary constraints continued to be a significant hurdle.

From the 1947 to the decade starting in 1967, over a span of more than 20 years, despite the good intentions expressed by every government of every era to expand services, the progress remained concentrated mainly in central areas, rather than in the regional ones. Various policies were implemented during this time frame, demonstrating the government's earnestness to extend healthcare services. These policies included the establishment of second-class health centers in rural areas at a rate of 100 centers per year until coverage included every sub-district, or Tambon (1948). The creation of the midwifery center was launched in 1954. The policy to establish district hospitals nationwide and the policy to ensure that every sub-district had a second-class health center within 4 years (1972-76) were also enacted. However, expansion efforts of healthcare facilities before the 1977-86 decade were predominantly centralized, rather than being evenly distributed in the regional areas. The decade starting in 1977 was another significant period for the development of both the quantity and quality of hospitals at the provincial and district levels.

The "Crown Prince Hospitals:" Politics and upgrading access to health services

In the 1977-86 decade, Thai politics became a significant driving force, influenced directly by political factors. For example, the establishment of hospitals served as a means to solidify political ideologies and compete for the support of the masses between the self-proclaimed democratic faction or the right-wing. Simultaneously, underlying factors aimed at improving the country's public health to uplift the underprivileged played a role in enhancing overall political stability. A direct political factor with an impact on healthcare was the "Crown Prince Hospital Project," initially intended as a single hospital but ultimately expanded to 21 hospitals due to unexpected groundswell of grassroots donations. This project was aimed at honoring the Crown Prince at the time, proposed by the Cabinet on December 28, 1976, shortly after the events of the crackdown on student protests, also known as the "Right Kills Left," on October 6, 1976.

The initial phase of the Crown Prince Hospitals project carried significant motives, particularly to declare the "*benevolence that extends to the masses,"* aimed at counteracting the communist movement, which at that time was composed of the royal subjects themselves (the right-wing faction referred to the communists or the left-wing faction as the "saboteurs"). Dr. Winai Sawasdivorn recounted his experiences while overseeing the financial aspects of the Crown Prince Hospitals in Lerng Nok Tha District, Yasothon Province, circa late 1970s: "*The hospital construction was part of the mass work. Crown Prince Hospitals were located in the red (*i.e. communist insurgency*) zone, as it was a strategic move by the Ministry of Public Health. The Ministry took good care of the hospitals to show that [*the state] *cares... so the hospitals received a bigger budget than others.*" (Interview with Dr. Winai Sawasdivorn, May 16, 2022). While the government's intention to utilize public health for political gain was evident, the Crown Prince Hospitals project itself helped elevate the service system and acted as a mechanism that emerged to enhance access to healthcare services during that particular era. Subsequently, not long after, the expansion of services at the district or community hospital level received support to move forward, once again in a significant wave, as the country entered the decade of 1977-86.

Expansion of community hospitals to all districts (1982-1986)

Similarly, due to political factors, the mid-period of 1977-86 witnessed a continuous expansion of healthcare units, driven by factors like politics. This expansion primarily focused on district-level healthcare facilities, including the increase in the number of beds and the capacity for medical services. During that time, under the leadership of Gen. Prem Tinsulanonda (serving

as Prime Minister between 1980-1988), the government made the decision to curtail the growth of large hospitals in Bangkok and provincial-level hospitals under the Ministry of Public Health. This decision aimed to utilize the limited state resources to prioritize the improvement of district or community-level hospitals. Additionally, the midwifery centers were upgraded collectively to become health centers (Suwit Wibulpolprasert, 2003, p. 36). As recounted by Komol Chobchurnchom, former Deputy Secretary-General of the National Economic and Social Development Board, describing the working environment during that era: "The 'freeze mechanism' meant that the budget was not allocated as extensively to large hospitals in Bangkok and provinces. That policy emphasized a shift toward primary care rather than secondary/tertiary care. We urged the Ministry of Public Health to adjust the budget to be in line with the government's policy" (Interview with Komol Chobchurnchom, 15 May 2022).

The outcome of this policy resulted in budget allocation and resource distribution favoring district and sub-district level healthcare services between 1982 and 1989. This allocation encompassed various resources that exceeded those allocated to provincial-level healthcare services. While the provincial-level budget increased every year, it still grew at a slower pace compared to the budget allocated to district and sub-district level services. Clearly, the budget reallocation aimed at developing healthcare facilities at the district and community levels had an impact on larger hospitals in Bangkok as well as several provincial-level hospitals. These hospitals had to defer their development and improvement efforts in order for the state to prioritize community-level hospitals by allocating a significant portion of the budget to rural areas. A prime example illustrating this phenomenon was the new building project for Lerdsin Hospital, which was allocated a budget of 500 million baht. This budget could have been utilized to construct up to 50 community hospitals. Eventually, the Lerdsin Hospital building project had to be postponed. This information highlights that, throughout the 5th National Economic and Social Development Plan (1982-86), larger hospitals in Bangkok and provincial-level hospitals did not receive budget considerations for expanding bed capacity (Suwit Wibulpolprasert, 2003, pp. 36–38).

By 1987, Thailand had a total of 557 community hospitals and 89 branch hospitals, along with 7,649 health centers and 478 community health offices in sub-districts and disaster-prone areas. Throughout the period from 1967 to 1987, the number of health centers (including midwifery centers) had tripled, and the number of hospitals under the Ministry of Public Health had increased sixfold (Suwit Wibulpolprasert, 1988, p. 145). Comparing data between 1981 and 1987, it can be observed that the number of community hospitals increased by 247 and health centers increased by 1,326.

The expansion of healthcare facilities continued in the years ahead. In 1992, the "*Decade of Health Center Development*" project was initiated, with the aim of establishing 1,400 new health centers between 1992 and 2001. Additionally, efforts were made to enhance the capabilities of existing general health centers, transforming them into larger health centers equipped with improved facilities and tools (National Archives of Public Health (14) SB 1.4/2.284, n.d.). A campaign for cleanliness, painting, administrative system organization, indexing, and health information filing system implementation took place. In sum, a total of 1,576 centers were established and upgraded as a gesture of reverence and goodwill to Her Majesty Queen Sirikit on the occasion of her 60th birthday. These centers were bestowed with the name "Health Centers Celebrating the Auspicious 60th Birthday Anniversary of Queen Sirikit."

In general, the period of rapid expansion of healthcare facilities must be credited to the political climate, leadership, political policy involving the military to counter communism, and other contextual factors of that time. The good and favorable political atmosphere, along with the leadership's commitment to overcome communism, played a significant role. The health policies also aligned with the concept of Primary Health Care (PHC), which had been pushed forward through to the late 1970s, transforming it into an era of elevating lower-level healthcare services in the regional areas of Thailand.

When the government allocated significant budgets to rural areas, allowing for the extensive expansion of district-level hospitals and community health centers, it became a significant historical event. Certainly, the expansion of various levels of healthcare facilities would lack significance if there wasn't an accelerated effort to enhance the production of medical professionals. This workforce was essential to provide consistent care and service at these healthcare facilities. The expansion of health service facilities is inherently tied to the need for a corresponding increase in the medical workforce, ensuring that there were enough personnel to fulfill roles and responsibilities within these facilities.

When streams converge,
Universal Health Coverage
was born, c.1868-2002

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Crisis and solutions for health workforce

Being sent to rural areas
was like sending someone to their doom.
The travel was arduous,
and neither the medical representatives
nor government officials ever visited.
It was difficult. When you're out there,
the communist influence starts to take hold.

Dr. Siriwat Thiptharadol,
a physician who worked under the compulsory service policy,
former Director of the Health Systems Research Institute (HSRI) and
former Secretary-General of the Food and Drug Administration (FDA).
(Interview with Dr. Siriwat Thiptharadol, May 20, 2022)

It is commonplace that if there are healthcare facilities like hospitals, it is necessary to have doctors and healthcare personnel fulfilling their duties. The pathway of producing physicians and medical professionals in Thailand started alongside the period when Western-style hospitals were established. After the founding of Siriraj Hospital and the subsequent expansion of healthcare units throughout the country to provide public health services, the need for human resources to sustain the system became an unavoidable necessity.

From Bhatayakorn School to a contemporary medical institution

Before introducing Western medicine into pre-industrial Thai society, there were "Moh Chaloeisak," which referred to local doctors who treated people with traditional Thai and Chinese remedies. This traditional approach to healthcare was rooted in Siamese society. Some individuals might have learned about traditional healing methods through oral transmission and copying hand-written guides or recipes. This knowledge transmission was often limited within families. In some cases, individuals received training or education from experienced doctors who took them as close apprentices until they became skilled enough to practice medicine themselves. Some learned from textbooks and engaged in self-directed practice until they became proficient enough to claim they could serve as doctors. However, the path of traditional medicine began to change when the Siamese state established medical and nursing schools following the establishment of Siriraj Hospital.

Origin of Nursing care

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Science-based nursing and midwifery care began for the first time in 1896 through a donation from Her Majesty Queen Saovabha Phongsri, who established the "School of Midwifery and Nursing" and utilized facilities in Siriraj Hospital. However, people in society still preferred not to give birth in hospitals, so the development of modern OB-GYN care progressed quite slowly.

In 1908, there was a reopening of the "Department of Midwifery and Nursing School" at the Royal Medical College. Subsequently, specialized nursing courses were introduced at Chulalongkorn Hospital (1914), and two years later, the General Nursing Council took over the hospital and nursing school, leading to the establishment of the "General Nursing School of Siam." Later, its name was changed to the "General Nursing School of Thailand."

During this time, Vajira Hospital started offering a 6-month midwifery training program without certification. In 1942, a 1-year midwifery course was introduced based on the midwifery center approach.

Finally, in 1956, the first Bachelor of Nursing degree program was initiated at the Midwifery and Public Health Nursing School, Faculty of Medicine and Siriraj Hospital.

The state-run medical school following the Western model was called the "Bhatayakorn School." It is considered the first medical school in Thailand aimed at producing physicians and nurses in the Western medical tradition. At that time, the Department of Nursing oversaw its operations. This school commenced its first day of instruction on September 5, 1890 (Pitakpol Wisuth-umporn, 2018). Subsequently, there were improvements to the school's buildings and another name change to the "Rajapattayalai" (Royal Medical College) in 1900 (National Archives of Thailand, ST 59.1/3, 1907; National Archives of Thailand, ST 59/1, 1900). During the early years of instruction at the Rajapattayalai, the curriculum for both Western and Thai medicine was combined. The criterion for admission for the first class of students was only basic literacy. The curriculum was initially set at three years, leading to graduation. Later on, the duration of study was gradually extended to four, five, and then six years.

In 1916, a significant transformation took place in the medical education landscape. The merging of the Royal Medical College (Rajapattayalai) with the Civil Servant School led to the establishment of Chulalongkorn University. The Royal Medical College, or the current Faculty of Medicine, Siriraj Hospital, then evolved into the "Faculty of Medicine" of Chulalongkorn University. However, in 1943, the Faculty of Medicine separated once again to become an entity known as the "Faculty of Medicine, Siriraj Hospital under the University of Medicine (until when Mahidol University was established in 1969, it was changed to be affiliated with Mahidol University). Chulalongkorn University itself established its own Faculty of Medicine as the second medical school (1947). This was followed by the Faculty of Medicine, Chiang Mai University, as the third Thai medical school in 1959, and the Faculty of Medicine Ramathibodi Hospital as the fourth in 1965. Thus, these are considered the first four medical education faculties in Thailand. Subsequently, numerous other medical schools affiliated with universities emerged to address the challenge of medical personnel shortages in different eras. The history of medicine in Thailand also highlights a significant event known as the *"brain drain"* phenomenon in the late 1950s, which had a profound impact on the Thai public healthcare system.

Shortage of Thai medical personnel: A classic dilemma, from past to present

One of the issues that persisted since the establishment of medical education was the insufficient annual production of physicians to meet the demand. Moreover, there was an ongoing concern about the standards of medical education, which were relatively low, and a shortage of modern equipment. Part of this stemmed from the fact that Western medicine was relatively new to Thai society. Thus, it is not surprising to encounter issues regarding lower-than-expected standards of medical education. When Prince Rangsit Prayurasakdi (Prince of Chai Nat), assumed control of medical education in 1915, he emphasized basic medical sciences and introduced the teaching of Pharmacy for the first time. The medical school also hired numerous foreign professors to teach various subjects. Subsequently, efforts were made to improve the situation, including collaboration between Siam and the Rockefeller Foundation. In October 1922, this collaboration led to significant changes. Notably, Prince Mahidol Adulyadej, later the Father of Medicine in Thailand, played a crucial role in attracting the Rockefeller Foundation's assistance in curriculum development and infrastructure. The prince also donated his personal funds to construct buildings and support physicians to continue their overseas studies. The mid-1920s marked a turning point in establishing the direction of medical education in Thailand, aiming to align it with Western practices. In the midst of the decade from 1917-1926, significant advancements were made to steer medical education more fully toward Western standards.

In terms of the quantity of graduates, there continued to be an insufficient number and an inadequate supply to meet the needs of the Department of Public Health (during the period when it was under the Ministry of Interior). As a service provider and user of medical personnel, the Department proposed implementing education in the 'second-tier medical system.' This would expedite the process of producing a sufficient quantity of workforce in the near-term, while reserving quality for later. This approach aimed to address the specific shortage of personnel promptly and utilize medical professionals in various provincial capital cities that were severely undersupplied. However, this strategy of emphasizing quantity over quality in medical workforce production was strongly contested by the Rockefeller Foundation, as they strove to produce highly distinguished physicians more than anything else (Chatchai Muksong, 2018, pp. 353–354). These conflicting positions are reflected through the Medical Act of 1923, in which the Department of Public Health attempted to expand its authority to control and oversee medical education. Previously, this authority was under the jurisdiction of medical schools (under the Ministry of Education). The Department of Public Health began by enforcing regulations in Bangkok and then extended these declarations to other cities. Consequently, the conflict between producing physicians for "quantity" and for "quality" became a focal point, highlighting that knowledge,

teaching methods, and the objectives of medical education have been questioned and challenged since the inception of the public health framework. These issues would intensify over time, particularly during the period of 1957-1977, as seen in the phenomenon of the brain drain.

Brain drain of Thai physicians during the expansionist era of the US government

Based on the numbers found, it is evident that during the decade from 1957-66, there was an increasing trend of Thai physicians traveling abroad for work. In 1965, a total of 277 physicians went abroad for further study or work, but only 91 returned. In the years 1966-1969, the numbers increased to 337, 281, 616, and 655, respectively. Combining the figures from 1965 to 1969, a total of 2,165 physicians went abroad, but the number of those who returned to Thailand was only 987. This indicates that less than half of the physicians who traveled abroad to work had returned to Thailand (Thassanee Thammathat, 1972, p. 45). Additionally, there was one highly publicized occurrence where the first class of medical graduates from Chiang Mai University, totaling 50 individuals, traveled to the United States immediately after graduation, with 48 of them working and continuing their education in the US (Santisuk Sophonsiri, 2012, pp. 148-149; Wibulpolprasert, and Pengpaibon, 2003, 12). That incident can be referred to as chartering a flight solely to work in the United States. One significant condition that influenced the brain drain situation during this era was the demand for physicians in the United States. This was due to the need to compensate for doctors who were sent for service in the Viet Nam War and the establishment of health insurance for the low-income and older persons. When the United States facilitated convenience for newly graduated doctors by standardizing and certifying them through examinations, this only intensified the phenomenon (Wiwan Ekarintarakul, 2004, p. 140). Indeed, at one point, the number of Thai doctors working in the state of New York alone exceeded the number of doctors in rural areas throughout Thailand. This propelled the issue of physician (mal-) distribution in Thailand between urban and rural areas to become more prominent.

The issue of medical personnel along with the dimension of inequity in public health

Apart from the already low number of physicians within the system, the problem became more pressing when the distribution of physicians is disproportionate. Records show that in 1970, even though the population in the areas of Phra Nakhon and Thonburi accounted for only 8 per cent of the total population of the country, two-thirds of Thai physicians were practicing

in those two locations, equivalent to a doctor-to-population ratio of less 1 per 1,000 (Bryant, 1970, p. 48). If we exclude the number of physicians in Bangkok and Thonburi and calculate the remaining ratio of physicians to the population in all provinces nationwide, the ratio could be as unfavorable as 1 doctor per 31,000 people and, in some areas, it could be as bad as one doctor for every 100,000 population.

A query posed by Mr. Boonchuai Srisawad, a Member of Parliament representing Chiang Rai Province in 1958 vividly illustrates the unequal distribution of physicians between urban and rural areas at the time. The government admitted that each province had a doctor-to-population ratio of approximately 1 per 100,000 people. Furthermore, there were five provinces—Buriram, Sisaket, Surin, Kalasin, and Roi Et—with doctor-to-population ratios lower than 1 per 100,000 people. Moreover, around 254 districts across the country had no resident doctors at all. All of these districts with insufficient resident doctors were concentrated primarily in the northeastern region, totaling 82 districts, followed by the northern region with 64 districts, and the third highest being the southern region with 43 districts. The central, eastern, and western regions followed with 29, 19, and 17 districts, respectively (Royal Thai Government Gazette, 1958). What is worse is that the doctors who were assigned to different provinces were often few in number, and many of them were confined to working exclusively in city-center areas of those provinces.

The issue of being tied to working exclusively in city-center areas arose due to the fact that a significant portion of physicians could not operate in areas lacking basic facilities, such as transportation, electricity, water supply, educational institutions, and even well-equipped hospitals. Being stationed in a remote area denied medical personnel the opportunity to further their education and progress academically, hindering their professional advancement. Additionally, the unfamiliar social environment in rural areas presented another challenge, including impoverished populations, low levels of education, communication difficulties due to the use of local dialects, and adherence to traditional customs. All these circumstances can be labeled as “incompatible with medical knowledge,” as extensively observed. This situation evolved into a persistent and formidable challenge for newly graduated doctors in general. Therefore, it would be unfair to solely blame physicians for opting to reside in urban areas in those early days. Instead, it helps to reflect on the educational approach that did not necessarily prepare medical students to work in Thailand’s rural areas. Nevertheless, the pressing issue of personnel shortage was becoming more severe, compelling the government to implement “mandatory funding policies for physicians” as a strategy to create conditions to more directly address the health workforce shortage problem.

The origin of the system of government bonding for medical graduates

The method of compulsory rural service through mandatory bonding emerged in the Thai medical education system to combat the brain drain problem. This strategy was first introduced in 1967 when medical students were initially given the choice between government service in exchange for funding or paying a high penalty to be exempted from service (which essentially meant choosing one or the other). At that time, the Cabinet resolved that medical students in public medical schools could pay an annual educational fee of around 10,000 baht to exempt themselves from serving the government in rural hospitals after graduated. They would then be free to pursue their career independently upon completing their studies. On the other hand, medical students who opted not to pay the educational fee were required to sign a contract to serve the government for a period of three years (Secretariat of the Cabinet, 1967; Matichon Online, 2018). Initially, all female medical students were compelled to pay the higher fee only. This was due to the fact that there was limited government demand for female physicians in rural hospitals. It is also possible that the policy makers felt that young, female medical graduates would have a hard time adapting to life on their own in a remote rural district. This led to resistance from female students who argued that there was gender discrimination. Subsequently, the approach gradually shifted towards the compulsory rural service policy, requiring all new doctors (from public universities), to work for the government in exchange for a subsidized medical education. This is the origin of the physician rural service program, which has evolved over time and adjusted to match societal conditions up to the present day. Although, initially, there was opposition from some medical students who disagreed with the compulsory nature of the program, the resistance gradually decreased amid the political turmoil of the late 1960s, which compelled some physicians to feel a duty to serve the public.

The emergence of the pioneering mindset of the progressive era's physicians

The social and political context during the 1967-76 decade became a significant driving force that enabled the implementation of a policy to allocate funds for spreading doctors to rural areas, which became a reality in the 1977-86 decade. Part of this was due to forward-thinking senior medical professors within the university at that time who attempted to guide the work approach for medical students as mentors to their disciples. While the medical student movement within the university itself was in a phase of growth and nurturing their own thoughts and ideas, many medical students during that time felt a strong urge to use their knowledge

to help provide medical services to people in distant rural areas. This sentiment evolved into a "contemporary ideals," where medical students aspired to reciprocate and embrace the state policy of mandatory bonding with enthusiasm. For instance, the role of the Medical Student Center of Thailand (MSCT) was a significant group that advocated for the abolition of expensive semester fees in lieu of rural work. They strongly urged that "every new graduate doctor should have an obligation to work to offset the expenses" (Suwit Wibulpolprasert, 2003, pp. 8–9). The response to this bonding policy differed from the previous environment, as a considerable number of newly graduated doctors chose to turn their attention away from urban areas and focus on rural communities.

Beyond the implementation of compulsory amalgamation policies driven by political forces, addressing the issues of scarcity and equitable distribution of resources in the 1977-86 decade remained within the strategies of the 4th National Economic and Social Development Plan (1977-1981) and the 5th National Economic and Social Development Plan (1982-1986). These plans emphasized the expansion of community hospitals to cover all districts, as previously explained, along with the foundational concept of Primary Health Care (PHC). Both approaches brought about a transformation in roles according to the principles of PHC. On one hand, the policy of expanding community hospitals in every district necessitated the recruitment of a considerable number of new medical personnel to serve various hospitals. On the other hand, the PHC approach shifted the responsibilities of personnel towards promoting community participation in addressing health-related issues through the framework of PHC. This led to the emergence of Village Health Volunteers (VHV) and Village Health Communicators (VHC), both of which became crucial forces in advancing fundamental public health efforts. These roles encompassed health promotion, disease surveillance, prevention, basic healthcare provision, and community health development activities (Nonglak Phakaiya and Pennapa Pongthong, 2011, pp. 17-18).

The changing perspectives in rural areas and the transformation of the roles of medical personnel in rural settings, as mentioned, led to adjustments in the curricula of medical, nursing, and pharmacy education to align with these changing roles (Somsak Chunharas, 1998, p. 43), among other things. For instance, there were improvements in the medical education curriculum to prepare physicians for practicing in rural areas according to PHC principles. This included the segmentation of medical services into three levels: primary, secondary, and tertiary care. Furthermore, there was a policy of sending medical students for skills training in community hospitals across various provinces for a period of 3-6 months. This was part of the effort to ensure that medical education prepared physicians adequately for their work in rural communities and to enhance their practical skills within these settings.

Additionally, in 1982, the establishment of the "Medical and Public Health Coordination Committee" and the "Medical and Public Health Coordination Center" took place (Mahidol University Archives and Museums MU.OP.A6.1.5, File 342, Box 95, n.d., pp. 37-41). These initiatives were aimed at serving as mechanisms to align human resource production with the country's healthcare service development direction. They fostered collaboration among organizations involved in personnel production and utilization for healthcare, such as educational institutions, the National Economic and Social Development Board, Office of the Civil Service Commission, the Budget Bureau, the Medical Council, the Nursing Council, and more. These efforts resulted in the ability to develop plans for training physicians and healthcare personnel to meet the demands of rural healthcare systems. Consequently, there was an increase in healthcare personnel in every community hospital and health center. The distribution of physicians to different regions also improved significantly, enhancing the overall healthcare landscape in rural areas (Nonglak Phakaiya and Pennapa Pongthong, 2011, pp. 11-12).

The compulsory rural service policy was implemented in 1982 to expand the coverage of dentists in public health facilities, and this policy was extended to pharmacists in 1984, with an obligation period of 2 years. The policy was also applied to nurses and public health officers who successfully completed their education under the aegis of the MOPH. Scholarship recipients were required to work in hospitals or health centers under the jurisdiction of MOPH for a period equivalent to their study duration (e.g., studying for 4 years required 4 years of service). This approach was sustained throughout the 1977-87 era, leading to a continuous increase in Thailand's capacity for producing healthcare personnel. By examining the numbers, in 1978, Thailand was able to produce only 452 doctors per year. This number grew to 793 in 1984, and in 1985, a year in which the production quantity nearly doubled, the count reached 1,022 doctors (Praboromarajchanok Institute, Ministry of Public Health, 1999, p. 21). This significant increase was attributed to curriculum adjustments that reduced the curriculum from 7 to just 6 years (Somsak Chunharas, 1998, pp. 44-45). Consequently, this became the sole year when two batches of medical students graduated simultaneously.

Certainly, the improving situation of physician distribution was "looking good" due to these policy interventions. However, one much consider the effect of the larger context, especially during the period of 1977-87. When it comes to human resources, the issue of relocating medical personnel workplaces is subject to the ever-changing political, economic, and societal contexts. For instance, at the peak of private hospital growth around the late 1980s, there was a substantial outflow of medical personnel from the public sector to the private sector. Yet, when the economic crisis of 1997 hit, healthcare personnel from the private sector returned to government positions, indicating a similar trend. Various mechanisms were used to address

the issue of shortages, many of which are not extensively discussed here (such as projects to increase rural doctors, new graduate orientation programs, specialized training for physicians by the Medical Council, specialized physician distribution to community hospitals, and more). In sum, it is important to highlight that uneven personnel distribution remained a "classical problem" that has persisted from the past (and continues to be a challenge even today). The severity of the situation may vary, but ignoring the importance of human resource development is not an option. This is because healthcare personnel would continue to be a crucial element driving the establishment of UHC and propelling the overall health system forward.

Amidst the decade of 1957-66, there were still pressing issues regarding physician shortages, particularly in rural areas. This crisis was partly due to the brain drain to Western countries, especially the United States, or the attraction of physicians to urban areas. Consequently, policy measures were initiated to address this gap by obligating new medical graduates to serve as government employees in rural areas. Initially, enforcing these policies proved difficult. Fresh medical graduates often felt ill-prepared for the challenges of remote rural practice, believing their training did not align with the demands of such settings. However, in the atmosphere of political awakening of the time, the vision of "public health for the masses" emerged, forming the foundation for the idea of "working for rural development" and promoting "community-oriented medicine." These ideas would later become one of the answers to rural healthcare development. While there were minor improvements due to the emergence of a commitment to rural work among healthcare personnel, it should not be forgotten that the resolute dedication of rural healthcare personnel to serve the masses was not a natural occurrence. The political context in the 1960s and 1970s, including the events of October 14, 1973, and October 6, 1976, served as catalysts to the emergence of a powerful current of thought, which will be discussed further.

Human resources for health remain a crucial component driving the creation of Universal Health Coverage and ensuring the overall health system continues to move forward.

When streams converge,
Universal Health Coverage
was born, c.1868-2002

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Two decades (1967-1987): Nurturing ideas and leaders in the Thai health system

The older generation of professors
had these thoughts long before,
about how being ignorant, poor, and sick.
It is not that they belittled others,
but they wanted to convey that the situation
was like that. As for students in that era,
they believed they had to ‘go to the community’;
and serving rural areas was the answer.
Most of the physicians who went out to
rural areas did so because they [felt]
it was a responsibility, not just due to
the government bonding requirement.

Dr. Amphon Jindawatthana,
reminiscing about the atmosphere when he was
a medical student, graduating in 1976.
(Interview with Dr. Amphon Jindawatthana, May 18, 2022)

Starting from 1973, the aim of developing rural communities transformed into a fundamental premise and significant concept within the realm of "healthcare system reform." This has had a lasting and interconnected impact, linked to the emergence of comprehensive health security principles in the late1990s and into the new millennium.

Streams of thought: Forces pushing for health reform

The shared experiences and memories of the events on October 14, 1973, and their aftermath, leading to the incident on October 6, 1976, ignited a *spark of thought* within the minds of the people during those times. This included a considerable number of medical professionals and healthcare personnel who wished to work to better the condition of the rural population. This determination can be observed through the notable contributions of the Rural Doctors Society and various non-governmental organizations (NGO) that helped propel the reform of the Thai healthcare system.

At the same time, the Thai economy, since the late 1950s, significantly contributed to the emergence of a critical awareness of binary opposition in various dimensions within society. This divergence is evident between high-ranking doctors with specialized degrees and village doctors or traditional healers, between Western medical knowledge and traditional medical practices, and between the advanced healthcare systems in urban areas compared to the slower progress in rural settings. The concentration of healthcare professionals in urban areas alongside severe shortages in rural areas created a distinct dichotomy between progress and lagging behind, with the rural areas (and its inhabitants) becoming emblematic of the latter, underserved and in need of development (Kongsakon Kawinraweekun, 2002). Even though students, scholars, and the general public during that era had diverse political affiliations (ranging from liberalism, social democracy, to even communism), they shared a common belief in one aspect – the need to emancipate villagers and the labor force from the trap of hardship in life and to address the problem of inequality. They believed that political power should not remain within an authoritarian regime. Thus, both the October 14 event and the October 6 incident utilized the idea of stark binary division or the unjustness or inequity in society as crucial rallying points for demanding political change from the government.

Sulak Sivaraksa, a significant intellectual figure in Thailand, reminisced about the atmosphere of debates surrounding the concept of "equity" within Thai society, spanning from the period before October 14, 1973, and continuing through to October 6, 1976. This reflection was published in the journal "Social Science Review," a platform that served as a conduit for ideas and discussions among scholars, students, medical professors, and intellectuals, including the following excerpt:

> *"The understanding of equity in the rural context was something that many medical students needed to grasp. People like Vichai [Dr. Vichai Chokwiwat] took a firm stance on this matter. When it came to the concept of equity, it is definitely related to public health, well-being, life, the rural population, artisans, and so on. These are topics that were extensively debated at the time…We even invited Professor Puay Ungpakorn from the Central Bank, we invited Professor Sanya [Dharmasakti], and one after another…They came to have casual discussions with the youth. Sometimes, 5, 6, or 7 youth peer leaders would want to know about something. So, we talked about everything*
>
> *– public health, equity, etc." (*Interview with Sulak Sivaraksa, May 29, 2022).

When the debates made the issue of rural areas and inequity a clear moral example, the group of medical students and intellectuals from the middle class began to gain a better understanding of the social situation. The initial notion that villagers in rural areas were "ignorant, poor and sick" was the catalyst and motivating force for these individuals sense it was their duty to extend knowledge and assistance to the rural folk in order to promote social equity. The intense fervor of that time was reflected very prominently, to the point where the phrase "ignorant-poor-sick" became a significant philosophy of the founding university of medical education, Mahidol University (Sanguan Nitayarumphong, 2004, pp. 34-36). This philosophy also became the origin of the "walking together" movement, a significant activity for rural development involving numerous groups of students from Mahidol University and other universities during the period of 1967-77.

Entwined with the issue of "ignorant-poor-sick" vicious cycle

The issue of "ignorant-poor-sick" was approached directly through three distinct avenues during this time. Thammasat University took on the responsibility of tackling education and economics to alleviate "ignorance." Kasetsart University focused on agricultural development to alleviate "poverty," while Mahidol University took charge of public health to alleviate "sickness"

(Interview with Professor Saichol Sattayanurak, May 26, 2022). These efforts were undertaken as part of the "*Mae Klong Integrated Rural Development Program* (MIRDP) in 1974," aimed at fostering development in provinces including Nakhon Pathom, Ratchaburi, Suphan Buri, Phetchaburi, Kanchanaburi, Samut Sakhon, and Samut Songkhram. Moreover, as Mahidol University was producing medical professionals, it utilized this opportunity to reflect the community-based approach, a concept being discussed and advocated for during that time. For instance, creating community volunteers (MIRDP, n.d.) was one of the visions being pursued and aimed to materialize then. However, while the MIRDP did not ultimately fulfill its aspirations and was halted shortly after its inception, the core ideas and the entirety of the program's plans showed that the solution to the ignorant-poor-sick issues lay in recognizing the importance of collaboration to provide assistance to society in multiple ways. This highlighted the concept of "interconnectedness as a chain" (William H. Becker, 2013, pp. 138-140).

The concept of interconnectedness as a chain is simply about linking problems and their solutions through collaborative integration. Individuals who excel in certain areas contribute their distinctive attributes to provide assistance, while those with lesser expertise should seek collaboration from other sectors that possess more relevant skills. Another crucial aspect is that problem-solving should be community-focused, aiming to enhance the potential of villagers by elevating their "quality of life," addressing essential "needs" and local "wants," such as increasing income, improving health, enhancing education, promoting community cooperation, and collaboration with governmental entities. This collective effort aims to "empower villagers to become self-reliant." "When revisiting the core principles of being a physician, it becomes evident that political factors have shifted the perspective from being a 'healer of *individuals*' to becoming a 'healer of society.' This signifies that being a physician should involve not only addressing patients' medical conditions but also inquiring about other sufferings in their lives" (Interview with Emeritus Professor Dr. Prawase Wasi, May 29, 2022).

"Ignorance-poverty-sickness"

...

is a depiction reflecting a significant issue in Thai society at that time, where a majority of people had limited knowledge. with limited knowledge, their income was also diminished. when they fell sick, they lacked the funds for medical treatment. falling ill frequently further impacted their income. When lacking money, they chose not to seek treatment due to their lack of awareness, creating a cycle of ignorance leading to repeated suffering.

While the concept of "ignorance leading to poverty and illness/suffering" was becoming a prevailing sentiment in societal discourse, there was a fervent intensification of ideas and practices in the late 1960s. Influences from the global health arena and international figures in the early 1970s had an impact on shaping the trajectory of Thailand's health system development in the subsequent years.

Toward "Health for All"

In 1978, the Alma-Ata Declaration, held in Alma-Ata (later known as Almaty), USSR, marked the official launch of the Primary Health Care approach, aimed at developing health systems globally towards the goal of achieving "*Health for All by the Year 2000*." Since then, the PHC approach has become a central narrative widely discussed in Thailand's health sector.

The essence of the Alma-Ata Declaration was that health signifies well-being across p**hysical, mental, and social dimensions;** it goes beyond solely considering disease and disability, emphasizing a **basic human right to health.** The approach seeks **comprehensive health services accessible to all**, aiming to reduce inequalities. Emphasis is placed on **health promotion and prevention** as integral components that drive economic and societal development,

N-E-W-I-T-E-M-S

The 8 fundamental components of Primary Health Care in its initial stage were as follows:

1. Nutrition
2. Education concerning health
3. Water and basic sanitation
4. Immunization
5. Treatment
6. Essential drugs
7. Maternal and child health care including family planning
8. Surveillance for local disease control

Later, in 1993, six additional components were introduced, which are:

9. Mental health
10. Dental health
11. Environmental health
12. Consumer protection
13. Accident and rehabilitation
14. Prevention and control of AIDS

leading to a better quality of life. While governments should be responsible for providing sufficient health services to their populations, the **"PHC as the key to reach the goal"** principle underlines the importance of equality in social development. The PHC approach also empowers individuals, families, and communities to develop self-reliance and make decisions regarding their own healthcare. Its implementation depends on the country's budgetary capacity to support such developmental efforts. This is the origin of using the Primary Health Care approach as the solution to achieving comprehensive well-being (World Health Organization, 1978, pp. 2-4).

The four key strategies of PHC are community participation, intersectoral collaboration, appropriate technology, and essential health systems. These strategies are aimed at driving healthcare reform in rural areas. These dimensions of reform can be summarized into eight components often referred to as "N-E-W-I-T-E-M-S."

Upon thorough consideration, it became evident that any solution to the perplexing issue of "ignorant-poor-sick" vicious cycle would have to confront the political reality and social injustice prevailing in Thai society at the time. The solution must also align with the global PHC framework. Both approaches offered interesting avenues for addressing public health concerns that are coherent. When looking at health from various dimensions, it became clear that the solution was not solely a matter of health. Rather, it would necessarily involve examining family factors, societal influences, environmental elements, and the diverse aspects of individual lifestyles. This approach led to methods of addressing health-related problems. The situation would be even better if the general population was empowered to self-sustain, self-manage, and self-prevent their health status. All of this was the foundation of initial knowledge that was emphasized during the intense period of reflection from 1967 to 1977.

Therefore, the decade of 1977-86 is considered a period when the government placed special importance on rural development. It can be said that Thailand's public health expanded from urban to rural in a genuine and comprehensive manner. In particular, there was an acceleration to extend PHC to cover the rural population. The Thai government set a goal for a 5-year plan to expand coverage of PHC services to 22,400 villages in 68 provinces, benefiting a total of 18.5 million people. This effort was also guided by the 4th National Economic and Social Development Plan (1977-1981) proposed by the MOPH, which led the health sector toward a clearer direction of PHC. The strategies outlined by the MOPH since 1977 contributed to the creation of health personnel who were more "closely linked" to the community and rural areas, which are at the heart of PHC. This involved establishing cadres of Village Health Volunteers (VHV), Village Health Communicators (VHC), and even the deployment of medical personnel from the central administration to rural areas.

Although the policy-driven financial compensation for physicians in rural areas during the majority of the 1977-86 decade was somewhat coerced, a portion of doctors and healthcare personnel started to embrace the lifestyle and work in rural areas. Some professors, students, and newly graduated medical professionals believed that venturing into rural communities allowed them to utilize their expertise to contribute to rural development, and assist villagers in breaking free from the chains of ignorance, poverty, and illness. Concurrently, the personal convictions of individuals aiming to establish equity for rural inhabitants prompted them to redefine the term 'rural' as an 'opportunity-rich area.' This concept led students, upon completing their studies, to engage in further learning and practical experiences to comprehend the significance of sacrificing oneself for the well-being of the public. As observed by Dr. Sanguan Nitayarumphong, a rural physician and the founding Secretary-General of the NHSO, this trend exemplified the decisions made by medical students who aspired to become rural doctors during that time:

> "*Upon graduating as physicians in 1977, many of my friends and I immediately went to work in rural areas according to our intentions... At that time, we felt that going to work in cities after graduating wasn't the right choice. It seemed like those who did were just seeking comfort and luxury. We would have felt ashamed among our peers... The more challenging and difficult the place we were assigned to, the better it was for us."*
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> (Chatree Charoencheewakul and Opiwan Nitayarumphong, 2011, pp. 50–51).

Dr. Winai Sawasdivorn, a rural physician and former Secretary-General of the NHSO, also shared a similar perspective of rebuilding and restoring, stating that:

> "*After graduating from Siriraj [medical school], I went to work at a* Crown Prince *Hospital in Yasothon Province…I traveled by tour bus. I had been there for less than a year when the Communist insurgency attacked and burned down the dormitories. There were issues at that time, but I worked with determination, wanting to utilize my knowledge and abilities in my work…I used to see around 200-300 patients a day in the Out-Patient Department (OPD). It felt like an endless stream of patients, but if we could do it, we did. We took care of each other"*
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> *(*Interview with Dr. Winai Sawasdivorn, May 16, 2022).

There were also many medical professionals of the same era who shared a similar viewpoint. Thus, it must be acknowledged that the political atmosphere greatly influenced medical students who were eager to make progress and contribute to the underprivileged population in rural areas.

Empowering rural doctors in the era of Primary Health Care

Generally, medical graduates from universities were typically allocated to work in various areas where there was a shortage of medical personnel. This process begins with a one-year internship at larger hospitals in urban areas, followed by a two-year mandatory service in underserved regions. During their internship, these medical graduates received approximately six months of training before rotating to work in health centers or district hospitals for periods ranging from five months to a year. The specific destination for health personnel varied; it could be health centers or district hospitals, depending on the timing of their deployment. However, due to incomplete and slow administrative reforms by the government, some health centers or district hospitals were ill-equipped to provide an ideal working environment in those years. As one doctor put it, "*Being sent to rural areas was like sending someone to their doom. The travel was arduous, and neither the medical representatives nor government officials ever visited. It was difficult. When you're out there, the communist influence starts to take hold*." (Interview with Dr. Siriwat Thiptharadol, May 20, 2022.) Therefore, becoming a doctor in rural areas required self-training in both medical and managerial roles, adapting to the prevailing circumstances (Interview with Dr. Winai Sawadivorn, May 16, 2022; Interview with Dr. Vichai Chokewiwat, May 17, 23, June 2, 2022; Interview with Dr. Phusit Prakongsai, May 23, 2022; Interview with Dr. Siriwat Thiptharadol, May 20, 2022). In simpler terms, being a young rural physician in those years involved taking on all tasks, including patient care, hospital management, and responsibilities beyond medical duties, such as teaching, leading health teams, electrical and plumbing work, roofing, and even driving patients to a referral hospital.

Unfamiliarity with the area made the work of medical personnel more challenging than before. One had to be concerned about political issues under the influence of communism, especially in the remote northeast and northern regions. Some of the hospitals where newly graduated doctors were assigned were located in "red zones," indicating that having a hospital in those places is a display of the state's commitment to its citizens. However, the work of medical personnel became even more difficult because these areas were targeted by insurgents and posed risks, especially to government personnel (Interview with Dr. Winai Sawasdivorn, May 16, 2022).

In those days, there were issues related to both language and ethnicity that required rural doctors to learn and adapt themselves to the community's environment and the traditional ways of the villagers. In the case of language, for instance, healthcare personnel, mostly beyond their official working hours, often engaged in community activities during the nighttime to disseminate information on various matters, such as how to construct a sanitary latrine, nutritious eating practices, refraining from raw food, and communicating through film projection. If doctors or healthcare personnel could speak the local language used by the villagers, health knowledge could be much more effectively conveyed to the villagers and endear oneself to the community. (Interview with Dr. Phusit Prakongsai, May 23, 2022). Another challenge was the issue of "stateless people," as seen in several border provinces in the northern region where there were still many members of certain minority groups without Thai national identification cards. Even though they resided (or were even born) within Thailand's borders, they were unable to access state-subsidized healthcare services. When working as doctors in those areas, the rural physician had to go to great lengths to ensure that people in the region could access hospitals. As recounted by Dr. Suwit Wibulpolprasert:

> "*It was like being in Hot [a district in Chiang Mai]...There were people who didn't have their 13-digit Thai ID number, or ID card, nothing like that. We never knew about those stateless individuals until we actually went there. Even though they might live in shacks not far from the hospital, why didn't they come to see the doctor…They didn't come to give birth. When someone needed to give birth, they wouldn't come. But then, when someone was in labor and it got complicated, and they couldn't deliver the birth on their own, they came to our hospital. We completed the delivery for them. We asked why they didn't come for prenatal care. They said they didn't have money. So, we devised a plan to issue a special health card for these low-income individuals. We told them to come later for free treatment. They said they couldn't get the card because they didn't have an ID card… So, we cut some corners and signed the card to make it look official – but they only use the card at our hospital. That way, they wouldn't just come to the hospital when they were desperate or in an emergency. We issued these health cards for the whole community....*"
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> (Santisuk Sophonsiri, 2021, pp. 102-103).

These unfamiliar situations were major challenges for doctors and healthcare personnel working in the field. They were also a "realm of knowledge" that did not manifest during medical

school but must be sought from experiences outside the classroom. This was especially true in those days the rural areas of Thai society, where issues of marginalization and poverty often prevailed. Therefore, going out to practice and address the convictions of these healthcare personnel wasn't just about learning how to be a "healer." It was about facing difficult and unprecedented circumstances, navigating decisions, and molding doctors and healthcare workers through the cycles of experience into "innovators" and "leaders" simultaneously.

Lessons from rural areas in creating Thai public health leaders

After knowledge and experience had been gathered, the majority of doctors in rural areas returned to specializing in their medical roles. However, there was a portion that decided to work in central positions within the Ministry of Public Health so that they could translate their experiences as policies to drive certain initiatives. There were also groups that chose to continue their work in rural areas. Undoubtedly, both groups were crucial mechanisms of a system that sought diverse ways of functioning. Although different people performed different tasks, they could coordinate their thoughts in some way. These doctors engaged in discussions through the "*Sampran Forum,*" which became a significant space for learning and exchanging diverse opinions (Interview with Dr. Suwit Wibulpolprasert, May 16, 2022). Although the Forum's objective was not to reach resolutions or establish ideological stances, the debates led to "mutual understanding and proposals that could be put into practice. Often, the Sampran Forum introduced new topics or ongoing discussions that encouraged collective dialogue. The increased exchange of ideas was deemed more important as discussions progressed" (Sanguan Nitayarumphong, 2005, p. 51). Hence, whether working centrally or in rural areas, both groups of doctors played crucial roles in formulating and implementing policies. In this context, only the central working group will be discussed to provide insights into driving various public health initiatives under the MOPH, including efforts that would have a lasting impact on building UHC in the future.

It must be acknowledged that the experiences from the work of medical personnel in rural areas during the 1970s, with a specific political context that was distinct from the general situation, played a crucial role in helping this group of medical personnel understand the reality of working within the healthcare system. When they had the opportunity to work in central government roles, they often brought the lessons, truths, and a realistic understanding of limitations they had gained from rural areas to benefit the design of the country's healthcare system. Dr. Wichai Chokwiwat pointed out that the work experience in district hospitals by Vanvilai Chandrabha, a nursing figure who had previously worked closely in rural areas, significantly contributed to nurturing future leaders.

> *"The community hospital, formerly known as the district hospital, often faced the challenge of frequent changes in management personnel, especially the hospital director. This had an impact on the management and operations, affecting the hospital staff's work. The Nursing Division initiated a team to promote and support the development of hospitals at this level (during 1980-1986), with the main objective being to assist in structuring management, services, and clear coordination that all working groups could follow systematically, without disruption when management personnel changed*
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> (Vanvilai Chandrabha, 2007, pp. 82–83).

Wanwilai Chantharapa was one of the key figures in driving the internal management restructuring of the hospital for improved efficiency. Later, she became a significant contributor to the establishment of the "Nursing Council" in 1985 and also served as its first vice president.

Many rural doctors had similar career trajectories after experiencing life as "rural physicians." For instance, Dr. Suwit Wibulpolprasert transitioned to become the Head of the Evaluation Unit and later the Head of the Project and Budget Division at the Ministry's Planning Division (1982-1987). He served as the Director of Academic Division, Food and Drug Administration, the Director of the Public Health Policy and Planning (1988-1991), then became the Deputy Permanent Secretary of the MOPH (2000-2003). Similarly, Dr. Wichai Chokwiwat served as the Director of the Epidemiology Division (1990-91), an Expert in data information at the Permanent Secretary Office, and the Deputy Director-General of the Department of Disease Control (circa 1991-95). He later became the Secretary-General of the Food and Drug Administration (2000-2002) and then the Director-General of the Department of Thai Traditional and Alternative Medicine (2002–2007). Around the same time, Dr. Amphon Jindawatthana became the Director of International Health Division, General Medical Officer, Department of Communicable Disease Control (1992–1994), and Director of the Praboromarajchanok Institute during the years 1992-1999. As for Dr. Somsak Chunharas, he served as the Head of the Office of Academic Coordination and Human Resource for Health Development (1985–1990), the Director of the Division of Health Statistics, Permanent Secretary Office (1990–1992), and subsequently the first Director of the Health Systems Research Institute (HSRI) (1992–1998). In a similar vein, Dr. Sanguan Nitayarumphong, after working as the Director of Bua Yai Hospital in Nakhon Ratchasima Province, joined the MOPH headquarters. He contributed to the Medical Council and later became an Assistant to the Permanent Secretary in policy and planning, Director

of the Health Insurance Office from 1992-1996, later being Deputy Permanent Secretary of the Ministry of Public Health in 2001-03, and finally the founding Secretary-General of the National Health Security Office (NHSO) in 2004-2008. These former rural doctors, alongside many others unmentioned, brought their experiences from rural work to advance challenging public health initiatives through their work within the MOPH at various administrative levels. As stated by Dr. Prateep Thanakitcharoen, a former Director of Rasi Salai Hospital (1983-1989), "this journey from rural students to central HQ bureaucrats equipped them with the strength to turn them into functional mechanisms" (Interview with Dr. Prateep Thanakitcharoen, June 6, 2022).

The fact that many rural doctors were able to shift their roles from rural to central movements for the reform of the increasingly empowered central public health system must be considered in light of the "collaborative partnership with senior physicians". These senior physicians were leaders in the field of public health. For example, Dr. Sem Pringpuangkeo, Dr. Somboon Vachrotai, Dr. Pairode Ningsanon, Dr. Prawase Wasi, Dr. Damrong Boonyoen, and Dr. Paichit Pawabutr were among them. These senior physicians within the MOPH already supported the ideas of rural doctors. For instance, when Dr. Amorn Nondasuta served as the Permanent Secretary (1983-1986), Dr. Paichit Pawabutr, who was previously a provincial public health doctor in Nakhon Ratchasima, was called upon to assist in central tasks (Interview with Dr. Paichit Pawabutr, May 30, 2022). When Dr. Paijit Pawabutr became the Permanent Secretary (1992-1994), he brought in Dr. Samreung Yaengkratok, who had previously helped work on hospital development in Ubon Ratchathani and Nakhon Ratchasima Provinces, to help in the MOPH as Deputy Director-General of the Department of Disease Control (1993) (Interview with Dr. Samreung Yaengkratok, June 24, 2022). This led to a vertical relationship between younger rural doctors and senior physicians, where collaboration and mutual influence for the advancement of public health began from the late 1970s. However, we must not forget that as we entered the 1980s era, political, economic, and social factors would change over time. The traditional approaches, methods, or development strategies for public health might not be suitable for the new environment. Hence, there was a need to adjust perspectives on health and society once again.

Reforming health meant reforming society

DR. SEM PRINGPUANGKEO	• Former Minister of Public Health, 1980–1982.
DR. SOMBOON VACHROTAI	• Former Director-General of the Department of Health, 1974-1979 • Former Director-General of the Department of Communicable Disease Control, 1979-1980
DR. AMORN NONDASUTA	• Former Director of Nutrition Division • Chief Medical Officer, Department of Health • Former Director-General of the Department of Health, • Deputy Permanent Secretary of the Ministry of Public Health • Director General of the Department of Health • Former Permanent Secretary of the Ministry of Public Health
DR. PRAWESE WASI	• Former Director of the Medical and Public Health Coordination Center, Ministry of Public Health, 1984-1987 • Medical Professor • Head of the Department of Internal Medicine Faculty of Medicine Siriraj Hospital • President of the Health Systems Research Institute (HSRI) • President of Thailand Foundation • President of National Public Health Foundation
DR. DAMRONG BOONYOEN	• Director of the Public Health Planning Division • Former Director-General of the Department of Communicable Disease Control, 1994-1997
DR. PAIRODE NINGSANON	• Former Deputy Director-General of the Department of Health, 1975-1980 • Deputy Minister of Public Health, 1980-1982 • Director-General of the Department of Health, 1983-1986 • Minister of Public Health, 1987-1988
DR. PAICHIT PAWABUTR	• Former Permanent Secretary of the Ministry of Public Health, 1992-1994

During the 1987-96 decade, due to changing political and economic factors, the resulting impact led to the adaptation of health system ideologies to match the circumstances. The central focus of issues began shifting from matters concerning poverty, underdevelopment, and lack of education – or the cycle of "ignorance, poverty, and illness" – toward more topical concerns. These included evaluating health related to modernity, economy, urban and rural lifestyles, and changing societal landscapes. Up to this point, the new goals the reform network aimed for were the development and transformation of the healthcare system to a broader societal reform, encapsulated in the concept of "redefinition of health" as it related to "societal reform." This implied that the reform of the healthcare system had to be interconnected with societal reform at all levels, according to Dr. Prawase Wasi. He believed that Thai society still held a narrow and confined view of health, worrying primarily about hospitals, doctors, or medication. These components were considered mere symptoms or conditions rather than the comprehensive health that encompasses a much wider perspective, as health should equate to holistic well-being (Prawase Wasi, 2000, p. 93).

Therefore, the movement towards reforming the public health system under the notion of "complete well-being," dating back to the 1987-96 decade, was not a call solely for "Health Care Reform", but rather a demand for "Health Systems Reform" at its core. This was based on the principle that public health and quality of life are intricately linked with political, economic, social, environmental, and mental aspects of development, extending even to human rights (Chettha Sapyen, 2013, p. 147). This concept of "well-being" remained closely tied to the idea of "Health For All" introduced by the World Health Organization in the previous decade. It emphasized that considering health means understanding livelihood, family, and environment, in summary, comprehending the essence of illness through an understanding of the patient's society. Similarly, for health system reform to succeed, societal reform must progress simultaneously.

Here, once the command of knowledge and the culmination of ideas regarding the direction of healthcare reform had been attained, the actual implementation of reform towards establishing Universal Health Coverage (UHC) in Thailand still required reliance on continuous "study" and "experimentation." These were vital steps in practicality. Among these crucial yet challenging components in building UHC, one stands out prominently: "budgetary constraints."

Rural areas
(and rural dwellers)
have come to represent a picture
of underdevelopment, uncivilized
conditions, and are seen as
requiring development
. . .

(Kongsakon Kawinraweekun, 2002)

When streams converge,
Universal Health Coverage
was born, c.1868-2002

- 5 -

To understand health security one must understand financing

The capitation payment
“enables better cost control and easier
management compared to other methods.
This per capita compensation will be paid
to the primary insurer, calculated based on
the number of individuals for whom various
service providers are responsible,
regardless of the number of insured individuals
these service providers may have,
whether they provide care to severely or
mildly ill patients, or even if they do not provide
any care due to the absence of patients.
Cost control and management through
this method can be straightforward,
but a quality control system for
service delivery must be in place.

(Sanguan Nitayarumphong and Pathom Sawampanyalert, 1994, p. 20)

Upon thorough consideration, starting from the state, monarchy, royal dynasties, private sector, and the general public, all have contributed to the establishment of the first hospitals in Siam up until today. The major challenge that often delayed the development of the healthcare system beyond the planned timeline was typically associated with "budgetary matters and fiscal management."

Starting with the absolutist state that did not have enough financial resources to establish hospitals in every cities, a method of voluntary contribution and fundraising was employed. Wealthy Thais were encouraged to contribute funds to collectively establish hospitals for public charity. Even as Thailand transitioned to a democratic regime after 1932 under the constitutional monarchy, the state demonstrated a clear intention to build "Flagship" hospitals in major provinces. However, the number of hospitals that increased did not meet the expectations, and the fundraising system continued to persist, such as the case of the "maintenance fund." This is one illustrative example created to alleviate financial issues that festered over time. The challenge of financial management continued to persist, including the establishment of a comprehensive health security system that would eventually come to be.

Understanding the maintenance fund system through legacy of Dr. Sem Pringpuangkeo

When discussing fiscal matters, it is necessary to look back well before the year 1957 to gain a broader perspective on the healthcare sector and the country's financial potential. During 1932-1941, due to political instability and consistent economic decline, some of the provincial hospitals that were established according to the Flagship policy did not arise from a "full state budget allocation" to the region. However, in certain areas, fundraising efforts were initiated from the private sector in the form of charitable donations, such as land donations from merchants and high-ranking officials, or through fundraising efforts involving both the government and the private sector. Examples of these hospitals include Nong Khai Hospital and Chiang Rai Prachanukroh Hospital. Since the budget was insufficient to expand the state-owned service system, this situation further propelled hospitals to become some of the earliest state institutions with the autonomy to manage financial measures on their own.

In some respects, the life journey of the venerable Dr. Sem Pringpuangkeo reflects the "mechanism of autonomy," which was a distinct characteristic of hospitals as mentioned in various aspects. During the accelerated implementation of the Flagship hospital construction policy, Dr. Sem (in 1936) was appointed to oversee a hospital in Chiang Rai Province. However, upon arriving at the site, he discovered that there was not even a functioning hospital facility to provide patient care. This prompted him to initiate development efforts, starting with soliciting donations to establish the hospital and gathering funds from the community members' affordable payments for treatments. These funds were then utilized to maintain and sustain the hospital moving forward.

In this case, the initiative to build hospitals was not an easily achievable endeavor due to the substantial funds required for construction. However, given the hospital's characteristics as a societal space where various community groups had the opportunity to benefit, favorable relationships emerged that could commonly be observed during the collaborative efforts to construct hospitals. For instance, "Kaha Bodhi," a wealthy merchant, generously donated land for the construction of the Chiang Rai Prachanukroh Hospital. Even high-ranking government officials (such as Khun Phra Phanom Nakararaksa, the Governor of Chiang Rai Province) made efforts to push for the successful establishment of Flagship hospitals in the northern region. Meanwhile, local villagers collectively contributed funds to "pool financial resources" for hospital construction, enabling the creation of hospitals without solely relying on central government budget allocations. As a result of these community-driven fundraising efforts, when hospitals were built using the collected contributions from community members, the hospitals gained the appellation "Prachanukroh" in their names, signifying "public support." Consequently, hospitals transformed into communal spaces where individuals from all groups within the region felt a sense of shared ownership. In this way, local residents came to believe that every aspect of the hospital was 'ours,' collectively belonging to everyone, and all had to cooperate to save on expenses, provide care, and attend to illnesses instead of relying solely on the hospital for these needs (Santisuk Sophonsiri, 2012, p. 77)

When hospitals were built through the collective contributions of local villagers, subsequent financial management, whether incurring losses or making profits, should have remained within the hospital itself as revenue. It should not have been sent back to the Treasury. This led to the emergence of the system known as the "maintenance fund." Eventually, before the hospital system could retain its revenue for self-management, there were necessary efforts in place. On one occasion, Dr. Sem utilized the hospital as a negotiation space with the government regarding the issue of the "hospital fund accumulation." Dr. Wichai Chokwiwat described the atmosphere, highlighting that:

"When we arrived and there were no hospitals, no medications [we had to] rely on the philanthropy of the people, like the case of Chiang Rai Prachanukroh Hospital. People in Chiang Rai were asked to donate a certain amount of baht each to build the hospital. Once the hospital was built, and if there were no medications, we asked for donations to buy medicines for treating patients. When we received the treatment fees from patients, the central government saw the income and demanded that we send the money back to the government... Dr. Sem made the point to the Director-General of the Comptroller General's Department, [who] at the time was Phraya Chaiyot Sombbat, that the government did not provide even a single baht. Instead of imposing a fine or tax on the hospital, Phraya Chaiyot Sombat agreed with Dr. Sem, and instructed the hospital to continue doing what they were doing, resulting in the creation of the 'maintenance fund' system."

(Interviews with Dr. Wichai Chokwiwat, May 17, May 23, and June 2, 2022).

The acceptance by Phraya Chaiyot Sombat was influenced by his first-hand observation and explanation from both Dr. Sem, government officials, and villagers about the origin and management of hospital revenue. This marked the starting point for the hospital's maintenance fund system as a result, budgeting and financial management have been issues regarding healthcare operations from the very beginning. The Chiang Rai Prachanukroh Hospital's maintenance fund system, born from addressing specific circumstances, served as a successful example of hospital management and budgeting during the Flagship policy era. Currently, the maintenance fund still refers to the money received by hospitals or healthcare facilities from service provision. This goes beyond managing expenses and revenue derived from government budget allocations. Healthcare facilities can keep this money themselves without returning it to the Treasury.

Aside from the maintenance fund system, financial management approaches and fiscal policies in various healthcare insurance systems that Thailand has experienced remain significant challenges in the Thai healthcare system due to financial constraints. Following the events of October 14, 1973, the evolution of financial management methods in the health security system saw the emergence of four different formats. Before moving towards budget management in the UHC system, it is important to understand the developments of the various healthcare security systems that existed previously in Thailand.

The origin of the national health security system of Thailand

> *"The state is committed to promoting public health, extending to family health and safeguarding individuals' well-being. It supports active citizen participation.* ***The state provides healthcare to the underprivileged without considering cost.*** *Preventing and controlling dangerous communicable diseases is an obligation of the state towards the people, without considering cost."*
>
> *The 10th Constitution of the Kingdom of Thailand, 1974 (Royal Thai Government Gazette, 1974)*

When the Constitution of 1974 was promulgated, which emerged after the events of October 14, 1973, during a period when democracy was beginning to flourish, it had an impact that led to the birth of the "Low-Income Card Scheme (LICS)" in 1975 by the government of Prime Minister M.R. Kukrit Pramoj. This was considered one of the first healthcare assurance systems in Thailand and was a direct outcome of the events of October 14, 1973, which significantly accelerated the focus on issues of justice. After those events, various political parties developed policies to address and respond to social challenges, attempting to provide solutions to the crisis of poverty and deprivation. Following the victory in the elections, the Social Action Party, led by M.R. Kukrit Pramoj, initiated the above community development project, which connected political dimensions, poverty, and healthcare. This project was closely linked to the policy initiative "Price Stabilization Fund for Agricultural Products, Free Healthcare for the Poor, and Free Bus Rides."

This project aimed to provide a "guarantee for those with low income" to access medical and public health services "without cost." The criteria for determining the division line of "low-income individuals" were set to those with a monthly cash income of less than 1,000 baht. Those who wished to receive the benefits could apply for a card issued by the responsible agency. However, during the first year, there were fewer recipients than anticipated, leading to the cancellation of the card issuance process and granting the authority to hospitals to determine eligibility for assistance. "*Back in the day in Mahasarakham Province, when I was a doctor, we would prescribe medications. However, when the pharmacy wanted to collect money, the villagers didn't have any. They would come back to us, and we would sign for them to receive social welfare. If it's a slightly larger provincial hospital, they would have this* (social welfare) *department. Then the patients would go through the hospital's screening process. The social workers would inquire whether they were genuinely in need…*" as mentioned by Dr. Winai Sawasdivorn (Interview with Dr. Winai Sawasdivorn, May 16, 2022). Subsequently, the project

extended its coverage to include groups such as older persons(60 years or older), children (under 12 years), people with disabilities, war veterans, families, novices, and religious leaders. This led to a name change of the program to "Medical Welfare Scheme (MWS)."

The payment method used in the LIS and the MWS project can be described as a 'global budget' approach. Under this method, a total budget is allocated to various healthcare facilities based on predefined criteria. The responsibility for budget management lies with the hospitals themselves. The advantage of this system is that it allows for "effective cost control," but a potential drawback is that it might lead to compromised service quality (Sanguan Nittayarampong and Pathom Sawanpanyalert, 1994, pp. 5–6). Although both projects faced several challenges during their implementation and began with the concept of targeting the "economically disadvantaged," it is essential to note that access to healthcare was not yet fully covered for the entire Thai population. However, it should not be forgotten that both schemes became the "first" major healthcare security initiatives in Thai society. The strengths and weaknesses learned from this system served as a foundation that contributed to the development of the UHC system in the following two decades. Furthermore, this project led to a substantial increase in the operating budgets of various hospitals, multiplying their financial capacity several times over.

Moving forward into the 1977-87 decade, there were three additional healthcare insurance systems developed. In reality, the Civil Servant Medical Benefits Scheme (CSMBS) had its origins as early as 1963, initially for low-income civil servants, but it was progressively expanded to cover all cases by 1980. Close in time, there was the Voluntary Health Card Scheme (VHCS) introduced in 1983, leading up to the establishment of the Social Security System (SSS) in 1990. Each of these systems covered different population groups, including civil servants and their families, individuals with higher incomes beyond the poverty line, and employees of private companies, respectively. Each system employed varying budget allocation methods.

Strengths and weaknesses of the CSMBS

The CSMBS started back in 1963, beginning with providing welfare to low-income civil servants (Saman Ramlek, 1964). Subsequently, the "Royal Decree on Welfare Funds for Medical Treatment 1978" (Royal Thai Government Gazette, 1978) extended healthcare benefits to cover all civil servants and salaried employees receiving income from budgetary expenditures, retired civil servants, and even family members of eligible individuals, including spouses, parents,

and children under 20 years old. This system offered comprehensive healthcare coverage but also utilized a substantial budget compared to other healthcare insurance programs. The cost management approach was termed "*fee for service*," which meant that beneficiaries of this system could claim reimbursements for payments made to state hospitals for all services. The Comptroller General's Department was responsible for budget allocation and expenditure control. Admittedly, this financial management approach was simple and required only minimal administrative costs, but it resulted in high expenses due to the lack of strict cost containment measures. It is important to acknowledge that this system covered various types of services but had weaknesses in terms of escalating expenses, as the mechanism for cost control was not stringent enough. Thus, the strength lay in the coverage of multiple services, while the notable weakness was the escalating costs that couldn't be effectively controlled. The funds for managing and expanding welfare did not come from employers' assets, but rather from nationwide taxation. Moreover, the right to receive comprehensive healthcare was limited to civil servants, salaried employees, and their immediate relatives.

For these reasons, the limitations of using the healthcare welfare system were undoubtedly linked to the country's long-term financial stability and also tied to political stability, as well as the interests and impacts on stakeholders. This led to extensive debates and continuous efforts for improvement over time. The weaknesses of the CSMBS became a significant lesson that contributed to the evolution of reform proposals, transitioning from a "fee for service" to a "capitation" payment. This expansion aimed to encompass a broader population and concurrently circumvent various limitations to avoid repeating the patterns that had emerged in the previous healthcare welfare system. Additionally, there was also the "Voluntary Health Card Scheme (VHCS)," which similarly evolved as a financial and treasury challenge. This scheme highlighted both strengths and certain weaknesses, contributing to the development of the capitation payment system in a more comprehensive manner.

Voluntary Health Card Scheme: Co-payment approach and risk distribution

For the Voluntary Health Card Scheme (VHCS), another type of financial management approach was implemented, starting in 1983, driven by the efforts of Dr. Amorn Nondasuta, as part of the foundational Primary Health Care (PHC) and the Health for All policy advocated by the WHO. The VHCS originated from the "Maternal and Child Health Fund Project (MCH)," which took the form of a community-financing scheme to promote MCH, family planning,

disease prevention, and basic healthcare services. Initially, it was just a pilot project with a duration of three years from 1983 to 1986, and initially limited to a specific area for only eight months. After Dr. Amorn was promoted from the Director-General of the Department of Health to the Permanent Secretary of the MOPH, there was an order to expand the VHCS nationwide. Simultaneously, the MCH project was expanded to cover healthcare services and was renamed the "Voluntary Health Card Scheme." The goal was to extend the project's coverage to sub-district levels nationwide by 1987. The VHCS continued to manage funds in the form of revolving funds in communities and issued two types of cards for project entitlement: the Maternal and Child Health Card and the Family Healthcare Card. These cards allowed beneficiaries to receive services up to 8 times per year, with coverage not exceeding 2,000 baht per visit (Samrit Srithamrongsawat, 2001, p. 91).

Subsequently, there was a growing academic interest in the topic of "voluntary public health insurance" within the framework of the project. It became a subject of discussion among university scholars and government employees within the MOPH. This intellectual atmosphere led to the establishment of the "Center for Health Policy Studies," a collaborative effort between the Health Card Center of the MOPH and Mahidol University (Interview with Emeritus Professor Thavitong Hongvivatana, June 15, 2022). Scholars from various universities and disciplines came together to share their opinions on this approach. Notable figures included Professor Somkid Kaewsonthi, Dow Mongkolsmai, Emeritus Professor Thavitong Hongvivatana, Emeritus Professor Thienchai Kiranandana, and numerous reform-minded physicians, including Dr. Damrong Boonyoen, Dr. Amorn Nondasuta, Dr. Suwit Wibulpolprasert, Dr. Sanguan Nitayarumphong, Dr. Somsak Chunharas. They engaged in exchanges, learning, and observation. Additionally, Dr. Viroj Tangcharoensathien, contacted by Dr. Prawase Wasi, pursued his doctorate in Health Economics at the London School of Hygiene and Tropical Medicine (LSHTM) with support from the Rockefeller Foundation (Interview with Dr. Somsak Chunharas, May 17, 2022). Subsequent research conducted by Dr. Viroj would lead to policy decisions, such as the case of capitation in the Social Security Scheme (SSS) and the calculation of the 1,202 baht per capita rate for the Universal Coverage Scheme (UCS).

The expansion of academic knowledge into the fields of economics and social sciences in a comprehensive and systematic manner caused a stir among reform-minded physicians, prompting them to "awaken" and start planning the design of a comprehensive health management system that incorporated knowledge of Health Economics.

The conclusions drawn from this collaborative effort suggested that the main objective of the Voluntary Health Card Scheme should focus on "health security," which is the origin of

the concept of co-payment. This concept envisions services that the government provides but with a portion of the cost borne by the individuals. Emeritus Professor Thienchai Kiranandana highlighted an important consideration: "[The Health Card project] *can motivate people to actively participate in healthcare by creating a concept of co-payment, where individuals contribute money to inquire about what they receive in return. This has economic and psychological implications...Therefore, co-payment is a crucial key*" (Interview with Emeritus Professor Thienchai Kiranandana, May 28, 2022). Consequently, the knowledge base established during 1987-1991 regarding health insurance served as the foundation for a significant transformation of the project in 1994, resulting in the creation of the "Voluntary Health Card Scheme (VHCS)." This project involved a joint contribution of 500 baht from the government and 500 baht from households for each health card. This marked a shift in the financial management of the healthcare system towards a nationwide revolving fund system.

The target population of the project consisted of individuals with incomes above the poverty threshold, who did not qualify for the low-income card and did not possess any form of health insurance. It could be said that the health card project functioned as a "social safety net" for the disadvantaged group that did not have access to the LICS and the MWS. Furthermore, the transformed health card represented a concept of risk sharing (Interview with Emeritus Professor Thienchai Kiranandana, May 28, 2022). In this case, the burden of the risk of falling ill was shared between the individuals and the state. The state collected accumulated insurance premiums to be used in cases where insured individuals, holding the health card, fell ill. The principle of sharing was based on the assumption that the likelihood of all cardholders falling sick simultaneously was very low, akin to the principles of private insurance. During the period between 1994 and 1997, the project expanded to cover the largest portion of the population, approximately 13.5 per cent or one in seven Thais.

However, some weaknesses of the voluntary health card project were still evident. In general, purchasing a health card was possible at any time, leading to a significant challenge when individuals waited until they fell ill before buying a card. Meanwhile, those who had purchased the card but had not used it, in the following year might decide not to renew, resulting in a situation where only those who reaped the benefit maintained their membership. As a result, the financial sustainability of the system could not be ensured (Interview with Dr. Viroj Tangcharoensathien, May 31, 2022). Looking at the budget perspective, it signified the unsustainability in financial terms of the system. For this reason, the concept of "risk sharing" had yet to smoothly come into effect. This presented another lesson for building the next phase of Thai universal health coverage. Subsequently, the development of the Social Security Scheme (SSS) in the late 1980s aimed to fill gaps and enhance the financial knowledge of the

system, including those of other public health insurance schemes that had been established. It also aimed to address the shortcomings of the future UHC that will continue to emerge. This represented a continuous effort to strengthen the health security landscape.

Regarding social security and financial matters in the capitation payment system

Before the late 1980s, it can be observed that the Thai healthcare system had utilized various payment methods that were already in place, including the payment by global budget in the LICS and MWS, and the payment by services (fee for service) in the CSMBS. On the other hand, the VHCS operated on a co-payment basis. However, payment methods such as capitation and the "Diagnostic Related Group" (DRG) system were new proposals that had not been implemented before in Thailand's healthcare system. It was not until the birth of the Social Security Scheme (SSS) in 1990 that the capitation payment method was first introduced, marking a significant change. In fact, this payment method became the central idea for improvements in other state health insurance systems, particularly the development of the UCS in the years to come.

Indeed, Thailand had previously passed a Social Security Act in 1954 as the initial legal framework, which required the establishment of a social security fund from contributions made by individuals, employers, and the government (Royal Thai Government Gazette, 1954). However, it was later suspended due to significant opposition. Later, in 1972, Revolutionary Council Announcement No. 103, Section 3, mandated the creation of a compensation fund within the Department of Labor (Royal Thai Government Gazette, 1972), but this was considered more as a labor protection measure rather than a comprehensive social security system. Although there were efforts to study the feasibility of social security during the early 1970s, no substantial progress was made. It was not until the Social Security Act of 1990 (Royal Thai Government Gazette, 1990) that Thailand's official Social Security System was established, marking the first official instance of the SSS in the country. The responsibility for this initiative was placed under the Social Security Office (SSO), and the funds from the previously established compensation fund were incorporated under the same agency.

During the establishment of the SSS at that time, two models for compensating medical services were considered. The first model was fee-for-service, while the second model was capitation. Eventually, the SSO's Medical Board chose to adopt the capitation payment method as the primary option. The main reason behind this decision was that the capitation

payment method allowed better control of costs compared to the fee-for-service model. In the fee-for-service model, healthcare facilities tended to provide more services, and patients themselves had a tendency to utilize additional services without necessity (such as providing certain elective services, retrospective payment audits, and most importantly, rapid increases in expenditures). Also, due to the budget constraints as always, an assessment was made that if the fee-for-service system was used, the social security fund might experience an annual deficit of around 500 million baht (Jiruth Sriratanaban and Sukanya Khongsawat, 2001, pp. 17–18). Therefore, it is no exaggeration to say that the establishment of SSS was built upon the severe challenges of CSMBS. The limitations in terms of financial resources led to the decision to adopt the capitation payment method.

Dr. Sanguan Nitayarumphong, a contributor to the design of SSS, once explained the use of the capitation payment method as follows:

> *"The capitation payment "enables better cost control and easier management compared to other methods. This per capita compensation will be paid to the primary insurer, calculated based on the number of individuals for whom various service providers are responsible, regardless of the number of insured individuals these service providers may have, whether they provide care to severely or mildly ill patients, or even if they do not provide any care due to the absence of patients. Cost control and management through this method can be straightforward, but a quality control system for service delivery must be in place"*
>
> (Sanguan Nitayarumphong and Pathom Sawanpanyalert, 1994, p. 20).

However, Dr. Sanguan believed that adopting the capitation payment system might motivate fewer healthcare facilities to participate, and they might prefer the "payment by services" method, especially private healthcare facilities with varying high and low costs. This trend gained momentum, suggesting that if private hospitals decided to become service units under the SSS, the possibility of facing losses would be high.

Consequently, the weighty burden fell on the Social Security Development Committee, which had a significant role in calculating the "capitation payment amount" that the Social Security Office had to allocate to healthcare facilities in the most appropriate manner. This action was intended to prevent heading towards a deficit scenario. After thorough calculations and discussions, the figure settled at 700 baht per person per year. Dr. Viroj Tangcharoensathien's

calculations were based on reasonable costs for outpatient and inpatient services derived from a study conducted in 89 regional and general hospitals under the MOPH. The study found that the average cost for outpatient services was 137 baht per visit, while the average cost for inpatient services per day was 496 baht. These calculated results were then considered alongside another set of data – the utilization rates for both outpatient and inpatient services. This second set of data was based on a survey by the MOPH and the Institute for Population and Social Research at Mahidol University. The study found that the number of outpatient visits was 2-3 times per year, and the number of inpatient days was 0.35 days per person per year. Therefore, when factoring in reimbursement for healthcare facilities, calculated as an expense per capita, and incorporating the growth rate during the actual operation based on data from 1991, the estimated amount landed around 665 baht per person per year. When comparing this with the project budget of the SSS, which amounted to 150 million baht, and considering the two million workforce participants requiring social security coverage, the feasible budget to be allocated would not exceed 754.5 baht per person per year. Consequently, the proposed per capita budget was in the range of 665-754 baht, or specifically 700 baht per person per year.

Cost per Outpatient	
Average outpatient costs	137 baht/time
Estimate 1991	157 baht/time
General population in need of care	2-3 times/year
Total outpatient costs	471 baht/case/year
Cost per Inpatient	
Average inpatient costs	496 baht/day
Estimate 1991	555 baht/day
General population in need of care	0.35 days/case/year
Inpatient costs	194 baht/case/year
Total cost per person	471+194 = 665 baht/case/year

Table 1 Estimating the cost for providing services to insured individuals per capita: 1990

Source: Sanguan Nitayarumphong and Pathom Sawanpanyalert, "Introduction to the Health Insurance System under the Social Security Act: Proposals and Origins," 1994, p. 2.

After the establishment and operation of the SSS for about three years, the fear of potential financial losses among the providers faded away, and it was found that the social security fund was in a "very sound financial position." The fund had revenues exceeding

expenditures, resulting in a significant accumulation of funds. This demonstrated that the financial management approach of the social security fund using the capitation method at a rate of 700 baht per registered healthcare facility was appropriate and effective in controlling healthcare expenses (Thienchai Kiranandana, 1996, p. 84). Therefore, it was assessed that the overall financial management of the social security fund had progressed well, as its financial status was stable and there was a tendency for funds to accumulate further. Meanwhile, the compensation expenses were increasing at a lower rate. Part of this success was attributed to the payment system provided to healthcare facilities at the capitation rate, which allowed providers to operate within cost containment measures, and fostered competition between public and private healthcare facilities (Thienchai Kiranandana, 1996, pp. 89–90; Tangcharoensathien, Supachutikul & Lertiendumrong, 1999, pp. 913-923).

During the same period when the capitation payment system in the SSS was being developed, efforts were also made to enhance the prototype of "Primary Health Care System," along with a focus on understanding budgetary considerations.

The Ayutthaya Project: Prototype of primary health care system

The dedication to reform the entire healthcare system by Dr. Sanguan led to the initiation of the "Ayutthaya Project," a practical research experiment that Dr. Sanguan had previously explored on a smaller scale, implementing a prototype of the primary health care system at the district level in Khun Han District, Sisaket Province. Later, this model was expanded to the provincial level, with a strong base in Ayutthaya Province due to existing alliance there. The project was executed through collaboration among three parties: (1) Institute of Tropical Medicine, Belgium, (2) Faculty of Medicine Ramathibodi Hospital, Mahidol University, with key representatives being Professor Dr. Athasit Vejjajiva, the Dean at that time, and Associate Professor Dr. Surakiat Achananupap, and (3) The Planning Division of the MOPH, with Dr. Sanguan Nitayarumphong, who was the Director, as the representative. The research was funded by the European Communiy (Rawinan Sirikanokwilai, Taweekiat Boonyapaisarncharoen, and Yongyuth Pongsupap, 1998, p. 13). Beyond the dialogue between Dr. Athasit and MOPH, Dr. Sanguan, along with Dr. Surakiat, developed project proposals and budgets. The team of experts and individuals closely involved in the continuous situation also included Dr. Somchai (Rawinan) Sirikanokwilai, Dr. Taweekiat Boonyapaisarncharoen, Dr. Yongyuth Pongsupap, Dr. Sombat Triprasertsuk, and Dr. Suwat Wiriyapongsukij.

In terms of conceptual framework, the promotion of the primary health care system was believed to provide a solution to the challenges faced by the overall healthcare system in Ayutthaya Province. The new concept could potentially serve as a model for addressing similar problems in other provinces. Thus, the Ayutthaya Project became a prototype for a comprehensive healthcare system, utilizing primary care as a crucial unit to deliver healthcare services to the public.

Furthermore, there were experiments conducted with a payment approach in the form of a fixed rate for all treatments, known as the "70 baht for all diseases" model. The experiences from the Ayutthaya Project represented important lessons learned in creating a universal health coverage system. The key focus was on reforming financial management to eliminate barriers to accessing healthcare without concerns about costs. Patients, whether seeking treatment at local healthcare units for minor illnesses or at major hospitals for severe illnesses, were charged the same service fee, which resonated with the principle of "average suffering, average happiness." In retrospect, it can be said that the 70 baht project was a starting point for the evolution that later led to the 30 baht project, as Dr. Sanguan affirmed, "*The 70 baht project provided comprehensive healthcare and treatment for all dimensions and diseases, or you can call it the 70 baht project for treating all diseases*" (Sanguan Nitayarumphong, 2005, p. 65).

Therefore, in addition to considering the establishment of a robust primary healthcare system, the second condition is to implement a suitable health insurance model based on the notion that healthcare should be a fundamental human right. Without a primary care system that is strong and well-developed, the development of primary care services cannot occur. "*Primary care and health insurance must go hand in hand in order to create capabilities and efficiency in utilizing healthcare services*" (Ayutthaya Research Project and Health Systems Research Institute, 1990, pp. 34-35). The two aforementioned conclusions reveal the clear directions that have already been set, as discovered from the Ayutthaya Project, which is to establish health security that is a basic right for individuals, not a form of charity for those who are in genuine need.

The Ayuthaya Project became a significant model, and subsequently, this project's nature was expanded to various settings. It was implemented and financially supported under the responsibility of MOPH, known as the "Health Care Reform Project" (Sanguan Nitayarumphong, 2005, p. 66). In its initial expansion phase from 1996 to 1999, the project was conducted

in five provinces: Ayutthaya, Khon Kaen, Yosathon, Phayao, and Songkhla (Thai-European Cooperation Project, 1998, p. 20), as well as in various sub-projects in other areas such as Samut Sakhon, Nakhon Sawan, Nakhon Ratchasima, Phitsanulok, and Bangkok (Suwit Wibulpolprasert, 2003, p. 172). Additionally, it was extended to Ban Phaeo District in Samut Sakhon Province, and other sites.

In sum, it is not an exaggeration to say that "money was the significant challenge" that influenced the course of developing various healthcare and health insurance systems throughout the history. Reform-minded physicians endeavored to explore, experiment, and dedicate themselves to finding the best solutions for Thailand's UHC. Looking back, one can see that the creation of UHC was built upon the experience of numerous experimental projects. These lessons and various forms of experimentation later became a pool of knowledge about budgeting, which eventually led to the successful integration of the financial, management, and service provision aspects as part of the UCS in 2001.

Beyond the financial aspect, another component that also affected budget fluctuations was "medicine." The quantity of medication used for treatment had an impact on the "price of medication," which in turn affected the overall budgeting of the health system.

When streams converge,
Universal Health Coverage
was born, c.1868-2002

- 6 -

Medicines and security of the health system

When there is a national essential drug list, it becomes one of the tools that ensures that hospitals provide medicines by “considering” the benefits of the medication, its necessity, quality, and appropriate pricing, without burdening the population with the cost of disease treatment, which is one of the four factors that contribute to excessive burden.

The situation of pharmaceuticals production prior to 1981

Originally, Thai society had limited knowledge of Western-style pharmaceutical preparation, even though Western medicine had been introduced. Siam/Thailand primarily relied on traditional herbal remedies. The "Sala Yaek That" (Government Laboratory) later transformed into the Department of Science. In the era of the absolute monarchy, it was located within the Royal Mint Department, responsible for researching various substances, such as alcohol, poisons, fertilizers, minerals, counterfeit money, and more. Additionally, pharmacy was discussed but not emphasized significantly. The produced medications were mostly oils used to treat skin diseases and vitamin B deficiency.

In 1915, during the administration of Prince Rangsit Prayurasakdi (Prince of Chainat) considered to be the father of pharmaceutical science in Thailand, and who became the head of the Royal Medical College (Rajapattayalai), greater emphasis was placed on basic medical science. Prince Rangsit introduced the teaching of "Pharmaceutical Science" for the first time and hired many foreign professors to teach various subjects. However, when it came to production, the majority of medicines were still imported, and domestic production was limited.

Until 1932, (pure) science gradually became a crucial tool in the development of the economy for the elite class in the new regime. This transformation can be observed in the writings of Mr. Tua Laphanukrom, a member of the People's Party and the Director-General of the Department of Science at that time. His reflections on that period highlighted the importance of science and its contribution to the country's development: "*Developed nations around the world have invested significantly in scientific research because, as mentioned, research and exploration are what gave birth to industries...If our industries flourished, the country's financial stability*

would undoubtedly improve." (Excerpt from Memorial book for the Royal Cremation Ceremony of Dr.Tua Laphanukrom at Wat Thepsirintharawat, December 4, 1941, p. 61) Therefore, during the period when Field Marshal Plaek Phibunsongkhram rose to power, it appeared that the science affairs was gradually growing in response to economic policies such as encouraging Thai people to use consumer goods made in Thailand according to the 5th version of the statism policy of Field Marshal Phibunsongkhram. When the role of the Science Department (Developed from Sala Yaek That) led by Mr. Tua Laphanukrom has clearly grown, the promotion of pharmaceutical work and the establishment of pharmaceutical factories followed suit. These efforts were undertaken to initiate the production of medicines as a state-owned industry and to replace imports during World War II (Ibid, pp. 55-56).

Subsequently, the government continued its ongoing development concerning the focus on the state's drug management system, starting from the 1960s. For instance, the first edition of the "*Hospital Formulary*" was compiled in 1963 (Wichai Chokwiwat, 2021, p. 631), the enactment of the Pharmaceutical Act in 1967 (Royal Thai Government Gazette, 1967) or the 1976 Pharmacopoeia of the Ministry of Public Health, which was the adjustment from the previous reference, aimed at making it more contemporary (MOPH, 1977). However, these changes were not yet considered a comprehensive approach to drug administration. The planning and strategy development for Thailand's pharmaceutical sector took a more systematic form with the declaration of the National Drug Policy in 1981. In sum, until 1981, Thailand did not possess a comprehensive systematic drug policy. Approximately 25 per cent of the total drug consumption value was comprised of imported finished pharmaceutical products, while the remaining 75 per cent was domestically produced. However, a significant portion of the domestically produced drugs still relied on raw materials imported from abroad. These challenges illustrate the instability of Thailand's pharmaceutical manufacturing in various dimensions (Pradit Hutangkoon, 1977), such as technological limitations, a lack of expertise in drug research and development, as well as insufficient availability of essential raw materials for local drug production.

While the pharmaceutical production landscape reverted back to 1980, there were a total of 543 pharmaceutical manufacturing and importing facilities. Out of these, 506 were situated in Bangkok. As for nationwide pharmacies, their count was 14,586, while Bangkok alone had 3,530. The remaining pharmacies were spread across various provinces, averaging about 155 pharmacies per province (Suwit Wibulpolprasert, 1994, pp. 61–62). This reality highlighted the inequitable nature of the pharmaceutical distribution infrastructure, concentrated mainly in Bangkok and urban areas. Meanwhile, rural areas with a significant population faced challenges such as shortages and inadequate access to essential medications. Issues like shortages of medical personnel persisted in these rural regions.

The pharmaceutical system remained interconnected with various issues related to the utilization and management of medications in Thailand. Firstly, the incorrect and excessive use of medications was prevalent (Samlee Jaidee et al., 1980). Data from 1979 to 1981 revealed a consistent upward trend in drug consumption in Thailand. This was evident from the expenses related to medications, which accounted for 80 per cent of the total healthcare expenditures. This high proportion was mainly due to self-medication practices, whereby around 60 per cent of the population opted for self-treatment (self-medication) by purchasing over-the-counter medications from general pharmacies (Suwit Wibulpolprasert, 1994, pp. 60-61). This led to a significant number of individuals treating themselves without receiving a medical diagnosis from healthcare professionals. Simultaneously, self-medication was coupled with the promotion of sales, advertising, and the gradually growing private sector medication distribution system. These conditions contributed to excessive medication consumption issues, leading to problems such as drug dependency, microbial resistance to medications, and adverse effects of improper self-medication. Even individuals receiving services through the public healthcare system and obtaining medications from state-run centers faced similar problems. These issues encompassed unnecessary medication use, stockpile issues, and challenges in storing medications. Therefore, the prescription practices of physicians and the hospital procurement systems also played a crucial role in exacerbating medication consumption-related problems (Ibid, 1994, p. 61).

Derived from the push from WHO, which aimed to have all countries establish medication policies and raise awareness about issues in the pharmaceutical system, various developing countries including Myanmar, India, Indonesia, Nepal, and Thailand faced common challenges. These challenges encompassed scarcity of medications, excessive usage, and reliance on foreign medications. These issues were intensified due to the absence of a "regulatory mechanism" with strict enforcement. The WHO's assembly in 1979 prompted and expedited member countries to formulate national medication policies. This gathering marked the beginning of the journey towards specific and tailored policies to develop Thailand's pharmaceutical system. Financial and academic support from the WHO contributed to this endeavor (Ibid, 1994, p. 60). As part of its desire to address the pharmaceutical system issues, the MOPH established a working group on October 6, 1980, named the "Central Committee for Formulation of National Drug Policy." Dr. Sem Pringpuangkeo, the Minister of Public Health at that time, chaired the committee. The committee successfully formulated the "National Drug Policy - 1981" (MOPH, 1981), which was Thailand's inaugural version of such a policy. Simultaneously, to ensure policy implementation, a working committee called the "National Drug Committee" was established on June 21, 1982 (Wichai Chokwiwat, 2021, pp. 12–13).

Initial version of the National Drug Policy and its development to the present day

Thai national policy on pharmaceuticals outlined the directions and objectives for the development of the drug system through five projects: procurement and distribution of drugs, development of pharmaceutical personnel, quality control of drugs, drug production by the pharmaceutical organization, and research on traditional medicine by the Department of Medical Sciences. All five projects aligned with the five objectives of this national drug policy: 1. Ensuring safe, quality, affordable drugs that can be widely distributed in rural areas through procurement and distribution, including support for domestic drug production; 2. Reducing inappropriate drug use through the establishment of a national essential drug list; 3. Ensuring drug quality, safety, and efficacy through the development of agencies responsible for drug standards; 4. Collecting necessary data for the pharmaceutical industry, studying the potential for local drug production; and 5. Exploring the possibilities of using traditional medicines for public health and guiding operations to comply with the aforementioned policy. Therefore, an entity to be responsible for this policy was established, known as the "National Drug Policy Committee." This committee was tasked with setting policy directions, objectives, and guiding the development of Thailand's drug system, as well as "overseeing" relevant government and private entities in drug-related matters.

During the periods of the 5th Public Health Development Plan (1982-1986), the 6th Public Health Development Plan (1987-1991) (MOPH, no date [b], pp. 188–235), and the 7th Public Health Development Plan (1992-1996) (Committee for Health Development Planning, Public Health Development Plan according to the 7th National Economic and Social Development Plan (1992-1996), 1992, pp. 596–600, pp. 607–12, pp. 647–65; Office of Policy and Plan for Public Health, 1993, pp. 12.1-12.15), actions were carried out in accordance with the strategies outlined in the national drug policy. This policy laid the foundation for the management and administration of Thailand's drug system, with the core idea that enhancing the efficiency of the drug system required the development and improvement of all four components: "drug selection," "production and procurement of drugs," "distribution of drugs," and "drug utilization."

For the first aspect, "drug selection," the process was carried out through the creation of the National Essential Drug List and the List of Necessary Medicines for Public Health. Dr. Sem Pringpuangkeo, who led the working group responsible for compiling the National Essential Drug List, explained that this list referred to "essential drugs," which meant "*the most important drugs that are fundamental, irreplaceable, and necessary for the health of the population, gathered together as the National Essential Drug List*" (MOPH, 1981, preface). In fact, the concept of the National Essential Drug List was inspired by the idea of creating an "Essential Drug List" by

WHO as a model for member countries. The first version of the WHO's Essential Drug List was established in 1977. In Thailand, the "Committee for the Preparation of the National Essential Drug List" was formed (MOPH, 1981, pp. 72–73) in March 1981, leading to the announcement of the "National Essential Drug List 1981" in August of the same year (MOPH, 1981; Wichai Chokwiwat, 2021, pp. 629–631). After the initial implementation of the "Essential Drug List," there were subsequent revisions to keep the list up-to-date with changing circumstances in 1982, 1984, 1987, and 1992.

In conjunction with the announcement of the National Essential Drug List, regulations were established to enforce its practical implementation. One such regulation was the "MOPH Regulation Regarding the Procurement of Medicines Using Budget Funds of MOPH 1981," which stipulated that MOPH-affiliated units must procure medicines by their generic names listed in the National Essential Drug List through the pharmacy organization, "except" for cases of emergency. For non-listed essential medicines, funds could be allocated for their procurement as necessary. This regulation served to centralize MOPH's medicine procurement efforts and played a crucial role in price control (Niyada Kiatying-Angsulee and Yupadee Sirisinsuk, 2011, pp. 19–20). In 1986, the scope of using the National Essential Drug List was expanded to include other government agencies and gradually extended to the private sector. The aforementioned approach was incorporated into the "Prime Minister's Office Regulation on Procurement (Version 7)" (National Drug Policy Committee, 1987), outlining the procurement framework for both MOPH and non-MOPH agencies, stipulating that procurement should primarily be carried out through the Government Pharmaceutical Organization (GPO) using the standardized drug prices from the National Essential Drug List (Chanpen Wiwat et al., 2011, p. 20). Concurrently, the process of setting drug prices according to the National Essential Drug List was initiated (Drug Price Study Group/Foundation for Health and Development et al., 1987). The "Drug Price Setting Committee" was responsible for this task. Central prices for the first 373 essential medicines were announced in August and an additional 278 medicines in October 1986. Then, in October 1988, after two years, central prices were announced for another 787 medicines (Suwit Wibulpolprasert, 2005, pp. 81–82). The first edition of the Essential Drug List pricing catalog was successfully compiled in mid-1992.

The second aspect is "production and procurement," which designates the GPO as the central entity responsible for producing medicines and integrating them into the state's healthcare service procurement system. The objective was to increase the local production of essential medicines by 20% annually and to augment the production of disease-specific medicines by 25 per cent per year between 1981 and 1992 (Suwit Wibulpolprasert, 1994, p. 83). Simultaneously, the MOPH policy supported general and specialized hospitals that were equipped to produce certain necessary types of medicines on their own.

The third aspect is "distribution," aimed at developing a medicine distribution system to reach people in remote areas, particularly at the village level. The GPO, which was the state's production and distribution hub, developed various distribution models, including the establishment of stores and branches across all regions to facilitate pharmaceutical services (National Archives of Public Health (11) SSM 2.6/2.15, n.d.). In addition, the MOPH formulated policies to ensure medicine availability for villages through the VHC and VHV mechanisms. These efforts were carried out through the establishment of a Medicines and Supplies Fund (National Archives of Public Health [11] SSM 2.6/2.3, n.d.; National Archives of Public Health [11] SSM 2.6/2.7, n.d.; National Archives of Public Health [11] SSM 2.6/2.10, n.d.). This project supported the formation of community-based organizations, with the villagers contributing an initial fund of 700 baht to start the initiative. During the 5th National Public Health Development Plan, the project managed to establish these medicine and supplies funds, with participation from the communities exceeding 70 per cent, reaching 23,941 funds out of the target of 48,507, and increasing to 39,031 funds out of the target of 58,178 by 1988, covering approximately 52.2 per cent of villages nationwide (Suwit Wibulpolprasert, 1994, pp. 88–89). However, by 1991, the trend declined to around 25,000 funds (National Archives of Public Health [11] SSM 2.6/13, n.d.). The promotion of these funds' establishment is evident in the records of the work at Rasi Salai Hospital by Dr. Sanguan, who attempted to set up "Community Medicine Funds" to "acquire necessary non-hazardous medicines for community use." The villagers were asked to pool their funds to establish the fund, while the hospital would also contribute to the fund. The hospital adopted a service provision approach involving mobile medical units outside regular working hours and contributed all the revenue to the medicine fund (Sanguan Nitayarumphong, 2008, pp. 30–31).

The final aspect is "utilization," and the objective of development in this area was to promote appropriate and cost-effective medication use (National Archives of Public Health [11] SSM 2.6/2.5, n.d.). The responsible agency for this aspect was the Thai Food and Drug Administration (FDA). Several projects were initiated to support this goal, such as research projects on medicinal plants to harness the maximum medicinal benefits from herbs, particularly in using them as raw materials for drug production (Faculty of Pharmacy, Mahidol University, 1981). Workforce development was emphasized to ensure knowledge about medications both in academic and practical aspects. Universities offering medical and health science programs were mandated to include courses on the national essential drug list to equip graduates with fundamental knowledge in this field. Additionally, projects were implemented to control medicines and promote effective drug consumption among the public (Suwit Wibulpolprasert, 1994, pp. 90–103).

The subsequent phase of drug policy development occurred after the initial 12 years of the first national drug policy. This was marked by the announcement of the "National Drug

Policy 1993" (National Drug Policy Committee, 1994). This revised national drug policy aimed to improve and adapt the ongoing initiatives and address the issues arising from the earlier version of the national drug policy. Additionally, it was aligned with the changing economic, societal, technological, and situational landscape. The emphasis remained on addressing fundamental healthcare issues related to appropriate medication use. Overall, the new version of the national drug policy maintained the core structure of the original policy while enhancing clarity and expanding its coverage. As a result, the content of the new policy further promoted and built upon the principles of the original policy (Suwit Wibulpolprasert, 1994, pp. 124–25). Three key focal points were promoting the expansion of the use of the national essential drug list in private healthcare facilities, strengthening research capabilities in preventive and herbal medicine (previously focused primarily on traditional medicine), and safeguarding consumers, which was related to the effectiveness of integrated drug management (Wichai Chokwiwat, 2021, p. 15).

In summary, Thailand has formulated two national drug policies, namely the versions of 1981 and 1993. Following these, there were two more rounds of revisions to the national essential drug list before the establishment of UHC. These revisions occurred in 1996 with the National Essential Drug List (MOPH, 1996; National Drug Policy Committee, 1996) and in 1999 (National Drug Policy Committee, 1999; National Drug Policy Committee, 2002). The national essential drug list became one of the tools considered in hospitals when "taking into account" the benefits of medications, their necessity, quality, and appropriate pricing, without burdening the population excessively with the costs of disease treatment. The national essential drug list transformed into a component that efficiently complements the workings of the UHC. Simultaneously, the fundamentals of the UHC were incorporated into the details of the national essential drug list. The enactment of the National Health Security Act in 2002 included provisions for pharmaceutical benefits based on the national essential drug list, enabling the list to shift from minimum necessary medications to essential medications supported by the UCS.

In the preceding section, we observed progress in knowledge and experimentation to address budgetary issues. In this section, we witnessed significant developments in the control and management of disease treatment, a pivotal factor. This was aimed at achieving both quality and maintaining budgetary stability. In the next section, we will witness the power of the social sector, which had emerged with a leading role in society, driving reform and advocating for rights in health and well-being. This development represented another significant trend that expanded greatly during the 1987-96 decade.

Hospitals decide on the type of medication based on considering the benefits of the drug, its necessity, quality, and appropriate pricing, without adjusting the cost of the medication, which is one of the four requisites, to become an excessive burden on the public.

When streams converge,
Universal Health Coverage
was born, c.1868-2002

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The People's Constitution: The role of civil society in the health reform movement process

The fact that NGOs have come together,
Dr. Sanguan is significant.
The majority of the NGO group came from
the TVF [Thai Volunteer Foundation].
For instance, almost all NGOS
in the northern region at that time
were all members of TVF. And NGOs
weren't that numerous...Some doctors,
like Dr. Sanguan, had a long-standing
relationship with NGOs...I myself used to
teach him back in the science faculty.
He was one of my students,
and we've known each other for quite a while.

(Interview with Jon Ungpakorn, June 25, 2022)

The role of medical personnel and various volunteers in rural areas since the 1970s often involved "community-oriented work" in conjunction with hospital duties, gradually evolving to become the foundation for the concept of human rights, which later emerged.

Power outside the bureaucratic system in the early stage

It must be acknowledged that the "October People" who ventured into remote areas during the period from 1967 to 1977 became a catalyst for the consolidation of power in the external power outside the bureaucratic system in the early era. Organizations like the People's Union for Civil Liberties (PUCL) (1973) played a crucial role in promoting the understanding of human rights among marginalized individuals in society. The Labor Union (1975), established from state enterprise and private sector employee association of 45 people in 1974, became an organization that advocated for the rights and benefits of the people in the early era and was recognized through legislation (Labor Relations Act 1975). Furthermore, there were the Rural Doctors Federation in the initial era (1976) and the Pharmaceutical Associations for the Community (which later became the Rural Pharmaceutical Association) formed in 1975. These were groups formed by pharmacy students and graduates to help rural communities with medication issues. Various types of projects also led to the formation of groups of people who worked and mobilized for societal causes as a force outside the governmental system. Examples include the creation of the Professional Volunteer Certificate Project (P.O.B.) (later becoming the Volunteer Graduate Certificate Program) initiated by Professor Puey Ungphakorn, in 1969, and the Mae Klong River Basin Development Project (1974), a collaboration among three institutions (Kasetsart University, Thammasat University and Mahidol University). The formation and establishment of groups from various sectors marching into rural areas simultaneously led to certain interconnections that eventually contributed to the strong foundation of future Universal Health Coverage.

The relationship between rural doctors and civil society organizations (CSO)

During the period of 1977-1987, the term "civil society" was still not widely known, as it was a new term introduced by academia. At that time, the influence of non-governmental entities on the governmental system was still relatively limited, and the direction of state policy was not clearly defined. This was due to the political landscape of the time, which revealed a balance of power among politics, bureaucracy, and business groups. Public health policies were largely controlled by professional technocrats during the period of 1967-1977. In reality, during that decade, a number of technocrats established non-profit organizations to carry out activities that could not be effectively conducted within the government sector. These organizations included the Family Planning Association, the Sterilization Association, and the Population and Social Development Association, among many others. The founders were high-ranking officials from the Ministry of Public Health. The administrators of the ministry at that time became accustomed to working as part of civil society section. In the subsequent years (1977-1990s), even during the "semi-democratic" phase when the public did not have "full freedoms," the emergence of NGOs played a significant role in filling the gaps in state development efforts. They can be considered the initial steps towards the development of ideas related to freedom and access to healthcare services.

A review of the role of NGOs during the 1970s-80s reveals that several organizations managed to regain their influence and play important roles once again after the political crisis of October 6th. Examples of these include the Rural Doctors Society (1978) and the Association for People's Rights and Liberties (1983), which changed its name from the Union for People's Rights and Liberties. These organizations actively participated in pushing for the development of the "Health Security Act" since 1986, collaborating with other groups. In the area of labor networks, many groups were established anew after the dissolution of labor unions during the October 6th period. These groups included the Federation of Labor Organizations of Thailand (1979), the Federation of Labor of Thailand (1983) and the union groups that continued to operate were the Rangsit/Phra Pradaeng/Om Noi-Om Yai areas, as well as the State Enterprise Relations Union (1982-1983). This movement subsequently played a significant role in pressuring the legislature to pass the "Social Security Act" in 1990.

The organizations directly involved in healthcare that should be mentioned are the "Coordinating Committee of Private Organizations for Primary Health Care," established in 1983, later renamed as the "Foundation for Consumers (FFC)" in 1996. They worked on consumer protection initiatives, such as advocating for appropriate medication use, pushing for changes

from combination to single-drug formulations for pain and fever relief, opposing pharmaceutical patents, and supporting the use of generic drug names. In the early years, FFC also campaigned against smoking (Foundation for Consumers, 2022). Prominent members like Saree Aongsomwang worked closely with Dr. Sanguan for an extended period. Subsequently, Saree invited Jon Ungphakorn, founder of the Aids Access Foundation (1991), and former director of the Thai Volunteer Foundation in 1986, to join the network of NGOs outside of the state sector, collectively referred to as the NGO coalition.

After the October 6th incident, some NGO groups were sent to rural areas, especially where progressive doctors were working. Some NGOs collaborated with medical personnel and worked in those rural areas. Thus, during the 1977-86 era, these specific rural areas were filled with the enthusiasm of young volunteers who interacted with the working medical staff in remote hospitals. These groups collectively contributed to the aggressive development of rural areas, such as providing knowledge to the community, assisting orphaned children, and creating community hospitals to allow graduate volunteers to aid villagers. They also established cooperatives, imparted herbal knowledge, and created village doctors, among other efforts (Interview with Dr. Komatra Chuengsatiansup, June 21, 2022; Interview with Dr. Prateep Thanakitcharoen, June 6, 2022). Although these tasks were not the direct responsibilities of medical personnel who worked in those areas, their involvement in the nitty-gritty aspects demonstrated the perspective of the civil society sector during that time. This perspective aimed to understand and address every issue related to the lives and overall environment of villagers, which hindered their access to healthcare services.

From this point, it can be stated that the “ideology for rural dwellers” and “empowering villagers become self-reliant” had become shared objectives between rural doctors and CSOs since they started working in rural areas. Even though some progressive doctors returned to central areas after a period of rural work, they continued to maintain relationships and create mechanisms to support these NGOs. A clear example of this is during the time when Dr. Sanguan was the Director of the MOPH Planning Division. He allocated a budget to support these NGOs, which still exists today. During that time, part of this support extended to NGOs working on HIV/AIDS issues. With relationships and mechanisms like these, a network of various NGO groups, along with Jon Ungphakorn, became representatives from NGOs outside the state sector. They played a significant role in advocating for the establishment of UHC in the late 1990s, fueled by catalysts such as the Black May incident in 1992.

Civil society and advocacy for the right to health security

One of the significant social phenomena in Thailand that demonstrated the power of People's Movement is known as the "May 1992" or the "Black May" incident. This involved a collective effort of students, laborers, civil servants, farmers, students, company employees, small business owners, and self-employed individuals who came together to protest for political change in the early-1990s. This massive movement was a rebound and a surge towards restoring politics to a form of "democracy." Even though the bloody events of May concluded with an agreement among the elite groups (Puli Fuwongcharoen, 2020, pp. 533-539), it was also another catalyst that jarred the emergence of people's power, leading the process towards democratization. Simultaneously, the intense political atmosphere further ignited the concept of civil society within the realm of public health, making it more pronounced. This perspective views that the civil society sector should separate itself from the wings of the government and businesses to challenge power dynamics and create a certain balance (Kasian Tejapira, 1988, pp. 25-28). The public health community itself partially supported this notion, recognizing the importance of the role of the civil society in acting as a "counterbalance" or "leverage" to private entities profiting from healthcare, preventing the burden of excessive healthcare expenses from falling onto the citizens.

Therefore, in order to prevent the general population from being financially crippled by exorbitant healthcare costs and to mitigate the exacerbation of social disparities related to health issues, the group of reform-minded physicians turned their focus towards empowering the people as the most sustainable solution. These progressive groups needed to come together and establish themselves as social organizations in various forms, such as foundations, associations, clubs, and non-governmental organizations (NGOs). The unity among these groups would allow individuals sharing similar convictions to collectively advocate for the public interest, as exemplified by the network between physicians and the civil society jointly pressing numerous issues. For instance, the MOPH budget allocation in 1992 to support the endeavors of these CSO groups aimed to address the concerns of people infected with HIV/AIDS. Additionally, networks were formed among the government, private sector, academia, and Civil Society, as seen in the case of the "Anti-Smoking Campaign Network," comprising musicians, physicians, and rural community workers nationwide, which successfully rallied support from seven million Thais to push for the enactment of the Tobacco Control Act (1992) and the Non-Smoker's Health Protection Act (1992). This led to the establishment of the "National Committee on Tobacco Control." Consequently, the public health sector recognized the importance of promoting the involvement of the "civil society" as a significant force in the multifaceted development of the healthcare system. As Dr. Suwit Wibulpolprasert emphasized, the solution to the critical development of the "third power"

for creating a society of health empowerment lays in fostering collective consciousness across society, involving the government, businesses, and civil society, seeking harmonious approaches to address health issues together (Suwit Wibulpolprasert, 25 39, pp. 18-19). With this in mind, the key gates were opened, allocating substantial workspace to civil society within the public health arena in an official capacity.

After the "May 1992 Crisis," the parliamentary system increasingly endorsed the concept of "decentralization" and promoted greater "participation" of civil society. This initiative began with the establishment of the Democracy Development Committee" (DDC) on June 9, 1994, comprising 58 members. The committee was tasked with researching, investigating, and recommending political and governance reforms in Thailand to align with democratic principles. Professor Dr. Prawase Wasi chaired the committee. The outcomes of this effort became the framework for the subsequent drafting of the constitution that emerged later. This constitution contained several key components emphasizing the "rights and freedom of citizens," "people's participation," and the explanation that "*non-governmental organizations or NGOs are a professional organization in society*." These organizations possess high capabilities and play a significant role in the social development and democracy of Thailand.

During the time of grappling with the flourishing of civil society, there was a significant issue that followed – the "1997 Economic Crisis." This crisis marked one of the most severe downturns in Thailand's history, affecting the overall budget for healthcare as well. The 1997 economic crisis, also known as the "*Tom Yum Kung Crisis*," was a result of the country's economic conditions leading up to that point. Throughout the 1980s, foreign investors had anticipated that Thailand was on the "Newly Industrialized Countries" (NICs) path. This trend led the Bank of Thailand to promote financial activities freely through the "Bangkok International Banking Facilities-BIBFs," facilitating "Thai Financial Deregulation." During this period, the financial system underwent a major transformation in Thai economic history. Bangkok became a financial center of the region, with interest rate restrictions eased and foreign financial institutions allowed to conduct business within the country. Consequently, there was an influx of low-interest foreign loans invested in real estate and hospital businesses. The Thai economy surged forward due to private sector investments both domestically and internationally. However, this situation also laid the groundwork for the bubble crisis. The construction industry was the first to show signs of decline, leading to a direct impact on the financial sector, especially investment firms. The real estate sector accumulated significant debt. As foreign investors began losing confidence in the Thai economy, they decided to divest their baht holdings, leading to the baht devaluation crisis in July 1997. The Bank of Thailand eventually announced a "managed float" exchange rate policy, causing a severe and continuous depreciation of the Thai baht. The exchange rate tanked

to a historic low of 56.1 baht per US dollar (Kiatnakin Phatra, 2022, pp. 195-196). Meanwhile, interest rates rose by more than 10 per cent, resulting in a dramatic increase in debt principal. Interest rates continued to rise, further multiplying the debt by nearly threefold.

Certainly, the 1997 economic crisis had an adverse impact on the overall financial situation and fiscal health of the country. The MOPH also faced the challenge of economic instability as the inflation rate surged from 4.8 per cent in 1996 to 7.7 per cent in 1997, resulting in the MOPH budget for 1998 declining from 63 billion baht to a net value reduction of 12.7 per cent (Suwit Wibulpolprasert, 2005, p. 401). However, crises often bring forth "opportunities." Developments in public health were achieved in a short period. The MOPH swiftly implemented measures to tighten the overall budget, focusing on the principle of "*Good Health at Low Cost*" to address the budget-related issues stemming from the economic crisis, such as reducing healthcare expenses for civil servants. Meanwhile, the reform-oriented group of doctors continued to "seize opportunities" amidst the ongoing situation, driving healthcare reform to expand on various dimensions. For example, efforts were made to promote the use of primary care services and to establish the "Ban Phaeo Hospital", which is "public organization" or "state-autonomous hospital." Although it is the first and only one in Thailand, this initiative contributed to the growth of the notion that a new public management system emphasizing a reduction in the role of the government (Interview with Dr. Jadej Thammatacharee, June 8, 2022). However, the most outstanding aspect was the integration of civil society to bolster efforts towards achieving UHC. At that time, civil society became visibly more active in the aftermath of the economic crisis. Eventually, their significant involvement led to the successful endorsement of the 1997 Constitution. When the 1997 Constitution was enacted, it became a critical pillar that upheld the determination to establish UHC over the next four years.

The 1997 Constitution of the Kingdom of Thailand is often hailed as the "People's Constitution" because it was the first constitution that "empowered" the significant growth of civil society and also resulted in direct advancements in the healthcare system. This is evident in Section 3, which addresses the rights and freedoms of Thai citizens, specifically in Article 52, which states that:

> "*Individuals are equally entitled to receive standardized healthcare services, and the underprivileged have the right to receive medical treatment from public healthcare facilities without incurring any charges"*
>
> *(Royal Thai Government Gazette, 1997)*.

The Constitution also emphasized the provision of state healthcare services that are "universal and efficient," while promoting the involvement of local authorities and private sector to the extent possible. The "Draft National Health Act," formulated and promulgated later in 2007, clearly articulates the aspiration for equal and comprehensive rights and emphasizes participation, in line with the spirit embedded in the 1997 Constitution. This serves as evidence of the power of the people's participation in the process of developing Thailand's healthcare.

Another event that demonstrated the role of civil society in overseeing the functioning of the state occurred shortly after the enactment of the 1997 Constitution. This event was the effort to expose corruption in the procurement of medicines in 1998. The trigger for this event came from directives from central government officials, instructing hospitals to purchase medicines from pre-designated companies at significantly higher prices than usual. There were attempts to inflate the prices of medicines, leading to a movement aimed at investigating corruption in the procurement of medicines and medical supplies by the MOPH. This movement was a collaboration between the Rural Doctors Society (led by Dr. Wichai Chokwiwat), the Rural Pharmacists Association, and a network of over 30 NGOs. The NGO network included the Foundation for Consumers as its core, playing a central role in facilitating communication, document compilation, information dissemination, forums, meetings, and press releases, while advocating for the establishment of a committee to investigate corruption. The investigation process, chaired by Dr. Banloo Siriphanich, found instances of corruption involving both politicians and government officials. The movement orchestrated by the NGO network utilized the mechanisms provided by the 1997 Constitution, which mandated the public's power to scrutinize state actions under Articles 303 and 304, where at least 50,000 citizens could collectively demand an investigation into political corruption (Nualnoi Treerat and Kanoksak Kaewthep, 2002, p. 56). The process

Health-related Family Organization

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The push of the health system reform network in the decade of 1987-1997 has resulted in a powerful "mechanism–tool" of health system reform that went beyond the parent H agency, the Ministry of Public Health, which is "Health-related. Family Organizations." The key 4 agencies are:

(1) Health Systems Research Institute (HSRI) in 1992

(2) Thai Health Promotion Foundation (ThaiHealth) in 2001

(3) National Health Security Office (NHSO) in 2002, and

(4) National Health Commission Office (NHCO) in 2007

of collecting names for the movement occurred from September 11 to November 18, 1998, resulting in a total of 52,554 names. Although this mechanism stumbled and faced challenges in practical implementation, it did not prevent the exposure of corruption. This event had widespread repercussions, affecting the positions of both wrongdoers and those involved.

The outcome resulting from the extensive investigation into pharmaceutical corruption by the civil society sector was the emergence of proposals for designing a 'quasi-autonomous organization.' Such proposals included structuring the composition of boards of committees with proportions representing civil society, NGOs and local government organizations, thus allowing them to play a significant role in oversight and policy-making decisions with greater fairness. This development contributed to the design of the organizational restructuring of the public health system, including the Thai Health Promotion Foundation (ThaiHealth), the National Health Security Office (NHSO), and the National Health Commission Office (NHCO) in 2001, 2002, and 2007 respectively. Each of these agencies outlined the proportional composition of committees represented by diverse sectors, marking a major shift in power relationships within the healthcare system. This progress marked a "further step" beyond the establishment of "independent knowledge organizations," exemplified by the Health Systems Research Institute (HSRI) in 1992. It is evident that fragments from various events were employed as experiences and driving forces that led to the creation of the UCS, ultimately enabling the realization of the UHC ideal in Thailand.

However, even with a sufficient service and facility system, comprehensive health knowledge, awareness of strengths and weaknesses for budget management in an efficient health insurance framework, and active involvement of the civil society sector in driving the healthcare system, the establishment of Thailand's UHC still was undergoing a gradual evolution. It was not until the "window of political opportunity" emerged when the Thai Rak Thai Party accepted the proposal of a UHC policy as part of its campaign platform, and secured victory in the 2001 elections.

When streams converge,
Universal Health Coverage
was born, c.1868-2002

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The political momentum toward UHC implementation in practice

No. 7: Create universal health coverage
to reduce the overall expenditure of
the country and people on health care.
The cost is 30 baht per time and creates
opportunities to access public health services
that meet standards thoroughly and equally.

One of the nine policy statements that
PM Thaksin Shinawatra made to Parliament
(Policy Statement of the Cabinet, Police Lieutenant Colonel Thaksin Shinawatra, Prime Minister,
delivered to the Parliament on Monday February 26, 2001", 2001, pp. 4–5).

Apart from the positive signals that emerged from the 1997 Constitution, which serves as the highest institutional principle of the country, facing the economic crisis also led to the emergence of political resilience within the framework of democracy. The Thai Rak Thai Party, founded by. Thaksin Shinawatra in 1998, received support from large business groups that had survived the economic crisis. The party introduced several interesting policies to reform the country's fundamental structures. One of these policies was the "30 Baht Treats All Diseases" policy.

Acceptance of the "30 Baht Policy " by the political sector

One policy that was clear and well-received by the general public during the campaign period, allowing the Thai Rak Thai Party to stand out compared to other political parties, was the proposal of the "*30 Baht Universal Healthcare Scheme*." This policy played a significant role in the triumph of the Thai Rak Thai Party in the election, securing up to 248 parliamentary seats. They successfully formed the government on February 6, 2001. For instance, *Naew Na Newspaper* documented the atmosphere and highlights of Thai Rak Thai Party's election campaign in 2001, stating that:

> *"The Thai Rak Thai Party campaigned by making numerous promises to the people...Recently, they announced that every citizen across the country, all 62 million people, could seek treatment at hospitals for any illness, paying only 30 baht per visit, including the cost of medications. Treatment would continue until recovery..."*
>
> *(Naew Na, 2001).*

This was considered the most exciting and interesting topic for people all over the country, garnering unanimous support from various sectors (Ibid, 2001). The journey of the prominent idea of UHC "meeting" with the political sector and evolving into a resonating campaign promise deserves recognition for the efforts and dedication of Dr. Sanguan Nitayarumphong.

Key champions or seller of the UHC concept

Previously, Dr. Sanguan had attempted to sell the idea of UHC to various political parties, but only the Thai Rak Thai Party decided to adopt the policy as part of their campaign platform. "[Sanguan] *approached several parties...including the Democrat Party, but they declined. When he proposed it to Thai Rak Thai, they accepted"* (Interview with Dr. Paijit Pawabutr, 30 May 2022). Some political parties that hesitated to respond to the policy did so due to concerns about budget limitations. Former Prime Minister Abhisit Vejjajiva, who held the position of Minister of the Prime Minister's Office from 1997 to 2001, during the period of Dr. Sanguan's advocacy, clarified the rationale behind the Democrat Party's refusal to adopt UHC proposal at that time, as follows:

> "*Before Dr. Sanguan's team approached Thai Rak Thai, the economic crisis exploded. We were concerned about the potential for uncontrolled costs and lack of fiscal discipline…The Democrat Party was concerned about the budget, and when we calculated the projected costs, we felt we weren't ready yet…Within the Party, it wasn't that they disagreed in principle with UHC, but rather, they felt we weren't prepared. If we're not ready, there will be consequences in terms of the quality of care…Certainly, anything that could benefit the public we would not often deny. However, if we promise and can't deliver, then the Democrat Party must take responsibility. We were overly cautious, more than just opposing the principle*"
>
> (Interview with Abhisit Vejjajiva, May 26, 2022).

Dr. Surapong Suebwonglee reflected about the prevailing atmosphere when Dr. Sanguan presented the UHC policy to the Thai Rak Thai party:

> *"At the time when Dr. Sanguan presented to Thaksin, it was on Christmas Eve (December 24, 1999) ... As a businessman, looking at the budget, you would know where the money comes from, but other parties might not go into such detail...It depends on what kind of mindset they have. If they want to do it, they will find the money"*
>
> *(Interview with Dr. Surapong Suebwonglee, May 27, 2022).*

Therefore, Dr. Sanguan was considered a significant figure who actively sought avenues to promote UHC and was behind the policy concept of "*30 baht treats all diseases*." This slogan eventually became a political symbol for the Thai Rak Thai party. However, at the same time, it must be acknowledged that the decision to adopt the policy from the leader of the Thai Rak Thai party was a political earthquake, a crucial moment that marked the beginning of creating an environment where healthcare professionals and reformists could work to make the policy a reality. Certainly, pushing for the acceptance of the principle of UHC was a challenging task, and implementing it in practice was even more challenging. Fortunately, the experiences gained from working to transform the healthcare sector taught healthcare professionals and reformists the importance of planning and preparation, involving not only intellectual capacity but also tools, resources, and people for future endeavors.

UHC in practice

After winning the January, 2001 elections and following it with a policy announcement in February 2001, the "*30 baht treats all diseases*" project was considered an urgent policy that the Thai Rak Thai party was determined to implement as quickly as possible. They had a group of rural physicians and Dr. Mongkol Na Songkhla closely monitoring the progress. The pilot phase of this project was initiated in April 2001, starting in six provinces: Phayao, Yala, Nakhon Sawan, Pathum Thani, Yasothon, and Samut Sakhon. This pilot project operated under the MOPH regulations on creating UHC

Dr. Mongkol Na Songkhla

...

Dr. Mongkol Na Songkhla served as a government-employed physician affiliated with the MOPH. he previously held positions as the Director of Pimai Hospital in Nakhon Ratchasima Province, and Director of the Office for the Promotion of Academic and Public Health Services in Buriram Province, Surin Province, and Chiang Mai Province. He later served as the Provincial Chief Medical Officer in Phrae Province, and subsequently moved to hold the position in Lampang and Nakhon Ratchasima provinces. In recognition of his outstanding contributions, he received the "Outstanding Rural Physician Award" in the year 1976.

He then went on to become the Director-General of the Department of Medical Services, the Secretary-General of the Food and Drug Administration, and eventually reached the highest position as the Permanent Secretary of the Ministry of Public Health. In the political arena, he also held the position of Minister of Public Health between 2006 and 2008.

in 2001 and the regulations on financial support for the UHC program. The reason these particular provinces were chosen as pilot areas was that all six provinces had previously implemented Social Investment Program (SIP) projects with loans from the World Bank, making it convenient to expand upon their previous work. Dr. Mongkol, who served as the Permanent Secretary of the MOPH at that time (2000-1), played a crucial role in selecting these six provinces, stating that they were "prepared and ready to go" and ready to start the project immediately.

Dr. Mongkol also enlisted the help of a team of doctors in the pilot areas, including Dr. Sanguan Nitayarumphong, Dr. Prateep Thanakitcharoen, and even Dr. Surapong Suebwonglee. During the initial phase of the service model, citizens were issued comprehensive health insurance cards, often referred to as "gold cards." Each province surveyed eligible individuals and distributed these cards to prepare for the program. Starting on April 1, 2001, these cards allowed cardholders to access services at any healthcare facility for a co-pay of 30 baht per visit. Just two months later, in June 2001, the second phase of the project commenced, expanding to an additional 15 provinces, including Nonthaburi, Saraburi, Sa Kaeo, Phetchaburi, Nakhon Ratchasima, Surin, Nong Bua Lam Phu, Si Sa Ket, Ubon Ratchathani, Amnat Charoen, Sukhothai, Phrae, Chiang Mai, Phuket, and Narathiwat. These provinces were willing and prepared to participate as pilot areas after witnessing the success of the initial phase. Then, in October 2001, the project's coverage was further extended until it reached all provinces nationwide. This was in line with Dr. Mongkol's determination, as the MOPH Permanent Secretary, to ensure nationwide coverage within the specified timeframe. This goal was successfully achieved, with the exception of the Bangkok Metropolitan Area, which would be covered in the following year, in January 2002. Dr. Surapong observed the following: "*I have to thank you [Dr. Mongkol] because if someone else were the Permanent Secretary of the Ministry of Public Health at that time, there might have been more complications*" (Interview with Dr. Surapong Suebwonglee, May 27, 2022).

In Phase 1 (April 2001), there were only 1.4 million Thais who were eligible for the Universal Coverage Scheme (UCS), or the Gold Card. This number then increased to 4.2 million and 39.8 million people in Phases 2 and 3, respectively. By the end of 2002, a total of over 45.4 million people were covered by the UCS, accounting for 73 per cent of the entire Thai population. Regarding access to healthcare services, in the initial phase, only healthcare facilities under the MOPH participated. Later, the coverage expanded to include almost all state-owned hospitals by September 2002. There were a total of 1,011 registered participating healthcare facilities, categorized into 818 hospitals affiliated to the Office of the Permanent Secretary of the Ministry of Public Health, 21 hospitals not affiliated to the Office of the Permanent Secretary but belonged to the Ministry of Public Health, 70 state-owned hospitals not affiliated to the Ministry of Public Health, and 102 private hospitals (Pongpisut Jongudomsuk, 2004, pp. 24–26). Currently,

there are numerous healthcare units of various sizes that provide services to UCS beneficiaries, covering all regions throughout the country.

In addition to public relations efforts and the expansion of participating UCS providers, the major considerations for ensuring the long-term sustainability of the system were the design of the governing system before the enactment of the National Health Security Act in 2002. Furthermore, there was a need to manage the budget of the UCS, including determining "who" should be responsible for overseeing and efficiently managing the budget allocation for the system.

The fact that the concept of Universal Health Coverage has converged with politics, turning it into a prominent and impactful campaign policy, is credited to the efforts and determination of Dr. Sanguan Nitayarumphong.

When streams converge,
Universal Health Coverage
was born, c.1868-2002

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Constructing the main pillars of the National Health Security Fund administrative system

If providing access to the core healthcare system is the goal of establishing (UHC), then the creation of the NHSO organization with official legal backing, along with the design of the content in the “Act,” can be likened to the “backbone” of the reform. This backbone ensures that the objectives of building a robust, sustainable, and resilient UHC system are achieved.

The National Health Security Office (NHSO), established under the National Health Security Act of 2002, has the responsibility to reform the public healthcare system through financial measures. In other words, the NHSO acts as the "representative of the people" to manage the "benefits and budgets" for all health services officially within the Universal Coverage Scheme (UCS).

The concept of "average suffering, average happiness": The aspiration in managing the budget of the UCS.

On the day when the budget management for the 30 baht policy, or the UCS, needed to be designed, the principle of "average suffering, average happiness" of all members in society became the guiding principle for sustainable system development from the very beginning. Reform-minded physicians believed that the UCS should be operated using the principle of risk-sharing, which arises from illness, in order to promote good health, assist those who are ill, and enable the wealthy to support the poor, even if indirectly. This is encapsulated in the phrase "*The well help the sick, the wealthy help the poor*." Based on the experiences gained from the Voluntary Health Insurance Card, it has been suggested that the application of the principle of 'balancing suffering and happiness' yields effective results and should be implemented in a comprehensive manner to enable automatic mutual assistance among members of society, even if they do not have personal connections to one another (Sunthorn Tunmuntong, 2010, pp. 46).

In order to design a comprehensive healthcare insurance system in line with the principle of "average suffering, average happiness" that can be sustained over time, it is essential to consider three key components: (1) policy sustainability: ensuring that the policies supporting the system are sustainable in the long run; (2) financial sustainability: ensuring that the financial aspects of the system are sustainable, meaning that it can be funded effectively and efficiently

indefinitely; and (3) institutional sustainability: ensuring that the institutions and organizations involved in the system are capable of maintaining the system over the long-term. These three components are referred to as the "think tank" of the UHC, or the "war room," which played a crucial role starting from the selection of pilot provinces, the design of service delivery models, and even budget calculations. This "war room" was at the core of the transformation towards achieving UHC at the time.

Policy sustainability relied on mechanisms to rapidly implement the UCS, also known as the 30 baht program, nationwide in January 2002, to minimize factors that could make the policy obsolete. As for **financial sustainability**, it became a major challenge that required careful planning from the outset to ensure the long-term viability of the scheme. It was clear that the UCS intended to use the "capitation payment" budget allocation method, as previously conceived and tested in the SSS. However, both systems had different sources and allocation mechanisms for budget funds. The key issue for the UCS was determining the appropriate per capita rate and whether the salaries of the personnel providing the services to beneficiaries should be included in the capitation payment or not. Sudarat Keyuraphan, the Minister of Public Health at the time, stated that aside from advancing public relations efforts to make the policy understandable, the major decisions revolved around "*the per capita budget and whether to include salaries or not*" (Interview with Khun Ying Sudarat Keyuraphan, June 10, 2022).

Budget allocation through capitation payments and the inclusion of salaries.

The UHC war room included budget calculations for capitation payments during the pilot phase in six provinces. Key figures involved in budget calculations had been significant players since the SSS project, and this continued to be a responsibility of Dr. Viroj Tangcharoensathien and his team. Before this, Dr. Viroj had proposed capitation payment models in the SSS in 1990 and suggested a cost-sharing system between the government and the public in the Voluntary Health Card Scheme (VHCS). He was also part of the team that proposed per capita budget figures in the reform of Ban Phaeo Hospital project in 2000. His experience in public health finance and academia was invaluable for the creation of the UCS that came later.

Around April 2001, during the pilot phase of the project, the capitation payment figure of 1,202.40 baht was introduced, which was derived from workshops held at the Santi Maitri Building (Government House) and was met with debate, generating multiple iterations. The process of arriving at the 1,202.40 baht figure was not straightforward. In the words of Dr. Viroj: "*The*

capitation [budget calculation per capita] *was not a bed of roses; it had operational discourse, but it was due to Dr. Sanguan's leadership that a consensus was reached*" (Interview with Dr. Viroj Tangcharoensathien, May 31, 2022). Dr. Viroj also mentioned that the decision to use a capitation payment system raised another important issue, whether to include personnel salaries in the per capita budget, which was a subject of debate among those in favor and those against it.

Regarding the issue of including personnel salaries in the per capita budget, when using the capitation payment method, it causes the budget to flow according to the number of people registered with service providers in each area. This is a budget management approach following the concept of 'money follows people' to better meet the healthcare needs of the population. This method results in areas with a larger population receiving a larger budget, which, in turn, enhances the potential of healthcare facilities in those areas. This also attracts various resources and healthcare personnel to regions that are in need. Conversely, areas with excessive resources but a relatively small population in need of care may have their budgets redistributed to healthcare facilities in high-need areas. This budget allocation approach leads to a more equitable distribution of healthcare resources of all types to areas with genuine service needs, thus expanding and improving the healthcare system without excessive budget increases. One of the budget items that must be distributed following this principle is personnel salaries.

The allocation of per capita budgets at the beginning of the UCS resulted in the inclusion of salaries as part of the budget allocation for each province. This led to financial imbalances in provinces with a high number of personnel compared to their population, as the budget allocated per capita for salaries was relatively high. There was also an issue of consolidating salary expenses within the per capita budget in practice because salaries, governed by royal decree, could not be deducted and included directly in the per capita budget. Consequently, a "deduction account" system was used to deduct the salaries already paid from the per capita budget, causing some provinces to have a very limited or even negative remaining budget at the beginning of the year.

This financial strain resulted in difficulties in providing healthcare services. Conversely, hospitals with fewer personnel but a large population to serve faced budget surpluses. This was because the increase in funds could not immediately be converted into additional personnel, thus limiting the expansion of healthcare services. Nevertheless, the issue of consolidating salary expenses had various complexities and challenges, especially after 2002. For instance, from 2003 to 2005, in the first three years following the introduction of the UCS, the MOPH was still responsible for budget allocation, not the NHSO. While the NHSO was set up to manage the budgets for UCS beneficiaries (details omitted here), it is important to understand that during the

initial phase of UCS implementation, budget calculations and allocations were not straightforward. This was an issue that could not be immediately resolved and required negotiation and adjustment over time. In conclusion, the initial principles of consolidating salary expenses within the per capita budget in the 2002 budget year and subsequent financial issues had complex details and challenges. This required further discussion and deliberations about financial matters, which continued over time.

Understanding the budget management concept, we now shift our focus to the role of the NHSO as an organization and its historical context to comprehend the third dimension, which is **institutional sustainability**. The NHSO was (and still is) a crucial pillar that provided essential support to ensure that the UCS remained more than just a fleeting phenomenon and a short-term policy measure.

The NHSO as an institutional outcome derived from the historical trajectory of health system reform

The emergence of the NHSO is considered one of the "institutional outcomes" of the health system reform network in the 1987-1997 decade. The aim was to design an organization that was "autonomous" in its management and self-governance, adaptable to its responsibilities, and not characterized as a bureaucratic system, a political party, or a non-governmental organization. At the same time, it needed to be an organization that aimed to establish relationships with the government, political groups, and civil society organizations simultaneously.

To achieve the aforementioned objectives, healthcare reform advocates proposed a new organizational structure as a mechanism and tool to drive healthcare system reform during the seminal period of the 1987-1997 decade. Subsequently, this structure often came to be referred to as the "health-related organizations" (i.e., each starting with the Thai letter 'Sor' meaning 'health'). These organizations consisted of the following: (1) HSRI (Health Systems Research Institute) in 1992, (2) the Thai Health Promotion Foundation (ThaiHealth) in 2001, (3) the NHSO (National Health Security Office) in 2002, and (4) the National Health Commission Office (NHCO) in 2007. These organizations were established to institutionalize healthcare reform proposals into stable "institutions" that could not be easily dismantled or altered with changing political trends.

HSRI served as the academic body, while ThaiHealth was tasked with allocating resources to support civil society organizations to play a pivotal role in driving public policy, focusing on health promotion, disease reduction, and mitigating health risks from adverse

environmental conditions. The NHSO, on the other hand, was responsible for health system reform through financial measures, primarily by providing services based on ethical principles and restructuring public health services. Finally, the NHCO aimed to expand the role of baht from healthcare to health and promote the active involvement of civil society organizations on a knowledge-based foundation. This strategy is considered a smart approach that led to impressive outcomes. When it comes to the specific role of the National Health Security Office (NHSO) in the dimension of financial management and its central role in the stability and sustainability of the system, it is often closely associated with the NHSO organization directly. The establishment of the NHSO under the National Health Security Act of 2002 is considered a significant manifestation of the financial reform mechanism to oversee the UCS. The key principle that was essential to creating a new organization to manage the core healthcare financing system was the 'purchaser-provider split.' This involved separating the budget management authority from the Ministry of Public Health (MOPH), which acted as the service provider, and establishing a new organization to represent the UCS beneficiaries and procure services from the MOPH. The newly established NHSO organization in 2002 had two important missions: (1) Negotiating and supporting services: – This was a crucial part of efficiently managing the UCS fund to ensure its highest effectiveness; and (2) Controlling the public health service system to ensure that the population had access to standardized, high-quality services. These missions aimed to provide the best possible healthcare services to the UCS beneficiaries while maintaining financial stability and sustainability within the healthcare system.

Dr. Sanguan Nitayarumphong played crucial roles in drafting healthcare laws, including the Health Systems Research Institute Act (HSRI), the Health Promotion Fund Act (ThaiHealth), and the National Health Security Act (UCS 2002). For the National Health Act, Dr. Amphon Jindawatthana was instrumental behind the scenes for the National Health Act (NHCO). Both previously served as Presidents of the Rural Doctors Society, with Dr. Amphon Jindawatthana was the 7th President (1984-85) and Dr. Sanguan Nitayarumphong served as the 8th President (1985-86).

The reform of budget management systems, as described, necessitated that organizations like the NHSO be independent and not under the control of the MOPH. This was to allow the NHSO, as the state's representative, to carry out its mission of supporting services and negotiating service fees on behalf of the population, while the MOPH focused on service production. These

"Purchaser-provider split"

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This is a term that is translated literally from Western concepts, sometimes reducing the relationship between the two terms. It often has more of a marketing dimension related to customers rather than the characteristic of friendship.

two separate roles needed to be independent of each other in principle (Nualnoi Treerat and Bank Ngamarunchot, 2012, p. 52). The establishment of the NHSO organizational mechanism, as mentioned above, with legal support both officially and in line with the content of the Act, can be likened to the 'backbone' of the UCS. It aimed not only to achieve the goal of creating UHC, but also to ensure stability, strength, and sustainability. It was not merely a short-term policy to gain political favor for any government but a crucial and enduring design with significant implications in the context of the Act.

The "Act" as the backbone of the Thai Universal Health Coverage

In fact, the concept for the National Health Security Act drew inspiration from various drafts of royal decrees that had been designed by representatives from different parties. The initial draft of the Act was proposed as early as 1995-96, with a working group comprising Dr. Sanguan as an advisor, along with representatives from political parties such as the Democrat Party, the Chart Thai Party, civil servants from the MOPH, the Ministry of Labor, and the Legislative Committee. They successfully crafted the "draft National Health Security Act," which introduced the concept of having a 'mandatory health scheme' where citizens and the government collectively contributed supplementary funds to the healthcare security fund. However, the progress of this version of the Act, spearheaded by Dr. Sanguan, did not move forward significantly. This was due to the belief held by many scholars and organizations that Thailand was not yet "ready" in terms of budgetary matters.

Next, Dr. Sanguan took this concept to discuss and exchange ideas with CSOs such as AIDS Access Foundation, Thai Volunteer Foundation, Foundation for Consumers, etc. These CSOs saw the benefits that could be realized for the public and, therefore, embraced the principles of the UCS. They proceeded to establish a network of CSO with a common goal: to advocate for the enhancement of comprehensive healthcare. This organization was called the "Universal Health Coverage Campaign," which brought together NGOs in public health and a network of

11 CSOs, with Jon Ungphakorn playing a pivotal role. Jon referred to the starting point that led to the participation in the UHC campaign as follows:

> *"Before 2000, I worked at the AIDS Access Foundation. We encountered a persistent problem that they didn't have the funds to purchase medicines, not even antiretroviral drugs or antifungal medications for oral and ocular infections for AIDS patients. Many HIV people were dying from preventable death as a result. So, we decided to tackle the issue of access to medicines. We wanted to provide access to medicines and healthcare services. At that time, Dr. Sanguan was advocating for the concept of UHC. We conducted public polls asking if people would support a healthcare insurance system where they wouldn't have to pay for treatment. The response was overwhelming, and people wanted it. Dr. Sanguan then convened a meeting with us. Dr. Sanguan proposed the principles for establishing healthcare insurance legislation, and the NGOs that attended the meeting agreed wholeheartedly. Consequently, we formed a working group to represent the NGOs and proceed with drafting the legislation. At that time, we recognized that Dr. Sanguan's draft legislation was not yet complete, and we wanted to have a say in it"*
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> *(Interview with Jon Ungphakorn, June 25, 2022)*

Jon, along with academics, legal experts, and several consultants who possessed the ability, collaborated to form a team to draft the Act. These individuals included Nakorn Chomphuchat, Sureerat Treemakka, Dr. Yupadee Sirisinsuk, and others. This collaboration led to the content of the draft "Peoples Version of the Act," which emphasized free-of-charge services funded by taxes, not fees collected from service recipients (Ibid, June 25, 2022). Furthermore, several principles were subsequently applied, such as the establishment of two committees that could independently select their representatives without political interference.

Concept of Free Service

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This way of thinking is a concept that has its origins in the National Health Service of the United Kingdom, from which Dr. Sanguan Nitayarumphong, Dr. Viroj Tangcharoensathien, and Jon Ungpahkorn gained experiences and ideas.

These committees evolved into the National Health Security Board and the Service Quality and Standard Control Board. Additionally, the proposal for a no-fault compensation system, which later became Article 41 in the Act, was put forward, and this provision obviated the need to prove liability in case of grievances or claims of damages due to service under the UCS.

In terms of political activities, the Cabinet passed a resolution in favor of the Prime Minister's Office regulation on national reform on May 9, 2000. Subsequently, the "National Health System Reform Committee" (NHSRC) was established. The Prime Minister served as the chairperson, and the Director of the National Health System Reform Office served as the secretary. The "National Health System Reform Office" (NHSRO) was established under the framework of the Health Systems Research Institute (HSRI). The main responsibility of the NHSRC was to draft the National Health Act and to build the knowledge and capacity of civil society organizations and the mass media. Professor Ammar Siamwalla, a renowned economist, served as the chairperson (Viroj Na Ranong, Anchana Na Ranong, and Sornchai Triamworakul, 2004, p. 25). The Committee included Dr. Sanguan Nitayarumphong, Dr. Viroj Tangcharoensathien, Dr. Supasit Panarunothai, and Dr. Yupadee Sirisinsuk, they were also part of the working group that proposed the UHC system. The core concept presented by the NHSRO and HSRI in this report was the "purchaser-provider split." This was an innovation drawn from UHC systems in various countries that required market regulation to prevent the healthcare service market from operating freely, as it could lead to market failure. The suggestions and strengths from all draft versions, starting with the working group under the public health committee, the people's draft, the NHSRO version, and the HSRI version, were carefully selected and further developed to become the "prototype" for drafting the National Health Security Act proposed to the Thai Parliament by the Thai Rak Thai government later on.

The process of presenting the draft National Health Security Act to the Members of Parliament for approval began in Session 1 on November 15, 2001. There were a total of six draft versions submitted, consisting of one from the government, four from political parties, and one from Civil Society, which included the names of approximately 50,000 citizens. This process was initiated by the UHC Campaign in late 2000. In each draft version, there were some differences in details. For example, the interpretation of "service fees" varied between drafts, particularly in terms of the money paid by service recipients to healthcare units. These differences became evident in Section 1 related to receiving healthcare services, Article 5, where many drafts emphasized the same direction that all Thai citizens have the right to receive essential healthcare services that meet standards and are efficient. However, the point of contention was regarding the phrase "*according to the country's fiscal capacity*," which some parties suggested removing.

Regarding the provisions related to the establishment of the UCS office, most parties agreed that it should have legal jurisdiction and not be a government agency but should operate under the supervision of a minister.

While some versions presented differing proposals, such as the one presented by the Democrat Party, which specified text variations from the other drafts, there were common elements to the key proposals. One significant proposal was to specify that vulnerable and disadvantaged populations, as well as those who contribute to society (such as children, the elderly, monks, nuns, the disabled, or individuals who perform acts of goodwill for the nation), could receive medical services without any charges. This was because these groups had historically been exempt from charges. Another proposal suggested opening the opportunity for the public to choose their fund type from the previous system. As for the draft proposed by civil society itself, there were several significant differences from other drafts. For instance, one notable proposal was to establish a single health insurance law applicable to all Thai citizens, ensuring equality. This was suggested because the current system had disparities due to the existence of multiple fragmented funds and management systems (Report of the 33rd House of Representatives Meeting, November 15, 2001). The proposals included suggestions that there should be no service fees, and that financing should be the responsibility of the state. Additionally, there were proposals to have representatives from NGOs, with a maximum of 8 members selected through a selection process, which allowed for the highest level of involvement by CSOs (Office of the National Health Security, MOPH, unpublished). This version reflected different perspectives that were not considered from a governmental standpoint as seen in other drafts. It can be characterized as providing a space for diverse and creative opinions and critiques of the institutionalized legal framework, as evident in the meeting report of that House of Representatives session (Ibid, 2001).

Finally, the "National Health Security Act of 2002" was 'born' in mid-November 2002, which marked a paradigm shift in society's perception of health. Key issues included transitioning from a "target-based assistance" system to a "rights-based" system, ensuring that all Thai citizens had the right to comprehensive and universal healthcare access without financial barriers. Article 41, which required a 1 per cent contribution for compensation in case of medical harm, meant that if harm occurred during medical treatment, the patient had the right to receive initial compensation to alleviate the distress of both the patient and their relatives. The design of a quasi-autonomous organization, the "Quality Control Board," included proportional representation from NGOs and local government organizations, which played a significant role in policy oversight, policy decision-making, and monitoring policy implementation to enhance fairness within the system. This law also led to the establishment of the "National Health Security Office (NHSO),"

to manage the UCS. In other words, the 2002 Act established a UHC system with robust legal support and created the NHSO as the "people's representative." The NHSO would manage and administer all healthcare benefits and budgets for the UCS, marking a 20-year journey in pursuit of a genuine benefit for the public that all Thais could enjoy equally.

When streams converge,
Universal Health Coverage
was born, c.1868-2002

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Conclusions:
The past steps and future strides of Thailand's Universal Health Coverage

When the UCS law was successfully passed, in addition to the joy of UHC becoming a reality, I also knew well that it was just the beginning of a new chapter in the process of healthcare system reform. I knew that there were still many hills to climb to improve the healthcare system beyond what it used to be. However, I had no doubt they we could prevail in this endeavor, and I was ready to work hard for the next phase...

Dr. Sanguan Nitayarumphong”

(Chatree Charoencheewakul and Opiwan Nitayarumphong, 2011, p. 79)

Pathway for Universal Health Coverage

The creation of the Universal Coverage Scheme (UCS) is a significant milestone that has contributed to the successful establishment of Universal Health Coverage (UHC) for the benefit of the majority of the Thai population. It also solidified its sustainability through the design of the NHSO organization, which was tasked with overseeing the entire system. However, it is important to note that this achievement was not without its challenges. It required facing the difficulty of aligning the various perspectives from all relevant sectors, including the government, academia, and civil society organizations, through the process of producing and synthesizing multiple drafts of the National Health Security Act. After 20 years of implementation, the success of the UCS thus far reflects the historical, political, economic, and social contexts surrounding healthcare and public health have played a significant role in shaping the path forward.

As a reflection of the historical priority to boost the "*quantity*" of service facilities, every administration of the government since the 19th century has attempted to enhance this work. It all began with the construction of the first state hospital during the reign of King Rama V, and it continued through the seismic events of 1932, leading to the establishment of public hospitals in every province. The era of accelerating the construction of community hospitals in every district followed, and then the decades of developing health centers until the present day, focused on improving the "*quality*" of healthcare services. Throughout these efforts, the ultimate goal has remained the same: to ensure that Thailand has comprehensive and sufficient public health service facilities to serve all in need. Therefore, the rapid expansion of healthcare facilities, both large and small, to cover every part of the country, from provinces and districts to sub-districts, as well as the increase in the number of private hospitals and clinics, can be considered the starting point of success that paved the way for universal health coverage to become a reality. If Thailand had not had a complete and ready array of service facilities, the vision of "quality" and "equity" could not have been realized.

At the same time, as the push continued until there was a hospital in every province and the policy was transformed until there was a hospital in every district, with health centers in every sub-district and village health volunteers deployed to every village, what had to be considered and challenged alongside the expansion of healthcare facilities was the human resources aspect of public health workers practicing in these facilities. Initially, it was undoubtedly challenging and as daunting as increasing the quantity and quality of human resources in line with the expansion of healthcare facilities. However, as time passed, the truly pressing and ongoing issue shifted from quantity and quality to the wide "*distribution"* of health personnel. Most medical professionals wanted to work in areas where they could see clear career progress, work according to their qualifications, and not have to endure arduous or dangerous living conditions. However, after they began working in rural areas of Thailand, many doctors saw a different path. It is true that the challenges of every kind that entered their work lives, led many doctors and other medical professionals who had recently graduated to avoid rural Thailand altogether. Even though the government had been using compulsory funding measures since 1967, the effort to anchor doctors in rural areas did not achieve the intended objectives to the extent desired. Indeed, some Thai medical graduates sought opportunity abroad immediately upon graduation. However, when the government introduced conditions on Thai medical students which included virtually mandatory loan funding for medical education, these new cadres of physicians reluctantly went to work in the allocated areas. That said, it was work they did with the intention of completing it and eventually retreating to central areas (or abroad) as soon as their contracts ended.

Thailand found itself in a unique political atmosphere, especially during the late 1960s, when it was immersed in the shadow of the Cold War filled with conflict between the forces of democracy and the threat of Communism. Encounters with events like October 14, 1973, and being a part of the events of October 6, 1976, left many young Thais filled with discontentment toward the political system that seemed oppressive, restrictive, and far from what was ideal. This also led a group of healthcare and public health professionals to choose a path of expression of their discontent and a clear determination to help liberate the nation by using their knowledge and expertise for the benefit of the neglected segment of society.

The medical professionals recognized that society saw their primary duty as caretakers of the public health. However, due to the unique and distinctive political environment, which was more special than usual and involved facing numerous crises and societal issues, the current of thoughts and feelings during that time was so unique that it couldn't be replicated or imitated. This exceptional uniqueness led to an interpretation of medical knowledge as intertwined with the complex problems of society. Some reform-minded doctors and newly-graduated medical professionals in that era did not simply aspire to be healers but, instead, aimed to be physicians

who 'heal society' simultaneously. They ventured out to search for the meaning of life and work in the remote rural areas of Thailand. This became the norm for newly graduated medical professionals in the 1970s, along with the momentum generated by senior reformist doctors who were already working in the MOPH at that time. Going into rural areas to work became a goal-oriented approach to elevate the quality of life for the people, ensuring that healthcare services were accessible to everyone or, at the very least, should be developed to meet the standards that every citizen deserved with equity.

Along with the different paths of medical life, the rural medical practitioners had the opportunity to accumulate valuable knowledge and life experience, both conscious and unconscious. Their way of thinking evolved dramatically, leading to a diverse and creative vision of what could be for the health of the nation. These rural doctors, as time passed, separated and went to work in their respective roles. Some of those who returned to work in the MOPH brought their experiences from working in rural areas to further drive challenging public health work through the MOPH structure. In addition, facing new conditions and problems led to the creation of a "knowledge readiness" process that was always at hand. They made efforts to seek opportunities for action and experimentation with determination. Up to this point, the reader can see that the driving force in the background of the emerging public health policies and the development of various health insurance systems, whether voluntary health insurance, the Ayutthaya Project, and many others, often involved senior reformist doctors and rural medical processes, both on and off the stage. The experiences from work, experiments, and pioneering efforts became tools to expand the boundaries of medical knowledge, leading towards the realization of UHC as envisioned.

However, setting goals that seemed far beyond the reach of UHC was not an easy task, especially when it came to finances. The financial aspect often posed a national-level challenge that could impact every sector and individual in society. Therefore, it is not surprising that one of the most formidable obstacles to the development of UHC was the severely limited budget. What is even more interesting is how pioneering doctors persevered and were prepared to deal with budgetary constraints throughout their careers, starting from their days managing rural areas when they were required to be frugal and cost-effective. This continued through problem-solving and readiness to face challenges every moment while working in the MOPH. Constant research and experimentation with various budgeting methods over time led to progress in fiscal knowledge, culminating in the principle of "average suffering, average happiness" combined with "capitation payment with the inclusion of health workers' salary" which was later designed and applied to UHC.

One thing that allowed the group of pioneering doctors to tackle budgetary issues effectively was the fact that some of them took on the role of budgetary heads in the MOPH Planning Division. Some physicians became well-versed in budget matters, such as Dr. Suwit Wibulpolprasert and Dr. Viroj Tangcharoensathian. Furthermore, the pioneering doctors later realized that solving health problems required knowledge from beyond the medical field, as health issues were intricately linked to personal lives, families, society, and national concerns. Therefore, knowledge from economics, social sciences, and other fields offered valuable perspectives on addressing healthcare coverage challenges. The methods of budget calculation, which incorporated economics into public health work, demonstrated the clear and expansive thinking and beliefs of these reform-minded individuals.

Similarly, just as societal changes could not be solely driven by the power of medical personnel, healthcare system reform could not rely solely on the strength of medical professionals. As evident from the need to open up space for building good relationships with the civil society sector, it also required the art of persuasion until the political sector was willing to open up space for advocating UHC. Eventually, it necessitated a consensus from all parties to establish institutional organizations like the NHSO. Therefore, the statement following Professor Prawase Wasi's "A Triangle Moves a Mountain" strategy that pushing for difficult matters required broad knowledge, reliance on civil society and social movements, and commitment from the political sector was closer to reality than many expected.

To summarize, the essence of the path to building UHC in the Thai case, one must not forget to consider the history of medicine and public health, the political, economic, and social factors of the country. Also, one should not forget the role played by those involved, especially the senior doctors and rural doctors who transformed into pioneering or reformist doctors. All of them were linked and integral to the history of building UHC in Thailand. It should also not be forgotten that the success of UHC happened due to a combination of factors, including knowledge, collaboration from civil society organizations, political opportunities, luck, and the decisions made by the reformist doctors. All of these factors had to come together simultaneously, much like "*converging streams*," within an appropriate timeframe. This is what made UHC a reality in Thailand.

Furthermore, the birth of UHC in 2001, and its nationwide implementation in the following year, were considered the first step of a long-standing effort. Creating something new was challenging enough, but sustaining and maintaining the UCS system proved to be even more difficult. The progress of the NHSO, from 2002 onward, still had many towering obstacles for the reformist doctors, the inheritors of the spirit, the working individuals, and all relevant

sectors to overcome. As Dr. Sanguan Nitayarumphong, the father of Thailand's UHC and the first Secretary-General of NHSO, observed: "When the UCS law was successfully passed, in addition to the joy of UHC becoming a reality, I also knew well that it was just the beginning of a new chapter in the process of healthcare system reform. I knew that there were still many hills to climb to improve the healthcare system beyond what it used to be. However, I had no doubt they we could prevail in this endeavor, and I was ready to work hard for the next phase...

Universal Health Coverage was born

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Even though many might see
the "30 Baht Treats All Diseases" policy,
also known as the "Gold Card",
as something challenged and altered by those in power
over various periods, in the end,
it has conclusively been proven not just to be
a populist policy aimed solely at political gains.
Instead, it has ensured that the majority of the population,
regardless of their socio-economic status,
does not have to face financial ruin due to
illnesses like before.

When streams converge,
Universal Health Coverage
was born, c.1868-2002