

The Art of Establishing Universal Health Coverage in Thailand: From Past to Present, c.1868-2002



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Finally, as with any other publication, this document may have some errors, due to constraints of time, page space, and decisions made in selecting topics that may challenge the opinions of certain readers. The authors deeply apologize and humbly acknowledge any and all mistakes that may have occurred throughout.

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General Statement

Before becoming the Universal Coverage Scheme that provides healthcare access to over 48 million Thais across the country via the administration of the National Health Security Office (NHSO) over the last two decades, it must be acknowledged that numerous significant events in history have played a pivotal role in contributing to the historical trajectory of the Thai universal health coverage. In order to fully realize its comprehensive trajectory, this volume aims to unravel the intricate narrative and data that constitute the origin of this fundamental health security system. It retraces the historical “ingredients” through the context of politics, economy, and social culture leading up to the year 2002, starting from the reign of King Rama V (King Chulalongkorn) in 1868 amidst the backdrop of the prevailing Western influence that gradually reached the territory of present-day Thailand.

Based on a research study, this book employs qualitative research methods, commencing with data collection from primary media sources as secondary evidence. It involves preliminary document research and in-depth interviews with experts or individuals involved in the reform of the Thai healthcare system. The study framework is guided by the “Triangle that Moves the Mountain” strategy, which encompasses the power of knowledge creation, social movement, and political involvement, and is integrated with the framework of “Historical Institutionalism.” This approach combines political science and history perspectives as analytical tools to examine “critical junctures” in political, economic, social, and cultural transformations. These junctures have long-lasting implications for the national health system and its foundation towards the creation of Thailand’s universal health coverage.

This book adopts the Chicago of Manual Style throughout in order to display the details of the various documents, especially the primary and secondary sources of evidence that form the heart of history books, as fully as possible.

Overall, the contextual and pivotal political, economic, and socio-cultural events throughout history, each unique to its era, play a significant role in shaping Thailand’s healthcare endeavors. They have induced crucial shifts in ideologies, experiences, methodologies, and network formations, both within and beyond the medical and public health spheres. These transitions involve contributions from various sectors, including government, professionals, academia, and civil society, in the process of health system development. Additionally, the pivotal events in each historical phase of healthcare often hold substantial influence on propelling the Universal Coverage Scheme, a vital component of Thailand’s comprehensive universal health coverage system, which has played a key role in the nation’s healthcare success. These events also impact the determination of the National Health Security Office as the steward of the system, responsible for its continuous operation up to the present day.

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Turning Point of UHC History

1

1887



2

1932

Influence of Western medicine

- Colonial ideas and the formation of an absolutist state
- Wang Na Hospital / Osot Sala / private hospitals
- Department of Nursing / Department of Public Welfare / Department of Public Health / Ministry of Public Health
- Rajapattayalai (Royal Medical College)

Siam Revolution

- The Municipal Organization Act has clearer duties regarding public health, particularly the mission to take care of the population's health in the provincial areas.
- "Flagship" hospital policy to stimulate the construction of hospitals in cities, especially along borders with neighboring countries.

8

1990s

Black May (1992)

Growth of the private sector and civil society

- Social Security System (1990)
- Ayutthaya Project + Health Care Reform Project (HCR)
- Health Economics
- Holistic Health Development
- Samphran Forum, Medical Council platform
- Human rights and health
- Birth of an independent organization - Health Systems Research Institute (HSRI)

9

1997

Economic Crisis

- 1997 People's Constitution (B.E. 2540)
- (draft) National Health Act
- Case against drug corruption
- Ban Phaeo Hospital (Public Organization)

10

2000

Victory of the Thai Rak Thai Party

- "Universal Health Coverage Policy"
- 30 Baht Treats All Diseases
- Gold Card



3

1950s

Era of American Power

- Budget and opening up of rural areas
- Shortage of medical workforce
- Birth of the Medical Council
- Moving towards preventive medicine (Experimental project/Criticism of the medical curriculum by reformist doctors and students)

4

1973

October 14 Event

- 1973 Constitution (B.E. 2517)
- Reforming the structure of the Ministry of Public Health
- Discover the chain cycle "Ignorance-Poverty-Suffering"
- Low-income Card Scheme (LICS)

5

1976

October 6 Event

- Stream of thought "go to community"
- The beginning of a meeting between a network of doctors, pharmacists, and medical personnel in rural areas. with NGOs

7

1982

The 5th National Economic and Social Development Plan

- Principles of Basic Necessities and the 'Korat Phatthana' Project
- Expanding hospitals in every district
- Voluntary Health Insurance Scheme (1983)

หมอชาวบ้าน

6

1977
Decade

Alma-Ata Semi-Democracy

- Health For All
- Primary Health Care
- People-centered
- Role of volunteers
- Village Doctor Magazine
- Civil Servant Medical Benefit Scheme (1978)

11

2001

Universal Coverage Scheme in practice

- Roll out of UCS in every region.
- Act establishing the Thai Health Promotion Foundation

12

2002



- Expand "rights" to the Universal Coverage Scheme (UCS) throughout the country
- The birth of Universal Health Coverage (UHC) in Thailand
- The birth of the National Health Security Office (NHSO)





The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868–2002

– Preface –

Moving the mountain:
The success of Thailand's Universal
Health Coverage

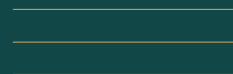




Figure 2 Image of Dr. Sanguan Nitayarumphong, reserved during the meeting on “The Quality of Life Project Works” between Thailand and Sudan from 8th to 15th July 1987.

Source: National Health Commission's Archives, (13) B.NEG S.2.1/44.26, 154/30, “Low-Income Individuals Project, dated 15th July 2530.

“

“After the successful enactment of the National Health Security Act, apart from the joy of knowing that universal health coverage is becoming a reality, I also understand that this is just the beginning of a new phase in the process of healthcare system reform. I am well aware that there are many more challenges to overcome in order to develop a better healthcare service system than before. However, I am not afraid; I am ready to work hard in the next steps...”¹

Dr. Sanguan Nitayarumphong

”

The year 2022 marked the 20th anniversary of the establishment of the “Universal Coverage Scheme” (UCS) or commonly known as the “Gold Card” or “30 Baht for All Diseases.” It was initiated as a pilot project in 2001 and fully implemented nationwide in 2002. This UCS is considered a crucial component that has made “Universal Health Coverage” (UHC) a comprehensive reality in Thailand.

Meanwhile, the year 2022 also marked the 20th anniversary of the National Health Security Office (NHSO), the leading organization responsible for overseeing and managing the UCS since 2002. Due to these milestones, the UCS and NHSO are considered the “achievements” of a major healthcare reform that has transformed and elevated the quality of life of the Thai people in various aspects

Establishing the UCS still emphasizes that healthcare is an urgent and essential service, and it is the responsibility of the government to provide accessible and equitable healthcare services for all Thai citizens. It is considered a “fundamental right” of the Thai people to receive fair and just healthcare.² Thailand has become one of the first developing countries to successfully create a comprehensive and sustainable universal health coverage system, offering equal opportunities for all Thai people, regardless of their financial status, to access necessary healthcare services without worrying about the cost.³ With the significant achievements of the UHC and the role of the NHSO over the past two decades, more than 48 million people, or approximately 75% of the total population, now have access to essential healthcare when needed.⁴ Therefore, when talking about the “Gold Card” or the UCS rights, it often goes hand in hand with mentioning the “role of the NHSO” as a cornerstone of effective administration and coordination.⁵

The introductory text above reveals the significant essence of this volume, which aims to invite readers to organize their thoughts about the UHC in Thailand. It does so by presenting the narrative through a “historical lens,” which looks back at the “origins” of the country’s public health work to examine the structures, institutions, political processes, economy, and socio-cultural changes that have influenced medical and public health activities. It also highlights the power struggles among different actors and the workings of various sectors that often faced situations that require them to “make decisions” and “take certain actions”. These decisions became determining factors shaping the destiny of the subsequent health system. In essence, the present state of Thailand’s public health and health system depends greatly on the “decisions made in the past.”⁶

Here, we will know how to identify the turning points of the narrative. Historians must examine and search for “critical junctures,” which are pivotal points that lead to different paths and outcomes.⁷ In simpler terms, the events or results in the present day are all consequences of decisions made when facing critical junctures. These decisions have become transformative points that shape the history of the health system and cannot be avoided.

This book explores the “critical junctures” of the history of Thailand’s Universal Health Coverage. Starting from 1868, then the decade starting in 1887, was a significant turning point when Siam accepted Western medicine as a determinant factor in the direction of medical and public health practices. Subsequent key junctures include the 1932 Revolution, then on to the Cold War atmosphere, the political uprising during the events of October 14, 1973, and October 6, 1976, the influence of international and global health governance like the World Health Organization (WHO), the rise of medical intellectuals, the social awakening after the May 1992 event, and the economic crisis in 1997. All of these events had profound influences on the development and history of medicine, public health, and systemic reforms, including material structures, policy direction, and the flow of progressive ideas among innovative doctors, new-generation medical students, volunteers, and various interest groups. These events became pivotal moments in the country’s health system, leading to significant transformations, including the formation of the vision for what would become the UHC and the successful management of UCS by organizations like the NHSO.

The period from 2001 to 2002 marked a significant milestone for rural doctors and various stakeholders who played a crucial role in advocating for the establishment of the UCS and the formal creation of the NHSO organization. The National Health Security Act of 2002 (B.E. 2545) undoubtedly played a pivotal role during this time. It cannot be denied that this period was characterized by a “convergence of readiness” in terms of knowledge, social forces, and political power, aligning appropriately within a suitable timeframe, as described by the Triangle that Moves the Mountain strategy of Emeritus Professor Dr. Prawase

Wasi (hereafter Dr. Prawase Wasi). Environmental factors, solid infrastructure, and historical background also played crucial roles in contributing to the success during this transformative phase.

The progress made during the first half of the decade from 1997, which can be further explored in this volume, can be considered a paradigm shift in Thailand's health sector and also in the eyes of other countries. One crucial aspect that deserves mention is the shift in the perspective of healthcare services from "charity-based" to "rights-based," aiming to provide every individual in Thai society with access to essential and comprehensive healthcare services on a universal and equitable basis. This fundamental development in Thailand's public health can be traced back from the year 1868 to the vision of UHC, which eventually evolved into the birth of the UCS in 2002. This UHC model has become a significant exemplar for developing countries worldwide.

However, the creation of the national health insurance system, which is a vital complement to the universal health coverage system and the functioning of the NHSO, was not without challenges. It involved navigating through turbulent times, facing various forms of challenges, and handling the tensions arising from differing opinions. Therefore, analyzing and enriching data based on political, economic, and sociocultural factors will lead to a better understanding of the pivotal turning points in the historical trajectory of the universal health coverage system. This includes the "art" of reformists and various actors who have navigated and adapted to the changing political, economic, and sociocultural landscapes, in order to sustain the vision of building a comprehensive health coverage system. All of these aspects are at the core of this historical book, allowing readers to delve deeper into this journey.

Preface

¹ Chatree Charoencheewakul and Opiwan Nitayarumphong, *Starlight of Faith: Sanguan Nitayarumphong* (Bangkok: Sahamit Printing and Publishing, 2011), 79.

² Working group for the Development of Universal Health Coverage Policy of Health Systems Research Institute, "Proposal for a universal health coverage system: report on a study on health system reform and the draft National Health Act B.E. ...," (Nonthaburi: Health Systems Research Institute, 2001).

³ Isranews, "Anisong Universal Health Coverage' Protects 290,000 Thai Households from Poverty," Isranews, 2016, https://www.isranews.org/isranews/45448-artical_4544833.html.

⁴ National Health Security Office (NHSO), "Executive Summary NHSO Annual Report 2020" (Bangkok: National Health Security Office, 2021), https://www.nhso.go.th/storage/downloads/operatingresult/47/F_NHSO_Annual_Report_2020.pdf.

⁵ Atthaporn Limpanyakert, *Between the Lines: A Historical Record of 'The Golden Card Epic'* (Nonthaburi: Phabphim, 2020), 46; Wichai Chokwiwat, *Legend of The Golden Card: History of the creation of Thailand's universal health coverage system* (Bangkok: Heart To Heart Foundation, 2015), 43.

⁶ Glenn Morgan, ed., *The Oxford Handbook of Comparative Institutional Analysis*, Oxford Handbooks (Oxford; New York: Oxford University Press, 2010).

⁷ Ruth Berins Collier and David Collier, *Shaping the Political Arena: Critical Junctures, the Labor Movement, and Regime Dynamics in Latin America* (Notre Dame, Ind: University of Notre Dame Press, 2002).



The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868-2002

Modern Medicine in the decade
following 1887:
Ideas, history, and dynamics of Thai
medicine and public health

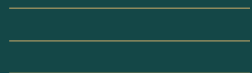




Figure 3 Pictures of patients at Siriraj Hospital

Source: National Archives, Po. 002 Hwy 5/19, patients with mumps, year 1917 at Siriraj Hospital.

Medical knowledge from the Western world emerged during the time when Siam faced significant issues, such as population shortages and deaths due to epidemics. This situation provided an opportunity for Siam's leaders to discover that Western medical knowledge could effectively address illnesses, treat epidemics, and reduce mortality rates. As exemplified by King Chulalongkorn (Rama V), who later founded the Faculty of Medicine in 1933, earning him the title of the 'Father of Pharmaceutical Sciences' in Thailand. In reflecting on the state of public health during the 1880s-1890s, the King observed that *"the key to improving and strengthening the people lies in public health."*¹ For these reasons, the Siamese government began to pay attention to the establishment of hospitals thereafter.

Modern medicine: Tool for "increasing" population and "reducing" epidemics

Amidst significant societal changes in Thailand since 1887 during the reign of King Rama V, there have been notable transformations. Notably, the centralization of power in the hands of the state through the Siamese bureaucratic reforms allowed rulers in Bangkok direct access to the populace and resources in the distant provinces, thus establishing a more centralized governance. Furthermore, there were the emerging economic ties between the Siamese (Thai) economy and the global economy, fostering links and connections on an international scale. These developments have shaped the course of Thai society and have played a crucial role in its evolution over time.² This period also saw the dissolution of the commoner status to become regular citizens (manpower), which became an urgent need to provide the state with enough labor to produce goods that the market needs.³ These transformed serfs became workers, the military, and tax payers to the state under the new regime.⁴ **Since the 1880s, as the population became the pillar of state and existence of the state, modern medical knowledge grew in importance as a "tool" to help "increase the number of the population" and "decrease death rate", since human labor was the main resource needed by the state at that time.**

Modern medical knowledge was also proving to be indispensable in keeping the workforce well and functioning at full capacity given the shortage of the population.⁵ For example, during the period 1850 – 1901, Siam's population increased by only 1 million people, and that increase took more than half a century to be realized as there was a very low rate of population growth.⁶ At the same time, the state needed to control the districts so that the population in both the vicinity and the region became under the authority of Bangkok. That was still an unsuccessful process in a short period of time. It was these conditions that accelerated the formation of modern medicine and Western public health since those were seen as one of the strategies to reduce deaths, increase the number of people, and make the working-age population a vital force in building the nation.⁷ At that time, the quest to stop epidemics of illness was the key to achieving all of these objectives.

Epidemics have been a periodic threat to traditional society for a long time. That said, the value from interacting with traders from abroad, intercontinental migration, and the rapid expansion of trade since at least the second decade of the 1800s outweighed the threat of plague and pestilence in Siamese society. Thus, public health and modern medicine became an increasingly important tool to protect the labor force in the face of new and unfamiliar epidemics as Siam opened up more to the outside world.

Epidemics of diseases such as cholera, (which is commonly known as “Rok Puang Yai” or “Rok Long Rak” in Thai), are caused by the bacterium, resulting in severe symptoms of diarrhea and vomiting, leading to dehydration and, in some cases, death. Cholera has been a long-standing and recurrent disease, often endemic in regions such as present-day India and Southeast Asia but not known to spread beyond these areas. However, rapid and convenient travel and trade have led to the spread of the disease to other regions. The first cholera epidemic in Siam (Thailand) occurred simultaneously with outbreaks in other parts of the world.⁸ As recorded, “*Cholera outbreaks in severe form appeared along the coasts from Calcutta to Madras and Ceylon; after 1819 - 1820, the disease spread in Burma and Siam, where it wreaked havoc...*”⁹ This outbreak resulted in more than 30,000 deaths in Bangkok and nearby areas. Subsequently, there were three more severe outbreaks: in 1849, the epidemic persisted for over 7 months, leading to a death toll of no less than 40,000 people. Then, in 1873, approximately 6,660 people died, and the disease erupted again in 1881.¹⁰ That latter outbreak had such severe consequences that the government had to establish 48 temporary hospitals across Bangkok to treat the patients. Due to this situation, the cholera epidemic is often considered the catalyst that prompted the rulers of Siam to pay serious attention to public health, and eventually led to the establishment of the first permanent state hospital in 1888.¹¹

In addition to cholera, there were also two other significant diseases that Siam constantly faced severe outbreaks of, which were smallpox and the plague (also known as the Black Death). These three diseases were considered the major epidemics that Siam had to constantly confront and battle against their rapid and widespread transmission.¹² As for smallpox, or known locally in central region as Feedat, Dr. Dan Beach Bradley alluded to the epidemic as follows: “*It spreads in the Siamese population for three to four months every year without exception... It’s almost impossible for any family to live here for several years without being visited by smallpox... The urban population has significantly decreased due to the devastation caused by this disease.*”¹³ Smallpox is another disease that causes shivering, fever, and the appearance of small pustules on the body. Victims lost the use of their arms, legs, and eyesight, and experienced a festering of pustules in their chest and abdomen. Some survived, while most died. This led to the initiation of smallpox vaccination or inoculation to prevent the disease and reduce the mortality rate.¹⁴ As for the plague, or “Rok Ha”, it has been occurring in present-day Thailand since the early Ayutthaya Era (around 1893), coinciding with the time when the disease was also epidemic in Europe. There was a

major outbreak of the plague in Siam during the reign of King Rama V (around 1894). That outbreak was traced to China and Hong Kong. The situation became serious enough that quarantine stations were set up on islands near the mouth of the Chao Phraya River to prevent the spread of the disease from inbound vessels.¹⁵ During subsequent decades, the spread of the aforementioned diseases continued to occur intermittently in the region of Siam.¹⁶ **Therefore, cholera, smallpox, and the plague are three major pathogens that have led to a significant number of deaths and have prevented the population from growing since the early Rattanakosin Era.**

In the overall picture before the development of public health during 1887-1896, apart from addressing and mitigating the dangers posed by severe epidemic diseases, “healthcare” or “fever treatment” for the general population was not considered a direct responsibility of the state. Therefore, disease control became solely one of the public health tasks of the state, which was carried out in response to emergencies and urgent situations, lacking an organized system.¹⁷ Starting from 1887-1896 and onwards, the emergence of ideas related to healthcare services began to take shape. Part of this development was due to the fact that Siam had just experienced significant losses during a major cholera epidemic in 1881. However, a crucial turning point in the medical and public health systems of the Siamese state would not have been possible without the incorporation of “medical knowledge from the West.”

Western medical knowledge and the missionary role in Siam

Missionaries from Western countries played a significant role in introducing modern medical knowledge and healthcare services to Siam. Although their primary objective was to spread religion and education, another important mission was to provide healthcare to the sick. Medical care became a prominent part of their charitable activities both locally and globally, including in Siam. Jacob Tomlin, one of the first Protestant missionaries to arrive in Bangkok in August 1828 during the reign of King Rama III, recorded, *“The blessing of the Lord is with our humble efforts in the medical department. This room is crowded every day with a group of patients who are helpless and pitiable... By the power and goodness of the physicians, they have shown favor to these non-believers... A great number of people have recovered from serious illnesses in just a few days.”*¹⁸ With the aim of motivating people to embrace Christianity, they distributed medical books and provided medical treatment to the sick. This led some individuals to start recognizing and accepting Western medical practices. Initially, treatment was often offered to commoners or serfs first, and when it proved successful, it gained acceptance among higher-ranking individuals.¹⁹ Since the first group of missionaries arrived in Siam until the end of the reign of King Mongkut (King Rama IV), a total of more than 40 years had passed. During this period, 86 missionaries came to Siam, and among them, there were six medical practitioners.²⁰ Two significant medical

missionaries who played a role in disseminating modern medical knowledge in Siamese society must be mentioned. Of course, the first person to talk about is Dr. Dan Beach Bradley, who was part of the third missionary group to arrive in Siam in 1835. Shortly after his arrival, he established a hospital to provide medical treatment and distribute free medicines to the public.²¹ Three years later, an outbreak of smallpox occurred in Bangkok, and Dr. Bradley initiated the practice of smallpox vaccination to prevent the disease, which later developed into vaccination efforts. Additionally, he was also the first to introduce surgical procedures using Western medical methods in Siam.²² Dr. Bradley published a book called “Bangkok Recorder” between 1844-1845, which served as a platform to introduce knowledge of Western medicine in Siam. The book covered various topics, including wound irrigation, wound healing, smallpox vaccination, treatment of fever and malaria, the discovery of quinine, and the functions of the heart, lungs, and blood vessels. It also contained advanced knowledge in anatomy and physiology, which was considered groundbreaking for Thai society at that time.²³ Dr. Bradley’s medical abilities made Western medical knowledge increasingly recognized and popular, especially among the high-class society in Bangkok. Many prominent individuals invited Dr. Bradley to provide medical treatment at their homes or in the palaces. For example, he treated members of the royal family, including the consorts of King Rama IV (while he was still a monk) and King Rama V.²⁴ Both of these monarchs were considered leading examples in Siamese society, as they were open to and interested in various aspects of Western knowledge, including medicine.

Dr. Samuel Reynolds House was another important missionary who came to Bangkok after spending approximately 12 years practicing medicine, a time when Western medical knowledge was beginning to take root among the city’s prominent community. The arrival of this new “foreign doctor” sparked curiosity and attracted a significant number of people seeking treatment. Dr. House opened a clinic in a small house in front of the former residence of Dr. Dan Beach Bradley.²⁵ At that time, patients often suffered from illnesses or injury (e.g., due to quarrels) or chronic wounds. Dr. House, therefore, decided to use ether as an anesthetic for the first time in surgery on an 84-year-old female patient (around 1848). The surgical procedure was successful and satisfactory.²⁶ For this reason, Dr. House became one of the famous western doctors of that era. Dr. House also frequently organized lectures and experiments on physiology, astronomy, natural sciences. These activities received the attention of the populace and the nobility in the royal court, eventually leading to an invitation to perform experiments in the palace. With these activities, Dr. House was a western doctor who had good relations with noblemen, royalty and royal courts since the end of the reign of King Rama III to King Rama V due to a shared interest in modern knowledge from the western world, e.g., science, astronomy, and medicine.²⁷ For example, King Chulalongkorn would often summon Dr. House to engage in discussions about science, and Dr. House also served as a translator for His Majesty in negotiating the Bowring Treaty.²⁸



Figure 4 Provincial Hospital in Petchburi Province

Source: National Archives, Document No.P002 3-1, Hospital, Petchburi Province.

The fact that these missionary doctors played a significant role in saving the lives of many people from the outbreak of epidemic diseases and other potentially lethal conditions led to the expansion of their involvement in medical work, both within the capital city and into the regions between 1861-1911. The missionaries expanded their medical work to various provinces outside of Bangkok, with Petchburi being the first area where they established a hospital. This decision was made because, previously, King Chulalongkorn had granted permission for the missionaries to reside in the area, propagate religion, establish schools, and provide modern medical treatment to the local residents.²⁹ As a result, the area progressed towards the establishment of an official hospital in the year 1880 by Dr. E.A. Sturge before falling ill and deciding to return to the United States.³⁰ Therefore, it can be said that the hospital in Petchburi was established before the first government hospital in 1888 which opened eight years after the Petchburi Hospital.³¹ Afterward, the medical efforts of the missionaries expanded to other areas, such as in Chiang Mai around the year 1886. The Board of Foreign Missions, United States, approved a budget of 10,000 U.S. dollars to construct a hospital in Chiang Mai.³² However, the amount of money was still insufficient to construct an entirely new hospital. Therefore, the missionaries in Chiang Mai decided to

renovate the existing dispensary into a hospital and named it “American Mission Hospital.” It was located on the west bank of the Ping River and opened its doors in 1888 (after the Siriraj Hospital had been established) to provide medical treatment and perform surgeries. The following year, Dr. James W. McKean was appointed as the hospital director, and he further expanded the facility to include a laboratory for producing smallpox vaccines with funding support from Mrs. Cyrus H. McCormick.³³ By 1920, the Chiang Mai hospital was relocated from its previous location along the banks of the Ping River to a new site, eventually becoming the present-day McCormick Hospital. During this time, the hospital received financial support from Chao Kaew Nawarat and Prince Chaiya Charayadham. Besides the hospitals in Phetchaburi and Chiang Mai, the missionaries continued to expand their medical work to other areas, such as Lampang, Lamphun, Ratchaburi, Phrae, Nan, Chiang Rai, Pitsanulok, Nakhon Si Thammarat, and Trang. Due to these efforts, the missionaries’ healthcare initiatives proved to be even more successful than their religious propagation activities.³⁴ The aforementioned expansion can be considered a transformation of Thai healthcare practices. Previously, doctors had to travel to treat patients at their homes; but now the pattern changed to patients traveling by train to meet the doctors themselves at smaller healthcare facilities.

Wang Na Hospital: The “first step” of public health facilities in the era of the absolutist monarchy

The history and public health efforts of Siam between 1888 and 1906 focused on establishing hospitals primarily within the Bangkok area. It also involved development that required financial support and contributions, particularly from the ruling elite and influential members of Siamese society.³⁵ The group of wealthy merchants and foreign nationals with significant wealth or valuable items played a crucial role in providing the initial budgets for the establishment of public health facilities in the early era, such as hospitals, hospices, and dispensaries. Often, these budgets were obtained through monetary contributions or donations of valuable items from charitable individuals. Therefore, hospital premises were considered a place of merit-making in addition to their healthcare functions.³⁶ As stated in the document announcing the opening of Wangna Hospital, which was the first government hospital in Siam, it is mentioned that... *“This hospital is part of the royal charity, where the royal family generously donated royal funds to establish it, to provide medical treatment and prevent various illnesses for the general public. Doctors and nurses are not allowed to charge patients for medicine or treatment, except for those who have privileges in this royal charity.”*³⁷

With the influence of Western medicine and the challenges of epidemics and population deficiencies, combined with the experiences of His Majesty King Chulalongkorn (Rama V), who observed and learned from hospitals treating the sick and caring for the disabled in Singapore during his first overseas royal visit in 1886, the healthcare system underwent significant changes.³⁸ In the same year, it led to the establishment of Siam's first hospital in 1886, under the command of His Majesty King Chulalongkorn. The royal command "Regarding the Management of the Hospital" was issued to form a committee responsible for the establishment of "Wangna Hospital" or "Wanglang Hospital," also known as "Siriraj Hospital." Its main role was to oversee the treatment of fever patients and provide healthcare accessible to all citizens without discrimination.³⁹ Initially, a resolution was passed to establish one hospital first, and if it proved beneficial, the operations could expand later. His Majesty King Chulalongkorn graciously allowed the dismantling of structures, timber, and various belongings from the personal estate of Prince Siriraj Kakudhabhand, to be used in constructing Wangna Hospital. Additionally, Her Majesty bestowed a sum of 200 Chang (approximately 16,000 baht) as financial support for the project.⁴⁰ Construction began with the creation of a patient care facility, consisting of three large buildings and three small buildings, designed for patient care, doctor's residence, and medication storage.⁴¹ Two months after the construction, additional contributions were received from the inheritance of Prince Siriraj Kakudhabhand, who had passed away due to Dysentery 's disease, totaling 700 Chang (56,000 baht). This money was used to build a building for medical education.⁴² Subsequently, an additional donation of 30 Chang (2,400 Baht) was received from the contribution of Her Royal Highness Princess Saovabhark Nariratana, combined with additional contributions from His Majesty King Chulalongkorn. Following that, another 10 Chang (800 baht) was received from the English community in Siam, allowing for the construction of two more small buildings. The first of these buildings was named the "Saovabhark Building," serving as a special patient residence. Another building, funded by donations from the English community, was named the "Victoria Ward/Building," in line with the donors' intention to create a commemorative space for the Golden Jubilee of Her Majesty Queen Victoria's reign.⁴³ As a result, Wangna Hospital, also known as Siriraj Hospital, was completed and opened on April 26, 1888, marking a significant symbol of the modernization of medical and public health practices in Thai society, and this legacy continues to the present day.



Figure 5 Patient wards and the first-era classrooms, year 1893 (84 years of Siriraj).

National Archives of Thailand, PA.002 KJCH (A) 4-1, Siriraj Hospital, Patient Wards and Classrooms.



Figure 6 Image of patient wards at Siriraj Hospital

Source: National Archives of Thailand, PA.002 HWY 5/3, Patient Ward for Various Diseases in the year 1916 at Siriraj Hospital.

Figure 7 Atmosphere inside Siriraj Hospital within the area for caring for patients with various improving conditions.

Source: National Archives of Thailand, PA.002 HWY 5/20, Various diseases with ameliorated symptoms in 1917 at Siriraj Hospital.





Figure 8 Saovabhark Building used to serve as a special patient ward and dormitory for nursing students.

Source: National Archives of Thailand, PA.002 KJCH (A) 4/5
Image 1, Siriraj Hospital, Saovabhark Building

Figure 9 Victoria Ward used to serve as a special patient ward and dormitory for medical students

Source: National Archives of Thailand, PA.002 KJCH (A) 4/4 Image 1, Siriraj Hospital, Victoria Ward - Special Patient Ward and Medical Student Dormitory.



After the establishment of Siriraj Hospital, several more hospitals were established in the central area of the state, both in Bangkok and Thonburi. For instance, the “Rim Pom Mahachai Hospital” (*Rong Phayaban Rim Pom Mahachai*) was founded in 1888 and later renamed Burapha Hospital (*Burapha Phayaban*) due to its proximity to the Buri Ram Palace. Subsequently, it closed during the reign of His Majesty King Chulalongkorn.⁴⁴ state hospital near Wat Thepsirin or Thepsirin Hospital (*Thepsirin Phayaban*), elevated to a third medical institution in the year 1889, and was used as a place for dispensing both Thai and Western medicines. There were doctors and nurses taking care of patients.⁴⁵ In the same year, there was also the “Bang Rak Hospital” or Doctor House Hospital, which King Rama V granted permission to Thomas Heyward Hays.⁴⁶ The Bang Rak Hospital located at the intersection of Silom Road and Charoenkrung Road was used to establish a hospital, and Dr. Hays was appointed as the manager to provide medical services to foreigners residing in the Silom, Charoenkrung, Bang Rak, and Siphaya areas. Later, in the year 1891, it was transferred to the Department of Nursing, and eventually transformed into the present-day Lersin Hospital.⁴⁷ This was followed by the “Samsen Hospital,” established in the same year by transferring equipment from the Thepsirin Hospital. Later, it was merged with Vajira Hospital in the year 1912.⁴⁸ While the first psychiatric state hospital, was established in the year 1889, called the “Hospital for the Mentally Ill” (*Rong Phayaban Kon Siacharit*), located near Pom Patchamit, it was later renamed the “Somdet Chaophraya Hospital.” There was also the establishment of the prostitute hospital (*Rong Phayaban Yinghagoen*) in the year 1897, which was later renamed the “Klang Hospital” in the year 1915. This was intended to treat women in distress according to the royal command of Her Majesty Queen Saovabha Phongsri, to prevent diseases and maintain cleanliness within the city.⁴⁹ In the same year (1897), there was a proposal to establish a nursing home or Bangkok Nursing Home (BNH) for the treatment of foreigners without seeking profit. This initiative was funded through community fundraising by the English community. During the same period, His Majesty King Chulalongkorn also contributed 960 baht initially and provided ongoing support of 80 baht per month.

Figure 10 Image of the interior of Somdej Chaophraya Hospital.

Source: National Archives of Thailand, Reference number 52 M00002, Somdej Chaophraya Hospital.



Figure 11 Image of the dining area inside Somdej Chaophraya Hospital.

Source: National Archives of Thailand, Reference number 52 M00003, Somdej Chaophraya Hospital.

Initially, the hospital provided both traditional and Western medical services, as documented: *"Hospitals [such as Siriraj Hospital and Rim Pom Mahachai Hospital] will treat all kinds of diseases, whether it is by using Thai medicine if preferred or Western medicine if desired."*⁵⁰ Patients from any nationality and language could seek treatment at these hospitals. Upon admission, three meals were provided daily, and accommodation was offered without charge. Male and female patients were separated. The services provided during that time ranged from childbirth, immunizations, caring for chronic illnesses, to general disease diagnosis and treatment, which included dispensing medications and returning home.⁵¹ This group also included the examination of villagers with mental or psychological symptoms. As the number of patients seeking treatment for mental health increased, it led to the establishment of specialized hospitals specifically for those with mental disorders. Surgical services were only available at Siriraj Hospital and Doctor House Hospital, however.



Figure 12 Image of Bangkok Nursing Home (BNH) Hospital opening in 1898

Source: National Archives of Thailand, Reference number 52 M00032, Bangkok Nursing Home Hospital.

Another significant public health service that should be mentioned in this era is the “Thai Red Cross Society,” (*Sapha Unalomdaeng Haeng Chat Sayam*) which was first established in the year 1893. It was founded to provide assistance in public health to soldiers on duty during the crisis of Franco-Siamese War (R.S.112). The initial establishment was triggered by the conflict over the territory along the Mekong River between Siam and France. King Chulalongkorn graciously donated 80,000 baht from the royal treasury to support the activities of this philanthropic society. Those involved in this charitable organization were predominantly high-ranking women who were wives of senior officials or dignitaries.⁵² The establishment of the Thai Red Cross Society in Siam reflected the philanthropic mindset towards public health within the upper echelons of society. It aimed to contribute to the well-being of human lives in a societal context where manpower has become something that the Siamese elites have begun to focus on.⁵³ This aligns with the expansion of knowledge in Western-style medicine and public health, as previously mentioned.

However, the activities of the Thai Red Cross Society diminished after the border conflicts ended. As the country transitioned to the reign of His Majesty King Vajiravudh (Rama VI), there was a desire to reestablish Siamese culture, which had been previously initiated. However, His Majesty believed that cultural revival should not be limited to wartime but should also encompass the general public’s well-being. For this reason, it was deemed necessary for the Red Cross Society to have its own hospital. This led to the establishment of a hospital in the year 1914, named “King Chulalongkorn Memorial Hospital.”⁵⁴ It can be considered that the work of the Red Cross Society played a role in reinforcing the medical and public health aspects of the government, which was still insufficient to meet the demands of that era.⁵⁵ Afterward, the enactment of the first Red Cross Society of Siam Act in 1918 established objectives to support healthcare for patients and the wounded during times of war and peace. Two years later, in 1920, the International Committee of the Red Cross recognized the Siam Red Cross Society. Then, in 1921, a resolution was passed to admit the Siam Red Cross Society as a member of the International Red Cross.

Overall, the expansion of healthcare services through hospitals faced two main challenges. Firstly, the general public was not accustomed to seeking treatment in hospitals as it was a novel concept and hospitals were often associated with severe illnesses, leading to a perception that hospitals were places where people died from sickness. Secondly, there was a shortage of funds, resulting in a lack of medical equipment and personnel.⁵⁶ Statistics on the number of patients reveal that there were relatively few individuals utilizing services at Siriraj Hospital. In the year 1890, there were only 1,017 patients throughout the entire year. Even in the subsequent years, such as 1902, 1903, and 1905, the number of patients remained relatively consistent, with 916, 1,095, and 1,557 patients, respectively.⁵⁷ In this regard, budgetary factors played a role in the delayed development, and it also affected the challenging establishment of state hospitals in the provinces, utilizing modern medical science. The government continued to view public health as a charitable endeavor, especially in regional areas seen as the responsibility of private individuals or local communities, such as monastic communities, civil servants, and merchants.



Figure 13 the Thai Red Cross Society Building

Source: National Archives of Thailand, Reference number P002 KJCH (A) 5-15, the Thai Red Cross Society

Public health and service facilities in the region

A. Regional hospitals

During the period from the late 1880s to before the year 1932, the Siamese government did not have a comprehensive policy for establishing hospitals in the capital area. The government mainly relied on the capital city to raise funds for constructing hospitals through donations from government officials and local citizens, aimed at acquiring land and building hospitals themselves. In some areas, there were funds generated from taxing businesses without utilizing land budget. Another approach was that the central government supported the establishment of hospitals in the capital by providing partial financial assistance to Christian missions. This approach was easier than having the government invest in entirely new constructions.⁵⁸ This clearly confirms that the capital city hospitals continued to be a matter of “public charity and philanthropy.”⁵⁹

Moreover, even Siam itself did not have any intention to expand hospitals in the provinces, as indicated in the response to a letter requesting funds to establish a hospital in the province of Chumphon in the year 1906. The response stated, *“In this matter, there is no money to give, and there is no way to attempt to raise funds in any manner. The hospital is a public charity. If the local administration deems it necessary, it should be considered a charity, including its maintenance. Do not involve government funds; that would be preferable.”*⁶⁰ Budget constraints remained a significant issue, leading to the establishment of a relatively small number of hospitals.⁶¹

Overall, the central government directed local administrations in various regions to take responsibility for providing healthcare services to their respective communities. Assistance and disease prevention were emphasized, focusing on establishing resident doctors and supporting the establishment of ‘Osot Sala’ dispensary to distribute state-provided medicines. This policy continued throughout the reign of King Rama V.

As the era of King Rama VI, or King Vajiravudh, began until the change in government after 14 years (1921-1932), there was only one government-initiated and locally supported central hospital, which was Ranong Hospital established since 1925.⁶² It was established for political reasons, as there was a preference among patients in the Ranong Province to seek medical treatment at the British hospital in Victoria Point (Ko Song). This led to the construction of Ranong Hospital to provide assistance to the local population without the need to travel abroad for treatment, while also aiming to uphold the prestige of the nation.⁶³ Ranong Hospital is considered the first hospital to have a resident physician position funded within the national budget for a provincial capital hospital.⁶⁴ Another hospital that the central government attempted to establish is the hospital in Pattani, which was related to the ongoing unrest in

Pattani. The Pattani Provincial authority believed that it should demonstrate to the “local people” in Pattani that the government genuinely cared for them. Therefore, they saw the necessity to build a hospital to the extent that a building could be constructed. Construction had begun, but due to budget constraints, the hospital could not be opened for service.⁶⁵ While another hospital where the state did not directly provide funding for construction but received some budget from the government was the Vajira Hospital in Phuket Province.⁶⁶

Regarding local hospitals in various towns, their management was still under the control of the state through provincial governors and municipal authorities. They had to submit monthly and yearly reports on income and expenditure, medication sales records, patient statistics, etc. This group of hospitals often faced personnel challenges that they had to address themselves. Some hospitals had to request resident municipal doctors, whose main responsibility was caring for government officials, to also take care of healthcare at the local hospital to save on the cost of hiring additional doctors. In some cases, foreign doctors were hired on a regular basis, leading to a situation where local hospitals were in a state of instability due to budget constraints, lack of staff, and medical equipment shortages. Meanwhile, the Department of Public Health had no policy to directly manage these hospitals on the part of the central government, mainly due to limited central funding.⁶⁷ This has led to the establishment of some hospitals that were later forced to close due to insufficient funding to continue operations. According to data from the year 1924, it was found that all the hospitals in the capital city had fewer than 2,000 patients receiving treatment throughout the year. There were two hospitals that had no patients at all, namely, Mueang Sukhothai Hospital and Krung Kao Hospital.⁶⁸ In the case of hospitals established by missions, you will find that the majority were located in the northern region, followed by the central and southern regions. However, expansion was often limited in the eastern and northeastern regions. One reason is that the donors from the United States perceived these areas as bordering Laos and Cambodia, which were then emerging towns within the French colonial sphere of influence, propagating Roman Catholicism.⁶⁹ In this regard, from the compilation of hospital names from various sources that have been mentioned, hospitals can be categorized into two main groups. The first group consists of hospitals established through local fundraising efforts in the provincial capitals and mission hospitals. However, in many cases, hospitals from these two groups did not have distinctively separate characteristics. Some hospitals involved local fundraising but were managed by missions, such as the Mission Hospital in Phitsanulok established in 1906. Additionally, some hospitals that originated from community fundraising also received support from the monarch, government officials, and nobility, such as the Leprosy Hospital founded in 1923.⁷⁰ The list of local hospitals in various towns and the hospitals established by missions before 1932 are as follows:

Table 1 List of local hospitals in various towns before 1932

Source: Compiled by the authors

Order	Name	Year established	Origin of Establishment
1	Phuket Hospital ⁷¹	1891	Prince Phraya Ratsadanupradit (Kho-simbi) contributed funds along with government officials to later establish the hospital, which eventually became Phuket Health Hospital.
2	Inburi Hospital ⁷²	before 1893	It is estimated that the hospital was established before the year 1893, as there are records from the years 1893-1894 that mention a storm damaging the hospital, causing medicines and various items to be destroyed. As a result, they requested Western medicines and medical supplies to be used in the subsequent operation of the hospital.
3	Songkhla Hospital ⁷³	1896	Phra Wichit Worasat (Pun Sukhum) requested the establishment of a hospital in Songkhla town to provide medical care for the people and promote public health.
4	Nakorn Ratchasima Hospital ⁷⁴	1907	Phraya Rachanikul (Oub Paorohit) was a solicitor.
5	Sri Maharacha Hospital, also known as Somdej Phraboromratchathewi Hospital at Sriracha	1902	It was built according to the wishes of Somdej Savang Vadhana to be a public facility. Later, His Majesty King Chulalongkorn bestowed the name "Somdet Hospital" on it, sometimes also referred to as "Somdet Na Sri Racha." In 1918, it was handed over to Chulalongkorn University for management. ⁷⁵ Currently known as Somdej Phraboromratchathewi Hospital at Sriracha.

Order	Name	Year established	Origin of Establishment
6	Punjamathirat Uthit Hospital in the city of Krung Kao ⁷⁶	1912	The municipality officials, government employees, merchants, and the general public of Ayutthaya collectively donated 65,757 baht, and Queen Saovabha Phongsri contributed an additional 6,000 baht. The hospital opened for service on November 16, 1912.
7	Sukhothai Hospital ⁷⁷	1913	Built from donations provided by municipal officials, merchants, and the general public, amounting to 2,981 baht, the hospital was a small-sized establishment that eventually closed down later on.
8	Vajira Phuket Hospital in Phuket Province	1917	The official name is “Vajira Hospital,” but it is often referred to as “Vajira Hospital on Cheung Khao Rang” or “Vajira Hospital in Phuket.” His Majesty King Vajiravudh (Rama VI) graciously donated 30,000 baht from personal funds, and the operations received support from the Sanitation District.
9	Thung Song Hong Subdistrict Hospital, Nakhon Si Thammarat Province ⁷⁸	1918	The district officer, local authorities, traders, and general public collectively raised a sum of 5,980 baht and 36 satang. The hospital opened its services on March 31, 1918. The operations received financial support from the Health Department.
10	Nakorn Nayok Hospital ⁷⁹	1923	The total donation from government officials, traders, and the general public amounted to 5,145 baht and 58 satang. This money was used to establish an operating theater, a pharmacy, a workspace, and an examination room.
11	Leprosy Hospital	1923	The Phrapadaeng Hospital in Samut Prakan Province was inaugurated on May 4, 1923, under the auspices of the Red Cross Society of Siam. It received support from His Majesty King Vajiravudh (Rama VI), government officials, traders, and the general public. The Ministry of Finance also allocated an annual budget of 25,000 baht for its maintenance.

Order	Name	Year established	Origin of Establishment
12	Songkhla Hospital ⁸⁰	1925	Yugala Dighambara, Prince of Lopburi, initiated the construction of the hospital. The funds for this endeavor were contributed by traders and the general public, amounting to 170,573 baht and 58 satang. The hospital was inaugurated on June 26, 1925, and commenced its services.
13	Chao Phraya Yommarat Hospital (Pun Sukhum), Suphanburi Province ⁸¹	At least before 1927	Chao Phraya Yommarat initiated the construction of a hospital in one location in Suphan Buri province. The hospital was equipped with tools, instruments, and surgical equipment. Furthermore, Chao Phraya Yommarat also contributed 100 baht per month for the maintenance of the hospital. Subsequently, the hospital was placed under the supervision of the Ministry of Public Health.
14	Chiang Mai Hospital ⁸²	1924	It was observed that the existing facilities of the Sanitation District and the Osot Sapha were limited and outdated. Therefore, the Health Committee decided to construct new ones. They invited government officials, merchants, traders, and community leaders to convene and collaborate in establishing the new facilities. The new facilities were opened on January 14, 1924.
15	Nakorn Sawan Hospital ⁸³	1925	the Sanitation District of Nakhon Sawan established a pharmacy and a clinic, each with one building. They obtained funds through fundraising efforts from local suppliers in the amount of 4,000 baht in the year 1919. The center commenced medical services on December 1, 1925, and inaugurated the medical supplies unit on May 23, 1926.

Table 2 Hospitals Established by Missionaries Before 1932

Source: Compiled by the authors

Order	Name	Year established	Origin of Establishment
1	Petchburi Hospital	1880	It is the first hospital established by the American Mission in the regional part of Thailand, and was established 8 years before Siriraj Hospital.
2	Vincent Wood Hospital, Lampang ⁸⁴	1885	Received a royal grant from His Majesty King Chulalongkorn (King Rama V), through Dr. Samuel C. Peoples, the first director, under the name "American Mission Hospital." The name was changed several times and eventually became known as Vansantvoord Hospital.
3	American Mission Hospital	1888	The first hospital in the city of Chiang Mai, which has now become McCormick Hospital.
4	Missionary Hospital – Nakorn Si Thammarat ⁸⁵	1904	The Ministry of Interior allocated a budget of 4,000 baht. Another name for it is the Jennie Weast Swart Memorial Hospital.
5	Mission Hospital- Pitsanuloke	1906	The provincial governor of Phitsanulok approved a lump sum of money for the construction of a hospital.
6	Mission Hospital – Chiang Mai	1908	Carried out by the American Missionary, Dr. James McKean. Received financial support from the Lord Krom Phraya Damrong, the Red Cross Society, government officials, merchants, the general public, and foreign churches. Currently known as the McKean Hospital.
7	Overbrook Hospital – Chiang Rai ⁸⁷	1908	It involved collecting funds from members of the Overbrook Church, totaling 5,000 dollars, and presenting them to Dr. William A. Briggs to construct the first hospital building. The construction was completed in the year 1908, with a total of 44 patient beds.

Order	Name	Year established	Origin of Establishment
8	Talad Taptieng Mission Hospital, Trang ⁸⁸	1913	Prince Yaratsanupradit, along with the local villagers of Taphieng sub-district in Mueang Trang District, jointly contributed funds to build a hospital and purchase land for the hospital. Consequently, they reached an agreement with Presbyterian Missionaries from the United States to manage the construction and operations of this hospital.
9	Phrae Christian Hospital ⁸⁹	1913	The first hospital in Phrae Province was established on the banks of the Yom River, Ban Chetawan, Mueang District, Phrae Province. The operation was carried out by a group of American Presbyterian missionaries.
10	Leprosy Hospital – Nakorn Si Thammarat ⁹⁰	1922	Operated by Presbyterian missionaries, then in the year 1934, it received government support of 4,000 baht per year ⁹¹
11	Missionary Hospital - Nan ⁹²	1927	The hospital building in the year 1927 was an expansion of the original Presbyterian mission center, which had been providing medical services since 1893 under the care of Dr. Samuel C. Peoples.

B. Osot Sala

In addition to establishing hospitals, the government also promoted the establishment of “Osot Sala” for the distribution of medicine to treat fever. This had become the most important medical service facility provided by the state in this era.⁹³ Starting around the year 1895, in accordance with the policy to promote the establishment of medicine distribution centers more than city hospitals, various Osot Sala were established throughout this region. The Department of Health took responsibility for sending doctors regularly, while the tasks of finding locations and budgeting for construction were carried out by local municipalities under the jurisdiction of the Ministry of Interior.⁹⁴ These were distributed to various areas, such as Chachoengsao, Krung Kao, Prachinburi, Phitsanulok, and Uthai Thani.⁹⁵ However, some early Osot Sala businesses faced profit losses and had to close down.⁹⁶ Then, in the year 1902, the government supported the reopening of a similar venture under a different name, known as “Osot Sapha,” which operated alongside Osot Sala. Princess Vibhavadi played a key role as the chairperson responsible for procuring medicines from foreign countries. Records about the establishment of Osot Sapha state: *“Today, there are numerous effective medicines available for various diseases. However, if these medicines have not yet reached the distant rural villages and communities, the abdominal pain from these illnesses can become highly dangerous... Thus, please establish Osot Sapha...”*⁹⁷ As a result, there was a distribution of Western medicines, also known as “modern plan medicines,” to various provincial capitals. These included medicines like quinine, chloroquine for malaria treatment, fever-reducing medicines, digestive aids, and more. These medicines gained significant popularity among the public during the initial years.⁹⁸ Part of the reason may be that medicines from Osot Sala were distributed at affordable prices that still covered their costs. Along with this, some merchants and officials in certain areas often preferred to purchase medicines to distribute to the fever-stricken population.⁹⁹ In 1907, there was a directive to merge Osot Sala with the government, becoming one entity.¹⁰⁰ Although the expansion of Osot Sala was slow, it can be observed that in the year 1921, there were only a total of 43 Osot Sala branches throughout the country.¹⁰¹ **However, it must be acknowledged that Osot Sala played a crucial supportive role for the people in each area. Many Osot Sala branches not only had the responsibility of selling medicines, but also functioned as modest-sized hospitals, offering only outpatient services without admitting patients for treatment.** This kind of setup eventually gave rise to the establishment of health pavilions, health stations, rural medical centers, and health and medical centers. Later on, it evolved into district hospitals.¹⁰²



The initial establishment of hospitals in a Western manner marked the beginning of infrastructure investment in terms of facilities and treatment equipment. While the construction of hospitals and ongoing funding for the maintenance and care of healthcare facilities in this era could be described as arising from “altruism” and “collective efforts,” it was primarily led by the Siamese bureaus and the royal court, which provided

initial funding, as well as donations from missionary groups, local merchants, foreigners, and ordinary citizens, each according to their beliefs and capacities. It was more of a collaborative investment rather than solely relying on state budgets. However, it can be said that the 1887 decade was the starting point for the transformation and expansion of comprehensive healthcare services in that era.

Despite the slow start in the construction of hospitals and Osot Sala, their numbers gradually increased over time. This necessitated the establishment of supervisory agencies to oversee public health operations, particularly the birth of the Department of Health to ensure coordinated healthcare efforts.



Figure 14 A depiction of the staff quarters of Somdej Phraboromratchathewi Hospital at Sriracha, one of the regional hospitals constructed before 1932.

Source: The National Archives of Thailand, P.PT. 4/73, Staff Quarters of Somdej Phraboromratchathewi Hospital at Sriracha.

Figure 15 Overbrook Hospital, Chiang Rai, constructed and completed in 1908, with 44 patient beds.

National Archives of Thailand, P.002 HWY.25/6, Overbrook Hospital, Chiang Rai.

Chapter 1

¹Ministry of Public Health, Ministry of Public Health Celebrates 15 Years 1942-1957 (Bangkok: Ministry of Public Health, 1957), 430.

²Kullada Kesboonchoo Mead, *The Rise and Decline of Thai Absolutism* (Nonthaburi: Same Sky Books, 2019), 323–25.

³Chaicon Praditsil, “The political economy of family planning in Thailand : A study on policy process” (Master’s thesis, Faculty of Political Science, Thammasat University, 1990), 120–28; Anchalee Susayanha, *Changes of the phrai system and their effects on Thai society in the reign of King Chulalongkorn* (Bangkok: Sangsan Books, 2009).

⁴Kullada Kesboonchoo-Mead, *Absolute monarchy Evolution of the Thai state*, 323–25.

⁵Chaicon Praditsil, “The political economy of family planning in Thailand: A study on policy process,” 131.

⁶Pensri Kaweewongprasert, “The Role of the State in Public Health Issues (1782 - Post-Political Transformation 1932)” (Master’s thesis, Faculty of Social Sciences and Humanities, Mahidol University, 1985), 55.

⁷Chaicon Praditsil, “The political economy of family planning in Thailand: A study on policy process,” 137-38; Society and Health Institute, Davisakd Puaksom, ed. *Community Health: History and Memories*, The first witness seminar for the history of the Thai health system on September 19, 2008 (Nonthaburi: Society and Health Institute, 2009), Introduction (ch).

⁸*Chronicles of Yonok (the National Library Edition)* (Phranakhon: Silpa Bannakarn, 1961), 222-223; R. Pollitzer, S. Swaroop, W. Burrows. ‘Cholera’. *World Health Organization Monograph Series No. 43*, World Health Organization, Geneva, 1959, pp. 19-21.

In the Eastern region, the epidemic began from India, spreading to Sri Lanka, Myanmar, Siam, Malacca, Singapore, the Indonesian archipelago, Manila, China, and Japan. Meanwhile, in the Western region, it spread from India to the Persian Gulf and entered Europe.

⁹N. C. Macnamara. *Asiatic Cholera: History up to July 15 1892 Causes and Treatment*, London: Macmillan and CO and New York, 1892, 3

¹⁰Pensri Kaweewongprasert, “The Role of the State in Public Health Issues (1782 - Post-Political Transformation 1932),” 32-38.

¹¹Nopphanat Anuphongphat et al., *Roi Wela: A Journey Through the History of Health* (Bangkok: Sukhasala, 2013), 117.

¹²Chatchai Muksong, “The history of medicine and public health in Thailand” (Bangkok: Faculty of Social Sciences, Srinakharinwirot University, 2018), 66.

¹³William L. Bradley, *Siam Then* (Bangkok: Thai Khadi Research Institute, 1986), 85.

¹⁴Dan Beach Bradley, *A Narrative of the Introduction and Successful Propagation of Vaccina in Siam - 1840 & 1844* (Bangkok: E.B.C.F.M. Press, 1855), 4; "Smallpox and Vaccination in Siam: A Remarkable Educational Campaign." *Hospital* (London 1886), 1915 Feb 6; 57(1494): 419. PMID: 29823756; PMCID: PMC5229083; The Editor of the *Boston Medical and Surgical Journal*, "Vaccination and Smallpox in Siam." *The Boston Medical and Surgical Journal*, 21(12), 1839, 185–188. doi:10.1056/nejm183910300211201.

¹⁵Department of Fine Arts, *Black Death during the reign of King Rama V* (Bangkok: Department of Fine Arts, 2019), 7; Pollitzer, R. (1951). "Plague studies*: 1. A Summary of the History and a Survey of the Present Distribution of the Disease." *Bulletin of the World Health Organization*, 4: 479. <https://apps.who.int/iris/bitstream/handle/10665/266229/PMC2554113.pdf?sequence=1>.

¹⁶Davisakd Puaksom, "Of Germs, Public Hygiene, and the Healthy Body: The Making of the Medicalizing State in Thailand". *The Journal of Asian Studies*, 66(2), 2007, 311–344. doi:10.2307/20203160; World Health Organization. (1939). *Plague in Siam = La peste au Siam*. *Weekly Epidemiological Record = Relevé épidémiologique hebdomadaire*, Switzerland. 14 (08), 1939. from <https://policycommons.net/artifacts/602345/plague-in-siam-la-peste-au-siam/1581905/>; *Siam: Report from Bangkok. History of Plague Outbreak. Public Health Reports (1896-1970)*, Vol. 20, No. 28 (Jul. 14, 1905), pp. 1442-1444 <https://www.jstor.org/stable/4555559>

¹⁷Pensri Kaweewongprasert, "The Role of the State in Public Health Issues (1782 - Post-Political Transformation 1932)," 230.

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⁴⁰ 1 Chang (ชั่ง) is worth 80 baht.

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0%B9%82%E0%B8%A3%E0%B8%87%E0%B8%9E%E0%B8%A2%E0%B8%B2%E0%B8%9A%E0%B8
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The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868-2002

Evolution of the Thai public health
structure and health workforce
mission

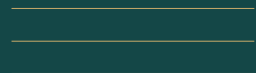




Figure 16 Image of medical students preparing medication at Siriraj Hospital

Source: National Archives, PO 002, HWY 5/24, Student pharmacists preparing medication at Siriraj

On December 25, 1888, the establishment of the “Department of Nursing” was announced with the aim of providing personnel to supervise and assist in managing the operations of the hospital. The hospital's name was later changed to “Siriraj Hospital,” and it opened for operations in the same year. The Department of Nursing would take over the responsibilities of the Hospital Construction Committee, with His Royal Highness Prince Sri Saovabhangaas the first appointed Director-General.¹ The Department of Nursing thus transformed into an organization with the responsibility of managing medical education, overseeing other hospitals, and providing healthcare services to the public free of charge. For instance, organizing physician deployment to provide medical care to the citizens in the capital city.² After the restructuring of the territorial administration system into 12 ministries in 1892, the Department of Nursing was placed under the Ministry of Education. It then functioned as the central hub for medical expertise, personnel, and various equipment. In essence, the Department of Nursing was tasked with the continuation of construction-related work for healthcare facilities, managing and budgeting for hospitals or charitable institutions (both monetary and material donations), overseeing medical education, and providing comprehensive healthcare services to the society. In addition to the Department of Nursing, the Ministry of Interior collaborated with the Department of Nursing to take responsibility for healthcare services in the capital city and regions. Meanwhile, the Ministry of Municipal Affairs was in charge of public health matters within the city.³ Therefore, initially, the structure of public health operations between the central area in Bangkok and the regional areas still consisted of various separate units responsible for different tasks and managed independently.

From the Department of Nursing, Department of Public Protection, Department of Public Health to the Ministry of Public Health

The existence of the Department of Nursing has undergone several changes. It was dissolved on multiple occasions due to budget shortages in the year 1906. Hospitals in Bangkok, including Siriraj Hospital, were transferred to municipal administration. Meanwhile, healthcare in the capital was placed under provincial municipalities.⁴ The Department was reestablished once again in 1912 with the purpose of overseeing and planning disease prevention. This time, it was placed under the Ministry of Interior. Subsequently, the Department of Nursing was merged with the Department of Phalampang (under the Ministry of Interior), which was responsible for regional administration.⁵ Therefore, its name was changed to the “Department of Public Protection” (1916) to align with its expanding mission. However, one of the most significant events related to the restructuring of the Department of Nursing was the pivotal merging of nursing and public health services in both the capital city and regional areas, creating a new entity named the “Department of Public Health.” Prince Rangsit Prayurasakdi, was appointed as the Director-General under the Ministry of Interior in 1918. As His Majesty King Rama VI graciously decreed, *“Public Health, the sector*

responsible for safeguarding the well-being and happiness of the people by preventing illnesses, is now (Public Health).” This mandate was previously separated and operated under the Ministry of Interior and Ministry of Metropolitan. His Majesty further emphasized that these functions should be unified under one entity, establishing a major department called the “Department of Public Health” under the Ministry of Interior.”⁶ This led to the consolidation of public health efforts between the Bangkok area and the previously dispersed regional areas, all of which are now unified under the oversight of a single department.⁷ Although only medical education responsibilities remain under the jurisdiction of the Ministry of Education, with this new role, the Department of Public Health was now able to have a greater influence over curriculum, teaching methods, and examinations related to public health.

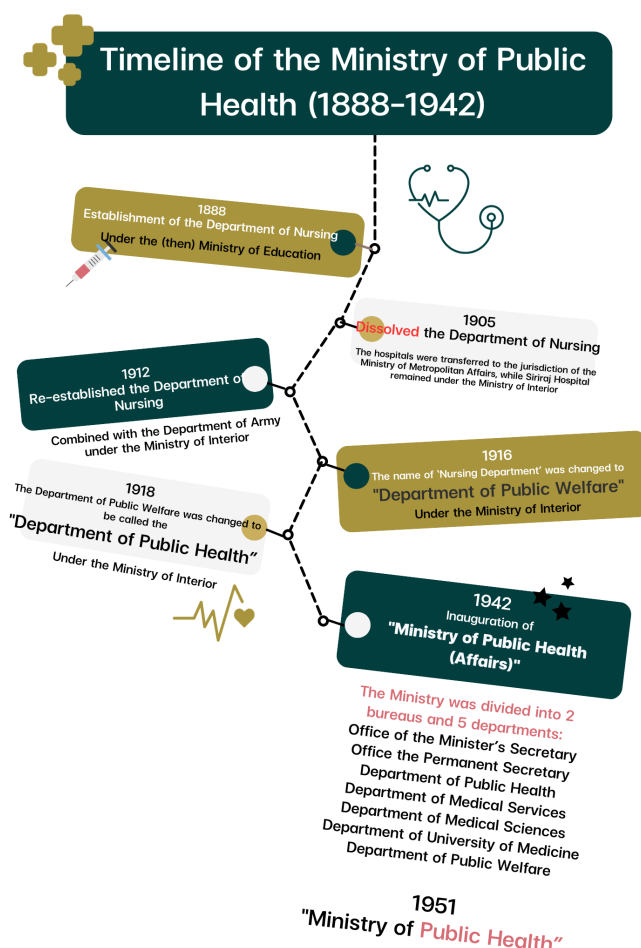


Figure 17 Image depicting the evolution of the Ministry of Public Health (1888-1942).

Source: Adapted from Suwit Wibulpolprasert, ed., “Thai Public Health 2001-2004,” Logistics Organization Press, 2005, p. 354.

Therefore, it can be said that since the late 1880s, the birth of hospitals marked the establishment of institutions such as the Department of Nursing to oversee hospitals. The evolution leading to the formation of the Department of Public Health reflects a significant transformation in the field of public health. Notably, the merging of public health management with the territorial administration of the Ministry of Interior, which became the starting point of the “Art of Governance” concept that persisted until the post-1932 era. Further changes were observed during the first era of Field Marshal P. Phibulsongkram (1938-1944), where public health work started to specialize and differentiate itself from administrative functions, eventually culminating in the creation of the “Department of Public Health” on March 10, 1942 (later renamed the “Ministry of Public Health” in 1952). This new structure comprised 2 bureaus and 5 departments within the government, with the aim of integrating medical and public health operations into a single entity.

Health workforce, knowledge, and the starting point of medical education in Thai society

The transformation of healthcare services and the structure of the public health sector also impacts the dimension of “human resources” or “medical personnel.” This shift opens up opportunities for the general public to have increased access to medical education. Simultaneously, the “knowledge assets and medical education approach” have become increasingly intricate issues, stemming from the overall expansion of the public health domain.

A. Birth of medical schools and medical education approaches

During the decade starting in 1887, there was a significant advancement in the production of medical professionals to strengthen the human resources. The state established a Western-style medical school called the “Siriraj School of Medicine,” which was the first institution in Siam aimed at training physicians and nurses under the supervision of the Department of Nursing. In its initial stages, Dr. Thomas Heyward Hays was appointed as a teaching professor until 1891, when Dr. George Bradley McFarland, also known as Phra Ach Vidyagama, succeeded Dr. Hays after he relocated to Bangrak Hospital. Dr. McFarland is considered the “cornerstone of the medical school” because of his foundational knowledge, educational contributions, and effective communication skills in both Thai and English.⁸ The Bhatayakorn School commenced its teaching activities on September 5, 1890.⁹ Subsequently, improvements were made to the school’s buildings, and its name was changed to the “Royal Medical College” (*Rajapattayalai*) in the year 1900.¹⁰ During the initial period at the Royal Medical College, the curriculum utilized medical textbooks called *Phatthayasat Songkro* (medicine for welfare)¹¹ The curriculum primarily consisted of a blend of Thai

traditional medicine and Western medicine.¹² The admission of the first batch of medical students initially required basic literacy skills, including reading and writing. Subsequently, the selection process shifted towards admitting individuals who had completed their sixth year of secondary education.

Initially, the duration of study was three years to complete the curriculum, gradually expanding to four, five, and eventually six years. During the early stages, due to a decrease in the number of applicants from around 40 to only 13 students, a contract was introduced for the first time, offering students a monthly salary of 12 baht and a monthly allowance of 7 baht while residing at the school. If after three years a student did not pass the exams, they could choose to continue or become assistant physicians at hospitals with a monthly salary of 25-40 baht. Those uninterested in pursuing their studies would be considered in breach of the contract and would need to repay their entire salary and allowances to the ministry. Later on, the system was divided into four categories: the first type consisted of boarders who resided at the school and received a 10 baht monthly allowance; the second type included day students who did not receive an allowance and were not required to pay tuition fees; the third type comprised boarders who paid for meals and tuition fees at 10 baht per month; and the fourth type included day students who paid a tuition fee of 3 baht per month. The first two categories, upon successful completion of exams, were obligated to enter government service as directed by the ministry, while the latter two categories depended on the students' preferences.¹³

Figure 18 The image shows the building of the Royal Medical College, later transformed into a maternity ward and nursing classrooms. Subsequently, the building was demolished and reconstructed as a radiology building in the early months of 1939.

Source: National Archives, PO 002, HWY5/12, The Royal Medical College building converted into a ward for wild animal patients, 1917, at Siriraj Hospital.



When Prince Rangsit Prayurasakdi took command of the school in 1915, he emphasized the study of basic medical sciences and introduced the teaching of pharmacy for the first time. Moreover, he hired numerous foreign professors to teach various subjects. By the year 1916, a significant transformation occurred in the Medical College. The Medical College was merged with the Civil Service Training School, leading to the establishment of Chulalongkorn University.¹⁴ The Royal Medical College (Faculty of Medicine Siriraj Hospital, Mahidol University at present) became a part of Chulalongkorn University. However, a significant problem arose in the early stages of medical education, which was the insufficient number of physicians being produced to meet the demand, and the relatively low standards of medical education due to a lack of various essential tools and equipment.

Figure 19 Image of the first-year medical students studying anatomy (c.1890).

Surgical anatomy lessons in the current curriculum began in 1889, but at that time, teaching did not involve dissection and mainly relied on photographs. It wasn't until 1891 that teaching involved using anatomical models. The instructor was Phra Ach Vidyagama, and by 1896, students were learning through dissection of cadavers.

Source: National Archives, PO002 HWY36/26 (4), Educational Activities in the Medical School.



Figure 20 Dr. George Bradley McFarland was a professor at the Medical School starting from 1891 until 1926.

He was bestowed with royal titles as Phra Ach Vidyagama and authored several textbooks in Thai, including subjects like Bacteriology, Medicine, Anatomy, and Pathology.

Source: National Archives, Image PO002 HWY36/26 (3), Educational Activities in the Medical School.

The issue of inadequate physician production is evident from the fact that the government was unable to appoint district physicians. During the 1890s, it was found that there were only 106 “qualified” physicians for a population of 7 million, and there were 104 districts without any physicians at all.¹⁵ The shortage of physicians is also evident in the Military Service Exemption Act of King Rama IV, Article 124, which was first enforced in 1905. This act granted exemptions to certain groups, such as monks, civil servants, disabled individuals, students, those caring for disabled parents or guardians, incarcerated individuals, and indigenous people. However, the exemption from military service was not granted to the esteemed group of physicians.¹⁶ However, in 1910, there was an amendment to the Military Service Exemption Act of King Rama IV, Article 124, to “grant exemption to distinguished physicians” from temporary military service requirements.¹⁷ By specifying that one person per sub-district is exempted, individuals who received this privilege had to possess two qualifications: being a qualified medical practitioner and having been granted a certificate by government officials to serve as a local district physician. If they were district physicians within the area of Bangkok, the certificate was issued by the Ministry of Interior.¹⁸ If they were district physicians in various provincial capitals, the responsibility fell under the Ministry of Public Health. This aforementioned exemption illustrates the insufficiency of the number of district physicians in each area at the time. This exemption continued consistently until Siam participated in World War I (1914-1918), prompting a revival of the elite physician criteria in 1917 to prepare for military medical duties.¹⁹

While the issues regarding standards and equipment shortages persisted, Dr. Victor Heiser, the Director of Public Health in the Western Hemisphere of the Rockefeller Foundation, conducted an assessment of the operations of the Royal Medical College and provided recommendations for improving medical education in 1915. This was in response to a request for assistance from the Siamese government led by Prince Rangsit Prayurasakdi, the Director-General of the Royal Medical College, who sought help to enhance medical education. This was in line with the foundation’s policy to aid developing countries in various aspects.²⁰ Heiser recorded his impressions during the time he had the privilege to be in the presence of His Majesty King Chulalongkorn, and he candidly expressed his thoughts about the medical school at that time, stating, *“I have visited medical schools all over the world, West as well as East...I regret very much to say that Your Majesty’s Royal Medical School is the poorest I have ever seen.”*²¹ Heiser also wrote a report concerning the Royal Medical College, indicating that the various subjects taught in the medical school were comparable to those of a lower-grade medical school in the United States. The teaching facilities and equipment were lacking. Thus, he proposed that the Rockefeller Foundation provide assistance to develop medical education in Siam by sending foreign consultants to provide guidance, as that could potentially be a valuable opportunity for improving the health of people in the East.²²



Figure 21 An image of an operating room at Siriraj Hospital with a physician cleansing a wound in 1916, prior to subsequent improvements.

Source: National Archives, PO002, HWY5/7, Operating Room, Siriraj Hospital, Physician Cleansing a Wound, 1916.

The earnest collaboration between Siam and the Rockefeller Foundation began in October 1922. Part of this collaboration was due to His Royal Highness Prince Mahitala Dhibesra Adulyadej Vikrom (or Prince Mahidol Songkhla), considered the “Father of Thai medicine,” who played a crucial role in engaging the Rockefeller Foundation to assist in supervising and enhancing the curriculum. Additionally, His Royal Highness contributed personal funds to construct buildings and send physicians abroad for further education. As a result, the period of transformation in the mid-1917s marked a pivotal juncture in the comprehensive overhaul of medical education, aligning it more closely with Western standards.²³ The main agreements for assistance from the Rockefeller Foundation included the revision of the curriculum at the Faculty of Arts and Sciences, Chulalongkorn University, to prepare students for medical studies over a period of two years. They also established a four-year medical curriculum at Siriraj Hospital, equivalent to a total of six years of study. The granting of the first batch of medical degrees (6-year curriculum) occurred in 1928. Moreover, the curriculum was divided into six departments: Anatomy, Physiology, Pathology, Medicine, Surgery, and Obstetrics and Gynecology. The Rockefeller Foundation provided financial support to establish various laboratories, and assisted in selecting professors from the West to teach for a certain period, along with contributing a modest additional monthly salary (the Thai government provided 800-1000 baht, and the Foundation added 300-500 baht)²⁴ in order to structure the curriculum and train individuals capable of assuming the aforementioned positions, and to also have the option to select Thai professors for further education to potentially replace foreign professors in the future.²⁵

With the assistance of the Rockefeller Foundation and collaboration from the administrators of the medical school under the Ministry of Education, the elevation of medical education was accelerated, and it achieved higher international standards. This became a significant period for laying the foundation of “producing physicians to meet global standards.” However, the challenge remained that the number of graduates was still insufficient to meet the demand. The Department of Public Health, as a service provider and consumer of medical professionals, held a different perspective. They viewed that the Rockefeller Foundation’s approach, emphasizing the production of specialized physicians, did not adequately address the substantial need for doctors in Siamese society at that time. A proposed recommendation was to establish a “Junior Doctor” or “Second-Tier Medical Education” system to better manage teaching and learning.”²⁶ In order to expedite the process of producing manpower, ensuring an adequate workforce to meet the specific needs, particularly addressing shortages in various up-country provinces, the aforementioned proposal faced significant opposition from the Rockefeller Foundation. This was mainly because they aimed to create academically-distinguished physicians²⁷

Indeed, the scarcity of physicians was an urgent and vital challenge that the Department of Medical Services (later known as the Department of Public Health) consistently faced since the establishment of hospitals, medical facilities, and the restructuring of public health operations. The establishment of

medical schools served as a significant testament to this situation. Consequently, the distribution of physicians to each region became another challenging task intertwined with various developments, dating back to the late 1880s.



Figure 22 The image depicts teachers and medical students participating in the first public health training in Thailand, which took place from June 28 to September 15, 1924, at the Thai Red Cross.

Seated from the left: Person 2: Dr. J.R. Redfield; Person 3: Mom Chao Sakonvannakorn Varavarna; Person 4: Prince Rangsit Prayurasakdi; Person 5: Dr. P.M. Powell; Person 6: Prince Mahidol Songkhla

Source: National Archives, P.001 KJCH(A) 8-19, Teachers and Students First Public Health Training.

B. Municipal and sub-district physicians

When hospitals were established in accordance with the regional capitals, whether they were local, private, or state-supported, the central government further promoted the presence of “local physicians” affiliated with the Department of Nursing, Ministry of Interior. This was done by assigning one physician per town, following the administrative reforms of 1892 when the system transitioned from the old capital-based structure to a provincial and centralized system. During this transition, government officials were sent to oversee the provinces in place of local leaders. These officials brought physicians from Bangkok to provide medical care, placing more emphasis on treatment (medical care) rather than disease prevention. These physicians were often assigned duties to provide medical care for provincial officials, government employees, and their families. As evident in the medical book issued by the Ministry of Education for town appointments in the regional areas, it is stated, *“If a high-ranking official or an employee falls ill, it becomes a burden.”* This then includes the statement, *“Criminals nearing death are numerous.” Hence, the need for “local physicians... to provide medical care for government officials and prisoners when they are sick.”*

In 1899, Prince Damrong Rajanubhab proposed that local physicians should possess knowledge in surgical procedures and wound treatment, specifically referring to physicians with Western-style expertise. During that time, such expertise was predominantly held by physicians who had graduated from medical schools or foreign doctors. Consequently, the Ministry of Interior, as the overseeing authority for local physicians, had to facilitate the appointment of physicians who had graduated from medical schools to serve as local physicians in various towns.³⁰ The monthly salary rate for physicians with a medical license was set at 80 baht.³¹ As for local physicians without a medical license, they received a salary of 30-60 baht. Local physicians were considered government officials of the town, operating under the jurisdiction of municipal authorities and provincial governors. Their responsibilities included providing medical care and health services in the town, conducting inspections of sub-district physicians’ work, administering medical care for government officials and their families, as well as overseeing matters related to disease control and prevention, such as implementing preventive measures against contagious diseases like planting medicinal herbs. This also extended to the supervision of police officers and prisoners.³² However, the responsibilities and obligations of local physicians still did not extend to the general public. If members of the public sought medical assistance for their illnesses, they received appropriate treatment; but it was not considered a governmental duty.³³ As a result, the healthcare and treatment for illnesses of the general public in the capital area still relied on self-care or primarily on traditional healers, called as *Moh Chaloeisak*.

“*Moh Chaloeisak*” or “*Phat Chaloeisak*” in this context refers to traditional healers who provide general healthcare to the community. They used both Thai and Chinese herbal remedies, which was a familiar way

of treating the villagers in the traditional manner of Siamese society. Some individuals may have learned traditional healing methods through oral transmission and manual copying of manuscripts. This knowledge transmission remained limited within specific family lineages. In some cases, they may have received training or teachings from experienced practitioners who served as mentors, eventually becoming like *"apprentices to the master."*³⁵ Some individuals even resorted to studying from textbooks and conducting self-practice experiments until they became proficient and established themselves as lay *'doctors who treat the sick.'*³⁶ Due to this, the official status and privileges between municipal doctors and traditional healers remained unequal. This pertained not only to the process of acquiring knowledge and training, where municipal doctors followed a more structured system compared to traditional healers. Municipal doctors were considered government employees with salaries, while traditional healers were not.

However, even though there was the institutional norm that municipal doctors should possess Western-style medical knowledge, in practice, municipal doctors encompassed both certified and uncertified individuals. This situation arose from the fact that the medical school's production of healthcare professionals was insufficient to meet the demand. Between 1893, the first year graduates emerged from the medical school, and 1899, when it was mandated that municipal doctors must hold certificates, only 33 individuals became graduates. Out of these, only 12 entered government service under the Ministry of Interior. Subsequently, from 1900 to 1910, although the number of certified doctors increased to 128, only 29 were employed by the Ministry of Interior, despite there being 93 municipalities in need of municipal doctors. Often, the Ministry of Interior, then responsible for medical education, addressed this shortage by deploying uncertified traditional healers to replace municipal doctors without certificates.³⁷

However, even for certified traditional healers, who have passed the selection process by the Ministry of Interior, there was another group of doctors who did not graduate from the medical school under the Ministry of Interior's jurisdiction. These were practitioners who have completed their education at the "Vetchasamosorn Medical School," a specialized institution that produces practitioners of traditional medicine, as established by Phraya Pitsanuprasatwet.³⁸ Some provinces employed the strategy of hiring local traditional healers (*Chaloeisak*) in their respective areas. In certain regions, doctors from Western or missionary backgrounds were appointed as municipal doctors to fulfill the role of the town's physician when there was a shortage of official municipal doctors. For instance, this approach was taken in Chiang Rai, Phuket, and Monthon Payap.

Another challenge closely linked to the insufficient number of doctors was the lack of readiness on the part of the Ministry of Interior. Many municipal doctors lacked proper medical facilities for treatment, and they often received inadequate budget for procuring medicines to treat patients. Moreover, there was a shortage of Western-style medical equipment. Faced with these challenges, some municipal doctors,

including those trained in Western medicine, had to resort to using local herbal remedies for treating patients, deviating from the methods taught in certified medical training. This situation sometimes led to some municipal doctors requesting to return to Bangkok or seeking alternative roles due to the difficulties they encountered in their assignments.³⁹ Due to the shortage of doctors in Siam, the position of municipal doctors encompassed various categories, including certified medical doctors, Chaloeisak doctors who passed selection examinations, traditional medicine doctors from medical schools, general Chaloeisak doctors in local areas, and Western-trained doctors.

In addition to the role of municipal doctors, there was also the position of “Rural District Doctor” or “Tambon Doctor.”⁴⁰ This initiative stemmed from the proposal of Monthon Phitsanulok governor in 1906, which aimed to establish a new position for village headmen (*phu yai baan or kamnan*), as outlined in the Provincial Administration Act of 1897. This proposal suggested selecting one doctor for each sub-district, and the government would appoint these sub-district doctors to have the same status as village headmen. Their responsibility would be to provide healthcare services to the local population. This proposal was endorsed by Prince Damrong Rajanubhab, who was the Minister of the Interior at that time.⁴¹ It was understood that those appointed as Tambon doctors probably came from the traditional Chaleoysak doctors, who lacked modern medical knowledge. Indeed, some of them were not solely physicians but also engaged in other professions like farming or trading, and provided medicine (as a sideline when requested) for a fee. However, there was a recognition of the benefits of establishing these cadres of Tambon doctors. It was seen that the Tambon doctors could complement the work of the existing municipal doctors. At the same time, municipal doctors could also pass on their knowledge to the Tambon doctors. Another advantage was that Tambon doctors were often local practitioners who could fulfill roles such as registering births and deaths, which contributed to the administration of civil affairs. This system of Tambon doctors was piloted in Monthon Phitsanulok and expanded into a formal practice in 1907. The Ministry of Interior delegated the provincial governors of various Monthon to appoint local physicians as Tambon doctors. In cases where a sub-district did not have a doctor, it would be merged with another sub-district, and the district chief would officially issue appointments⁴²

The duties of a Tambon doctor encompassed two main responsibilities. Firstly, they were responsible for dispensing medications provided by the local authorities within their sub-district and for cultivating preventive measures against infectious diseases. In this regard, the municipal doctor took on the role of instructing and training the Tambon doctor. However, the Tambon doctor did not receive a regular salary like other government officials. Instead, they were exempted from paying official fees.⁴³ They also received permission to collect medical fees. As a result, the Tambon doctor became an extension that helped expand healthcare services to areas outside the town more cost-effectively. When public health responsibilities in the town were transferred from the Ministry of Interior to the Ministry of Public Health in

1912, the Tambon doctor received a position as a member of the sub-district committee. They were tasked with managing educational and healthcare aspects within the sub-district. The municipal doctor supervised the Tambon doctor in this capacity.⁴⁴

When comparing the methods of producing medical professionals from the central medical schools that focused on developing “outstanding physicians” with the actual situation in remote provincial municipalities, the localities had to prioritize “quantity of doctors first” or having “second-tier doctors,” and they seemed to make the rational decision. This demonstrates the factors that led to the emergence of two divergent approaches: The approach of producing outstanding physicians versus producing second-tier doctors is evident through the Medical Act of 1923. During that time, the Department of Public Health (under the Ministry of Interior) attempted to expand its control and supervision over the teaching methods of physicians who operated under the authority of the medical schools (under the Ministry of Education). This effort began by enforcing regulations in Bangkok and would later extend the provisions to other provincial capitals.

C. Medical Act of 1923 (B.E. 2466) and the role of the medical council

When the overall public health responsibilities were transferred to the Department of Public Health, under the Ministry of Interior, starting from 1918, it had significant implications. This led to the enactment of the “Medical Act of 1923,” a crucial step aimed at regulating and establishing rules and regulations for physicians and medical practice. The central focus was on controlling and organizing the medical profession, as indicated in the royal proclamation of His Majesty King Vajiravudh (Rama VI), which states:

“

“The art of healing should have a significant influence on the well-being of the population... In Siam, there is no regulation or control over such practice, leaving the public vulnerable to danger caused by the practice of untrained and inexperienced individuals... Therefore, it is deemed necessary to regulate, establish rules and regulations, and elevate the status of the medical profession.”⁴⁵

”

This marked an important milestone in the development of the medical field, ensuring that medical practice was conducted by qualified professionals for the benefit and safety of the population.

The interest in the details of this particular version of the law can be categorized into three significant points. **Firstly**, the explanation of the term “Art of Healing” itself⁴⁶, which is characterized as a professional practice.⁴⁷ This term encompasses various aspects of medical practice, including pharmaceutical treatment, surgical procedures, obstetrics, dentistry, veterinary medicine, compounding of medicines, nursing, massage, or any method for treating the sick or feverish individuals. **The second point** is the establishment of the “Medical Council”, responsible for regulating the Ministry of Public Health. Its crucial role included issuing licenses for individuals practicing the art of healing, thereby requiring approval from the Medical Council before anyone could practice such art. Article 9(k) also specifies the Council’s authority to investigate the qualifications of those seeking registration and to approve, temporarily suspend, or revoke licenses. **The third point** posed a significant challenge to the authority of the Ministry of Education⁴⁸ Regarding the guidelines for medical education, as this version of the Royal Medical Act allowed the Medical Council to serve as an “advisory body” to the Ministry of Education concerning curriculum, examinations, and expertise in various departments or branches that are taught by the Ministry of Education. This led to the classification of physicians in accordance with the law, distinguishing between contemporary and traditional medicine. For this reason, the Medical Act of 1923 granted authority to the Department of Public Health to have control over the curriculum of medical education beyond the jurisdiction of the Ministry of Education The authority of this Royal Decree served as the basis for the distinction between the approaches to medical education, between aiming to produce physicians with internationally-standardized qualifications and the production of secondary-level physicians.

In this regard, the stratification of physicians became clearer when the “Medical Professions Act of 1936” defined Western medicine physicians and traditional medicine physicians, distinguishing them based on the knowledge that relies on scientific principles versus knowledge that does not heavily rely on scientific principles.⁴⁹ This led to a clearer definition of the distinction between physicians of levels one and two. Level one physicians referred to those who have graduated from schools recognized or directly endorsed by the Ministry of Education, and who had received official certification or direct transmission of knowledge from traditional medical lineage. As for level two physicians, they were individuals who had pursued studies and learning outside the established system not recognized by the registration law. Therefore, they had to obtain certification from the “Medical Professions Regulatory Board,” a newly established organization that took over the responsibilities of the former Medical Council, dissolved in 1936.



The crucial essence of the evolution of the Medical Council highlights the atmosphere of “divergent perspectives” between two categories of physicians: those emphasizing excellence and those focusing on prevention. This divergence has had a far-reaching impact on matters of knowledge, teaching methods, the objectives of medical education, and the number of healthcare professionals that can be produced in a given year. This challenge emerged since the early days of shaping the modern public health system, during the era of King Rama VII. Subsequently, these issues gradually intensified, leading to a parallel approach in medical education between curative and preventive medicine. However, before reaching this juncture, the development of public health encountered another transformation when confronted with a significant political turning point, known as the “Siamese Revolution” or the event of the change in government in 1932.

Chapter 2

¹ Royal Thai Government Gazette, “Proclamation Establishment of the Department of Nursing” (Volume 5, Part 40, Page 432, 13 February 1888).

² The Royal Thai Government Gazette, “Proclamation Department of Nursing [Royal Kindness to Provide Doctors and Medical Equipment for Vaccinating in Provinces Without Charge]” (Volume 6, Part 35, Page 300, 1 December 1889).

³ Nipaporn Ratchatapattanukul, ‘Public Health in Modern Siam: Elite Thinking, External Pressure, and Popular Attitudes’, *Journal of the Siam Society*, Vol. 101, 2013, 178 (177-192).

⁴ National Archives of Thailand, ST 8/180, Box 5, “Kindness to Have Hospitals Administered by the Ministry of Metropolis.”

⁵ Department of Palampang (Pha-Lam-Phang) was responsible for local administration, under the Ministry of Interior, until 1933 when it was renamed the Department of Interior. The term “Palampang” was used for the Palampang army under the Department of Interior for central administration until 1942 when the Palampang army was renamed the “Provincial Administrative Division” (Kong Kan Pokkrong) In 1962, the Department of Interior (formerly known as the Department of Palampang) was renamed the Department Of Provincial Administration, under the Ministry of Interior. Please refer to details in the Office of the Royal Society and Piyarat In-on, “Department of Palampang,” Office of the Royal Society, 2010, <https://bit.ly/3vMndnL>.

⁶ Royal Thai Government Gazette, “Proclamation Establishment of the Department of Public Health and Appointment of the Director-General of the Department of Public Health” (Volume 35, Pages 302-3, 7 December 1918).

⁷ Ministry of Public Health, “Royal Duties of Prince Rangsit Prayurasakdi (Somdej Phra Chao Borom-mawongther Chainat Narenthorn)”, Concerning Medicine and Public Health, Published in Memorial book for the Royal Cremation Ceremony at Wat Benchamabophit Dusitwanaram on 29 January 1952 (Phranakhon: Kan Phim Phanit Printing, 1952), 20-21. Public health work at that time included promoting health education and awareness, caring for infants and mothers, tending to be disabled individuals and special activities like preventing epidemics such as malaria, cholera, and smallpox.

⁸ 60 years of collaboration between the Faculty of Medicine Siriraj Hospital and the Rockefeller Foundation (Bangkok: Siriraj Hospital, 1983), 9; Prapas Tangsangiamwisai, The Essay of Phra Ach Vidyagama (George MacFarland) Striving for Medical Education (Phranakhon: Rongphim Thai Khasem, 1967), 32.

⁹ Pitakpol Wisuth-umporn, “Thirteen decades of Siriraj Hospital and Faculty of Medicine Siriraj Hospital, 1888-2018: 130 Years Hospital of the Land”.

¹⁰ National Archives of Thailand, ST 59.1/3, “Regulations for the Royal Medical College [1-20 Nov 1907]”; National Archives of Thailand, ST 59/1, “Royal Medical College [25 Sep - 6 Jan 1900]”.

¹¹ This is a newly compiled important textbook of Thai traditional medicine, based on the official medical compendium, which is the ancient medical textbook. Please refer to Phraya Pisanuprasatwet (Khong), *Medicine for welfare* (Phatthayasat Songkro), Volumes 1 and 2, (Phranakhon: Rongphim Supakan Jamrun, 1907).

¹² Around 1904, the practice of Thai traditional medicine, both in hospitals and in medical schools, was discontinued.

¹³ National Archives of Thailand, ST 59/6, "Royal Medical College [3 Dec 1903 - 15 Aug 1906]."

¹⁴ Ministry of Public Health, *Royal Duties of Prince Rangsit Prayurasakdi Concerning Public Health and Medicine*, 5-6.

¹⁵ Apichat Satitniramai and Itsakul Unahakate, *Capital, Palace, Treasury and Feudalism: The Battlefield of Thai Socioeconomics and Democracy that Has Not Settled Down*, 269-70.

¹⁶ Royal Thai Government Gazette, "Military Conscriptions Act in Rattanakosin Era 124" (Volume 22, Page 513, 3 September 1909).

¹⁷ Royal Thai Government Gazette, "Proclamation Amendment to Military Conscriptions Act Rattanakosin Era 124, section 13-14" (Volume 27, Part 0, Page 140, 15 January 1910).

¹⁸ Royal Thai Government Gazette, "Except for Phat Cheloëysak from temporary military conscription" (Volume 27, Page 90, 1 January 1910).

¹⁹ Royal Thai Government Gazette, "Military Conscriptions Act in B.E.2460 (1917)" (Volume 34, Page 259, 27 June 1917).

²⁰ Hfocus, "Rockefeller Foundation and the Thai Public Health System," Hfocus, 26 January 2015, <https://www.hfocus.org/content/2015/01/9155>.

²¹ Victor Heiser, *An American Doctor's Odyssey: Adventures in Forty-Five Countries* (New York: W.W. Norton, 1936), 482.

²² Davisakd Puaksom, *Infectious Diseases, Body, and Medicalizing State: History of Medicine in Modern Thai Society*, 183-84.

²³ Tongchan Hongladarom, "The Development of Medical Education in Thailand," *Chula Med J* 32, no. 4 (April 1988): 320.

²⁴ Well-known professor including Prof. Dr. Aller Gustin Ellis and Prof. Dr. Edgar Davidson Congdon

²⁵ Davisakd Puaksom, *Infectious Diseases, Body, and Medicalizing State: History of Medicine in Modern Thai Society*, 195-96.; 60 years of collaboration between the Faculty of Medicine Siriraj Hospital and the Rockefeller Foundation, 9

²⁶ National Archives of Thailand, (2) SR0201.27/4, "Dr. Ellis Inquires About the Establishment of Medical Schools in the Department of Public Health (Or the Establishment of Medical Schools) (23 Dec 1932 - 17 Nov 1953)."

²⁷ Chatchai Muksong, "The history of medicine and public health in Thailand", 353–54.

²⁸ Nopphanat Anuphongphat et al., *Roi Wela: A Journey Through the History of Health*, 135.

²⁹ National Archives of Thailand, ST 8/74 Box 2, "Phraya Maha Thep Requests Nai Tee, a Physician to Be Royal Physician Resides in Monthon Nakhon Chai Si."; National Archives of Thailand, ST 8/45 Box 2, "Request to Send Doctors to Treat Patients in Krung Kao"; National Archives of Thailand, ST 8/170 Box 5, "Sending Nai Ek, a Physician to Serve in Rayong Province."

³⁰ National Archives of Thailand, ST 8/821 Box.8, "the Ministry of Interior inform Mueang and Monthons they could request a doctor through the Ministry of Interior. [21 Jul - 6 Aug 1908]."

³¹ National Archives of Thailand, ST 8/85 Box 3, "Phraya Norawit Rachakit Requests two Physicians to Serve in Monthon Payap and receives Nai Jam to reside in Nakorn Lamphu, Nai Maen resides in Nakorn Lampang [11 Jun 1901 - 20 Dec 1902]."

³² Yuwadee Tapaneeyakorn, "The evolution of Thai medicine from its beginning until the end of the reign of King Chulalongkorn," Master's Thesis, History Department, Faculty of Arts, Chulalongkorn University, 1979, 241-243.

³³ Pensri Kaweewongprasert, "The Role of the State in Public Health Issues (1782 - Post-Political Transformation 1932)," p. 68.

³⁴ National Archives of Thailand, ST 169 Box 5, "Registration of Mor Chaleoysak [3 Jun - 22 Jul 1905]."

³⁵ Weerawat Amphansook, "Book of Medicine for welfare (Phatthayasat Songkro): Local Wisdom Heritage," *RSU Library Journal* 2, Vol. 5 (Jul. - Dec. 2542): 61-75.

³⁶ Yuwadee Tapaneeyakorn, "The evolution of Thai medicine from its beginning until the end of the reign of King Chulalongkorn", 52-53.

³⁷ National Archives of Thailand, ST 8/177 Box 5, "Sending Physicians to Chaiyaphum and Buri Ram Provinces in 1905 [31 Aug - 3 Oct 1905]."

³⁸ National Archives of Thailand, ST 59/16, "Inquiring Phra Pisanuprasatwet Whether Thai Medical Students Will Apply for Governmental Service [6 Dec 1907]."; National Archives of Thailand, ST 8.2K /18, "Considering the Establishment of a Fever Hospital [17 Jan 1906]."

³⁹ Yuwadee Tapaneeyakorn, "The evolution of Thai medicine from its beginning until the end of the reign of King Chulalongkorn", 243-244.

⁴⁰ National Archives of Thailand, ST 8/293 Box 8, "Various Monthons Send Lists of Physicians [3-14 Jan 1908]."

⁴¹ Damrong Rajanubhab, *Historical Anecdotes*, 271-272.

⁴² Borirak Vechakarn (Borirak) et al, *Public Health and Public Administration*, 246-248.

⁴³ National Archives of Thailand, ST 59/1, "Monthon Nakhon Sawan Requests Regulations for Appointing Tambon Doctors [19 Nov - 29 Dec 1909]."

⁴⁴ Borirak Vechakarn (Borirak) et al, Public Health and Public Administration, 248-250.

⁴⁵ Royal Thai Government Gazette, "Royal Medical Proclamation, 1923" (Volume 40, Part 2, Page 136, 16 Nov. 1923).

⁴⁶ History of Thai Medicine and Public Health, Bangkok: Medical Council, 2020, 234.

⁴⁷ Krasuang Thammakan (The Ministry of Education) was renamed Krasuang Sueksathikan in 1919 and changed back to Krasuang Thammakan in 1926. It was renamed Krasuang Sueksathikan again in 1941 and remains so to the present.

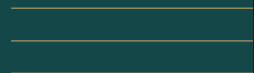
⁴⁸ Davisakd Puaksom, Infectious Diseases, Body, and Medicalizing State: History of Medicine in Modern Thai Society, 198.

⁴⁹ History of Thai Medicine and Public Health, 250-260.



The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868-2002

Siam Revolution 1932:
Change in Public Health Work
(1932-1957)



วันที่ ๒๗ พฤศจิกายน เป็นวัน สาธารณสุข



Figure 23 Poster advocating for public health care in residential areas on World Health Day.

Source: National Archives, MT 0201.2.1.10/15 (12), Subject: World Health Day, Year 1950.

The 1932 Siamese Revolution, or the transformation from the absolute monarchy under the reign of King to a democratic rule with the king as a constitutional figurehead, is considered to have had significant and far-reaching effects on the political framework of the Siamese state. The fundamental principles of democracy had a substantial influence on the structure of the healthcare system. **Simultaneously, public health itself had implications for the overall atmosphere and direction of politics, to the extent that it can be said that the post-1932 era of public health in Siam serves as a crucial example illustrating that changes in the field of public health are both a “cause” and an “effect” of changes in politics, economics, and societal culture.**

Governing structure after 1932 and its “outcomes” in public health

Starting from the year 1933, the People’s Party aimed to instill reverence for the constitutional regime among the citizens. As a result, they organized the first general election in November to bring representatives into the parliamentary system, along with providing opportunities for checks and balances and comprehensive government oversight.¹ Phraya Phahonphonphayahasena, one of the architects of the Siamese revolution and serving as the Chairman of the People’s Committee (or Prime Minister at that time), established a committee to draft the “Municipal Regulation Act of 1933.”² The purpose of this was twofold. Firstly, it aimed to establish municipalities as local governing units that served as central hubs for the decentralization of power to the regions.³ It is said that Mr. Pridi Phanomyong, one of the members of the People’s Committee, drew inspiration from the governance structure of France, which was deemed suitable for the era. This is because a decentralized form of governance promotes citizens’ understanding of the constitutional monarchy in a democratic context. This was due to the increased emphasis on local self-governance, thus encouraging citizens’ involvement in the democratic system.⁴ Therefore, a governance structure was established, divided into three main components: central governance, regional governance, and local governance. For local governance, it was designated into municipalities, sub-district municipalities, and sub-district administrative organizations, differentiated based on population density and geographical size.⁵ Establishing municipalities to be present throughout all areas was a way of enhancing the role of local governance more than that of regional governance. Additionally, it assigned regional administrative centers with responsibilities related to judiciary, maintaining public order (police), and election centers only⁶

The second objective is to have municipalities serve as new local governing units, replacing the sanitation system (*Sukhaphiban*) that was in place during the absolute monarchy era. In the old governance structure, the “Sukhaphiban” had the responsibility of investigating and controlling diseases and disease prevention, maintaining cleanliness in various areas such as markets, water supply, bathing areas, sewage, roads,

public toilets, and waste disposal.⁷ However, in practice, the public health aspect of the Sukhaphiban system remained largely focused on “nurturing” the population through the authority of central representatives (under the Sukhaphiban committee). The majority of power still resided within the Ministry of Interior⁸ This led to a lack of direct authority to effectively manage and address various issues. Sometimes, it might have been possible to handle certain matters temporarily. Therefore, the establishment of municipalities not only brought about changes in the political dimension, but also significantly affected the scope of their responsibilities. If we examine the duties outlined in the Municipal Act of 1933, it becomes evident that the responsibilities of municipalities were more directly related to public health missions, encompassing a broader range of tasks that were once part of the Sukhaphiban’s responsibilities. For instance, general public health management and providing potable water for consumption were transformed into primary tasks of municipalities, and these are areas of great importance. When considering the scope of responsibilities specified in the Municipal Act of 1933, it becomes clear that the responsibilities of municipalities were more directly tied to public health tasks, and these responsibilities are now broader and more encompassing than before. For example, responsibilities such as general public health management and providing potable water for consumption shifted to become top-tier duties. This shift in responsibilities applied to municipalities at all levels: City municipalities, town municipalities, and sub-district (*Tambon*) municipalities. However, for city municipalities, due to their larger population, had additional duties concerning healthcare services, as stated in Article 52. City municipalities must *“establish and maintain public halls and hospitals, provide and maintain maternity and infant welfare services, provide and maintain services for the care of the sick, establish and maintain cemeteries, provide and maintain public sports and physical education facilities.”*⁹ This allocation of responsibilities by the state reflected the growing importance of the public health dimension within city municipalities. These municipalities served as pivotal centers for governance and economic exchange, emphasizing the roles of local officials (at the municipal level) in managing public health for the population and within their jurisdiction. This emphasized compliance with the regulations and guidelines set forth by the laws, under the principle of a democratic regime where the government is responsible for the welfare of all citizens.

Furthermore, the Municipal Regulation Act of 1933 also paved the way for the “Public Health Act of 1934,”¹⁰ which was to be enforced in the regional areas where establishments were established in the form of municipalities (as well as provincial administrative organizations). Along with the “Communicable Diseases Act of 1934”¹¹ both statutes help establish a more extensive and distinct role for local officials involved in public health-related tasks within the regional entities formed as municipalities as evident in the provisions of the Public Health Act of 1934. Certain clauses of this act delineate the responsibilities of public health officials (representatives from the central government), who were to work in tandem with local municipal officials. Local officials held significant responsibilities in ensuring that public health was in line with the principles outlined by the state regulations.”¹² Meanwhile, under Article 7 of the Communi-

cable Diseases Act of 1934, substantial authority was granted to public health officials for the comprehensive management of “preventing and controlling diseases” themselves. If there was reason to suspect or an occurrence of a contagious disease, there was no necessity to refer the matter to the municipal council. Additionally, according to Article 10, the provincial governor had the power to declare and designate “contagion zones” in any area if a dangerous contagious disease emerged.¹³ Although subsequently, the Communicable Diseases Act (2nd version) of 1936 was enforced,¹⁴ however, the essential content did not deviate significantly from the original version.

At that time, public health affairs were deemed highly significant, on par with other responsibilities. The state considered public health to be a matter directly linked to the lives and existence of the population. As noted by Dr. Sem Pringpuangkeo, “After the change in governance, around 1942, municipal affairs received support and underwent another revival....”¹⁵ Furthermore, it was evident that the state’s intention was to incorporate democratic principles into the design of public health initiatives. Just under a month after the revolution, a committee was formed to prepare a public health project proposal for presentation to the National Assembly. This action was taken as they believed that *“our current approach to public health is not adequately aligned with the times.”*¹⁶ Subsequently, a series of continuous public health policies and projects were implemented. These included initiatives related to cleanliness and waste management (August 1933), metropolitan hygiene and mental illness control projects (December 1935), maternal and child welfare programs along with school hygiene (October 1936),¹⁷ National food promotion project (2481)¹⁸ and a project to promote consumption of a traditional Thai diet (1938).¹⁹ Additionally, there were indications from the government of its intent to extend healthcare services to regional areas by establishing hospitals and health centers in various provinces, commonly referred to as “flagship hospital policy” (*Nayobai Auad Thong*)

Background before the establishment of flagship (uat thong) hospital

It cannot be denied that public health initiatives during the era of the Absolute Monarchy were a crucial foundation that led to the advancement of healthcare services in subsequent periods. However, due to various factors and political, economic, and socio-cultural contexts, there were differences in the approach to health issues between the time before 1932 and the post-1932 era. These differences influenced the evolution of hospital construction and healthcare facilities over time.

Before 1932 (driven by political, social, and economic factors), there was a rapid expansion of various types of hospitals and healthcare facilities. The centralization of state power during the Absolute Monarchy

prompted the government to pay more attention to healthcare aspects. For example, various transportation systems were developed, and regional administrative units, known as Monthon and Thesaphiban, were established throughout the kingdom.²⁰ As a result, there were changes in geographical dimensions and governance structures, leading to the emergence of administrative centers, railway stations, and modern cities. Many areas in the regions transformed into hubs of political power and economic activities. However, the economic and political context during the era of the Absolute Monarchy did not lead to a significant awakening of a capitalist system. Even though Siam's exports became more connected to the global economy through networks of international trade, considering the mode of production, it wasn't until around the year 1957 that Thailand began to transition fully into an industrial production mode. Therefore, before 1957, cottage industries remained the primary occupation for most Thais.²¹ Because of this, the status of the populace did not inherently facilitate the acceleration of production factors or lead to the accumulation of wealth through a state treasury system that would be sufficient for the establishment and expansion of hospitals. At that time, constructing hospitals was not considered a top priority that the state "must do." If they were built, it was often as tools to control and facilitate governance. On various occasions, hospitals were constructed based on Buddhist beliefs in performing acts of merit or due to urgent factors like epidemic outbreaks of infectious disease.

Nonetheless, the significant overarching issue of epidemic diseases was a driving force for changes in the worldview that had significant implications for public health. While it is true that endemic diseases, such as fever (of unknown origin at the time), had long been prevalent in tropical rainforest regions, the ways of thinking and coping with illnesses in the past differed significantly from the periods before and after 1932. During the early Rattanakosin Era, people believed that diseases were a part of a certain supernatural phenomenon caused by spirits. Remedying the causes of these occurrences was achieved through ritualistic processes rooted in beliefs and religion, alongside local medical practices. However, the influence of Western medicine gradually took hold, which led the Siamese elites to adapt to the changing trends. For instance, they began accepting concepts like "contagion" (*Khwam-ai-pit* or poison gas and germ theory) and "hygiene," which were influenced by Western environmentalism during the Reign of King Rama IV, followed by the "Pasteurian" perspective during the Reign of King Rama V, which attributed diseases to germs and their impact on explaining disease etiology.²² Furthermore, there were cultural dimensions where Siam's elite found themselves in a period that required them to navigate their "civilization" against the influence of Western powers. This was evident in the way they grappled with opposing concepts, such as between refinement and primitiveness, cleanliness and filth, science and natural phenomena, among other dichotomies. For instance, during the Reign of King Rama V, there was criticism directed towards the "Arphatphinat" ceremony. This was a ritualistic practice involving chanting and sprinkling holy water to exorcise malevolent spirits believed to be the cause of severe illnesses. It was criticized with the argument that *"this royal ritual is conducted... with a misconception that the disease is*

*caused by spirits... and thus, attempting to exorcise spirits is a misunderstanding because this disease is not caused by spirits but rather by the atmosphere, weather, and the behaviors associated with human consumption – factors that spirits cannot dispel. Therefore, the royal ritual has no useful purpose.*²³

These words indicate a rejection of the belief in spirits that had an impact on illnesses, and a shift towards using modern medical methods instead. This change aligned with the increasing application of scientific explanations. However, scientific progress during that time was considered slow. State institutions dedicated to scientific pursuits were still limited to the level of elemental separation, lacking substantial progress.²⁴

After 1932, purescience (*Withayasat Borisut*) gradually became a significant tool for the economic development of the leading class in the new era. This can be understood from the statement by Tua Laphanukrom, one of the members of the military civilian group and the director-general of the Science Department at that time. His words reflected the emerging awareness of the importance of science in national development, stating that *"prosperous nations have heavily invested in scientific research, as it has been said that various research efforts give birth to industries... If we experience industrial advancement, the country's financial status will undoubtedly become more secure."*²⁵ Therefore, during the period when Field Marshal Pibulsongkram rose to power, it became evident that scientific activities gradually grew in importance in response to economic policies aimed at promoting the use of domestically produced consumer goods, following the 5th version of the People's Constitution by General Por. Meanwhile, the role of the Science Department (developed from the Institute of Elements) led by Tua Laphanukrom also expanded. This was evident from the promotion of pharmaceutical work and the establishment of pharmaceutical factories, aimed at starting the production of medicine as a state industry to replace imports during World War II.

Furthermore, the expansion of urban areas, economy, and issues related to epidemics led the Siamese elite to establish various government departments to oversee public utilities and health. This was intended to maintain control and order in each area, starting with urban areas. This marked the starting point where "public health" became part of the "governance" mission of the Siamese elite during the era of the Absolute Monarchy. Therefore, it's not surprising that the Department of Public Health was placed under the Ministry of Interior, responsible for direct governance. In some cases, during that era, a physician assigned to a provincial hospital would even be referred to as "Physician in Charge of the Hospital" (*Nai Phat Phu Pokkrong Rong Phayaban*) before evolving into the role of a hospital director, as is the case today.²⁶

When public health became a part of governance efforts since the decade following 1887, it had a significant impact on the way “hospitals” were conceptualized and established throughout the country, continuing into the post-1932 era. Many of the governing officials within the Ministry of Interior had to collaborate closely with public health officials. This was due to the nature of the work being closely intertwined, including aspects like determining the size (number of hospital beds) and the authority of hospitals. These aspects extended to regional and local levels in accordance with the governance structure of the Ministry of Interior (such as provinces, districts, and sub-districts). These elements have become an important legacy with both positive and negative implications for budget allocation and manpower planning in the subsequent years. When viewed from a governance perspective, it was understood that provincial hospitals must have larger bed capacities and a greater number of personnel compared to district and sub-district levels. This is because they have responsibilities for public health care coverage throughout the province. Consequently, it is essential for provincial hospitals to receive the highest budget allocation due to their extensive responsibilities.²⁷ It can be said that the political, economic, and socio-cultural changes that occurred between the Absolute Monarchy under the reign of King Rama VII and the Constitutional Monarchy under the Constitution led to different directions in the development of state healthcare initiatives. For instance, the expansion of regional hospitals after 1932 was partly a result of economic growth. State-sponsored healthcare management was one reflection of the mechanisms within the expanding capitalist system in Thai society. This was because labor was a crucial factor in production within the economic system. The act of “creating” or “repairing” the body to maximize productivity is considered imperative in order to generate “surplus value” in the country’s economy.

The flagship hospitals: A cause of national prosperity

After 1932, a significant transformation occurred, wherein the state’s ideology aimed to turn public health into a tool for nation-building and industrial development. This was particularly emphasized during the tenure of Field Marshal Pibulsongkram as the Prime Minister in his first term (1938-44).²⁸ For example, there was a policy to transform people of diverse ethnicities into mainstream Thais (Thai-ization) as a strategy to increase the workforce for national development. The policy of promoting public health became a crucial political ideology that aimed to ensure the citizens were physically strong, turning them into tools of the state to lead the nation to economic success. There was also investment in foundational infrastructure such as “hospital construction” to stimulate and drive industrial development. In this context, the government adopted a strategy of refining and extending contrary ideologies that were rooted in the era of the Absolute Monarchy. This involved reconciling concepts such as “cleanliness vs. dirtiness,” “healthiness vs. unhealthiness,” and “progress vs. regression” with the government’s nation-building projects, as evidenced in the “Phramuan Watthanatham Haeng Chat” (Code of National Culture).²⁹ Regulations regarding food consumption were decreed, such as the requirement to use forks and spoons

instead of eating with hands, the prohibition of betel nut chewing and spitting betel nut in public places, toothbrushing, or dress codes for hygiene, such as wearing long-sleeved shirts, shoes, sun protection hats, and dust masks. All of these were connected to promoting public health, disease prevention, and maintaining cleanliness. Similarly, the construction and opening of new hospitals or health centers in this era became symbols of the grand national development project. This showcased the utilization of “progress in public health” as a cultural tool to demonstrate Thailand’s identity, nationality, and ethnicity.³⁰ Healthcare facilities were seen as a gesture of honor to be displayed in the eyes of the Western world.³¹ As a result, the construction of hospitals and health centers began to shift from the realm of “charitable acts” in the past to “services” that the state must provide to the “Thai people” who are living or in the process of growing as a significant number of citizens. This was aimed at harnessing their potential to build a grand and prosperous “Thai nation” with pride and significance.

In this way, the “flagship hospital” became a noteworthy example reflecting the establishment of Thailand’s healthcare service system during a time when nationalistic sentiments were flourishing. It often involved creating healthcare facilities in the Thai border regions adjacent to French-controlled Indochina (present-day Laos) as a first step. Examples include Ubon Ratchathani, Nong Khai, Nakhon Phanom, and Chiang Rai. Although the political atmosphere after the change of governance was quite challenging due to the nationalistic fervor, the early Siamese governments proceeded cautiously. This was linked to one of the main tenets of the “Six Principles:³² To uphold the independence of the nation’s sovereignty.” Consequently, the urgent task was to address the unequal treaties that disadvantaged Siam’s sovereignty in favor of Western powers, in order to expedite the transformation of Siam into a fully sovereign state. Siam thus needed to continue negotiating with foreign powers, particularly with France, which had ongoing disputes dating back to the era of the Absolute Monarchy. Therefore, even though Nong Khai Hospital was a symbol of showcasing Siam’s strength in the heart of the Laotian Vientiane, a crucial seat of French power, the local authorities simultaneously had to maintain a positive relationship with France while upholding good relations within its own administration.³³

Being a governor (i.e., provincial governor) in the border areas adjacent to the French-controlled territories during that era necessitated being a special envoy responsible for diplomatic affairs to simultaneously manage bi-lateral affairs.³⁴ Coupled with the fact that these governors were individuals with direct experience of the local situation more than the central administration, the establishment of borderland hospitals they pushed for was a response aligned with the ongoing political events. This was evident, for instance, when Thailand successfully reclaimed territory from France for a brief period during that time.³⁵ There was an expedited effort to establish hospitals in these towns. For example, in the case of Kengtung (in Shan State of then Burma), hospital construction/naming was prompted by military forces in 1942.³⁶ Similarly, there were instances where hospital names were changed, as in the case of the city of Lan Chang,

with a policy to “choose names of individuals who participated in the Vientiane and Luang Prabang campaigns... to showcase Thailand’s care and protection toward Luang Prabang.” Eventually, the hospital was named “Surasak Montri Hospital” in Lan Chang Province, which is the name of a military leader who had successfully subdued Haw Rebellion in Luang Prabang.³⁷

Therefore, positioning hospitals was not merely a random or haphazard action. It relied on factors accelerated by political circumstances and collaboration from all sides in the creation process. This was because the government itself had just recovered from the economic downturn in the early 1920s, which led the new post-1932 government to seek avenues for economic recovery and stability. Additionally, the disadvantageous terms of trade agreements and the leading role of Chinese traders also contributed to the fact that, between 1932 and 1941, the economic situation had not significantly improved. Despite attempts to accumulate budget through the promotion of the socialist economic system by the state.³⁸ The “flagship hospitals” were not always established by allocating full state budgets as initially intended for the specific locations. In some instances, the establishment of hospitals was the result of joint fundraising efforts between the government and private sector, in the form of fundraising or charitable donations. For example, in the case of Chiangrai Prachanukroh Hospital and Ubon Ratchathani Provincial Hospital (now known as Sunpasitthiprasong Hospital), donations of land were made by influential merchants and high-ranking officials. Similarly, there were cases where fundraising involved contributions from both the state and the private sector, such as with Nong Khai and Chiangrai Prachanukroh Hospitals.³⁹

Origins of the maintenance of government services budget (Ngoen Bamrung)

An interesting observation is the limitation of the state in allocating budgets for building hospitals. This has provided opportunities for local governors to become key players in utilizing the channels of charity funds to coordinate and pool resources from various sectors to support ongoing projects. Furthermore, in a system lacking oversight and monitoring of operations, provincial governors (administrators) had relatively more freedom in procuring funding from different sources. In cases like Phra Pathom Thewa Phiban, where special funds beyond territorial budgets were sought (from municipalities and lottery proceeds), they were able to dance creatively to secure extra funds to build the Nong Khai Hospital, completed in 1935. This demonstrates the significance of the image bestowed by these governors upon the hospitals. They emphasized their commitment by presenting large images of themselves as a memento for the hospital, accompanied by inscriptions underscoring the message that *“this image is dedicated to Nong Khai Hospital, to inform the people of Nong Khai Province that creating a hospital required the owner of this image to endure emotional trauma and hardship”*.⁴⁰

In this regard, the persistent issue of expanding healthcare services in Nong Khai Province has roots that date back even before the construction of the provincial hospital. This is reflected through the inquiries posed by Khun Worasit Darunwet, a member of the Nong Khai Provincial Assembly, during the regular assembly meeting of 1933-1934. In the first year, the inquiry was about the shortage of physicians in the area. Despite having a population of over a hundred thousand in Nong Khai, the state allocated only one royal physician for the entire province. Subsequently, Phraya Phahonphonphayuhasena, a high-ranking official, pointed out that, at that time, the state was lacking both “funds” and “certified physicians” to allocate universally. As a preliminary solution, it was considered appropriate to provide military medics with proper training to act as assistant physicians before addressing the situation properly.⁴¹ However, during the subsequent regular assembly meeting of 1934, the same representatives posed inquiries to explain the progress of the government’s commitments and how far they had been implemented. The response from Luang Praditmanutham (Pridi Banomyong), who was the Minister of the Interior at the time, clarified that *“the government will establish a hospital in Nong Khai Province, and construction will begin this year. Additionally, the government has allocated funds to increase physicians and assistants to operate the hospital in the future.”*⁴² It can be observed that, even though the government declared a policy to expand hospitals in every province, in reality, this did not result in substantial progress. This is because the construction and establishment of hospitals, or even secondary healthcare facilities, often had to await the government’s deliberation and consideration.⁴³ Or, in another sense, it means “waiting for financial and fiscal readiness” in the future.

The inadequacy of the services is also reflected through the account of Dr. Surin Prompitak, the only provincial physician of Nong Khai at that time. He described that in the period before the government initiated the policy of establishing hospitals in the province, the initial working place had *“no name yet because it was a rented private house... equipped with only a medical cabinet and medical instruments... the medical instruments included old and rusted scalpels, 2-3 of them, and 3-4 old and rusted blood pressure cuffs. Besides, there were old and incomplete sets of weighing scales for medicines and some missing parts.”*⁴⁴ Later, it was found that there were few people coming to receive services due to the location factor. Therefore, they moved and rented a two-story private building to establish a clinic, which turned out to be more popular among the public. When Nong Khai Hospital opened in 1935, Dr. Surin Prompitak was appointed as the first hospital director.

Despite the inadequate budget for expanding the state’s healthcare system, this situation inadvertently encouraged the hospital to become one of the initial state institutions with its own financial autonomy and management. This was because the budget allocation process still relied on philanthropic donations from the private sector, and in some areas, the state partly supported the process, reaching the final stages where hospitals had their own fee collection mechanisms. Meanwhile, the government also aimed to

decentralize power to local municipalities by managing healthcare institutions like hospitals or health centers under the local administrative structure. In this regard, medical institutions played a role in establishing societal relationships, involving civil servants, merchants, and the public in the development of healthcare services. The complex interplay of these relationships resulted in hospital construction extending beyond merely serving as facilities for medical treatment, but rather as institutions deeply integrated into the fabric of society.

The life of Dr. Sem Pringpuangkeo reflects the unique characteristics of the hospital as mentioned in various dimensions. In the cultural aspect, Nidhi Eoseewong elaborated that hospitals are spaces that *"subdue and persuade citizens to accept the authority of the knowledgeable."*⁴⁵ For instance, Dr. Sem, during his time as a physician at Nakhon Sawan Municipal Hospital, had enough freedom to attract local residents to assist him as medical assistants. The knowledgeable individuals served as intermediaries to pass on their knowledge to those less informed. Similarly, while working at Chiangrai Prachanukroh Hospital, Dr. Sem engaged with the villagers as someone who helped alleviate their suffering. This continued until the point where, due to limited resources, people willingly volunteered to work with him, even if the compensation was not at full rate. This was because the community had trust and faith in Dr. Sem.⁴⁶



Figure 24 Image of Dr. Sem Pringpuangkeo

Source: National Archives of Public Health, (13) B.NEG S.2.1-38.28 No.21 roll 1, Prime Minister and Minister of Public Health inaugurated Bua Yai District Hospital, Nakhon Ratchasima on 23 March 1983 (Photo by Boonlerd)

In the realm of social dimensions, it is of no small importance that hospitals were a societal space where diverse groups of people interact. This fostered relationships among individuals within the community that could be observed widely during the hospital construction period. For instance, such interactions were exemplified by the likes of a Chinese merchant who generously donated land for the construction of Chiangrai Prachanukroh Hospital. The push from high-ranking government officials to establish a flagship hospital in the Northern region, as well as the concerted efforts of the residents “to collectively fundraise” (Ruam Ngoen) for Chiangrai Prachanukroh Hospital, all contributing to the transformation of hospitals into public spaces that instilled a sense of ownership among all segments of society. Consequently, every aspect of the hospital became a source collective pride. Everyone had to collaborate to economize on resources for care and treatment, substituting for the functions of hospitals collectively.⁴⁷ It’s not surprising at all that Dr. Sem utilized the hospital as a negotiating platform with the government in the context of “hospital funds accumulation,” eventually leading to the establishment of the “ maintenance budget” (*Ngoen Bamrung*).

In general, a ‘maintenance budget’ refers to funds that hospitals or healthcare units receive from providing services, apart from managing expenses and revenues obtained from the government budget. Healthcare units can retain these funds without returning them to the treasury. The origins of this concept can be traced back to a specific situation during the acceleration of the flagship hospital policy, such as the case of Chiangrai Prachanukroh Hospital. In this scenario, when medical personnel like Dr. Sem (around 1936) took up the responsibility of overseeing the hospital in Chiang Rai province, they found that there wasn’t even a hospital facility available for patient care in the area. This compelled them to initiate fundraising efforts to construct hospitals and gather money for healthcare treatment that the local residents could afford, to subsequently sustain the hospital. As recounted by Dr. Wichai Chokwiwat, the atmosphere at that time can be described as follows:

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“When [Dr. Sem] arrived, there was no hospital, no medicine. We relied on the generosity of the people, as in the case of Chiangrai Prachanukroh Hospital. The people of Chiang Rai contributed a little each to build the hospital. Once the hospital was built, and we had no medicine, we asked for donations to buy medicine for patient care. When we received money for treatment from patients, the central government saw that there was revenue and demanded that the money be returned to the state treasury... Dr. Sem pointed out to the Comptroller General, who was Phraya Chaiyot Sombut, that the state did not provide any funds. Instead of imposing sanctions, Phraya Chaiyot Sombut told us to continue in this manner and issued regulations to support the maintenance budget.”⁴⁸

”

The aforementioned circumstances became the foundation for internal management skills within hospitals, particularly in the area of “budget management,” or the creation of the maintenance fund system stemming from the investment efforts of local residents in the region. This was done to ensure confidence that hospitals would be developed by the people, for the benefit of the people themselves. Chiangrai Prachanukroh Hospital, in particular, became a successful example during the era of constructing hospitals in all provinces according to the “flagship hospital policy”.

Furthermore, as time passed and the political climate shifted towards an intense nationalist sentiment, driven by the government's policy of reclaiming land from France, leading to the Indochina Crisis (1940-1941), Thailand soon engaged in conflict with Indochina. The Thai government took the initiative of attacking Indochina, aiming to regain the territories previously lost to France. During this time, medical supplies, medical equipment, and construction materials saw significant price hikes due to the ongoing conflict, which resulted in nearly exhausting imports. Consequently, this led to a temporary suspension of hospital expansion projects in 1943.⁴⁹

The concept of building flagship hospitals rapidly dissipated after the end of the World War II, along with the diminishing role of The People's Party (*Khana Ratsadon*). The continuous aftermath of WWII had various impacts, including the political context of neighboring countries transitioning from the post-colonial era, gradually shedding the influence of Western colonial powers. This led to the emergence of a new form of conflict between Communist and Capitalist ideologies.

During the tenure of Prime Minister Pridi Banomyong (March-August 1946), a clear proposal was made for each province to raise funds independently through the establishment of public health organizations. This was to ensure the continuation of the nationwide hospital construction effort. This was driven by the fact that the post-war economic downturn had weakened the state treasury's stability. “It was recognized that waiting solely for state budget allocations would not lead to comprehensive success in a timely manner. The explicit statement was that provinces and districts would need to pool resources to complement the support provided by the government. In this context, it was crucial to understand that waiting for state budget allocations alone was not a viable solution.”⁵⁰ During that time (July 1947), there were as many as 41 provinces that still lacked hospitals (under the Department of Medical Services).

However, in the end, only two hospitals were successfully established: Sukhothai Hospital and the Chonburi Hospital.⁵¹ Compounded by the economic downturn, the actual income of municipalities was adversely affected, leading to a deficit until the year 1951.⁵² When the municipalities faced financial difficulties to the extent that they couldn't generate sufficient income to cover expenses, it led to the transfer of hospitals under municipal jurisdiction that were “deteriorating and in poor condition.” As a result,

these hospitals couldn't fully provide care to the public as they had become the responsibility of the central government's Ministry of Public Health⁵³ The organizations related to public health began to exhibit a more centralized nature, along with a decline in the role of municipalities. This was a consequence of the central authority extending its reach to both urban and rural areas.⁵⁴

Even though budget constraints were a significant obstacle during the period from 1946 to 1951, starting from 1951, there emerged a renewed expansion of provincial hospitals. Part of this expansion was due to the determination of Field Marshal Phibulsongkram, led by Lt.Col. Dr. Nit Wetchawisit (Luang Nit Wetchawisit), the Director-General of the Department of Medical Services at the time. Together with Dr. Sem, who was recalled to Bangkok, they played a crucial role in reviving the role of today Rajavithi Hospital.⁵⁵ During this time, the United States emerged as a supporter, providing both budgetary assistance and technical support to the Thai Ministry of Public Health (MOPH). This support was influenced by economic and political factors under the shadow of the Cold War that was beginning to unfold. With both internal and external pressures at play, it led to the rapid expansion of provincial hospitals, ultimately achieving the goal of establishing a hospital in every province before 1957.⁵⁶

It can be said that this era marked the 'golden age' of the Department of Medical Services. Dr. Nit Wetchawisit recorded the situation between 1950-56, stating that that *"over the span of 6 years, the activities of the Department of Medical Services progressed significantly... Every province had its own provincial hospital, with 10 provinces having hospitals when the Department of Medical Services was established in 1942. Some provinces had district hospitals... Every hospital had physicians who had completed their education abroad."*⁵⁷ At the same time, there was also a significant acceleration in the production of healthcare workers to fulfil various roles such as vaccination, immunization, childbirth assistance, and treatment of various diseases for communities in many areas of the country. This became a crucial factor in addressing issues like infant mortality, smallpox, tuberculosis, tetanus, diphtheria, and polio, gradually reducing or eliminating them from Thai society⁵⁸



In sum, as Thailand entered the post-1932 revolution era, the concept of public health transformed into a "state duty" that needed to be performed. During this time, knowledge about public health advanced, solidifying the foundation of political power and building citizens' physical strength to support industrialization. The flagship hospitals held significant importance as they represented cultural advancement promoted by the state. The initiative to establish hospitals in provincial areas began along the border regions with neighboring countries, which were mostly still under colonization. Expanding

healthcare services took place in provinces such as Nong Khai, Ubon Ratchathani, and Chiang Rai. The medical personnel actively embraced these policies. However, due to budget constraints, the policy of building hospitals in every province saw success in only a few.

Faced with economic stagnation after World War II and the impending threat of communism during the late 1940s, the government, influenced by both domestic and international factors, accelerated hospital construction and reconstruction efforts to combat potential challenges. The urgency and efficiency of local initiatives led the central government to become more involved in healthcare management. Alongside this, the government began to see the need to expedite rural development as a strategic response to challenges, considering it a front line or a “barricade” to counter threats. This era marked a time of significant expansion in various sectors, including education, industry, public utilities, and particularly public health. Therefore, the opening up of extensive rural areas was closely tied to global political circumstances, particularly the Cold War and the close relationship between the Thai government and the United States during the early years of the decade following 1957, all of which were essential factors.

Chapter 3

¹ Charnvit Kasetsiri, *Political History of Thailand 1932-1957* (Bangkok: Social Science and Humanities Textbook Foundation, 2001), 168–70.

² This is equivalent to the year 1934 in the current calendar, as the start of the new year was counted from April 1st of each year until 1941, it was changed to January 1st until now see in Royal Thai Government Gazette, “Municipal Regulations Act, Buddhist Era 2476” (1933) (Volume 51, Page 82, April 24, 1933).

³ Pinyapan Potjanalawan, *Municipalities: Area, City, and Time: The Birth and Transformation in the First Three Decades of People's Democratic Municipalities in Urban Areas* (Bangkok: Siam, 2017), 45–50.

⁴ Suwassadee Photpun, “Municipalities and their Impact on Local Authority 1933-1957”, (Master's Thesis, History Department, Faculty of Arts, Chulalongkorn University, 2000), 48–54.

⁵ Subdistrict Municipality has fewer than 3,000 residents.

⁶ Municipal Municipality has 3,000 or more residents.

⁷ City Municipality has 30,000 or more residents.

⁸ Suwassadee Photpun, “Municipalities and their Impact on Local Authority 1933-1957,” 67-68.

⁹ Royal Thai Government Gazette, “Royal Regulation on the Sanitation Administration of Bangkok Metropolis, R.S.116”, (Volume 14, Part 34, Page 517, November 21, 1922).; Royal Thai Government Gazette, “Proclamation to Amend the Sanitation Administration Tax System of Talat Tha Chalom Municipality, Samut Sakhon”, (Volume 22, Part 51, Pages 1155-1156, March 18, 1925).; Royal Thai Government Gazette, “Royal Act on the Establishment of Sanitation Administration in Provincial zones, R.S.127”, (Volume 25, Part 51, Pages 668-673, September 13, 1908).

The sanitation administration in Siam began first time in Bangkok in 1897, followed by the sanitation administration of Talat Tha Chalom Municipality in Samut Sakhon, then extended to different regions.

¹⁰ Nattapoll Chaiching, “Prince Sakolworanakorn Worawan and Thai Municipality,” *King Prajadhipok's Institute Journal*, Vol. 17, No. 3 (2019): 107–8.

¹¹ Royal Thai Government Gazette, “Royal Decree on Municipal Regulations, 1934.” (Volume 51, Page 82, April 24, 1935).

¹² This is equivalent to the year 1935 in the current calendar. Royal Thai Government Gazette, “Royal Decree on Public Health, 1935” (Volume 52, Page 281, May 1, 1935).

¹³ This is equivalent to the year 1935 in the current calendar. Royal Thai Government Gazette, “Royal Decree on Contagious Diseases, 1935,” (Volume 52, Page 344, May 5, 1935).

¹⁴ Monrueathai Chaiwiset, *Social History: lavatories and sanitary in Thailand (1897-1997)* (Thammasat University, 1999), 259.

¹⁵ Royal Thai Government Gazette, “Royal Decree on Contagious Diseases, 1935.”

¹⁶ Royal Thai Government Gazette, “Royal Decree on Contagious Diseases (Version 2) 1937.” (Volume

53K, Page 1265, March 14, 1936).

¹⁷ National Archives of Public Health, (14) SB 1.1/1, "History of Nakhon Sawan Hospital in the time of Dr. Sem Pringpuangkeo, 1936-1937, written for inclusion in the book commemorating the opening of the new Nakhon Sawan Hospital [1967]."

¹⁸ National Archives of Thailand, (2) SR0201.27/1, "Committee to Plan Public Health (July 17, 1932)."

The committee to plan public health consists of Phra Chanwithiwet, Phra Chetsadavitikan, Luang Chalem Kamphiwet, Major Luang Sanit Raksat, Luang Praphan Phairatchaphak and Prayun Phamonmontri.

¹⁹ National Archives of Thailand, (2) SR0201.27/9, "Report of the Meeting of the Committee for Considering Public Health and Medicine (December 6, 1935-April 12, 1937)."

²⁰ National Archives of Thailand, (2) SR.0201.27/10, "National Nutrition Promotion Program (October 5-8, 1938)."

²¹ Yonghua Chua-yua-seng, "Medical Treatment, Hospitals, and Medicine," in Borirak Vechakarn (Borirak), Public Health and Public Welfare, 4-5.

²² The Thesaphiban Administrative Organization was a regional governance system used during the 5th reign until it was abolished in 1933.

²³ See more in Chatthip Nartsupha and Sompop Manarangsarn, Economic History of Thailand until 1941 (Bangkok: Thammasat University and Social Science and Humanities Textbook Foundation, 1984).

²⁴ See more in Davisakd Puaksom, Infectious Diseases, Body, and Medicalizing State: History of Medicine in Modern Thai Society (Bangkok: Illuminations Editions, 2018).

Louis Pasteur, the French chemist and microbiologist who formulated the principles of disease causation, rabies vaccine, immunology, and pasteurization.

²⁵ King Chulalongkorn, Royal Ceremonies of the Twelve Months, King Mongkut bestowed for the funeral of Princess Charoensri Chanamayu, year of Monkey 1920 (Bangkok: Rongphim Thai, 1920), 157.

²⁶ Sala Yaek That (a place for separate elements), later known as the Department of Science, during the era of the Siamese Absolute Monarchy, was situated within Royal Thai Mint Department and was responsible for chemical research and testing of various substances such as alcohol, poison, fertilizers, minerals, counterfeit silver, etc. Additionally, pharmaceutical work was also considered important, although medicines produced were mostly skin disease remedies and vitamin B, while the majority of other medicines were imported. For more details, see Memorial book for the Royal Cremation Ceremony of Dr. Tua Laphanukrom at Wat Thepsirintharawat on December 4, 1941 (Kan Phim Thai, 1941), 22–27.

²⁷ Memorial book for the Royal Cremation Ceremony of Dr. Tua Laphanukrom at Wat Thepsirintharawat on December 4, 1941 (Kan Phim Thai, 1941), 61.

²⁸ Santisuk Sophonsiri, Thai Physicians' Legacy for Future Generations: Life and Work of Professor Dr. Sem Pringpuangkeo (Bangkok: Society and Health Institute (SHI), Office of the permanent secretary, 2012), 76.

²⁹ The shift from size-based budget allocation to a capitation payment system under the Golden Card

scheme marked a structural reform related to the authority and responsibilities of the Ministry of Public Health, reflecting a significant change (further details will be discussed in subsequent sections).

³⁰ Stefan Hell, *Siam and the League of Nations: Modernisation, Sovereignty and Multilateral Diplomacy, 1920-1940, Thailand: Sirivatana Interprint Co., Ltd., 2010*, 156

³¹ Plaek Phibunsongkhram, *Collection of national culture* (Phranakhon: Government Public Relations Department, 1943), 67-86.

³² Plaek Phibunsongkhram, *Messages, Addresses and Speeches of the Prime Minister, and the Declaration of the Office of the Prime Minister on the National Day Celebration 1940* (Phranakhon: Government Public Relations Department, 1940), section kho, pages 26-27; Kongsakon Kawinraweeekun, "Constructing the Body of Thai Citizens during the Phibun Regime of 1938-1944" (Master's Thesis in Social Anthropology, Anthropology Department, Faculty of Social Sciences and Humanities, Thammasat University, Bangkok, 2002), pages 72-73."

³³ Weerasak Chansongsaeng, *One Standing Century: Sem Pringpuangkeo, A Model Physician with Ethical and Moral Dedication to Thai Society for a Century* (Chiang Rai: Bodin Kan Phim, 2011), p. 2-7; Nopphan-at Anuphongphat et al., *Roi Wela: A Journey Through the History of Health*, p. 240.

³⁴ The 6 Principles include: Principle of Sovereignty, Principle of national security, Principle of Equality of Rights, Principle of Freedom, Principle of Economy, and Principle of Education.

³⁵ Further reading from the history of Phra Pathumthewaphiban, Former Governor of Nong Khai Province in Pathumthewapiban (Yiam), *Lecture on: Governance Related to Religion* (Bangkok: Thai Watana Panich, 1959).

³⁶ Santisuk Sophonsiri, *Thai Physicians' Legacy for Future Generations: Life and Work of Professor Dr. Sem Pringpuangkeo*, p. 69.

³⁷ Thailand regained the territory of Luang Prabang on the right bank, the territory of Champasak directly opposite Pakse, and some of the territory of Cambodia in March 1941. It was later returned to France after the end of World War II.

³⁸ National Archives of Thailand, (2) SR0201.27.2/16, "Establishment of Ken Tung Municipal Hospital (20 Aug-10 Oct 1942)."

³⁹ National Archives of Thailand, (2) SR0201.27.2/17, "Surasakmontri Hospital, Lan Chang Province (2-22 Feb 1943)."

⁴⁰ For more information, see Phopan Uyyanon, *Economic History of Thailand* (Bangkok: Chulalongkorn University Printery, 2021).

See the history of Chiang Rai Prachanukroh Hospital at 'Chiang Rai Prachanukroh Hospital,' Accessed May 8, 2022, <https://www.crhospital.org/home/index1.php?group=1/>.; See the history of Sunpasitthiprasong Hospital (Ubon Ratchathani) at 'Sunpasitthiprasong Hospital,' Accessed May 8, 2022, <https://www.sunpasit.go.th/history.php/>.; See the history of Nong Khai Hospital at 'Nong Khai Hospital,' Accessed May 8,

2022, <https://www2.nkh.go.th/nkh/page/history.php/>."

⁴¹ Nong Khai Hospital, 'History of Nong Khai Hospital,' Accessed May 8, 2022, <https://www2.nkh.go.th/nkh/page/history.php/>.

⁴² Tanwa Wongsangiam, "The Thai state and its citizens' health, 1932-1957," (Master's Thesis Arts Program in History, Department of history, Faculty of Arts, Chulalongkorn University, Bangkok, 2010), 67-69.

⁴³ The Secretariat of the House of Representatives, Report of the Second Ordinary Session of the House of Representatives, B.E.2477 (1934) (The Secretariat of the House of Representatives, 1936), 1467-69.

⁴⁴ Royal Thai Government Gazette, "Question No. 111/2478 by Khun Sena Satsadi, Representative of Roi Et Province, Regarding 'Construction of Roi Et Provincial Hospital'" (Volume 52, page 3323, February 9, 1935); Royal Thai Government Gazette, "Question No. 469/2478 by Bunma Sertsri, Representative of Loei Province, Regarding 'Construction of Road from Khon Kaen to Udon Thani, Construction of Hospital, Fee for Cutting Wood in the French Border Zone, Prohibition of Thai Side Residents from Working for a Living in the French Border Zone, Deportation of Convicts 3 Times'", (Volume 53, page 929, August 2, 1936).

⁴⁵ Memorial book for the Royal Cremation Ceremony of Dr. Surin Prompitak at Wat That Thong, Bangkok, on Saturday, December 27, 1997' (Fah Aphai Co.,LTD, 1997), 103-4.

⁴⁶ Tanwa Wongsangiam, "The Thai state and its citizens' health, 1932-1957," 97.

⁴⁷ Santisuk Sophonsiri, Thai Physicians' Legacy for Future Generations: Life and Work of Professor Dr. Sem Pringpuangkeo, 75.

⁴⁸ Santisuk Sophonsiri, 77.

⁴⁹ Interview with Dr. Wichai Chokwiwat, May 17, May 23, and June 2, 2022.

⁵⁰ Tanwa Wongsangiam, "The Thai state and its citizens' health, 1932-1957", 153-154."

⁵¹ National Archives of Thailand, M 201.2.1.10/7, "Ministry of Public Health Requesting Cooperation from Village Leaders and District Chiefs to Assist in Disease Prevention and Hospital Construction (1947)".

⁵² Davisakd Puaksom, Infectious Diseases, Body, and Medicalizing State: History of Medicine in Modern Thai Society.

⁵³ Pinyapan Potjanalawan, Municipalities: Area, City, and Time: The Birth and Transformation in the First Three Decades of People's Democratic Municipalities in Urban Areas, 117.

⁵³ National Archives of Thailand, (2) SR0201.27.2 /22, "Transfer of Hospitals between Municipality and Ministry of Public Health (December 8 - March 27, 1953)."

The following hospitals are listed: Klang Hospital, Vajira Phayaban Hospital, Contagious Disease Hospital of Bangkok Metropolitan Administration, Songkhla Municipality Hospital, Nakhon Si Thammarat Municipality Hospital, Nakhon Sawan Municipality Hospital, Phuket Municipality Hospital, Chachoengsao Municipality Hospital, Ratchaburi Municipality Hospital, Lampang Municipality Hospital, Nakhon Pathom Municipality Hospital, Suphanburi Municipality Hospital, Ayutthaya Municipality Hospital, and Chiang Mai Municipality Hospital.

⁵⁴ Pinyapan Potjanalawan, *Municipalities: Area, City, and Time: The Birth and Transformation in the First Three Decades of People's Democratic Municipalities in Urban Areas*, 119-120.

⁵⁵ Currently known as Rajavithi Hospital.

⁵⁶ Department of Health, Work, and Ideas Dr. Damrong Boonyoen: A Hero in the Epic of Thai Public Health Development (Nonthaburi: Department of Health, 2008), 24-25.

⁵⁷ Dr. Nittwechawisit, Memorial book for the Royal Cremation Ceremony of Lieutenant Colonel Dr. Nittwechawisit (Luang Nittwechawisit), September 29, 1980 (Bangkok: Thai Watana Panich, 1980), 71.

⁵⁸ Department of Health, Work and Ideas, Dr. Damrong Boonyoen: A Hero in the Epic of Thai Public Health Development, p. 26."



The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868-2002

Foundations of Thailand's
public health structure in the
context of the Cold War

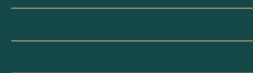




Figure 25 The villagers brought their grandchildren to receive medical treatment at the health pavilion of the Ministry of Public Health. Expert American officials were present to provide assistance under the American Aid for Thai Public Health project in the year 1955 (Photo from the American Information Service).

Source: National Archives of Thailand, CH/T/1590, Health Pavilion Examination by American Experts.

The expansion of public health initiatives during the first two decades of the post-WWII era in Thailand took place within a context of political, economic, and social circumstances, shaped by the global confrontation between capitalist democracies and communist worlds. The United States played a significant role in shaping the framework and injecting financial support to the Thai government. These factors collectively had a significant impact on the “accelerated development of basic public health infrastructure” in rural areas of Thailand, a development unprecedented until then.

Amidst such circumstances, public health initiatives were considered a “benchmark” of the country’s development, receiving substantial financial support from foreign sources. Nevertheless, despite the government’s efforts to expand rural development through numerous projects, a crucial challenge arising from this intense collaboration was that the majority of rural development projects were predominantly geared toward fulfilling political policies, rather than focusing primarily on improving the healthcare system for better living conditions. Consequently, the time span of each project was relatively “short” and often dealt with “immediate” issues, failing to bring about long-term changes in the quality of life and health of the population.

While the societal landscape within the country was changing, such as the continuous increase in population size, it signaled a crisis in the field of public health, particularly in terms of a “shortage of medical personnel.” This problem stemmed from the inclination of medical professionals to seek advancement abroad rather than serving society, resulting in a brain drain of doctors. Additionally, there was an issue of doctors congregating in urban centers rather than working in rural areas, and the challenge of adapting newly graduated or foreign-trained doctors to the local environment. With the variety of challenges surrounding public health, coupled with the crisis of medical personnel shortage, the medical community found themselves standing at the crossroads of thought. This led to divergent viewpoints within the medical community, particularly among grassroots doctors, between those who emphasized “specialized treatment and curative medicine” and those who focused on “preventive medicine.” The resonating voice of the prevention-focused doctors became louder and influenced the direction of the healthcare system more significantly as time progressed.

Development of fundamental public health infrastructure to address immediate challenges

The intensifying situation of the Cold War accelerated processes of political, economic, and social changes in Thailand. Following another coup d’état in October 1958, Field Marshal Sarit Thanarat emphasized that the decision to seize power this time was considered a “revolution” aimed at developing the nation’s economy. As stated during one instance, *“The important matter concerning the well-being of*

the people is the economy and livelihood. This government thus adopted policies to lay out economic plans and proposed a national budget that prioritized economic matters. It actively encouraged and incentivized domestic industrial investment."¹ Soon after the coup, there were multiple policies aimed at promoting large-scale private sector investments, particularly from foreign countries, notably the United States and Japan, as evidenced by various proclamations of the revolutionary council.² The results of these transformative changes within the country led to the development of fundamental infrastructure such as roads, highways, bridges, power plants, schools, airports, and reservoirs.³ Furthermore, numerous state agencies were established for investment and development purposes, including the Budget Bureau (1959), the National Statistical Office, the National Economic Council (1950) which later changed its name to the National Economic and Social Development Board (NESDB) in 1959, and the Board of Investment.⁴ Subsequently, not long after, the NESDB, which included some personnel from the United States, played a consultative role. They utilized various proposals from the World Bank concerning agriculture, industry, education, and public health as templates to formulate the country's first economic development plan (1961-66). Undoubtedly, the advisory representatives from the United States played a significant role in shaping this initial plan.⁵ In such a context, the field of public health was integrated into the First National Economic Development Plan, known as "the First Health Development Plan (1961-66)"⁶ This plan aimed to expedite the expansion of service facilities in rural areas and accelerate the training of medical personnel, both doctors and nurses, through the establishment of new schools to produce doctors and nurses.⁷ **At that time, public health became one of the development indicators of the country that received substantial financial support from various countries.** This could be seen from the healthcare budget, and that Thailand received significant backing from the United States. The total amount of this support ranked as the third highest among all the foreign aid Thailand received at that time.⁸

In this regard, the United States placed special emphasis on certain areas that were exacerbating poverty and underdevelopment, and were geographically distant from the center of state power. Significantly, the US felt that these peripheral regions were believed to have characteristics that could potentially lead them to become vulnerable to communist influences. The apprehension about the spread of communism prompted the Thai government's interest to focus on the eastern and northeastern regions, which were considered Thailand's rural areas at the time. The US began to play a significant role in generating knowledge related to "rural education" or "peasant education" through anthropological methodologies, established under its economic and political strategies.⁹ These efforts were promoted through the roles of international organizations like the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF), which worked to support long-term control of diseases such as malaria, tuberculosis, leprosy, trachoma, and yaws. Meanwhile, the United States Operations Mission (USOM) primarily focused on disease control, environmental health, development of agencies or institutions, local health services, nutrition, and population management. The United US for

International Development (USAID) supported efforts to eradicate malaria and improve local health, among other wide-ranging initiatives, including agriculture, education, public safety, fieldwork practices, and organizational development. Additional support came from the United States Information Service (USIS) and the Rockefeller Foundation.¹⁰ During that time, there were both policies and projects where foreign agencies from the United States worked in collaboration with the Thai Ministry of Public Health (MOPH) to innovate and provide new directions for public health in Thailand. Overall, it can be stated that the governments of the US and Thailand, along with the MOPH, engaged in specific collaborative efforts since the end of the 1940s, but this collaboration intensified notably during the 1960s. The intensified cooperation was driven by the increasing concern of both governments over the threat posed by communism, which was directly related to the escalation of the Vietnam War from 1964 to 1968.

The improvement of basic public health and infrastructure services for the purpose of preventing the communist threat had been ongoing since the 1950s. These projects often involved aid provided by the US or international organizations responsible for public health, such as the project to improve 40 health centers funded by UNICEF in 1953, which included providing various tools and supplies for maternal and child welfare, with an approximate value of one million baht.¹¹ Another noteworthy example was the “Local Health Development Project” conducted from 1957 to 1959. This project was under the supervision of the Department of Health and received cooperation and assistance from USOM. The goal of this project was to introduce new health initiatives to improve rural communities based on the principles of community development, emphasizing self-reliance in collaboration with the public sector.¹² Afterward, in 1960, the aforementioned project was expanded to become the “Village Health and Sanitation Project,” aimed at addressing epidemic diseases and promoting proper sanitation practices. This project continued to receive budget allocations and expert support from USOM and international organizations. Following this, in 1963, USOM established the Office of Rural Affairs.¹³ To promote agricultural development, education, community development, and public health access for villagers in the area, USOM officials worked alongside Thai government officials. By 1966, the United States entered into additional agreements to enhance and expand rural public health efforts in the northeastern and northern regions, along with supporting training in public health and disease prevention. A budget of over 30 million baht was allocated for these initiatives.¹⁴ There were reports stating that US government aid directly to Thailand had risen to \$100 million dollars at that time. This funding was dedicated to implementing comprehensive health projects aimed at developing and improving healthcare service systems for local populations in various areas, particularly in regions that were considered vulnerable to communist propaganda and infiltration.¹⁵

At this time, there were also massive efforts to construct secondary roads to connect remote villages with the main highways, facilitating transportation. These roads also served as pathways for villagers to engage

with market-oriented economic activities. During this period, it marked the first time in Thailand's modern history that the mechanisms of the state reached a grassroots level. US agencies, such as USIS and USOM, played a key role in assisting with agriculture, irrigation, livestock management, education, and public health. These activities helped open up opportunities for the state's mechanisms to reach villagers at the grassroots level to a greater extent.¹⁶ Especially during the first phase of the US-Vietnam War (1964–1968), the development policies of the United States underwent changes to achieve the goal of countering communism to a greater extent.

With the underlying belief that the expansion of communism is a matter of the “populace,” efforts were made to defend and improve the quality of people's lives to promote better living conditions and hope for the future.¹⁷ Therefore, it was advisable to “initiate and carry out projects by civilian means,” and not through the military, which was the origin of various projects aimed at connecting distant communities to feel more closely tied to the government. The interest of the US in rural development and public health between 1958 and 1976 is reflected in the budgetary allocations for assistance. The total budget for community development received from the US amounted to over \$82 billion, ranking second, after the funding for national security. Meanwhile, the budget for public health ranked third, with a total of \$54 billion.¹⁸ Indeed, this assistance does not yet include another significant amount of aid from various international organizations such as the UN, WHO, the Rockefeller Foundation, and others.



Figure 26 The green areas on the map of Thailand are the provinces that USAID and USOM have identified as high-risk areas for communist infiltration.

Source: Extracted from USOM THAILAND Office of Program, “The US/AID Program in Thailand: Summary of Economic AID to Thailand and Selected Statistical Data” (USOM THAILAND Office of Program: USOM, October 1969).

In addition to collaborating on specific projects between international organizations and government agencies in the field of public health, the Thai government also established rural development units that worked in tandem with healthcare development. For example, Mobile Development Units were established in 1961 to expand outreach to the more remote areas. Furthermore, in 1962, the Thai National Security Council (NSC) established a central management division to oversee security and safety matters.¹⁹ The Ministry of National Development, established in 1962, the Community Development Department, established in 1962, the Border Patrol Police, established in 1963, and in 1966, the Department of Accelerated Rural Development (ARD) were all integral parts of the comprehensive mission to develop and care for the (primarily rural) population. These agencies had various tasks, including road maintenance, promoting industries, drilling wells, developing drinking water sources, family healthcare, local health development, vaccination programs to eradicate malaria, installing electricity, among others. These tasks were distributed among various agencies and were not concentrated within a single unit.

However, even though the government accelerated the expansion of rural development projects through numerous initiatives, a significant issue arising from the collaboration between the Thai and US governments was that the majority of rural development projects were driven by political considerations rather than primarily focusing on improving the healthcare system for the betterment of people's lives. It can be observed that the assistance provided by USOM in many areas of the northeastern region was a decision that emphasized aid in politically sensitive regions rather than prioritizing the enhancement of the healthcare system at large.²⁰ Because of this, the duration of each project was relatively short, superficial, and aimed at addressing specific issues, which did not lead to substantial long-term improvements in the quality of life and health of the population.²¹ As Dr. Damrong Boonyoen, a public health planner with extensive experience in government service and a key figure in the development of the National Health Development Plan, expressed, the relationship between the economy and health policy during the decade following 1957 can be understood as follows:



Figure 27 The image depicts the inauguration ceremony of the Northern Region Malaria Control Office in 1955. In the photo, the ceremony's presiding official stands beneath a banner displaying the office's name. (Image from the United States Information Service)

Source: National Archives of Public Health, CH/T/1588, Northern Region Malaria Control Office

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“The various policies that were incorporated into the early versions of the National Economic and Social Development Plans... gave increasing importance to social development. In most cases, these plans intertwined national health policies in a manner that attempted to provide health services to the population as a valuable state resource, aiming to contribute to the economic prosperity of the country... **This reflects the principles and directions of development that utilized public health as a spearhead to enhance the economic benefits of the state... However, it did not explicitly emphasize the fundamental role of public health as a foundation for comprehensive development in all aspects**”.²²

”

Therefore, even though the close relationship between the Thai and United States governments influenced medical and public health knowledge focused on rural development and village areas, simultaneously, knowledge also changed and flowed in response to political interactions and the economic situation more than towards addressing the fundamental healthcare issues of rural society at that time. Apart from external factors, e.g., the role of the US and international agencies affecting healthcare work, the internal societal changes within the country, such as the continuous increase in population, which contrasted with the critical shortage of medical personnel, had evolved into two significant issues that profoundly impacted healthcare during that time, which should be mentioned.

Population challenges: Family planning courses

A. Transition from “increase” to “decrease” in population

Throughout history, a significant reason for the Thai state and the Siamese Court accepting Western medical knowledge was the need to increase the population to bolster the nation’s productive capacity. This was in response to the prevailing issues in Siam at that time, which was a dearth of the working-age population.²³ Therefore, modern medical and public health practices were considered essential components that consistently contributed to increasing the population for the state. The utilization of public health was most evident during the first reign of Field Marshall Phibunsongkhram (1938-1944). This was explicitly highlighted by General Phibunsongkhram on the occasion of the National Day anniversary on June 24, 1943, in regard to the relationship between public health and the population, where he stated the following:

“

“Moreover, our nation’s self-reliance greatly depends on the issue of population. Having a population exceeding 40 million will enable our country to stand on its own. It can be observed that the Royal Health Campaign has made efforts to work towards building the population, which is a crucial factor that will greatly contribute to Thailand’s prosperity. This endeavor is pursued through various means, including marriage, child-rearing, disease prevention, and healthcare, among others.”²⁴

”

Accelerating population growth became one of the objectives of public health efforts, and continued even after World War II, during General Phibunsongkhram’s second term as Prime Minister between 1948-54. The promotion of early marriage and large families received significant encouragement from the government during that time.²⁵ This is evident from the establishment of the Women’s Hospital in 1951 to enhance healthcare services for reproductive-age women.²⁶ However, within a few years, the perspective on population growth shifted, and it began to be seen as an obstacle to national development.



Figure 28 Health officers at a rural clinic are explaining infant care to rural women as part of the US aid to Thailand’s health program, 1955.

Source: National Archives of Thailand, CH/T/1627, Health officer explaining infant care.๗

Therefore, starting from the decade after 1957, the concept of “building the nation through childbirth,” which had been widely promoted in the preceding era, came to an end when the perspective on population changed in the international context. This shift was driven by development pressures from the global community, including the World Bank and various international organizations. They became key players in propagating and advocating the doctrine of “population control” as a development strategy, arguing that the rapid increase in population portended rise of “problems” and “grave dangers” that could adversely impact economic development and give rise to other associated ills.

The population control movement operated systematically through the roles of vital international organizations, notably the Population Council, in close collaboration with the United Nations, the Ford Foundation, and the International Planned Parenthood Federation (IPPF). Consequently, “birth control” emerged as a pivotal strategy for support and development. This became a significant policy of the US during the presidency of Lyndon B. Johnson. As a result, the US, through initiatives like USAID or the World Bank, provided financial assistance to developing countries to reduce fertility rates. In this context, USAID, as a major funding source, played a crucial role in supporting Thailand’s family planning program.²⁷

Formerly, before the implementation of a national census in 1911, Thailand had a population of merely 8 million people. However, the population increased to 14, 17, and 26 million people in 1937, 1947, and 1960, respectively. Eventually, the Thai population grew to 34 million people in 1970, reflecting an annual population growth rate of 3.3%. This placed Thailand among the countries with the highest population growth rates. Consequently, Thailand rose to become the 16th most populous country globally during that period.²⁸ Concerns about the continuous increase in population were highlighted in a report by experts from the International Bank for Reconstruction and Development, also known as the World Bank. That report was conducted to examine Thailand’s economic situation between 1957 and 1958. The findings indicated that rapid population growth could lead to problems such as housing shortages, overcrowded schools, unemployment, and even shortages in services and healthcare personnel. As a result, this became the basis for proposing the promotion of knowledge about “population control” or “family planning.”²⁹ **By disseminating knowledge through health outposts, with the MOPH as a key agency, this approach to family size limitation was suggested.**

B. Voluntary family planning, maternal and child health, and preventive medicine

Field Marshall Sarit’s government in 1960 strongly acknowledged that *“they had to face the challenge of a population increase of 600,000 to 800,000 people annually, which significantly added to the burden of healthcare provision.”*³⁰ However, during the initial period, the government remained hesitant in making decisions regarding birth control.³¹ This led to the resolution on birth control still being based

on the voluntary choice of the people.³² Thus, the recommendations regarding birth control to the public could be made only discreetly and not openly. Nevertheless, there were seminars organized by the National Research Council on this issue during the period 1963-68, totaling three occasions. In these meetings, concerns were raised about the increasing population, and warnings that this could lead to reduced national savings and investments. With an increasing population, internal consumption within the country could rise, potentially leading to higher commodity prices and even shortages. The rising population would also contribute to severe unemployment and insufficient social services. Worried about the overall situation, the meetings concluded that these issues could be the starting point for moral and ethical degradation and might even create vulnerabilities to communist infiltration. Therefore, it was suggested that the government should expedite and promote voluntary family planning in the field of public health to the greatest extent possible.³³ Research in demography should be expedited to monitor population changes. Furthermore, hospitals, health stations, and various medical institutions should promote 'family health' services to the general population across the country. Additionally, there should be an "inclusion" of family planning education in the curricula of medical, nursing, and midwifery schools.³⁴

A national family planning policy in Thailand was officially launched in 1970, with the government setting a goal to reduce the population birth rate from 3.2% to 2.1% within five years. This led to reforms in public health services to support the "Maternal and Child Health and Family Planning" policy. This policy shift is reflected in the 3rd National Economic and Social Development Plan (1972-76), where family planning was incorporated into the national public health development plan.³⁵ In order to encourage each family to be able to determine the size of their family or space the births as they wish, the policy was aimed particularly at low-income families, those in poor health, and those with many children. It was expected that by the end of the 3rd development plan (1976), the results would contribute to reducing the population growth rate.³⁶

The issue of overpopulation is closely related to family planning policies, and it is connected to the curriculum and concepts of the medical personnel group. This has led to the establishment of family planning centers alongside the medical faculties of all universities at that time, including

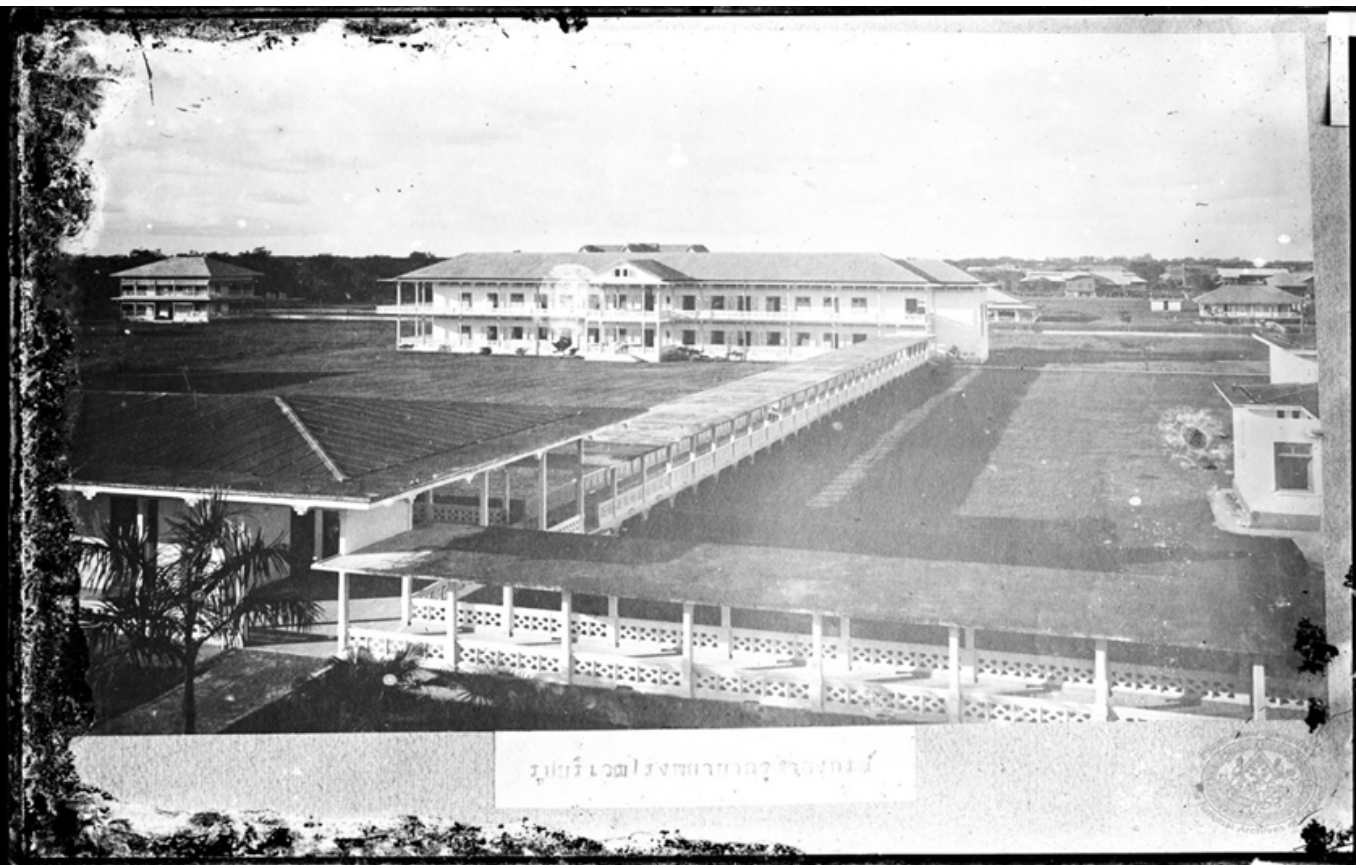


Figure 29 Chulalongkorn Hospital

Source: National Archives of Thailand, P.PT. 4/56, Chulalongkorn Hospital's Surrounding

Siriraj Medical School (formerly Royal College of Medicine).³⁷ The Faculty of Medicine, Chulalongkorn University (1947), Faculty of Medicine, Chiang Mai University (1959), and Faculty of Medicine, Ramathibodi (1965) expanded their family health departments at the provincial level, and supported budgets for birth control and sterilization procedures in various hospitals.³⁸

While Dr. Chek Thanasiri, the former president of the Planned Parenthood Association of Thailand (PPAT), provided information about the perspectives of medical personnel on family planning issues, he intriguingly explained that a certain portion of healthcare professionals, particularly the group referred to as “protective doctors,” hold an interesting viewpoint. This group did not solely focus on disease treatment,

but rather envisioned the societal and economic impacts. This was in contrast to the majority of doctors who emphasized disease treatment. Accordingly, the “protective doctors” believed that physicians should be responsible for promoting family planning to reduce birth rates.³⁹ The origin of the “Family Health Project” began its implementation in 1967, prior to its development into a national policy incorporated in the 3rd National Economic and Social Development Plan (1972-76). Subsequently, the project trained doctors and nurses in understanding population issues and family planning. Additionally, the project provided assistance to families with many children and those in need of family planning. The project set a target to train one doctor and one nurse from each provincial hospital to be capable of family planning education and contraception counseling. Within three years, all physicians, nurses, and midwives within the Department of Health would receive training.⁴⁰

However, due to the lack of initial government funding, the Family Health Project operated initially with financial support from international organizations.⁴¹ These included USOM, the Population Council, the Ford Foundation, and UNICEF. During 1967 to 1970, the project successfully trained a total of 6,125 personnel, and encouraged all types of healthcare facilities to provide family planning services, totaling 3,719 establishments. As a result, 542,551 individuals received contraception services during those four years.⁴² In 1970, following the government's declaration to implement a population reduction policy, the aforementioned project changed its name from the “Family Health Project” to the “Family Planning Project” under the management of the MOPH. The operational format and main principles remained unchanged from before. The project continued to expand the training of healthcare personnel to cover all aspects of public health, increase family planning services without charging fees, and enhance the dissemination of family planning knowledge. Despite the policy being incorporated into the state's objectives, the majority of project personnel were still funded through assistance from international organizations.



Figure 30 Images of promotional brochures of the Family Planning and Birth Control Project by the Ministry of Public Health (MOPH).

Sources: National Archives of Public Health, (14), SB 1.12/1, Family Planning and Birth Control Project Brochure.

As follows, the issue of population is another matter that highlights the significant influence of the US and international organizations in driving family planning policies. As noted earlier, this issue was intricately linked with the concern about potential expansion of communist influence, connecting the mentioned problem with the spread of communist ideology.⁴³ Between 1964 and 1968, a group of Thai professionals, including doctors, nurses, sociologists, and demographers, totaling 90 individuals, received scholarships to further their studies and engage in fieldwork related to family planning. This program of continuing education was the fruit of collaboration between the National Research Council, the MOPH, the Population Council, IPFF, the Ford Foundation, and the Rockefeller Foundation. Most of the graduates joined the workforce directly in the fields of population and family planning within the MOPH, the National Statistical Office (NSO), the National Economic Development Board (NEDB), medical faculties, and various faculties in universities.⁴⁴ Therefore, the issue of “overpopulation,” was primarily addressed through family planning to reduce birth rates, reflecting the challenge of an insufficient cadre of “medical personnel” across the country. The already dire shortage of healthcare professionals worsened, exacerbating the situation due to the continuously increasing population. This crisis posed a greater threat to the healthcare system of that time.

Medical workforce crisis: Central axis of Thailand's public health issue

Amid the context of the current Cold War era, there was a hastened inclination among certain groups of doctors to seek advancement abroad rather than merely serve society through their work. In addition, the issue of doctors being concentrated more in central areas and urban centers rather than practicing in rural regions, or even fulfilling their roles within the Medical Council, stems from various factors. These factors led to different perspectives within the medical community, namely between doctors who “emphasized treatment” and those who “emphasized prevention.” Over time, the voice of the prevention-focused group of doctors became louder and increasingly influential in shaping the direction of the Thai healthcare system. This influence gained more prominence with the October 14, 1973 uprising.

A. Overview of the number of medical personnel in Thai society during 1957-1977

If we look back at the medical education system and the number of medical schools in Thailand, it can be observed that after the opening of the first medical school in 1890 until 1971, a paradigm shift occurred. This evolution was articulated by Dr. Prawase Wasi, a key reformer of Thailand's healthcare system, published a seminal article in the December issue of the Social Science Review magazine, to address the “shortage of Thai medical personnel”⁴⁵ In the article, Dr. Prawase Wasi observed that, over the past 81 years, Thailand had a total of four medical education institutions. The first was the Faculty of Medicine of Siriraj Hospital, originally under Chulalongkorn University, but then transferred in 1942. At that time, the newly established medical university held the status of a department under the MOPH. The second institution, established in 1947, was the Faculty of Medicine within Chulalongkorn Hospital.⁴⁶ Subsequently, in 1959, the third institution was established as the Faculty of Medicine, Chiang Mai University, with the goal of producing medical doctors, nurses-midwives, and public health professionals to aid patients. This initiative received financial support and consulting assistance on aspects such as space, infrastructure, and design from USOM.⁴⁷ Following that, Field Marshall Sarit transferred all universities, including the medical universities under the MOPH, to be under the purview of the Prime Minister's Office. As a result, the medical education sector became independent from MOPH's oversight in 1965. During this period, the fourth medical school, the Faculty of Medicine of Ramathibodi Hospital, was established.⁴⁸



Figure 31 Building Construction at the Faculty of Medicine, Nakhon Chiang Mai Hospital, 1962

Source: National Archives of Thailand, PJ (6) SR2/17, Image No. 8/12, Nakhon Chiang Mai Hospital.

When we examine the number of doctors who successfully completed their education from 1957 to 1971, it is found that, on average, around 250 doctors graduated each year.⁴⁹ Therefore, there were only a total of 3,725 medical graduates during the approximately 15-year period (1957-1971).⁵⁰

The issue of insufficient personnel becomes evident when considering the situation in 1969. At that time, Thailand had a population of 34,347,145 people. The total number of registered and licensed medical doctors was 5,322, but the actual number of practicing physicians was only 4,133. By rounding off the figures, it becomes apparent that for a population of around 34 million in the 1960s, Thailand should have had approximately 36,000 doctors to achieve a doctor-to-population ratio similar to more developed countries (i.e., around 1 doctor per 500 or 1,000 people).⁵¹

Table 3 Comparing Doctor-to-Population Ratios in Thailand and Other Countries

Source: Adapted from Thassanee Thammathat, 'The problem of doctor shortage in Thailand' (Economics Department, Faculty of Political Science, Chulalongkorn University, 1972).

COUNTRY (1960-70s)	NUMBER OF DOCTORS : POPULATION
THAILAND	1 : 8,310
PHILIPPINES	1 : 1,390
JAPAN	1 : 920
UNITED KINGDOM	1 : 860
UNITED STATES	1 : 650
ISRAEL	1 : 420

In reality, Thailand had only about 4,000 doctors. When comparing the doctor-to-population ratio in Thailand with other countries during the same period, the proportions are as follows:⁵² The problem that arose was not only the insufficient number of doctors, but also the shortage of nurses, which had been a concern in the healthcare system since before the 1967 decade.⁵³ It can be observed that between 1955 and 1973, the government accelerated the establishment of nursing schools, adding 17 institutions spread across various provinces.⁵⁴ However, the production of nurses still fell short of the demand. There were issues with discrepancies between practical work and knowledge, along with other contributing factors such as low salaries, seeking career advancement through various means, and the hospital environment.⁵⁵ The numbers in 1975 reveal that there were only 12,658 nurses nationwide, calculated as a ratio per population as follows:

Table 4 compares the nurse-to-population ratios between Thailand and other countries.

Source: Adapted from Arun Nuraksake, "Development of Nursing Administration in Thailand" (Nursing Education, Faculty of Graduate Studies, Chulalongkorn University, 1978), 4-5.

COUNTRY (1975)	NUMBER OF NURSES : POPULATION
THAILAND	1 : 3,349
JAPAN	1 : 352
UNITED STATES	1 : 307
UNITED KINGDOM	1 : 186

Although in 1972, two more medical faculties were established, namely the Faculty of Medicine at Prince of Songkla University and the Faculty of Medicine at Khon Kaen University, both of which were established in regional areas to meet the demand for physicians practicing in different provinces.⁵⁶ However, it wasn't until the mid-1970s that the newly established faculties could begin producing qualified physicians. Since the 1960s, excluding the aforementioned two newly established medical faculties, Thailand had produced only about 360 physicians per year up until that time.⁵⁷

One of the reasons was due to the medical education focus at that time on producing specialized physicians in conventional medicine, which prolonged the physician training curriculum to as long as six years and required significant funding. Consequently, the number of physicians who underwent a training

process emphasizing high-quality physicians was insufficient to meet the demand.⁵⁸ While the establishment of medical schools in different provinces still faced obstacles related to the issue of physician shortages, a similar situation persisted in Bangkok. This resulted in a limited number of medical professors responsible for teaching students. It should also be noted that not all individuals graduating with a medical degree actually pursued a career as a practicing physician. Additionally, other challenges such as retired or deceased doctors, along with the ongoing issue of physician and nurse shortages, became more pressing when facing the “brain drain” phenomenon.

B. Brain drain of Thai physicians in the era of American prominence

The conditions that contributed to the “brain drain” in the medical field were the demand for physicians by the US to compensate for doctors who were sent for service in the Vietnam War. In 1956, the US conducted exams in various countries to provide opportunities for physicians from all nations to compare standards and receive certification from the US.⁵⁹ From the data between 1965 and 1969, a total of 2,165 Thai physicians traveled abroad. Among them, only 987 physicians returned to the country. This indicates that more than half, or approximately 54%, of the applicants chose to go abroad within a 5-year period.⁶⁰ There were still instances where 50 graduates from the first batch of the Faculty of Medicine, Chiang Mai University, immediately traveled to work and further their studies in the US right after completing their education. Out of these, 48 individuals pursued further education upon graduation.⁶¹ Under the USOM-RTG Joint Grant program,⁶² in 1966, there was research conducted on medical students and public health work in rural areas, collecting data from 1,009 medical students. It was found that out of the total, 858 students expressed their intention to study abroad if given the opportunity, while only 19 students considered not going. Professor Dr. Prakit Vathesatogkit, a medical professor, was one of the physicians who received a scholarship offer to study in the US after completing his education. This reflected a personal perspective through his life experiences, suggesting that accepting a scholarship for further studies abroad could be a reason and personal necessity. The decision to return to work in Thailand encompassed both personal considerations and the timing of opportunities to secure positions in the country. Dr. Prakit decided to return to Thailand, stating, *“I had to return because Thailand was in need of doctors. Even though in foreign countries they asked why I returned when it’s a gold mine here... but at that time, I contacted the Ramathibodi Hospital and there were available positions... part of the problem was due to the bureaucratic process of placement through the [MOPH], some years there were placements, and some years there weren’t. It was very challenging at that time... when there were no positions, some people went into private practice and continued on abroad.”*⁶³ It must be acknowledged that the data in the overview allowed for the anticipation that the number of physicians traveling abroad for further studies was threatening to increase every year. This was due to reasons related to knowledge development and better work opportunities. However, the problem reached such a critical point that the government had to establish a “committee to address the issue of physicians studying abroad” in order

to find a solution.⁶⁴ In reality, the issue of physicians going abroad and the problem of Thai doctors not wanting to work in rural areas were closely related and interconnected. This is because working in rural areas involved unfamiliar environmental conditions, particularly for those doctors who had returned from studying abroad. Some individuals may have found it challenging to adapt to working in a rural Thai setting.

C. Challenges of dispersing physicians to rural areas

In addition to the glaring dearth of physicians within the system, the problem was even worse when the distribution of so few physicians is uneven. Numerical data demonstrates that Bangkok and Thonburi, which only constituted 8% of the total population, had two out of three of the nation's practicing physicians. This meant that there was less than one physician per thousand population in these areas.⁶⁵

Therefore, if the number of physicians in urban areas like Bangkok was excluded, the physician-to-population ratio in different provinces might be as high as 1 physician for every 31,000 people. Furthermore, the situation was actually worse as physicians in remote provinces tended to concentrate in urban or provincial centers. In 1958, Boonchuai Srisawat, a representative from Chiang Rai province, raised a question to the government regarding medical graduates nationwide. This question highlighted the unequal distribution of physicians between urban and rural areas. The government acknowledged that each province at that time had a physician-to-population ratio of approximately 1 for every 100,000 people. There were still five provinces – Buriram, Sisaket, Surin, Kalasin, and Roi Et – with ratios lower than 1 physician per 100,000 people. Additionally, around 254 districts nationwide lacked resident medical graduates altogether. Among these districts, the majority, 82, were located in the northeastern region, followed by the northern region with 64 districts, and the southern region with 43 districts. The central, eastern, and western regions had 29, 19, and 17 districts, respectively, in descending order.⁶⁶ Therefore, in truly remote rural areas, the actual physician-to-population ratio could be as unfavorable as 1 physician for every 110,000 or even 1 physician for every 450,000 people in certain districts where there were no resident medical graduates at all.⁶⁷ After the passage of a decade (1968), in the northeastern region of Thailand, apart from the province of Loei, most other provinces had a physician-to-population ratio of around 1 physician per 25,000 people. There were a few provinces where the ratio remained even higher than that, estimated at 1 physician per 70,000 people, such as Nakhon Ratchasima, Si Sa Ket, Chaiyaphum, and Kalasin. As for the northern region, there were nine provinces where the physician-to-population ratio was 1 per 25,000 people or worse. In the southern and central regions, only a few provinces had such ratios.⁶⁸ Although the physician-to-population ratio may have improved to some extent, the majority of physicians still remained concentrated within urban areas of provinces or districts as before.

The fact that most physicians did not want to practice in rural areas, especially in remote regions, was due to the differing environment compared to urban areas. Lack of basic facilities in the rural area, limited opportunities for further education and research, and a lack of academic progress were contributing factors. The social environment was also another condition that discouraged physicians from working in rural areas, such as the impoverished population, low levels of education, and difficulty in communication with patients due to clinging to old traditions that contradicted medical knowledge. Based on a survey of 200 fourth-year medical students in 1966, it was found that 60% expressed a desire to practice in urban and nearby areas, followed by 17% in the central region, 10% in the northern region, 8% in the southern region, and only 5% in the northeastern region.⁶⁹ The issue of physician distribution and the reluctance to adapt to rural areas among physicians may sometimes be attributed to the outcome of the professional development of physicians from the beginning of their medical education to their entry into the field. This process molded them to better fit the Western cultural context (Western type doctor) rather than the original environment of the Eastern world, which had a greater influence.⁷⁰

D. Birth of the Medical Council: Professional group's authority within the ministry and the identity of being a physician

At this time, Thai thinking of these matters started to be influenced by the concept of utilitarianism, i.e., the impact of the utilitarianism philosophical approach or the path leading to maximizing benefits.⁷¹ There were factors contributing to the emergence of the specialization trend in medicine, which affected various aspects of societal phenomena and dimensions of medical power. Firstly, due to the influence of physicians as a professional group, they had outsized impact in administrative matters and could influence government operations.⁷² *"The most reformed system within the Thai government is likely the medical field, particularly the Ministry of Public Health... It serves as a leader in society, you know, the medical profession. It attracts top brains into it."*⁷³ Simply put, the medical profession was a group that excels in performing the role of technicians within the MOPH compared to other ministries.

The next aspect was the growth of the medical profession along with the values, status, and culture of being a physician in Thai society. This factor contributed to elevating doctors to a prestigious and privileged class with the authority to treat patients as the sole individuals.⁷⁴ One aspect resulted from the enforcement of the 'Medical Professions Act of 1968,' which emphasized *"...the importance of separating the control of the medical profession from the control of the practice of arts related to diseases, and establishing a Medical Council to specifically regulate the practice of the medical profession."*⁷⁵ On one hand, this version of the law grants authority to Western-trained doctors to have exclusive rights in treating patients. On the other hand, it also marginalized other professions that used to perform similar roles, such as traditional village doctors or alternative medicine practitioners, gradually excluding them from the realm of 'diagnosis and treatment' using the legal power it conferred.⁷⁶

The same set of laws also established the 'Medical Council' to serve as an independent regulatory body overseeing medical practitioners, particularly Western-trained doctors. This council is considered the first healthcare professional council to separate itself from the control of traditional arts and crafts (later followed by the Nursing Council, Pharmaceutical Council, Dental Council, and others). Even though the subsequent 'Medical Profession Act of 1982' replaced the original law⁷⁷, the essence and role of the Medical Council remained largely unchanged from the 1968 version. Therefore, the evolution of the Medical Council can be broadly categorized into three periods: the Medical Assembly Era (1923-1936), the Control of Medical Practice Committee Era (1936-1968), and the Medical Council Era (1968-present).⁷⁸

Figure 32 A cartoon image satirizing specialist doctors featured in the publication 'Public Health for Society,' circa 1977.

Source: National Archives of Public Health, (12) SB 12.8/3.8, Public Health for Society



One of the significant tasks was identified as functioning like an independent organization outside the government, providing public knowledge in the field of public health or proposing public health policies to the state for the benefit of the people.⁷⁹ However, in practice, the Medical Council aimed to 'promote unity and honor among its members.'⁸⁰ It emphasized that this was a more crucial aspect, especially in cases where the Medical Council expressed opposition to actions taken by the Minister of Public Health who is 'not a doctor' (Lt. Col. Prasert Rujirawong), in order to prevent the prosecution of doctors who violate regulations.⁸¹ Another prominent role of the Medical Council was to ensure that the responsibility for medical examination and treatment remained solely in the hands of qualified physicians, by for example, being the authority to approve medical licenses. With these roles, at times, the Thai Medical Council became a guardian of the interests of doctors, i.e., having the duty to protect and preserve the benefits of the medical profession more than safeguarding the interests of the public.⁸²

With an organizational culture that aimed to preserve the 'dignity' of the medical profession, the Medical Council was often associated with the wing of specialist doctors or what is referred to as a 'reactionary group.'⁸³ Therefore, when significant changes occurred, such as the reform of medical education curricula or the functioning of the Medical Council, especially among the conservative-minded specialist doctors, there was resistance to educational reforms that emphasize community-based approaches. As Dr. Pairode Ningsanon, a member of the Poysian group, who agreed with the educational reform, stated that even though the Medical Council appointed him (and Dr. Prawese) as members of the curriculum development committee during 1972-1973 and eventually presented a community-based curriculum (Community Medicine), the Medical Council rejected the curriculum and insisted on continuing with the existing curriculum, which they perceived as already effective. This further led to accusations of them (the Poysian Group) as being communist sympathizers.⁸⁴

At this point, it can be observed that the role of the Medical Council and the pursuit of the highest professional prestige for doctors were closely related to the policies and directions of medical education in Thailand. These policies indirectly encouraged newly graduated doctors to choose specialization or pursue further studies abroad. On the other hand, the option to work in underserved areas was less appealing due to the lack of curriculum emphasis. As a result, doctors became the first profession criticized for being focused on 'diseases' rather than 'patients,' leading to the emergence of a 'newly graduated doctor culture' that was averse to working in remote rural areas. This was because some groups of doctors felt that venturing into rural areas was a challenging and unappealing prospect.⁸⁵

Therefore, the issue of brain drain, the challenges faced by doctors in urban areas, and the direction of the Medical Council aiming to uphold the values of the medical profession had become top priorities for policy makers. They had to expedite the search for solutions, and one of the crucial measures was the implementation of financial policies for doctors. This served as a method to create conditions that alleviated the complex issues related to healthcare workforce shortages.

Physician fund mandatory policy: cultivating people, motivation, and conditions

Due to the trend of many new medical graduates seeking employment abroad, which had become a significant concern criticized by the media and societal discourse, the MOPH, as the direct consumer of physicians, put forth a proposal. They suggested that medical schools should categorize medical students into two types. The first type entailed free education, but with the condition that after graduation, medical student graduates must work for the government for an additional two years. The second type involved a

higher tuition fee structure, with no obligation for post-graduate government service. These proposed approaches led to the concept of the 'Policy of Mandatory Use of Funds' or a regulation that requires medical students to enter into a contract, utilizing government funds, committing to serve as government-employed physicians in hospitals affiliated with the MOPH and the Ministry of Defense, during both the post-graduation period and internship.⁸⁶

At first, the conditions were voluntary. Medical students could 'choose' between government service in exchange for funding or paying fees to avoid mandatory service. The approval for the concept of 'funding utilization' from the Cabinet on March 14, 1967, led to an increase in the 'Medical Education Maintenance Fee.' This fee was established to be collected at a rate of 1 out of every 3 units of the educational expenses for each medical student,⁸⁷ or about 10,000 baht.⁸⁸ Those who paid the maintenance fee were not required to undertake mandatory service. Upon completion of their studies, they were free to pursue their professions independently. As for those who received government scholarships or chose not to pay the maintenance fee, *"they must 'enter into a binding agreement' that upon graduation, they will serve in government employment for a minimum of 3 years. If they breach the agreement, they are obligated to reimburse three times the amount of the maintenance fee..."*⁸⁹ When calculated as a total payment of 40,000 baht multiplied by three, the fine would amount to as much as 120,000 baht (which covered the entire period of clinic rotations, both in the clinical years and during the internship phase). This calculation was made to account for cases where students opted to fulfill their service obligation through work but later breached the contract. Subsequently, the fine rate was increased to 200,000 baht in 1971 and 400,000 baht in 1973.⁹⁰

The first cohort who were compelled to adhere to the aforementioned conditions consisted of medical students at Siriraj Hospital who skipped their third year in 1967. The Ramathibodi Hospital's first batch of medical students who entered university in 1965 and were in their third year, along with medical students from Chiang Mai University and Chulalongkorn University, were all subjected to the same conditions. However, initially, all female medical students were required to choose the option of paying a higher fee. The MOPH explained that this was due to the government's lesser demand (for female M.D.s) at that time.⁹¹ On the other hand, it is also possible that they were viewed as unable to work in rugged areas of remote districts, especially in areas with a shortage of doctors.⁹² After that, the regulations gradually transitioned towards 'mandatory' measures, which led to newly graduated doctors, both male and female, being required to work as civil servants in order to fulfill the funding obligation.

Subsequently, the voluntary agreement was canceled in 1970, and all medical students were considered 'government scholarship students.' This resulted in all medical students having to work to fulfill the funding obligation for at least 3 years after completing their education.⁹³ The enforced funding policy led to

varying reactions among medical students, categorized into two main groups. The first group consisted of those who rejected the funding conditions. Most of them planned to work or study abroad after graduation. The second group supported the policy but sought negotiations regarding the terms of time commitment and benefits. Dr. Wichai Chokwiwat, a former medical student from Siriraj Medical School in that era (who graduated in 1970), recounted the memories of that time, mentioning that the policy back then was enforced without considering a voluntary agreement. It began to be implemented even for third-year students, who had been studying for two years without knowledge of the upcoming enforced funding policy. Additionally, pressure tactics were used to coerce students into signing, threatening them with exclusion from examinations if they refused to comply.⁹⁴ This was one-sided conversation.⁹⁵

Another problem that arose was that newly graduated doctors were often trained to be suitable for working in large hospitals with sufficient medical equipment, even though the reality in most rural areas at that time was a shortage of tools, medical equipment, medicines, and budgets. Dr. Siriwat Thiptharadol, reflecting on his experience as a last-generation voluntary service doctor, stated, *"Being sent to work in rural areas is like going to face battle with a sword in hand. Traveling is difficult, representatives rarely visit, and the government doesn't come to check either... That's where communism starts to gain influence."*⁹⁶ Moreover, the initiation of requiring students to serve in their third year was because the government hoped to be able to send doctors to work in various provincial areas within a few years ahead. If it were to start with first-year students, the government would have to wait for about six years before being able to deploy these doctors.



Figure 33 Image inside the laboratory classroom of Neuroanatomy, taken in the 3rd floor laboratory room of the Anatomy Building, Siriraj Hospital (circa 1947).

Source: The National Archives of Thailand, P003 (A) 10-5, Early Days of Anatomy Education.

However, the opposing currents to the policy in its initial stages were merely temporary reactions that occurred in the transitional phase of the policy. Ultimately, the direction of dispersing doctors to rural areas for the purpose of providing medical services to remote communities became a contemporary consensus among progressive groups of reform-minded medical professors and forward-thinking senior physicians in a society where they played significant roles in guiding and advising medical students as mentors. While the Thai Student Movement was in a phase of growth and blossoming, embracing the policy of financial restitution, it can be observed that after the implementation of the compulsory funding policy, the Thai Medical Student Association (TMSA) was established to negotiate with the policy makers. This group played a pivotal role in advocating for the abolition of the expensive semester fee system in favor of work-based alternatives, and demanding that every new graduate physician must fulfill an obligation to work in order to offset their educational expenses.⁹⁷



Amidst the various challenges surrounding the crisis of physician shortages, these factors became key catalysts that motivated physicians from various organizational affiliations, including progressive groups of physicians within and outside the government sector and those from universities, to come together with a shared recognition of the problem. They united to 'address' the fundamental ideas and curriculum of medical education in a serious manner. Dr. Prawese Wasi, a prominent physician, proposed an important solution to a significant problem, which is emphasizing the importance of preventive medicine more than solely focusing on curative medicine.⁹⁸ **And, of course, these aforementioned ideas certainly posed a significant challenge to the prevailing beliefs of medical schools and the methods of producing physicians that had been in place. This is because in the 1950s, the medical field still heavily emphasized 'treatment' as the primary and most important focus of medical education. Meanwhile, the concept of 'disease prevention' was not within the realm of interest in medical education at that time.**⁹⁹ Therefore, the process of reform had to be approached patiently, through 'real-life experience' and 'experimentation' in various projects, before it could evolve into a foundational model of public health work. This model illustrates the shift from a curative approach to a preventive approach, in a just and equitable manner.

Chapter 4

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² Compilation of National Executive Council Statements by the National Executive Council, Anek Boonpakdee, Printed as the Funeral Memorial of Phuak Khamkut at Wat Phra Phiren, (Phra Nakhon: Rongphim Phanit Charoen, 1959).

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⁵ Ukrist Pathmanand, "The United States and Thai Economic Policy (1960-1970)," (Master's Thesis, Faculty of Political Science, Chulalongkorn University, 1983), 77-79; Kullada Kesboonchoo Mead, Thai Politics in the Sarit-Thanom Era under the Global Power Structure (Research Report from the 50th Anniversary of Pridi Banomyong Foundation, Bank of Thailand, 2007), 89; Pasuk Phongpaichit and Chris Baker, A History of Thailand's Economy, 220.

⁶ Public Health Planning Division, "Development of Policies and Development Plans for Thailand's Health," in 45 Years of the Ministry of Public Health 2485-2530 (1942 - 1987) (Bangkok: Rongphim Sahaprachapanit, 2531), 25.

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¹⁴ Chatchai Muksong, "'Development Politics': Nutrition Policy, Rural Development, and State Intervention in Health Development for Villagers in Communities during the Cold War Era*", 63-65.

¹⁵ Davisakd Puaksom, *Infectious Diseases, Body, and Medicalizing State: History of Medicine in Modern Thai Society*, 318.

¹⁶ Kullada Kesboonchoo Mead, *Thai Politics in the Sarit-Thanom Era under the Global Power Structure*, 134-136.

¹⁷ Kenedy, John E., M.D. and staff, "A Brief History of USOM Support to Public Health & Population Programs in Thailand," United States Operations' Mission to Thailand - Agency for International Development, One of a Series of Reports on U.S.A.I.D.'s Participation in Thailand's Development, (Bangkok, Thailand, December 1972), 1.

¹⁸ Tipayawan Homgralop, "Thai and Foreign Assistance: A Case Study of American Aid in 1950-1976," 94.

¹⁹ In BE 2540, it was renamed "the Armed Force Development Command" (AFDC)

²⁰ Kenedy, John E., M.D. and staff, "A Brief History of USOM Support to Public Health & Population Programs in Thailand," United States Operations' Mission to Thailand - Agency for International Development, One of a Series of Reports on U.S.A.I.D.'s Participation in Thailand's Development, 8.

²¹ Wiwan Ekarintarakul, "Public Health Administration in Thailand 1958 - 1977," 70-75.

²² Damrong Boonyoen, "National Health Policy," Proceedings of the First Thai National Health Assembly organized by the Ministry of Public Health, BE 2531, (1988) in Department of Health, Works and Ideas Dr. Damrong Boonyoen: A General in the Epic of Thai Health Development (Nonthaburi: Department of Health, 2008), 89.

²³ Davisakd Puaksom, *Infectious Diseases, Body, and Medicalizing State: History of Medicine in Modern Thai Society*, 167.

²⁴ Plaek Phibunsongkhram, Speech of Field Marshal Phibunsongkhram, Prime Minister and Leader of the Nation, on National Day, June 24, 1943 (Bangkok: The Government Public Relations Department, 1943), 31-32.

²⁵ The National Economic Development Board, The National Statistical Office, and The Institute of Population Studies, Chulalongkorn University, "1974 World Population Year: The Population of Thailand," C.I.C.R.E.D. Series (Bangkok, 1974), 63.

²⁶ Tanwa Wongsangiam, "The Thai state and its citizens' health, 1932-1957", (Master's Thesis Arts Program in History, Department of history, Faculty of Arts, Chulalongkorn University, Bangkok, 2010, p. 181.

²⁷ Pinkaew Laungaramsri, "Nation's Pregnancy: Building Discipline for Population Growth and the History of State and Gender of Thai Women" (The Thailand Research Fund (TRF), 2019), 34-38.

²⁸ Kanchana Kanchanasinith, "A Study of the National Family Planning Project of The Ministry of Public Health" (Thesis, Faculty of Political Science, Chulalongkorn University, 1972), 65, 72.

²⁹ The International Bank for Reconstruction and Development (World Bank), A Public Development Program for Thailand: Report of a Mission Organized by the International Bank for Reconstruction and Development (the World Bank), The International Bank for Reconstruction and Development (Baltimore: The Johns Hopkins Press, 1959), 160.

³⁰ Sarit Thanarat, Compilation of Field Marshal Sarit Thanarat's speeches, 1959-1961, 195.

³¹ Kanchana Kanchanasinith, "A Study of the National Family Planning Project of The Ministry of Public Health", 27-28.

³² The National Economic Development Board, The National Statistical Office, and The Institute of Population Studies, Chulalongkorn University, "1974 World Population Year: The Population of Thailand," 63.

³³ The National Economic Development Board, The National Statistical Office, and The Institute of Population Studies, Chulalongkorn University, 63.

³⁴ Kanchana Kanchanasinith, "A Study of the National Family Planning Project of The Ministry of Public Health", 34-45.

³⁵ Public Health Planning Division, "Evolution of Policies and Development Plans of Thailand's Public Health," in 45 Years of the Ministry of Public Health, 1942 – 1988" (Bangkok: Sahaprachaphanit, 1988), 28-29.

³⁶ Office of The National Economic and Social Development Council, "The Third National Economic and Social Development, 1972-1976," Office of The National Economic and Social Development Council, Accessed June 12, 2022, https://www.nesdc.go.th/main.php?filename=develop_issue."

³⁷ Separated from Chulalongkorn University to establish the Faculty of Medicine, Mahidol University in the year 1943.

³⁸ The method of family planning through birth control had been developed earlier, through the efforts of modern medical professionals who began using surgical sterilization methods for postpartum women and promoted contraception. This method started to spread and gained significant public attention, particularly in some healthcare facilities. For more details, see Pinkaew Laungaramsri, "Nation's Pregnancy: Building Discipline for Population Growth and the History of State and Gender of Thai Women," (The Thailand Research Fund (TRF), 2019), 44-45.

³⁹ Chaicon Praditsil, "Political Economy of Thai Family Planning: A Study from Policy Processes" (Thesis, Department of Political Science, Faculty of Political Science, Thammasat University, 1990), 256.

⁴⁰ Kanchana Kanchanasinith, "A Study of the National Family Planning Project of The Ministry of Public

Health, 102-102.

⁴¹ Allan G. Rosenfield, Chitt Hemachudha, Winich Asavasena and Somsak Varakamin, Thailand: Family Planning Activities 1968 to 1970, Population Council, Vol. 2, No. 9 (September 1971): 181-192.

⁴² Kanchana Kanchanasinith, "A Study of the National Family Planning Project of The Ministry of Public Health", 112-115.

⁴³ Pinkaew Laungaramsri, Nation's Pregnancy: Building Discipline for Population Growth and the History of State and Gender of Thai Women,' 36-37.

⁴⁴ Chaeyon Praditsil, "Political Economy of Thai Family Planning: A Study from Policy Processes," 287-288.

⁴⁵ Prawese Wasi, 'Medical and Public Health in 25 Years,' Social Science Review, Volume 9, No. 6, (2514): 48-59.

⁴⁶ Sanjai Sangvichien, Siriraj Centennial: History and Development (Bangkok: Faculty of Medicine Siriraj Hospital, Mahidol University, 1988), 85, 181.

⁴⁷ Royal Thai Government Gazette, "Royal Decree on the Establishment of the Faculty of Medicine, Chiang Mai University, in The university of medicine 1959" (Volume 76, Part 102K, Special Issue, Page 15, November 1, 1971); John Kennedy and Staff, 'A Brief History of USOM Support to Public Health & Population Programs in Thailand,' 9-10; Wikun Wiranuwat, "The Establishment of the Faculty of Medicine, Nakhon Chiang Mai Hospital," in Memorial book for the Royal Cremation Ceremony of Professor Wikun Wiranuwat, M.D., held at the Royal Cremation Ceremony, Wat Thepsirintharawat, on Wednesday, April 29, 1987 (Bangkok: Rom Phim Sathan Songkroh Ying Pak Kret, 1987), 35-43.

⁴⁸ Royal Thai Government Gazette, "Royal Decree on the Establishment of the Faculty of Medicine, Ramathibodi Hospital in the university of medicine, 2508" (1965) (Volume 82, Section 61K, Page 104, August 3, 1965).

⁴⁹ The number of physicians who graduated from the years 1957-1971 is as follows: 1957 - 192 graduates, 1958 - 242 graduates, 1959 - 193 graduates, 1960 - 239 graduates, 1961 - 225 graduates, 1962 - 230 graduates, 1963 - 234 graduates, 1964 - 262 graduates, 1965 - 262 graduates, 1966 - 236 graduates, 1967 - 250 graduates, 1968 - 265 graduates, 1969 - 243 graduates, 1970 - 293 graduates, and 1971 - 359 graduates.

⁵⁰ Thassanee Thammatat, "The problem of doctor shortage in Thailand" (Economics Department, Faculty of Political Science, Chulalongkorn University, 1972), 24-29."

⁵¹ Prawese Wasi, 'Medicine and Public Health in the Past 25 Years,' in Social Science Review: 48-59.

⁵² Thassanee Thammatat, "The problem of doctor shortage in Thailand," 4-12.

⁵³ National Archives of Thailand, (2) SR0201.27.2 /34, "Establishment of Nursing and Public Health in the Isan Region (6 Nov 1950 - 17 Nov 1953)."

⁵⁴ National Archives of Thailand, (2) SR0201.27.2 /26, "Phitsanulok Provincial Hospital (26 Jan - 11 Feb 1949)."

For example, Phitsanulok Province in 1948, Nakhon Ratchasima Province in 1955, Chiang Mai Province in 1961, Chanthaburi Province in 1965, Nakhon Sawan and Ubon Ratchathani Provinces in 1970, Khon Kaen Province in 1971, and Songkhla Province in 1973.

⁵⁵ Arun Nuraksake, "Development of Nursing Administration in Thailand" (Nursing Education, Faculty of Graduate Studies, Chulalongkorn University, 1978), 4-6.

⁵⁶ National Archives of Thailand, (14) SB 1.6/5.56, "Faculty of Medicine, Khon Kaen University [15 Dec 1972]."

⁵⁷ Thassanee Thammathat, "The problem of doctor shortage in Thailand," 39.

⁵⁸ Wiwan Ekarintarakul, "Public Health Administration in Thailand 1958 - 1977," 138.

⁵⁹ Wiwan Ekarintarakul, 140.

⁶⁰ Thassanee Thammathat, "The problem of doctor shortage in Thailand," 45.

⁶¹ Santisuk Sophonsiri, Thai Physicians' Legacy for Future Generations: Life and Work of Professor Dr. Sem Pringpuangkeo (Bangkok: Society and Health Institute (SHI), Office of the permanent secretary, 2012), 148-149; Wibulpolprasert S, and P Pengpaibon. "Integrated strategies to tackle the inequitable distribution of doctors in Thailand: four decades of experience." Hum Resour Health. 2003 Nov 25;1(1):12. doi: 10.1186/1478-4491-1-12.

⁶² John Kennedy and Staff, "A Brief History of USOM Support to Public Health & Population Programs in Thailand," 10.

⁶³ Interview with Professor Dr. Prakrit Vathesatogkit, 10 June 2022.

⁶⁴ National Archives of Thailand, (3) TM. 2.1 /70, "Problems of Doctors Studying and Working Abroad (26 Jan - 20 Jun 1966)."

⁶⁵ John Bryant, "The Health Needs of Rural Thailand: A Challenge to traditional University Structure and Function", the Siam Society. Volume 58.1, 1970, 45-66 (48).

⁶⁶ Royal Thai Government Gazette, "Announcement W. 81/2501 of Boonchuay Srisavasdi, Member of the House of Representatives, Chiang Rai Province, Subject: Medical Degree" (Volume 75, Section 78NG, Page 2744, 7 October 1958).

⁶⁷ Thassanee Thammathat, "The problem of doctor shortage in Thailand," 51-52.

⁶⁸ Thassanee Thammathat, 50.

⁶⁹ Thassanee Thammathat, 51-52.

⁷⁰ Harold E. Smith (1982). Doctors and society: A Northern Thailand study, Soc Sci Med, 16(5), 515 (515–526). doi:10.1016/0277-9536(82)90305-7.

⁷¹“Utility is meant that property in any object, whereby it tends to produce benefit, advantage, pleasure, good, or happiness...to prevent the happening of mischief, pain, evil, or unhappiness.) Bentham, Jeremy. (2000). “An Introduction to the Principles of Morals and Legislation.” Kitchener: Batoche Books, 14-15.

⁷²Wiwan Ekarintarakul, “Public Health Administration in Thailand 1958 - 1977”, 124-126.

⁷³Interview with Professor Dr. Prakrit Vathesatogkit.

⁷⁴Harold E. Smith (1982). Doctors and society: A Northern Thailand study, 515–526.; William Edgar Maxwell, Modernization and Mobility into the Patrimonial Medical Elite in Thailand, American Journal of Sociology, Vol. 81, No. 3 (November 1975), pp. 465-490. <https://www.jstor.org/stable/2777640>.

⁷⁵Royal Thai Government Gazette, “Medical Profession Act 2511” (Volume 85, Part 91K, Page 990, October 8, 1968).

⁷⁶Wiwan Ekarintarakul, “Public Health Administration in Thailand 1958 – 1977”, 149-154. In the subsequent period following political changes in the month of October 1973, the medical field took significant steps forward. In the month of October 1973, a movement began to gain importance in establishing general practitioners. The focus shifted towards the potential benefits of this group. Dr. Prawese Wasi, stated clearly that these “quack doctors” could be trained in basic medical knowledge to provide patient care. These quack doctors often had a closer relationship with the local community and were better acquainted with the people compared to university-trained doctors. This transition to “paramedics” was a positive step in addressing rural issues.

⁷⁷Royal Thai Government Gazette, “Medical Profession Act 2525 (B.E.1982)” (Volume 99, Part 111K, Special Issue, August 11, 1982).

⁷⁸History of Medicine and Public Health in Thailand. Bangkok: The Medical Council of Thailand, 2020, 235.

⁷⁹Secretariat of the Medical Council of Thailand, 50 Years of the Medical Council of Thailand (1968 - 2018) (Nonthaburi: Secretariat of the Medical Council of Thailand, 2019).

⁸⁰Royal Thai Government Gazette, “Medical Profession Act 2511(B.E.1968)” (Volume 85 Part 91K Page 690 October 11, 1968)

⁸¹Wiwan Ekarintarakul, “Public Health Administration in Thailand 1958 – 1977”, 143-149.

⁸²Interview with Dr. Amphon Jindawatthana, May 18, 2022; Interview with Dr. Suwit Wibulpolprasert, May 16, 2022.

⁸³Interview with Dr. Supattra Srivanichakorn, June 21, 2022.

Reactionary Group refers to people who disagree with changes and still prefer traditional systems or values.

⁸⁴Santisuk Sophonsiri, Thai Physicians' Legacy for Future Generations: Life and Work of Professor Dr. Sem Pringpuangkeo, 161.

⁸⁵ Sombat Chantarawong and Rangsan Thanapornphan, *Love Thailand: Volume 1 - History and Politics*. Bangkok: Thai Watana Panich, 1976.

⁸⁶ Sanguan Nitayarumphong, ed., *Mahidol Historical Almanac for Democracy Part 1: The Birth of the Movement* (Bangkok: Committee of Mahidol historical almanac for democracy, 2003), 108.

⁸⁷ The Secretariat of the Cabinet, "Solving the Problem of Doctors Working Abroad," March 14, 1967, https://resolution.soc.go.th/?prep_id=80508.

⁸⁸ Matichon Online, "How Much is the Fine for Contract Violation by Medical Students?" by Dr. Chanwalee Srisukho, December 6, 2018, https://www.matichon.co.th/article/news_1257650.

⁸⁹ The Secretariat of the Cabinet, "Solving the Problem of Doctors Working Abroad."

⁹⁰ Nonglak Phakaiya and Pennapa Phongthong, ed., "Health workforce in Being, Living, and Future" (Bangkok: ThaiHealth Promotion Foundation, 2011), 49

⁹¹ The Secretariat of the Cabinet, "Solving the Problem of Doctors Working Abroad."

⁹² Sanguan Nitayarumphong, ed., *Mahidol Historical Almanac for Democracy Part 1: The Birth of the Movement*, 108.

⁹³ Sanguan Nitayarumphong, ed., 83.

⁹⁴ Wichai Chokwiwat, *Legend of conflict in the public health field* (Nonthaburi: Healthy Social Development Coordination Office, 2016), 41.

⁹⁵ Sanguan Nitayarumphong, ed., *Mahidol Historical Almanac for Democracy Part 1: The Birth of the Movement*, 226 - 227.

⁹⁶ Interview with Dr. Siriwat Thiptharadol, May 20, 2022.

⁹⁷ Suwit Wibulpholprasert, ed., *25 Years of Rural Doctor Movement in Thailand* (Bangkok: World Health Organization, 2003), 8–9.

⁹⁸ Prawese Wasi, "Medicine and Public Health in 25 Years," *Social Science Review*, 48–59.

⁹⁹ Davisakd Puaksom, *Infectious Diseases, Body, and Medicalizing State: History of Medicine in Modern Thai Society*, 330–331.



The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868-2002

Rural development advancement
towards the concept of preventive
medicine

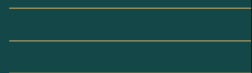




Figure 34 Image of the Rural Water Development Project for Clean Drinking Water in the Countryside by the Department of Health, Khon Kaen Province, 1967.

Source: National Archives of Public Health, (13), B.NEG 2.1/11.61, Number 19/10 Roll 1, Khon Kaen Rural Water Project, 29-7 May 1967." (Photo by Somphong Untarikanon)

The developmental discourse of the state, which began to expand into rural areas from the 1957 decade, transformed into one approach in which the state (as a service provider) engaged in relationships with the public (service recipients) following a top-down approach. During this period, the state emphasized 'creating the most' in terms of both infrastructure and human resource development, believing that if the government could establish stability for these policies, it would lead to the widespread distribution of benefits to the lower levels. In terms of objectives, this approach seemed clear, but in practicality, various development efforts were dispersed and a consistent direction of progress was not apparent.

Nevertheless, amidst the prevailing disparities, what emerged was the accelerated rural development expansion, which provided numerous opportunities for initiation. It aimed to fulfill agreements in a trans-sectoral and multi-stakeholder manner between the government sector and international organizations, such as introducing the concept of community-based programs as pilot projects to experiment and promote community-based healthcare and preventive medicine. Consequently, with financial support from organizations like the WHO, UNICEF, and the US, combined with the responsibility of the Thai government's disease control efforts under the Department of Health, it allowed for the observance of the growth of the Department of Health as a knowledge producer.

Department of Health and health development projects in rural areas

If we compare global trends with community development projects in rural areas of Thailand at the time, the structure of Thailand's public health system was aligned with the direction set by international indicators. This alignment has been evident since the late 1940s when the US emphasized broad-based rural development. Vertical programs were implemented to combat specific diseases, supported by budget allocations for building medical institutions and striving to establish hospitals in every province or expand healthcare outposts to cover remote areas. However, even during that time, the existing healthcare system was not as comprehensive as desired, with issues like uneven distribution of medical personnel (hospitals had doctors, but health centers did not), a service approach that required recipients to seek providers (or wait for doctors to be available), and difficulties for villagers in accessing care due to transportation challenges. Furthermore, public health, nutrition, and population growth remained problematic. As a result, focusing solely on disease eradication and medical care proved insufficient. Consequently, the US and international organizations, starting from around 1957, adjusted their rural public health strategies, and their support shifted toward infrastructure development for public utilities and planning for preventive health measures in rural areas.

“In Thailand, the strategy for economic development began to take shape, aiming to stimulate investment in the industrial sector through the National Economic Development Plan. This led to the establishment of foundational infrastructure to support investments in various regions. For instance, the expansion of roads into remote areas facilitated greater connectivity between peripheral and the central region, fostering increased economic activity. This era is often associated with the phrase ‘Flowing water, bright lights, good roads, and employment opportunities’ - a testament to the growing economic momentum.”¹

Due to this context, the challenge of developing public health initiatives began to reveal a shift in perspective, looking back to address health issues in rural areas that were increasingly intertwined with the citizens’ way of life. The focus expanded beyond mere healthcare maintenance or addressing specific causes of diseases (such as combating mosquito vectors linked to diseases like malaria). Dr. Paichit Pawabutr recounted how the strategy for rural areas was evolving during that period: *“After World War II, there were many diseases like Smallpox, Yaws, etc., and WHO tackled this. After successful implementation of the vertical program approach for a while, as the prevalence of these diseases decreased, there was a suggestion for a more horizontal program to train personnel with general knowledge to manage the situation.”*² This became the foundation for initiating the study and development of tools used in the implementation of ‘Prevention and Promotion’ activities for health in rural areas, through the management of the rural health development projects by the Department of Health.

Meanwhile, a group of Thai public health personnel supporting the approach of Integrative Medicine started to exert influence, dating back to the 1957-1966 decade, coinciding with the time when the Department of Public Health was re-named to simply the Department of Health in 1952.”³ As a result, the Department of Health has transitioned into a significant mechanism in the development of Thailand’s healthcare system, closely aligned with the Medical Services Department. This transformation gave rise to a collective mindset among various ‘Public Health Physicians,’ who evolved into a new group of key players in establishing the foundation for rural public health, starting from the 1957 decade.

Figure 35 Image of UNICEF staff conducting a field visit in the Northeastern Region in January 1964

Source: National Archives of Public Health,, (13) B.NEG 2.1/8.1, UNICEF Field Visit to the Northeast, Jan 1964.



Before the substantial rural development initiatives took place, the Department of Health played a vital role in both administrative and academic aspects of disease prevention and control, health promotion, and primary health care at the level of health centers (with hospital-based disease treatment falling under the jurisdiction of the Medical Services Department). Following the renaming to the Department of Health, experienced medical professionals in disease and nutrition took up pivotal leadership roles. Consequently, the personnel within the Department of Health played a significant role in pushing for the establishment of numerous units and rural development projects, with substantial support from USOM, UNICEF, and WHO. Therefore, the Department of Health, which began to develop public health into a more comprehensive system, had its origins with Dr. Kamthorn Suvarnakich, a nutrition expert within the MOPH. During his tenure as Director-General of the Department of Health (1958-1966), Dr. Kamthorn led the 'Local Health Development Project,' supported by USOM. This project is considered a blueprint for the early rural development initiatives, aiming to address the healthcare system in rural areas (which was previously only organized within municipal areas). It aimed to provide various public utility services, such as clean water supply, proper sanitation facilities, and environmental health regulations, as an attempt to manage public health in rural communities. This was crucial due to the high prevalence of gastrointestinal diseases that led to significant illness and mortality rates among rural populations.⁴ The subsequent

mission involved training village residents in basic hygiene practices, facilitated through the establishment of field operation centers in Nakhon Ratchasima Province. This choice was due to the province's significance as a gateway to the northeastern region, making it an initial area of focus within the project. The process included training health officers (from health centers and Midwife's Office) to instruct villagers in building proper water wells and sanitation facilities. Additionally, a funding system was set up to create water wells in the province. The local health development project was deemed successful, and achieved a high level of success. Soon after, it rapidly expanded to villages nationwide.⁵



Figure 36 Image of UNICEF staff conducting a field visit in the Northeastern Region in January 1964.

Source: National Archives of Public Health, (13), B.NEG S. 2.1/8.1, No.3/07 Roll 1, UNICEF Field Visit to the Northeast, 6-19 January 1964. (Photo by Amnat)

Moreover, there were efforts to control and prevent nutritional deficiencies and iodine deficiency disorder. Projects included the Iodine Deficiency Disorder Control Program and the Pilot Salt Production Project in Phrae Province in 1965. These initiatives were conducted under the leadership of Dr. Amorn Nondasuta and Dr. Romsai Suwanik, a senior health officer stationed in Phrae Province and a faculty member of the Faculty of Medicine, Siriraj Hospital, respectively. These projects received strong support from the Deputy Director and the Director of the Nutrition Division at that time.⁶ In this regard, the preventive efforts for goiter were supported by UNICEF and FAO (Food and Agriculture Organization) when they were continuously implemented to control goiter using iodized salt. This led to a reduction in the prevalence of goiter in the northern region provinces, such as Phrae, Chiang Mai, Chiang Rai, Uttaradit, Nan, Lampang, and Lamphun. Eventually, the scope of the project expanded to a national level in 1968. During this period, Dr. Amorn assumed the role of Director of the Nutrition Division, and directly promoted goiter prevention. Subsequently, as the Permanent Secretary of the MOPH, he pushed for addressing iodine deficiency disorders, making nutritional issues a part of the 4th and 5th National Economic and Social Development Plan (1977-1981 and 1982-1986, respectively).⁷

Another type of project under the supervision of the Department of Health is the 'Rural Health Service Promotion Project,' which began as the 'Rural Health Service Promotion Project at Wat Bot District,' Phitsanulok Province. This initiative was initiated by Dr. Kamthorn Suvarnakich, who collaborated with Dr. Somboon Vachrotai, an experienced professional in combating Yaws in Thailand during the final phase of Yaws disease control (1964-1966). During this period, the concept of 'training and educating villagers' was introduced to empower them in self-care and health management. This approach was born out of the recognition that the state's healthcare service system, including provincial hospitals and district health offices, was not widely accessible, and there were shortages in both medical personnel and resources. Relying solely on doctors or health workers would not yield sustainable results, as he mentioned regarding the scarcity of resources, stating: *'In a certain province, even the provincial hospital and the district health office have only a few health centers, mostly at the sub-district level, where there is usually only one doctor and one nurse or midwife.'* Given the aforementioned challenges, the 'Rural Health Service Promotion Project' was launched in Wat Bot District, Phitsanulok Province, to establish a mechanism for an integrated healthcare network aimed at achieving maximum effectiveness in disease control within the community.⁸ Eventually, the framework of health centers at the first and second levels, as well as the midwifery center, became the foundation adopted by the MOPH.⁹ This project was also supported by WHO and UNICEF. Dr. Somboon was responsible for overseeing it, starting from the Phitsanulok Project, and later continuing with the Sarapee Project (1968) and the Lampang Project (1974) and beyond.

A. Phitsanulok Project (1964-1967) to other projects: First steps of Primary Health Care

The Phitsanulok Project (1964-68) received support from WHO and UNICEF. It was led by Dr. Somboon Vachrotai, who was then the Director of the Division of Control of Endemic Diseases and Yaws at the Department of Health, as well as being a driving force behind the community medicine project at Ramathibodi Medical School, during that time.¹⁰ The Phitsanulok Project emerged in response to two significant challenges. Firstly, it addressed the issue of inadequate coverage by public health personnel, compounded by the uneven distribution of healthcare infrastructure. Secondly, it tackled the lack of training provided to doctors to become leaders in public health teams.¹¹ Hence, there was a need to establish a network of healthcare services through district, sub-district, and village-level facilities (Health Center Level 1, Level 2, and Midwifery Center), and to identify individuals in the local area with at least a high school education (having completed 10 years of schooling) for training, enabling them to take on the responsibility of providing integrated local health services.¹² The principle was to train villagers to serve as sub-district health assistants and midwives. Dr. Chamroon Meekanon, one of the project implementers, emphasized that a key objective was to involve 'local residents' as sub-district health assistants, responsible for monitoring and providing care to people in the area. Additionally, health centers were established through local donations to support trained female health assistants who served as midwives within their own communities.



Figure 37 Image of the Family Health Project, Maternal Training (Health, 3rd Batch), Suphan Buri - Phetchaburi Province, January 19-23, 1970

Source: National Archives of Public Health, (13) B.NEG S. 2.1/17.5, Maternal Training, Suphan Buri and Phetchaburi, January 1970

Although mechanisms had been discovered to establish a network of health centers at the district and sub-district levels, including midwifery centers at the village level, which greatly contributed to improving the effectiveness of disease control campaigns, it is evident that the state's healthcare services remained relatively unchanged. For instance, *"out of every 100 patients, only 15 seek assistance from various types of Ministry of Public Health facilities. This underscores the need for further examination of this reality."*¹³

However, this experiment highlighted the significance of the 'villagers' role' that gradually evolved into the heart of preventive medicine practices. Thus, the reality that the project team encountered was the natural inclination of villagers to sustain their own health within their community, without heavy reliance on the state, unless absolutely necessary. Except in cases of severe illness, they tended to seek care within the community. Their traditional way of life was often tied to their locality, and traveling to seek healthcare was often a disruption to their daily sustenance. Therefore, *"seeking medical care from distant places became an arduous task for rural residents, to the point that they sometimes endured pain and sickness until they passed away at home."*¹⁴

Figure 38 The United Nations Children's Fund (UNICEF) conducted a field visit to the Northeastern region of Thailand in January 1964.

Source: National Archives of Public Health, (13) B.NEG S2.1/8.1, UNICEF's visit to the Northeast, January 1964."



The evident truth reveals that the healthcare service system characterized by a passive approach, where villagers waited for healthcare personnel to come to them, did not foster meaningful community participation. Despite training villagers as auxiliary personnel or midwives, and distributed across connected service units, even extending to the village level, it still failed to elicit strong cooperation between the villagers and the state. With this in mind, the community-oriented medical practitioners devised a new strategy, centered around the community and aligned with its traditional way of life. The objective was to establish a mechanism within the community that could self-monitor and control health issues.

Simultaneously, there should be a network linking healthcare personnel to this community-centric approach. This community-centered approach was further adapted and developed in the 'Sarapee Project,' with support from USAID. This project can be considered the first step toward organized Primary Health Care (PHC) in Thailand, before the WHO would announce the "Health for All" vision a decade later.¹⁵

In 1968, when the 'Sarapee Project' began its implementation in collaboration with the Faculty of Medicine, Chiang Mai University, experimental training was initiated for 'Community Volunteers.' Additionally, medical students were trained as 'Community Health Team Leaders.' This project achieved considerable success,¹⁶ and it also encouraged community participation in filling the gaps in healthcare services alongside the government. During that period, there was a proliferation of continuation projects and new initiatives across various provinces and originating from different affiliated organizations. For instance, projects like the 'Ban Pai Project' (Khon Kaen Province), 'Sameng Project' (Chiang Mai Province), 'Non-Thai Project' (Nakhon Ratchasima Province), and many other pioneering projects emerged. An example of this is the Bladder Stones Project (1964-79), where Ari Wanlayasevee, a faculty member in the Department of Pediatrics at Siriraj Hospital, participated in surveying and researching.¹⁷ The Health Development Planning Project in Chonburi Province in 1972 utilized the Project Systems Analysis method of the WHO. The project involved a team of professionals including Dr. Yutthana Suksamitti, M.R.W.Chalermasuk Bunthai, Dr. Damrong Boonyoen, Dr. Uthai Sudsukh, and other experts from the Health Planning Division, MOPH, who received assistance from WHO. The objective was to develop a prototype health development plan for Chonburi Province. Among all of these projects, the 'Lampang Project' stands out as the most prominent.

Figure 39 An image during the meeting in "Sarapee Project" in January 1969.

Source: National Archives of Public Health, (13) B.NEG S. 2.1/13.105, the meeting in "Sarapee Project" in January 1969.



B. “Lampang Project”: New horizon of Thai public health

When political, social, and economic opportunities emerged after the events of October 14, 1973, it provided a favorable environment for the expansion of rural development projects by the MOPH. This led to larger-scale initiatives compared to the previous pilot projects. The project that stood out as the most successful flagship initiative was the ‘Lampang Project,’ which spanned a period of 7 years from 1974 to 1981. The MOPH received support from various quarters, including collaborative research efforts from Chiang Mai University and the National Institute of Development Administration, with significant funding from the United States, facilitated through cross-border resource management, joint evaluations, and academic partnerships involving the University of Hawaii’s School of Public Health, the American Public Health Association (APHA), the Asia Foundation, USAID, WHO, and UNICEF.¹⁹

development project spanning nearly a decade, resulting from collaboration between USAID and APHA. The project aimed to serve as a testing ground for integrated medical approaches in various developing countries, seeking the best methods to address the imbalances in the healthcare system of underdeveloped nations. In the case of Thailand, the MOPH selected Lampang Province due to its economic and social suitability. Importantly, Lampang was an area with ‘minimal interference from hostile forces’ (representing a notable shift in U.S. policy, as stability was no longer a determining factor as it had been in previous decades).²⁰ Operated through a belief that the conventional healthcare service approach, which focused on eliminating specific diseases, could not adequately address the more complex needs in rural areas, a blended approach was deemed most effective and efficient. The fundamental approach was divided into two main components: (1) Strengthening healthcare provision for healthcare workers and hospitals, coupled with (2) a training strategy to equip the community with skills for self-care and health promotion. Following this, a network of community-based components was developed, including Village Health Volunteers (VHVs), Traditional Birth Attendants (TBAs), and Public Health Communicators (PHCs). The success of this project led the government to adopt these principles, and implement the Primary Health Care (PHC) system in the National Economic and Social Development Plans, spanning over a period of more than 10 years, as outlined in the 4th and 5th National Economic and Social Development Plans.²¹ Hence, the Lampang Project is considered a “model” of provincial and community-level PHC development in a truly developmental country context.²²

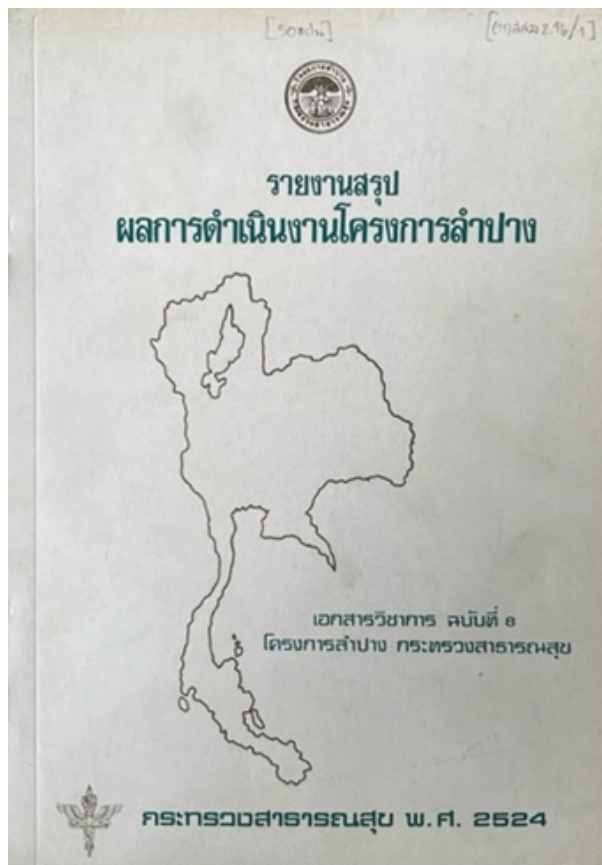


Figure 40 Image of the cover of the report summarizing the results of the Lampang Project.

Source: National Archives of Public Health, (11) SSM 2.16/1, (Cover) Summary Report of the Lampang Project

Overall, the projects of the Department of Health mentioned above were mostly collaborative endeavors between Thailand and international partners. This was largely due to budget constraints, as the Department of Health often received less funding from the government compared to the Medical Services Department. As a result, foreign aid contributed to the continuous implementation of various pilot projects. Additionally, the strategies of the Department of Health aligned with the funding directions from international partners, such as the health policies of the US, WHO, and UNICEF. Furthermore, the personal networks of individuals from the Department of Health, including “outsider” physicians like Dr. Kamthorn Suvarnakich, Dr. Amorn Nondasuta, and Dr. Somboon Vachrotai, played a key role in attracting budgetary support from

foreign sources. While many projects initiated by physicians from the Department of Health experienced varying degrees of success or failure, a consistent finding from multiple rural area experiments in the 1950-60s was the importance of “returning to the village” and the involvement of the host community.²³ Subsequently, it began to take shape and further develop in order to become a central hub in addressing ongoing issues within the healthcare system.



Figure 41 Image of a meeting of US Peace Corps volunteers on health development

Source: National Archives of Public Health, (13) B.NEG S. 2.1/8.203, Number76/07 Roll 1, Meeting of US Peace Corps Volunteers on Health Development in Nakhon Ratchasima, 9-16 September 1964

Therefore, from 1957 onwards, the Department of Health’s role gradually increased, growing in tandem with the expansion of its scope of work. Another contributing factor was the network of “Rural Health Doctors” which began to interact through various pilot projects. The Department of Health thus became a melting pot of ideas, promoting the elevation of various key figures within the department to play roles in the structural transformations of the MOPH during the late 1960s. Notably, individuals like Dr. Pairode Ningsanon engaged with progressive groups of leading physicians under the name “Poysian Group” (a prominent physicians’ group), aiming to propose curriculum reforms for preventive medicine education and holding significant positions such as Director-General of the Department of Health, Permanent Secretary of the Ministry of Public Health, and Minister of Public Health.²⁴ In the case of Dr. Amorn Nondasuta, he evolved into a crucial influencer within the MOPH, holding positions such as Director of the Nutrition Division, Deputy Permanent Secretary, and Permanent Secretary, all of which played a significant role in advancing the PHC concept. Meanwhile, Dr. Somboon Vachrotai went on to serve as the Director-General of the Department of Health from 1974 to 1979 and as the Director-General of the

Department of Communicable Diseases Control in 1980, until his retirement. As the influence of rural health doctors within the MOPH expanded, another branch of preventive medicine ideology emerged within the walls of universities. Both of these trajectories aimed to propel preventive medicine as a gateway out of the crisis of medical personnel shortage and inadequate access to healthcare services within society at that time.

From experimentation to classroom: Emergence of preventive medicine approach within university

The approach to medicine focused on “prevention” has a significant standpoint: medical knowledge and physician education should commence with learning the health issues and societal needs, moving towards seeking treatment methods rather than just preparing theoretical treatments. Inefficient treatments occur when faced with real-life societal situations because of a lack of understanding of the patient’s context or their way of life. The emergence of preventive medicine marked a turning point in various aspects of Thailand’s medical and public health arena. For instance, discussions about the role of physicians and their contributions to society were brought forth by groups of physicians outside traditional boundaries, often referred to as “Young Turk” doctors within the Ramathibodi Faculty of Medicine. Debates regarding structural reform in public health to enhance freedom in management, organization, and more efficient care in provincial areas gained momentum. Efforts to streamline decision-making processes of central authorities in relation to regional public health initiatives also intensified.

A. Community medicine approach in medical schools

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“...In those days, doctors understood each other well. In the beginning, there was no electricity, and we used oil lamps. Water was fetched from wells. Sometimes even toothbrushes had debris on them... We didn’t prepare ourselves for work with consultations like medical school. We had to make decisions ourselves. Sometimes it felt like we were experimenting with people’s lives so that they wouldn’t die in the future. Another thing is that the curriculum we learned didn’t prepare us for rural practice. It was more suitable for further studies or going abroad...”²⁵

Dr.Mongkol Na Songkhla

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The story of Dr. Mongkol Na Songkhla reflects the conflict between the theoretical medical curriculum and the real-life experiences of the working world, clearly illustrating the significant origins behind the establishment of the Faculty of Medicine at Ramathibodi Hospital (1965). This was initiated by the group of “Young Turk” doctors who aimed to bring about certain changes in the field of medical education, aspiring for teaching and learning to be directed towards confronting and dealing with the realities of society more effectively.



Figure 42 Health survey in rural areas
Health survey in rural areas

Source: National Archives of Public Health, (13) B.NEGS.2.1/9.51, Director of Health Development meets with USAID on health matters, March 1965.

However, determining the direction of the Faculty of Medicine at Ramathibodi Hospital was not an easy task. One of the supporters of the establishment of the Faculty of Medicine at Ramathibodi Hospital was the Rockefeller Foundation.²⁶ This meant that the professors and scholars of the Foundation played a significant role during the establishment and design of this medical school. Therefore, it is not surprising that the Faculty of Medicine at Ramathibodi Hospital continued to emphasize the production of “top-tier doctors” as its focus.²⁷ Furthermore, undoubtedly, the significant issue faced by the medical field in Thai society at that time was the “insufficient medical personnel.” The establishment of this medical school aimed to increase the capacity to produce medical personnel for society. In the 1950s, representatives from the Rockefeller Foundation held discussions with representatives from the Faculty of Medicine at Siriraj Hospital, Mahidol University, including Dr. Chatchawal Osathanondh and his colleagues, to explore solutions for the shortage of doctors, a problem closely related to the increasing Thai population and the disparity between urban and rural areas. It became apparent that both the Faculty of Medicine and the Rockefeller Foundation representatives agreed that the root cause of the doctor shortage was the lack of “pre-clinical

instructors” or “pre-clinical faculty members” in Thailand. There was a pressing need to accelerate the production of such instructors through budget allocation and academic collaboration with the Faculty of Medical Sciences (Faculty of Science, Mahidol University) in order to produce graduates with the capability to be integrated into the newly established departments within those faculties.²⁸ Additionally, they provided financial support and academic assistance to the Faculty of Medicine at Ramathibodi Hospital to produce more physicians, building upon the foundation of the three existing medical schools.

Although the primary objective of the foundation was to produce specialized doctors and instructors, it must be acknowledged that a significant portion of the budget was allocated to instructor production within the university.²⁹ During the 1957-1966 decade, the Rockefeller Foundation's role shifted toward a greater focus on rural areas, leading to the establishment of community-oriented medicine through the formation of "Community Medicine Centers." These centers served as educational hubs for preventive medicine and acted as intermediaries between the university and students, facilitating work in rural regions.

Another reason why some medical professors pushed for the establishment of the Faculty of Medicine at Ramathibodi Hospital was the need to break away from the atmosphere and framework of Siriraj Hospital's medical establishment. This environment was seen as inhibiting the creation of new ideas. It was this very mindset that differentiated the early atmosphere of the Faculty of Medicine at Ramathibodi Hospital from that of Siriraj Hospital's Faculty of Medicine. The former emphasized open debate, bold expression, the importance of philosophical problem-solving, and the ability of instructors to critically analyze their teaching methods.³⁰ *"Siriraj and Ramathibodi differed distinctly from each other, right from the intentions of the professors. The individuals who chose to study at Siriraj or Ramathibodi were distinct... If it's Siriraj, it tended to be more conventional, whereas Ramathibodi was more modern and liberal."*³¹ With an atmosphere like this, it led to raising questions among some groups of professors and students about what the medical profession should be like. The group of professors who played a significant role at Ramathibodi during that time clearly outlined that this medical school was established to produce doctors for rural areas, aiming to address the doctor shortage and to create a new generation of doctors who would be leaders in driving social change.³² As stated by Dr. Aree Valyasevi, the first dean of the Faculty of Medicine at Ramathibodi Hospital, *"During that period, we were awakening to the stark reality of a severe shortage of doctors in the rural regions... Our goal at that time was to prepare medical students to go and practice in rural areas once they graduated."*³³

B. Doctors outside the tradition and the push for community medicine approach

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“At a certain healthcare facility... we went to inquire about who the doctor was and wanted to have a conversation about their daily activities. The doctor said, ‘There’s not much to do. Patients come, and I see about 7-8 of them a day. The rest of the time, I sit and wait for them. Then I count the days, waiting for when my funding runs out so I can return to Bangkok.’ So, I asked, ‘Don’t you engage with the community or think about disease prevention?’ ‘No, not really. I didn’t study for that. I learned only to treat. I sit and wait, keeping an eye on when they’ll come next.’ It’s like this... It won’t work. If we continue producing like this, what are we going to achieve? So, we started discussing how these things need to be community focused.”³⁴

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Dr. Aree Valyasevi

In reality, the study of community medicine had already taken place prior to this at the Faculty of Medicine, Siriraj Hospital. However, it wasn’t given much importance and was often seen as having a status akin to a “neglected step-child.” Even during the efforts at Ramathibodi, there were still those who disagreed, viewing it as *“teaching people to become quack doctors.”*³⁵ However, Dr. Prem Buri, one of the proponents behind the establishment of the Faculty of Medicine at Ramathibodi Hospital, emphasized that the essential principle behind the creation of community medicine centers was to produce doctors who prioritized understanding the community, saw societal issues systematically, and comprehended the interconnected problems within society. Dr. Prem’s viewpoint was that the significant challenges faced by medical education lay in these broad perspectives.

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It poses a significant challenge when the education and training system for medical professionals follows the traditional path of developed countries, while potentially providing graduates with the necessary knowledge and skills for working within hospital settings and other urban environments. However, this system may not adequately equip them with the knowledge, skills, and appropriate attitudes required to address novel and diverse health problems encountered in rural community settings....”³⁶

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Under the pressure of the physician's reform initiatives, efforts were made to merge the approaches of doctors focusing on treatment and prevention to address public health issues during that time. This eventually led to the inception of the "Community Medicine Program," aiming to encourage medical students to observe and learn about communities alongside their clinical studies. This program encompassed surveys, analyses, and planning to address community issues. After completing their sixth-year clinical studies, students were required to spend six weeks working in rural community hospitals. The program was established as "Community Medicine Centers," a collaborative effort between Ramathibodi Hospital and the MOPH. This collaboration facilitated the deployment of medical students for study and practical training at Bang Pa-In District Hospital in Ayutthaya Province, with hospital personnel or physicians serving as supervisors to guide the learning process.³⁷ Being a training ground for Ramathibodi medical students, Ayutthaya Province was turned into a pilot area for healthcare system reforms in the future.³⁸ When the push for the establishment of community medicine centers within the Faculty of Medicine, Ramathibodi Hospital, was successful, Dr. Prem emerged as one of the reformist physicians who came together to drive changes in the medical curriculum, along with certain colleagues. This group of physicians was also known as the "Poysian Group."

The term "Poysian" (or the reformist physician) refers to a collective of doctors who aimed to reform the healthcare system in the early 1960s due to a shortage of medical professionals. This group of physicians had a significant influence on shaping the trajectory of medical and public health reforms following the events of October 14, 1973.³⁹ Dr. Prawese Wasi, one of the key members of the group that initiated the concept of community-oriented healthcare, recalled that during that time, he held positions as a committee member of the Medical Council and was appointed as the chairman of the committee responsible for formulating recommendations for national medical and public health planning. Reflecting on the events leading up to October 14, 1973, he said *"Back then, when I was appointed as chairman, I wanted to improve the well-being of people, but I didn't know much about the system. I only knew the technical aspects. So, it became a starting point for seeking knowledge. I conducted surveys to listen to the villagers' issues, created questionnaires... because if you don't understand the country's context, you may fail a hundred times even after attempting a hundred times."*⁴⁰ The exploration during that period marked a significant turning point in Dr. Prawese's mindset, transitioning from being a "doctor treating individuals" to becoming a "doctor treating the community." This implies that being a doctor means not only inquire about the patient's symptoms but also delving into other aspects of the patient's life and suffering.⁴¹

Within the committee tasked with formulating proposals and planning for the national healthcare system, where Dr. Prawese served as the chairman, numerous individuals were invited to contribute their opinions as part of the committee, but the core group consisted of 8-9 members. Among them were Dr. Prem Buri,

Dr. Aree Valyasevi,⁴² Dr. Pairode Ningsanon, Dr. Thongchan Hongladarom,⁴³ Dr. Damrong Boonyoen Dr. San Hatthirat, Dr. Prasarn Tangjai, and Dr. Sem Pringpuangkeo, a senior physician who joined later. The group participated in gatherings held at Ramathibodi Hospital. The guiding principles of significant healthcare reform included the imperative to integrate preventive and curative work (integrated) and to transform doctors into leaders of the health team. This point necessitates revisiting aspects that have been considered since the medical education system emphasized that teaching should not be compartmentalized. However, when the real situation arose, many of the taught aspects were not applicable. Therefore, the learning content needed to be organized into a comprehensive package, leading to a major adjustment to the prevailing medical curriculum at that time.⁴⁴

Although the concept of community medicine as an important foundation of preventive medicine had been contemplated from the 1950s to before the events of October 14, 1973, it had not been vigorously pursued to yield significant policy outcomes. It wasn't until after 1973, when the political, social, and economic landscape underwent transformations, that a new imaginative space emerged for rural areas. This shift facilitated the convergence of diverse groups, allowing for the exploration of novel approaches. This change, in part, led to a shift away from the utilitarian perspective or an emphasis solely on utilitarianism, which opened the door for community medicine and preventive healthcare to flourish.

C. The events of October 14 and the acceleration of community medicine approach in the late 1960s

The sudden downfall of the repressive government under the administration of General Thanom Kittikachorn on October 14, 1973, led to the emergence of a new government. This event paved the way for a proposal regarding the “modification of the medical curriculum.” Progressive physicians recognized that medical education at that time placed greater emphasis on technology than on human and societal concerns. Thus, they advocated for a shift towards problem-based learning, utilizing community targeting as the foundation of education. This approach placed problem-solving at the forefront of learning, directing efforts towards addressing community issues, rather than predefining subjects without prior knowledge of the problems at hand.

Figure 43 Image of doctors and nurses providing care to injured individuals from clashes during the events of October 14, 1973, at a mobile medical unit in front of the Rattanakosin Hotel on October 14, 1973.

Source: National Archives of Thailand, CH/S1/258-259 (2), Events of 14th October 1973



During that time, there was still a shortage of general practitioners to serve in rural areas, communities, or outpatient departments (OPD). Therefore, the group's proposal did not emphasize a specialized specialty-based curriculum following the Rockefeller Foundation's model. Instead, the group aimed to shift the curriculum's focus towards producing physicians who understand the local population and the community's needs. They believed that knowledge acquired through education should be fully practical and applicable in real-life situations.⁴⁵ The group of physicians proposed that the medical curriculum should "start in the community." The first essential aspect was to select individuals from the community to enter the medical workforce pipeline. For example, choosing qualified nursing assistants working at the local health centers and providing them with additional education to elevate their status to nurses. If there were capable nurses in hospitals or health centers, they could also be further developed to become practical nurses who could perform minor surgeries. If their potential was deemed sufficient, these practical nurses could then enter the same educational system as general physicians to become doctors. In these cases, healthcare professionals could continue working while upgrading their skills through the education system. Dr. San Hatthirat summed up the vision of the solution to the problem by stating the following:

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“Therefore, the curriculum we envision is one that people should be familiar with – the society they grew up in. Once they are acquainted with the society they have grown up in, they begin to learn about the problems that arise societal problems, physical problems, problems of diseases and fevers... and progress to the next level, dealing with diseases. They learn how to treat diseases, advancing into roles of nurses and then doctors. In other words, they start from the broader aspects and delve deeper... so that they can truly benefit the rural population”.⁴⁶

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It is said that the proposal suggests a shift towards producing general practitioners who would serve in rural or community areas. Physicians should be familiar with the local population and the geographical context, so that the knowledge they acquired through their education could be fully utilized for the benefit of the community, rather than solely aiming to become specialized doctors.

However, this proposal faced significant opposition. Some opponents viewed the emphasis on producing community-oriented physicians as aligning with communist ideologies.⁴⁷ Certain physicians argued that

altering the curriculum in this way would lead to the production of second-tier doctors, resulting in lower standards in medical education.⁴⁸ Ultimately, despite the opposition, the reform ideas for the medical education system continued to influence some school administrators who attempted to adjust their medical curriculum to align with the needs of the community to the extent that each institution's capabilities allowed. This was evident in initiatives such as the "Medical Education for Students in Rural Area Research Program" by the Faculty of Medicine, Chulalongkorn University, and the "Rural Medical Student Program" at Mahidol University. On the students' side, they created platforms for exchanging knowledge and engaging in activities that embraced the broad concept of community medicine. The development of community-oriented medicine with a focus on community enhancement and rural areas had gradually begun to flourish from this point onward.

D. Streams of thought: Student movement, medical education reform movement of the 1960s, and preventive medicine

The seminar entitled "Mahidol University Development Project," organized by the Mahidol University Student Club, took place at the Training and Research Center of the Faculty of Public Health, Sung Noen District, Nakhon Ratchasima Province, from December 8-10, 1973.⁴⁹ It marked the dawn of a new era in the public health movement by medical students. A significant proposal emerged from the seminar, urging the university to revise the curriculum to cater to the needs of underserved populations. The emphasis was on instilling a sense of social consciousness in the students who would become public health professionals, ensuring they possessed a strong commitment to serving society. One could say that the spirit of the events of October 14, which had occurred just a few months prior, was transferred into the proposal presented by the medical students during this seminar.⁵⁰

This activity received support from university administrators, as well as from certain faculty members, particularly from the Faculty of Medicine of Ramathibodi Hospital, who were eager to drive changes in the medical education approach. Notable individuals such as Dr. Aree Valyasevi, Dr. Rajit Buri, Dr. Prem Buri, and others were involved. At the same time, the movement of medical students was also aligned with the reform agenda of this group of professors, creating a reciprocal relationship aimed at reshaping the medical curriculum.⁵¹ This seminar had around 250 participants, including students from all faculties and professors. The seminar's theme encompassed four key topics: the university's mission, the teacher-student relationship, the role of students in society, and the student association's structure. From these topics, it can be considered a seminar aimed at thoroughly analyzing and critiquing the university and the medical education system from its roots. As stated in the seminar's supporting documents: *"The university, like an elephant sanctuary, cannot sustain itself without being nourished by society to maintain its opulence for the future. A new resolution for the university's development should be 'learning for application'... The outcomes of the new Mahidol must be utilized for the benefit of many people who are less privileged."*⁵²

Some professors also participated in the discussion, such as Dr. Sritham Thanaphum, a psychiatrist from the Faculty of Medicine of Ramathibodi Hospital, who shared that the educational philosophy of medicine lacks a clear goal and direction. There was uncertainty about what one would do after studying. This was coupled with issues related to cultural norms, where some professors adhered strictly to traditional values. Dr. Siriwat Thiptharadol recalled the atmosphere during his time as a medical student in the early 1967: *“Back then, the medical school had a high hierarchy, a lot of conservatism, and a strict demeanor. Respecting seniors was emphasized.”*⁵³ While the faculty side emphasized deep learning that may lead to disagreements, the seminar served as a stage for the confrontation between senior professors who hold conservative views and younger professors with more liberal perspectives, and which aligned with the collective thinking of the students. This clash of ideas centered around the crucial question of the university's direction and the approach to medical education. Should it lean towards the “service to the community” direction as advocated by the student movement, or should it aim to produce “experts” who excel in knowledge?⁵⁴

The direct and candid discussions led to the culmination of the seminar's findings regarding medical education and the production of physicians, asserting the need for a commitment to advocate for the underprivileged population. Therefore, the university's mission should be oriented towards “serving the community.” As for the students, being the direct products of the university, they should utilize their knowledge to assist the disadvantaged population. Thus, the curriculum should avoid teaching overly technical or excessively theoretical subjects that lack practical application. In order to align the medical education with its intended purpose, several practices were proposed, such as introducing a quota system specifically for medical students from rural areas and stipulating that graduates must work in their local communities to address physician shortages. Legislation should require medical graduates to fulfill country-specific requirements before being granted degrees. Collaborative efforts with student organizations beyond the university were also suggested, aiming to demonstrate leadership roles in public health through projects addressing rural health issues. Hence, the seminar contributed significantly to the development of student education and the university's mindset. It serves as a cornerstone for future healthcare system reforms.⁵⁵

After the completion of the seminar at Sung Noen, in less than a year, the university student association joined forces with the MOPH to organize another seminar under the theme “Development of Public Health in Thailand.” This event took place at Rai Siri-Amphai, Si Racha District, Chonburi Province, during July 26-27, 1974,⁵⁶ comprising students from the Faculty of Medicine Siriraj, Faculty of Medicine Ramathibodi, and Faculty of Public Health.⁵⁷ This seminar highlighted the push for healthcare reform through the establishment of connections between the progressive medical professionals, the student movement of Mahidol University's medical students, and representatives from the MOPH.⁵⁸ Clearly, the MOPH side at that time

was led by Dr. Sem Pringpuangkeo, who observed: *"We see that those who can bring about change are the students... When there are conflicts or issues within the ministry, the students step in to organize seminars like this to facilitate coordination."*⁵⁹ The key issues of this seminar revolved around the problems concerning the relationship between medical education institutions and the agencies utilizing medical professionals, as well as the challenges related to the restructuring of the MOPH. One of the proposed solutions discussed during the seminar, which reflected the efforts to ensure healthcare professionals fully reach rural areas, was the "Barefoot Doctor" model presented by Dr. Weng Tojirakarn. This proposal stemmed from the recognition of the limitations of the Thai healthcare system in providing adequate medical care to remote, rural communities. Despite policies in place, medical graduates often only reached the district level, failing to extend their services to the sub-district and village level. The "Barefoot Doctor" proposition clearly highlighted one of the main concerns of this seminar – the push for community-level healthcare professionals to provide services directly to the villagers.⁶⁰

There were other interesting proposals discussed during the seminar. Firstly, the concept of "Public Health in the Mindset" suggested that educational institutions should instill an attitude of sacrifice in students for serving the public. Curricula should be adapted to reflect the realities of society, with a focus on decentralizing healthcare services to rural areas. Secondly, concerning the "Relationship between Educational Institutions and the MOPH," the seminar concluded that current medical curricula were copied from foreign models and did not align with Thai societal conditions. Universities neglected the issues faced by rural populations, resulting in inadequate rural healthcare components within medical education programs. Thirdly, regarding the "Ministry Structure," participants emphasized the scarcity of personnel and resources in rural areas. They proposed elevating the importance of health centers at the community level, including secondary health centers and midwifery clinics. Moreover, they suggested involving local government agencies, village leaders, and elders in community healthcare efforts.⁶¹



Figure 44 Image Book Cover: Summary of Seminar Results - Thai Public Health Development Project, July 26-27, 1974, at Rai

Siri-Amphai

Source: National Archives of Public Health, (12) SB12.5.3,
Topic: Seminar "Development of Thai Public Health"
2nd Edition (1974)

All these proposals might encompass problem areas, as referred to in a 1976 rural medical journal, which characterizes them as addressing the issues in medical education that previously focused on producing doctors as “exports” or products for urban areas. Instead, the proposals advocated for producing doctors who were “suited for work in the community.”⁶² This way of thinking was continuously propagated within the student activist groups at Mahidol University for several more years. This is evident from the establishment of a student party called “Ruam Mahidol” (Unite Mahidol) in the early 1980s. The party recognized the situation at that time, stating that *“the bureaucracy of the MOPH was largely aware of the failure of the health system that was copied from other countries... Even the MOPH policies began to pay more attention to this issue, especially focusing on rural areas and promoting medical schools to produce personnel that are better aligned with the needs of Thailand.”*⁶³

Subsequent developments included multi-dimensional initiatives within the university to address the shortage of doctors in rural areas. The first dimension was the pioneering project known as the “Rural Medical Student Program” initiated by Mahidol University. This project emerged due to the limitations of medical students from different provinces, who were significantly fewer compared to those from Bangkok. As a result, doctors from Bangkok struggled to adapt well to working in provinces. This program specifically reserved seats for medical students from rural areas, under the condition that upon completing their medical education, they would return to work in their home regions. This initiative called for collaboration between the MOPH and local communities to jointly coordinate and select students. The program started by admitting the first batch of medical students in 1975, consisting of 16 individuals.⁶⁴ However, not long after its inception, this project had to be discontinued due to differing opinions among the working group, lack of personnel interested in this field, and a lack of workforce planning.

Nevertheless, this project became a prototype for many other universities to use as a model for selecting students from rural areas to address the shortage of doctors. For example, in 1978, the “Medical Education for Students in Rural Area Research Program” was initiated by the Faculty of Medicine, Chulalongkorn University, with Dr. Thongchan Hongladarom serving as the project director. The main principle was to admit students from rural areas who had completed their compulsory 8th grade education through a two-step selection process, including an initial screening and a practical assessment at a hospital to evaluate their basic hospital work abilities. Those who successfully passed both stages were eligible to participate in the program. Students in this program would study alongside other medical students from Chulalongkorn University for the first three years, while the following three years would be spent at Phra Pok Klao Chanthaburi Hospital and Chonburi Hospital, which were prepared to function as medical schools specifically for this program.⁶⁵

In this era, conferences led to a reconsideration of the traditional medical education approach, which emphasized specialization, prompting society to question once again the effectiveness of reducing the doctor-to-population ratio through such methods. This also included the development of educational strategies by foundations, which had not entirely alleviated the hardships of rural communities. Particularly, the voices of reform-oriented physicians and medical students in the late 1960s were significant. Soon after, the government shifted its focus towards a more holistic approach, aiming to create sustainable knowledge and new rural development strategies. Clearly, these changes were influenced by political events, starting from the 14th October 1973 incident to the 6th October 1976 event, as will be further discussed.



In sum, the crisis of physician shortage in rural areas stemmed from the problem of urban-based doctors clustering and the issue of newly graduated doctors pursuing further education or practicing abroad. When the government couldn't deploy doctors to address the shortage in these areas, policies mandating funding emerged to fill the gap. Simultaneously, progressive reform-minded physicians endeavored to improve both medical education and practice concurrently, ensuring that graduates were better suited for remote rural work.

Nevertheless, the shift from a curative to a preventive curriculum wasn't immediate but evolved gradually. This curriculum transformation was driven by experimentation, often initiated by groups within the MOPH, especially the Department of Health and the reform-oriented physician groups. Projects like the Phitsanulok Project, Sarapee Project, Lampang Project, and others were introduced, sparking debates in university seminars among students and faculty. Despite outcomes that ranged from success to abandonment prior to the late 1970s, the vision of "Public Health for the Masses" began to take shape. It brought comprehensive consideration to economic, social, and educational aspects, intermingling with public health concerns, thus beginning to form a coherent framework.⁶⁶ This served as the foundation for the concept of "working towards rural development" and promoting the approach of "preventive medicine," which would become the answer to the future development of public health in rural areas.

One must not overlook the political atmosphere during the events from October 14, 1973, to October 6, 1976, which prompted long-term and immediate changes. The long-term effect was the "reform of the MOPH structure," while the immediate impact was the "flow of ideas in the era."⁶⁷ It all began with a ripple under the water, like "rural doctors," where numerous physicians ventured to work in remote areas, with the ultimate goal being the welfare of the people. These two events formed essential roots that should be closely examined. They served as driving forces towards the full-fledged development of Primary Health Care (PHC) during the late 1970s onwards.

Chapter 5

¹ Pinyapan Potjanalawan, *The Birth of 'Thailand' under Dictatorship* (Bangkok: Matichon, 2015).

² Interview with Dr. Paichit Pawabutr, May 30, 2022.

³ Department of Health, "History of the Department of Health," Department of Health, Ministry of Public Health, Accessed May 23, 2022, <https://anamai.moph.go.th/th/history>.

⁴ Memorial book for the Royal Cremation Ceremony of Professor Dr. Kamthorn Suwankit at Wat Thepsirintharawat, Royal crematorium in front of Phlapphla Issariyaphon, Saturday, March 26, 1988, (Bangkok: Amarin Printing Group Co., Ltd., 1988), 77.

⁵ Memorial book for the Royal Cremation Ceremony of Professor Dr. Kamthorn Suwankit at Wat Thepsirintharawat, Royal crematorium in front of Phlapphla Issariyaphon, Saturday, March 26, 1988, 83-84.

⁶ Dr. Prachum Intharamphan (Former Deputy Director-General of the Department of Health, 1968-1970) and Professor Uthai Phisonyabut (Former Director of the Nutrition Division, 1975-1976).

⁷ Nutrition Division, Department of Health, Ministry of Public Health, Thai Nutritional and Public Health Heritage "Amorn" Created (Nonthaburi: Nutrition Division, Department of Health, Ministry of Public Health, 2020), 91-92.

⁸ Santisuk Sophonsiri, 80 years of Dr. Amorn Nondasuta: A shining diamond in the Thai public health sphere (Nonthaburi: Consultant Bureau, Department of Health, 2009), 96-97.

⁹ Nutrition Division, Department of Health, Ministry of Public Health, Thai Nutritional and Public Health Heritage "Amorn" Created, 99.

¹⁰ Racha Phuchong, Nopphanat Anuphongphat, Komatra Chuengsatiansup, Rural Doctor, Good Governance and Health Politics (Nonthaburi: Health Systems Research Institute (HSRI), 2013), 41.

¹¹ Memorial book for the Royal Cremation Ceremony of Professor Dr. Somboon Vachrotai at Wat Makutkasattriyaram, Sunday, September 6, 1981 (Bangkok: Amarin Printing, 1981).

¹² Chamroon Meekanon, Project Report Summary for Lampang Project, (Bangkok: Lampang Project, Ministry of Public Health, 1981), 2.

¹³ Santisuk Sophonsiri, 80 years of Dr. Amorn Nondasuta: A shining diamond in the Thai public health sphere, 99-100.

¹⁴ Santisuk Sophonsiri, 100.

¹⁵ Santisuk Sophonsiri, 80 years of Dr. Pairode Ningsanon: A giant grain rice in the Thai public health sphere (Prachinburi: Chao Phraya Aphai Phubet Hospital Foundation, 2007), 117-119.

¹⁶ Memorial book for the Royal Cremation Ceremony for Professor Dr. Somboon Vachrotai at Wat Makutkasattriyaram, Sunday, September 6, 1981.

¹⁷ Faculty of Medicine Ramathibodi Hospital and Faculty, Memorial for Professor Dr. Aree Valyasevi Com-

pleting 60 Years on October 20, 1997 (Bangkok: Mahidol University, 1997), 35-36.

¹⁸ Department of Health, Work, and Ideas Dr. Damrong Boonyoen: A Hero in the Epic of Thai Public Health Development, 36-37

¹⁹ Chamroon Meekanon, Project Report Summary for Lampang Project, 6-7.

²⁰ Chamroon Meekanon, 1-3.

²¹ Chamroon Meekanon, 9.

²² Memorial book for the Royal Cremation Ceremony for Professor Dr. Udom Poshakrishna at Wat Thepsirintharawat, Royal crematorium in front of Phlapphla Issariyaphon (Bangkok: Amarin Printing, 1997), 134.

²³ Nutrition Division, Department of Health, Ministry of Public Health, Thai Nutritional and Public Health Heritage “Amorn” Created, 98.

²⁴ Examine the Relationships and Origins of the Group in Santisuk Sophonsiri, 80 years of Dr. Pairode Ningsanon: A giant grain rice in the Thai public health sphere, 138-159.

²⁵ National Archives of Public Health, (12) SB 12.9.31, “Chunlasan Saiyai, Volume 1, February 1979 (1979).”

²⁶ Tongchan Hongladarom, “The Development of Medical Education in Thailand,” Chula Med J 32, no. 4 (April 1988): 324.

²⁷ Sanguan Nitayarumphong, ed., Mahidol Historical Almanac for Democracy Part 1: The Birth of the Movement, 62-63.

²⁸ William H. Becker, Innovative Partners: The Rockefeller Foundation and Thailand, (New York: The Rockefeller Foundation, 2013), 116-119.

²⁹ William H. Becker, Innovative Partners: The Rockefeller Foundation and Thailand, 118-119.

³⁰ Sanguan Nitayarumphong, ed., Mahidol Historical Almanac for Democracy Part 1: The Birth of the Movement, 65-67.

³¹ Interview with Dr. Winai Sawasdivorn, May 16, 2022.

³² Joe D. Wray, “Motivating Medical Students in the Ramathibodi Community Health Program”, Studies in Family Planning, Vol. 5, No. 4 (Apr., 1974), pp. 134-139, <https://doi.org/10.2307/1965297>; Sanguan Nitayarumphong, ed., Mahidol Historical Almanac for Democracy Part 1: The Birth of the Movement, 72.

³³ National Archives of Public Health, (12) SB 12.8/2.12, “San Jai 1979 (1979).”

³⁴ National Archives of Public Health, (12) SB 12.6.29, “Transcription of work 33 Years of Mahidol Historical Almanac.”

³⁵ Sanguan Nitayarumphong, ed., Mahidol Historical Almanac for Democracy Part 1: The Birth of the Movement, 75-78.

³⁶ Prem Buri, ‘Training in Community Medicine in Undergraduate Medical Education, Ramathibodi Hospital, Faculty of medicine, Mahidol University, Bangkok (Paper for the Technical Discussions)’, World Health Organization, Regional Office for South East Asia, Twenty-fifth Session, Provisional agenda item 11, 26

July 1972.

³⁷ Tongchan Hongladarom, "The Development of Medical Education in Thailand," 324.

³⁸ Interview with Emeritus Professor Dr. Samreung Yaengkratok, June 24, 2022.

³⁹ Santisuk Sophonsiri, Thai Physicians' Legacy for Future Generations: Life and Work of Professor Dr. Sem Pringpuangkeo (Bangkok: Society and Health Institute (SHI), Office of the permanent secretary, 2012), 150.

⁴⁰ Interview with Emeritus Professor Dr. Prawese Wasi, May 29, 2022.

⁴¹ Interview with Emeritus Professor Dr. Prawese Wasi.

⁴² He was the first Dean of the Faculty of Medicine, Ramathibodi Hospital, and an expert in nutrition, which is the foundation of public health.

⁴³ President of Songkla Nakarin University.

⁴⁴ Santisuk Sophonsiri, Thai Physicians' Legacy for Future Generations: Life and Work of Professor Dr. Sem Pringpuangkeo, 147-148.

⁴⁵ Santisuk Sophonsiri, 163.

⁴⁶ Santisuk Sophonsiri, Thai Physicians' Legacy for Future Generations: Life and Work of Professor Dr. Sem Pringpuangkeo, 155.

⁴⁷ Nualnoi Treerat and Bank Ngamarunchot, Politics and Power in the Universal Health Coverage System (Nonthaburi: Health

Systems Research Institute (HSRI), 2012), 30.

⁴⁸ Santisuk Sophonsiri, Thai Physicians' Legacy for Future Generations: Life and Work of Professor Dr. Sem Pringpuangkeo, 165.

⁴⁹ National Archives of Public Health, (12) SB 12.3.6, "Document of Mahidol University Student Association, Topic: Summary of Seminar Results, University Development Project organized by Mahidol University Student Association (1973)."

⁵⁰ Sanguan Nitayarumphong, ed., Mahidol Historical Almanac for Democracy Part 2: Coordinating People to Dedicate for the Ideology (October 14, 1973-October 6, 1976) (Bangkok: The committee of Mahidol historical almanac for democracy, 2004), 66.

⁵¹ Sanguan Nitayarumphong, ed., Mahidol Historical Almanac for Democracy Part 2: Coordinating People to Dedicate for the Ideology (October 14, 1973-October 6, 1976), 68.

⁵² National Archives of Public Health, (12) SB 12.2.2, "Political Party Statement in University (1979)."

⁵³ Interview with Dr. Siriwat Thiptharadol, 20 May 2022.

⁵⁴ Sanguan Nitayarumphong, ed., Mahidol Historical Almanac for Democracy Part 2: Coordinating People to Dedicate for the Ideology (October 14, 1973-October 6, 1976), 74-75.

⁵⁵ Sanguan Nitayarumphong, ed., 76-83.

⁵⁶ National Archives of Public Health, (12) SB 12.5.3, "Second Conference on 'Thai Public Health Development' (1974)."

⁵⁷ Sanguan Nitayarumphong, ed., Mahidol Historical Almanac for Democracy Part 2: Coordinating People to Dedicate for the Ideology (October 14, 1973-October 6, 1976), 89.

⁵⁸ Department of Health, Work, and Ideas Dr. Damrong Boonyoen: A Hero in the Epic of Thai Public Health Development, 49.

⁵⁹ Sanguan Nitayarumphong, ed., Mahidol Historical Almanac for Democracy Part 2: Coordinating People to Dedicate for the Ideology (October 14, 1973-October 6, 1976), 86.

⁶⁰ Sanguan Nitayarumphong, ed., 88.

⁶¹ Sanguan Nitayarumphong, ed., 91.

⁶² National Archives of Public Health, (12) SB 12.8/3.1, "Rural Doctors, August 1976."

⁶³ National Archives of Public Health, (12) SB 12.2.7, "Mahidol Party Documents, Duties and Activities of the Party, 1980."

⁶⁴ National Archives of Public Health, (12) SB 12.8/3.2, "Rural Doctors 22 (1979)."

⁶⁵ Santisuk Sophonsiri, Thai Physicians' Legacy for Future Generations: Life and Work of Professor Dr. Sem Pringpuangkeo, 161–162.

⁶⁶ Sombat Chantarawong and Rangsan Thanapornphan, Love Thailand, Volume 1: History and Politics, Chapter: Public Health for the Masses.

⁶⁷ Interview with Dr. Amphon Jindawatthana, 18 May 2022.



The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868-2002

Events of October 14, 1973, to
October 6, 1976: Turning points in
politics and public health in the
1970s

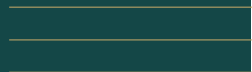




Figure 45 The photo was taken on June 28, 2527, at 15:30 hrs. His Majesty King Bhumibol Adulyadej graciously presented at Chitralada Villa Royal Residence to bestow the Royal Decoration upon Mr. Marut Bunnag, the Minister of Public Health, who led Dr. Mahler T. Halfdan, the Director-General of the World Health Organization (WHO) Representative Office in Thailand, and Dr. R. Vekal, the Coordinator and WHO Representative in Thailand, to participate in the joint coordination meeting for the special program on tropical diseases and to assess the assistance provided by WHO to Thailand. Also present was Dr. Amorn Nondasuta, the Permanent Secretary of the Ministry of Public Health.

Source: National Archives of Thailand, CH/R/1768, His Majesty King Rama IX, Minister/Permanent Secretary of Public Health, and WHO Director-General (2).

With financial support from foreign countries since World War II, the goal of increasing specialized personnel and establishing basic public services became a continuous mandate for the Thai government. As Thailand entered the 1960s, rural areas became witnesses to the nation's development. However, the healthcare sector had not undergone significant transformation, despite efforts to reform ideas and practices initiated by progressive medical groups within the MOPH and certain universities.

Even after 1973, when a democratic political atmosphere began to emerge, more diverse groups from various sectors participated in problem-solving, especially in healthcare. Many progressive medical professionals became important intermediaries, playing a coordinating role with other sectors related to the national healthcare system. Opportunities opened for doctors interested in working in rural areas, particularly highlighting the significant roles of the Rural Physicians Association and various private development organizations that contributed to the Thai healthcare system. It is said that the reform efforts in the healthcare system initiated since 1972 have been a continuous and long-standing reform force, closely related to the development of the Universal Coverage Scheme introduced in the 1990s to provide comprehensive healthcare coverage for all citizens by the decade starting in 1997.¹ **Therefore, it can be considered that 1973 became a significant turning point for the “power of healthcare system reform,” which had implications in both the political and social sectors, with the events of October 14 serving as a catalyst and being connected to the October 6 incident.**

One clear example that illustrates the long-term development of the healthcare sector from 1957 to 1976 is that not all physicians shared the same perspective on healthcare delivery systems. Not all doctors were of the same mindset. Progressive physicians emerged, characterized by a “Protective” stance, who were awakened and emphasized the issue of population growth. The significant problem of the physician shortage served as a catalyst, prompting the emergence of a group of doctors voicing opinions about “reforming” the healthcare sector. The focus of the reform shifted more towards “preventive medicine” rather than exclusively curative medicine.² The act of integrating community medicine as a part of teaching activities, specifically as a preventive measure, led to conflict with the conservative beliefs of some medical school staff. This has resulted in the issue of “disease prevention” not receiving much attention within the medical school community.³ The economic and political circumstances contributed to shaping the mindset of contemporary medical students and professionals. Additionally, the intertwining of “economy and politics” created significant turning points (critical junctures) that influenced both the direction of politics and the healthcare system in the 1970s. This led to a comprehensive shift towards preventive medicine, guided by principles and tools like “Primary Health Care” (PHC).



Figure 46 The image depicts doctors and nurses pushing an injured person on a stretcher into the Emergency Department at Siriraj Hospital on October 14, 1973.

Source: National Archives of Thailand, CH/S1/261, Case File October 14, 2516 (1973)



Figure 47 The image shows doctors and nurses providing care to injured individuals who were hurt in clashes during the incident on October 14, 1973, at the mobile medical unit in front of Rattanakosin Hotel on October 14, 1973

Source: National Archives of Thailand, CH/S1/258-259 (2), Case File October 14, 2516 (1973)

Poverty and health: Origins of the “ignorant, poor, and sick” vicious cycle

By undertaking development that is believed to lead to prosperity in the upper echelons of the economy, it is expected that the wealth will be distributed to other sectors. This process can be likened to the heart pumping blood from the major arteries to smaller capillaries in succession. However, economic liberalism has given rise to a network of capital groups, particularly within the realm of private commercial banks. These tightly-knit groups have led to a clustering effect, primarily among these smaller capital entities.⁴ This does not lead to competition and the broad distribution of resources as expected. Professor Rangsan Thanaphonphan referred to these capital groups as “social leeches” because they tended to draw and concentrate the blood of Thai society without fostering widespread competition and resource distribution.”⁵

The consequences of policies since the era of military dictatorship that emphasized economic growth through accelerated industrial development to replace imports, supported by the budget from the United States and the increasing consumption by foreign residents in Thailand, led to significant expansion of the economy, particularly in urban areas, notably Bangkok. Bangkok became the powerhouse of the largest labor market in the country and the epicenter of a continuously growing service industry, including hotels, restaurants, department stores, and hospitals. Hospitals like the Bangkok General Hospital emerged during

this period, as well as conglomerates, such as the Bangkok Dusit Medical Services Co. Ltd. (1972).⁶ Cities experiencing economic growth necessarily relied on low-cost labor, leading to the attraction of inexpensive daily-wage workers from different provinces. This resulted in seasonal migration or permanent resettlement in the city. As economic development in urban areas was prioritized, the government promoted industrialization, and continuously pushed to maintain a low-cost labor force. Consequently, the income inequality between urban and rural areas widened, worsening the economic divide.⁷ The rural areas became mere suppliers of human resources to feed the cities. Consequently, the economic relationship between urban and rural areas gradually deteriorated. This is one of the main reasons behind the emergence of the 'peasant movement,' which demanded better living conditions from the government. Measures such as increasing labor value and aiding in agricultural land issues were called for. The movement of a significant labor force became even more evident following the events of October 14.

As a result, economic boosterism had a significant impact, leading society to become more aware of the "binary opposition" across all dimensions. In the field of public health, this dichotomy was strikingly evident between highly educated doctors and lower-ranking doctors, e.g., traditional village doctors or "Chaloeisak doctors." There was a clear distinction between Western medical knowledge and traditional healing practices. The discrepancy between the advanced urban healthcare system and the slow progress in rural healthcare was pronounced. While the urban healthcare workforce was over-represented, severe shortages were evident in rural areas. These circumstances gave rise to distinct ideologies divided between "prosperity" and "decline," with rural areas (and rural inhabitants) representing decline. There was a lack of sustainability, and it was imperative for these rural areas to undergo development.⁸ During that era, even though groups of students, scholars, and medical intellectuals had diverse political stances ranging from liberalism, semi-socialist democracy, and even communism, they all shared a common belief. They agreed that if politics were not a democratic system, it would fail to liberate the workforce and rural population from the shackles of hardship in life, and it wouldn't be able to address the issue of inequality. Thus, both the events of October 14 and the case of October 6 used the concept of "binary opposition" or "inequality" in society as a crucial standpoint to demand political transformation. This was because they believed that politics would serve as the catalyst for initiating various socio-economic changes.

A. The role of physicians and social equity

Sulak Sivaraksa an influential figure in Thailand, reflected on the atmosphere of intellectual discussions about "social justice" from the period before October 14, 1973, continuing through to October 6, 1976. He recounted the ambiance of networking within the intellectual circle of the Social Science Review, which served as a platform for expressing ideas through books and seminars involving students and medical professors. They became a motivational part of the group of people during the October events. Sulak Sivaraksa highlighted:

“

“The concept of justice needs to be understood. Many medical students were involved, like Wichai [Dr. Wichai Chokwiwat]. He was a key figure... In matters of justice, it is certainly connected to public health, well-being, livelihoods, peasants, workers – these were all debated topics... We invited Professor Puey from the Central Bank, we invited Professor Sanya [Dharmasakti], we invited one after another... They came to have friendly discussions for the younger generation to listen to. We discussed everything – public health, justice.”⁹

”

When focusing on the issue of “rural areas and inequality,” it can be observed that groups of medical students and intellectuals from the middle class were influenced by the concept of cross-class divide. This perspective, which originated from the elites, shaped their view of rural areas. This led them to feel the need to extend knowledge and assistance to rural inhabitants and the working class, to create social equality. For instance, during that time, students from Mahidol University who participated in activities viewed rural villagers fell into the cycle of “ignorance, poverty and illness,” which eventually transformed into an important philosophy within Mahidol University,¹⁰ and it became the origin of numerous rural development activities during the period of 2510-20, aimed at helping villagers escape from the aforementioned situation.

The advantage is that, even though they were from the middle class and not directly affected by the economic system, the discourse on inequality influenced the imagination and understanding of students and intellectuals towards rural areas. **This awareness transformed the meaning of “rural areas” into a space of critical consciousness for some students to learn and live with a genuine sense of sacrifice for the community. This is different from the past when some newly graduated doctors had a somewhat negative view of working in rural areas.** At that time, the role of being a doctor in rural areas, in accordance with government policy, had turned into a more voluntary endeavor rather than a forced one. For instance, Amphon Jindawatthana, who was a medical student in that era, described the atmosphere as follows: *“The senior doctors had these ideas before, about the cycle of ‘ignorance, poverty and illness’. It’s not that they wanted to belittle the villagers, but they wanted to point out reciprocal nature of the situation. As*

for students at that time, they believed in the concept of 'going down into the community.' Serving rural areas was the answer. Most doctors went because of their sense of duty, not because of financial constraints."¹¹ Similarly, like other medical students of that era, who also emphasized that it was a phenomenon of the time, about one in three students was deeply interested in societal issues. This led most of them to see working in remote rural areas as something ordinary.¹² This trend is further reflected in the publication of contemporary students' journal "Mahidol News, Graduate Edition" in September 1974, with its cover boldly stating, "*Mahidol University graduates must serve the nation and the people.*" One article in this edition shed light on the working conditions of rural doctors, stating:

“

"My health station is a small wooden house, with an operating room covered in dust and dirt, which has accumulated over the years. There are only a few tools, and I take great pride in being able to save the lives of many seriously ill patients and am glad to genuinely serve the people of the country. Some patients I've operated on had no money to pay for treatment. Still, they managed to borrow from relatives and friends to cover the cost of medicine. Actually, I was hesitant to collect fees from these impoverished individuals because I saw the injustice in society first-hand."¹³

”

At the same time, the political context that inspired the "October People" was also an important starting point for the emergence of extra-governmental power, e.g., the coordinating committee of student volunteers for national development (1970),¹⁴ the Union for Civil Liberty (UCL) (1973) which fostered an understanding of the concept of freedom and rights for marginalized individuals in society,¹⁵ and the Federation of Labor (1975), established from an association of 45 members, comprising both public and private sector employees. The UCL emerged as an organization dedicated to safeguarding the rights and benefits of the public during the early phase of this period, and it received official recognition through the Labor Relations Act of 1975.¹⁶ The Community Pharmacy Association (established in 1975 and later known as the Rural Pharmacy Association) was a collective initiative of pharmacy students and graduates from the Faculty of Pharmacy. Its purpose was to aid rural communities in addressing medication-related issues.¹⁷ The Rural Doctor's Association, which emerged in its initial phase (1976), brought together young physicians who ventured to work in rural areas. This association also included various projects that united working individuals and movements for societal well-being. These initiatives were outside the realm of

government structure, such as the Volunteer Graduate Certificate Program (later known as the Volunteer Graduate Program). Professor Puey Ungphakorn was the initiator of these efforts, starting from 1969.¹⁸ There was also the Mekong River Basin Development Project (1974), which was a collaborative effort among three universities,¹⁹ also emerged in this era, with the consideration of the Mekong River Basin Development Project in detail, which further clarified the middle-class perspective on rural issues related to “ignorance, poverty and illness.”

B. Mae Klong Integrated Rural Development Program: A case study of the “ignorant, poor, and sick” vicious cycle

The “Mae Klong Integrated Rural Development Program” (MIRDP) in 1974,²⁰ was designed to harness the potential and strengths of three universities, namely Thammasat University, Kasetsart University, and Mahidol University. This initiative received support from the Rockefeller Foundation. Under the leadership of Dr. Puey Ungphakorn, who served as the director of the project during his tenure as the Economic Advisor to the Prime Minister between 1974 and 1975, MIRDP aimed to enhance the quality of life by focusing on meeting essential needs and local desires. Key objectives included increasing local income, improving healthcare, enhancing education efficiency, fostering community collaboration, and promoting cooperation between communities and government agencies. The overall aim was to empower local residents to become self-reliant.²¹ The aspiration was to make professors, students, and graduates the intermediaries in utilizing knowledge for the collective rural development. MIRDP aimed to highlight that assisting villagers to overcome challenges necessitated recognizing the interconnectedness of various forms of aid as “help chain.”²² The objectives of this project were aimed at proposing solutions to the issue of “ignorance, poverty and illness,” directly addressing the broad and encompassing discussions of this matter during this period.

The participants involved were strategically aligned with the three aforementioned issues, with Thammasat University overseeing education and economics (to address ignorance), Kasetsart University managing agricultural matters (to alleviate poverty), and Mahidol University taking charge of

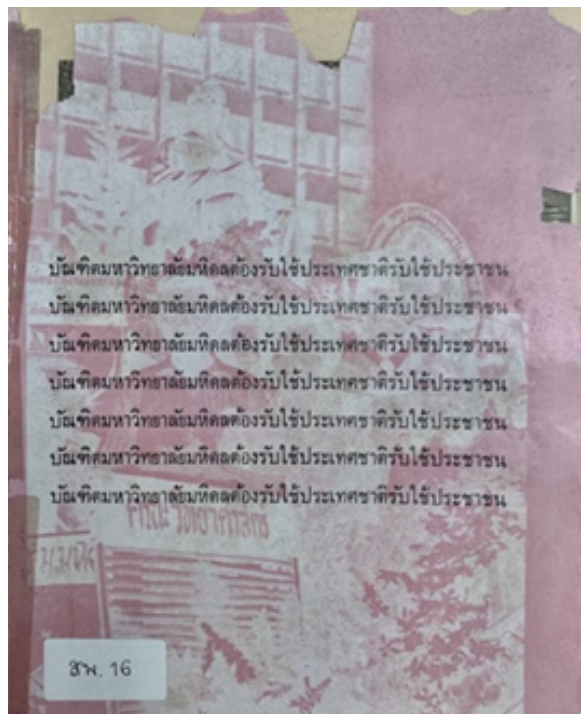


Figure 48 Book cover image of “Mahidol Sarn, Chabab Bandit” September 2517

Source: National Health Archives, (12) SB 12.8/2.5, (Cover) Mahidol Sarn, Chabab Bandit (September, 1974)

public health (to mitigate illness).²³ In view of the fact that Mahidol University was an institution known for producing medical professionals, this opportunity was utilized to reflect the emphasis on a community-based approach, which was a vision being discussed and pushed at that time. This direction was in alignment with various other government projects previously implemented, such as the establishment of community volunteers.²⁴

However, the Mae Klong Integrated Rural Development Program did not proceed as planned due to political challenges. Professor Puey Ungphakorn, the director of the project, had to go into exile abroad following the events of October 6. Nevertheless, the project presented alternative solutions for rural issues at that time. It emphasized a “consolidation” of efforts and cooperation from all relevant parties to collectively address problems. The approach of the “Community-based Program” was proposed to elevate the role of villagers as integral components in developing the healthcare system. These findings would be revisited again as the 1970s progressed beyond the aftermath of October 6.

During the implementation of the MIRDP, there was another significant milestone directly influenced by the demands of the October 14 events. This shift demanded a transition from military dictatorship to democracy. As the political landscape transformed, it also brought about changes in the healthcare sector, leading to the “reform of the Ministry of Public Health,” which has had a lasting impact on the system’s structure up to the present day.

Reforming the Ministry of Public Health (1974)

Although the proposal for medical education reform had been in motion prior to the events of October 14, it would face setbacks. However, the crucial task that reform-minded doctors were able to successfully push forward was the restructuring of the MOPH. In the biography of Dr. Sem Pringpuangkeo written by Santisuk Sophonsiri, this reform in the MOPH in 1974 is likened to “a major surgery”, perhaps one of the most significant since the establishment of the ministry.

Previously, there had been ongoing conflicts within the Ministry of Public Health (MOPH), particularly between the Department of Medical Services (DMS) and the Department of Health (DOH). These conflicts could be traced back to the establishment of the MOPH in 1942.²⁵ The significance of the public health mission was heavily focused on treatment, leading the DMS to control half of the ministry’s budget. Meanwhile, the preventive efforts of the DOH received less importance, resulting in issues such as budget shortages, manpower deficits, and even lack of attention from the MOPH leadership. Indeed, preventive initiatives often required less funding compared to treatment, despite their importance.²⁶ Especially after 1957, there were changes within the MOPH during the era of Field Marshal Sarit Thanarat. He ordered the

transfer of the Faculty of Medicine to be placed under the supervision of the Office of the Prime Minister in 1959, aiming to align academic operations with the educational policy of the National Education Council.²⁷ As a result, following those changes, the MOPH was left with three main entities: the DMS (treatment section), the DOH (prevention section), and the Department of Medical Sciences (health promotion section). The budget allocated to the DMS steadily increased, reaching 60-70% of the total MOPH budget²⁸

However, while the operations were still characterized by a distinct separation that hindered efficient functioning, with such problems in place, an advisory committee was established in 1971 to find ways to improve the structure of the MOPH. The committee summarized four key issues regarding the structure of the MOPH: (1) The primary division of responsibilities, where the DMS focused on treatment while the DOH focused on prevention and promotion, resulted in a lack of coordination between departments that should have worked in synergy; (2) Staff shortages were evident, and both the DOH and the DMS lacked a balanced distribution of tasks. This led to fragmented services and a lack of continuity in overall public health services; (3) Coordination at the operational level was lacking due to the absence of a coordinating body at the provincial level, and there was a lack of joint planning, leading to conflicts between staff from both departments; and (4) Unclear job roles and responsibilities complicated the situation. While numerous issues existed between the DMS and the DOH, progress had been made because of “efforts to maintain good relations between senior officials from both departments.”²⁹ The challenges posed by these four issues prompted the working group to recommend improvements to the MOPH. They suggested enhancing operational coordination between treatment and prevention/promotion functions by advocating for collaborative efforts to create a seamless and continuous cycle, strengthening capacities, and sharing the workload.³⁰

However, the intention to integrate treatment and prevention efforts together was distorted during the period when General Thanom Kittikachorn seized power in 1971. This led to the amalgamation of the two agencies into the “DMS and Public Health” in 1972, with most of the responsibilities of the Department of Public Health being placed under the decision-making authority of the DMS.³¹ Lack of understanding of the objectives behind the proposal for integration led to a period of confusion. *“The act of combining is like setting a time bomb... it seems like we’re combining, but in order to reduce opposition [from those who disagree with the integration], we end up controlling those who resist, even though the idea originated from the side that supported the integration.”*³² Collaboration between the DMS and the DOH continued under challenging circumstances, until the political event of October 14, 1973, occurred. This event led to a significant political transformation under the leadership of the government of Prime Minister Thanom Kittikachorn, who had two key figures in the MOPH, namely Dr. Udom Poshakrishna, the Minister of Public Health³³ and Dr. Sem Pringpuangkeo, the Deputy Minister of Public Health, who contributed to

the emergence of the “legend of continuous reform of MOPH,” leading the organization through a series of transformations until it became well-established. This period marked a significant time for the restructuring that continues to impact public health work to the present day.



Figure 49 The image of Dr. Udom Poshakrishna (left)

Figure 50 Dr. Sem Pringpuangkeo (right)

Source: National Archives of Public Health, (13) B.NEG S.2.1/48.90, 92/20, Portrait of Dr. Udom Poshakrishna; National Archives of Public Health, (13) B.NEG S.2.1/48.93, 88/20, Portrait of Dr. Sem Pringpuangkeo.

One of the special characteristics of the MOPH in the post-October 14 era is that the government refrained from intervening in development efforts. Instead, it allowed matters to be handled by experts within the ministry. Nualnoi Treerat refers to this as the era of “Public Health Technocracy.”³⁴ Especially when Dr. Sem was appointed as the Deputy Minister of Public Health, it led to the progressive doctors becoming actively involved as unofficial advisors to drive internal structural reforms within the ministry. This can be observed from November 1973, just one month after the October 14 incident, when an 11-member working group was established to formulate proposals for improving the administrative and service delivery aspects of the MOPH. The members of this working group were all medical personnel, many of whom were considered reform-minded doctors. For instance, Dr. Pairode Ningsanon, a member of the Poysian Group, was one of the individuals in this group who held progressive ideas.³⁵ Alternatively, the chairman of the working group, like Dr. Somboon Vachrotai, was an individual who had previously experimented with community health projects that emphasized the significance of preventive medicine.³⁶ Dr. Chitt Hemachudha, Dr. Amorn Nondasuta, Dr. Yutthana Suksamitti, and Dr. Damrong Boonyoen were also key figures in this reform movement.

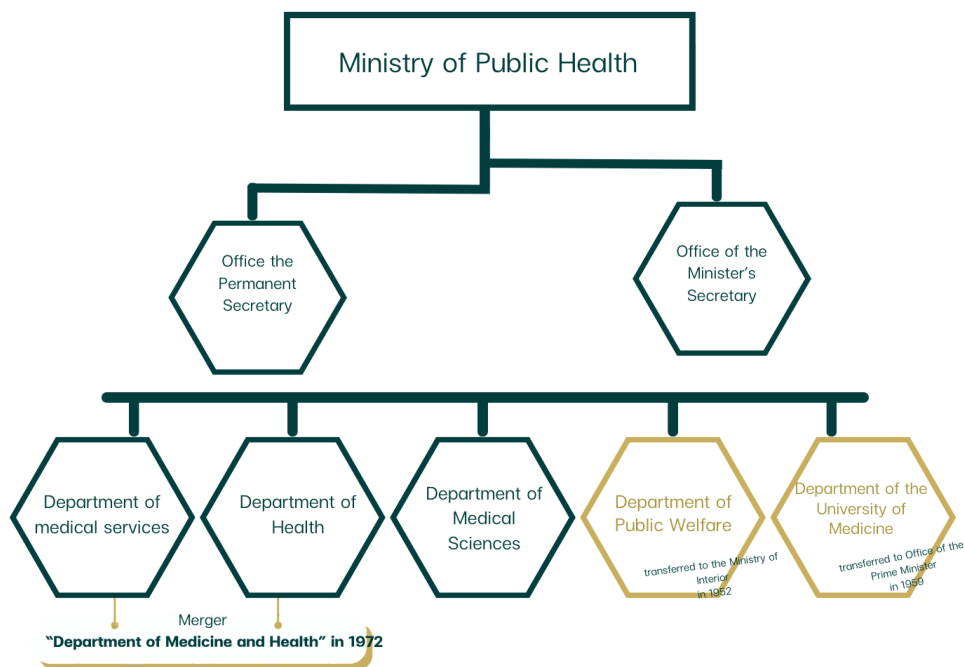


Figure 51 The image of the Ministry of Public Health (MOPH) structure before the year 1974

Source: Adapted from National Archives of Thailand, T.M.2.1/11, Organization Charts of the Ministry of Public Health Kingdom of Thailand 1962.

One of the main proposals from the structural reform working group within the MOPH that helped address significant issues was the matter of overlapping management. This involved the “consolidation of responsibilities” between the DOH and the former Medical Department at the regional level, which were combined with the “Regional Public Health Administration” unit situated under the supervision of the Office of the Permanent Secretary for Health.³⁷ This essentially meant that, starting from 1974, hospitals in the regional areas, medical centers, health stations, and midwifery centers were placed under the authority of Provincial Chief Medical Officer (PCMO) who gained increased administrative power delegated from the central ministry. This change in the chain of command aimed to enhance control and expand services, ensuring that all healthcare activities were coordinated under the control of a single unit, as opposed to the previous division into two separate entities.³⁸ Hence, this is referred to as “decentralization,” where authority was distributed to the regional level, empowering provincial entities and removing the need for centralization as it had been before.



Figure 52 Cartoon images satirizing Dr. Udom Posakrisna and Dr. Sem Pringpuangkeo, which were circulated during the period when the proposed restructuring of the Ministry of Public Health was being presented in 1974.

Source: National Archives of Public Health, (14), SB 1.4/2.19, Information on Opponents of the Plan to Revise and Restructure the Sections of Administration in the Ministry of Public Health (1974)

It is evident that such changes generated dissatisfaction among certain doctors who did not wish to be placed under the jurisdiction of the PCMO, but instead desired to remain under the authority of the DMS, as it was previously.³⁹ Therefore, this reform not only involved transferring the command of doctors from various provinces, but also entailed the revocation of the authority of the DMS over the previous chain of command for all provincial hospitals. As a result, regional hospitals no longer were accountable to the Director-General of the DMS in Bangkok. Instead, they were now under the jurisdiction of the PCMO who received delegated authority from the central administration.⁴⁰ Some dissenting doctors who disagreed with the adjustments by the MOPH threatened to resign in protest. There were depictions mocking those who desired changes in the ministry's projects, sent out to several hospitals.⁴¹

Meanwhile, on the other hand, there emerged the formation of the "People's Health Support Group", aimed at supporting the restructuring of the ministry. They believed that it was the "most complete structure of the ministry that it ever had..." and gathered a list of healthcare personnel who supported the reform efforts.⁴² This included receiving support from the student movement of the Thai Medical Students' Center, who perceived that enhancing decision-making authority and accountability for regional entities was a decentralization of power aligned with democratic principles. They saw that "*this new organizational arrangement as being tied to the benefits of the majority of the population, and reasons to oppose it should not revolve around the interests of a small group...*"⁴³ Subsequently, the draft Royal Decree mentioned above underwent deliberation in the House of Representatives in August 1974. Dating from the establishment of the working group for formulating the proposed ministry amendments in November 1973, this process took a mere nine months.

Amidst the politically charged atmosphere of the election process and the health structure reform movement that emphasized collaborative efforts, such a development occurred. Within a year, the primary healthcare assurance policy was introduced for the first time. This policy was aimed at providing health security to low-income individuals under the name “ Low-Income Card Scheme (LICS)”. Its goal was to ensure that economically disadvantaged individuals could access medical services from state healthcare facilities without any cost.⁴⁴

Low-Income Card Scheme (LICS): Beginning of the development of Thailand’s Universal Health Coverage

The proclamation of the 1974 Thai Constitution is considered highly significant in the birth of Thailand’s first-ever primary healthcare insurance system. This system was initiated in 1975 under the name “Low-Income Card Scheme (LICS)”. The objective of this project was to provide individuals with low incomes guaranteed access to medical and public health services, in line with the aspirations outlined in Article 92 of the new Constitution, which clearly stated that...

“

“The state shall promote public health, encompassing family health, and protect the health of individuals, supporting public participation. The state shall provide medical treatment to the indigent without charge, and prevent and suppress dangerous communicable diseases. The state shall take these actions for the public without any charge.”⁴⁵

”

Although the 10th Constitution of the country has directed the provision of healthcare to the indigent “without charge” (including prevention and control of dangerous communicable diseases “without charge”), the political parties themselves still had to have the determination to use this as a framework to formulate policies that achieve these goals. During that time, the entire nation was well aware of the issues of “poverty and inequality,” which were crucial concerns that needed to be addressed immediately after the events of October 14.

A. Political parties, policies, and issues of poverty and marginalization

As the economic situation made poverty and inequality more prominent than ever before, these issues were pushed to the political forefront as the “political parties” became institutions searching for solutions in times of crisis. Each political party was required to present policies that addressed the societal problems most effectively during that period. Undoubtedly, “poverty” and “inequality” became the triggers to rally the masses. This led to rural areas, which clearly reflected the stark image of poverty, gaining increased significance in an era when democracy was flourishing.⁴⁶ In the case of the “New Force Group,” a political faction led by Dr. Krasae Chanawongse, they issued a declaration aligning with clear populist principles. They formulated policies emphasizing equal access to public health benefits for all Thai citizens, stating that it is something every individual should receive equally. They also emphasized that *“the medical and public health systems and methods must be improved to serve the public comprehensively.”*⁴⁷ Subsequently, this group was formally established as the “New Force Party” (on November 21, 1974), with several professors from Mahidol University as its core leaders. In addition to that, numerous Mahidol University students joined as well, making the party’s youth movement more pronounced.⁴⁸ The New Force Party thus reflected a political dimension that correlated with issues of poverty (economy) and translated them into public health matters (society) quite effectively. Despite not achieving political success both in Bangkok and at the national level, the party managed to establish this correlation well.

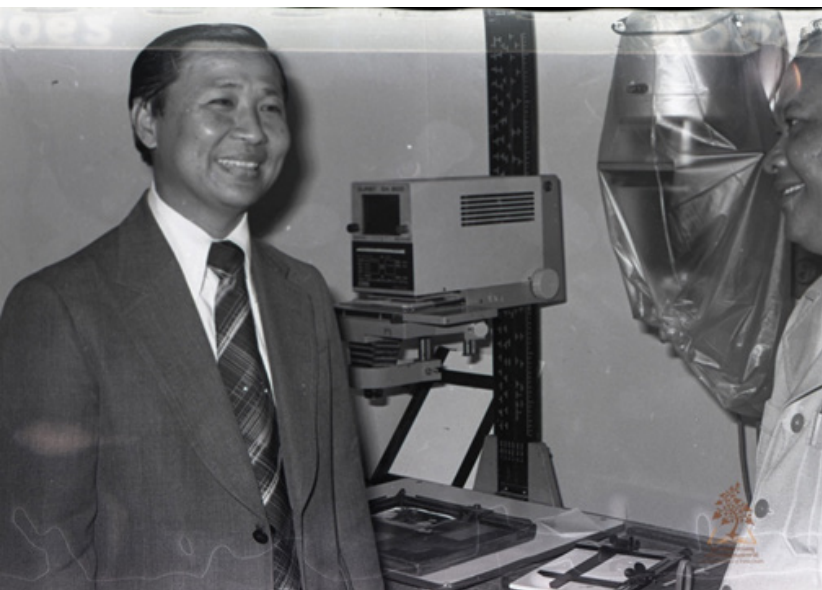


Figure 53 Dr.Krasae Chanawongse (former leader of the New Force Party) inspecting public health activities while serving as the Deputy Minister of the Ministry of Public Health (MOPH) in the government led by General Kriangsak Chamanan in 1979.

Source: National Archives of Public Health, (13) B.NEG S.2.1/30.52, Number 53 Roll 1, Dr.Krasae Chanawongse 's public health Inspection on 19 September.

On the other hand, the Social Action Party led by M.R.Kukrit Pramoj (who drew inspiration from Singapore's People Action's Party) achieved more success beyond electoral politics. This was because the Social Action Party was a newly formed political party, established on November 4, 1974, just a month after the new constitution was enacted. Consequently, the party needed support from both private sector networks (such as notable individuals like Khun Boonchu Rojanastien, a banker) and public support. This led to the adoption of a "strategy on poverty" as a policy aimed at gaining electoral support in alignment with the country's sentiment and responding to the needs of the people. The party formulated policies to alleviate specific issues, such as for rural areas, by reallocating funds from financial institutions to agriculture, ensuring price stability for agricultural products, and promoting fisheries and animal husbandry. When the Social Action Party garnered enough votes to form a coalition government, Kukrit Pramoj became Prime Minister, serving from March 14, 1975, to January 12, 1976. At this juncture, the program to aid low-income individuals, namely the "Low-Income Card Scheme (LICS)" emerged, bridging political aspects, poverty, and public health. This was evident in the government's policy declaration at the inaugural meeting of the House of Representatives, targeting poverty eradication in urban and rural areas across the country:

“

“Ensuring that individuals who have reached legal adulthood and earn an income lower than 1,000 baht per month receive comprehensive assistance as follows. This assistance will be provided within six months of assuming office: (1) The right to use public transportation on all routes without charge. (2) The right to education, exempt from tuition fees, textbook costs, and other educational fees, including compulsory education for all children. (3) Access to medical care and treatment without incurring costs.”⁴⁹

”

B. Low-Income Card Scheme (LICS) to Medical Welfare Scheme (MWS)

For the “ Low-Income Card Scheme (LICS)”, the income threshold for eligibility was set at a monthly income of less than 1,000 baht. During the first year of the project, individuals seeking to qualify had to present their request for assistance by filling out form, along with their identification card, household registration, and proof of income. These documents were then submitted to the responsible agency for review. Once the responsible authority in each district or sub-district approved the application, a card was issued as evidence of eligibility. This card had a validity period of one year, after which individuals needed to apply

for a new card when the expiration date is near.⁵⁰ However, during the initial period, there were relatively few people requesting to obtain the card. As a result, between 1976 and 1979, the process of card issuance was discontinued, and the authority to grant the card was transferred to hospitals for evaluation based on the criteria set by the Ministry. Dr. Siriwat Thiptharadol observed the following: *“During that time when I was an intern in Sisaket Province, we used Low-Income Card Scheme. When patients came to see the doctor and received treatment, they wouldn’t have to pay. We would refer them to the social assistance program.”*⁵¹ Dr. Winai Sawasdivorn had the same experience: *“During the time when I practiced medicine in Mahasarakham, as doctors, we would prescribe medications. When the pharmacy wanted payment and the villagers didn’t have money, they would come back to us. We would then sign a certificate of destitution to send to the social assistance department. If it was a larger provincial hospital, they might have this department. Then the patients would go through the hospital’s screening process. The social workers would question whether the poverty was genuine.”*⁵²

In 1979, there was a modification to the criteria for individuals with low income. The criteria were set at an income lower than 1,000 baht per month for single individuals and a new condition was added, setting the income lower than 2,000 baht per month for families. Following that, during the administration of Prime Minister General Prem Tinsulanonda from 1981 to 1985, there was a declaration to implement the “Regulation of the Prime Minister’s Office regarding the Assistance of People with Low Income in Relation to Healthcare, 1981;”⁵³ and the “Regulation of the Prime Minister’s Office regarding the Assistance of People with Low Income in Relation to Healthcare (Version 2), 1982” was established to provide clarity and expand coverage, along with granting the issuance of assistance cards for each family every three years;⁵⁴ and the minimum income for single individuals entitled to benefits was raised from not exceeding 1,000 baht to 1,500 baht per month. For individuals with families, the threshold remained the same, not exceeding 2,000 baht. The aforementioned cards did not restrict the user to a certain healthcare facility, i.e., to allow service usage at any medical institution. This card issuance system was considered the first of its kind.

However, in 1984, the practice of receiving services anywhere was discontinued, and healthcare facilities were designated to be assigned health centers or local hospitals for each cardholder. Subsequently, a significant development occurred in 1989 when individuals age 60 or older were incorporated into the project. Three years later in 1992, further additions were made, including children under 12 years old, persons with disabilities, war veterans, Buddhist monks, as well as religious leaders. This prompted a renaming of the project to “Medical Welfare Scheme (MWS).” The criteria for individuals with low income were adjusted to not exceed 2,000 baht for individuals and not exceeding 2,800 baht for families. Those residing in their communities would receive permanent cards with benefits valid for up to three years, enabling them to seek services from healthcare facilities in their local areas or nearby. As for those

residing outside their communities, temporary cards would be granted with benefits lasting for up to one year, and they would be eligible to receive services from a single designated healthcare facility.⁵⁵

Since the Medical Welfare Scheme (MWS) was one of the initial models of health insurance, certain issues were encountered. The first pertained to the management system, particularly the problem that some cardholders were not genuinely financially disadvantaged, while some genuinely impoverished individuals did not receive cards. One reason for this was the bureaucratic requirement that the card issuance process had to go through the Ministry of Interior for each locality. Consequently, the responsibility for screening fell upon local leaders and village elders, who were tasked with determining who was poor and who was not. At times, it became a widely known joke that individuals holding “The Project for People with Low Income” cards would wear gold necklaces or ride motorcycles to the hospital for services. This phenomenon became an observable symbol of social status, indicating that some cardholders were not truly impoverished. As a result, the concept of using “Low-Income Card Scheme” *was sarcastically referred to as a system for “those who aspired to appear financially disadvantaged but were not actually so.”*⁵⁶

Additionally, there were issues concerning the perceptions and thoughts of the service recipients themselves toward “Low-Income Card Scheme” Sometimes, the term “songkroh”, which translates to “assistance” or “aid,” made cardholders feel like they were being portrayed as supplicants, undermining their dignity and self-esteem. This led the government to attempt a name change from “Low-Income Card Scheme (LICS)” to “Medical Welfare Scheme (MWS),” even though the policy’s essence remained unchanged.⁵⁷ However, despite the challenges that the aforementioned project may have encountered during its implementation, it started with the noble idea of targeting the underprivileged population first, even though it might not have initially covered the entire Thai population in need. It’s important not to forget that “Low-Income Card Scheme (LICS)”/“Medical Welfare Scheme (MWS)” was the first significant healthcare insurance program in Thai history. It paved the way for the establishment of a comprehensive healthcare insurance system in the coming decades. Moreover, it stands as one of the early state initiatives in the field of public health that aimed to highlight the deep connection between “poverty” and “lack of access to healthcare services” for the people, demonstrating their profound interdependence.

C. Poverty and access to health services

The transformation of poverty into a significant issue within the healthcare system arose from the fact that state healthcare facilities operated in a passive manner. This excessive passiveness led to situations where rural people encountered more difficulties than they normally should when trying to reach a hospital. This became an undeniable condition, given factors such as long distances, lack of public transportation, absence of travel or service subsidies, and even time constraints due to livelihood responsibilities. Dr. Prawese Wasi vividly illustrated the intersection between poverty and healthcare services, highlighting

that the healthcare system (prior to the 1977-86 decade) operated as a system where *"people were expected to seek services, rather than services reaching out to the people."*⁵⁸ This caused rural people to endure hardships when traveling to receive services from the government. Therefore, to establish genuine "public health for the masses," it was imperative to restructure the system so that services reached the population instead. However, from Dr. Prawese's perspective, the solution should not merely address immediate problems like those in the 1957-86 decade, where mobile health units were introduced to expedite rural development tasks. This approach not only served political interests but also failed to generate any tangible benefits. Redirecting funds to bolster state personnel might have proven to be even less beneficial.⁵⁹

The concept of bringing services to the people or following the path of mass-oriented public health, apart from Dr. Prawese's support, also received backing from a group of doctors from the Department of Health lineage. They experimented with this approach, encountering the fundamental issue of the local population's hardships as a starting point (from around 1952 onwards, as detailed in Chapter 5). As community health physicians responsible for managing medical service units at the district level, they took on disease prevention and control as a primary role. Consequently, their work demanded much closer interaction with the local residents than simply providing general treatment services. With the experiences gained from these roles, the concept evolved beyond mere prevention, control, and eradication of diseases. It aimed to establish a mechanism empowering communities toward "self-reliance" and "participation," as seen in various Department of Health's projects like Wat Bot, Non Thai, Sarapee, Lampang, and other special projects. Doctors working in this field fully understood that relying solely on the state would only aggravate the villagers. They would have to leave their fields, professions, and even family members behind to travel to hospitals. This led to the sentiment that *"villagers were reluctant to seek medical help and were more willing to stubbornly endure illness at home."*⁶⁰ Sometimes, when feeling unwell or experiencing fever, people may have preferred to consult traditional or alternative medicine practitioner rather than conventional doctors. In the bigger picture, it must be acknowledged that medical and public health services had not yet reached the majority of the population, especially in rural areas.⁶¹

Therefore, due to the difficulties faced by rural villagers, it becomes evident that the "economic backdrop" had a role in reflecting the problems within the healthcare system. Apart from the fact that villagers were reluctant to seek unnecessary medical attention, it's also common for them to lack personal resources to access healthcare services. When the Project for People with Low Income was introduced in 1975, those in need faced with economic challenges began to declare their own "low-income" status to hospitals because they lacked the financial means to afford medical treatment.⁶² The truth that poverty is closely linked to health was well recognized during that era by medical professionals and even newly graduated medical students who later became healthcare personnel on the front lines. The expansion of healthcare

facilities and the promotion of self-care awareness among the population would receive full support as politics entered the era of the late 1970s, having just passed through the October 6 incident.

When Thai politics “changes” and the global situation “adjusts”

The advent of the October 6 incident (1976) showcased a political stance that evolved from the preceding multidimensional struggle during the events of October 14. This evolution was undoubtedly influenced by long-standing political, economic, and social factors. In the political dimension, the return of General Praphas Charusathien and General Thanom Kittikachorn to the country on August 16 and September 19, 1976, respectively, became pivotal events that stirred a new generation to react to the unfolding situation in society, commonly referred to as the “October 6 incident,” once again.⁶³ Although the decision to flee the country resulted from challenging demands during the October 14 events, simultaneously, the atmosphere of the Cold War, which still enveloped Thailand’s political, economic, social, and cultural landscape, had a significant and continuous impact on the thoughts and perceptions of students and young people during that era. This situation gave rise to the term “Youth-New Generation,” encompassing young students and individuals, who were deeply affected by the prevailing circumstances⁶⁴ that was festering amidst the intricate challenges of Thai society.

A. The October 6 Incident and accelerated awareness of doctors towards the rural areas

The initial complexity revolved around the influence of the “anti-U.S. imperialism” sentiment that had a longstanding impact in Thailand. This was a consequence of previous collaborations between the United States and various Thai administrations. The October 6 incident thus represented a stance taken by the new generation in society, carrying forward the spirit of resistance from the events of October 14. They aimed to counter the old leadership that had been problematic and sought to protect and foster opportunities for democratic growth and development. Another crucial issue was the “social gap.” Despite the country’s economic advancement, uneven development had led to widening disparities between the rich and the poor, urban and rural areas, as well as industrial and agricultural sectors.⁶⁵ This issue was truly recognized as a serious problem after the country emerged from authoritarian rule.⁶⁶ This led to the intertwining of political and economic issues of the country with the thoughts and perceptions of people in the society who were aware of these problems during that time. Medical students, healthcare professionals, and public health workers are some of the clear examples of this phenomenon known as the “products of the era.”

During that period, it was as if a “stream of consciousness” had emerged from the unique history of politics and society. The words of Dr. Sanguan Nitayarumphong, reflecting the decisions made by medical students who were determined to become rural doctors during that time, vividly capture the sentiment: *“When I graduated as a doctor in 1977, many of my friends and I immediately went to work in rural areas as we had intended... At that time, we felt that going to work in urban areas after graduating was not right. It seemed like the prosperous ones, the comfortable ones, would be ashamed of their classmates... Who went to live where there was hardship, the better it was.”*⁶⁷ Due to this, it must be acknowledged that the political atmosphere significantly influenced the motivation medical students to rise up and advocate for the welfare of the underprivileged people in rural areas. This emphasis on working for society rather than solely for the profession aligned with the prevailing public-oriented mindset at that time.

One clear illustration of this prevailing mindset is the “purpose” behind the establishment of rural physician associations, which generated considerable debate whether they should exist for the benefit of rural communities or for the physicians themselves. Dr. Wichai Chokwiwat, who was part of the realization during the initial meetings, recalled, *“I was in the group that said, Number 1 is for rural communities, and then Number 2 is for physicians. There was a lot of debate. In the end, the majority agreed that it should be for the rural communities, because we are rural physicians... We came together for the rural communities, to improve rural medical care.”*⁶⁸ Or even the very name “Sahaphan Phat Chonnabot” (Rural Doctor Federation), which was established in 1976 (before the events of October), still carried a political undertone, due to the democratic movement’s inclination towards using “Sahaphan” (Federation) rather than “Chomrom” (Society), following the example of the Federal Republic of Germany.⁶⁹ Although the Rural Doctor Federation had to suspend its activities due to the impact of the events on October 6, 1976, they regrouped once again in 1978 under the name “Chomrom Phat Chonnabot” (Rural Doctor Society). Subsequently, they continued to establish and consolidate ideas, fostering cooperation among rural physicians in various regions. This led to the development of the club’s structure, enabling access for members across the country. By 1979, branches of the Rural Physicians Club were established in all five regions.⁷⁰

In this context, when the political landscape of Thailand underwent changes, driven by the country’s public health policies, significant transformations occurred. Alongside this, the efforts of numerous rural physicians collectively emphasized collaboration with the government to the extent possible. This approach led to substantial advancements in rural development throughout the 1970s.⁷¹ With the concept of “Primary Health Care” (PHC), the focus was on fostering fairness in the dimension of health and creating opportunities for rural populations to access healthcare services more extensively.

B. Health for All: Origins of Primary Health Care (PHC)

When discussing the concept of “Primary Health Care” (PHC), many parties often understand that the push by the World Health Organization at the Alma-Ata Conference in 1978, which was held in the Soviet Union (now Almaty, Kazakhstan), served as the starting point for the aspiration of PHC development. The goal was to advance the healthcare system towards the objective of “Health for All” by the year 2000. This became a prominent narrative widely discussed within the healthcare sector in Thailand, indicating that Thailand considered that period as the inception of implementing PHC initiatives in the country.⁷² When the World Health Organization coined the term “Primary Health Care,” Thailand embraced and organized “National Conferences on Basic Health Care” twice during 1977-1978 to vigorously support this direction. After these two conferences, it was discovered that Thailand had around 70 different plans aligned with the concept of “Basic Health Care.” These plans were compiled into a report to present to the assembly at the Alma-Ata Conference in 1978.⁷³

Figure 54 Dr. Halfdan Mahler, Director-General of the World Health Organization (WHO), visiting Thailand in February 1980

Source: National Archives of Public Health, (13) B.NEG S2.1-32.33, WHO Director-General's Visit to Thailand, 10-12 February 1980.



Derived from the Alma-Ata Declaration, the following key principles can be summarized: Health, encompassing physical, mental, and social well-being, is not solely concerned with disease prevention, but is regarded as a fundamental human right. Universal health services must be provided to bridge inequalities and disparities. Emphasis should be placed on health promotion and prevention as crucial components supporting economic and social development, leading to an improved quality of life. The government bears the responsibility of ensuring health for its citizens and providing adequate healthcare services, with PHC as the cornerstone to achieve societal equality. PHC also underscores the importance of empowering individuals, families, and communities to become self-reliant and make decisions about their own healthcare. These efforts should be supported within the country's budget to facilitate the aforementioned development.⁷⁴ Hence, this is the origin of using PHC as the answer to achieving comprehensive well-being and good health.⁷⁵ Therefore, the event at Alma-Ata signified a pivotal moment in the history of global health, representing a shift in perspective towards a vital and distinct notion of universal public health.⁷⁶

However, it's crucial not to overlook the domestic context encompassing the transformation amidst the grand shift in perspective. Within the Thai societal context, Alma-Ata might sometimes represent merely a period within a broader and longstanding paradigm shift, the roots of which extend further back in time.⁷⁷ Due to intensive "exploration" and "experimentation" in Thailand's rural areas, dating back at least three decades after World War II (around 1947-1977), it cannot be denied that the models derived from these rural experiments, led by both progressive medical professionals within the MOPH and university circles, were transformed into a knowledge legacy regarding Thai rural areas. This legacy strongly contributed to the development of the Thai application of the PHC concept, and has been earnestly applied in policy context, particularly during the periods of the 4th and 5th National Economic and Social Development Plans (1977-1981 and 1982-1986, respectively).

While the reform of PHC in Thailand was influenced by external factors within the international system, the domestic societal, political, and economic contexts (such as the Cold War atmosphere, military regimes, and dependency on foreign aid) also played significant roles in shaping Thailand's unique PHC system. Even though the term "PHC" had not been coined prior to the Alma-Ata Conference and was relatively "new," it can be said that the pre-existing projects in Thailand, supported by international cooperation for rural development, already employed an integrated medical approach.⁷⁸ These are all fragments and small components of the essential elements of PHC. Therefore, the term "PHC" in itself became a social construct born out of changes in societal, political, and economic aspects. These changes resulted from both internal factors within the country and external forces exerted from outside the nation.

C. The 4th National Economic and Social Development Plan (1977-1981) and the approach to Primary Health Care

The decade from 1977-1986, encompassing the administration of General Kriangsak Chamanan (November 11, 1977 - May 12, 1979, and May 12, 1979 - March 3, 1980) was a time when the government placed significant importance on rural development. Around mid-1978, the MOPH proposed the report "Basic Health Plan MOPH 1978-1981," emphasizing the special development of rural areas."⁷⁹ Subsequently, on March 20, 1979, the Cabinet reached a resolution to adopt the principle of "Primary Health Care" as a crucial and urgent measure for the country. They deemed it a policy that the government would continue to support. Along with this decision, the term "Basic Health Care" was changed to "Primary Health Care," as proposed by the MOPH.⁸⁰ The backdrop of the movement on the MOPH side is considered significant during the time when Dr. Amorn Nondasuta, while serving as the Deputy Permanent Secretary of the MOPH (1974), played a crucial role in incorporating the principles of PHC and the concept of "Health for All" into the national agenda. This initiative was introduced by Dr. Halfdan T. Mahler, a Danish physician who was then the Director-General of the World Health Organization (WHO). It was pushed to be included in the national agenda forcefully. *"He formulated the policy known as 'Health for All,' based on the principles of PHC. This policy aimed to involve communities in taking ownership of their own health development."*⁸¹ After the Cabinet adopted the principle, approximately three weeks later, on April 12, 1979, the "PHC Project" was initiated to expand the coverage, capacity, and provision of PHC services to rural populations within five years. The aim was to extend services to 22,400 villages in 68 provinces, covering a total population of 18.5 million. This initiative was included in the 4th National Economic and Social Development Plan (1977-1981), as proposed by the MOPH.⁸² The era of General Prem Tinsulanonda, who assumed the position of Prime Minister in March 1980,⁸³ was another period when fundamental public health efforts continue to progress. On December 3, 1980, the "Primary Health Care Committee Office" was established as a department within the MOPH, under the central administrative government, to oversee the ongoing advancement.⁸⁴ This change aimed to establish the newly-created PHC Committee Office to function as a central unit responsible for formulating policies, plans, and supporting the operations of agencies involved in PHC services. The goal was to ensure comprehensive access to services for rural populations.



Figure 55 Dr. Amorn Nondasuta (center) on the national-level seminar stage, engaged in public health promotion for overall well-being, from October 13-15, 1981 at the Indra Hotel, Bangkok.

Source: National Health Security Office, (13) B.NEG S2.1-23.17, Number126/24 3-3, Seminar on Overall Well-being, October 15-17, 1981.

Figure 56 Emeritus Professor Dr. Prawase Wasi, inside the national-level seminar, engaging in public health promotion for overall well-being, from October 13-15, 1981 at the Indra Hotel, Bangkok.

Source: National Archives of Public Health, (13) B.NEG S2.1-23.17, Number126/24 3-3, Seminar on Overall Well-being, October 15-17, 1981.





Figure 57 Dr. Sem Pringpuangkeo, within the national-level seminar, participating in public health promotion for overall well-being, from October 13-15, 1981 at the Indra Hotel, Bangkok.

Source: National Archives of Public Health, (13) B.NEG S2.1-23.17, Number126/24 3-3, Seminar on Overall Well-being, October 15-17, 1981.

Therefore, as Thailand entered the decade of 1977-86, structural changes occurred within the national and ministerial levels of the healthcare system. These changes led to a clear goal for the overall healthcare sector and incorporated the issue of healthcare service organization into the 4th National Economic and Social Development Plan. This plan emphasized an integrated medical approach that combined treatment and disease prevention, along with the promotion of public health. This approach aimed to address the challenges of unequal access to healthcare services, particularly in rural areas, where the population had grown by over 30 million people. This also led to a situation of backlog and insufficient access to healthcare services, affecting more than 80% of the population residing in regional areas.⁸⁵ As the ministry-level structure underwent enhancement and refinement, it steered the healthcare sector more clearly towards the direction of PHC. It is evident that the empowered officials within the various departments of the MOPH were dedicatedly driving and supporting the initiatives under the oversight of the MOPH headquarters.⁸⁶ They evolved into a pivotal group responsible for planning and advocating PHC initiatives within the MOPH during this era.

D. Core missions of Primary Health Care

The operational endeavors aimed to achieve the eight fundamental components of the basic structure of comprehensive healthcare, which are as follows: (1) Nutrition; (2) Health education; (3) Sanitation and clean water provision; (4) Disease immunization; (5) Primary healthcare treatment; (6) Access to essential drugs; (7) Maternal and child health, including family planning; and (8) Surveillance and control of local infectious diseases.⁸⁷ These eight components were given the catchy acronym of “N-E-W-I-T-E-M-S”⁸⁸ This often involved building upon previously initiated efforts to make them more substantial. For instance, there was an emphasis on expanding services related to maternal and child health (MCH) promotion, family planning, and nutrition, with the goal of reducing the birth rate to 2.1% by

1981.⁸⁹ Furthermore, the government also promoted family planning, which can be considered an ongoing measure with sustained positive impact, as Thailand's population growth rate had decreased to nearly 2.1% towards the end of the 4th Development Plan. This reflected consistent progress in reducing Thai population growth was targeted to further decline to 1.5% by the end of the 5th National Economic and Social Development Plan.⁹⁰ On the front of nutritional enhancement, there has been a continuous and significant improvement. According to reports from the Nutrition Division, from 1979 to 2532 (1989), the nutritional status of children under 5 years old within normal range increased from 47% to 79.1%.⁹¹

The progress in prevention is reflected by the coverage of vaccination, access to clean water, and the use of toilets according to sanitary principles. The work of Dr. Somsak Chunharas showed that the government expanded the work on immunization according to the guidelines of PHC through vaccination since the 4th National Economic and Social Development Plan (1977-81) and the coverage has clearly increased during the period. The beginning of the development plans, No. 5-6 (1982-1991), which coincided with the expansion of the sub-district health center, coincided and the emergence of the Public Health Communicator (PHC) and Village Health Volunteers (VHV), all of whom played an important role in speeding up the coverage of vaccination services. Vaccine-preventable communicable diseases began to decline rapidly in the middle of the 4th Plan period and throughout the 5th Plan (1982-1986).⁹² By the early part of the decade from 1997-2006, the range of communicable diseases prevented by vaccination had clearly declined. Data in 1996 showed that 96% of eligible Thai children had been vaccinated against diphtheria, pertussis, tetanus and polio, 92% had been vaccinated against measles, and 98% with BCG.⁹³

Another area of prevention was sanitation and clean water supply, including the provision of clean drinking water and sanitary use of toilets. When considering the availability of clean drinking water in rural areas, it was found that during the 1st-3rd Development Plans (1961-1976), the availability of clean drinking water was very low. Looking at the access to clean drinking water in 1976, it was found that only 16.7% of households had access to clean water. After that, during the 4th National Development Plan (1977-81), the coverage of clean and sufficient drinking water began to increase and expanded to cover the population more rapidly during the 5th Plan (1982-86). Data for 1982 show that only 32.7% of households had access to clean water, but this increased to 93.2% in 1996. Hygienic practices to reduce the morbidity rate of communicable diseases caused by water and food, which had been implemented since the 1st-3rd Development Plans, had achieved coverage of sanitary toilet use of 42.3% by 1982 and, by 1996, coverage was nearly universal at 96.9% of households.⁹⁴



Figure 58 The image of the rural water supply project in Khon Kaen Province, dated 1967.

Source: National Health Security Office, (13) B.NEG S2.1/11.61, Rural Water Supply Project, Khon Kaen, May, 1967.



The political transformation that led to opportunities brought about a shift in the direction of creating an expansion of services to establish district-level hospitals and elevate all midwifery clinics to become health centers in the 1977-86 decade. These service units transformed into solid foundations for healthcare personnel and the socio-community sector, aiming to participate in promoting the extensive development of the PHC system. This expansion included rural doctors and, thus, the growth of these service units not only contributed to the resilience of the PHC system but also served as operational bases for rural medical practitioners who played a significant role during that period.⁹⁵ The awakening of healthcare personnel's willingness to work in remote areas during that era can be considered a "product of the times," influenced significantly by the political, economic, and social circumstances that played a crucial role in shaping this phenomenon.

Chapter 6

¹ Nualnoi Treerat and Bank Ngamarunchot, Politics and Power in the Universal Health Coverage System, (Nonthaburi: Health Systems Research Institute (HSRI), 2012), 31–32.

² Prawese Wasi, ‘Medical and Public Health in 25 Years,’ 48–59.

³ Davisakd Puaksom, Infectious Diseases, Body, and Medicalizing State: History of Medicine in Modern Thai Society, 330–331.

⁴ For more information, refer to Kiatnakin Phatra, 50 Years: The Making of the Modern Thai Economy (Bangkok: Kiatnakin Phatra Financial Group, 2022).

⁵ For more information, refer to Rangsan Thanapornphan, Financial Crisis and Thai Financial Economy, 2nd Edition (Bangkok: Khobfai, 1999).

⁶ For more information, refer to Bangkok Dusit Medical Service, ‘Company History,’ Accessed June 3, 2022, <https://investor.bangkokhospital.com/th/general/company-background>.

⁷ Phopan Uyyanon. ‘Economic History of Thailand’, Chapter 4.

⁸ For more information, refer to Kongsakon Kawinraweeekun, ‘Constructing the Body of Thai Citizens during the Phibun Regime of 1938–1944’ (Master’s thesis in Sociology and Anthropology, Faculty of Sociology and Anthropology, Thammasat University, 2002).

⁹ Interview with Sulak Sivaraksa, May 29, 2022.

¹⁰ Sanguan Nitayarumphong, ed., Mahidol Historical Almanac for Democracy Part 2: Coordinating People to Dedicate for the Ideology (October 14, 1973–October 6, 1976), 34–36.; Interview with Dr. Komatra Chuengsatiansup, June 21, 2022.

¹¹ Interview with Dr. Amphon Jindawatthana, May 18, 2022.

¹² Interview with Dr. Siriwat Thiptharadol, May 20, 2022; Interview with Dr. Winai Sawasdivorn, May 16, 2022.

¹³ National Archives of Public Health, (12), SB 12.8/2.5, ‘Mahidol Letter (September 1974).’

¹⁴ National Archives of Public Health, (12), SB. 12.4/2, ‘Coordinating Committee for Student Affairs (1970).’

¹⁵ Napaporn Ativanichayapong and Friend of Women Foundation, Path to Social Security: History of Struggle and Reform in Social Security Law (Bangkok: Friend of Women Foundation, 2008), 64.

¹⁶Napaporn Ativanichayapong, *Thai Labor Union: A Social Movement Perspective* (Bangkok: Puey Ungphakorn School of Development Studies, 2018), 35–36.

¹⁷Wiwan Ekarintarakul, “Public Health Administration in Thailand 1958 - 1977,” 160.

¹⁸For further information, see Napaporn Ativanichayapong, Kanokwan Raluek, and Kanokwan Sae-jang, “Rural Thai Society from the Perspective of Volunteer Graduates: A Synthesis of Knowledge from the Studies of Volunteer Graduates, Thammasat University” (Thammasat University: The Graduate Volunteer Centre, 2014), 2–5.

¹⁹For more information see Mae Klong Integrated Rural Development Project, Published Documents, Mae Klong Integrated Rural Development Project, https://digital.library.tu.ac.th/tu_dc/frontend/Info/item/dc:128000, Accessed March 23, 2022.

²⁰In the provinces of Nakhon Pathom, Ratchaburi, Suphan Buri, Phetchaburi, Kanchanaburi, Samut Sakhon, and Samut Songkhram.

²¹The Mae Klong Integrated Rural Development Project: Responsibilities and Roles of Local Faculty-Student Units in the Mae Klong Integrated Rural Development Project (TU Digital Collections, n.d.); The Mae Klong Integrated Rural Development Project: The Mae Klong Integrated Rural Development Project within the Context of Mahidol University (TU Digital Collections, n.d.).

²²William H. Becker, *Innovative Partners: The Rockefeller Foundation and Thailand*, 138-140.

²³Interview with Professor Saichol Sattayanurak, May 26, 2022.

²⁴Mae Klong Integrated Rural Development Project, Published Documents, Mae Klong Integrated Rural Development Project.

²⁵The Ministry of Public Health is divided into 2 bureaus and 5 departments, including Office of the Minister's Secretary, Office the Permanent Secretary, Department of medical services, Department of Health, Department of Public Welfare, Department of Medical Sciences, and Department of the University of Medicine. In 1952, the Department of Public Health was renamed to the “Department of Health” and the Department of Public Welfare was separated and placed under the Ministry of Interior. In 1959, the Department of the the University of Medicine was transferred under the office of the Prime Minister.

²⁶ Santisuk Sophonsiri, 80 Years of Dr. Pairode Ningsanon: A giant grain rice in the Thai public health sphere, 101–2.

²⁷ Royal Thai Government Gazette, “Royal Decree Transferring Kasetsart University, Chulalongkorn University, Thammasat University, The university of medicine, and Silpakorn University to be under the Prime Minister’s Office, 1959” (Volume 76, Issue 85K, Special Issue, September 2, 1959).

²⁸ Santisuk Sophonsiri, 80 Years of Dr. Pairode Ningsanon: A giant grain rice in the Thai public health sphere, 102.

²⁹ Interview with Dr. Wichai Chokwiwat, May 17, May 23, and June 2, 2022.

³⁰ Public Health Planning Division, ‘Evolution of Policies and Development Plans of Thailand’s Public Health,’ in 45 Years of the Ministry of Public Health, 1942 - 1988 (Bangkok: Sahapacha Panit, 1988), 44.

³¹ Department of Health, Work, and Ideas Dr. Damrong Boonyoen: A Hero in the Epic of Thai Public Health Development, 31.

³² Interview with Dr. Wichai Chokwiwat, May 17, May 23, and June 2, 2022.

³³ Dr. Udom Posakritsana, renowned for his surgical skills and dubbed the “Surgical God,” was also interested in rural issues. During his tenure as the Dean of the Faculty of Medicine Siriraj Hospital, he initiated a policy to send doctors, pharmacists, and nurses to work in remote rural areas, which significantly connected the institution to rural communities. This effort earned the Faculty of Medicine Siriraj Hospital the Outstanding Rural Doctor Award. As a Minister of the Ministry of Public Health, he diligently inspected and improved healthcare services in various provinces. For more details, refer to the memorial publication “In Remembrance of Professor Dr. Udom Posakritsana” at Wat Thepsirintharawat, Bangkok (Bangkok: Amarin Printing and Publishing, 1997).

³⁴ Nualnoi Treerat and Bank Ngamarunchot, Politics and Power in the Universal Health Coverage System (Nonthaburi: Health Systems Research Institute (HSRI), 2012), 21.

³⁵ Santisuk Sophonsiri, Thai Physicians’ Legacy for Future Generations: Life and Work of Professor Dr. Sem Pringpuangkeo (Bangkok: Society and Health Institute (SHI), 2012), 179.

³⁶ Office of Primary Health Care Commission, Primary Health Care in Thailand (Nonthaburi: Office of the Permanent Secretary, Ministry of Public Health, 1984), 9.

³⁷Yutthana Suksamiti, “Improving the Organizational Structure of the Ministry of Public Health, B.E. 2517,” in *45 Years of the Ministry of Public Health, 1942-1987* (Nonthaburi: Ministry of Public Health, 1988), 41–63.

³⁸Santisuk Sophonsiri, *Thai Physicians' Legacy for Future Generations: Life and Work of Professor Dr. Sem Pringpuangkeo*, 179–85.

³⁹Memorial book for the Royal Cremation Ceremony for Professor Dr. Udom Posakritsana at Wat Thepsirintharawat, Royal crematorium in front of Phlapphla Issariyaphon, Bangkok 134.

⁴⁰Santisuk Sophonsiri, 179-185.

⁴¹National Archives of Public Health, (14) SB 1.4/2.19, “Data of Opponents to the Plan for Restructuring and Reorganizing Ministries within the Ministry of Public Health [1974].”

⁴²National Archives of Public Health, (14) SB 1.4/2.17, “List and Letters from Supporters of the Plan for Restructuring and Reorganizing Ministries within the Ministry of Public Health (1) [1974].”; National Archives of Public Health, (14) SB 1.4/2.18, “List and Letters from Supporters of the Plan for Restructuring and Reorganizing Ministries within the Ministry of Public Health (2) [1974].”

⁴³National Archives of Public Health, (14) SB 1.9/1, “Statement from the Central Student Doctor of Thailand on the New Organizational Structure of the Ministry of Public Health 2517 [1974].”

⁴⁴Wirot Na Ranong and Anchana Na Ranong, “From Alleviating Poverty to Building Universal Health Coverage: The Background of the ‘30 Baht Program’” (Nonthaburi: Health Systems Research Institute (HSRI), 2012), 5.

⁴⁵Royal Thai Government Gazette, “Constitution of the Kingdom of Thailand, 1974” (Volume 91, Part 169K, Page 1, October 7, 1974).

⁴⁶Interview with Professor Saichol Sattayanurak, May 26, 2023.

⁴⁷For further details, see Phiman Room at Montien Hotel, the signing ceremony of the New Force Group (n.p.: 1974).

⁴⁸Sanguan Nitayarumphong, ed., *Mahidol Historical Almanac for Democracy Part 2: Coordinating People to Dedicate for the Ideology* (October 14, 1973-October 6, 1976), 95.

⁴⁹The Secretariat of the Cabinet, “Cabinet Members, Cabinet No. 36 M.R. Kukrit Pramoj: Report of the

Fourth Session of the House of Representatives (First Ordinary Session), Wednesday, March 19, 1965" (Pages 237-250), https://www.soc.go.th/?page_id=6134.

⁵⁰The Secretariat of the Cabinet, "(Copy) Regulation of the Prime Minister's Office Concerning Assistance to Low-Income People in Urban Areas B.E. 2518" (1975) (Office of the Government Information Commission), <http://www.oic.go.th/FILEWEB/CABINFOCENTEROPM/DRAWER01/GENERAL/DATA0004/00004005.PDF>.

⁵¹Interview with Dr. Siriwat Thiptharadol May 20, 2022.

⁵²Interview with Dr. Winai Sawasdivorn, May 16, 2022.

⁵³Royal Thai Government Gazette, "Regulation of the Prime Minister's Office Concerning Healthcare Assistance for Low-Income People related to Medical Treatment 1981" (Volume 98, Part 11K, Special Issue, Page 6, January 23, 1981).

⁵⁴The term "family member" refers to individuals who have not yet reached legal capacity or have reached legal capacity but are incapacitated or quasi-incapacitated and are under guardianship.

⁵⁵Royal Thai Government Gazette, "Regulation of the Prime Minister's Office Concerning People's Welfare in the Aspect of Healthcare 1994" (Volume 111, Special Issue 33 NG, Page 16, August 10, 1994).

⁵⁶Interview with Dr. Winai Sawasdivorn, May 16, 2022.

⁵⁷Interview with Dr. Prateep Thanakitcharoen, June 6, 2022.

⁵⁸Sombat Chantarawong and Rangsarn Thanapornphan, *Love Thailand: Volume 1 - History and Politics*, 16.

⁵⁹Davisakd Puaksom, *Infectious Diseases, Body, and Medicalizing State: History of Medicine in Modern Thai Society*, 323-325.

⁶⁰Santisuk Sophonsiri, 80 years of Dr. Amorn Nondasuta: A shining diamond in the Thai public health sphere, 100.

⁶¹Office of the National Economic and Social Development Council, "The 4th Economic and Social Development Plan, 1977 - 1981" (Office of the National Economic and Social Development Council, 1976), 19, Accessed March 25, 2022, https://www.nesdc.go.th/main.php?filename=develop_issue.

⁶² Chatree Charoencheewakul and Opiwan Nitayarumphong, *Starlight of Faith: Sanguan Nitayarumphong* (Bangkok: Sahamit Printing and Publishing, 2011),

⁶³ Recording of October 6, "October 6 Incident," Accessed June 8, 2023, <https://doct6.com/learn-about/how/chapter-4>.

⁶⁴ Chamvit Kasetsiri, October 14, Recorded History (Bangkok: Social and Humanities Project Foundation, 2546), 12.

⁶⁵ Chamvit Kasetsiri, October 14, Recorded History, 12.

⁶⁶ Interview with Dr. Siriwat Thiptharadol, May 20, 2022.

⁶⁷ Sanguan Nitayarumphong, "Work and Ideals of Dr. Sanguan Nitayarumphong's Life" (n.p.: n.d.), Chatree Charoencheewakul and Opiwan Nitayarumphong, *Starlight of Faith: Sanguan Nitayarumphong*, 50–51.

⁶⁸ Wichai Chokwiwat and Santisuk Sophonsiri, "Interviews in 'Research Project on the Life and Accomplishments of Dr. Wichai Chokwiwat,'" (Unpublished Document).

⁶⁹ National Archives of Public Health, (12) SB 12.8/3.1, "Rural Doctors, August 1976 (1976)"

⁷⁰ Nuttarute Vongtangswad, "The dynamics of framing and mobilization of the rural doctor movement: conflicts and political transformation" (Thesis, Faculty of Political Science, Chulalongkorn University, 2017), 122-123.

⁷¹ Joseph Harris, *Achieving Access: Professional Movements and the Politics of Health Universalism*, Cornell University Press: ILR Press, 2017, 38

⁷² Amornsri Yodkham, Monwadee Prakairungthong, Viroj Lengrugsa, Chutisuda Netikul, Auengprai Asawasinan, "Evolution of Primary Health Care in Thailand, 1978 - 2014" (Nonthaburi: Primary Health Care Division, Department of Health Service Support, 2014), 8-13.

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⁷⁴ World Health Organization. 'Primary Health Care: Report of the International Conference on Primary Health Care Alma-Ata, USSR, 6-12 September 1978' (World Health Organization, Geneva, 1978), 2–4.

⁷⁵ National Archives of Public Health, (11) SSM 2.1/1, "Health for All and Development of Primary Health Care in Thailand, Volume 1 (1982)."

⁷⁶ Mahidol University Archives and Museums, MU.OP.A6.1.1.4.18, File 269, Box 46[1], Document AL-MA-ATA: SIGNPOST TO A NEW HEALTH ERA [24 May 1982].”

⁷⁷ Muscat, R. J., Thailand and the United States: Development, Security, and Foreign Aid (STUDIES OF THE EAST ASIAN INSTITUTE). Columbia University Press, 1990, 217.

⁷⁸ Chamroon Meekanon, Project Report Summary for Lampang Project, 33.

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⁸⁰ The Secretariat of the Cabinet, “Country Policy on Initiating Basic Health Services,” March 20, 1979, https://resolution.soc.go.th/?prep_id=88275.

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⁸² The Secretariat of the Cabinet, “Project for Primary Health Care of the Ministry of Public Health,” April 12, 1979, https://resolution.soc.go.th/?prep_id=72214.

⁸³ March 3, 1980 to April 30, 1983, from April 30, 1983 to August 5, 1986, and from August 5, 1986 to August 4, 1989.

⁸⁴ Royal Thai Government Gazette, “Royal Decree on the Division of Departmental Administration, Ministry of Public Health, 1980,” (Volume 117, Part 186K, Special Edition, Page 7, December 3, 1980).

⁸⁵ National Archives of Thailand, (2) ST 1.1/30 Box 4, “Project for Regional Health Service Organization According to the 4th National Economic and Social Development Plan B.E. 2520-2524 [1977 - 1981]”.

⁸⁶ (1) Central Division (2) Staff Division (3) Medical Practice Division (4) Nursing Division (5) Foreign Public Health Division (6) Treasury Division (7) College of Nursing Division (8) Maintenance Engineering Division (9) Legal Affairs Division (10) Planning Division (11) Public Health Planning Division (12) Training Division (13) Epidemiology Division (14) Regional Hospital Division (15) Public Health Statistics Division (16) Regional Public Health Division (17) Health Education Division and (18) Office of the National Health Commission. Primary health care

⁸⁷ World Health Organization, ‘Primary Health Care: Report of the International Conference on Primary Health Care Alma-Ata, USSR, 6-12 September 1978’, 4.

⁸⁸ In the 4th National Economic and Social Development Plan (1977 - 1981), there are 8 components. Later, 2 more were added to make it 10 components (Mental Health and Oral Health) in the 5th National Economic and Social Development Plan (1982-1986), and then an additional 4 were added to make it 14 components (Environmental Health, Consumer Protection, Prevention and Control of Non-communicable Diseases, and Prevention and Control of AIDS) in the 6th National Economic and Social Development Plan (1987-1991).

⁸⁹ National Archives of Thailand, (2) ST 1.1/30 Box 4, "Project for Regional Health Service Organization According to the Fourth National Economic and Social Development Plan B.E. 2520-2524 [1977 – 1981]."

⁹⁰ Memorial book for the Royal Cremation Ceremony for Professor Dr. Somboon Vachrotai at Wat Makut-kasattriyaram, Sunday, September 6, 1981 (Bangkok: Amarin Printing, 1981), 59.

⁹¹ Sanguan Nitayarumphong, "Evolution of primary health care in Thailand: what policies worked?," Health Policy and Planning, Vol. 5, No. 3 (September, 1990), 250.

⁹² Somsak Chunharas, "History of Health Development in Thailand: Analysis of Power Distribution and Impact on the Health System," (Nonthaburi: Health Systems Research Institute (HSRI, 1998).

⁹³ Somsak Chunharas, "History of Health Development in Thailand: Analysis of Power Distribution and Impact on the Health System," 92.

⁹⁴ Somsak Chunharas, 94.

⁹⁵ Somsak Chunharas, 95.



The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868-2002

Era of Thai public health leadership:
Experiences of physicians and
healthcare personnel in rural areas

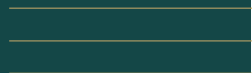




Figure 59 Includes pictures of many reformist doctors and rural doctors

Source: National Archives of Public Health, (13) B.NEG S.2.1-23.17, Seminar on Comprehensive Health, October 15-17, 1981, (1) FP SCH.4.3/1, Seminar of Health System Reform Team, December 2-3, 2000 at Pattaya; (13) C.NEG S.2.2/6.111, Reception for the Medical Council Committee, November 1993; (13) B.NEG S.2.1/40.60.1-40.60.2, Number 194/28, Roll 1-2, Regarding the the Permanent Secretary of the Ministry of Public Health Presenting Health Cards in Nan Province and Receiving SPN Cards on September 9, 28; (13) C.NEG S.2.2/6.29, Health Insurance Committee Meeting, March 11, 1989

It's not only the October 6th incident that instilled a sense of purpose in rural physicians to contribute to society as fundamental leaders. However, within the context of social, cultural, political, and economic circumstances since post-1977, there has been a societal “squeeze” that compelled physicians working to repay their education loans to possess an inherent courage to become leaders automatically. The announcement of the PHC Service Strategy (including the use of the Basic Minimum Needs, or BMN, policy and the allocation of funds for district hospital development, which will be elaborated in the following section) served as a tool for rural development. These policies positioned rural physicians as spearheads, essentially becoming machinery propelling change. This period signifies a time when rural physicians were increasingly integrated into the state apparatus, i.e., representing the government in rural development. They also had the opportunity to establish relationships with the technocrat groups within the Ministry of Public Health (MOPH) and witnessed the growth of social development organizations venturing into rural areas. The mutual support between the civil sector and the network of rural physicians greatly facilitated the work of both sides in the field.

Rural doctors in the era of Primary Health Care and semi-democracy

Given the political climate fostering ideologies, coupled with issues of degradation and poverty that were concentrated particularly in the Northern and Northeastern regions of Thai society, these areas became continuous operational zones for rural physician groups. Generally, physicians who graduated from the university-based medical colleges were assigned to work in various areas where there was a scarcity of medical personnel. This started with a one-year internship, followed by three years of work to repay their education loans. For the first generation of scholarship-receiving physicians, there was a rotation among different district hospitals, lasting from five months to one year. However, due to incomplete and slow state administration, along with resistance to change in many aspects, most district hospitals, where the majority of physicians worked, were ill-prepared for any substantial work. Consequently, becoming a rural physician necessitated self-training as both a medical practitioner and a manager, adapting to the circumstances at hand. In simpler terms, one had to do everything themselves, from patient care and hospital management to tasks beyond the scope of medical personnel's responsibilities. As Dr. Sanguan Nitayarumphong, a rural physician, noted in his work experience as a rural doctor:

“

“The hospital I chose to be at was in Rasi Salai District of Si Saket Province... It was the poorest district in the country at that time. The roads, the food, and the living conditions were all rustic and rugged. The hospital was more than 35 kilometers away from the provincial center. The road was a red dirt road. It took about an hour to drive in and out of the province each time, and the road was just full of dust. When you were driving, if you didn't close the windows, all you would see is the dust. But if you closed the windows, it gets very hot since the vehicles did not have air conditioning.”¹

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There were many rural physicians who had experiences like this during their work to repay their loans, and these experiences were not significantly different from one another. They all reiterated the fact that those newly graduated physicians had to perform multiple roles, at least 4 to 5 aspects: being a physician, a manager, a teacher, a leader of a public health team, and sometimes even a transporter or a driver to transport patients.²

In many areas, there were numerous obstacles causing the work of medical personnel to become even more challenging than before. This was due to the societal and cultural conditions inherent to these regions, differing from the central Thai population's natural characteristics. This has led to issues regarding language and ethnicity, requiring physicians working in such areas to learn and adapt themselves to the local community's environment and traditional way of life. Take the example of “language” in communication. For instance, most public health personnel, aside from their official working hours, often engaged in community activities during the evenings to communicate, promote various issues, and advocate for matters. These activities might involve constructing toilets, promoting hygienic eating habits, refraining from raw food consumption, and communicating through 32 mm. projected films. If physicians or public health workers were capable of speaking the language used by the local community (such as Isaan or Northern dialects), they could more effectively convey health-related knowledge to the villagers.³ Another challenge concerned the issue of “stateless individuals,” as seen in many provinces in the northern regions where there were several minority groups who, at that time, did not possess national identification cards. This led to a situation where even if they were born and resided within the territorial borders of Thailand, they were unable to access subsidized healthcare services. Dr. Suwit Wibulpolprasert reflected on the situation when he provided special health cards to the Hod District Hospital in Chiang Mai Province:

“

“We never knew about people who lived in Thailand, who didn’t have a 13-digit ID cards, or any documentation of right to citizenship. We never knew about stateless people at all. Indeed, there was a Karen village right behind my hospital... but they would not want to come to the hospital, even when giving birth. Only if they had an obstructed delivery would they finally come for help. After the delivery was successful, I asked them why they didn’t come for prenatal check-ups. They said they didn’t have money. So I arranged to issue cards for those with low income to come for free treatment later. They said they couldn’t get the card because they didn’t have a Thai ID card. I wondered them how they managed living in Thailand without proof of citizenship. Thus, I decided to make our own set of health cards. Even though that was technically illegal, the Chief District Officer said it was okay in this situation. But, the villagers had to understand that they could only use the card at my hospital. It is not valid at other places. So, I issued cards for the entire village... I don’t know if it’s right or wrong, but I felt like I couldn’t give them cards to be treated anywhere. I issued cards for my hospital. If they were in pain, feverish, or ill, I would treat them, and treat them for free.”⁴

”

These cases represented challenges for the physicians and personnel working in these areas. Their medical education never included real-life anecdotes that would have prepared them for the situations described above. Therefore, even though these physicians had to learn about more than “healing; and in that process they transformed into “pioneers” together. Furthermore, it’s important not to overlook the political factors that played a specific role during that era. Hospitals were often constructed and established in “red zone” areas, which were targeted, risky, or operational zones for insurgents advocating communist ideologies. Thus, operating a rural hospital was a demonstration that they were not neglecting the people. During that time, there was also psychological operations where medical units were sent to provide services to the public⁵ While medical personnel were not the primary targets of terrorist attacks, the prevailing political unrest had an impact on the complex conditions under which rural physicians operated. According to the experience of Dr. Suwit Wibulpolprasert:

“

“... I spent two years at a 12-bed hospital [Ban Kruat District, Buriram Province]. It was right on the border with Cambodia. During that time, it was the killing field era. The Khmer Rouge attacked, and villagers had to flee to the Thai side to escape death. Thai soldiers placed landmines along the border to prevent the Khmer soldiers from coming in. When villagers escaped and crossed over, they often triggered the landmines. My hospital was like a field hospital for infantry casualties. Most patients had amputations. It was said that you could lose a leg just by closing your eyes. It happened every day. We had to do everything ourselves. We were not only doctors but also surgeons, obstetricians, orthopedic surgeons, and pediatricians. We were ‘Med’ doctors [general practitioners], and ‘Dom’ doctors [anesthetists]...”⁶

”

Therefore, facing unique and challenging circumstances enabled these rural physicians to learn and develop the accurate understanding in order to choose whether to continue working in rural areas or return to central region, as deemed appropriate.⁷ Furthermore, during the period around the late 70s and early 80s, establishing personal relationships between medical professionals and villagers at the district hospital played a crucial role in survival in rural areas. This led to the documentation of experiences by many physicians, recounting events that varied based on the received experiences. However, what truly became a measure of real-world capabilities was the ability to solve problems individually while working in rural areas. While technical knowledge is indeed a professional asset, the “resilience” of these rural physicians has continually helped them navigate through specific situations. Additionally, in some cases, the mentor-mentee relationships and interactions between senior and junior physicians contributed to the ongoing development in rural areas.

A. Transition of local doctors to work in central ministry

Rural doctors’ ability to transform their roles from rural physicians to agents of public health reform is due to the creation of “collaborative alliances” with senior doctors who were leaders in public health, such as Dr. Sem Pringpuangkeo, Dr. Somboon Vachrotai, Dr. Pairode Ningsanon, Dr. Prawese Wasi, Dr. Damrong Boonyoen, Dr. Paichit Pawabutr, and others. At that time, senior doctors within the MOPH already supported the ideas of rural doctor groups, acting as a “shield for rural doctors.” This led to the

development of a vertical relationship between rural doctors and senior doctors, who had complementary roles and jointly propelled movements for healthcare development since the 1977-86 decade. Part of the favorable relationship between the Rural Doctors Association and the central group of leading doctors provided opportunities for rural doctors to engage in various functions within the central authority structure of the MOPH.¹⁰ For example, when Dr. Amorn Nondasuta held the position of Minister of Public Health (1983-1986), Dr. Paichit Pawabutr, who had previously served as a PCMO in Nakhon Ratchasima, was called upon to assist in central duties.¹¹ And when Dr. Paichit Pawabutr assumed the position of Minister of Public Health (1992-1994), he brought in Dr. Samreung Yaengkratok, who had abilities and had previously collaborated in developing hospitals in Ubon Ratchathani and Nakhon Ratchasima Provinces, to work within the MOPH as the Deputy Director-General of the Department of Disease Control (1993).¹²

Figure 60 Image of Dr. Damrong Boonyoen and Dr. Sanguan Nitayarumphong at a MOPH conference in 1993.

Source: National Archives of Public Health, (13) C.NEG S.2.2/6.93, Government and Social Security at the Parliament, September 1993.



Figure 61 Image of Dr. Paichit Pawabutr (dark gray suit on the left) and Dr. Samreung Yaengkratok (light gray suit on the right) during a visit by Dr. Paichit Pawabutr to government officials in Ubon Ratchathani Province, where Dr. Samreung Yaengkratok was stationed.

Source: Public Health National Archives, (13) C.NEG S.2.2/4.31, Dr. Paichit Pawabutr's visit to Ubon Ratchathani, February 1991.

With the experience gained from their work, rural doctors had come to understand the true picture of the healthcare system. When they had the opportunity to work in central government positions, they often brought with them lessons, truths, and limitations learned from rural areas to benefit the design of the country's healthcare system. For instance, Dr. Wichai Chokkiwat pointed out that the experience gained from working in district hospitals by Dr. Vunvilai Chandrabha, a leading figure of the field of nursing who had participated in rural healthcare activities, played a role in promoting leadership qualities later on.

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“In the past, community hospitals, formerly referred to as district hospitals, often faced the problem of frequent changes in management, especially hospital directors. This had an impact on administrative and operational aspects, affecting the hospital staff's work... The Nursing Division began to establish teams to support the development of hospitals at this level (from 1980-1986), with the main objective being to help structure management, service delivery, and clear coordination, allowing all groups to follow systematic guidelines without disruption when management changed...”¹³

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Later, Dr. Vunvilai became a crucial figure in the establishment of the “Nursing Council” in 1985 and held the position of the first Deputy President of the Council. She played a pivotal role in improving the internal management structure of hospitals to enhance efficiency. Many rural doctors had similar career paths. For instance, Dr. Suwit Wibulpolprasert gained experience as the head of the Evaluation and Budget Division at the Department of Planning and Health Development (1982-87), Director of the Bureau of Food and Drug Administration (1988-91), Deputy Minister of Public Health (2000-03). During the same period, Wichai Chokkiwat served as the Director of the Epidemiology Division (1990-91), an expert in data and information at the Office of the Permanent Secretary of the MOPH, Deputy Director-General of the Department of Disease Control (around 1991-95), Secretary-General of the Food and Drug Administration (2000-02), and Director-General of the Department of Thai Traditional and Alternative Medicine (2002-07). Simultaneously, Dr. Amphon Jindawatthana served as the Director of the International Public Health Division, Chief Physician of the Bureau of Disease Control (1992-94), and Director-General of the National Institute of Health (1994-99). As for Dr. Sanguan Nitayarumphong, he transitioned from being the hospital director of Bua Yai District Hospital in Nakhon Ratchasima province to work in the MOPH.

He played a role in the Medical Council and eventually became the Deputy Minister of Public Health, responsible for policy and planning (2001-03). He also served as the Secretary-General of the National Health Security Office (NHSO) from 2004 to 2008.¹⁴ These rural doctors have taken the experiences gained from working in rural areas and applied them to further drive challenging public health efforts. They have accomplished this through various management roles within the MOPH. For instance, Dr. Prateep Thanakitcharoen, former director of Rasi Salai Hospital (1983-89), interestingly summarized that, *"The experience starting from being a student in rural areas and progressing to work in central administration has provided us with significant strength. It has become a working mechanism."*¹⁵

Working in rural areas involved tasks that went beyond the scope of hospitals and the workings of the government system. These tasks encompassed multidimensional aspects, particularly those related to societal development. Coupled with the unique environmental conditions and socio-cultural factors aforementioned, rural areas not only served as testing grounds and creators of future healthcare leaders but also functioned as spaces where other organizations, including private development organizations, played an increasingly significant role in societal progress. On one hand, these organizations contributed to enhancing the completeness of rural healthcare efforts, thereby making substantial contributions to public health in rural areas.

B. Addressing the relationship between rural doctors and civil society organizations

Between 1977 and 1987, the term "Civil Society" was not widely recognized, and extra-governmental forces had little role in state policy due to the political structure during that period of semi-democracy. The political landscape revealed a tripartite power dynamic among politics, bureaucracy, and business groups. In terms of healthcare policy, it was influenced by professional technical groups. Dr. Amorn Nondasuta, a key figure in establishing the foundations of PHC, supported this notion by stating that *"The direction of healthcare development has largely depended on two conditions: 1) the political environment and 2) the professional environment [the need to protect professionalism]."*¹⁶ However, even though one cannot fully proclaim that the political environment of this decade was a "complete" democracy, it was still somewhat democratic. Associate Professor Sanae Jamrik, a prominent figure in the Campaign for Popular Democracy (CPD), expressed an opinion that even in this period of "half" democracy where people do not possess full freedom, the emergence of Civil Society organizations is a crucial component that helps fill the gaps in the state's development efforts and can be seen as the initial steps toward the concept of freedom. As he stated on the occasion of the 12th anniversary of the Campaign for Popular Democracy on November 24, 1985:¹⁷

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“...In the present, the government recognizes the importance of non-governmental organizations because local development, since the government has not had convincing results consistently over time. They see that volunteer development organizations can reach the people better because the government waits for the people to come to them, whereas volunteer development organizations go to the people... This is an activity that truly addresses the essence of life, existence, and the grassroots problems of the people in the region.”¹⁷

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If we look at the development of civil society organizations, during the 1977s, there were several organizations that began to regain their roles after passing through the political crisis of October 6, such as the Rural Doctor Society (1978) and the Campaign for Popular Democracy (1983), which changed its name from the People's Liberation Union for Civil Liberties. They began advocating for the creation of the “Basic Health Security Law” since 1986, collaborating with various groups, particularly labor unions. There was a campaign through the slogan “Survival Path for the Thai People, the State Must Sincerely Ensure Society” using various media outlets since that period onwards.¹⁸ There were also numerous labor networks that were established once again after the dissolution of labor unions during the October 6 period. Examples include the Council of Employers' Organizations of Thailand (1979) and the Federation of Thai Labour Associations (1983), along with the ongoing establishment of labor unions such as the Rangsit/Phra Pradaeng/Amphoe Om Noi-Amphoe Om Yai Labor Union and the State Enterprise Relations Labor Union (1982-83). These movements played a role in pushing for the “Social Security Act” to be passed by the Parliament in 1990.”¹⁹

The organizations directly involved in health included the “Herbal Self-Reliance Project” established in 1979 under the name of the Komol Keem Thong Foundation, initiated by pharmacists Supoj Ussawapanthanakul and Rosana Tositrakul (later becoming the “Thai Health Foundation” in 1996).²⁰ This aimed to enable villagers to be self-reliant by utilizing local herbs and traditional knowledge, with a strong connection to many senior leaders who desired to revive traditional medicine practices. As stated by Pharmacist Supoj Ussawapanthanakul, the head of the project in its early days, “*The herbal project for*

*self-reliance originated from the Komol Keem Thong Foundation. The project office utilized the resources of the Foundation for seven years before moving to a new office. It can be said that the foundation played a significant role in initiating, promoting, and supporting the project, particularly with the assistance of Sulak Sivaraksa and Dr. Prawese during the initial stages.*²²

Another organization worth mentioning is the Coordinating Committee for Primary Health Care of Thai NGOs Foundation for Consumers in Health Network (1983), which later changed its name to the "Foundation for Consumers" (FFC) in 1996. This organization worked on consumer protection issues, such as advocating for appropriate drug usage, pushing for the transformation of combination pain and fever remedies into single-component drugs, opposing pharmaceutical patents and the use of generic drug names, and promoting anti-smoking campaigns in its early days. A key member, Saree Aongsomwang, had worked alongside Dr. Sanguan for a long time. Afterward, Saree invited Jon Ungphakorn, the founder of the AIDS ACCESS Foundation (1991), and former director of the Community Volunteers for Society Project (CVS) that later transformed into the Thai Volunteer Service Foundation (TVS) in 1986, to join the network of non-governmental organizations (NGOs).²³ The Community Volunteers for Society Project, or CVS, was established in 1980 as part of the Thai Volunteer Service Foundation (TVS). Leading figures in its founding were Amporn Meesuk, Gothom Arya, Sulak Sivaraksa, and Srisawang Puawongphat, along with Jon Ungpakorn. CVS was structured akin to a volunteer corps, comprising recent graduates or individuals capable of working full-time, dedicated to aiding underprivileged people in rural areas and collaborating with NGOs for a period of two years. Each year, CVS could produce around 20-30 volunteers, and many who had worked in rural areas went on to become leaders of NGOs outside the state sector nowadays. During the initial stages of CVS, the first batch of volunteers, fresh university graduates following the October 6 incident, were deployed nationwide, especially in the northern and northeastern regions. Some worked alongside medical personnel, while others contributed to the Council of Thai Medical Education, allowing volunteers to interact with doctors in rural hospitals. As recounted by Jon Ungpakorn regarding the relationship between volunteers and doctors, particularly Dr. Sanguan, he said, *"When NGOs came together, the majority came from TVS, mainly from the northern region. There were not many NGOs at the time....Doctors like Dr. Sanguan had a long-standing relationship with NGOs... I myself used to teach him back in the Faculty of Science. He was my students, and we already knew each other."*²⁴

Regarding Dr. Samreung Yaengkratok, one of those experienced rural physicians based in Korat, a province acclaimed as the pinnacle of success in grassroots health development within the country through the Korat Development project, he further elaborated on his experience with the volunteer group, stating:

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“The Phumtham Group [Phumtham Wechayachai] from the era of Primary Health Care, everyone was involved, Thammasat University, Chulalongkorn University... volunteers who got in touch with these four hospitals, we readily accepted them. We were very pleased. It was like they were using our area for training... The volunteer spirit, their mindset was full of determination. They wanted to learn about the villagers. A few of them, like 2-3 individuals, came each year and worked persistently. This led to the growth of volunteer work, and the villagers also developed, because the group of volunteer graduates was right there. As for the Village Health Volunteers (VHVs), they were villagers themselves. This truly led to the establishment of the Primary Health Care.”²⁵

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Similarly, Dr. Prateep Thanakitcharoen, Dr. Komatra Chuengsatiansup and Dr. Phusit Prakongsai, who had experience working and engaging with the Korat region during the 1970s and 1980s, pointed out that while working in the area, it was a time when *“they got to know many NGO leaders, such as Apichart Thongyou and P’Auan (Phumtham Wechayachai), who were overseeing the Chulalongkorn University Volunteer project. During that time, there was a movement of these kinds.”*²⁶ This is of great significance as NGOs have played a crucial role in actively participating in rural development work, such as community strengthening, caring for orphaned children, and supporting community hospitals. These community hospitals have provided a foundation for volunteer graduates to assist the villagers, establish cooperatives, offer knowledge about herbal medicine, and serve as local doctors.²⁷ Although these tasks were not directly related to fundamental public health knowledge, they were intertwined with the lives of rural residents who were surrounded by challenges regarding access to various services. Therefore, the role of community hospitals and medical personnel in rural areas had to involve “community matters”. This community work evolved into the concept of human rights, which continued to develop over time. **Starting from this initial point, the network of various NGOs, along with Jon Ungpakorn, became one of the representatives from non-state organizations to play a significant role in pushing forward the comprehensive health reform agenda in the late 1990s. They stated that “commitment to rural communities” and “empowering villagers themselves” had become a shared objective between some groups of rural physicians and civil society organizations since the time they began working in rural areas.**

In addition to the opportunity to interact with NGOs in the region, medical personnel were also involved from the very beginning in advocating policy directions for fundamental health development, from local to national levels. In line with the Alma-Ata Declaration, two main approaches were proposed: (1) the development of “community and public participation” in planning, implementation, and evaluation, and (2) the establishment of “basic health service units” and referral units where professionals, assistants, and community members are trained to appropriately apply their knowledge and technology to address local issues effectively.²⁹

Regarding the evolution of “community and public participation,” due to Thailand being a developing country still constrained by budget limitations, the interpretation of basic health services started by prioritizing opening opportunities for community involvement. This strategy aimed to empower the public to take part, enabling them to acquire knowledge that allows them to care for and independently manage basic health issues.³⁰ Part of the insights gained came from the pioneering projects of the MOPH and progressive physicians in universities that had been attempted previously. These included ideas for developing a mass-oriented health system and promoting self-reliance among the population. Therefore, one distinctive aspect of PHC operations was the emphasis on fostering the role of Civil Society. This was evident through the emergence of roles such as the “Village Doctor,” the Village Health Volunteer (VHV), the Village Health Communicator (VHC), and various related mechanisms dedicated to health development. These efforts aimed to transform these groups of individuals into citizens capable of self-care and establishing a foundation for providing comprehensive health services and caring for rural populations on a broader and more widespread scale than ever before.

Civil society organisations and the development of Primary Health Care (B.E. 1978–1986)

A. “Village Doctor Volunteers”

The “Village Doctor” program was a project that emerged under the political influence of the military-led government policies. It noteworthy that the Village Doctor concept aligned with the “Barefoot doctor” concept in China, which initially emphasized extending medical services to rural areas. This involved deploying medical personnel (lay clinicians) with a level of training that allowed them to manage common illnesses, perform minor surgeries, provide health education, disease prevention, and basic family planning services stationed at medical outposts.³¹ The 2nd Army Division adopted the “Barefoot doctor” concept and adapted it to suit the conditions of Thailand. This was done to compete with Communist Party of Thailand (CPT) doctors and gain the support of people who had previously received healthcare from CPT-affiliated doctors. It aimed to redirect people to use the services of Village Doctors instead. In one aspect, the policy of producing Village Doctors in rural areas was a politically driven initiative by the state

to prevent the CPT from using “Barefoot doctors” to extend their political influence from the masses. It also demonstrated to residents in operational areas that the government did not abandon them. In addition to their basic healthcare responsibilities, Village Doctors were also tasked with reporting CPT activities in their own villages. Thus, Village Doctors were simultaneously involved in both political activities and healthcare services, providing support to the government.

For this reason, becoming a Village Doctor required training in various fields, including medicine, public health, economics, politics, culture, and emergency response to the CPT’s threats. Village Doctors were trained to work for the community, not for personal gain, aligning with the three vows of Village Doctors: to be loyal to the nation, religion, and the monarchy, to benefit others without seeking any rewards, and to adhere to moral conduct by being disciplined, empathetic to villagers, fostering unity, and performing good deeds every day.”³² As stated in the objectives outlined in the “Village Doctor” project document by Internal Security Operations Command (ISOC), there are six main objectives:

- (1) To provide trainees with knowledge in disease prevention, basic healthcare, and disease treatment.
- (2) To expand the reach of new healthcare services to rural areas.
- (3) To intervene in patients’ lives before medical professionals can attend to them.
- (4) To reduce the rates of illness, death, and disease outbreaks in villages.
- (5) To replace doctors and nurses in providing basic healthcare during emergencies for military and police personnel working in that area.
- (6) To become community leaders, countering opposing propaganda that manipulates the villagers’ ailments as conditions, and fostering positive relationships between the government and the people in the villages.³³

The “Village Doctor” project was launched on June 1, 1976. The initial implementer was the Second Army Division, specifically in sensitive areas of Sakon Nakhon Province. Initially, the project expanded to cover all provinces in the Northeastern Region. Subsequently, during the period when Prime Minister Thanin Kraivichien (October 8, 1976 - October 20, 1977) was in office, ISOC was tasked with managing and providing additional budget support to the project. As a result, the Village Doctor project expanded to cover various areas across 39 provinces, with a total of 4,356 Village Doctors in operation.

The process of becoming a Village Doctor involved training selected representatives from villages in insurgency-prone areas, where new physicians had limited access. After completing training, Village Doctors took on responsibilities in providing basic healthcare or distributing medications to the

community members. The selection process for Village Doctors involved identifying target villages that were susceptible to infiltration by insurgents. Once the villages were selected, the provincial ISOC would coordinate with the provincial public health office to avoid redundancy with the training of VHV and VHC. The intake of trainees for the Village Doctor program was limited to around 30 individuals per batch, with a training period of 30 days. Participants had to be Thai citizens age between 18-25 years, preferably female, with at least a basic education level of primary school grades 4-7 and the ability to read and write. They should have local roots and not have been engaged in an occupation outside their hometown, with a stable family background suitable for assuming the role of a Village Doctor. They must have previously undergone training in "Thai National Defense Volunteers. (TNDV)"³⁴ Furthermore, the selected individuals had to be approved by TNDV to participate in the training.

The training program was divided into an 80-hour theoretical section, covering topics such as basic nursing, common diseases, public health and hygiene, preventive medicine, anatomy and pharmacology. The practical section, totaling 100 hours, included hands-on training in emergency care, geriatrics, obstetrics, and community health. Practical training was conducted at hospitals, health centers, community health service centers, or military medical units, depending on the appropriateness and necessity of the area. In addition to medical knowledge, there was training in economic, political, and social aspects, focusing on instilling patriotism as a way to respond to the movements of the CPT³⁵

The responsible organization for the Village Doctor project was the Civil Affairs Division of ISOC. This unit was directly responsible for providing support, including supplying medicines and medical equipment (with an approximate value of 700 baht) every two months. Most of the medicines provided were common household medicines sourced from the Government Pharmaceutical Organization (GPO).³⁶ Although Village Doctors did not receive monetary compensation and could not charge patients for their services, they were granted various privileges as a form of compensation. As Type 1 military personnel under ISOC, they received benefits such as healthcare, family compensation for death, disaster relief according to the Disaster Victim Compensation Act, and welfare for spouses and family members in cases of illness. Because of this, the Village Doctor project focused on areas infiltrated by ISOC, making their healthcare duties exempt from the military's cost consideration strategy. This is considered a mechanism to enhance stability within the targeted communities. Furthermore, another significant workforce related to the Village Doctor project within the ISOC's Civil Affairs Division, as described above, went hand in hand with the introduction of PHC guidelines by the MOPH in 1977. This led to the production of community-oriented healthcare personnel, the essential core of PHC work in rural areas, namely the VHV and VHC.

B. Village Health Volunteers (VHV) and Village Health Communicators (VHC)

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“Efforts should be made to identify existing local resources in rural and community areas and engage them as volunteer aides to assist their fellow villagers. These individuals are those who have an interest in community health work and are already providing services in terms of healthcare, childbirth assistance, and local community support. It would be beneficial to bring these individuals into training programs focused on public health expertise. This would greatly help alleviate the shortage of healthcare personnel, which is insufficient in the present circumstances. In the execution of their duties, these volunteers would not require regular salaries or compensation from the state. This is because they are volunteers who willingly offer their services to their neighbors without expecting any form of remuneration. This approach allows the state to avoid using budgetary allocations for regular salaries or compensations for these volunteers, as they are driven by genuine willingness and commitment to serve their community.”³⁷

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Indeed, the core principles underlying the development of VHV and VHC encompass four essential components. The first component involves a “blended” development approach among various organizations (Intersectoral collaboration). The second component emphasizes the “participation” of the community to take care of their own well-being (People participation). The third component focuses on establishing a service system for “linking” government officials (Referral system). The fourth component aims to utilize “appropriate technology” effectively (Appropriate technology). When looking at the overall picture of these principles, one will discover that the approach of “blending-participating-linking-utilizing technology” serves as a method to foster social relationships between the government as a service provider and the citizens as service recipients in a new way.³⁸

Therefore, VHV and VHC, as integral parts of PHC, aim to promote community involvement in self-management within the community (deconcentrating), rather than decentralizing authority. This could be seen as the establishment of community cohesion, where the VHV serves as the mechanism for management, while the VHC aids in observing and caring for the community, with villagers feeling the sense of responsibility they hold towards society. As highlighted by Dr. Amorn Nondasuta, a leading figure in PHC development, the role of the population is of utmost importance in PHC, and he stated:

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“This perspective is extremely significant. This is because both the perspective and attitudes of villagers and state officials often tend to be misguided. State officials frequently perceive that providing services is the sole responsibility of the government. However, within the framework of grassroots health work, the government’s service is enabling villagers to learn and engage in activities for their own benefit. We do not work on their behalf, and they do not work for us.”³⁹

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With an approach that emphasizes empowering individuals to take care of themselves and participate continuously in development, it has led to the creation of the “Grassroots Health Self-Reliance Village Project,” serving as a model for other villages to follow. This initiative has culminated in a mechanism for the exchange of knowledge among communities. Another co-developed mechanism is the financial aspect, involving the establishment of a “fund” to serve as a source of funds to drive the development of health work in numerous rural areas. Specific health-related funds are operated using the concept of the Referral System (which has been in use since the Phitsanulok Project), aiming to strengthen the effectiveness of healthcare services.⁴⁰ Alternatively, the concept of establishing a local fund aimed at enabling individuals to meet essential basic needs (Basic Minimum Needs, or BMN) has been pursued. Given that a significant portion of the population, especially pregnant women and impoverished individuals, cannot afford essential healthcare expenses, including pre-natal care, childbirth, infant care, and postpartum care, a “Health Development Fund for Mothers and Children” initiative was established in MCH centers across all regions of Thailand. The introduction of a “Maternal and Child Health Card” priced at 100 baht allowed for a one-time payment to access services at healthcare facilities without the need for additional payments. Ultimately, this initiative, stemming from small-scale funds, has been continuously expanded to encompass various forms of healthcare, leading to the establishment of a “Health Card Project” priced at 500 baht.⁴¹ Therefore, the “Village Self-Reliance Project” aligned with the PHC approach, and the establishment of a health fund in each area evolved into a depiction of community development in its utmost potential. It could be considered the epitome of public health practitioners’ aspirations during that era, or perhaps termed as the pinnacle of achievement for public health professionals during that time.⁴²

The recruitment and training of VHV and VHC was seen as a mechanism to foster a Civil Society sector, serving as intermediaries between the government and the private sector within each village or community. VHV are individuals who undergo training in basic healthcare treatment and first aid, family planning, as well as organizing the procurement of essential and generic medicines for distribution to the community.⁴³ As for the VHC, their role involves supporting the activities of health centers by disseminating health-related information to households within their designated area of responsibility.

It can be observed that the roles, objectives, and aims of Village Doctors and VHVs are quite similar, with the common goal being the expansion of healthcare services to the utmost extent in rural communities. There is a minor distinction in that Village Doctors, trained by ISOC, are assigned duties in areas influenced by the movement of the CPT and are not allowed to charge for medical services. On the other hand, VHVs, under the supervision of the MOPH, can calculate medication and treatment costs for those who can afford it, often at a nominal fee (2-3 baht), which contributes to help others and ensuring the sustainability of VHVs in the long term.⁴⁴

The topic of “Village Fund for Medications,” under management of the VHV, is another important matter to mention. In the initial phase, the MOPH allocated medicines and medical supplies, including medical kits, first aid equipment, and essential drugs, as well as a budget to support the cost of medicines and medical supplies (provided at once) to VHVs. This fund was intended to circulate (i.e., as a revolving fund) within the village. In 1977, VHVs received 200 baht each, and in 1978, this was increased to 500 baht. However, the operations in the early stages didn’t achieve much success, mainly due to the villagers’ lack of understanding of the budget replenishment principle, which led to the rapid depletion of the circulating funds. This was partly because VHVs “distributed” the medicines instead of “selling” them to the villagers to replenish the funds. Another factor was the villagers’ expectations from the government’s role in providing services to the community. They believed that the government should distribute essential drugs without expecting any payment.⁴⁵

From these challenges emerged the concept of community financing, which led to the establishment of funds to promote community participation in budget management through cooperative mechanisms. This was achieved through mechanisms of fundraising, management, and manpower coordination, similar to cooperatives. The goal was to elevate community development for and by the community itself. The establishment of Village Drug Funds was part of this initiative.⁴⁶ In 1980, the first prototype of utilizing “community-level financing” for rural development emerged in the context of PHC.

The operation of the Village Drug Fund was highly successful, and by 1987, it covered approximately 44% of all villages in Thailand, with a net budget of 27 million baht. The success of the Village Drug Fund served as a model for many other funds that followed suit, including a village Nutrition Fund, Sanitation Fund, Development Fund, and even a Health Card Fund.⁴⁷ The success of the Village Drug Fund, although from an overall perspective may not seem particularly striking, becomes noteworthy when compared to other subsequent development funds. Within the same timeframe, it is appropriate to say that the Village Drug Fund achieved an optimal level of success, not only in terms of expanding activities within the fund but also in terms of the sustainability of its operations and its financial stability.⁴⁸

Although the role of VHV operated on a voluntary basis without compensation, in order to achieve the goals, set by the MOPH that within 5 years, 22,400 VHV and 224,000 VHC should be established (i.e., one VHV per village and one VHC per 10-15 households), extra effort was required.⁴⁹ In this regard, the government used various incentives to motivate people to participate. For example, VHV members received free medical treatment from MOPH hospitals, were awarded certificates upon completing training, were empowered to distribute essential drugs, and were rewarded with recognition for outstanding volunteer work.⁵⁰

Therefore, Thailand's basic healthcare services in rural areas from 1976 were under the roles of the Village Doctors, VHV, and VHC. Between 1976 and 1980, ISOC was able to train a total of 4,256 Village Doctors in 36 provinces. During the same period, the MOPH trained 15,721 VHV and 156,732 VHC. However, there were several challenges in producing Village Doctors, such as high training costs, some projects not being in the ISOC's infiltrated areas, and shortages of project medical supplies. These issues were better suited for certain areas where the influence of ISOC could be diminished. The successful reduction of ISOC's influence and the gradual expansion of healthcare facilities were due to these conditions. These circumstances led to the reevaluation of the "overlap" of roles between Village Doctors, VHV, and VHC.

The transformation of Village Doctors occurred in 1980 when ISOC, responsible for the project, transferred the Village Doctor project to be under the MOPH. This resulted in a transition of Village Doctors to VHV and VHC due to similar duties and responsibilities. In November 1980, a measure was taken to transfer Village Doctors in most areas, amounting to 3,891 individuals, while only 343 Village Doctors remained under the supervision of ISOC.⁵¹ Subsequently, in 1983, Village Doctors were transformed into VHV and VHC roles for all villages to align with the PHC policy. The expansion of the number of VHV and VHC continued to grow over time. By 1989, the number of VHV and VHC had increased to 62,075 and 588,555 individuals, respectively. This represented a proportion of 98% of the total villages nationwide.⁵²

However, certain groups within society do not readily accept the principles and policies of PHC, as when examined from a systemic perspective, it becomes evident that most PHC policies were formulated centrally and may not have adequately recognized the role of the population in contributing to clear public policy. Nevertheless, when policies are implemented at the grassroots level, significant changes can occur in social relationships, and this has proven rather successful, especially in rural areas with low economic interventions.⁵³ At times, such changes can impact certain healthcare workers, causing them to feel a loss of authority and a lack of trust in the work of the population trained to perform duties as VHV or VHC. They may even fear that these methods could lead to the emergence of “quack doctors.”⁵⁴

However, the opposing voices did not resonate strongly, as the PHC approach was advocated both by global health organizations and was embraced by political forces (starting from the times of General Kriangsak Chamanan and General Prem Tinsulanonda). On the other hand, it must be acknowledged that implementing the policy vigorously by healthcare personnel, especially rural doctors who played a crucial role in areas of significant training, practice, and accelerating knowledge dissemination about healthcare for the local population, made the PHC efforts widely recognized. One of the vital methods of knowledge production during that time was sharing experiences and transmitting knowledge through printed materials.

C. Folk Doctor Foundation: Creating and disseminating self-care health concepts

Due to the efforts of the healthcare personnel for the community, they had attempted to promote the concept of “self-reliance” in health through various forms of printed media. This eventually led to the official establishment of the “Folk Doctor Foundation” in 1981, with Dr. Sem Pringpuangkeo as its inaugural president. The Folk Doctor Foundation had a mission to disseminate knowledge about healthcare and essential information about diseases and fevers to the public. Later on, they collaborated with NGOs and expanded their projects extensively. These included initiatives such as spreading knowledge through printed media in magazines like “Village Doctor” and journals like “Clinic,” as well as publishing books and knowledge posters. They also carried out knowledge dissemination through radio programs, self-care training programs, and health guidebooks for monks and teachers for distribution and further dissemination.⁵⁵

“The Village Doctor Magazine” is considered one of the most significant printed materials in this genre. Its motto, which states, “A Magazine for Self-Care and Basic Health,” reflects the essence of creating the magazine and other printed media. It is now well understood that healthcare personnel in communities recognize the importance of “turning to self-care.” They provided guidance and practices to keep illness

at bay, and promoted the idea of individuals taking care of their own health.⁵⁶ The term “Village Doctor,” which initially referred to the title of a magazine and was later adopted as the name of the foundation, held a dual meaning. At that time, the editorial team of the magazine explained that this term was considered respectful and used to refer to villagers who performed duties similar to those of a physician, treating the illnesses of people in the community. Some of these individuals might have been labeled as unqualified or unofficial doctors. The founders of the magazine made a deliberate decision to use the term “Village Doctor” because it conveyed a two-fold meaning. **On one hand, it represented empowering villagers to become their own doctors, promoting various aspects of health such as health promotion, disease prevention, and basic healthcare. On the other hand, it conveyed the desire for doctors to integrate into the community,** meaning that healthcare personnel should not only treat illnesses but also focus on health development and disease prevention. **Therefore, “Village Doctor” signifies both “villagers who are doctors” and “doctors for the villagers,” aligning with the essence of Primary Health Care.**⁵⁷ This is the origin of the phrase “Turn villagers into doctors, turn doctors into villagers,” which aligned with the context of public health work during that time. As documented by Dr. Prawese Wasi, a limited number of infectious diseases accounted for 80-90% of illnesses in Thai villagers. The approach could be summarized as follows: *“Empower the population with maximum knowledge, minimize the occurrence of illnesses (ideally no illnesses), and if illness occurs, minimize the severity of symptoms (minimize physical and time loss, emotional distress, and financial burden).”* This embodied the guiding principle of the Village Doctor.”⁵⁸ Taking care of one’s own health also includes what is known as “health culture.”⁵⁹ This refers to a health culture that emphasizes the benefits of food over mere taste. Behaviors such as avoiding raw animal consumption can prevent diseases like liver fluke or tapeworm infections. The culture also encompasses cleanliness in food, water, and daily life, such as not spitting or discarding phlegm on the road and not littering in streets or rivers. Proper hygiene practices can prevent various diseases like diarrhea, dysentery, minor fevers, and hepatitis. This ‘health culture’ includes physical activity and relaxation as an alternative to visiting recreational areas. When individuals eat moderately, engage in regular physical activity, cultivate mindfulness, and meditate, they can prevent hypertension, heart disease, and cancer.⁶⁰ Overall, self-care contributes to reducing the frequency of illnesses among the population.

Moreover, the advocacy of the “Folk Doctor” magazine is not solely focused on external factors, but also encompasses internal conditions and mental states. This is evident from articles like “*Satharanathuk*” (“Public suffering”), which explains that “suffering,” although rooted in the mind, is related to the body as well. It can lead to mental health issues, and one cause of this problem is that individuals often don’t prioritize the “development of the mind.” They might consider it unnecessary to develop. The approach to addressing universal suffering thus involves cultivating an attitude of “not getting angry, not hating, and being happy every day.” This extends to reducing greed, anger, and delusion as well.⁶¹ The essence of this concept reveals a broader perspective towards the health of Thai society. It reflects a shift from

focusing more on treatment to prioritizing prevention. Simultaneously, prevention has expanded from external bodily care to internal mental well-being.

There have been significant contributions from the Folk Doctor Foundation in various public health issues throughout the period from the 1970s to the 1980s. These activities include participation in restoring therapeutic massage practice, which evolved into the “Thai Massage Rehabilitation Program.” This program is considered one of the approaches to self-care, involving the use of traditional Thai medicine for relieving muscular pain instead of relying on painkillers. This movement served as a foundation that eventually led to the establishment of the “National Institute of Thai Traditional Medicine” under the MOPH.

The next issue involved the proliferation of pre-packaged medicine (*Yachud*) in which drug sellers took several popular medicines but rearranged their contents into combo packs and were promoted as better than the individual drugs alone. This practice was illegal and dangerous for consumers, especially children. Accordingly, the Folk Doctor Foundation and affiliated organizations collaborated to establish the “Campaign for appropriate use of medicines in children” They disseminated information from the project’s efforts through media outlets associated with the Foundation. This included addressing the problem of “A.P.C. (Aspirin-Phenacetin-Caffeine) medicine,” pain relievers that adversely affect gastric ulcers and digestive symptoms, and more.⁶² Among the activities in which the Folk Doctor Foundation has participated, one of the most impactful movements is the “Non-Smoking Campaign” This is a widespread initiative that has had far-reaching consequences.

D. Initiating health “prevention” promotion: “Non-Smoking Campaign” (1986).

In 1986, led by Dr. Prawese Wasi, the Village Doctor Foundation initiated the establishment of an organization to advocate against smoking for the first time in Thailand. Key participants included other doctors such as Dr. Athasit Vejajiva, Prof. Dr. Prakrit Vathesatogkit, Dr. Paiboon Suriyawongpaisarn, and Dr. Surakiat Achananupap. This advocacy organization was founded under the name “ Non-Smoking Campaign.”⁶³ Dr. Prawese retraced the inception of the aforementioned project in his book “On the Path of Life” (*Bon Senthang Chiwit*), recounting that it began with him receiving a donation of 60,000 baht to advocate against smoking. Initially, his intention was for government agencies to utilize this funding, but complications arose due to coordination challenges and officials constrained within bureaucratic frameworks. Consequently, Dr. Prawese redirected the funds toward collaborating with the network of NGOs until established “Non-Smoking Campaign Foundation”, chiefly the Folk Doctor Foundation, whose central figure was Dr. Surakiat Achananupap. At the time, Dr. Surakiat was working at the Community Medicine Center, Faculty of Medicine Ramathibodi Hospital, simultaneously serving as the manager of the Folk Doctor Foundation. This collaboration also involved Kaew Withunthian and Bang-orn Ritthipakdee,

who acted as project coordinators and worked for the Folk Doctor Foundation.⁶⁴ Dr. Prakrit Vathesatogkit, an important figure in the project, explained that the primary mission of the project was to address various dimensions of smoking-related issues. This included raising awareness about the dangers of tobacco through document production and posters. The project's focus was directed towards monks, teachers, and doctors, considering them influential leaders who could potentially shift societal attitudes. Dr. Prakrit recounted his genuine interest in the tobacco issue, mentioning that prior to this, there had been campaigns against the liberalization and promotion of tobacco sales in the Thai community residing in Hawaii. He noted that *"some doctors in Hawaii disagreed with this approach, as there were instances where names were collected to oppose actions taken by the USA, which then sided with tobacco companies and pressured Thailand to open the market to US cigarette imports. Dr. Supakorn Buasai had studied in Hawaii and became interested in the anti-smoking issue. Initially, he was clueless about it, but he became more knowledgeable after returning to Thailand and serving on the National Consumer Protection Committee. He and his colleagues advocated for some anti-smoking measures until laws were able to be passed"*.⁶⁵

In addition to raising awareness in society about tobacco, a parallel effort was policy advocacy, particularly pushing for the prohibition of tobacco advertising and advocacy for designated 'non-smoking' areas. These endeavors ultimately succeeded to an impressive degree.⁶⁶ Dr. Choochai Supawongse recognized that the "Non-Smoking Campaign" within the Village Doctor Foundation played a crucial role in tobacco consumption control in Thailand. Its standout feature lay in its flexibility, surpassing government organizations, coupled with the effective utilization of accurate and appropriate information. This approach led to efficient implementation under the guiding principle of *"We never oppose smokers, but we call on everyone in society to collaborate in creating a tobacco-free society"*.⁶⁷

The "Non-Smoking Campaign" established four key strategies, which are as follows: (1) Building networks with individuals and various organizations, such as singers, actors, athletes, cartoonists, songwriters, and media outlets, as allies to jointly advocate for a smoke-free environment; (2) Raising societal awareness through media advocacy, disseminating systematic information and the harmful effects of smoking through the media. Simultaneously, the project developed its own media resources; (3) Advocacy through lobbying efforts to enact various laws and measures, including pushing for the Tobacco Product Control Act and the Health Protection Act for Non-Smokers; and (4) Utilizing social marketing processes to distribute information about the dangers of smoking and the strategies of international tobacco companies to different target groups as effectively as possible. All four strategies above prioritize three key target groups: the media, decision-making authorities in the public sector, and schools.⁶⁸

Having Dr. Prakit Vathesatogkit, a medical professor from Ramathibodi Hospital, Mahidol University, as the project's secretary-general, significantly bolstered the project's credibility. Although the project involved a relatively small group of individuals, it employed strategies to engage respected figures from various social domains as advocates. This was further complemented by networking with nationwide media, including radio programs and newspaper columns, aligning with the strategies mentioned earlier. These efforts contributed to raising awareness in society beyond the medical and public health communities about the health issues stemming from smoking. Simultaneously, people began to understand that the relationship between health and smoking was not solely the responsibility of the MOPH, but required collaboration from various sectors.⁶⁹

An activity that garnered widespread attention for the campaign against smoking is the *"Non-Smoking Campaign Marathon."*⁷⁰ This event represented a collaboration among diverse organizations, including government agencies, private companies, NGOs, international organizations, and Civil Society. Organizations such as the Folk Doctor Foundation, MOPH, Rural Doctors Foundation, Rural Doctor Society, Medical Council of Thailand, Medical Association of Thailand, and the Community Volunteers for Society Project (CVS) were involved. The project's inception stemmed from the Sampran Forum led by Dr. Choochai Supawongse. The activity aimed to promote the anti-smoking campaign through a "Campaign Run," where participants from various regions across the country would run from their respective locations to gather at the Bangkok City Hall. The event was scheduled to take place over 7 days from October 16 - 22, 1987. This event drew participation from rural doctors, medical professionals, and public health personnel nationwide, totaling 250 individuals. The project's objective was to advocate for the protection of non-smokers' rights without attacking smokers themselves. The campaign run received support from the public, with over 6 million signatures collected in endorsement. This effort is often considered the "largest national referendum" of its time. The complete list of signatures was forwarded to the Bangkok Governor, then Maj.Gen. Chamlong Srimuang, for presentation to the National Assembly Representatives.⁷¹



Figure 62 News article from rural doctors regarding the anti-smoking campaign.

Source: National Archives of Public Health, (14) SB 1.5/1.35, Special Edition Rural Doctors Newsletter... Cigarettes.

The 7-day Marathon Campaign led to continuous media coverage, presenting the significant hazards of cigarettes as the most prominent topic in Thai society. This led to the creation of new values within Thai society, emphasizing that public smoking is inappropriate.⁷³ In terms of strategies and tactics in social movements, the anti-smoking campaign fostered the development of compelling, vibrant, and professional-grade media campaigns. These campaigns have spurred state agencies, professional organizations, and various private entities to collaborate in broader-reaching advocacy efforts. Furthermore, the campaign played a crucial role in coordinating domestic and international organizations against cigarette imports, notably contributing to the establishment of “smoke-free zones” in public spaces. This initiative has generated momentum among the younger generation to refrain from smoking, aligning with the belief that “offering cigarettes to monks is sinful.”⁷⁴ Most importantly, the sustained campaign led to significant changes in the law, e.g., “the Tobacco Products Control Act, 1992” and the “Non-Smokers’ Health Protection Act, 1992” during the tenure of Prime Minister Anand Panyarachun.⁷⁴ The overall content of the initial version of the law was to restrict the distribution, advertising, or promotion of tobacco products through print media, radio, television, or any other means to make tobacco or tobacco product symbols widely available. It also included regulations that production, import, distribution, or advertising must comply with the criteria set by the MOPH.⁷⁵ The second version of the law established designated

smoking areas equipped with proper ventilation according to standards and designates smoke-free zones. Additionally, clear signage had to be displayed. Individuals who did not adhere to these regulations were subject to fines.



Figure 63 Depictions of the anti-smoking campaign in the Rural Doctors Association's medical journal and the periodical "Rural Doctors Society"

Source: National Archives of Public Health, (14) SB 1.5/1.19, (Cover) Rural Doctors Association Medical Journal, Volume 7, Issue 3; National Archives of Public Health, (14) SB 1.5/1.32, Rural Doctors Society Journal, Volume 12, Issue 3

Upon careful consideration, it can be observed that the Rural Doctors Association and the initial stages of the prevention-focused health campaign, as embodied in the Non-Smoking Campaign (1986), received cooperation from numerous individuals and diverse organizations. This movement gradually applied the theory of the knowledge-attitude-practice model, utilizing knowledge dissemination, Civil Society engagement, and political acceptance. The Non-Smoking Campaign further evolved and extended to the establishment of the Thai Health Promotion Foundation (ThaiHealth) in 2001, institutionalizing this and other health campaigns.



Amid the changing political landscape, the establishment of the PHC concept in Thailand, spurred by global influences in 1978, was augmented by the consciousness of physicians borne from the political dynamics of the era. Thailand emerged as a crucible of experiences in health system development, deviating from other developing nations. The evolution and application of PHC took on a unique form within Thai society, influenced by past trial-and-error knowledge dissemination and a political environment favoring health benefits (in the 1970s-80s decade). The involvement of medical students and individuals within the medical field (known as the “Octoberists” or *Khon Duen Tula*) collaborating with the government also played a significant role. Interactions between physicians in rural and central regions, as well as between physicians and NGOs, contributed to the notable progress of PHC in Thailand. This era witnessed the emergence of the significant roles of Village Doctors, VHV, VHC and the Rural Doctor Society, which served as the foundation for preventive medicine promotion and building community-based health for self-sufficiency. Alongside the pivotal role of the Civil Society as a significant foundation of PHC development, another mission emerged: the establishment of “Basic Health Service Units.” The drive to construct community hospitals and health stations in every district received considerable impetus during the 1977-86 decade, a result of the 5th National Economic and Social Development Plan, followed by the “ignorance, poverty and illness” policy, embodying the nation’s aspirations.

Chapter 7

¹ Sanguan Nitayarumphong, *Work and Ideals of Dr. Sanguan Nitayarumphong 's Life*, 25

² Interview with Dr. Winai Sawasdivorn, May 16, 2022; Interview with Dr. Wichai Chokwiwat, May 17, May 23, June 2, 2022; Interview with Dr. Phusit Prakongsai, May 23, 2022; Interview with Dr. Siriwat Thiptharadol, May 20, 2022.

³ Interview with Dr. Phusit Prakongsai, May 23, 2022.

⁴ *Following the Footsteps of Komol KeemThong*, (Bangkok: the Komol Keem Thong Foundation, 2021), 102-103.

⁵ Interview with Dr. Winai Sawasdivorn, May 16, 2022.

⁶ *Following the Footsteps of Komol KeemThong*, 99.

⁷ Interview with Dr. Wichai Chokwiwat, May 17, May 23, June 2, 2022

⁸ 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. 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, and Minister of Public Health, 1987-1988.

Dr. Prawese Wasi, Medical Professor, Former Director of the Medical and Public Health Coordination Center, Ministry of Public Health, 1984-1987.

Dr. Damrong Boonyoen, Former Director-General of the Department of Communicable Disease Control, 1994-1997.

Dr. Paichit Pawabutr, moved from the Provincial Director of Public Health in Nakhon Ratchasima to work in the Ministry of Public

Health and later held the position of Former Permanent Secretary of the Ministry of Public Health (1992-1994).

⁹ Interview with Rosana Tositrakul and Santisuk Sophonsiri, June 15, 2022.5

¹⁰ Nuttarute Vongtangswad, "The dynamics of framing and mobilization of the rural doctor movement: conflicts and political transformation", 134-136.

¹¹ Interview with Dr. Paichit Pawabutr, May 30, 2022.

¹² Interview with Prof. Dr. Samreung Yaengkratok, June 24, 2022.

¹³ Memorial book for the Royal Cremation Ceremony Dr. Vunvilai Chandrabha, Wat Sommanat Ratchaworawihan, Bangkok, Sunday, April 22, 2007, (n.p.: n.d.), 82-83.

¹⁴ Dr. Wichai Chokwiwat, the 4th-5th Chairman of Rural Doctor (1981-1983); Dr. Suwit Wibulpolprasert, the 6th Chairman of Rural Doctor (1983-1984); Dr. Amphon Jindawatthana, the 7th Rural Doctor (1984-1985); Dr. Sanguan Nitayarumphong, the 8th Rural Doctor (1985-1986).

¹⁵ Interview with Dr. Prateep Thanakitcharoen, June 6, 2022.

¹⁶ Thavitong Hongvivatana, Penchan Pradubmook, and Nureehan Youso, eds., Proceedings of the Workshop on Research and Training in Health Economics, Thai Health Economics: Compilation of Articles and Explanatory Notes from the Workshop held on March 12-14, 1986, at Asia Pattaya Hotel, Chonburi (Nakhon Pathom: Mahidol University, 1986), 13.

¹⁷ Sanae Jamrik, Developing Human Rights in Thailand (Bangkok: Union for Civil Liberty, 1988), 89.

¹⁸ Napaporn Ativanichayapong and Friend of Women Foundation, Path to Social Security: History of Struggle and Reform in Social Security Law, 64-67.

¹⁹ Napaporn Ativanichayapong, Thai Labor Union as a Social Movement, 40-42.

²⁰ Wiwan Ekarintarakul, "Public Health Administration in Thailand 1958 - 1977," 160.

²¹ Interview with Khun Rosana Tositrakul and Khun Santisuk Sophonsiri, June 15, 2022.

²² Somthawin Luechapattanaorn, Thitima Khuntiranon, Pibhop Dhongchai, ed., From Crisis to New Dimensions of Thai Public Health. Bangkok: the Komol Keem Thong Foundation, 1987, 39.

²³ Foundation For Consumers, "About the Foundation", Accessed July 15, 2022, <https://donate.consumerthai.org/>.

²⁴ Interview with Jon Ungphakorn, June 25, 2022.

²⁵ Interview with Prof. Dr. Samreung Yaengkratok, June 24, 2022.

²⁶ Interview with Dr. Komatra Chuengsatiansup, June 21, 2022.

²⁷ Interview with Dr. Prateep Thanakitcharoen, June 6, 2022.

²⁸ Interview with Dr. Phusit Prakongsai, May 23, 2022; Interview with Dr. Komatra Chuengsatiansup, June 21, 2022.

²⁹ See details of the roles of the private sector in Primary Health Care in, National Archives of Public Health, (11) SSM 1.5/1, "Private Sector and Primary Health Care (1991)."; National Archives of Public Health, (11) SSM 1.5/2, "Development of Primary Health Care by the Private Sector (1993)."

³⁰ Supattra Srivanichakorn, "Primary Health Care, Primary Care, and Family Medicine: Definitions, Meanings, and Connections," *Journal of Primary Care and Family Medicine*, 2009, 11-15."

³¹ Prao Niwadwong, "Observations on Medical Practice in the People's Republic of China," *Chulalongkorn Medical Journal*, Volume 18, Issue 4, October 1973, 368.

³² Puchong Nutrawong, "Security at Village Level: Promotion of A Village Para-Medic Volunteer Program in Changwat Udon Thani" (Department of Public Administration, Faculty of Political Science, Chulalongkorn University, 1985), 118–120.

³³ Puchong Nutrawong, "Security at Village Level: Promotion of A Village Para-Medic Volunteer Program in Changwat Udon Thani," 120–123.

³⁴ Office of the Prime Minister's Information and Communication Committee, (Copy) Regulation of the Prime Minister's Office Regarding Village Defense Volunteers, B.E. 1978, Accessed June 2023, www.oic.go.th/FILEWEB/CABINFOCENTEROPM/DRAWER01/GENERAL/DATA0004/00004016.PDF.

³⁵ Puchong Nutrawong, "Security at Village Level: Promotion of A Village Para-Medic Volunteer Program in Changwat Udon Thani," 123–126.

³⁶ Puchong Nutrawong, 127–128.

³⁷ National Archives of Public Health, (14) SB 1.4/2.55, "Project on Village Health Volunteers [1975-1979]."

³⁸ Santisuk Sophonsiri, 80 Years of Dr. Amorn Nondasuta : A shining diamond in the Thai Public Health sphere, 206.

³⁹ Santisuk Sophonsiri, 202-203

⁴⁰ National Archives of Thailand, (2) ST. 1.1/30 Box 4, "Project to Provide Health Services in the Regional Areas According to the National Economic and Social Development Plan, Volume 4, 1977-1981 [1977-1981]."

⁴¹ Santisuk Sophonsiri, 80 Years of Dr. Amorn Nondasuta : A shining diamond in the Thai Public Health sphere, 246-250.

⁴² Santisuk Sophonsiri, 227-252.

⁴³ National Archives of Thailand, (2) ST. 1.1/30 Box 4, "Project for Providing Health Services in Regional Areas According to the National Economic and Social Development Plan, Volume 4, 1977-1981 [1977-1981]."

⁴⁴ Davisakd Puaksom, ed. Community Health: History and Memories, The first witness seminar for the history of the Thai health system on September 19, 2008, 27.

⁴⁵ Suthisit Maitrichit, "Drug-use behavior of villagers in Tambom Kunkhong, Hang Dong District, Chiang Mai Province: Factors associated with the performance of village drug co-operatives" (Chiang Mai: Graduate School, Chiang Mai University, 1991), 8-1

⁴⁶ This fund is known by different names such as the Village Medicine and Medical Supplies Fund (Kongtun Ya Lae Wetchapan Pracham Muban), Drug Bank (Thanakhan Ya), Drug Fund (Kongtun Ya), Cooperative Pharmacy (Sahakon Ya), Drug and Public Health Fund (Kongtun Ya Lae Satharanasuk), Medical Supplies Fund (Kongtun Wetchapan).

⁴⁷ Suwit Wibulpolprasert, "Community Financing: Thailand's Experience", Health Policy and Planning, Vol. 6, no. 4 (1991): 355-356.

⁴⁸ Suwit Wibulpolprasert, "Community Financing: Thailand's Experience", 354-360.

⁴⁹ Puchong Nutrawong, "Security at Village Level: Promotion of A Village Para-Medic Volunteer Program in Changwat Udon Thani", 134

⁵⁰ National Archives of Thailand, (2) ST. 1.1/30 Box 4, "Project for Providing Health Services in Regional Areas According to the National Economic and Social Development Plan, Volume 4, 1977-1981 [1977-1981]."

⁵¹ Puchong Nutrawong, "Security at Village Level: Promotion of A Village Para-Medic Volunteer Program in Changwat Udon Thani", 140-42.

⁵² Sanguan Nitayarumphong, "Evolution of primary health care in Thailand: what policies worked?," 249.

⁵³ Chamroon Meekanon, Project Report Summary for Lampang Project, 80.

⁵⁴ Santisuk Sophonsiri, Amorn Nondasuta : A shining diamond in the Thai Public Health sphere, 205.

⁵⁵ Theppitak Maneepong, 'Folk Doctors: Adaptation, Transformation, and the "Self-reliance" Approach', The 101 World, 2017, <https://www.the101.world/folkdoctorthailand/>.

⁵⁶ Even before the emergence of the Folk Doctor magazine, there were efforts to produce books that emphasized self-care, such as the book titled "Health Care Guide for the Public."

⁵⁷ Folk Doctor Foundation, 3 Decades of Village Doctors: 30 Years of Folk Doctors 1979-2552 (Bangkok: Folk Doctor Publishing, 2009).

⁵⁸ Prawese Wasi, "Folk Doctor Manual, Revised Edition 1985," in Memory of the Funeral Rite of Wat Tanthian, October 3, 1985, (Bangkok: H.N. Print, 1985).

⁵⁹ Folk Doctor Foundation, 30.

⁶⁰ Folk Doctor Foundation, 32.

⁶¹ Folk Doctor Foundation, 33–34.

⁶² Folk Doctor Foundation, 46–51.

⁶³ Folk Doctor Foundation, 16–17.

⁶⁴ Prawese Wasi, On the Path of Life: The Rural Doctor Movement in Thailand (Bangkok: Folk Doctor Publishing, 2011), 60–61.

⁶⁵ Interview with Professor Dr. Prakrit Vathesatogkit, June 10, 2022.

⁶⁶ Pongsadhorn Pokpermddee, ed., Behind the sculpture of public health: 20 behind the scenes of driving Thailand's health system, 133.

⁶⁷ Choochai Supawongse, 'The Evolution of Tobacco Consumption in Thai Society', (Nonthaburi: Health Systems Research Institute, 1998), 15.

⁶⁸ Choochai Supawongse, Two Decades of Controlling Tobacco Consumption in Thai Society, (Bangkok: Center for Research and Knowledge Management for Tobacco Control, 2007), 17–18.

⁶⁹ Choochai Supawongse, 'The Evolution of Tobacco Consumption in Thai Society', 16–17.

⁷⁰ National Archives of Public Health, (14) SB 1.5/1.35, "Rural Doctor Newsletter Special Edition...Tobacco."

⁷¹ Suwit Wibulpolprasert, ed., 25 Years of Rural Doctor Movement in Thailand, 150–51.

⁷² Choochai Supawongse, Two Decades of Controlling Tobacco Consumption in Thai Society, 25.

⁷³ Choochai Supawongse, 'The Evolution of Tobacco Consumption in Thai Society', 18.

⁷⁴ Choochai Supawongse, Two Decades of Controlling Tobacco Consumption in Thai Society, 19.

⁷⁵ Royal Thai Government Gazette, "the Tobacco Products Control Act, B.E.2535 (1992)" (Volume 109, Section 38 K, Page 4, April 5, 1992).

⁷⁶ Royal Thai Government Gazette, "the 'Non-Smokers' Health Protection Act, B.E.2535 (1992)" (Volume 109, Section 40 K, Page 20, April 7, 1992).



The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868-2002

The 5th National Economic and
Social Development Plan:
A pathway out of inequity

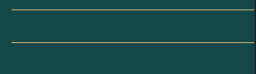




Figure 64 Seminar on Basic Public Health Infrastructure in the Nation using the Criteria of Basic Minimum Needs (BMN) for Provincial Governors, held from March 22-24, 2527. Mr. Marut Bunnag, Minister of Public Health (April 30, 1983 – August 5, 1986), presided over the event.

Source: National Public Health Memorandum, (13) B.NEG S.2.1/39.41, Governors' Seminar on Basic Minimum Needs (BMN)."

It is well known that the political structure during the period of democratic transition involved the collaboration of power among three branches, namely the government sector (military wing), the private sector (business wing), and the technological sector (civil servants' wing). This broad perspective led to the integration of medical technology into government efforts to design public health policies for rural development during the administration of General Prem Tinsulanonda. Starting from 1980, the Prime Minister, in cooperation with the "Office of the National Economic and Social Development Council (NESDC)," established a "Working Group for Rural Development Policy Study." This initiative mobilized resources and minds to formulate a new approach for rural development, involving experts and relevant technocrats directly associated with rural development. One of these individuals was Dr. Prawese Wasi, who played a significant role as a committee member. It was not surprising when the government incorporated the principles of the "New Rural Development" into the 5th National Economic and Social Development Plan (1982-1986). Primary Health Care (PHC) became a crucial cornerstone for the country's ongoing development, reflecting its importance in practical implementation.¹

The key focus of the 5th National Development Plan was to prioritize distributing income more than increasing production, developing people more than advancing materials, for rural communities to know how to think, know how to act, participate in development, and be self-reliant. This can be categorized into four main approaches: (1) Prioritize addressing issues in disadvantaged areas as the top priority; (2) Utilize limited material and human resources (with a main focus on people) to generate maximum benefits to meet basic needs, without emphasizing excessive production; (3) Establish mechanisms that involve citizens in development, including intermediaries that facilitate collaboration between the government and the people; and (4) The ultimate goal is to make the population self-reliant.² Hence, a new approach was introduced to achieve the rural development plan, emphasizing "Basic Minimum Needs" alongside the "Community Hospital and District Health Center Construction Plan" during the mid-1970s. Therefore, it is important to revisit the development progress, starting from the conceptual framework of "Basic Minimum Needs," which is a way of thinking to 'escape from inequality' and elevate the uneven opportunities or resources among individuals within society.

The 5th National Development Plan and the Basic Minimum Needs Approach

“

“If considering solely the aspect of economic growth in overall terms, it can be said that there has been relatively satisfactory progress. However, when examining the distribution of benefits resulting from development, it becomes evident that economic expansion is not consistently equitable across all regions. Issues of disparities and inequalities in income emerge both between sectors and between rural and urban areas of the country.”³

”

From the content presented in the 5th National Economic and Social Development Plan, concerning the policy direction and goals of rural development, the focus was directed toward the issue of “inequality and poverty,” which was considered the most significant problem at that time. With the government’s attention on this matter, that focus became the basis for addressing the primary concern of public health. This was because the government believed that poverty and economic hardship were directly linked to the deterioration of quality of life and various disease outbreaks, ultimately leading to the vulnerability of the Thai population and the national security of the country.⁴

In the recent past, one significant obstacle that occurred during the implementation of the PHC initiatives in the 4th National Development Plan was the lack of understanding of their roles by officials and the absence of coordinated efforts among them.⁵ It must be acknowledged that the operations of government agencies often focused solely on fulfilling their individual tasks. This approach, at times, led to a lack of “coordination,” resulting in overlaps and redundancies in their work. This perception reveals that the issue that health extends beyond the concerns of any single ministry; in reality, it is interconnected far beyond the purview of just one government department.

Apart from the disconnect among government officials themselves, the linkage between the government and the public in the realm of public health was characterized by a significant “gap.” Even though the 4th Development Plan aimed to address community-level needs, the benefits of various developmental efforts had not yet fully reached the hands of the general public, particularly the economically disadvantaged. This was primarily because the “fundamental issues” had not been rectified accurately. Meanwhile, the

general population was unaware of what the underlying problems were, leading them to be unable to self-improve. Consequently, they found themselves dependent on the assistance extended by the government alone.⁶ Therefore, the “BMN Concept” or “BMN Approach” was conceived and manifested in the 5th National Economic and Social Development Plan as a part of the “New Rural Development Policy.” This approach aimed to serve as a method to assist in adjusting the internal relationships within the bureaucratic system on one hand and, on the other hand, to help reshape the relationships between service providers (the government) and service recipients (the public) anew. The hope was that this would ultimately lead to a more problem-specific health development, progressively reducing disparities and inequalities in the long run.

“Ignorance, poverty and illness”: Roots of the Basic Minimum Needs

Basic Minimum Needs, or BMN, is a determination of the essential requirements necessary for individuals within households in various aspects related to the quality of life, usually with a focus on rural populations. Emphasizing self-reliance and state support, the BMN strategy aims to ensure equal opportunity for everyone to live in society with dignity. It necessitates meeting all comprehensive BMN indicator targets according to the agreed standards. The origin of the BMN concept incorporated into the 5th Development Plan traces back to the meeting of the leading social development axis under the “National Social Development Project” organized by the National Economic and Social Development Board (NESDB) on November 13, 1981. This gathering included government officials or representatives from four ministries at provincial and district levels, namely the Ministries of Education, Public Health, Agriculture and Cooperatives, and Interior.⁷ At that time, Dr. Amorn Nondasuta, the Director-General of the Department of Health, served as the chairman and leader who adopted the BMN concept from the International Labour Organization (ILO) in 1976. He spearheaded the adaptation of this approach to serve as a measure for the BMN of the rural Thai population.⁸ The original essence of the ILO’s adaptation of the BMN Approach pertains to the “minimum requirements of a household.” For instance, this includes having adequate food, shelter, sufficient clothing, as well as some basic household equipment and items. Additionally, it signifies the provision of “essential services” for the overall community. These services encompass safe drinking water, healthcare, public transportation, and facilities related to health and education.⁹ The ILO report also emphasized that fulfilling BMN is regarded as promoting human rights. Education and good health, in turn, foster participation, and conversely, participation reinforces legitimate claims for satisfying basic needs. When applying the BMN Approach to Thai society with its unique history, political foundation, economy, and diverse culture, the BMN framework was integrated with the message of “ignorance, poverty and illness” from the wisdom of the Thai people and leaders, carried on until the end of the 1967. The aim was

to position BMN as one of the avenues for development, striving for maximum self-reliance among the population,¹⁰ and to address longstanding persistent issues.

At that time, the concept of “ignorance, poverty and illness” wielded significant influence in shaping the direction of development. As recorded by Dr. Direk Rerkrai, an academic within the framework of social development around 1984, government agencies, particularly the Office of the Prime Minister, adopted this concept as a fundamental basis for development. According to his documentation, the Office of the Prime Minister summarized the major issues faced by disadvantaged rural areas in Thailand into three categories: “(a) lack and scarcity, (b) illness, and (c) ignorance”.¹¹ This concept held significant influence in fostering development strategies, aimed at addressing the persistent challenges. This concept was subsequently conveyed to the government to be used as a guiding principle for addressing the pressing issue of economic inequality that was causing great concern.

In reality, Thailand’s leadership began to recognize this problem as early as the 3rd National Development Plan. This can be observed through its strategies aimed at income distribution and the implementation of state welfare to alleviate economic disparity. Measures such as the “compensation policy” and the “free healthcare program” were introduced to augment income in rural areas. Subsequently, the emphasis on redistributing income and resources to rural areas was further specified in the 4th National Development Plan.¹² By the time of the 5th Development Plan, which coincided with a period when the global situation was beginning to shift, there were changes such as Thailand’s adoption of the principles of the Alma Ata Declaration (1979). Additionally, the concept of BMA as proposed by the ILO acted as a catalyst, steering the 5th National Development Plan toward eliminating the idea of “ignorance, poverty and illness,” and heralding in the era of the “New Rural Development.” Therefore, the objective of the BMN approach for Thailand was to guide the population toward achieving basic needs, however, with the notion of “necessity” representing genuine needs rather than those arising from subjective feelings (felt needs).¹³ When discussing “real needs,” it is akin to a hand that remains unseen in the shadow of poverty. This was because Thailand’s leadership (at the time) perceived that the general population was unaware of their own true needs. What rural residents were aware of were the needs they felt in their immediate circumstances, rather than comprehending the structural issues behind these problems. An example that highlights this is the matter of medical services. Due to their limited policymaking involvement, villagers often failed to recognize that the challenges they faced in accessing medical care were largely rooted in systemic issues associated with state-provided services. Consequently, they found themselves struggling to access healthcare when they needed it.¹⁴ However, when they considered that their homes were far from the hospitals, they opted to rely on traditional remedies instead, as depicted in a well-known criticism: *“The Thai healthcare system allows people to seek services, rather than providing services to people. Healthcare personnel are preoccupied with their own duties and do not pay attention to the well-being*

of the public.” For this reason, BMN emerged as the foundation of the leadership’s concept to create “tools” for measuring the actual problems faced by villagers. These problems often went unnoticed by villagers themselves. In addition to the antiquated concept “*Ignorance Begets Illness*,” it became evident that the foundation of Thai identity, Buddhist economics, and the concept of self-sufficiency were integrated as part of the effort to drive the BMN initiative forward.

Thai Buddhist economics and the development perspective in the Basic Minimum Needs

When re-considering the primary objective of BMN, which is defined as “aiming to make the people attain their BMN,” we can see the effort to leverage the existing social conditions to make BMN more widely accepted and understood by both practitioners and the general population. This is achieved by incorporating social and cultural dimensions, including Buddhist principles. This concept is related to the ideas of “Thai-ness,” “inequality,” and “sufficiency,” which help explain the operational guidelines in an intriguing manner.

The significance of the Buddhist principles that underlie the thinking of the policymakers of BMN, as well as those who would implement the policy, emerged during a period of political change from 1973 to 1976. During that time, the majority viewed the issues of economy and society as major structural problems. This led some doctors to adopt the ideas of the “New Buddhist Movement” to better understand rural areas. The New Buddhist Movement (which drew inspiration from forest monks who emphasize meditation) gained popularity among the middle class in Thailand, including reform-oriented doctors and medical students. Partly, this was because certain aspects of Buddhist principles could explain Thai public health issues from a broader perspective. Professor Saichol Sattayanurak, a prominent Thai historian, noted that “*Mahidol University is connected to the New Buddhist Movement. Some Mahidol students have ties to the Buddhist clergy, which has made certain Mahidol students connect to Buddhism.*”¹⁵

This was manifest through the role of the Buddhist Society of Mahidol University, which often organized activities at Wat Wat Cholpratarn Rangsarit in Nonthaburi Province due to its association with Phra Phrom Mangkhalachan, the senior monk of that temple. At the same time, Dr. Wichai Chokwiwat and Dr. Vicharn Panich experienced medical reformers during a time when Buddhist ideas were flourishing among the medical community, further articulated the connection between Buddhist principles and the doctors’ social contributions. At that time, Buddhism had several social dimensions and could be utilized to address various problems, such as generosity, making oneself useful, and being successful in a socially productive way. Buddhism also served as a source of good emotional support, nurturing people to mature and unify,

molding them to regain a social consciousness. Moreover, Buddhism itself is based on scientific foundations.¹⁶ While the level of adherence to Buddhist ethical principles among the group of doctors varied, ranging from genuine meditation practice to considering Buddhist precepts merely as values or virtues suitable for daily life and work, it can be suggested that the perspectives from Buddhism reinforced a shared ideology within the reformist medical community. This highlighted the importance of being individuals committed to benefiting the collective whole.¹⁷

Furthermore, Buddhist principles also interconnect with other aspects such as “Thainess,” “inequality,” and “sufficiency,” which have been incorporated to help elucidate intriguing pathways for action. “Thainess” provides an explanation for society’s endeavor to preserve Thai identity and characteristics, going beyond mere societal development into a Western culture.¹⁸ Regarding the issue of inequality, when viewed through the dimension of Buddhist philosophy as a matter of karmic consequences, the general principle in Buddhism teaches that those who experience adversity, are born in unfavorable circumstances, face poverty, illness, or ignorance, are experiencing the results of their past actions. However, it is the duty of Buddhist individuals to possess the virtue of generosity, a virtue that is socially supportive. Buddhism constantly reminds us to consider the well-being of all sentient beings. If someone is suffering, or if we are experiencing happiness, we should cultivate compassion and offer assistance.¹⁹ As Professor Saichol Sattayanurak further elaborated: *“The concept of ‘ignorance, poverty and illness’ is related to Buddhism, analogous to the lotus. It refers to the diverse karmic actions that lead to varied circumstances in which people are born, or the differences in wisdom that result in unequal conditions.”*²⁰

Understanding the origin of inequality, the concept of “sufficiency” is introduced as an antidote to the economic and livelihood challenges faced by rural communities. This concept explains that Thailand’s economic issues arise solely from dependence on foreign countries, resulting in increased desire within society since Western countries exploit and drain the country’s resources and wealth. To address these crises, it is necessary to start with the grassroots, reducing attachment to material possessions and reducing consumerism.²¹ Alternatively, to simplify, the government should ensure that rural residents practice a frugal, self-sufficient lifestyle, primarily based on their traditional agricultural sector, rather than using the mechanisms of a free market to stimulate rural economies and foster economic competition. People should live by the principle of “sufficiency first” rather than aiming for a higher standard of living. This process involves allocating limited resources, both material and human, to meet the basic minimum needs of impoverished rural areas, and to enable sustainable self-reliance. Implementing suitable mechanisms within the social fabric, such as forming community networks, empowers members to care for themselves, their families, and their affiliated social groups. The roles of VHV and VHC, and the village development fund initiatives also contribute to creating community involvement for local development.²² All of this constitutes the utilization of resources to yield valuable and maximally beneficial results.

It can be observed that the influence of the concept “Ignorance, poverty and illness Begets Illness” and Buddhist economics had significant implications for designing an effective BMN strategy that aligned well with the social challenges of Thai society at that time. In the practical implementation, progress moved towards engaging advisory teams from four relevant governmental entities: the Ministry of Public Health, the Ministry of Agriculture and Cooperatives, the Ministry of Education (along with the University system), and the Ministry of Interior. These teams came together to discuss ways to define the BMN for the Thai social context.

Viewed structurally, the foundational idea of BMN helped elevate the efficiency of top-down rural development management, creating a more efficient approach. This was achieved through designing management strategies that facilitated the enhancement of both horizontal and vertical relations. The former involved fostering coordination among same-level entities, such as collaborations between the four main ministries and universities. The latter involved harmonizing inter-level actions through different tiers of responsibilities and authorities. In this structure, the highest level wielded the power to frame ideas and set policies, which then cascaded down to lower levels. For instance, the provincial-level authority guided the district-level actions, and subsequently, the district-level body directed local actions. This hierarchical approach aimed to create an effective flow of policies and responsibilities, leading to comprehensive community development.²³ Therefore, with the management approach under the BMN concept, implementation took on a characteristic of a “rebranded” and new image of public administration. This endeavor sought to open up spaces for public involvement by employing surveys to identify solutions to the issues occurring in rural areas. Citizens were invited to contribute by filling out documents referred to as “BMN forms” to provide data and insights.

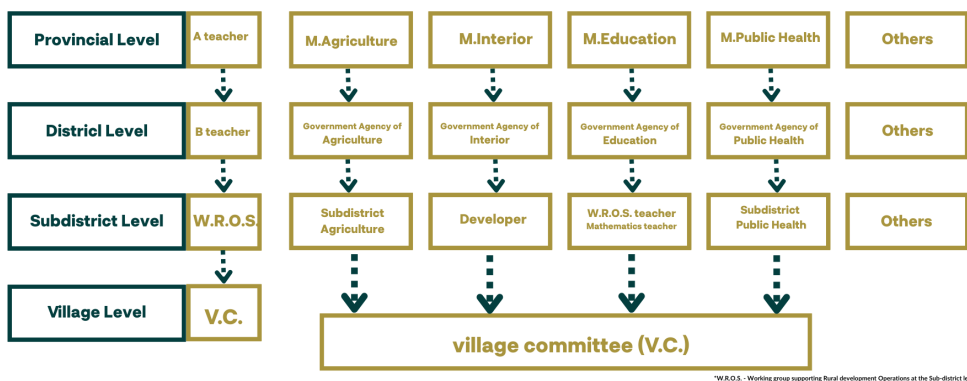


Figure 65 Characteristics of Administrative Coordination in Accordance with the Basic Minimum Need (BMN)

Source: Adapted from Korat Development Project. Korat Development. (2nd Edition, Nakhon Ratchasima: Nakhon Ratchasima Provincial Office, 1984)

Initially, the identification of the BMN for Thai people was based on data provided by the National Statistics Office, which collected fundamental community-level data through the Community Development Department's form. This data collection involved officials from four ministries at the sub-district level, collaboratively gathering information through surveys conducted with village committee members and community leaders in the target areas of 38 provinces. This initiative covered a total of 12,586 villages in 1982.²⁴ Coupled with input from academia and estimations of potential from both the government and private sector at the time, there were initially 15 essential points outlined for the BMN program. Later, in 1983, the program was reduced to 13 points with 52 indicators.

Although there was a desire to involve the public in planning, during the initial stages of implementation, it can be observed that the BMN concept encountered certain challenges and limitations. First, the BMN concept was entangled with the establishment of Community Development Committees. The attempt to impose a central management model onto communities led to a gradual erosion of their original culture. Contrary to the claim that this approach would enhance community participation, the reality was that fostering genuine civic engagement proved difficult. In truth, the vertical relationships still revealed characteristics of being "bureaucratic" due to the adoption of a top-down development model. Community-driven planning processes had to undergo filtration from "bottom to top" in accordance with the chain of command, perpetuating the power and influence of high-level officials in budget allocation decisions within ministries. In sum, the bureaucracy remained as the director of the people, as Dr. Amorn Nondasuta pointed out, rooted in a bureaucratic culture dating back to the era of Field Marshal Sarit Thanarat, keeping the public as "subordinates" of bureaucrats.²⁵

Another aspect is that several studies primarily originated from central authorities, which gave rise to numerous suspicions and doubts. The definition of "self-help" in terms of health care and maintenance still required much more clarity. Several studies also emphasized the role of bureaucrats, leading to the perception that the post-implementation study of the BMN seemed to focus solely on evaluating the successes and issues of government agency operations. Consequently, the studies overlooked the community's perspective, such as the behaviors of villagers in managing health for self-reliance, as an alternative to using state healthcare services, or the villagers' medication purchasing behaviors were not highlighted.²⁶ This resulted in a underreporting of the variations among each community, despite the fact that the context of each community was subject to constant changes.

However, during the period from 1983-1984, the aforementioned criteria were experimented with in several provinces. Coincidentally, this period aligned with the initial rural medical practitioner groups working in remote areas, particularly in the northeastern region. This situation became opportune for the alignment of developmental thinking in public health alongside the BMN concept. The push toward

experimentation was facilitated by individuals in ministerial positions in the Ministry of Public Health, collaborative efforts across various sectors, the readiness of medical personnel, and officials working in the field, culminating in the “Korat Development” project. This project was an experimental implementation of BMN that allowed greater community participation in defining a broader scope of BMN, beyond the data collection practices of previous projects. The BMN model of the Korat Development project would become a prototype that was replicated for practical implementation in various regions throughout the country in the future.



Figure 66 Provincial governors' seminar on the National PHC Criteria was held from March 22 to 24, 1984 as the framework.

Source: National Archives of Public Health, (13) B.NEG S.2.1/39.41, Governors' Meeting on BMN

Figure 67 Dr. Pairode Ningsanon (left) and Dr. Amorn Nondasuta (right) during the provincial governors' seminar on the National PHC Criteria (NBHCC), held from March 22 to 24, 1984 as the framework.

Source: National Archives of Public Health, Source: National Institute for Health Development, (13) B.NEG S.2.1/39.41, Governors' Meeting on BMN



Korat Development: Principles and practical implementation of the Basic Minimum Needs

“Korat Phatthana” or “Korat Development” is considered the most successful flagship project in terms of implementing the BMN criteria in practice within the area, along with advancing the development of basic health data towards practical application in Thailand. What is noteworthy is that this project originated from public health officials, notably Dr. Paichit Pawabutr (and colleagues), who were direct disciples of Dr. Amorn Nondasuta, the initiator of the BMN concept, played a significant role around 1982. During his tenure as the PCMO in Nakhon Ratchasima province (1978-1983), Dr. Paichit aimed to apply the BMN concept from NESDB for practical benefit. He initiated a pilot project in the province to develop the criteria as a measurement tool for BMN. Initially named the “Integrated Population Development Project in Nakhon Ratchasima Province,” the project was later renamed “Korat Phatthana” in 1983. In the first committee, representatives from four ministries involved in establishing various fundamental criteria were included. These representatives included Sombat Lertsuriyakul (Non-formal Education Center), FS1. Pairot Srichan (Zone 3 Education Center), Mr. Kongkiat Surisuk (Development Office, Sung Nern District), Aht Intharak (Provincial Agricultural Specialist), Dr. Samreung Yaengkratok (Director of Sung Nern Hospital), and Charoen Kromyai (Agricultural Officer, Sung Nern District).²⁷

In addition to inter-ministerial collaboration, the success of the project also stemmed from the wholehearted cooperation and teamwork among various sectors in the area. Dr. Paichit Pawabutr reflected on the past experiences as a principal leader of the BMN concept when he initiated pilot testing under the Korat Phatthana project. He recalls:

“

At that time, we were in the process of establishing hospitals, with four doctors (Si Sor) assigned: Samreung (at Sung Nern Hospital), Somchai or Rawinan (at Chum Phuang Hospital), Somsak (at Prathai Hospital), and Sanguan (at Bua Yai Hospital). The landscape of Korat was already auspicious due to the presence of prominent officials (district level), detailed personnel (department heads), and capable leaders (sub-district health centers). When we had the complete team of 4 + 3, the work progressed smoothly.²⁸

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These “four doctors”, they came together as a group called the “Korat PHC” of rural doctors practicing in the Korat region. It comprised of Dr. Samreng Yaengkratok, the director of Sung Nern Hospital; Dr. Somchai Sirikanokwilai, the director of Chum Phuang Hospital; Dr. Somsak Chunharas, the director of Prathai Hospital; and Dr. Sanguan Nitayarumphong, the director of Bua Yai Hospital. At that time, all 4 districts cooperated strongly and worked in harmony, fostering collaboration between the public and private sectors. They engaged in various endeavors beyond healthcare, such as rice and buffalo banks, integrated farming, local wisdom, and community group initiatives. The notion of self-reliance within the community was also promoted, with volunteers contributing across multiple generations.²⁹

Since the initial phase of the project did not involve coordination with the Ministry of Interior’s questionnaire, the form used for surveys in Korat was referred to as the “Minimum BMN Form” (prior to the Ministry of Interior’s change in terminology to “BMN”).³⁰ This form consisted of 8 questions. Dr. Samreung Yaengkratok, one of the physicians involved in the project from the beginning, explained that *“Quality of life or BMN back then, as measured, includes **having sufficient food, three banana trees and five papaya trees, suitable shelter, sun and rain protection, comprehensive health education, literacy, a secure family, good farm produce, limited family size, willingness to participate in development, and promoting virtues.**”*³¹ The working group then took these questions and asked the villagers to choose their own answers. For instance, if a household had many children, it indicated that the statement about having few children was not applicable. By doing so, villagers could assess themselves more effectively. In 1983, when the MOPH observed the work of the Korat Development, they saw examples of villagers comprehending the questions, reading and answering them (previously, the MOPH was skeptical whether villagers could answer the questions on their own, so the questions were asked through village committee members or community leaders).³² This led to a tendency to expand the nature of such projects to other areas throughout the country.³³ Subsequently, in the year 1985, the Cabinet approved and authorized on August 20, 1985, the implementation of the “Quality of Life Campaign for the Nation’s People” project, which was renamed from the “National Social Development Project.” This project marked the starting point of studying BMN principles. Additionally, it was announced that 1985-1987 would be dedicated to the Quality-of-Life Campaign for the Nation’s People, adhering to the 8-point assessment model with 32 indicators, detailed as follows:

Table 5 Details of the 8-point 32-indicator criteria of the BMN program

Source: Compiled by the author.

Item	Topic	Explanation	N Indicators
1	sufficient food	People can eat food that is hygienic and sufficient for the needs of the body	3
2	suitable shelter	People have suitable housing and environment.	4
3	comprehensive health education	People have the opportunity to access basic social services that are necessary for life and occupation	7
4	a secure family	People have security in life and property	1
5	good farm produce	People are producing and finding food efficiently	5
6	limited family size	Families can control the timing and number of children as needed	1
7	willingness to participate in development	People participate in the development of their livelihoods and the way of life of themselves and their communities	7
8	promoting virtues	People have a better mental health development	4

Therefore, the experimental evaluation approach used in the Korat Phattana Project as the foundation for problem identification significantly enhanced the efficiency of PHC work. This is because the evaluation framework enabled all units and levels of personnel to pinpoint development strategies for targeted solutions. Through the BMN approach, everyone adhered to the same set of principles.”³⁴ Hence, it has led to a collaborative effort in problem-solving and management.³⁵ While one important principle of PHC is to empower communities to take care of their own health, it is also promoted through the BMN approach. Therefore, *“Primary Health Care is a part of the fundamental guarantee (comprehensive health assurance) and serves as the foundation for integration and holistic perspective, involving community participation”*³⁷ in the words of Dr. Samreung Yaengkratok.



At that time, the work in the field of PHC (N-E-W-I-T-E-M-S) was advancing well. At the same time, the development of the 8 criteria and 32 indicators of BMN was being earnestly embraced. This was in line with the overarching philosophy of the Thai approach to PHC, aimed at addressing the issue of “Ignorance Begets Illness” and fostering ethical values within the overall healthcare and societal systems of Thailand. Simultaneously, the government was advancing according to the new rural development policy, with the “expansion of community-level hospitals to cover every district.” This was another path to rapidly bridge societal gaps in the most effective manner.

Chapter 8

¹ Oupakron Leeka, “Economic Policy of Pram Tinsulanonda’s Government, 1980-1988: The Study of The Office of The National Economic and Social Development Council’s Journals” (Independent Research, Department of History, Faculty of Arts, Silpakorn University, 2019), 112-114.

² Korat Development Project. Korat Development (Nakhon Ratchasima: Nakhon Ratchasima Provincial Office), 31.

³ Office of The National Economic and Social Development Council, “The 5th National Economic and Social Development Plan (1982-1986)”, Accessed August 6, 2022, https://www.nesdc.go.th/ewt_dl_link.php?nid=3780.

⁴ Office of The National Economic and Social Development Office, 340.

⁵ Bodi Dhanamun, “Fundamental Necessities and Quality of Life”, Chulalongkorn Journal of Medicine 10, no. 31 (1987): 822.

⁶ Office of The National Economic and Social Development Council, “The 5th National Economic and Social Development Plan (1982-1986)”, 341.

⁷ Subsequently, it will change its name to the “People’s Quality of Life Campaign Project”

⁸ Interview with Dr. Somsak Chunharas, May 17, 2022; Interview with Dr. Paichit Pawabutr, May 30, 2022.

⁹ Director-General of International Labour Office, “Employment, Growth and Basic Needs: A One World Problem, Report of the Director-General of the International Labour Office,” Tripartite World Conference on Employment, Income Distribution, and Social Progress and the International Division of Labour (Geneva, Switzerland: International Labour Office, 1976), 32.

¹⁰ Direk Rerkrai. “Indicators of Basic Necessities in Rural Development,” Kasetsart University (Social Sciences), Volume 2, Year 7 (1986): 194.

¹¹ Praphon Piyarat and Direk Rerkrai, “Development Trends, New Paradigm Policies of Rural Development,” Agricultural Science Newsletter 1, Issue 29 (1984): 79-85.

¹² Teeron Ngowsirimanee, ed., Thai Economy: Changes and Developments (Bangkok: Sangsan, 1982), 98-99.

¹³ Kerdhiri Yodpring, “Community Work Practices in Bangkok Metropolis: A case Study of BMN... Application in Health Centers,” (Thesis, Thammasat University, 1987).

¹⁴ Interview with Dr. Somsak Chunharas, May 17, 2022

¹⁵ Interview with Professor Saichol Sattayanurak, May 26, 2022

¹⁶ Interview with Dr. Wichai Chokwiat, May 17, May 23, June 2, 2022

¹⁷ Interview with Professor Dr. Wijaan Phaenid, June 22, 2022

¹⁸ Praphon Piyarat and Direk Rerkrai. “Development Trends, New Paradigm Policies of Rural Development.” Agricultural Science Newsletter 1, Issue 29 (1984): 79-85.

¹⁹ Phra Ratchaworamunee (Prayut Payutto), *Buddhist Society Characteristics*. (Bangkok: the Komol Keem Thong Foundation, 1984), 56–59.

²⁰ Interview with Professor Saichol Sattayanurak, May 26, 2022

²¹ E. F. Schumacher & Somboon Suphasin, *Small is Beautiful: Economics as if People Mattered* (Bangkok: Sami, 1994), Chapter 4.

²² Prayong Temchavala. 'Research Report on Basic Necessities and Thai Rural Development' (Bangkok: Health Education Division, Ministry of Public Health, 1998).

²³ More details in Korat Development Project. *Korat Development* (Nakhon Ratchasima: Nakhon Ratchasima Provincial Office).

²⁴ Direk Rerkrai. 'Indicators of Basic Necessities in Rural Development,' 193.

²⁵ Hfocus, "Dr. Amorn Nondasuta, Founder of Primary Health Care," Hfocus. Accessed July 20, 2013, <https://www.hfocus.org/content/2013/07/4026>.

²⁶ Luechai Sri-ngernyuang and Thavitong Hongvivatana. 'Strategies for Self-Healthcare.' (Nakhon Pathom: Faculty of Social Sciences and Humanities, Mahidol University, 1990).

²⁷ Korat Development Project. *Korat Development*, 81–83.

²⁸ Interview with Dr. Paichit Pawabutr, May 30, 2022

²⁹ Prachatai, "Komatra Chuengsatiansup, determined to provide the main health insurance work." Prachatai, January 22, 2008, Prachatai, Accessed June 15, 2022, <https://prachatai.com/journal/2008/01/15513>.

³⁰ Prachatai, "Komatra Chuengsatiansup, determined to provide the main health insurance work."

³¹ Interview with Associate Professor Dr. Samreung Yaengkratok, June 24, 2022

³² Interview with Associate Professor Dr. Samreung Yaengkratok

³³ Prachatai, "Komatra Chuengsatiansup, determined to provide the main health insurance work."

³⁴ Somboon Tanya, et al., "Research Report on the Evaluation of the Korat Development Project," (n.p.: Academic working group of the Korat Development Project, 1988), 13.

³⁵ Prime Minister Prem addressing rural issues: A case study of Nakhon Ratchasima Province, *Korat Development Project*. (Nakhon Ratchasima: 1986), 63–68.

³⁶ Interview with Dr. Paichit Pawabutr, May 30, 2022

³⁷ Interview with Associate Professor Dr. Samreung Yaengkratok, June 24, 2022



The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868–2002

A community hospital in every
district (1982–1986)

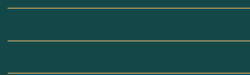




Figure 68 General Prem Tinsulanonda, Prime Minister, and Dr. Sem Pringpuangkeo, Minister of Public Health, are planting trees in the ceremony to inaugurate the Bua Yai Hospital, a community-level hospital in Nakhon Ratchasima Province, on February 26, 1983.

Source: National Health Archives, (13) B.NEG S.2.1-38.28, Opening of Bua Yai District Hospital, Nakorn Ratchasima.

It is often said that because Thailand has a ‘basic infrastructure of the healthcare system’ that has been developed continuously over time, it has become a crucial condition enabling the implementation of comprehensive health insurance policies.¹ In other words, the establishment of a primary care system, encompassing basic healthcare and health promotion, achieved through the expansion of health centers, allows the majority of individuals in rural areas to access essential services. This also includes the secondary care system, which provides more complex medical services, covering both outpatient and inpatient care, facilitated by the expansion of community hospitals. Lastly, there is the tertiary care system, which refers to specialized and intricate public healthcare services that rely on specialized knowledge, technology, and personnel. This involves the advancement of regional hospitals or general hospitals, along with mechanisms for patient referrals from community hospitals.² The development at all levels of these service facilities serves as a crucial foundation for the expansion of nationwide public healthcare coverage, which is the core of a comprehensive health insurance system.³ In this regard, a robust service system must start with “Primary Care Services,” which are units situated close to the population, providing proactive services and accessibility to marginalized groups within communities. This also serves as a vital mechanism in promoting equity in healthcare access.⁴ This includes the development of components within the healthcare system, such as knowledge, management, workforce quantity, and sufficient equipment, all of which are being developed in parallel.

After the government issued Prime Minister’s Directive No. 66/1980, which employed political strategies involving the military, often referred to as the “*Yook Pa Taek*” (When the communists came out of the forest) in 1980, the policy to establish district hospitals (later known as community hospitals in 1982 and subsequently as the original district hospitals) underwent a new emphasis and purpose to align more closely with the 5th National Development Plan. As part of the new rural development plan, this policy aimed to expand the fundamental healthcare services for the population comprehensively, especially in disadvantaged rural areas. Following the policy’s goals, the plan aimed to construct 10-bed district hospitals in each district, totaling 22 hospitals per year, and to establish 10 medical and health centers in each district and 15 in each sub-district during the period of 1982-1983.⁵ As stated by General Prem Tinsulanonda during the opening ceremony of the National Committee for Rural Development (NCRD) exhibition at the Government Public Relations Department on July 19, 1984, the expansion of district hospitals has significantly played a vital role in the crucial transformation of “basic service distribution” in rural areas:

“

“...The essential distribution of basic services necessary for rural residents, including knowledge enrichment, public health care, and access to clean water supply, has been successfully extended widely and tailored to areas with more pressing needs. Regarding the provision of public health care services, I'd like to emphasize that we now have community hospitals, also known as district hospitals, established in every district within the targeted rural development area. There are currently 286 such hospitals, and soon, there will be doctors assigned to each of them.....”⁶

”

However, prior to this policy, the establishment of healthcare facilities often emerged solely from the Ministry of Public Health's initiatives, without collaborative planning across other ministries. During General Prem's administration, district hospitals as well as various levels of healthcare facilities in rural areas were transformed into “social territory,” where development policies from the government were implemented, fostering intersectoral collaboration akin to the “sufficiency economy” approach. With an emphasis on cooperation between public health agencies and other sectors, combined with political support, this marked another crucial era for the expansion and creation of community-level healthcare facilities in every district. This initiative aimed to affirm the government's commitment to community health and to strike a balance between preventive and curative healthcare efforts, ensuring their simultaneous realization.⁷

Establishment of public health facilities before the 1977-86 decade

Looking back at the development trajectory of healthcare services in Thailand prior to the 1977-86 decade, it is evident that in 1935, there was an expansion of public health service units under the project “Urban Health.” This project aimed to promote the establishment of healthcare facilities beyond the boundaries of Bangkok and Thonburi. The Urban Health project stipulated that within the urban area, there should be at least one of the following six types of health units:

- (1) A first-tier hospital with approximately 200 beds
- (2) A second-tier hospital with approximately 100 beds
- (3) A third-tier hospital with approximately 50 beds, located in urban or community areas without the two types of hospitals mentioned above
- (4) A first-tier health center with at least 1 physician, situated in remote areas far from hospitals
- (5) A second-tier health center without a resident physician but with one assistant physician, established in areas without first-tier health centers
- (6) Mobile health units⁸

Based on the study conducted by Davisakd Puaksom, the development of hospital construction from 1942 to 1957 can be summarized as follows:⁹ Even though the Ministry of Public Health (MOPH) was established in 1942, the healthcare units in the form of hospitals were only present in a few provinces. During that time, there were only 23 hospitals under the jurisdiction of the MOPH.¹⁰ Hospitals under municipal authority totaled 16, and 9 hospitals were taken from adversaries until after World War II. Subsequently, following the policy of establishing hospitals in every province, called the “Project for Establishment of Hospitals and Health Centers by the MOPH” in 1946, this project aimed to create medium-sized hospitals (approximately 50 beds) anew in every province. Meanwhile, small-sized hospitals (around 25 beds) were to be established only in densely populated districts. Simultaneously, efforts were made to upgrade existing level-one and level-two health centers to small hospitals alongside the construction of new hospitals. Nevertheless, this hospital-building policy encountered significant budgetary challenges.¹¹ The government thus resorted to fundraising from the public to establish “Provincial Hospitals” and managed to create two in 1948 (Sukothai Hospital and Chonburi Hospital).¹² Then, in 1951, an additional 7 hospitals were opened, making a total of 9, which were Phetchaburi Hospital (currently Phra Chom Klao Hospital, Phetchaburi Province), Rayong Hospital, Mahasarakham Hospital, Surin Hospital, Khon Kaen Hospital, Chaiyaphum Hospital, and Uttaradit Hospital. From 1952 to 1956, 3 more hospitals were added: Krabi Hospital, Photharam Hospital, and Trat Hospital. Apart from establishing new hospitals, the elevation of the status of level one health centers to become hospitals was achieved for 4 facilities in 1949, namely Samut Songkhram Hospital, Yala Hospital, Sisaket Hospital, and Satun Hospital. Then, in 1954, the name of Suk Sala that hadn’t been upgraded yet was changed to “a first-tier health center.” These service units later evolved into community hospitals in the mid-1970s.¹³

Furthermore, starting from 1948, the government had a policy to establish “a second-tier Suk Sala “ in rural areas, with a mandate to build 10 centers per year until every sub-district had one. At the time this policy was introduced, Thailand already had 563 first-tier health centers and a second-tier health centers in place.¹⁴ Another type of healthcare facility that emerged during this period was the “Midwifery Center,”

which was first established in 1954 to address the issue of infant mortality, mostly occurring in areas without other public health service centers.¹⁵

As Thailand entered the “Development Era” after 1957, under the leadership of Field Marshal Sarit Thanarat, a closer look at the healthcare expansion strategy within the initial development plan (1961) reveals that during the first plan (1961-1966) and the second plan (1967-1971), the emphasis was placed on accelerating the expansion of healthcare facilities, including both hospitals and health centers, throughout the entire country. However, the focus was more on expanding healthcare services in the central region rather than in the peripheral areas.¹⁶

The policy of decentralizing healthcare services to rural areas became more explicit in the 3rd National Economic and Social Development Plan (1972-1976). This plan emphasized the policies of “establishing district hospitals nationwide” and “creating second-tier health centers at the sub-district (Tambon) level across the country.” These initiatives were to be accomplished within a 4-year timeframe.¹⁷ During the 4th National Health Development Plan (1977-1981), the focus was on both “quantity and quality” improvement of district-level hospitals. This was closely linked to the policy of enforcing physician funding and redirecting efforts toward remote areas by rural doctors. Consequently, a significant number of healthcare professionals began to disperse to district hospitals, leading to the development of these facilities in terms of both bed capacity and physician capabilities. Additionally, the increase in the number of district-level healthcare units was a result of restraining the growth of provincial hospitals, optimizing the utilization of limited resources for the enhancement of district-level healthcare facilities.¹⁸

Figure 69 Patients and individuals contacting the hospital in Muang Capital District, Lampang Province, 1967

Source: National Archives of Thailand, P.SB. 52.2.1/70 Number 3, Lampang Central Hospital, Lampang Province.



In addition to the expansion of healthcare services after 1957, as explained earlier, it is important to understand that before the major reform of the MOPH in 1974, healthcare units had different chains of command or central agencies responsible for them. There were two distinct entities: “hospitals” under the Department of Medical Services, responsible for providing medical treatment or what can be referred to as the “disease treatment” sector, and “health centers” and “midwifery centers” under the Department of Health, responsible for the “disease prevention” sector. This separation in chains of command led to hospitals and health centers/midwifery centers working independently of each other.¹⁹ Within the Department of Medical Services, the strategy shifted from simply increasing the number of hospitals to improving the quality of existing hospitals. It can be observed that between 1958 and 1971, regional hospitals were upgraded to advance-level hospitals in the provincial areas, totaling 8 facilities.²⁰ While the Department of Public Health was still responsible for overseeing first-tier and second-tier health centers, as well as midwifery centers, it continued to advance by increasing the number of service units through the construction of health centers to cover a larger area.

The challenges that both the Department of Medical Services and the Department of Health had to face were similar: they couldn’t allocate doctors to every establishment. However, the situation for the Department of Medical Services might have been slightly better than that of the Department of Health, as most doctors preferred to work in hospitals under the Department of Medical Services rather than in health centers under the Department of Health. Looking at the numbers between 1967 and 1971, there were more doctors practicing in hospitals under the Department of Medical Services compared to those in health centers under the Department of Health. Despite having a larger number of health centers, the Department of Health had fewer doctors. Moreover, the trend showed that the number of doctors under the Department of Medical Services continuously increased, while the number of doctors in health centers under the Department of Health slightly rose and fell in some years.²¹ However, the challenges of working between the Department of Medical Services and the Department of Health, which were previously distinct, were addressed when there was a restructuring of the MOPH in 1974. From then on, Thailand’s public health entered an era of expanding service units. This involved improvements, upgrading of statuses, replacements, and the creation of numerous new healthcare facilities. Notably, several service units that had been expedited and expanded even before 1957, such as first-tier Suk Sala, second-tier Suk Sala, and Midwifery Centers, served as essential foundations that were subsequently upgraded to become community hospitals and health centers during the 1977-86 decade.

Expansion and construction of district-level hospitals: Decade of 1977-86

Starting from the 1977-86 decade, the construction of district hospitals can be seen as a politically significant driving force. Both direct political factors, such as constructing hospitals to vie for political

dominance in certain areas, and indirect political factors, which aimed to elevate the country's public health to alleviate poverty, played pivotal roles. The addition of medical service units, expected to have positive implications for the overall political landscape, was intended to bring about favorable political outcomes.

A. Political factors behind the upgrade of community hospitals to become “Crown Prince Hospitals” (Rong Phayaban Somdet Phra Yuppharat)

An indicator of direct political factors is the “Crown Prince Hospital Construction Project,” totaling 20 hospitals (currently 21), which was approved on December 28, 1976. This decision followed the events of suppressing student movements or the “October 6th Massacre” in 1976. This project aimed to honor the Thai Monarchy. The establishment of the Crown Prince Hospital, initially, held significant reasons, including the declaration of the Monarchy's graciousness extended to the Thai communist sympathizers – the very citizens referred to as “the King's subjects” (during that time, the right-wing group termed the left-wing, a “subversive group”).²² This followed the same political dynamic and rationale as when the Thai government aimed to establish “Provincial Hospitals” for the purpose of “displaying prowess” as a spectacle to the eyes of its adversaries, particularly the “leader class” (the Westernized elites). The difference lay in the fact that the political target group for this aim was specific.

These hospitals were constructed in areas with CPT activities within Thailand as a gift to Prince Vajiralongkorn as the Crown Prince, on the occasion of the royal wedding ceremony (January 20, 1977).²³ The Crown Prince Hospitals were under the administration of the MOPH.²⁴ Certainly, it is not surprising that within the context of the Cold War, the development of public health not only aimed to improve the quality of life for rural populations but also served as a tool for the government to establish a stable political foundation to counter the influence of communism.²⁵ Whether driven by reasons of quality improvement or influenced by political factors, it can be said that the “Crown Prince Hospital” project contributed to elevating the primary healthcare system, promoting health equity, and enhancing access to public health services.²⁶

Figure 70 During the time when H.M. King Maha Vajiralongkorn, graciously held the royal title of “Somdej Phra Borom Orasathiraj, before ascending to the throne, he graciously inaugurated the Crown Prince Hospitals” (Rong Phayaban Somdet Phra Yuppharat)” in Lerng Nok Tha District, Yasothon Province. This hospital was one of the medical facilities established under the project of constructing Crown Prince hospitals.

Source: National Archives of Thailand, Ch/R/ 800, His Majesty the King graciously opens the Crown Prince Hospitals” (Rong Phayaban Somdet Phra Yuppharat)” in Lerng Nok Tha District, Yasothon



However, it should be noted that the “Crown Prince Hospital” project, totaling 21 hospitals (formerly 20), wasn’t entirely about creating new facilities. Instead, it involved a process of “expansion and transformation” from existing health centers, medical centers, and clinics from the past into community hospitals. This transformation was achieved through a combination of community and government funding, with an emphasis on selecting remote, vulnerable, disaster-prone, and underserved areas that were distant from existing hospitals. Dr. Winai Sawasdivorn shared his experience during his time working with the funding for the Crown Prince Hospital in Lerng Nok Tha District, Yasothon Province, in the early 1970s, by observing: *“Building hospitals was a part of public effort. The Crown Prince Hospital was usually in a red zone because it was a MOPH strategy. The MOPH ensured that the hospital was well cared for, to show that the government cared... So, the hospital received more funding compared to others.”*²⁷

In this regard, community hospitals (with approximately 30 beds each) were distributed across all regions, totaling 21 provinces. These provinces are: Muang District, Sa Kaeo Province; Chom Bueng District, Ratchaburi Province; Wiang Sa District, Surat Thani Province; Chawang District, Nakhon Si Thammarat Province; Yaha District, Yala Province; Sai Buri District, Pattani Province; Chiang Khong District, Chiang Rai Province; Den Chai District, Phrae Province; Pua District, Nan Province; Nakhon Thai District, Phitsanulok Province; Tapan Hin District, Phichit Province; Lom Kao District, Phetchabun Province; Kranuan District, Khon Kaen Province; Kuchinarai District, Kalasin Province; Dan Sai District, Loei Province; Tha Bo District, Nong Khai Province; Ban Dung District, Udon Thani Province; Sawang Daen Din District, Sakon Nakhon Province; That Phanom District, Nakhon Phanom Province; Det Udom District, Ubon Ratchathani Province; and Lerng Nok Ta District, Yasothon Province.²⁸ However, among these 20 hospitals, only one was entirely newly constructed, namely the Kranuan Hospital in Khon Kaen Province.²⁹



Figure 71 Image of Somdet Phra Yupparat Hospital, Tapan Hin District, Phichit Province

Source: National Archives of Public Health, (13) B.NEG S.2.1-25.2, Somdet Phra Yupparat Hospital

B. Increase in the number of community hospitals and clinical/health centers

In reality, the primary healthcare system began to take shape when the government initiated policies to expand community hospitals and health centers during the 3rd National Economic and Social Development Plan (1972-1976).³⁰ However, its substantial development occurred during the implementation of the 4th and 5th National Economic and Social Development Plans (1977-1986).³¹ Therefore, the period between 1972 and 1982 can be considered a crucial turning point in expanding healthcare services to cover rural areas, both through accelerating the establishment of new service units and upgrading existing ones to become more efficient. Starting in 1972, the “first-tier health center “ was elevated in status and renamed to “Rural Medical and Health Center.” Two years later, in 1974, the term “rural” was dropped, leaving it as the “Medical and Health Center.” Then, in 1976, the MOPH established criteria to further elevate the status of the Medical and Health Centers to become District Hospitals,³² then changing the name once again in 1982 to “Community Hospital.”

Another aspect that went hand in hand with the policy of expanding hospitals to cover every district was the expansion and improvement of health centers. In 1972, all “second-tier health center” facilities were changed to “health centers,” and in 1982, all “midwifery centers” were transferred to become part of the “health centers.”³³ One indicator that illustrates the trend of emphasizing the importance of expanding healthcare units in rural areas is the level of budget allocation for the “Health Center Improvement and Expansion Project” during the period from 1967 to 1976. In 1967, the budget allocated for the project was approximately 38 million baht. This was increased to 158 million baht in 1971, and further raised to 434 million baht in 1976. These figures demonstrate that the budget for improving and expanding health centers saw a more than tenfold increase between 1967 and 1976.³⁴ During the same period, the Regional Hospital Division, responsible for provincial hospitals, only managed to construct an additional five provincial hospitals.³⁵

To summarize the changes and improvements towards community hospitals and health centers, it can be observed that the development of community hospitals began with the transformation of “first-tier Suk Sala” into “first-tier Health Center” (1954). It then progressed to become “Rural Medical and Health Center” (1972), followed by a name change to “Medical and Health Center” (1974). Subsequently, a part of the Medical and Health Center was upgraded to “District Hospital” (1976), later renamed to “Community Hospital” (1982). Similarly, Health Centers, Medical and Health Centers, and a portion of District Hospitals were elevated to “Crown Prince Hospital” (1977), which also served as a community hospital.

Meanwhile, the development of Health Centers began with “Second-tier Suk Sala,” evolving into “Second-tier Health Center” (1952). These then transformed from second-tier Health Center to “Health Center,” and in parallel, the existing “first-tier Health Center” was enhanced to become “Rural Medical and

Health Center," ultimately leading to the transformation of more than a thousand "Midwifery Centers" into Health Centers in 1982. (See the picture below.)

Statistical data from the period 1967-1981 indicates that the expansion of healthcare units saw the creation of "new" entities, such as first-tier Health Center, Medical and Health Centers, and District Hospitals. They will be developed into 275 community hospitals. (which includes the replacement of 47 units and upgrades from 21 existing units). Moreover, there was newly the establishment of second-tier Health Center 2,084 units, including 355 replacements, the elevation of Midwifery Centers to Health Centers totaling 219, and the creation of new Midwifery Centers amounting to 1,064.³⁶ In 1981, a new type of service unit called "Community Public Health Office" was established, totaling 100 units.³⁷ Those were first establishes in 1981 as small community-based facilities in particularly rugged and remote areas that might be vulnerable for cross-border conflict or with mostly ethnic minority residents. Also, the personnel were recruited from the local community among those who had completed compulsory education (9 years) and received six months training in PHC.³⁸ By 1981, when including all regional health centers, there were 89 provincial hospitals, 310 district hospitals and medical and health centers, 5,037 health centers and 1,286 midwifery centers.³⁹ In terms of coverage, district-level service increased from 44% in 1962 to 61% in 1981, while sub-district level service increased from 14% coverage in 1962 to 82% coverage in 1981.⁴⁰

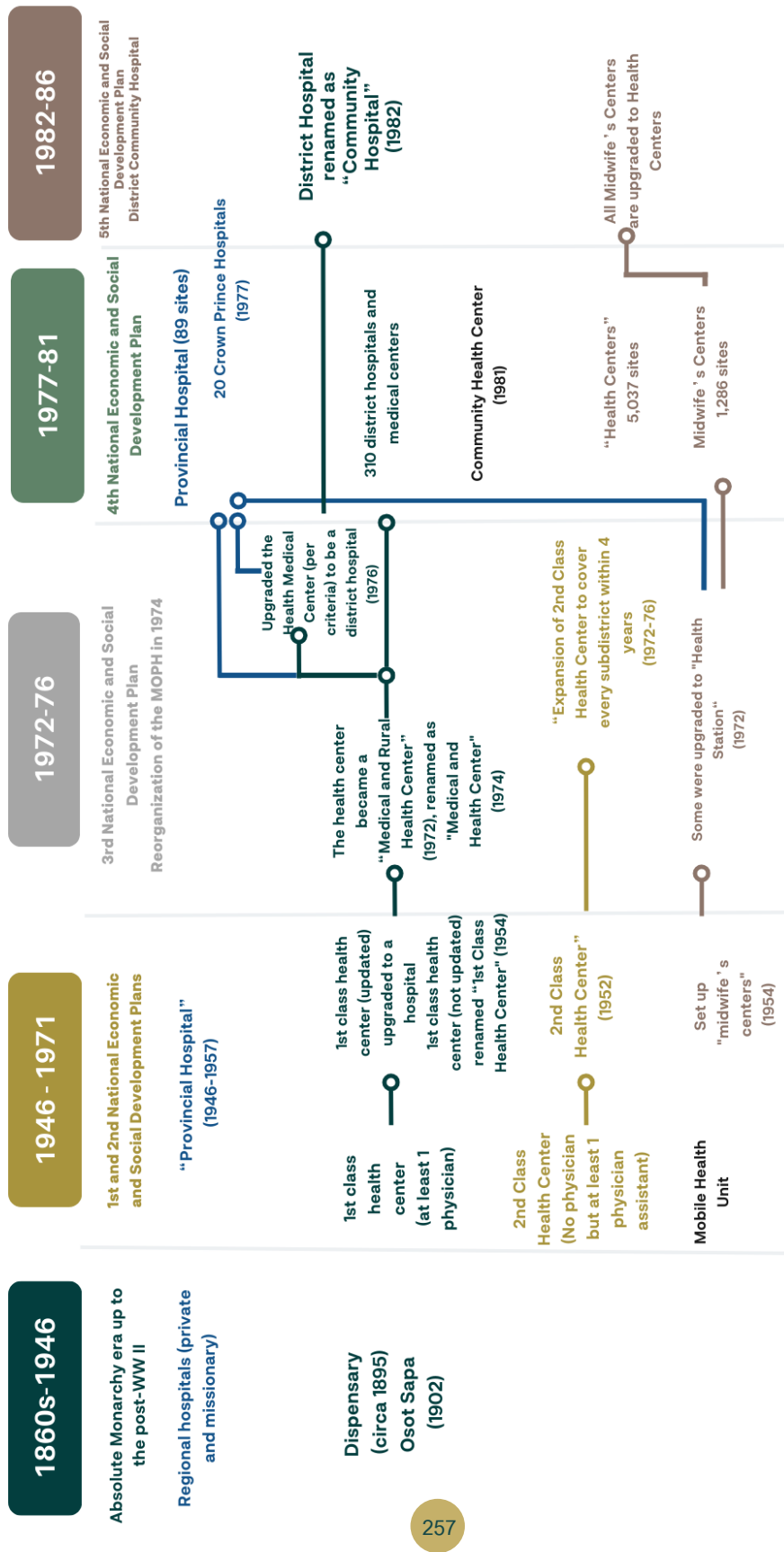


Figure 72 Diagram of the transformation of service facilities into community hospitals and health centers

Source: Compiled by Authors



Figure 73 Image of the Midwifery Center, Nakhoo Subdistrict, Kuchinarai District, Kalasin Province.

Source: National Archives of Public Health, (13) B.NEG S2.1-29.2, Ministerial Inspection Mission to the Northeast, 1979.



Figure 74 Image of second-tier Health Center, Nong Ruea Subdistrict, Khon Kaen Province.

Source: National Health Archives of Public Health, (13) B.NEG S.2.1-29.2, Ministerial Inspection Mission to the Northeast, 1979.





Figure 75 Image of the first-tier Health Center, Selaphum District, Roi Et Province.

Source: National Archives of Public Health, (13) B.NEG S.2.1-29.2, Ministerial Inspection Mission to the Northeast, 1979.

Figure 76 Image of Health Office in Roi Et Province.

Source: National Archives of Public Health, (13) B.NEG S.2.1-29.2, Ministerial Inspection Mission to the Northeast, 1979.



By 1987, there were 557 community hospitals and 89 branch hospitals, with a total of 7,649 health centers and 478 community health offices in rural and disaster-prone villages in remote areas at elevated risk. Overall, it was discovered that, between 1967 and 1987, the number of health centers (including midwifery centers) tripled, and the number of hospitals under the jurisdiction of the MOPH increased sixfold.⁴¹ When comparing the above data between 1981 and 1987, the number of community hospitals increased by 247 and the number of health centers increased by 1,326. Eventually, by 1992, the “Decade of Health Center Development” project was initiated with the goal of establishing 1,400 new health centers between 1992 and 2001, as well as enhancing the capacity of existing health centers to become larger-sized health centers.⁴²

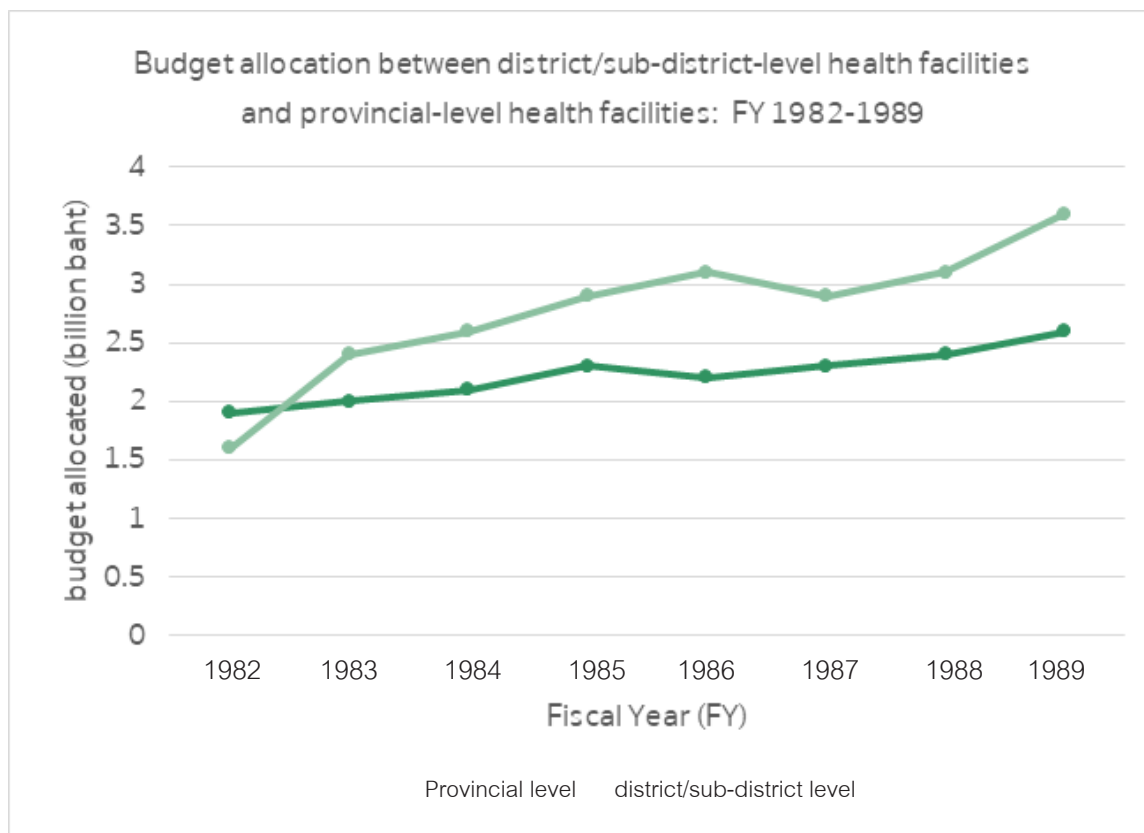
C. Turning point in budget allocation and community hospital development

While the development of community hospitals had its significant roots from the original service units in the past, when considering the fundraising project to establish 20 Crown Prince Hospitals, a crucial issue in expanding community hospitals becomes evident. This issue is the budgetary constraints, especially during a period when Thailand was facing economic downturns. The approach suggested by Dr. Sem Pringpuangkeo, the Minister of Public Health at the time, to address this problem was to maintain the distribution strategy of district and sub-district-level healthcare facilities, along with redistributing the budget from urban and provincial hospitals to district and sub-district levels.

This policy led to a scenario where between 1982 and 1989, the healthcare services at the district and sub-district levels received a greater allocation of budget and various resources than provincial-level healthcare services. Although the provincial-level budget increased each year, it grew at a slower rate compared to the budget allocated for district and sub-district facilities. The conflict over “budget reallocation” to district and community areas had an impact on large hospitals in Bangkok and provincial levels. A prime example that illustrates this was the project to construct a new building for Lerdsin Hospital with a budget of 500 million baht. This was used for comparison, suggesting that the same budget could have been used to build up to 50 community hospitals. Accordingly, the Lerdsin Hospital building project had to be put on hold. This demonstrates that throughout the 5th Development Plan (1982-1986), large hospitals and provincial hospitals were not considered for budget allocation to expand their bed capacity at all.⁴³ In order to redirect the government’s focus towards community hospitals by allocating a substantial budget to rural areas, as described by Komol Chobchurnchom, former Deputy Secretary-General of the National Economic and Social Development Council, the atmosphere during the execution of this task was recounted as follows: “*The mechanism of decentralization was to not allocate budgets extensively [to provincial hospitals]... The policy that was already in place was to emphasize primary care over secondary/tertiary care. Thus, we requested the MOPH to adjust the budget according to the government’s policy.*”⁴⁴

Table 6 Budget Allocation Distribution between District and Sub-District Level Public Health Services and Provincial Level Public Health Services, Fiscal Years 1982-1989.

Source: Adapted from "Rural Doctor good governance and health politics," Page 105.



Nevertheless, the budget reallocation to rural areas according to the 5th Development Plan continued to be a contentious issue that led to dissatisfaction between physicians in regional/general hospitals and physicians practicing in community hospitals across various rural regions. One aspect of this was the redirection of provincial hospital budgets towards community hospitals, resulting in physicians in community hospitals having more budgetary resources to develop their service systems than before. Meanwhile, physicians in larger hospitals felt that regional and general hospitals had an increasing workload and expenses compared to community hospitals. Despite this, community hospitals ended up receiving a proportionally greater budget increase.⁴⁵

Dr. Suwit Wibulpolprasert pointed out that the expansion of medical and public health facilities resulted in increased accessibility to services for rural populations. This was most evident through the statistics of service users at the district and sub-district levels. Concurrently, the proportion of people going to the provincial hospital as the first point of care decreased. This was due to the policy of not expanding hospitals in urban areas, but rather adopting a strategy to distribute budget resources to expand healthcare services in rural areas between 1982 and 1986.⁴⁶ Even though in the decade after 1987 the hospital bed-to-population ratio, as well as the healthcare personnel-to-population ratio showed an overall improvement throughout the country, the disparities between Bangkok and the regional areas remained a prominent shortcoming of the system, illustrating the unequal distribution of resources and the persistence of medical technology disparities in society.⁴⁷



In sum, during the 1970s-80s era, or when considering the timeframe of the 5th National Economic and Social Development Plan between 1982-1986, it can be observed that the political instability arising from the communist insurgency continued to be a factor causing concern for the government. This prompted the government's focus to remain on addressing the issue of inequality, particularly between urban and rural areas. This situation led to the inception of the "New Rural Development" policy aimed at accelerating the improvement of the quality of life for rural populations, encompassing healthcare services and enhancing living standards, as indicated in the 5th Plan. Due to this, the healthcare development policy in the 1977-86 decade adopted the principles of "basic minimum needs" (BMN) and construction plans for community hospitals and health centers in every district. This was intended to enable preventive healthcare services to reach the people, concurrently with accelerating the establishment of an inclusive healthcare system.

The concept of BMN emerged to seek methods of measuring the poverty level of villagers, aiming to fulfill the basic elements of life according to the needs of each community and area. These principles incorporated the problems pervasive in society such as “ignorance, poverty, and illness” encompassing knowledge, economics, and health. Coupled with Buddhist economics, these concepts were employed to design solutions for issues of inequality and disparity. The framework for measuring BMN was diversified and developed in the initial stages of implementation.

Nonetheless, the “Nakorn Ratchasima Integrated Development Project,” later known as the “Korat Development,” utilized the BMN concept in practice. The success of the project was facilitated by cooperation from various sectors in Nakorn Ratchasima Province, including medical personnel and public health officials at various levels, ranging from provincial public health officers to hospital directors and physicians from four pilot-site hospitals. Officials from different levels were brought together in a collaborative effort of four ministries, including students and volunteers. The project’s success allowed the adaptation of BMN principles and the identification of 8 principles and 32 indicators that subsequently served as a model for developing BMN in other provinces across the country.

Parallel to the development of BMN, the “Construction Plans for Community Hospitals and Health Centers in Every District” was another campaign that the government used to rectify societal inequalities between urban and rural areas. The acceleration of community hospital construction or the development of health centers in every district aimed to provide fundamental healthcare services (primary care) and expand healthcare access for villagers. This resulted in the phenomenon of “slowdown” in the development of provincial hospitals and general hospitals in urban areas, while the budget “flowed” toward building hospitals and upgrading health centers at the district level for enhanced health services. This ultimately led to a significant increase in the number of district-level healthcare facilities, still observable in the present era.

It can be concluded that the healthcare direction in the 1977-86 decade not only helped address the issue of overall societal inequality but also played a significant role in shaping healthcare services. These efforts contributed to the development of the “Health Security Concept,” which is a method of “uplifting” equality to be realized in the future. Therefore, understanding the ideas and foundational elements of the Thai social healthcare system, especially its development during the period from 1977-87, should commence with this background.

Figure 77 General Prem Tinsulanonda, the Prime Minister, inaugurated the Bua Yai Hospital on February 26, 1983.

Source: National Archives of Public Health, (13) B.NEG S.2.1-38.28, Volume 1, Roll 21, Prime Minister and Cabinet Ministers Open Bua Yai Hospital, Nakhon Ratchasima, March 23, 1983. Photograph by Boonlert.



Figure 78 General Prem Tinsulanonda was greeting the villagers who came to attend the hospital opening ceremony.

Source: National Archives of Public Health, (13) B.NEG S.2.1-38.28, Volume 1, Roll 21, Prime Minister and Cabinet Ministers Open Bua Yai Hospital, Nakhon Ratchasima, March 23, 1983. Photograph by Boonlert.

Figure 79 General Prem Tinsulanonda took a tour inside the hospital.

Source: National Archives of Public Health, (13) B.NEG S.2.1-38.28, Volume 1, Roll 21, Prime Minister and Cabinet Ministers Open Bua Yai Hospital, Nakhon Ratchasima, March 23, 1983. Photograph by Boonlert.



Figure 80 General Prem Tinsulanonda, the Prime Minister, inaugurated the Bua Yai Hospital on February 26, 1983.

Source: National Archives of Public Health, (13) B.NEG S.2.1-38.28, Volume 1, Roll 21, Prime Minister and Cabinet Ministers Open Bua Yai Hospital, Nakhon Ratchasima, March 23, 1983. Photograph by Boonlert.

Chapter 9

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¹⁴ Davisakd Puaksom, *Infectious Diseases, Body, and Medicalizing State: History of Medicine in Modern Thai Society*, 286.

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¹⁹ Wiwan Ekarintarakul, “Public Health Administration in Thailand 1958 - 1977,” 84–85.

²⁰ Wiwan Ekarintarakul, 88–89.

²¹ Wiwan Ekarintarakul, 95–96.

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²⁶ Samrit Srithamrongsawat, ‘Proposal for Developing Primary Care Services under the Ministry of Public Health’, 55.

²⁷ Interview with Dr. Winai Sawasdivorn, 16 May 2022.

²⁸ *Crown Prince Hospital Foundation, Crown Prince Hospital: Two Decades of Development*, 59–76.

²⁹ *Crown Prince Hospital Foundation*, 194.

³⁰ National Archives of Public Health, (14) SB 1.4/2.40, “Community Health Station Improvement Project by the Department of Health [1974-1975]”.

“Manual for the Improvement and Expansion of Health Stations” published by the Department of Health 1972-76.

³¹ *Crown Prince Hospital Foundation*, 35.

³² Mahidol University Archives and Museums, MU.OP.A6.1.5 File No. 348, Box No. 95, District Hospital Operations (2nd Edition, 1980), Office of the Permanent Secretary, Ministry of Public Health.

³³ Suwit Wibulpolprasert, ed., "25 Years of Rural Doctor Movement in Thailand," 36

³⁴ Ministry of Public Health, Commemorative Publication for the 40th Anniversary of the Establishment of the Ministry of Public Health, 492.

³⁵ Ministry of Public Health, Commemorative Publication for the 40th Anniversary of the Establishment of the Ministry of Public Health, 512.

³⁶ Ministry of Public Health, 497–99.

³⁷ Ministry of Public Health, 501.

³⁸ Amphon Jindawatthana and Suwit Wibulpolprasert, eds., Thai Public Health Assembly 1st Meeting, 269.

³⁹ Ministry of Public Health, Commemorative Publication for the 40th Anniversary of the Establishment of the Ministry of Public Health, 501–505.

⁴⁰ Ministry of Public Health, 239–40.

⁴¹ Amphon Jindawatthana and Suwit Wibulpolprasert, eds., Thai Public Health Assembly 1st Meeting, 145.

⁴² National Archives of Public Health, (14) SB 1.4/2.284, "Public Health Decade Development Project."

⁴³ Suwit Wibulpolprasert, ed., "25 Years of Rural Doctor Movement in Thailand," 36–38.

⁴⁴ Interview with Komol Chobchurnchom, May 15, 2022.

⁴⁵ Racha Phuchong, Nopphanat Anuphongphat, Komatra Chuengsatiansup, Rural Doctor Good Governance and Health Politics.

⁴⁶ Suwit Wibulpolprasert, The Healthcare System of Thailand (Nonthaburi: Health Systems Research Institute, 2001), 14–15.

⁴⁷ Suwit Wibulpolprasert, 24.



The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868-2002

Medical welfare and the Thai
health insurance system in the
decade 1977-87

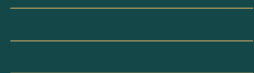




Figure 81 The image of Dr. Amorn Nondasuta, the Permanent Secretary of the Ministry of Public Health, in the ceremony of presenting health cards in Muang Jang Sub-district, Muang District, Nan Province, in 1985. He was the driving force behind the health card project.

Source: National Health Archive of Public Health, (13) B.NEG S.2.1/40.60.1-40.60.2, Letter Archive No. 194/28, Volumes 1-2, Subject: Permanent Secretary presents health cards in Nan Province on September 9, 1985

Due to the specific political context of awakening to the democratic movement, it became the origin of addressing the issues of poverty in order to respond to the needs of the people. It wasn't until the approach of the 1977-86 decade that a new healthcare insurance system emerged. During this period, two separate systems were introduced: the Civil Servants Medical Benefits Scheme (CSMBS) and, in close succession, the health card program in 1983. Both of these systems became important lessons, guiding the progression towards developing a comprehensive healthcare insurance system going forward. When discussing the health insurance system in Thailand since the 1977 decade, it might have its origins traced back to the consideration of the CSMBS introduced in 1980.

Civil Servant Medical Benefit Scheme (CSMBS): Lessons from “fee-for-service” to “capitation system”

The Civil Servants Medical Benefits Scheme (CSMBS) is a health protection benefit provided by the government to civil servants. It extends to retired civil servants as well as family members, including spouses, parents, and children under 20 years old. This system offers extensive healthcare coverage and has the highest budget allocation when compared to other healthcare insurance programs. This is due to its “fee-for-service” expense management approach. Under this approach, beneficiaries of this healthcare insurance system can reimburse expenses paid to state hospitals for any medical service, making it possible to cover all medical procedures.¹ The Comptroller General's Department is responsible for budgeting, controlling, and overseeing disbursements. This is a financial management approach that is easy to administer and involves minimal administrative costs. However, it can result in higher expenditures due to the absence of payment oversight and control mechanisms by the payer.² This civil servant welfare system has evolved in parallel with the development of the government itself. The central issue lies in the fact that the expenses for this welfare do not come from the employer's assets but rather from the national tax budget.³ However, the starting point of the CSMBS did not originate from the idea of providing benefits to all civil servants. Instead, it arose from a mindset aiming to assist specifically those civil servants with low incomes.

A. Path of Civil Servant Medical Benefit Scheme

The healthcare welfare for “low-income civil servants” began in the year 1963 when the Ministry of Finance issued the “Regulations on Providing Aid to Low-Income Civil Servants for Medical Care, 1963.” The essence of this regulation was to provide medical care assistance to civil servants with a monthly income not exceeding 2,650 baht, including family members such as parents, spouse, and children as defined by law, or who had not reached legal age. They were eligible to claim half of the medical expenses paid to healthcare facilities. Medical expenses at that time encompassed “normal medical treatment” and also included costs for special rooms in healthcare facilities, food while in special rooms, surgical expenses,

childbirth expenses, specialized examination fees, blood costs, various medication expenses, as well as body-maintenance medicines as prescribed by physicians, for which healthcare facilities were authorized to charge fees.”⁴ Subsequently, in 1965, there was an addition of a minimum threshold. Civil servants with an income not exceeding 1,200 baht were eligible to claim the actual medical expenses for themselves and their families. Then, three years later in 1968, the previous regulations were repealed, and a new regulation was announced, known as the “Regulations on Providing Aid to Low-Income Civil Servants for Medical Care, 1968.” This new regulation retained the principle of assisting only low-income civil servants, but it adjusted the criteria. Beneficiaries were required to be civil servants whose combined income with their spouse did not exceed 2,750 baht per month.⁵

In 1972, a significant change in the fundamental principle took place, transitioning from assisting only low-income civil servants to assisting both civil servants and permanent employees, as per the “Regulations on Providing Aid to Civil Servants and Permanent Employees for Medical Care, 1972.” The right to claim medical expenses was extended to cover civil servants, permanent employees, and their families without setting a minimum income threshold. However, there were still income criteria that were linked to the amount of assistance to be received. Specifically, those with a monthly salary not exceeding 1,300 baht could fully claim for both in-patient and outpatient care. However, if the income exceeded 1,300 baht, full reimbursement was allowed only for in-patient cases, and half reimbursement was permitted for outpatient cases, including additional expenses for prosthetics.⁶ Subsequently, in 1973, the income threshold was adjusted from 1,300 baht per month to 1,380 baht.⁷ Over the span of the past 10 years, starting from 1963, the criteria for requesting and receiving financial assistance for medical care have been based on the monthly income.

This continued until there was another significant change in the CSMBS with the issuance of the “Royal Decree on Welfare Funds for Medical Care, 1978.”⁸ The introduction of this decree marked a notable shift in the criteria for providing assistance regarding medical care expenses, as it was no longer solely tied to salary thresholds. This implied an “expansion of rights,” encompassing three groups: 1) Civil servants and regular employees who receive salaries or wages from the budget expenditure funds, 2) Foreign employees under contracts that do not specify medical care expenses, and 3) Individuals who are regularly retired or retired with special privileges due to disability as stipulated by the laws governing civil service and armed forces pension. Two years later, in 1980, these regulations were further amended and revised in the “Royal Decree on Welfare Funds for Medical Care, 1980.” This version broadened the scope of civil servants and regular employees who were entitled to clearer healthcare benefits, specifying *“civil servants and regular employees who receive salaries or wages from the budget expenditure funds under the salary and wage categories of ministries, departments, and bureaus.”* Additionally, it included the provision of annual health check-up expenses as part of the healthcare benefits that could be

claimed.⁹ This version became the continuously used criteria for nearly 20 years, until another significant change occurred in 1998. With the consistent upward trend in the budget allocation within the welfare system, the “Royal Decree on Welfare Funds for Medical Care (7th Version), 1998” was issued. This decree introduced measures to reduce the expenses of medical care welfare. For instance, it stipulated that health examinations must be conducted only at state healthcare facilities. Seeking treatment in private hospitals would only be allowed in cases of emergencies or accidents. It limited the reimbursement of medication expenses to only those listed in the National Drug List. It also discontinued the special compensation payments for physicians working outside of regular hours and imposed a cap on room charges for in-patient care, among other changes.¹⁰ All of these changes were aimed at ensuring budget expenditures were economical, efficient, and aligned with the current economic situation.¹¹

B. Although easy to manage, the weak point is it costs more money in the end

Professor Thienchai Kiranandana’s research illustrates that in 1981, there were approximately 1 million civil servants and regular employees (excluding military personnel) covered by the CSMBS. This number increased to 1.2 million and 2 million individuals in 1987 and 1991, respectively, when including military personnel and retired civil servants. However, there is no exact data available regarding the number of family members covered by this welfare program, but estimates suggest it could be around 2-3 family members per civil servant. Therefore, it can be estimated that the CSMBS covered a population of approximately 6-7 million people in 1987. Considering the budget, in 1981, the expenditure for medical care within this system was 988 million baht. This figure rose to 2,801 million baht in 1987 and 5,100 million baht in 1991. Consequently, during this period, the real increase in expenditure showed a growth rate of 21% per year, or from 0.8% of government expenditure in 1981 to 1.5% in 1990. In terms of the overall welfare expenditure, it increased from 8.4% in 1981 to 17.5% of all welfare expenditures in 1990. Therefore, the crucial issue lies in the substantial increase in CSMBS expenditures, despite the relatively minor growth in the number of civil servants and regular employees during the mentioned period.¹²

During the late 1980s, there was an endeavor to reform the CSMBS. This reform initiative was a shared consensus between the Ministry of Finance, responsible for the CSMBS budget, and the group of reform-oriented medical professionals from the Health Systems Research Institute (HSRI). Dr. Somsak Choonharas, the Director, and Dr. Viroj Tangchareonsathien, a researcher at HSRI, played significant roles in driving the CSMBS reform movement. In 1995, HSRI established a working group named the “Advisory Committee for CSMBS Reform” to gather opinions on reforming this welfare system. Dr. Sanguan Nitayarumphong, who was then the Deputy Permanent Secretary of the Ministry of Public Health, was a member of this committee. Other committee members included administrators and experts from the Ministry of Public Health, university academics, and the private sector. Dr. Viroj and the working group served as the secretariat of this committee from mid-1995 to early 1996. The committee convened a total of five

meetings during this period, and the outcomes of these meetings were compiled into a report by Dr. Viroj in 1997, titled “CSMBS Reform: Policy Options.”

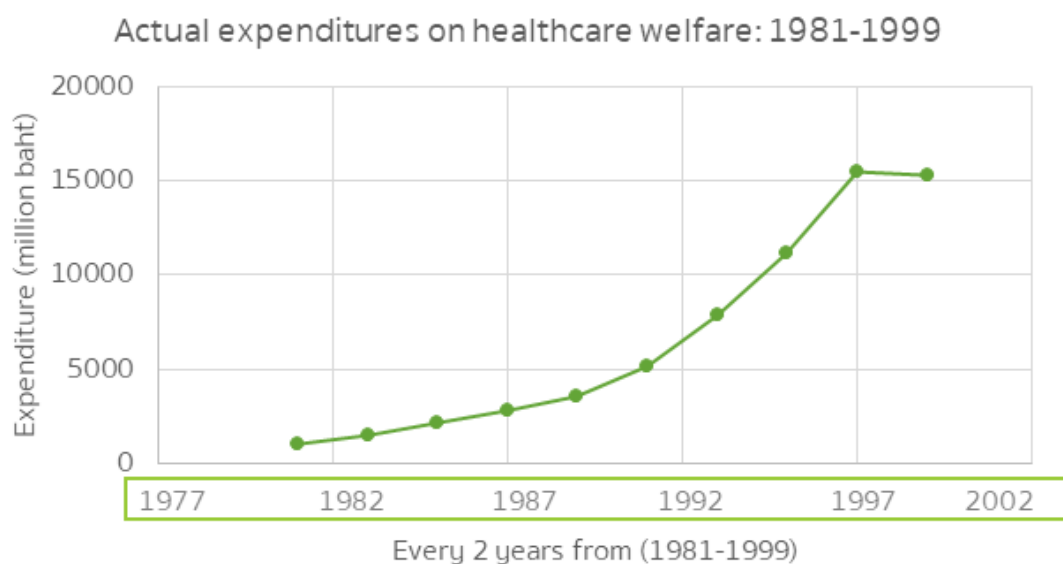
This report highlighted that a critical issue with the civil servant healthcare welfare system was the rapidly increasing and uncontrollable healthcare costs. This escalation was attributed to the fee-for-service payment mechanism that lacked control.¹³ There had been excessive and ineffective use of medications and diagnostic tests, along with instances of fraudulent claims. Lessons learned from various countries’ experiences, such as South Korea, Japan, and Taiwan, which have social insurance systems, indicate that fee-for-service payment mechanisms face challenges in controlling rising healthcare costs. These systems experience resource inefficiencies and high costs associated with evaluating the appropriateness of medical technologies.¹⁴ Dr. Viroj’s analysis reveals that the conditions contributing to the perpetuation of the fee-for-service payment system were difficult to change. These conditions included the lack of awareness among benefit-receiving groups regarding the rapidly increasing budget utilization, leading to a lack of financial incentives for cost-saving. Government officials advocating for the expansion of benefits for civil servants continued to seek opportunities for broader coverage. Civil servants and their families were perceived as a market for private hospitals, particularly in regional areas, leading to increased claims. On the other hand, state hospitals saw the CSMBS as a chance to generate additional revenue outside the regular budget. This was seen as a “supplementary income” to complement insufficient regular budgets. A critical factor was the role of the Comptroller General’s Department in financing the CSMBS. While it was a major purchaser of services, it did not fulfill fiduciary roles such as medical audits, quality assurance, and fraud claim oversight. Ultimately, political sensitivities greatly impacted reform efforts in this welfare system, directly affecting civil servants. Apart from limited awareness among stakeholders about budget constraints, other issues arose during the disbursement process. These included problems with non-congruent claims, attempts to change outpatient cases into inpatient cases to target healthcare expenditure claims, and, importantly, substantial per capita budget and expenditure discrepancies when compared to other health insurance programs.¹⁵

The issues highlighted above demonstrate that both the fee-for-service payment system and the charge-based reimbursement system employed by healthcare providers contributed to excessive healthcare utilization and medical resources. Simultaneously, relevant agencies had not established a systematic process to review hospital billing statements for appropriate disbursement. The Comptroller General’s Department, responsible for program expenses, merely accepted and processed claims. A clear escalation in expenditure is evident between 1988 and 1997. In 1988, expenditures were at 3 billion baht, then doubled to 6 billion baht in 1992, and further escalated to 16 billion baht in 1998. During 1988-1998, expenditure for the program increased by 4.5 times. Aside from the overall increase in costs, hospital charges per visit surged significantly between 1996 and 1997 compared to 1992. In Bangkok,

outpatient case charges rose from 667 baht to 1,172 baht during that period. This heightened cost of the system led to short-term measures to control expenses in 1998. These included limiting reimbursement for nationally listed essential drugs, waiving extra charges collected by healthcare facilities, restricting room and board charges, and excluding private hospital outpatient reimbursement except for emergencies. These measures led to a reduction in outpatient expenses in the private sector, dropping from 1.8 billion baht in 1998 to 788 million baht in 1999. However, a closer look at state hospital outpatient expenses revealed minimal changes. The payment method remained fee-for-service, with no contractual agreements between hospitals and the Comptroller General's Department, no registration for selecting contract hospitals, and no systematic claim audits.

Table 7 Actual Expenditures on Healthcare Welfare, 1981-1999

Source: Adapted from Thienchai Kiranandana, "The Financial Economics of Public Health," (Bangkok: Textbook Development Project, Faculty of Economics, Chulalongkorn University, 1996), 151; Jiruth Sriratanaban, "Healthcare Welfare System for Government Officials: Lessons from Uncontrolled Fee-for-Service Payment" in *Health Insurance System in Thailand*, 2001, 50.



Dr. Viroj's proposal for reforming the CSMBS, as outlined in the 1997 report, emphasizes key goals. The primary objective is to prevent expanding the inequity gap between this program and other state health insurance schemes, while effectively controlling healthcare costs in a suitable manner (cost containment). Quality of care should be maintained while guiding both service providers and patients to use resources efficiently, rationally, and effectively without diminishing the rights of program beneficiaries. Crucially, the reform must align with potential future healthcare system changes or serve as a catalyst for other subsystem reforms. Furthermore, the Comptroller General's Department must adopt a proactive purchaser role, playing a more active role in specifying the desired quantity, quality, and price of services. Its role should extend beyond being a mere financial conduit from the Comptroller General's Department to eligible beneficiaries.¹⁷

It can be observed that from the late 1980s to the early 1990s, there was a continuous stream of research and academic works addressing the issues and reforms of the CSMBS. These works, supported or published by the HSRI, were disseminated in various volumes. Notably, "Reforming CSMBS: A Case Study in 1995" is one such work. This publication stems from the research conducted by Dr. Viroj, which delved into the details of issues related to auditing and guiding the reimbursement processes of CSMBS. Specifically, the research highlights challenges such as the inability to adequately regulate appropriate hospitalization for patients, attempts to shift outpatients to inpatients to benefit from reimbursement, the appropriateness of healthcare costs, and the inability to verify whether hospitalized patients were indeed hospitalized for the stated duration or if the actual number of days matched the claims.¹⁸ The publication titled "CSMBS on the Path to Health - Efficiency - Equity?" published in 1998, is not a research report per se, but a compilation that condenses content from the research conducted by Dr. Viroj.¹⁹ Another report, titled "Reforming CSMBS Phase 2: 1997-1998" by Dr. Viroj, was published in 1999.²⁰ The complete report was submitted to the Ministry of Finance on the topic "Reforming the Healthcare Welfare System for Civil Servants" in mid-2000.²¹

It wasn't until a significant movement for reforming the CSMBS emerged later in 2000, when the Cabinet passed a resolution directing the Ministry of Finance to undertake reform of CSMBS based on the proposal by the HSRI. This proposal included four key components: (1) Utilizing budget caps and disease-based groups for managing inpatient medical costs, (2) Implementing a per-capita payment system for outpatient care, (3) Enhancing regulatory and auditing systems, and (4) Creating a drug pricing list to guide expenditures. The implementation of the Cabinet's resolution commenced following the establishment of the Universal Coverage Scheme (Gold Card). The reform process was initiated by the CSMBS Office in August 2001, and the Central Health Service Informatics Bureau (CHSIB) was established in October as the agency responsible for overseeing the reform.²²

Therefore, due to the constraints imposed by the healthcare welfare system, which is intricately linked to the country's long-term financial stability and political stability, as well as the stakeholders involved, this reform movement led to extensive debates and efforts toward improvement over time. These challenges have transformed into vital lessons that have contributed to the proposition for reform, shifting from a "pay-for-service" model to a "per-capita payment" system. This reform aimed to expand coverage to a broader population while avoiding many limitations that had been experienced in the previous healthcare welfare system. Simultaneously, another system that was previously in place, known as the "voluntary health insurance system," also served as an experience and driving force. It had highlighted certain strengths and weaknesses that contributed to the development of the capitation payment system, which was expected to be significantly more comprehensive and well-rounded moving forward.

Evolution of the Health Card Project: Voluntary Health Card Scheme (VHCS)

The Health Card Project (HCP) was initiated in 1983 through the efforts of Dr. Amorn Nondasuta, as a part of the organization's commitment to implement primary healthcare strategies and promote comprehensive health policies in line with the World Health Organization's guidelines. Initially named the "Maternal and Child Health Fund Project," the Health Card Project was established in the form of a community-financing scheme to enhance maternal and child healthcare (MCH), family planning, disease awareness, and basic medical services. These aspects were fundamental components of the PHC initiative. In its first year, the project was implemented in a limited area, specifically the location of the regional MCH Center, covering 8 sub-districts and 18 villages across 7 provinces: Ratchaburi, Phetchaburi, Khon Kaen, Roi Et, Lamphun, Nakhon Sawan, and Songkhla. The project was initially designed as a 3-year pilot program from 1983 to 1986. After an initial testing phase lasting 8 months, Dr. Amorn Nondasuta was promoted from Director-General of the Department of Health to Permanent Secretary of the Ministry of Public Health. With this appointment, the directive was given to expand the Health Card Project nationwide. Concurrently, the project's scope was expanded to include medical treatment services, and it was officially named the "Health Card Project." The goal was to extend the project's coverage to the sub-district level across the entire country by 1987.²³

A. Initiation of the Health Card Project

The Health Card Project continues to employ a community-based revolving fund management approach, with cards issued to beneficiaries for accessing the project's benefits. There were two types of cards: the MCH Card and the Family Health Card for medical treatment. Each card allowed for a maximum of 8 medical services per year and covered expenses of up to 2,000 baht per service.²⁴ Dr. Siriwat

Thiptharadol, observed the following: “Dr. Amorn Nondasuta initiated the Health Card Project in 1983. At that time, there were already welfare cards for low-income individuals. As for the Health Card Project with a 500 baht limit, it was visionary in its approach, involving community participation in contributions. During that period, the economy was facing a downturn [under the government of General Prem Tinsulanonda]. The value of the baht was decreasing, and there were rumors that government employees might not receive their salaries. The Eastern Seaboard was being developed, marking the gradual beginning of an insurance model.”²⁵



Figure 82 Image of Mr. Marut Bunnag, Minister of Public Health (30 April 1983 – 5 August 1986) (on the left)

Source: National Health Archive, (13) B.NEG S.2.1/33.65, Distributing Health Cards in Chiang Mai, August 1984.



Figure 83 Dr. Uthai Sudsukh (on the right)

Source: National Health Archive, (13) B.NEG S.2.1/33.65, Distributing Health Cards in Chiang Mai, August 1984.

Figure 84 The ceremony was attended by many participants in Chiang Mai, August 1984 (bottom left)

Source: National Health Archive, (13) B.NEG S.2.1/33.65, Distributing Health Cards in Chiang Mai, August 1984.





Figure 85 the campaign slogan, “Dignified, Economical, Affordable, Beneficial for Developing Communities - Everyone Has a Health Card” (bottom right).

Source: National Health Archive, (13) B.NEG S.2.1/33.65, Distributing Health Cards in Chiang Mai, August 1984.

It can be observed that the inception of the Health Card Project began with the policy-setting government officials, rather than being a political policy. Therefore, during the initial stages of developing the health insurance card, two challenges emerged. One was the short-term conflicts between the “political” and “civil servant” factions, as they understood that the Health Card Project might affect the operations of the CSMBS. At that time, Dr. Tertpong Chaiyanant, the Minister of Public Health (1986-1988), was exploring the possibility of expanding the coverage of the CSMBS to encompass a wider population. Another challenge was the lack of understanding between the “policy-making faction” and the “implementing faction.” Hospital and service unit personnel did not agree with the urgency conveyed by the MOPH Permanent Secretary in expediting the project’s implementation to cover all provinces²⁶ Some provinces and service providers were totally opposed to the Health Card Project.²⁷ Although the Project was not yet fully accepted, Dr. Amorn was able to advocate for the inclusion of the Health Card Project in the 6th National Economic and Social Development Plan (1987-1991). This indicated a step towards its official recognition. The plan specified a continuous effort to “expand health card activities in rural areas and initiate work in urban areas, to lead toward future health insurance based on self-reliance...”²⁸

B. Crystallization of voluntary enrollment in health insurance

Subsequently, when Dr. Pairode Ningsanon assumed the role of Permanent Secretary of the Ministry of Public Health (1987-1991), there was a restructuring of the “Health Card Operation Center” into the “Health Card Center” under the supervision of the Ministry of Public Health. The initial director of the Health Card Center was Dr. Prakrom Wuttipong. Later on, all directors of the Health Card Center were individuals who had previously held positions as program directors. On the other hand, the Health Card Center was an unofficial organization and did not have its own budget. The operations of the Health Card Center depended on the policies of the program division and the interest of personnel within the Ministry. This dynamic led to a situation where, after the late 1980s, the Health Planning Division played a crucial role in shaping the direction of the Health Card Project.²⁹ Apart from the structural changes in management, Dr. Pirode also shifted the focus of the Health Card Project towards emphasizing systemic development over rapid expansion. Consequently, the Project in this era adopted a “consolidation of existing areas” approach, wherein ongoing operations were sustained. Opening new areas depended on the readiness of each specific region.

The shift towards systemic development led the Health Card Project to adjust its conceptual philosophy and methodologies. Particularly, it accentuated academic engagement, especially related to the concept of “voluntary health insurance,” which was a topic discussed within the academic community, including university scholars and civil servants in the Ministry of Public Health. Such an intellectual atmosphere prompted the establishment of the “Center for Health Policy Studies” in collaboration between the Health Card Center, the Ministry of Public Health, and Mahidol University. The primary goal was to study the development direction of the Health Card Project towards Voluntary Health Card Scheme (VHCS). In late 1988, there were two academic conferences held to gather opinions from individuals involved in the Health Card Project. The first conference took place on August 18-19, 1988, in Chonburi Province. The key conclusion drawn from these conferences was that the Health Card Project could evolve to become a viable approach to health insurance.



Figure 86 Image of the day when Dr. Pairode Ningsanon assumed the position of Minister of Public Health (1991-1993) and Dr. Athasit Vejajiva assumed the position of Deputy Minister of Public Health (1991-1992).

(Front row, left to right) Dr. Pairode Ningsanon, Dr. Athasit Vejajiva, Dr. Uthai Sudsukh (Permanent Secretary of the Ministry of Public Health).

Source: National Archives of Public Health, (13) C.NEG S.2.2/4.18, Dr. Pairode Ningsanon and Dr. Athasit Vejajiva assume duties, March 1991.

True voluntarism means making risk-sharing a distinct element, such as transparent card prices, card sales management, population coverage, fund management, service cost reimbursements, and studying ways to integrate the Health Card Project into the country's healthcare insurance system, expanding its coverage to both fund members and the number of funds, as well as operational areas to ensure the fund's sustainability in the future. The second conference took place on December 22-23, 1988, aimed at gathering opinions and suggestions from high-ranking officials within the Ministry of Public Health, the Ministry of Interior for improving the Health Card Project. This conference demonstrated differing perspectives on the project's development. One side believed that health insurance and community development should be integrated, while the other side saw community development as merely a tool to expand the reach of health card purchases. Nonetheless, the shared conclusion was that at the national level, the primary objective of the Health Card Project should revolve around "health insurance."³⁰

In 1989, Dr. Somsak Vorakamin, the Permanent Secretary of the Ministry of Public Health (1988-1990), who succeeded Dr. Pairode Ningsanon, assigned an evaluation of the Health Card Project to the Planning Division under the supervision of Dr. Sanguan Nitayarumphong. During this period, Dr. Somsak invited academic experts like Emeritus Professor Dr. Thienchai Kiranandana to participate in the evaluation of the Health Card Project, which eventually culminated in the publication of a report titled "Evaluation of the Health Card Project, Ministry of Public Health."³¹ Professor Thienchai Kiranandana reached a positive conclusion, acknowledging that although the Health Card Fund had decreased in certain areas, in some regions, the status of the Health Card Fund was managed satisfactorily and effectively. He highlighted a significant point to consider: "[The Health Card Project] *can motivate people to participate in healthcare, introducing the concept of co-payment for services provided by the state. It's a situation where the state provides services, but people pay to ask what they receive in return. This has economic and psychological implications... Thus, having a co-payment element is a crucial key.*"³²

Nonetheless, apart from the aforementioned project evaluation, the Health Card Project did not gain much significance during the era of Dr. Somsak Vorakamin. This issue led some provincial-level officials to suspect that the project might be canceled. A significant turning point that brought the Health Card Project into the political arena was due to the efforts of an international organization called the "Deutsche Gesellschaft für Technische Zusammenarbeit" (GTZ), or the German Society for International Cooperation. Supported by the German government, this organization's involvement pushed the project into the spotlight of the political arena.³³ During the period of fluctuations in the Health Card Project, representatives of GTZ met with Chuan Leekpai, who was serving as the Minister of Public Health (1988-1989). They requested the support of the Ministry of Public Health to continue the implementation of the Health Card Project. As a result of this, official letters were sent to each province to proceed with the Health Card Project.³⁴ Subsequently, the Health Card Project underwent significant changes in late 1992, following the appointment of Dr. Paichit Pawabutr the Permanent Secretary of the MOPH (1992-1994).

GTZ is considered a part of the international organizations that supported the Health Card Project since its inception in the form of a research project in Chiang Mai Province. GTZ recognized that the Health Card Project's model could be developed into a prototype for use in other developing countries. GTZ's research support for Phase 1 took place from 1984 to 1989, while Phase 2 of the project, which extended the research to four additional provinces (Mahasarakham, Rayong, Surat Thani, and Lampang), occurred in 1989. The selection of research areas was based on the readiness of local administrators in those crucial regions.³⁵ The results of this experience followed a direction similar to the previous seminar (in 1988), emphasizing principles such as risk-sharing, expanding population coverage, multi-level pricing calculation, and enhancing service quality. These efforts aimed to transform the program into a sustainable policy.³⁶

Prior to Dr. Paichit Pawabutr's assuming the position of Permanent Secretary of Public Health (1992-1994), the operations of the Health Card Project were largely stagnant. However, in terms of academic knowledge, the program's development was advancing systematically. As mentioned earlier, the "Health Card Center," though unofficial, was contributing to the planning efforts since it was not an official entity and didn't have its own budget. This situation provided opportunities for the officials of the Planning Division to have a behind-the-scenes role in the health card project's development. One significant figure among the planning division officials was Dr. Viroj Tangcharoensathien, who had just completed his doctoral studies in health economics with a thesis focused on the Health Card Project in Chiang Mai province. This research was supported by the Rockefeller Foundation and was initiated under the guidance of Dr. Prawase Wasi, who was also starting to work within the MOPH's Planning Division.³⁷ Therefore, the concept of developing the Health Card Project in the form of health care financing proposed by Dr. Viroj, Dr. Sanguan, and some personnel from the Planning Division played a significant role in the subsequent development of the Health Card Project in the late 1980s and early 1990s.³⁸

Therefore, the knowledge acquired during the period of 1987-1991 regarding health insurance became the foundation for a significant transformation in 1994, which led to the creation of the "Voluntary Health Card Scheme. (VHCS)" In this scheme, both the government and households contributed 500 baht each, resulting in a shift toward a nationwide revolving fund system. Simultaneously, the benefits of the card were expanded without limitations on the frequency of service utilization or the monetary cap for treatments. The coverage included up to five family members and allowed them to access services at community hospitals without needing referrals from health stations. The expansion and increased benefits during this period were the outcomes of the Ministry of Public Health's Health Card Scheme, which utilized the program as a tool to widen the scope of insurance coverage extensively.³⁹ After the economic crisis in 1997, the demand for participation in the public projects increased due to households having reduced ability to pay. This led to an increase in state subsidies. Originally, the contribution was 500 baht, which was raised to 1,000 baht. However, the number of card sales per year was limited to no more than 3 million.⁴⁰

The target population of the project included individuals whose income exceeded the poverty line but did not receive low-income cards and lacked any form of health insurance coverage. Data from the 1996 survey by the Ministry of Public Health's Policy and Planning Division revealed that the majority of project members aligned with the set objectives. However, 27% of the participants reported having an income of less than 2,000 baht per month, which should qualify them for the project's criteria. Thus, it can be argued that the "Health Card" project served as a "Social Safety Net" for the impoverished individuals who don't qualify for the Low-Income Card Scheme (LICS).⁴¹ Furthermore, the transformed Health Card has become a health insurance card, indicating a perspective on risk sharing.⁴² In this case, it involved sharing the

burden of the risk of falling ill with the state, where the state accumulated insurance premiums to be used for cases in which insured individuals, or cardholders, became sick. **The principle of distribution here was based on the belief that the likelihood of all cardholders falling ill simultaneously was very low, similar to the principle underlying private health insurance.**

The period between 1994 and 1997 saw the most extensive expansion of the project, covering approximately 13.5% of the population.⁴³ However, the Health Card had very limited coverage among the population in Bangkok and its surrounding areas. In Bangkok, it was found that there are three Ministry of Public Health-affiliated hospitals: Nopparat Rajathanee Hospital, Lerdsin Hospital, and Rajavithi Hospital, which are designated to sell health insurance cards. Due to accessibility limitations, the majority of those purchasing cards under the program were patients who were already receiving services at those hospitals, implying that the majority of health insurance card purchasers belonged to high-risk groups and were a financial burden for the hospitals.⁴⁴



Figure 87 Image of the Health Insurance Committee Meeting at the Ministry of Public Health on March 11, 1993.

Dr. Paichit Pawabutr (first image)

Figure 88 Dr. Prateep Thanakitcharoen (third image) participated in the meeting.

Figure 89 Dr. Sanguan Nitayarumphong (third image)

Source: National Archives of Public Health, (13) C.NEG S.2.2/6.29, Health Insurance Committee Meeting, March 1993.

The case of the Bangkok metropolitan area and its suburbs had become an important example that highlighted certain “gaps” within the Voluntary Health Card Scheme. In contrast to other parts of the country, where health insurance cards could generally be purchased at any time, the Bangkok situation presented challenges that were not significantly different. People tended to wait until they were already ill before purchasing the card. Dr Viroj Tangcharoensathien summarized the limitations of the health card quite clearly, stating that *“People who are already sick, have hypertension for instance, only buy the card after they are sick. They don’t buy it this year, maybe not next year either. Only those who are ‘beneficial’*

will maintain their membership. Therefore, financially, it's not sustainable."...⁴⁵ Due to this reason, even though the project's highlight is the concept of "risk distribution," in practice, the endeavor to achieve risk distribution turned into a significant weakness of the Health Card Project. This dynamic hindered the project's aspiration from materializing smoothly.

Moreover, when comparing the utilization rates of the Health Card Project's service users with those of the Thai Social Security insurance program, it was evident that the Health Card project had much higher service utilization rates, even up to three times higher for inpatient care. This issue stemmed from the differences in the population structure of the beneficiaries. In the case of Social Security, the beneficiaries were often in the working-age group, and generally had relatively good health. However, within the Health Card Project, both children and elderly individuals were included. It is important not to overlook the significant trend that individuals with health issues tend to purchase the card more than those in good health.⁴⁶ This fact was evident from the average expenditure figure per card, which stood at 2,700 baht per year, exceeding the cost of purchasing the card at 500 baht, with an additional 1,000 baht being subsidized by the government. These conditions led to other social insurance or health coverage systems having a better risk distribution than the Health Card system. Ideally, there should be a diverse range of participants in the program, not just the population at risk of health issues.

While it is estimated that the expansion of the program was unlikely to reach beyond 15% of the entire population, this prediction was not far from reality. In 2000, there were around 7-8 million individuals who benefited from the MOPH health insurance card system, accounting for about 12% of the total population of the country.⁴⁷ Therefore, one proposal in the late 1990s aimed at achieving the establishment of a healthcare assurance foundation focused on treatment expenses was to adopt a "mandatory" health insurance system, rather than a "voluntary" health insurance approach.⁴⁸ Despite the voluntary health insurance framework not succeeding as initially intended, the experience with "voluntary risk-based insurance" and the program's survival until the late 1990s became valuable knowledge that drove comprehensive health insurance reforms forward. These reforms were careful to avoid retracing the same path. *"Voluntary health insurance is not the way for a country to succeed in achieving comprehensive health coverage... We need to move away from this point. This direction is not applicable, and therefore, a comprehensive health insurance system cannot be voluntary; it must be a right for everyone,"* stated Dr. Viroj Tangcharoensathien.⁴⁹



Figure 90 Photo of people waiting to receive health insurance cards from Dr. Udomsilp Srisaengnam (Deputy Minister of Public Health, 1992-1994 in March 1994 in Samut Songkhram Province)

Source: National Archives of Public Health, (13) C.NEG S. 2.2/7.114, Deputy Minister Udomsilp Srisaengnam handing over health insurance cards in Samut Songkhram, Mar. 1994.



If we consider the transformation of Thailand's primary health insurance system in the late 1980s, it becomes evident that the changes in every insurance system were interconnected, not only directly but also indirectly through the roles of Dr. Sanguan Nitayarumphong, Dr. Viroj Tangcharoensathien, and other reform-minded doctors. An example of this interconnectedness is the emergence of the Social Security Program in the late 1980s. Both Dr. Sanguan and Dr. Viroj played pivotal roles in shaping the system's direction. The experience gained from the Social Security system significantly contributed to bridging gaps and enriching the financial knowledge base for other health insurance systems, including the national health insurance system, in the years that followed. This was especially true for aspects like the "capitation" payment system.

Chapter 10

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³¹ Thienchai Kiranandana, Report on Evaluation of the Health Card Project, Ministry of Public Health (Non-thaburi: Health Planning Division, Office of the Permanent Secretary, Ministry of Public Health, 1990).

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³³ Office of German Technical Cooperation (Deutsche Gesellschaft für Technische Zusammenarbeit - GTZ), started supporting global cooperation since 1975 and later, in 2011, merged with the German Development Service (DED) and the German Foundation for International Development (InWEnt) to become the “Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)”, an organization of the German government, operating on behalf of both public and private sectors in Germany and abroad, including various governments, the European Union, the United Nations, the World Bank, and other funding organizations for sustainable development.

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⁴⁰ Samrit Srithamrongsawat, 92.

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The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868–2002

Budget allocation model
and service delivery system
for the Universal Coverage
Scheme





Figure 91 The image depicts Dr. Sanguan Nitayarumphong while serving as the Assistant Permanent Secretary for Policy and Planning at the Ministry of Public Health and Director of the Health Insurance Bureau, Ministry of Public Health. Also featured are Dr. Paichit Pawabutr and Dr. Prasop Ratanakorn

Source: National Health Assembly Bulletin, (13) C.NEG S2.2/6.93, Government and Social Security Affairs in the National Assembly, September 1994.

Before the establishment of the comprehensive universal health coverage system in 2001, Thailand had four different state health insurance schemes. The first was Low-Income Card Scheme (LICS), initiated in 1975, which later expanded to include the elderly and children under the name Medical Welfare Scheme (MWS) in the early 1980s. The second was the Civil Servant Medical Benefit Scheme (CSMBS), introduced in 1980. The third was the Health Card Project or Voluntary Health Card Scheme (VHCS), launched in 1983. Finally, the fourth and most recent was the establishment of the Social Security Scheme (SSS) in 1990. Each of these systems covered distinct population groups. The first covered low-income individuals, the elderly, and children. The second targeted government employees and their families. The third introduced a health card program for the general population. The fourth, the Social Security Scheme, was for employees of private companies. Each system had its own underlying principles, historical background, responsible agencies, budget sources, and different financial management approaches.

Although the previous health insurance systems were not based on the “comprehensive” principle, they are considered essential components of designing a “universal coverage” system that gradually expands to cover the population in different sectors of the country, albeit gradually. Each system, of course, had its own strengths and weaknesses. There were disparities between those who had health insurance in each system and those who did not. These issues and experiences from various past systems, including the development of the health system in the 1980s, as well as the development of the Social Security Scheme and the Health Care Reform Project during the 1990s, have become valuable knowledge to build upon. These experiences have become the foundation of important knowledge that would be used to further design a comprehensive universal health coverage system in the 2000s and beyond.

Origins of the Social Security System

Thailand had a Social Security Act since 1954 during the time of Field Marshal Pibulsongkram, as the first legal framework. It mandated the establishment of a social security fund through contributions of insured individuals, employers, and the government.¹ However, the aforementioned law was suspended due to significant opposition. Subsequently, in 1972, Announcement No. 103 of the Revolutionary Council was issued, which stipulated the establishment of a fund within the Department of Labor to provide compensation to employees in cases of accidents, injuries, illness, or death arising from work-related activities.² However, it can be said that the emphasis was still more on labor protection rather than social insurance, which has led to this issue being delayed significantly. Although there were attempts to study the principles and feasibility of social insurance again in the early 1970s.³ However, there was not much progress made, until the Social Security Act of 1990 was enacted.⁴ This marked the official establishment of Thailand's Social Security System, with the responsible agency being the Social Security Office. The administration of the Compensation Fund, which had existed prior to this, was transferred to be under the same agency.⁵

The Social Security Fund system was established under the Social Security Act of 1990 to provide coverage for employees in the private sector. It covers seven types of benefits: sickness, disability, death, maternity, child allowance, elder care, and unemployment. The Social Security Fund is funded through contributions from three parties: employers, employees (insured individuals), and the government. The Social Security Office manages the fund using the “capitation” payment method, and was the first health insurance system in Thailand to adopt this approach. This system served as a prototype for the comprehensive health insurance system that was to come a decade later.⁶ The Thai Social Security program covers healthcare under two funds: Treatment for illness/injury due to work-related activities is covered by the Compensation Fund; treatment for illness/injury unrelated to work are covered by the Social Security Fund.⁷ Regarding the Social Security Fund, in the initial period of the early 1990s, the Social Security Office provided coverage to establishments with 20 or more employees. Subsequently, it was expanded to include establishments with 10 or more employees (after 2002), and later extended to establishments with more than 1 employee.⁸ Professor Thienchai Kiranandana, was deeply engaged in academic work related to public health and health insurance systems and conducted research on “Economics of Public Health Financing.” Based on his research Dr. Thienchai proposed that the health insurance within the Social Security System is considered a mandatory insurance system based on the concept of *“average risk exposure, average responsibility sharing among insured individuals.”* *This system aimed to provide coverage for all types of illnesses, and ensures that individuals receiving coverage can access services when needed, regardless of their economic status.*⁹

During that period, the establishment of the Social Security System involved considering two models of medical service payment: The first being the Fee-for-Service model; and the second being the Capitation model. Eventually, the Medical Board opted for the “Capitation” method due to its effective management capabilities. When looking at outpatient numbers with an average annual medical service usage rate of 6 million cases, the CSMBS would require verifying over 6 million payment receipts, which the Social Security Office could not feasibly handle. The subsequent reason was that the Capitation payment method allowed for better “control” of costs compared to the Fee-for-Service model. The Fee-for-Service method often encountered issues where healthcare facilities and patients tended to “give” and “use” services more than necessary, along with problems of falsifying payment receipts and service recipients. The third issue was that the Fee-for-Service model could incentivize the provision of medical services using advanced and costly technologies, resulting in the redirection of the Social Security budget to large public and private hospitals. This led to a shift of healthcare personnel from the public sector to the private sector and exacerbated the concentration of doctors in urban areas. The final reason was the budget constraints, with estimates suggesting that the Social Security Fund might face an annual deficit of around 500 million baht if the Fee-for-Service system were used.¹⁰ Aligned with the research work by Anchana Na Ranong, titled *“Operations and Adaptation of Social Security,”* it can be observed that the Social Security Office opted for this system because it is a cost-effective method of administration that requires

fewer personnel for verifying medical expense reimbursements. Importantly, the Social Security Office can anticipate the costs to be paid to healthcare facilities in advance.¹¹ Therefore, it is not an exaggeration to say that the design of the Social Security system was heavily influenced by the challenges posed by the CSMBS. The financial limitations led to the adoption of the capitation payment method. Several reasons underlie this decision, all stemming from the operations within the CSMBS. These concerns include the worry about overutilization of services, retrospective payment audits, and most importantly, the rapid escalation of expenses within the CSMBS system, which operated on a fee-for-service basis.



Figure 92 The image of the government meeting with the Social Security framework at the Parliament features Dr. Paichit Pawabutr, the Permanent Secretary of the Ministry of Public Health (1992-94), and Boonpan Kaewattana, the Minister of Public Health (1993-95).

Source: National Archives of Public Health, (13) C.NEG S.2.2/6.93, Government meeting with the Social Security framework at the Parliament, September 1993.

Figure 93 The image features Dr. Prasop Ratanakorn, an expert in neurology and psychiatry, and Dr. Thienchai Kiranandana, a prominent economist from Chulalongkorn University, at the government meeting with the Social Security framework at the Parliament.

Source: National Archives of Public Health, (13) C.NEG S.2.2/6.93, Government meeting with the Social Security framework at the Parliament, September 1993.





Figure 94 The image showcases Dr. Viroj Tangcharoensathien, physician and public health economist, and Emeritus Professor Dr. Thavitong Hongvivatana, a notable sociologist from Mahidol University, at the government meeting with the Social Security framework at the Parliament.

Source: National Archives of Public Health, (13) C.NEG S.2.2/6.93, Government meeting with the Social Security framework at the

Figure 95 The image features Mr. Rakkiat Sukthana (Deputy Minister of Public Health, 1992-1993), Dr. Wichai Chokwiwat (Medical Board Member of Social Security), Dr. Udomsak Sirisangnam (Deputy Minister of Public Health, 1992-1994), and Dr. Wichai Chaijitvanichkul

Source: National Archives of Public Health, (13) C.NEG S.2.2/6.93, Government meeting with the Social Security framework at the Parliament, September 1993.



Importance of the capitation system

The “capitation” method is one of the payment models for healthcare services under insurance agreements. This method involves pre-determining a specific amount per insured individual (prospective) over a defined period of time as agreed upon. Capitated funds may be paid to an entity acting as an insurer, an intermediary, or directly to service providers such as physicians or medical facilities. The critical aspect is that the “recipient” of the funds must provide services to the “payer” who has purchased insurance during the agreed-upon period, and the conditions of service should remain unchanged regardless of the volume or quantity of services used during that period. However, the amount of capitated funds over the specified time frame can be adjusted when calculating future insurance premiums or initiating a new insurance agreement. It's important to note that these adjustments should not serve as compensation for services used in previous insurance periods. In sum, the primary rationale behind using the capitation payment model is to control costs and expenses. This approach aims to reduce the utilization of expensive services while encouraging the utilization of lower-cost services of comparable quality.¹²

In the book titled “Fundamentals of the Healthcare Insurance System under the Social Security Act: Proposals and Origins,” Dr. Sanguan Nitayarumphong outlined five different payment methods within the healthcare insurance system before the establishment of the Social Security system. **The first method** is “Payment by Services” or “Fee for Service,” which involves paying for individual medical services used within the CSMBS. The main issue with this payment method is the difficulty in cost control due to the tendency of both healthcare providers and patients to increase service usage, leading to unnecessary services and cost escalation. However, the advantage is that both patients and healthcare facilities are generally satisfied, and overall service quality is better compared to other systems. **The second method** is “Payment by Capitation,” where healthcare facilities receive a fixed amount of money per registered individual for the period of insurance coverage. This method offers clear cost control benefits, but potential drawbacks include reduced service quality as providers might focus on cost-saving measures and essential services only. Hence, the critical requirement is a quality control process to ensure satisfactory service quality. **The third method** is “Payment by Inclusive Day,” where compensation is provided on a per-day basis for hospital stays. While this method may facilitate better cost control, it can also result in lower service quality due to hiring less qualified personnel or using subpar medications. Additionally, there might be a tendency to prolong hospital stays unnecessarily. **The fourth method** is “Payment by Diagnosis,” which involves compensating based on groups of related medical conditions, often categorized as Diagnostic Related Groups (DRGs). Although this method allows effective cost control, it necessitates a standardized quality¹³ control process to ensure uniform service quality. Otherwise, there is a risk of healthcare facilities diagnosing patients with conditions covered by higher payment rates. In some cases, DRGs could potentially stimulate appropriate hospitalization rates. These

various payment methods have their own advantages and disadvantages, with the primary objective being efficient cost control while maintaining acceptable service quality. To address the problem of underservice, which may occur with the capitation payment method, the DRG system also serves as a payment approach for high-cost treatments that is more effective than the current fee-for-service approach used in the CSMBS.¹⁴

The fifth payment approach is the Payment by Global Budget method, which is used in the Low-Income Person Assistance Program. In this method, payments are made as a global budget to various healthcare providers based on predefined criteria. The management and administration of the received budget will be the responsibility of the healthcare facilities. While this system allows for effective cost control, it may result in lower service quality. Therefore, the necessity for quality control processes is crucial. Dr. Sanguan believed that different payment methods have varying impacts on costs and quality. They are also influenced by the behavior of service providers and the attractiveness of healthcare facilities in participation.¹⁵

Considering the health insurance environment in the early 1990s, when this report was created, all five payment methods that Dr. Sanguan has reviewed and pointed out the pros and cons are already used by some Thai health insurance systems. For example, payment by global budget in the Low-Income Person Assistance Program or payment by services or Fee for service in the CSMBS. However, the payment of Capitation and paying in “Diagnostic Related Group (DRG)” is a new proposal that has not been implemented before in Thailand’s health insurance system. However, the emergence of Social Security in the 1990s that capitation and diagnostic groups were introduced. This payment method later became the centerpiece of proposals to improve other health insurance systems, such as the Low-Income Person Assistance Program or CSMBS.

Certainly, in the aforementioned report, Dr. Sanguan proposed that the most optimal payment method to establish a solid foundation for Social Security is the “Payment by Capitation” approach. This is because it...

“

“...enables better cost control and is easier to manage in comparison to other methods... This method of paying compensation per capita is allocated to primary insured healthcare providers based on the number of enrolled individuals in each facility, without regard to the number of enrollees or the severity of their health condition. It ensures that these facilities take responsibility regardless of whether they have a certain number of insured individuals, whether they provide care to severely or mildly ill patients, or whether they provide any care at all due to a lack of patients. This method’s cost control and management are straightforward, but it requires a quality control system for service provision.”

”

However, in this proposal, Dr. Sanguan has also pointed out that the use of the capitation payment system may incentivize the participation of healthcare providers, particularly private facilities, more effectively than the “Payment by Services” approach. Therefore, he suggested that alternative motivators could be considered, such as implementing co-payments if individuals choose private healthcare services, increasing individual contributions, making per-visit payments, or even varying payment rates to hospitals based on their size. The consideration of hospital size is important as larger hospitals tend to have higher service costs.

Another crucial aspect in this report is the “per capita payment amount” that the Social Security Office would need to allocate to healthcare facilities, set at 700 baht per person per year. This figure is calculated from the reasonable cost for outpatient and inpatient care based on studies from 89 MOPH hospitals in 1990. That study found that the average cost for outpatient care per visit was 137 baht, while the average inpatient cost per day was 496 baht. These calculated values were considered along with another dataset, which included the number of service utilizations for both outpatients and inpatients, surveyed by the Ministry of Public Health and the Institute for Population and Social Research, Mahidol University. The study revealed that the number of outpatient visits ranged from 2 to 3 times per year, and for inpatients, it was 0.4 days per person per year. Consequently, the compensation amount for healthcare facilities, when converted into per capita expenditure and adjusted according to the actual operations of 1991, would be around 665 baht per person per year, when compared to the Social Security program

budget of 150 million baht and the estimated 2 million individuals seeking Social Security coverage. This means that the feasible budget allocation would not exceed 754 baht per person per year. Therefore, Dr. Sanguan's proposal for the per capita budget fell within the range of 665-754 baht or approximately 700 baht per person per year.¹⁷

Table 8 Estimation for Healthcare Services per Insured Person, 1990

Source: Adapted from Sanguan Nitayarumphong and Pathom Sawanpanyalerd, "Principles of the Healthcare Insurance System under the Social Security Act, Recommendations and Background, 1994, Page 22."

Outpatient Costs	
Average In-patient Cost	137 baht/time
Estimate 1991	157 baht/time
General population care need	2-3 times/year
Total outpatient costs	471 baht/person/year
In-patient Costs	
Average inpatient costs	496 baht/day
Estimate 1991	555 baht/day
General population care need	0.4 days/person/year
In-patient costs	194 baht/person/year
Total cost per person	471+194 = 665 baht/person/year

The First Steps of the Social Security System

The initial phase of the Social Security system implementation revealed that by April 1991, there were 25,789 participating establishments, rapidly escalating to 30,949 by December 1992. This continued to rise consistently, reaching 55,623 by December 1993 and 65,181 by the end of 1994. Similarly, the number of insured individuals increased swiftly from a mere 2.15 million at the project's outset to 3.87 million by the end of 1992, further growing to 4.62 million by December 1993 and 4.97 million by late 1994. Approximately three years after the inception of Social Security, it became evident that the Social Security Fund was in a strong financial position, with revenue surpassing expenses. This indicated a significant accumulation of funds. By the end of 1994, the fund had accumulated assets of 23,176 million

baht. These figures illustrate the effective financial management approach of the Social Security Fund, utilizing the “Payment by Capitation” model with a rate of 700 baht to registered healthcare providers under the Social Security scheme, proving to be appropriate and efficient in controlling healthcare expenditures.¹⁸ Consequently, it is estimated that the overall financial management of the Social Security Fund exhibits a positive developmental trend. This is due to the fund’s favorable financial status and the likelihood of an increasing accumulation of funds. Meanwhile, the expenses for compensation showed a rising trend, but at a rate lower than expected. Part of this success is attributed to the payment system implemented for healthcare providers at a capitation rate, which allowed them to operate within a cost-containment framework. This system ensured efficient service delivery while promoting competition among both public and private healthcare providers.¹⁹

In terms of the payment amounts, the Social Security Office has continuously developed and adjusted the capitation rates of the Social Security Fund for healthcare providers. Starting from the initial rate of 700 baht per member in 1995, it was increased to 800 baht in 1995. Subsequently, in 1998, the capitation rate was adjusted variably based on the number of insured members and healthcare providers. Specifically, it was raised to 1,000 baht for healthcare providers with up to 50,000 registered insured members and set at 900 baht for those with more than 50,000 registered insured members. However, after 2000, the Social Security Office reverted to a uniform capitation rate for all hospitals, which was 1,100 baht.²⁰ This demonstrates that the operations of the Social Security Fund from 1991 to 2001 consistently maintained a ‘revenue exceeding expenditure’ status, and exhibited a ‘rising’ trend each year, except during the economic crisis of 1997-98, during which there was an adjustment to reduce contribution rates.²¹

Table 9 Performance and Financial Status of the Social Security Fund

Source: Adapted from Anchana Na Ranong and Sornchai Triamworakul, 'Operations and Adaptation of the Social Security Project,' 2002, page 45."

Year	Contributions (million baht)	Compensatory Benefits (million baht)	Compensatory benefits/contributions (million baht)	Income (million baht)	Expenditures (million baht)	Net Income (million baht)	Net Fund Balance (million baht)	Total Assets (million baht)	Fund Assets/ Total Assets (million baht)
1991	2,962	778	26.27%	3,038	785	2,253	2,256	2,256	0.999
1992	6,016	2,057	34.19%	6,273	2,152	4,121	6,373	6,374	0.999
1993	9,358	2,473	26.43%	9,914	2,737	7,177	13,550	13,550	0.999
1994	12,172	3,773	31.00%	13,787	4,060	9,727	23,277	23,784	0.979
1995	12,724	3,991	31.67%	15,500	4,631	10,869	34,024	34,350	0.991
1996	15,234	6,239	40.95%	19,028	6,760	12,268	46,415	47,070	0.986
1997	16,448	10,245	62.29%	21,477	11,045	10,432	56,773	60,677	0.936
1998	10,735	7,637	71.14%	17,605	8,362	9,243	67,567	68,870	0.981
1999	22,471	7,676	34.16%	29,070	8,547	20,523	88,562	88,990	0.995
2000	32,278	10,553	32.69%	38,442	11,754	26,688	115,060	115,772	0.994
2001	34,512	11,223	32.52%	41,459	12,970	28,489	143,298	142,473	0.998

In sum, it can be observed that the cornerstone of the financial system has undergone experimentation across various health insurance systems during the period of 1977-1987 decade. In particular, the knowledge and practical insights from the Social Security system have evolved into a significant solution for progressing towards the establishment of a comprehensive and sustainable health insurance foundation for the Thai population, capable of efficiently managing expenses.²² Nevertheless, it must not be forgotten that there are two other projects that emerged in close proximity to each other, namely the 'Ayutthaya Scheme' and the 'Health Care Reform (HCR) Project.' These projects involved the integration of budget management and the organization of healthcare services, serving as crucial models for future development towards a national healthcare insurance system.²³

Experimentation room for service delivery and budget allocation to the future Universal Coverage Scheme

A. “Ayutthaya Project” (1990)

The “Ayutthaya Project” was officially named the “*Health Service System Development in the Provincial, District, and Sub-district Level*” project. It was an experimental project conducted in the form of action research to develop a model for efficiently connecting healthcare facilities at various levels (Referral System). The project focused on providing holistic care to patients and establishing strong doctor-patient relationships based on the concept of an Integrated Health System. The significant outcome of this project was the emphasis on the importance of “Primary Care” or the grassroots healthcare system development.²⁴ This was the key that led to achieving a comprehensive and high-quality healthcare service goal. The Ayutthaya Project still had Dr. Sanguan Nitayarumphong behind it, and who is referred to as the “prime mover” of the project.²⁵

Placing importance on “primary care facilities” was another source of inspiration that emerged while Dr. Sanguan was studying international health development at the Prince Leopold Institute of Tropical Medicine - ITM in Antwerp, Belgium, during 1983-1984. The significant foundation of this approach was the belief that physicians must have a comprehensive commitment to patient care, addressing both physical and mental well-being, rather than only treating illnesses on an episodic basis. Simultaneously, physicians in primary care units needed to work collaboratively and connect with specialists in higher-level healthcare facilities, functioning as an integral part of the integrated healthcare system.²⁶ In addition to the wealth of knowledge, the ITM in Antwerp also played a pivotal role in driving research projects aimed at developing a prototype healthcare system that emphasized the importance of primary care across various regions globally. This initiative sought to transform healthcare systems in different countries. Supporting the research and development of prototype systems in Thailand was part of the original strategy to expand experimental projects into other regions.

The ITM initially planned to launch such a project in the Philippines; however, the conditions in Thailand were more conducive. This decision was also influenced by the strong relationship between ITM and Dr. Sanguan Nitayarumphong, as well as Dr. Rawinan Sirikanokwilai and Dr. Surakiat Achananuparp, alumni of ITM. These doctors aimed to implement the research project to develop this prototype in Thailand. Upon returning from Belgium to serve in Bua Yai District, Nakhon Ratchasima Province, Dr. Sanguan initiated the first pilot project at the district level, using the Khunhan Hospital area in Khunhan District, Sisaket Province, under the name “Khunhan Project.” In the late 1980s, the project expanded to a provincial level, and the historic Ayutthaya Province was chosen as the experimental area. This choice was made due to its proximity to Bangkok, its ease of communication with the Ministry of Public Health

and the Ramathibodi Faculty of Medicine, and its socio-economic status, which was average for the country (neither extremely rich nor poor). Additionally, it garnered approval from Dr. Tassani Aim-amorn, a physician in Ayutthaya Province at the time.²⁷ This is the origin of the Ayutthaya Project, which began its formation around January 1989.

Therefore, *“academically, the Ayutthaya Project had a strong connection to Antwerp,”* said Dr. Yongyuth Pongsupap, one of the team members who collaborated with Dr. Sanguan to develop the Ayutthaya Project.²⁸ The project has been carried out through collaboration among three parties: (1) ITM Belgium, led by Professors Pierre Merciner, Van Belen, and Wim Debecker; (2) The Faculty of Medicine Ramathibodi Hospital, Mahidol University, represented by Professor Dr. Atthasit Vejajiva, the Dean at that time, and Associate Professor Dr. Surakiat Achananuparp; and (3) The Ministry of Public Health’s Planning Division, under the Office of the Permanent Secretary for Health.²⁹ Representing these parties was Dr. Sanguan Nitayarumphong, who was the Director of the Planning Division, and the research was supported by funding from the European Union (at that time known as the European Community).³⁰ Beyond Dr. Atthasit’s role in negotiations with the Ministry of Public Health, Dr. Sanguan, along with Dr. Surakiat, formulated project proposals and budgets. They were joined by a team of experts and specialists including Dr. Somchai (Rawinan) Sirikanokwilai, Dr. Twaekiat Boonyapaisarncharoen, Dr. Yongyuth Pongsupap, Dr. Sombat Triprasertsuk, and Dr. Suwat Wiriyaopongsukij, who were actively engaged in the ongoing situation.

In terms of conceptual framework, the promotion of primary healthcare system was believed to be a solution to address the healthcare system issues in Ayutthaya Province. This model could potentially address problems in other provinces as well. At that time, evaluating the number and distribution of healthcare centers in Ayutthaya Province revealed that there was a hospital at the central level, 12 community hospitals, and 206 health centers. In the private sector, there were 2 private hospitals with 150 and 60 beds respectively, along with more than 50 private clinics. Although the distribution of healthcare centers seemed to adhere to the policy of decentralization that began in the late 1970s, several problems were identified.

The first issue was that the provincial healthcare system suffered from centralized service delivery at the regional hospital, while the sub-district level healthcare units, which were closest to the people, lacked credibility. As a result, people overlooked the services provided by health centers and sought care at central hospitals. This created congestion at the regional hospital due to the lack of trust in the community and sub-district level healthcare centers, despite these centers being able to provide multiple services.³¹ Each level of healthcare service exhibited a higher degree of competition than complementarity, leading to overlap in responsibilities between hospitals and health centers. **One of the subsequent issues** stemming from the regional hospital’s dominant service role was the lack of quality of

care in primary healthcare units. For example, health centers struggled to establish trust within the community they serve. **The relationship between patients and service providers** was also affected due to the regional hospital's position as the focal point of all healthcare services, from primary to secondary care. This system configuration resulted in poor relationships between patients and service providers, ultimately leading to a decline in service quality. **The swift growth of private sector healthcare units** was another pressing issue, driven by the fact that around 50% of the province's population lacked health insurance coverage at that time. This growth aligned with the expansion of private healthcare services, exacerbating the existing inequities in access to healthcare services. This intensified the problem of "inequity," as not everyone could access private healthcare services. Furthermore, private clinics did not have well-defined catchment areas and failed to build strong relationships with the community.

Addressing the four aforementioned primary issues, the Ayutthaya Project aimed to establish an "Ideal Health Service Model," which integrates healthcare services in a comprehensive manner. This approach focuses on understanding patients' problems holistically and eliminating redundancies between service levels. Hospitals would be responsible for complex cases, while less severe cases should be addressed by local community-based services. Finally, the project aimed to establish strong connections between various levels of service centers to ensure smooth patient referrals. Alternatively, as explained by Dr. Sanguan, *"A patient-centered service system means that physicians at the primary healthcare level or the grassroots level must care for patients personally, know their patients well, take ownership of their patients' welfare, and provide care until recovery, rather than merely treating patients at each visit. To achieve this, effective collaboration between primary healthcare facilities and larger hospitals is essential."*³²

Following the principles outlined above, the foundation of care lies in the design of a primary care service system. The conditions for establishing primary care services include being situated within the community (decentralization), having a limited and appropriate population coverage plan, possessing versatile personnel with multifaceted capabilities (polyvalent), maintaining a facility size that does not hinder the relationship between the community and the service center (minimum package), offering consistent and necessary services to the population (permanent service), and being able to provide accurate advice to guide decisions for onward referrals (family consultation).

However, due to the lack of primary care units that meet these criteria in the urban area of the province, the working group collaborated with local organizations to create a primary care facility within the urban area, known as the "Nakhon Si Ayutthaya Urban Community Medical Center" (Government Clinic). This center was established within the municipal area of Ayutthaya, with a catchment area covering a population of 5,000 individuals. The new public health service system was organized with one practicing

physician providing comprehensive care for patients and families, and a mechanism was established to link this center with the hospital to create a seamless service experience as if they were the same entity. In rural areas, three health centers were chosen in Nakhon Luang District. Teams were formed, and doctors were dispatched to oversee these health centers. A comprehensive health service plan (coverage plan) was devised for the population in the area, aiming to bring the public health service system closer to the level of urban medical centers, albeit without having resident physicians. Meanwhile, in peri-urban areas, two health centers were designated to operate using the same approach as rural areas.³³ In the case of the community medical center responsible for a population of 5,000 people, apart from serving as a primary care unit in principle, it had also undertaken the task of designing a health insurance program for individuals without any existing health coverage. The service fee started at 70 baht and could increase subsequently.

The result of these efforts was the creation of a space where everyone had health coverage. This included individuals eligible for the Low-Income Person Assistance Program, CSMBS, and Social Security, who would receive coverage according to their respective entitlements. Meanwhile, individuals without any entitlements from existing programs were included in the experimental program, receiving healthcare services at a cost of 70-100 baht per medical visit. There was a referral system for severe cases, with the medical center bearing the expenses. In this regard, Dr. Sanguan noted that the experiences from the Ayutthaya project have turned into a crucial lesson for establishing a comprehensive health insurance system, with one of the key aspects being “financial and treasury reform.” This was aimed at eliminating barriers to accessing medical care without financial concerns, whether for minor illnesses treated at local service units or for more serious conditions requiring treatment at larger hospitals. Patients paid the same service fee, adhering to the principle of *“sharing pain and sharing joy.”* (Chalia Tuk Chalia Suk)³⁴ This project came to be referred to as the *“70 Baht: Comprehensive Health Care for All Dimensions and Treatment for All Diseases”* or simply the *“70 Baht: Treating All Diseases.”*³⁵

Therefore, in addition to considering the establishment of a robust primary care service system, the second condition is that an appropriate health insurance model must be introduced. This is based on the fundamental principle that essential healthcare should be a basic human right. Without a healthcare insurance system, the development of strong primary care cannot materialize. *“Primary care and health insurance must go hand in hand; only together can they foster capability and efficiency in the use of public health services.”*³⁶ The two aforementioned conclusions reveal the pivotal milestones that have been set forth through this project. The key findings indicated the establishment of a foundational health insurance principle as a “basic right” for individuals, not just as a form of “welfare” for those in need. The proposals from the Ayutthaya project also emphasized that building a health insurance foundation is not solely a success in itself, but an integral part of bolstering the development of a genuinely high-quality

public health service system. Consequently, the Ayutthaya project became a significant model that was subsequently expanded to numerous areas, under the name of the Health Care Reform Project or the Public Health Service System Reform Project.³⁷ The initial phase of the project was carried out between 1996 and 1999 in five provinces: Ayutthaya, Khon Kaen, Yasothon, Phayao, and Songkhla.³⁸ There were sub-projects in other locations, such as Samut Sakhon, Nakhon Sawan, Nakhon Ratchasima, Phitsanulok, and Bangkok Provinces,³⁹ as well as Ban Phaeo District in Samut Sakhon.

B. Health Care Reform Project (HCR)

Originally, the Ministry of Public Health had been developing proposals for reforming the Thai healthcare system since 1994.⁴⁰ Thus, it was anticipated that the Ayutthaya Project was likely to become a model for healthcare system reform that aligned with the service objectives of the MOPH. This led to the Ayutthaya Project becoming a prototype that was implemented in the Health Care Reform Project (HCR).⁴¹ This represented an elevation in the significance of research and service system development under the joint responsibility of the Ministry of Public Health and the European Union. The HCR project, which was implemented between 1996 and 1999, received financial support from the European Union amounting to 4 million ECUs,⁴² and funding from the domestic Thai budget in an amount equivalent to 60 million ECUs. This involved working within the framework of research and development projects, as well as policy-oriented research, to find a suitable healthcare service model that encompassed efficiency, equity, quality of care, and social accountability. The operational framework was structured into four aspects: policy-level research and development, the development of healthcare service system structures and models in the field, personnel development, and community engagement alongside coordination among various organizations. The reform initiatives defined ten subtopics that required attention, including (1) the healthcare financial and treasury system, (2) healthcare insurance and welfare systems, (3) enhancing the efficiency of public hospitals, (4) developing the quality of primary care services, (5) adapting the roles of healthcare facilities, (6) developing continuous education systems for healthcare personnel, (7) improving and assuring the quality of healthcare services, (8) the roles of the government and private sector in healthcare provisioning, (9) healthcare legislation, and (10) synthesizing healthcare policies.⁴³

One significant implication of transitioning from the Ayutthaya Project to the Health Care Reform (HCR) Project went beyond merely expanding experimental areas. It served to illustrate the concept of “establishing a knowledge foundation,” which had been developed by visionary medical professionals. This knowledge framework involved moving from being a single alternative in system development to becoming a proposition and a reform strategy led by the Ministry of Public Health. One of the strategies that virtually derived directly from the Ayutthaya Project was “health service delivery reform,” which stipulated the need to strengthen primary healthcare facilities, adjust the roles of hospitals to avoid

redundancy, and concurrently develop mechanisms to link various levels of healthcare services to establish an integrated healthcare delivery system.⁴⁴

While the strategies related to building the core health insurance system and extending from the proposals in the Ayutthaya Project were crucial, one that particularly stands out is “health care financing reform.” This strategy aimed to advance collective financing through the creation of a National Health Insurance System. This entailed making everyone part of a fundamental insurance system under the umbrella of one form of insurance mandated by law. In this model, individuals do not directly pay service providers but prepay to the insurance entities that act as purchasers of services. Additionally, other sub-strategies within the HCR Project revealed that the heart of the later “30-baht Project,” which emerged subsequently, had already been identified as a reform strategy for healthcare services prior to this Project. For instance, initiatives such as promoting payment systems like “Capitation Payment” and “Diagnostic Related Payment” (DRG) to replace “Fee for Service” had been implemented to shift the incentive structure of healthcare providers.⁴⁵

During the initial stages of the HCR Project, all five experimental provinces had to work on determining the unit cost for healthcare services at each level of healthcare facility. This was directly related to changing the criteria for budget allocation. Khon Kaen and Phayao were the two provinces that started using the capitation payment system for outpatient care and DRG for inpatient care from the first year of the project. Other provinces were in the process of implementing and adapting to the new budget allocation system as well.⁴⁶ The HCR Project effectively put knowledge organizations into practical action across all areas. This included tasks such as registering the population within the responsible area, developing referral and financial systems for patients referred to larger hospitals, initiating contracts for healthcare service procurement, establishing pooled funds from various sources, and allocating funds to hospitals acting as Main Contractors, among others. Dr. Sanguan later came to the conclusion that these efforts contributed not only to intellectual and capacity-building but also to the establishment of infrastructure. When the 30-baht Project was launched, these areas were able to implement policies more swiftly compared to other regions in treating various illnesses.⁴⁷

Nevertheless, despite the pivotal role of healthcare system development as a foundation for the establishment of comprehensive health insurance, the HCR Project encountered differing opinions during its implementation. Specifically, some team leaders, who were foreign representatives of certain European Union entities, did not fully support the Project. Simultaneously, challenges arose from the evaluation team, which noted that the Project had not achieved its intended goals after a certain period, resulting in the evaluation criteria not being met. However, a new evaluation was subsequently conducted, allowing the HCR Project to continue its operations going forward.⁴⁸

In sum, the progression and lessons from the Ayutthaya Project to the HCR Project are crucial components that have contributed to the design guidelines for establishing a national, comprehensive health insurance system. These are highlighted in the significant book written by Dr. Sanguan during the implementation of the HCR Project, titled *"Reforming the Thai Healthcare Service Delivery System."*⁴⁹ Intentionally written to organize his own thoughts and communicate with relevant parties, the content of this book has become a significant testament to the process of consolidating ideas and developing healthcare systems during the time when Dr. Sanguan was engaged in the HCR project. Many concepts presented in the book have resurfaced in subsequent presentations of the comprehensive health insurance plan to various political parties. One of the issues discussed in this book is the "Five-point Reform Formula," consisting of the following: (1) Unified Financial System: Combining taxation into a fund that guides the service system in a suitable direction, ensuring that even those with limited financial means can access services; (2) Localized Healthcare Facilities Enhancement: Strengthening community-based healthcare facilities and evenly distributing technology, preventing the concentration of resources in urban areas; (3) Patient-Professional Relationship Enhancement: Creating a family doctor system and local facilities capable of providing comprehensive care, improving the connection between patients and healthcare professionals; (4) Human Resources Restructuring: Adapting the workforce to support the new service model; and (5) Creating Societal Awareness: Fostering a collective societal awareness that extends beyond the medical field. These ideas, as presented in the book, offer a valuable insight into the transformation from the Ayutthaya project to the HCR initiative.⁵⁰ This reform formula was further developed and put into practice as an integral part of the comprehensive health insurance system project after 2001.

The pathway toward creating this comprehensive system was a culmination of various events, particularly those in the 1987-1990 period. It involved the agents of change, such as the reform-minded physicians, especially Dr. Sanguan Nitayarumphong and Dr. Viroj Tangcharoensathien, alongside a multidisciplinary team including civil servants, administrators, policymakers, planners, and academics both within and outside the public health sector. These individuals were instrumental in the development of various healthcare systems, and their efforts encompassed a multitude of activities such as learning and analyzing the merits and demerits of existing systems, generating knowledge, advocating policy changes, fostering new system developments, and playing pivotal roles in stimulating and inducing transformations within Thailand's healthcare insurance system, both directly and indirectly.

Of particular note is the path laid by the Social Security System, which provided a pivotal "axis of rotation" that facilitated changes across all of the state healthcare insurance systems. This involved budget management under a disciplined financial system, commonly known as the Capitation payment model. These highlighted issues arising from the rapid budget increase and the consequences of the Fee-for-Service payment model, medication use, diagnostic overuse, inefficiency, and abuse. The

capitation payment system and the payment based on Diagnostic-Related Groups (DRGs) proved to be the most viable solution for Thailand's healthcare insurance system.

Furthermore, the concept of PHC was supplemented by a commitment to reform the entire healthcare "system," leading to the "Ayutthaya Project." This practical research, initiated by Dr. Sanguan, was initially piloted at the district level (Khun Han District, Sisaket Province) and expanded to the provincial level in Ayutthaya Province. This was achieved through collaborative effort involving the Planning Division of the Ministry of Public Health, the Community Medicine Department of Ramathibodi Hospital's Faculty of Medicine, and the Institute of Tropical Medicine, Belgium. This project evolved into the prototype of a comprehensive, community-based healthcare system that emphasized primary care as the main provider of healthcare services to the public. Additionally, an experimental approach was undertaken in fee collection with a single-rate payment model of "70 baht to treat all illnesses," reflecting the philosophy of "shared suffering, shared happiness" for both the community and individuals. This later evolved into the nationwide Healthcare Reform (HCR) Project.



Therefore, the trajectory of change in the healthcare and health insurance systems, coupled with experimental projects aimed at integrating financial, managerial, and service dimensions of the healthcare system, has evolved into an experience to be selected for continuation, improvement, or integration into the structure of the national health insurance system in 2001. Nevertheless, the ambiance of knowledge creation and the push of ideas into practice during the 1980s-90s could not have materialized if the political, economic, and social circumstances did not facilitate it. Thus, this evolution should prompt readers to contemplate the societal context in Thailand and the dynamics of the public health domain during the 1980s-90s in greater detail.

Chapter 11

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⁶ Viroj Tangcharoensathien, Woranan Witthayapipopsakul, Warisa Panichkriangkrai, Walaiporn Patcharanarumol, and Anne Mills, ‘Health System Development in Thailand: Key Foundation for Achieving Universal Health Coverage’, the Lancet (blog), Accessed February 28, 2022, https://www.thelancet.com/pb-assets/Lancet/pdfs/S0140673618301983_Thai.pdf.

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⁹ Thienchai Kiranandana, The Economics of Public Health Finance, 80–81.

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¹⁴ Suphasit Panarunothai, ‘Diagnostic-Related Groups: Development and Benefits in Thailand’ (Nonthaburi: Health Systems Research Institute and National Health Security Office, Ministry of Public

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¹⁵ Sanguan Nitayarumphong and Pathom Sawanpanyalert, *Health Insurance Principles under the Social Security Act: Proposals and Rationale* (Nonthaburi: Bureau of Health Policy and Planning, Ministry of Public Health, 1994), 5–6.

¹⁶ Sanguan Nitayarumphong and Pathom Sawanpanyalert, *Health Insurance Principles under the Social Security Act: Proposals and Rationale*, 20.

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¹⁹ Thienchai Kiranandana, 1996: 89–90; Viroj Tangcharoensathien, Anuwat Supachutikul, Jongkol Lertien-dumrong, “The Social Security Scheme in Thailand: What lessons can be drawn?”, *Social Science and Medicine*, Volume 48, Issue 7, 1999, 913–923.

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²¹ Anchana Na Ranong, 44–45.

²² Sanguan Nitayarumphong, Suphasit Panarunothai, Samrit Srithamrongsawat, *Towards Building Universal Health Coverage* (Bangkok: Superior Printing, 2000), 14.

²³ Supasawad Chardchawarn, *Leader of Practical Wisdom: Dr. Sanguan, the Founder of Thailand’s Universal Health Coverage System* (Bangkok: Office of the Royal Society, 2020), 79.

²⁴ During that time, many still referred to it as the First Line Health Service.

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²⁶ Sanguan Nitayarumphong, *On the Path to Universal Health Coverage* (Bangkok: Matichon Publishing, 2005), 42.; Interview with Dr. Supattra Srivanichakorn, June 21, 2022.

²⁷ Rawinan Sirikanokwilai, Twaekiat Boonyapaisarncharoen, and Yongyuth Pongsupap, *Ayutthaya Project: New Alternative for Universal Health Care*, 20

²⁸ Interview with Dr. Yongyuth Pongsupap, June 7, 2022.

²⁹ Currently, the Planning Division of the Health Department has been elevated to the Office of Policy and Strategy under the Ministry of Public Health.

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³¹ Ayutthaya Research Project and Health Systems Research Institute, “Collective Wisdom of Public Health: Insights from Health System Research,” (Nonthaburi: Health Systems Research Institute, n.d.), 1–3.

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Insights from Health System Research,” 8–10.

³⁴ Sanguan Nitayarumphong, *On the Path to Universal Health Coverage*, 43–45.

³⁵ Sanguan Nitayarumphong, 65.

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³⁸ Thai Government-European Union Cooperation Project, “Strategy for Health care reform project and Progress Report, 1997” (Nonthaburi: Health care reform project, 1998), 20.

³⁸ Suwit Wibulpolprasert, ed., *25 Years of Rural Doctor Movement in Thailand*, 172.

⁴⁰ Suwit Wibulpolprasert, ed., 170.

⁴¹ Sanguan Nitayarumphong, *On the Path to Universal Health Coverage*, 66.

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The ECUS (European Currency Unit) was the currency used within the member states of the European Economic Community (EEC) from 1979 until the development of the European Union (EU) and the adoption of the Euro (EUR) currency.

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⁴⁴ Suwit Wibulpolprasert, ed., *25 Years of Rural Doctor Movement in Thailand*, 170.

⁴⁵ Thai Government-European Union Cooperation Project, “Strategy for Health care reform project and Progress Report, 1997”, 8–9.

⁴⁶ Thai Government-European Union Cooperation Project, “Strategy for Health care reform project and Progress Report, 1997”, 44.

⁴⁷ Sanguan Nitayarumphong, *On the Path to Universal Health Coverage*, 66.

⁴⁸ Interview with Emeritus Professor Dr. Thavitong Hongvivatana, June 15, 2022.

⁴⁹ Sanguan Nitayarumphong, *Health Services Reform in Thailand* (Nonthaburi: National Health Security Office (NHSO), 2004).

⁵⁰ Sanguan Nitayarumphong, *Work and Ideals of Dr. Sanguan Nitayarumphong 's Life*, 68–69.



The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868-2002

Politics, economics, and society in the
1987-96 decade:
A deepening of the concept of “Holistic
Health Care”





Figure 96 The image depicts Dr. Damrong Boonyoen, Dr. Sanguan Nitayarumpong, Dr. Viroj Tanchareonsathien, and Emeritus Professor Dr. Thavitong Hongvivatana at a government meeting discussing health insurance (social security) at the Parliament.

Source: National Archives of Public Health, (13) C.NEG S.2.2/6.93, Government Meeting on Social Security at the Parliament, September 1993.

The diverse healthcare systems that emerged during the period 1977-1987 (including the Low-Income Persons Program, Civil Servants Medical Benefits Scheme, Voluntary Health Insurance, Social Security, coupled with the Ayutthaya and Health Service Reform Projects) would not have come into existence without the influence of the concept of “Holistic Health.” This concept emerged as a result of grappling with systemic issues related to the growth of private hospitals, workforce challenges, budget expansion, or problems stemming from changing lifestyles that affected health. These issues were inherently intertwined with the political, economic, and social structures of Thailand in the 1980s. The complexity of the health dimension thus became the basis for adopting a holistic approach to healthcare. **One crucial idea was addressing public health issues during periods when societal conditions, disease, and ways of life were changing. It is imperative to consider other factors simultaneously influencing people’s lifestyles, such as nutrition, agriculture, environment, natural disasters, financial status, as well as local wisdom and values. These factors contributed to the development of a healthcare system that covered both physical and mental dimensions. This integration necessitated the involvement of knowledge from economics, sociology, and anthropology, which played a significant role in seeking solutions for the multifaceted challenges faced by the healthcare system.**

Another significant legacy of the political, economic, and social context in Thailand during the 1987-96 era, with implications for the movement to reform the healthcare system, is the environmental conditions that propelled the emergence of the “Social Sector” concept. This had an impact on increasing the role of the Civil Society in balancing the power of government administration and business capital. These conditions stimulated the consideration of “human rights,” particularly the “right to access healthcare systems.” Therefore, it is advisable to commence the deliberation from the political, economic, and social context, which constitutes the foundation of the direction for healthcare system reform in the 1987 era.

Expansion and growth of private business and Civil Society

In the decade from 1987 to 1996, a significant political transition occurred when General Prem Tinsulanonda stepped down from his position as Prime Minister after serving for over 8 years. The position of Prime Minister was then passed on to General Chatichai Choonhavan (1988-1991), who was considered the first democratically-elected Prime Minister in nearly a decade. This transition not only marked a change in the Prime Minister’s role but also signified a distancing from the political stage of the military faction, which had controlled the political system since the aftermath of the October 6, 1976 incident, coinciding with the fading shadow of the Cold War. Therefore, the premiership of General Chatichai Choonhavan led to a “reshuffling” of relationships within politics, involving the military, the parliament, the private sector, and civil society organizations.

The government under General Chatichai Choonhavan aimed to reduce the power of bureaucrats and the military, which had been crucial “supports” of the previous government’s tenure. Simultaneously, efforts were made to enhance the power of Members of Parliament and ministers, increasing their authority.¹ It can be observed that individuals not under the influence of the military were appointed to hold positions as ministers in key ministries. For instance, Mr. Chuan Leekpai, a member of the House of Representatives, served as Deputy Prime Minister and Minister of Public Health in General Chatichai’s government. There was also a push for the reduction of military budgets. These policy directions reflect a situation where the military’s role was diminishing. Naturally, civil servants, particularly those from the military faction, were discontented with the government’s diminishing of power that they used to hold.²

The reduction of the military’s political role created space for both the “Business Sector” and “Civil Society” to grow and actively engage in politics since the beginning of the decade from 1987-96. The business sector aimed for a democratic political system where decision-making power lay with the Parliament, while Civil Society sought comprehensive political reforms through amending the Constitution from its roots to rebalance power between the state and society. However, the mechanism of the Parliament proved inadequate to drive the intended political reforms and Constitutional amendments as envisioned by Civil Society. This is because business figures entering politics through parliamentary channels predominantly pursued their self-interests, much like before. Consequently, the outcome resulted in a compromise and the sharing of power between civil servants and business/political figures, from local to national levels. The starting point of the decade from 1987-96 turned out to be a regression of Thailand’s political system to a previous era, which Civil Society saw as unfavorable for pushing forward substantial political reforms.³ Apart from the power-sharing between the aforementioned forces in the political arena, the consequences that followed from this situation also had an impact on the functioning of Civil Society, particularly development organizations or Non-Governmental Organizations (NGOs). This was due to the fact that various state projects were seeking profits through exploiting resources, resulting in detrimental effects on local communities. Under these circumstances, the political landscape of Civil Society, rooted in the belief of “community culture and local wisdom,” had been shaped since the 1980s.⁴ They seized control of the political space outside the framework of the parliament since the beginning of the decade from 1987-96 and their role will become even more significant.⁵

In addition to the separation between the new government and the military, and the collaboration between some bureaucrats and business-political figures, the government implemented a policy called “shifting the battlefield to the marketplace,” which supported trade and led to rapid growth of the Thai economy. The annual budget expanded, and large-scale public infrastructure projects related to economic development emerged, such as roads, ports, and telecommunications. The significant economic growth brought about changes in public health services as well. The overall budget for healthcare in the country

increased. Private hospitals experienced growth, and expenditures on medical services and public health in the country, including preventive health services and medication expenses, also rose. These estimations are based on data from 1987.⁶ It was estimated that by 1991, or within four years, at the conclusion of the 6th National Health Development Plan (1987-1991), medical and public health expenditures in Thailand would amount to 99 billion baht, or approximately 1,774 baht per capita. That rate is close to or higher than that of developed countries such as the United States, Japan, and the United Kingdom. Importantly, for these expenses, citizens still had to bear out-of-pocket costs at the rate of around 73%.⁷ This raised an important question about the method of “allocation” of limited healthcare resources, both human resources and budget, in order to achieve maximum efficiency and fulfill the principle of “equity” in healthcare. With this in mind, the concept of “Health Economics” was employed to guide and formulate healthcare policies that maximize benefits for the population’s health and help address the challenges in healthcare development since the decade from 1987-96 and onwards.

Addressing Health Economics

In reality, it is not that ‘Health Economics’ never appeared in the research and educational landscape of Thailand before. On the contrary, after 1957, there emerged several studies that combined economics with health, although at that time the term “Health Economics” wasn’t explicitly used. For instance, among Thai students studying behavioral science (such as the study of brain function in its early stages) or research related to healthcare systems (highlighting disparities in healthcare facilities between urban and rural areas), there were elements of Health Economics. Similarly, research conducted by international organizations that studied Thailand and published reports related to healthcare systems also contributed to the understanding of Health Economics.⁸ Coupled with the political and economic conditions during the period of 1957-77, these studies weren’t within the focus of policy planners to a significant extent. Part of the reason is that during the era of national development plans, particularly in Development Plans 1-4, changes in policy or structural aspects of the healthcare system were often determined by two main variables: “political climate (both domestically and internationally)” and “professional atmosphere (the need to safeguard professional integrity and professionalism).”⁹



Figure 97 The image depicts a meeting on the topic of Health Economics since the year 1974; the speaker is Dr. Amorn Nondasuta.

Source: National Archives of Public Health, (13) B.NEG S. 2.1/18.29, Public Health and Health Economics Meeting at Chao Phraya Hotel, May 13, 1974.

Even when entering the new development trajectory in the 5th National Economic and Social Development Plan (mid-1980s), Thailand started to integrate the principles of Primary Health Care (PHC) and Basic Minimum Needs (BMN) to address the pressing issues of “ignorance, poverty, and illness” in rural areas. However, it was observed that the healthcare system still appeared not fully responsive to the convergence of economic and health concepts. The intention was to create a successful formula for systematic development. Nevertheless, during the late 1960s and early 1970s, Thailand faced several economic impact factors such as the oil crisis (1974) increasing inflation rates, rural-urban disparities, or currency devaluation policy (during the Prem era), which led to the decline of the national macroeconomy and a continuous rise in state healthcare expenditures. However, applying economic principles to the allocation of healthcare budgets at the household and individual levels remained limited. The majority of the budget was still concentrated on expanding the foundational infrastructure of the state (i.e., district hospitals and health centers). While there were cooperative efforts between the Ministry of Public Health and

international organizations through conferences and consultations regarding the utilization of health economics, it was apparent that the core concepts of health economics were still significantly absent from the 4th and 5th National Economic and Social Development Plans. As confirmed by Dr. Somsak Chunharas:

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“During that time, we designed the healthcare system without the financing dimension. However, the Western countries taught us over time. They believed in economics. The state does a little as well, but it uses the budget effectively... until during the era of Dr. Amorn [Nondasuta] as the permanent secretary [1983-1986], he was a key figure. He liked to provide documents. He used the paper for health system expenditure; documents from the World Bank in 1987, the work of Charles Myers; the study of Thailand’s public hospital system by Professor Somkid Khaewsonthi, Faculty of Economics, Chulalongkorn University; and training courses for district hospital doctors by Professors Dao [Mongkolsamai], Thavitong [Hongvivatana], and Thienchai [Kiranandana]. The Rockefeller Foundation provided funding for four people to work on this. One of them was Dr. Viroj [Tangcharoensathien], who went along.”¹⁰

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Emeritus Professor Dr. Thavitong Hongvivatana and Emeritus Professor Dr. Thienchai Kiranandana, prominent figures in Thai sociology and economics respectively, both agreed that it was due to Dr. Amorn’s encouragement that they became involved in establishing the relationship between economics and public health. Emeritus Professor Dr. Thavitong mentioned: *“Dr. Amorn was actively involved... Dr. Amorn continuously initiated new projects. One of the projects initiated later was the Health Card Project... [At that time], the study of public health required a broad perspective, involving various aspects of sociology. This led to the establishment of the ‘Centre for Health Policy Studies’ (Centre for Health Policy Studies, Faculty of Social Science and Humanities, Mahidol University).”*¹¹ As for Dr. Thienchai, he discussed his role in the healthcare system, saying: *“At that time, Dr. Amorn persuaded me to be a part of the committee for studying and evaluating the Health Card. The committee included Dr. Damrong Boonyoen,, the Office of the Permanent Secretary, and all provincial health offices. It was a significant project.”*¹² From the interviews mentioned above, it becomes evident that changes in the economy, society, politics, as well as the increasing healthcare expenditures had an impact since the late 1970s

onwards. In particular, the medical field, especially the reform-oriented physicians, started to awaken to the knowledge of health economics before others did.¹³ This entailed seeking a fresh perspective to analyze the issues, aiming to provide a pivotal mechanism for shaping public policies, and serving as a framework for healthcare system design, especially concerning budgets that are often intertwined with political, economic, and socio-cultural changes. This approach is consistently interconnected, as evidenced by the influential ideas impacting the trajectory of health insurance system development in the preceding decade.

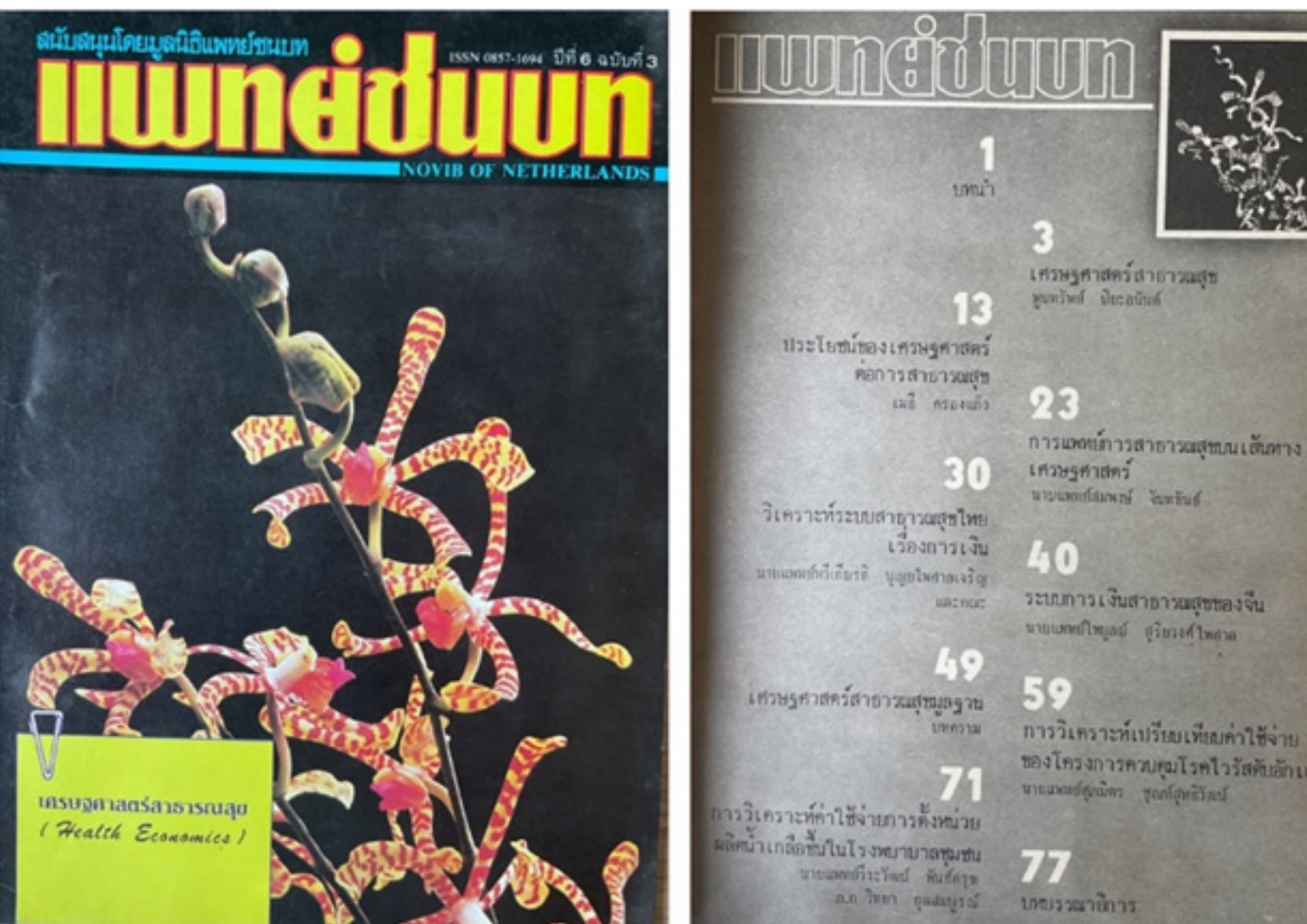


Figure 98 Cover image and table of contents of the Rural Doctor Journal "Health Economics"

Source: National Archives of Public Health, (14) SB 1.5/1.15, the Rural Doctor Journal Year 6 Issue 3.

Therefore, the expansion of the economy, trade, investment, or economic downturns all contribute to the fluctuating nature of Thailand's health issues in accordance with economic changes. The economic dimension consequently impacted the growth of the medical industry and gave rise to various new health system challenges. These can be categorized into economic dimensions affecting the healthcare system and economic dimensions influencing health aspects.

Health crisis due to economic changes

In the past, the Thai government hardly intervened in market systems related to healthcare, resulting in outcomes where market mechanisms expanded without control. This led to issues such as overconsumption of medicines and medical supplies due to continuous increases. Problems related to storage and management policies also arose. As a result, the proportion of healthcare expenses for households and individuals in the private sector was higher than that of the government since the 1980s. Dr. Sanguan reported on a financial assessment conducted by USAID in 1985, indicating that healthcare expenses for Thai individuals receiving services from private healthcare providers were as high as 67%. In many cases, expenses were also incurred for secondary and tertiary healthcare services. However, it should not be hastily concluded that channeling the government budget solely into basic healthcare would not lead to problems.¹⁴ Due to longstanding financial and fiscal management issues that were not integrated into the healthcare system, coupled with the growth of private sector medical businesses (supported by the government), there arose the need to address these issues. In the context of the 6th National Economic and Social Development Plan, there was a genuine intention to incorporate "Health Economics" into the plan for the first time.¹⁵

A. Systemic issues: The expansion of private hospitals alongside health workforce issues

Beyond the realm of state-involved service systems, the direct interaction between the demand for medical professionals and the supply within the market consistently posed workforce-related issues. The root cause of this predicament lay in the separation of healthcare issues from economic matters, leading to further complications. The Thai government's reluctance to intervene in the market relevant to private sector business contributed to a scenario where there were no clear measures to address the arising challenges. Remedies mostly focused on increasing physician production or enforcing cost controls, even though private hospitals remained a significant reflection of the economic disparities between urban and rural areas.

Private hospitals had been expanding continuously in Thailand since 1972, a period that can be deemed as the "boom era" for private hospital growth. The number of private hospitals surged dramatically during this period. From 1972, when there were 120 private hospitals, the count escalated to 252 by 1977, in just

5 years. During this time frame, the government unavoidably lost a substantial portion of medical professionals to private hospitals, due to the higher compensation provided in the private sector compared to the public sector.¹⁶ Subsequently, private hospitals continued to expand continuously, even though there were periods of slight slowdown between 1986 and 1988. However, they quickly resumed their rapid expansion from 1988 to 1992. By 1991, the numbers showed that there were as many as 445 private hospitals. While economic fluctuations did have some impact on the expansion of private hospitals, a portion of this growth was also attributed to state-led efforts to promote investment, such as providing incentives like customs duty exemptions for importing medical equipment.¹⁷ However, mechanisms were not established to control the growth of these private hospitals, due to the prevailing notion that private healthcare facilities would assist in “sharing the burden” with state-run hospitals.¹⁸ Therefore, the expansion of private hospitals in the decade from 1987 to 1996, on one hand, led to a higher concentration of doctors in urban areas and, on the other hand, resulted in urban residents being more reliant on profit-seeking healthcare services. This was the reason behind the increase in household health expenditures.

Nonetheless, a key measure that the state adopted to address the manpower issue was to increase medical production capacity while imposing stringent conditions on newly graduated medical professionals (e.g., compulsory service bonds). Strategies might have varied across different periods. For instance, a period of declining community hospital doctors after 1994 was attributed to a policy that focused on enhancing the skills of doctors using the budget of the Medical Council. As a result, some doctors moved to larger hospitals. Consequently, three years later, the Cabinet approved a budget to support the Collaborative Project to Increase Production of Rural Doctors (CPIRD), aiming to successfully produce the first batch of rural doctors in 2001 (commencing production in 1995). This project was a collaboration between the Ministry of Public Health and the Faculty of Medicine at the university level, with the goal of producing 300 new doctors each year, who would then be deployed to Ministry of Public Health facilities.¹⁹ In the overall context, the Thai economy exerted significant influence on the direction of issues in the healthcare system, such as the growth of private hospitals, workforce attraction, and extending its impact even to health-related problems.

Health-related issues: Shifting the definition from health to “well-being” for holistic health care

The changes in the economy also led to an increase in diseases related to behaviors. Therefore, there was a necessity to employ economic tools to study human behaviors. Furthermore, these diseases often became chronic conditions that required prolonged and costly care. As a result, it became imperative to explore economic strategies to prevent the rise of state healthcare expenses. Dr. Suwit Wibulpolprasert provided

intriguing insights regarding the relationship between economic growth and emerging health issues in an interview with the Komol Keem Thong Foundation in 1987:

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“As times change, there are many factors at play, such as education, living environment, economic conditions, and advancements in medical practices. These factors contributed to the shifting landscape of public health problems. With these shifts in Thailand’s public health landscape, we saw changes in the nature of diseases. Diseases like infectious fevers, which used to be associated with poverty, underdevelopment, and lack of education, started to decline. However, new diseases emerged in conjunction with modernization, economic development, and the transition from rural to urban lifestyles...”²⁰

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The emergence of new issues necessitated a reorientation in managing health-related knowledge. This was accomplished by adopting a foundation based on holistic medicine, combining sociological and anthropological perspectives with medical aspects. For instance, the interest of Dr. Komatra Chuengsatiansup in integrating anthropological insights with medical practice aimed to better understand how communities perceived illness. Additionally, the alignment of socioeconomic viewpoints with public health system development, as demonstrated by the work of Dr. Viroj Tangcharoensathien, sought to provide comprehensive healthcare services and emphasize all-around health care.

Observing the changes in thought patterns that influenced the healthcare system during the decade from 1987 to 1996, it becomes evident that there was a shift from the issues of poverty, underdevelopment, and lack of education, often framed as “stupid, poor, sick” to more complex interpretations. These included considerations of health related to modernity, economics, urban and rural lifestyles, which called for a broader perspective. This also implied that the new objectives of the reform network required the development and transformation of the healthcare system to be in tandem with broader societal reforms, **which encompassed a “redefinition” of health system reform that extended to societal reform at all levels.**²¹ Dr. Prawese Wasi offered his perspective on this matter, stating that Thai society still tended to view health in a narrow and limited manner, focusing solely on hospitals, doctors, or medications. These

components were seen as mere “disease factors” or “health conditions,” rather than embracing the broader concept of “health,” which entails a much more comprehensive sense of well-being. True health should equate to complete well-being, in his view.²² The concept of “well-being” stems from the “Health For All” approach of the World Health Organization (WHO), which defined health broadly to encompass more than just medical treatment. It also encompasses various dimensions, including society, economy, politics, environment, mental well-being, and even political participation and human rights.²³ Therefore, defining the “health system” must encompass well-being in a broad sense as well. It means *“complete well-being encompassing physical, mental, and social aspects, serving as the ultimate goal of life and development.”*²⁴ The components of health and the health system must include factors that exist “outside” the realm of public health, such as social factors, economics, the environment, and politics.

At that time, a significant issue was that both the general population and educational institutions in Thai society perceived health from the perspective of “ill health,” focusing more on treating those who were already unwell rather than paying attention to the concept of “good health.”²⁵ Although Thai society earnestly considered how to promote good health among the population, the benefits of achieving this extended significantly to the overall economy and society of the country, more so than simply addressing ill health issues. As Dr. Viroj Tangcharoensathien summarized, *“Household income, improved living standards, access to clean drinking water, proper sanitation facilities... all are contributing factors to good health. The role of economic and societal determinants is no less important than the determinants related to medical services and public health systems. Conversely, the good health of the population also serves as a crucial factor for economic development and productivity.”*²⁶ Hence, the movement for reforming the healthcare system under the concept of “well-being” since the decade from 1987-96 was not a call for improving healthcare services (Health Care Reform), but rather a demand for reforming the health system (Health System Reform) as a whole.²⁷ This included the underlying understanding that the health and quality of life of the population are closely related to separate developments in the economy and society.



As the political, economic, and social landscapes became increasingly complex, the perspective of medical practitioners alone could solely address the issues within the health system. This necessitated the integration of knowledge from various disciplines to analyze “public health” in order to create a more comprehensive and systematic understanding of health. Clearly, it was not the case that every public health professional shared a single answer directed towards establishing a fundamental right to health as a basic human right. This indicates that reforming the health system could not be easily accomplished when operating under a highly bureaucratic governmental structure.

Nevertheless, as the direction of health system reform became clearer, it led to the development of various practical approaches in healthcare. This is evident through initiatives that intertwined health with human rights, as seen in the Ayutthaya Project (1989), the Health Care Reform (HCR) Project (1994) (mentioned earlier), the establishment of the Health Systems Research Institute (HSRI, 1992), and the Health Center Development Decade Policy (1991-2000) of the Ministry of Public Health.²⁸

While each task may have had distinct objectives and specific strategies in detail, there would always be a “common goal” aimed at finding the best approach to achieving good health. This included ensuring equal access to healthcare services for the population, fostering holistic health knowledge, and developing basic or primary healthcare systems. It can be stated that all these developments would lead to enhancing the capacity for comprehensive healthcare provision to the population. The methods to achieve these aforementioned goals relied on working both “internally” and “externally” within the structure of the Ministry of Public Health.

Chapter 12

¹Uchen Cheangsen, “A History of Kanmuang Phak Prachachon (People’s Politics): The Ideas and Practices of “Political Activists” in the Present,” (Master’s thesis, Faculty of Political Science, Thammasat University, 2013), 91.

²Chris Baker and Pasuk Phongpaichit, *Contemporary Thai History* (Bangkok: Matichon Publishing, 2021), 343-344.

³Chris Baker and Pasuk Phongpaichit, 351-353.

⁴Interview with Professor Professor Saichol Sattayanurak, May 26, 2022.

⁵Chris Baker and Pasuk Phongpaichit, *Contemporary Thai History*, 355.

⁶In the year 1987, healthcare and public health expenditures in Thailand reached 67,771.3 million baht or approximately 1,282 baht per person. The population contributed 73.2 percent of this cost. See Suwit Wibulpolprasert, “Health Economics: A New Strategy for Health Development,” *Health Systems Research Institute*, 2(2) (1994): 92.

⁷Suwit Wibulpolprasert, “Health Economics: A New Strategy for Health Development,” 92.

⁸Thavithong Hongwiwat, Penchan Pradubmook, and Nureehan Youso, “Thai Health Economics: Compilation of Articles and Explanations from the Workshop on Health Economics,” (Nakhon Pathom: Mahidol University, 1986), 179-185.

⁹Observation by Dr. Amorn Nondasuta.

¹⁰Interview with Dr. Somsak Chunharas, May 17, 2022.

World Bank document from 1987 titled “Financing Health Services in Developing Countries: An Agenda for Reform” (B.E. 2530) (1987). Additional information can be found in Akin, John S., Nancy Birdsall, and David M. De Ferranti. “Financing Health Services in Developing Countries: An Agenda for Reform.” A World Bank Policy Study. Washington, D.C., U.S.A: World Bank, 1987.

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Emeritus Professor Somkid kaewsonthi (and Prirom kamolratanakul) studied “Health Economics: Analysis and Evaluation of Public Health Services” (1991).

¹¹Interview with Emeritus Professor Dr. Thavitong Hongvivatana, June 15, 2022.

¹²Interview with Emeritus Professor Dr. Thienchai Kiranandana, May 28, 2022.

¹³National Archives of Public Health (14), Memorandum (14), Letter No. 1.5/1.15. “Journal of Rural Doctor,

Volume 6, Issue 3 (1986)."

¹⁴ Sanguan Nitayarumphong, "Evolution of primary health care in Thailand: what policies worked?" *Health Policy and Planning* 5, no. 3 (September 1990): 252.

¹⁵ Thavithong Hongwiwat, Penchan Pradubmook, and Nureehan Youso, "Thai Health Economics: Compilation of Articles and Explanations from the Workshop on Health Economics," (Nakhon Pathom: Mahidol University, 1986), 167-168.

¹⁶ Netnapa Pokaisawunnumas. "The Loss of physicians from Government Hospitals to Private Hospitals." Social Medicine Master's thesis, (Nakhon Pathom: Mahidol University, 1981), Chapter 2.

¹⁷ Viroj Tangcharoensathien, "Economic/Social Development and Medicine, Thai Public Health: a review," *Journal of Health Systems Research*, Volume 1, Issue 1 (1992), 34.

¹⁸ Viroj Tangcharoensathien, "Census of private hospitals in Thailand in 1992," (Nonthaburi: Health Systems Research Institute, 1997), 1-5.

¹⁹ Choochai Supawongse, "History of Thai Health Development: Analysis of Power Distribution and Impact on Health System," (Bangkok: Health Systems Research Institute, 1998), 45-46.

²⁰ Suwit Wibulpolprasert, "Thai Health Crisis," in Pipop Thongchai, Somthawin Luechapattanaorn, and Thitima Khuntiranon, eds, *From Crisis to a New Dimension of Thai Public Health*, Lecture of the Komol Keem Thong Foundation (Bangkok: the Komol Keem Thong Foundation, 1987).

²¹ Chettha Sapyen, "A Study of the Rural Doctor Movement in the Policy Process of Health System: The Movement of Civil Society and its Contribution Toward Participatory Democracy in Thailand," (Ph.D. thesis, Faculty of Political Science, Chulalongkorn University, 2013), 167.

²² Prawese Wasi, *On the Path of Life: The Rural Doctor Movement in Thailand*, 93.

²³ Chettha Sapyen, "A Study of the Rural Doctor Movement in the Policy Process of Health System: The Movement of Civil Society and its Contribution Toward Participatory Democracy in Thailand," 147.

²⁴ Prawese Wasi, "Reforming for Health System" (Nonthaburi: Health Systems Research Institute, 1993), 2.

²⁵ Prawese Wasi, *On the Path of Life: The Rural Doctor Movement in Thailand*, 61.

²⁶ Viroj Tangcharoensathien, "Economic/Social Development and Medicine, Thai Public Health: a review.", 28

²⁷ Racha Phuchong, Nopphanat Anuphongphat, Komatra Chuengsatiansup, *Rural Doctor Good Governance and*

and Health Politics, 106-108.

²⁸ Komatra Chuengsatiansup and Prachatip Kata, *Primary Health, Primary Care: From Philosophy to New Dimension Health Practice*, 32-33.



The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868–2002

Reforming knowledge within the
health system through “internal” and
“external” structures of the Ministry
of Public Health (The 1987–96
Decade)

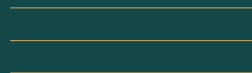




Figure 99 National-level pandemic conference opening event on August 20, 1986, featured Dr. Prawese Wasi, the chairman, sitting at the front row

Source: National Archives of Public Health, (13) B.NEG S.2.1/42.74 (Image No. 406), National-Level Pandemic Conference Opening, August 20, 1986.

The reformation of knowledge within the healthcare system through the “inside” and “outside” structures of the Ministry of Public Health is considered a significant developmental stride for the public health sphere in the 1987-86 decade. This had an impact on the expansion of the “knowledge frontier” and the “reform network” of the healthcare system, which saw the establishment of the Health Systems Research Institute (HSRI), leading to a transformation of power dynamics within the healthcare system that extended to its very core in the mid-1997 period and beyond.

Development of the health system “internally” within the public health sphere

At the time, the amalgamation of the concepts of “rights and freedoms” with “health” was considered a novel idea within Thai society. This was due to the fact that the relationship between the state and the citizens still remained in the form of “welfare provision.” The state had the responsibility to provide benefits to those who lacked financial means or in cases where collecting funds from the public was not feasible (such as in the CSMBS). **As a result, the healthcare service system before the decade from 1987-96 was grounded in the original concept of “state welfare,” which followed a selective approach where the state “chose” to provide welfare based on suitability, specifically targeting populations with limited access to various service levels.**

A. Emphasizing the concept of “Health is a Human Right”: Implementing Holistic Health Care

In reality, the integration of the concepts of rights and freedoms with health grew alongside the idea of social security. Political, social, and economic changes during the latter half of the 1967-76 decade transformed into a rich landscape of societal consciousness. Politics during that period led to various social phenomena, including the establishment of institutional mechanisms for democracy (such as the 1974 Constitution), the ideology of distributing social welfare to disadvantaged sectors, or the formation of organizations to represent the interests of various social groups, such as the Community Organization for People’s Freedom (COPF) in 1973 or labor unions in 1975. Although this new wave of societal movement was marginalized after the events of “Right-Wing Butchery” following October 6, it regained momentum in the 1977-86 decade, becoming a powerful force advocating for labor rights. Eventually, this movement played a significant role in the creation of the Social Security Act in 1990.¹ The Power outside the bureaucratic system reflected the growth of the idea of human rights coupled with the direction of establishing a health insurance foundation. It became a phenomenon that allowed the general population to increasingly have a voice and presence in the path of healthcare system reform.

However, even though the new societal forces emerged, when discussing the issue of “rights and freedoms” alongside “health” before the decade from 1987-96, it remained a concept limited to specific groups. It was possible that the topics of health and public health were still seen as specialized fields that were difficult for the general population to access. The majority of those who addressed the subjects of rights and freedoms in relation to health were often medical professionals, such as Dr. Prawese Wasī² and a group of progressive doctors in the political sphere, known as the “New Force Party”³ along with the group of progressive medical students at that time. Additionally, the volatile political climate, such as the events of October 14, 1973, and the suppression of students in 1976 temporarily halted campaigns for rights and freedoms. Discussions about health related to politics and freedom that the student group and medical professionals used to advocate for during the month of October began to lose significance from the political outskirts.

However, the concept of human rights regained momentum in the public arena again in the 1977-86 decade. Although still under the shadow of military politics, the period of “half-baked democracy” (approximately 1980-1988) which saw reconciliation between the military and Civil Society, allowed political parties, interest groups, and politicians to have roles within the parliamentary system. This prevented the military from unilaterally wielding political power. While this new form of political balance didn’t immediately lead to an immediate increase in political freedom in society, these factors played a role in giving rise to the concepts of rights and freedoms once again.⁴

The gradual transition towards democracy allowed the discourse on rights and freedoms to become more diverse, especially in the decade from 1987-96. For the medical field, this change became evident through the awareness of a certain group of reform-oriented doctors. As Dr. Sanguan Nitayarumphong clearly stated in the “*Six Principles*,” which is considered the “New Dimension of Thai Public Health” in 1987:

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“Good health is a human right that every individual in the world, regardless of their background, should have. Everyone should have equal opportunity to access or achieve good health without discrimination, especially for the underprivileged in rural areas, slums, minority groups, and other groups that have less opportunity in society. Every individual should be guaranteed not only equal access to essential healthcare services but also other factors affecting health, such as nutrition and education. This responsibility not only falls on the government to provide care but also on other relevant groups in society to push for equality.” [Emphasis by the author]⁵

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In addition to presenting the conceptual aspect of “ethical principles,” Dr. Sanguan also elaborated on the practical aspect using the “ethical framework.” He explained in detail how to achieve the intended results, covering all 6 points. The most significant implication is that the attainment of these rights must come with substantial responsibilities. These responsibilities are not confined under the jurisdiction of the state but apply to all members of society, including citizens, governmental organizations, and private sectors. They must collaboratively address issues within a holistic societal context. All sectors need to establish institutional mechanisms to ensure the existence and protection of these rights, which Dr. Sanguan reiterated as follows:

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“Having a security framework for health protection involves essential legislations to safeguard the population, preventing excessive marketization of healthcare. It entails having a National Health Insurance Act that assures every citizen of defined health coverage. Moreover, it involves basic necessities such as access to medical treatment, adequate housing, and other fundamental aspects. These measures are imperative to ensure the well-being of the people and to achieve good public health.”⁶

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The surge in awareness of the intersection of human rights and health within the medical field was partly inspired by doctors who ventured into rural community hospitals. Working alongside non-governmental organizations (NGOs) in rural areas was seen as an opportunity to foster community development. This initiative was considered to be the unveiling of new knowledge frontiers, creating experiences for doctors and NGO practitioners to collaborate in rural settings. This collaborative effort had already been in progress prior to the mentioned period, as exemplified by the experiences of Dr. Supattra Srivanichakorn, the sole female president of the Rural Doctors Society (holding the position 1988-1989). She shared the benefits of working in tandem with NGOs on numerous projects in rural areas, stating that “Learning from the community makes it easier for other sectors to work... Sharing experiences between doctors and NGOs covered various topics during that time.”⁷ In another instance, when Dr. Sanguan left the rural area and resumed duties at the MOPH, he continued to closely collaborate with development NGOs. This consistent partnership included working closely with individuals such as Professor Saneh Chamarik, a prominent figure in the field of human rights and freedom, who was also a driving force behind the Local Development Foundation (LDF).⁸ Supporting community rights to empower resource allocation and sustainable development, from the experience of rural medical groups working and collaborating with various NGOs,

there was a greater clarity in shifting the perspective of “health towards rights.” Simultaneously, the social sector focused on healthcare expanded during the decade from 1987-96.

In addition to interacting with other sectors that accelerated awareness of health-related rights, providing platforms for organizing thoughts and gathering opinions from diverse sectors to address healthcare issues helped professionals in the healthcare sector elevate the system. This enabled medical groups working in various urban and rural areas to strengthen relationships, while also fostering positive connections between medical professionals and non-medical individuals outside the medical field.

B. “Sampran Forum”: Organizing thought frameworks to advance the public health system

Reaching this point, it must be acknowledged that starting from the decade from 1977-86, there was a movement towards reforming the healthcare system in Thai society, closely associated with the roles of medical groups venturing into rural areas to work. This was the case for various associations, including the Rural Doctors' Association, Rural Pharmacists' Association, and other medical professionals. In the subsequent decade from 1987-96, these medical groups, which had previously worked in rural areas, transitioned to work within the MOPH and assumed various important positions in international organizations and within the Civil Society domain.⁹ The important issues within the healthcare system had started to be addressed and could be linked to the structure of the system and public policies. The “Sampran Forum” was utilized as a platform for debates and expressing opinions, which eventually evolved into significant ideas.¹⁰ This led many doctors and participants to begin recognizing the interconnections between health and other events occurring and persisting in society.

The real inception points of the Sampran Forum, indeed, resulted from the impact of a context where rural doctors were separated and reassigned to manage tasks within various agencies. This situation brought about a certain level of “communication breakdown” between them. Naturally, everyone was dedicated to fulfilling their assigned roles and responsibilities. Therefore, it became ordinary not to engage in joint problem-solving discussions as it had been before. Decreased communication at times led to conflicts among members working separately in different units. As Dr. Suwit Wibulpolprasert, the meeting's organizer, explained the origins of the Sampran Forum:

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“It began with [Dr.] Sanguan wanting to use the platform for consultation and discussions. Rural doctors are from various backgrounds, each having their own territory. But when they entered the MOPH, they were grouped differently, each part with its own interests. When in a group, they held onto the group's interests. This began causing differing opinions... which led to the idea of organizing a platform to present positions... It became a forum for exchanging creative learning experiences, though not everyone shared the same viewpoint. However, it wasn't to the point of clashing violently... Once they presented their position, the matter's owners took it in different directions.”¹¹

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These conditions led to the formation of the “Sampran Forum” in 1986, with Dr. Prawese Wasi invited to chair the meeting. Dr. Suwit Wibulpolprasert and Dr. Somsak Chunharas served as the meeting managers in an academic format. Additionally, support was sought from the Thailand country office of the World Health Organization.¹² As time passed, Dr. Sanguan, who was the central figure in organizing the forum, pointed out the benefits gained during the conference. This is because the Sampran Forum has become a platform for joint learning, able to have different opinions rather than being a forum for debate to decide on ideas. Topics discussed in the forum are often topics that members want to know and would like to receive opinions from others. Such process makes *“every party gained knowledge, opinions and turned the suggestions into practice. Often the Sampran Forum brings upcoming matters to discuss together. Some matters become more important when they were discussed.”*¹³ One of the examples that emerged and continued after the discussions in this exchange was the issue of social insurance. This led Dr. Sanguan to play a seminal role in establishing the national healthcare insurance system, starting from the early stages.¹⁴ In each meeting of the Sampran Forum group, there were various participants including senior physicians, rural physicians from central areas, provincial-level rural physicians, community hospital physicians, and groups from universities. Many times, experts, scholars from various fields, social activists, and members of Civil Society were also invited to participate.¹⁵ Due to the diversity of issues and participants, there was a continuous process of linking and adapting ideas to stay in line with global trends.¹⁶ Because the group's meetings linked a wide range of social and political issues, such as government reform, sustainable community development, the impact of IMF policies, public policies, educational reform, and even political reforms, they not only helped structure frameworks of thought for participants but also created connections within a broader network of collaboration. This extended from

the network of medical professionals to academic circles and various other segments of Civil Society. Moreover, the ideas generated from this platform drove societal changes beyond the realm of healthcare, such as the environmental movement, economic aspects, and even politics.¹⁷ It depended on who had the goals and the means to take the feedback further. No one firmly believed that it was the idea of just one person. As Dr. Prawese Wasi summarized the essence of the Sampran Forum: *“The Sampran Group is about us not needing to have identical thoughts. The more differences there are, the more those differences can transform into innovations.”*¹⁸ This led the Sampran Forum to be praised as a “treasury of knowledge” in the field of health, robust and capable of instigating transformative changes within the healthcare system.¹⁹

While the discourse on Thailand’s healthcare system was expanding extensively through the platform of the Sampran Forum, conversely, the professional group of engaged physicians who withdrew from the Medical Council’s arena began to gradually narrow down. This situation resulted from various changes within the public health system, such as the rapid growth of private hospitals, which led a significant number of government personnel to transition to the private sector. As a consequence, the shortage of doctors in rural areas became even more pronounced.²⁰ Most importantly, the conflicts with the Ministry of Public Health escalated, causing the divisions among medical professionals with differing objectives to become increasingly evident. This became particularly clear when considering the context of the Medical Council’s arena during the decade from 1987 to 1996.

C. Rights to health, the role of Medical Council and the changing relationship between physicians and patients

The awakening in health rights and the expansion of healthcare service boundaries led to a continuous increase in assertive demands. Health rights were directly related to defining the concept of “patient rights,” which was one of the discourses created to negotiate the direct relationship between doctors and patients.²¹ Due to the concept that the state should provide welfare (including healthcare services) to all citizens equally and as a right, it was seen as a return of dignity and honor to the people. This differed significantly from the past, where the status of patients had to be proven and measured based on economic conditions in order to qualify for state benefits. Certainly, this egalitarian concept contradicted the traditional belief of the medical profession that focused on “charity” work or what could be called selective welfare.²²

Furthermore, the growth of private sector healthcare services led to the emergence of a “purchasing” culture of healthcare services, where patients expected better services in exchange for the expenses incurred in treatment, rather than considering themselves under a charitable relationship. As private hospitals increased significantly from the decade between 1987 and 1996, the problem of medical service lawsuits brought before the Medical Council also escalated continuously. Statistics indicate that between 1991 and 2007, there were a total of 2,880 cases of medical service complaints filed. The majority, comprising 1,567 cases, stemmed from issues related to “substandard medical practice.”²³

The value of the healthcare service culture might not have been diminished. However, due to the increasing trend of demanding the protection of people’s rights among service recipients, hidden problems became more exposed to the public eye. Historically, it was well-known that doctors held authority over patients’ bodies and health due to their professional knowledge. **Yet, the rise in asserting rights to safeguard benefits led to a resurgence of patient autonomy. Consequently, under this new perspective, the power of service recipients (patients) increased to achieve a balance with the healthcare providers, while doctors felt more constrained due to changing roles and attitudes. Inability to maintain the status quo made them feel “diminished” and “challenged.”**

Furthermore, the concept of “charity” or “equality and equilibrium” also related to the role of rural physicians, who were involved in the Medical Council. This is because rural physicians emphasized balance and disagreed with establishing medical schools within private universities. They advocated for physicians’ ethical conduct to be scrutinized when they face complaints. By contrast, doctors from private hospitals and large state hospitals (e.g., regional and general hospitals) tended to oppose the rural physician approach and believed that doctors should protect each other. These differing perspectives requires tracing back to the policies of the Ministry of Public Health, which aimed to establish community hospitals in every district, thereby distributing healthcare budgets to rural areas. Health services at the district and sub-district levels received more funding compared to provincial-level healthcare services (large state hospitals), starting from 1983 onwards.²⁴ The allocation of budgets from central and general hospitals to rural areas implied that rural physicians had the opportunity to grow and expand their roles in resource allocation across all levels. On the other hand, other groups of physicians, such as those in central hospitals or general hospitals, felt that they could not access resources as they used to. This led to their coming together as a network to negotiate resource allocation issues and to express confidence in the welfare system. This network was named “Federation of Medical Advance/Standard-level Hospital Doctors.”²⁵ This group of physicians gradually entered the competition for positions within the Medical Council starting from the latter part of the decade from 1987-96, aiming to represent physicians in safeguarding their status. They adhered to the traditional service approach that had been in place (selective welfare) and sought to restore the prestige of physicians once again.

D. Dialogues on the stage of the Medical Council

The confrontations on the stage of the Medical Council during the latter part of the decade from 1987-96 resembled a power struggle between the groups supporting the direction of rural doctors and other medical professionals. Prior to this period, rural doctors had started to play a role within the Medical Council since 1978, with two members, Dr. Manit Praphansilp and Dr. Suwit Wibulpolprasert, being elected as committee members. By 1984, other rural doctors had gradually taken up more seats within the Medical Council, including Dr. Wichai Chokwiwat, Dr. Somsak Chunharas, Dr. Choochai Supawongse, Dr. Sanguan Nitayarumphong, and others. During the years 1991-1993, the proportion of rural doctors among the Medical Council representatives was the highest, with 11 out of 16 members coming from the elected committee.²⁶ This reflects the fact that during the early years of the decade from 1987-96, the members of the rural doctors were highly recognized by the physicians within the central power structure.²⁷ Plus, the increasing presence of members representing the rural doctors group as committee members inevitably impacted their role in shaping the direction of the Medical Council's work. At the same time, other physicians such as specialists, medical school professors, private sector physicians, as well as physicians from large hospitals and general hospitals, also formed groups to exert a greater role in the Medical Council.²⁸ The issues that have caused conflicts between private doctors and members of other groups within the Medical Council revolved around two major points. First, there was the opposition to the establishment of private medical schools within Rangsit University.²⁹ Moreover, the standpoint of the rural doctors, who believed that physicians could be held accountable for misconduct, led to the fact that accused doctors could not easily fight their cases. This resulted in members from various medical practitioner groups needing to become more involved in the Medical Council proceedings.³⁰ Subsequently, the proportion of supporters of the rural doctors' approach within the Medical Council began to decrease after 1993, resulting in the Medical Council's role being reduced to only protesting and overseeing the direction of the Council's work.³¹ In addition to losing confidence in professional organizations like the Medical Council, and being unable to expand collaborative efforts within professional groups, significant disruptive factors that necessitated a change in the direction of rural doctor reform emerged. One of the pivotal factors was the pursuit of reform through the governmental system, which did not unfold as anticipated, and led to conflicts with the Ministry of Public Health.



Figure 100 The image portrays a welcoming reception and expressions of congratulations for the Medical Council Committee, term 1993-1995.

Several prominent doctors were present, such as Dr. Choochai Supawongse, Dr. Somsak Lolekha, Dr. Burapha Ratnaratom, Pol. Lt. Col. Chumsak Prueksaphong, Dr. Suwit Wibulpolprasert, Dr. Prasobsri Euengthaworn, Dr. Anong Piankitchakam, Dr. Paichit Pawabutr, Dr. Athasit Vejajiva, Dr. Charan Chaiphat, and others.

Source: National Archives of Public Health, (13) C.NEG S.2/6.111, Medical Council Committee Reception, November 1993.

In several significant incidents, rural doctors were involved in conflicts with the Ministry of Public Health over a period. One of the most notable incidents was related to personnel transfers that were carried out unfairly by individuals in positions of power within the MOPH. Such a case occurred when Dr. Morakot Kornkasem and Dr. Suwit Wibulpolprasert were ordered to be transferred. The first case took place in September 1993 when Dr. Morakot was moved from the position of Secretary-General of the Food and Drug Administration (FDA) to become an inspector-general in the MOPH. This move was seen as a response to his “failure to provide political support” that was hoped to give him influence within the FDA. In response, rural doctors issued statements pressuring the MOPH, viewing this as an event where political figures were intervening in the civil service.³² On another occasion in 1995, Dr. Suwit was transferred again. He was moved from the position of Director of the Bureau of Policy and Planning for Health to the role of Chief Medical Officer of the Ministry of Public Health. This move was prompted by conflicts arising from a bidding competition for the Telemedicine project.³³ This case led to various groups becoming active. Dr. Sem Pringpuangkeo, Dr. Prawese Wasi, and even the president of the Rural Doctors’ Association at that time, all called for a fairer system within the Ministry of Public Health. Both instances highlighted how rural doctors attempted to take a stand against what they perceived as social injustice. Sometimes, this led to clashes with those in power within the MOPH, who were often politicians. These situations often left rural reform-minded doctors disillusioned with attempting to push for healthcare reform through the Ministry’s structures. The distancing from the MOPH was a pivotal moment. In the years leading up to the mid-1990s, rural doctors had worked collaboratively and cooperatively with the Ministry of Public Health. Ultimately, the most intense clash between the rural doctor groups and the Ministry occurred due to a major expose of pharmaceutical corruption and debates about the Patients’ Compensation Act, directly involving lawsuits against doctors.³⁴

The concept of “health rights” had grown alongside rapid economic expansion, along with the political atmosphere prior to the May 1992 events that accelerated and stimulated awareness of people’s rights. Another significant phenomenon influenced by this emerging line of thought was the demand for improvements in the healthcare system’s structure to keep pace with the growing economy and politics, as well as the expansion of knowledge about public health. All of this led to the development of the “outside” healthcare system structure, giving rise to independent knowledge organizations like HSRI, which would have implications for future reform efforts.

Pathways for reforming the health system “externally” outside the public health sphere

The economic expansion during the early part of the decade from 1987-96 (as outlined in the 6th National Economic and Social Development Plan between 1987-1991) and the trend towards business-oriented management became a new hope for the country's development. This hope reflected the prevailing sentiment that Thailand would transform into a Newly Industrialized Country (NIC), following the examples of Taiwan, Hong Kong, South Korea, and Singapore. The economic optimism prompted a reconsideration of administrative approaches within the governmental system, which had been the primary driving force for the country's development over time. However, this situation triggered a wave of criticism in society, suggesting that the governmental system was “sluggish” and hindered the country's progress. The desire for administrative reform thus emerged amid the ongoing momentum of economic growth.³⁵

A. Cultural aspects of the civil service that hinder development in public health

Dr. Prawese Wasi had previously criticized the centralized governmental system which had been a source of problems in Thailand's healthcare sector since the late 1960s. He fervently described it as an *“authoritarian system lacking accountability, where power is concentrated at the central level and hoarded at the highest echelons.”*³⁶ If there hadn't been a reform of the civil service system, the localities would not have been able to become democracies as they were subjugated by the system. Eventually, when the political, social, and economic contexts of the late 1980s provided an opportunity, along with a period during which rural physicians were drawn into central roles more frequently, they observed systemic issues similar to those experienced by senior doctors before. Dr. Prawese then spoke out again about the governmental system, recalling the words of Dr. Sanguan, stating that *“the bureaucratic system destroys the experts.”* Internal issues within the bureaucratic system stemming from administrators and personnel who did not cooperate with Dr. Sanguan were one of the reasons that led him to experience severe and prolonged stress.³⁷

The group of doctors who wished to see changes in the healthcare system believed that if internal changes were to occur within the Ministry's structure, it would require a solid knowledge foundation. To achieve this, they believed in establishing institutions responsible for producing excellent scholars and academic achievements to advance healthcare. This approach would not have to rely heavily on governmental bodies, seen as bureaucratic entities. The organization that initially supported academic endeavors emerged under the name “National Institute of Epidemiology,” sponsored by the Rockefeller Foundation. Dr. Prawese Wasi, who was involved in every event, explained that these mechanisms were crucial in seeking knowledgeable individuals to contribute to healthcare. He compared the mission of the

Rockefeller Foundation, which supported academic work in various countries, with the non-adaptive nature of the Thai bureaucratic system, stating:

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“They govern through knowledge to generate knowledge.

We govern through authority but lack knowledge and don't generate knowledge.

Please observe this carefully. This condition exists almost everywhere, from ministries, departments, bureaus, all the way to universities. Thus, there are various meaningless aspects. People still don't realize the importance of knowledge as much as they should.

If you ask what ‘on the path of life’ attempts to convey, the answer would be: to communicate the significance of the culture of knowledge.”³⁸

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It can be said that the “culture of knowledge” was an influential force in shaping the mindset of Dr. Prawese Wasi and the reform-minded group of doctors. Their efforts to bring about change in the healthcare system culminated in the most ethical form of successful advocacy, leading to the establishment of the independent knowledge-oriented organization known as “HSRI (Health Systems Research Institute).”

B. The establishment of the Health Systems Research Institute (HSRI) as an independent knowledge institution

The efforts of Nualnoi Treerat and Bank Ngamarunchot during the decade from 1987 to 1997 had a profound impact on driving healthcare reform. This resulted in the creation of a powerful “mechanism-tool” for healthcare system reform, known as the ‘family of four organizations.’ These four entities are: (1) HSRI (Health Systems Research Institute) in 1992; (2) Thailand Health Promotion Foundation (ThaiHealth) in 2001, (3) National Health Security Office (NHSO) in 2002, and (4) National Health Commission Office (NHCO) in 2007. These organizations were established to institutionalize healthcare reform proposals, making them stable and enduring. HSRI is responsible for the academic aspect, while ThaiHealth allocates resources to support Civil Society, which is a driving force in public policy. NHSO is tasked with reforming the healthcare system through financial measures, and finally, NHCO promotes the participation of Civil Society.³⁹ Therefore, it is not an exaggeration to say that the direct emergence of these four organizations had significant implications for politics, the economy, society, culture, and the ongoing reform movement since the decade from 1987-96.

On one hand, this is due to the political opportunities that were open for the active participation of Civil Society during the decade from 1987-96. On the other hand, it arose from the disillusionment with attempts to drive reform through state organizations and bureaucratic systems. As Dr Wichai Chokwiwat reflected on the period before the universal health insurance system was established, he noted that *"The evolution of the bureaucratic system cannot truly establish democracy... no matter how much money is poured into it. That lump sum of money can become ineffective and is highly susceptible to corruption and collusion."*⁴⁰ To prevent the healthcare service system from being kicked around within the MOPH again, it was necessary to establish a mechanism that embodies a "relational freedom." This meant that while *"being free, if it became excessively independent without relating to the system, it wouldn't work – this had been a longstanding consideration,"* said Dr. Prawese Wasi.⁴¹ Until it was concluded that there must be autonomy in self-management and governance according to roles and responsibilities, with a structure distinct from bureaucracy, political parties, and NGOs, while simultaneously aiming to establish connections with government bodies, political factions, and Civil Society, Dr. Prawese Wasi proposed the creation of a "new organizational structure" as an institutional mechanism to drive reform. This strategy was considered astute in its role of being "above politics" while aiming for tangible outcomes.

The first organization that embodied all these characteristics was the Health Systems Research Institute (HSRI), established in 1992. It was accompanied by the establishment of the Thailand Research Fund (TRF) and the National Science and Technology Development Agency (NSTDA). Professor Dr. Vicharn Panich, the first director of NRF, explained that *"One important movement was in 1992 when HSRI was founded, and a few months later the TRF was established, and then NSTDA. So, at that time, three independent organizations emerged simultaneously. The legislation for HSRI is commendable, as it provides research grants and in-house funding as well."*⁴² It can be observed that apart from being newly-formed organizations emphasizing autonomy and flexibility in their operations, all three of these entities also had roles aimed at "knowledge creation" for the benefit of society as a whole. This can be seen in the establishment of HSRI which was created to generate knowledge that supports the process of healthcare system reform, in particular.



Figure 101 World Health Day press conference and the Ministry of Public Health receiving a grant from the Rockefeller Foundation to set up an independent Epidemiology Institute.

Source: National Archives of Public Health, (13) B.NEG S.2.1/47.60, 28/31 Prime Minister's Office Press Conference on World Health Day, Ministry of Public Health Receives grant from the Rockefeller Foundation.

The establishment of HSRI began with discussions within the National Epidemiology Institute of Thailand, which was founded in 1986 with Dr. Prawese Wasi as the chairman and Dr. Sanguan Nitayarumphong as one of the architects of its structure. The Rockefeller Foundation provided financial support for the Institute. Four years later, in 1991, the Institute was dissolved, and its personnel, plans, and budgets were transferred to operate under the "National Health Foundation" (NHF). During that time, Dr. Prawese participated in the work of global health organizations focusing on health systems research. This made him realize that medical knowledge could not be directly imported from other countries due to the unique characteristics of each country's healthcare system. This became one of the topics discussed in meetings of the Sampran Forum group. As a result, it was concluded that there should be a "freedom mechanism" responsible for

supporting health system research.⁴³ HSRI was established in 1992 under the government of Prime Minister Anand Panyarachun. The primary objectives of the organization were similar to the National Epidemiology Institute, but HSRI had broader responsibilities. Dr. Sanguan continued to play a significant role in the drafting of the royal decree to establish the HSRI.⁴⁴ Once the HSRI was established, the choice of who would become the director was another important factor. Therefore, Dr. Somsak Chunharas was appointed as the first director of the organization. According to Dr. Prawese Wasi, *“Dr. Somsak possessed the most solid foundation, wisdom, integrity, and honesty according to the desired objectives of building systematic knowledge in order to create a system.”*⁴⁵



Figure 102 Dr. Somsak Chunharas (white shirt) during his tenure as the Director of HSRI (Health Systems Research Institute) (establishment - 1998). The photo was taken at a Medical Council Committee reception in November 1993

Source: National Archives of Public Health, (13) C.NEG S.2.2/6.111, Medical Council Committee Reception, November 1993

The establishment of HSRI marked the first instance of an organization driving reform with legal support, namely the “HSRI Act of 1992.” The significant points evident in this act revolved around two key aspects. Firstly, the role of the institution was defined to encompass surveying, studying, and academically analyzing to support plans, policies, and various measures for the development of the healthcare system. This mandate included coordination between public and private sector agencies, both domestically and internationally, as well as the responsibility to disseminate research findings to various sectors across the country. These tasks signified a pivotal shift in the power dynamics of knowledge production within the healthcare system.⁴⁶ Before the inception of the HSRI, the research and knowledge development units of the MOPH were the Policy and Planning Office and the Medical Research Office. These entities operated within the framework of the bureaucratic system, producing research and knowledge solely to support the Ministry’s operational structure. It was only when a research institution with a different perspective on the healthcare system emerged that the production of knowledge and the mobilization of research resources took on a new form. This shift in approach facilitated the design of policies and the establishment of a research network aimed at reforming the healthcare system, both from within and externally. This transformation altered the structure of the Ministry of Public Health.⁴⁷

The second aspect that distinguishes the role of HSRI from the previously existing research units was reflected through the phrase “healthcare system development” as outlined in the aforementioned Royal Decree. This term encompassed “...*studies, investigations, and research in public health, interdisciplinary in nature, involving fields such as sociology, science, medicine, economics, psychology, or behavioral sciences.*” *The intention is to enable healthcare activities to be systematically developed and to effectively address public health issues.*”⁴⁸ This elaboration further emphasized the clear intent of the reform-minded doctors to set a definitive direction for healthcare reform toward establishing a universal healthcare system. This objective was formally incorporated into the legal framework, as articulated by Dr. Somsak Chunharas, the first director of HSRI, who stated the following: “*If one were to argue that HSRI conducts research with a clear agenda, it can be said that is because we established HSRI to produce research that supports the reform of the healthcare system. This was necessitated by the limitations of the existing knowledge production structure, which couldn’t effectively generate research and knowledge to support healthcare system reforms.*”⁴⁹

The establishment of HSRI can be considered the initial step in transforming the relationships within the structure of the healthcare system, leading to a state known as “complex participatory democracy.”⁵⁰ This represents a state of having autonomy in self-governance within the structure of the Ministry of Public Health, while receiving state funding. However, the state bureaucracy and political parties could not control the operational direction of such an organization. Moreover, HSRI served as a significant foundation for expanding various independent organizations, as Dr. Prawese emphasized the inherent nature of HSRI

by stating: “Once HSRI is an independent organization, it can give birth [to new paradigms]; if it remains within the governmental system, it cannot function properly.”⁵¹ This emphasized that being an independent organization with a distinct systemic philosophy set it apart from the technically oriented government agencies. This was a crucial characteristic that led to the establishment of subsequent organizations, e.g., “The Family of Four Organizations.”



During the politically, economically, and socially distinctive decade from 1987-96, the concept of “human rights” gained momentum and became a central focus of societal development as a whole and within the healthcare system. Simultaneously, the multi-dimensional health-related issues created tensions and divergences within the various branches of the medical profession. This divergence led to the inception of the Sampran Forum, aimed at exchanging ideas and fostering mutual understanding among physicians from diverse backgrounds. Even the Medical Council was used as a platform to express varying viewpoints among doctors with different life experiences.

The stress within the health sector was further evident through a comprehensive analysis of the governmental structure, indicating a consistent lapse in the working system of the government as time went on. Due to these limitations, the emergence of “*external movements outside the framework of the Ministry of Public Health*” surfaced, fostering a formal avenue for systemic, integrative health knowledge to be developed. This was realized through the establishment of an independent organization like HSRI, supported by a formal law, despite its departure from the conventional governmental framework. This autonomy allowed HSRI to maintain the professionalism of its research endeavors, particularly in the production of research knowledge supporting healthcare reform.

This process of change saw the beginning of a flexible and adaptable management strategy within HSRI, responding to the ever-changing political landscape of Thailand. Thus, HSRI’s operational process aligned with the theory of the “*Triangle Moves a Mountain*.” The knowledge generated by HSRI needed to be applicable, goal-oriented, and practically relevant, such as studying healthcare economics systems and promoting Diagnosis Related Groups (DRGs). One vertex of the triangle, led by a group of physician-academics, connected with the Civil Society Network (the second vertex), and further drove

acceptance and recognition from the political/power entities (the third vertex). The convergence of these three vertices resulted in the practical implementation of political activities by the reform-oriented physician group. Dr. Viroj Tangcharoensathien, a key figure in health insurance research, explained that a significant condition favoring the success of health insurance policies was HSRI's *"capability to conduct policy research and analyze healthcare systems."*⁵²

Especially when this knowledge was applied to stimulate the awakened Civil Society network following the events of the May 1992 uprising, it catalyzed their increasing involvement in societal development alongside the government. This progression led to a social movement that firmly engaged in "supporting" healthcare reform, which eventually contributed to the emergence of the People's Constitution in the early 1997, a turning point that paved the way for the establishment of universal health insurance system which was on the horizon.

Chapter 13

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² Sombat Chantarawong and Rangsan Thanapornphan, *Love Thailand, Volume 1: History and Politics*, Chapter on Public Health for the Masses.

³ Phiman Room at Montien Hotel, the signing ceremony of the New Force Group.

⁴ Sanae Jamrik, *Developing Human Rights in Thailand*, 81-91.

⁵ Sanguan Nitayarumphong, "A New Dimension of Thai Public Health," in Pipop Thongchai, Somthawin Luechapattanaorn, and Thitima Khuntiranon, eds, *From Crisis to a New Dimension of Thai Public Health*, 21-22.

⁶ Sanguan Nitayarumphong, 28-29.

⁷ Interview with Dr. Supattra Srivanichakorn, June 21, 2022.

⁸ Chatree Charoencheewakul and Opiwan Nitayarumphong. *The Starlight of Faith: Sanguan Nitayarumphong*, 68.

⁹ Joseph Harris, *Achieving Access: Professional Movements and the Politics of Health Universalism*, 50

¹⁰ Racha Phuchong, Nopphanat Anuphongphat, Komatra Chuengsatiansup, *Rural Doctor Good Governance and*

and Health Politics, 59-60.

¹¹ Interview with Dr. Suwit Wibulpolprasert, May 16, 2023.

¹² Suwit Wibulpolprasert, ed., *25 Years of Rural Doctor Movement in Thailand*, 57.

¹³ Sanguan Nitayarumphong, *On the Path to Universal Health Coverage*, 51.

¹⁴ Sanguan Nitayarumphong, 53.

¹⁵ Interview with Dr. Suwit Wibulpolprasert, May 16, 2023.

¹⁶ Nuttarute Vongtangswad, "The dynamics of framing and mobilization of the rural doctor movement: conflicts and political transformation," 140-142.

¹⁷ Nuttarute Vongtangswad, 143-144.

¹⁸ Interview with Emeritus Professor Dr. Prawese Wasi, May 29, 2023.

¹⁹ The Coverage Insight, "'Goran Tomson' Friends from Sweden, Remembering the 'Reserved Doctor' with Vision Ahead of 'UN' 40 Years", *The Coverage Insight*, 2021, <https://www.thecoverage.info/news/content/990>.

²⁰ Nuttarute Vongtangswad, "The dynamics of framing and mobilization of the rural doctor movement: conflicts and political transformation," 154.

²¹ Regarding this issue, leaders have presented and attempted to define "patient rights" in various dimensions, including the legal dimension that addresses the protection of patient benefits. Prior to the society

proposing the draft Patient Protection Act, see details in Atchara Veerachalee, "Patient Rights," LL.M. thesis, Thammasat University, 1994.

²² Concerning the problem of ideological conflicts, see further in Nualnoi Treerat and Bank Ngamarunchot, *Politics and Power in the Universal Health Coverage System* (Nonthaburi: Health Systems Research Institute (HSRI), 2012), 26-33.

²³ Hathaichanok Sumalee, "Guideline for Right Protection of the Patients and Health Care Providers," (Social Welfare Administration and Policy, Thammasat University, 2009), 55-61.

²⁴ Racha Phuchong, Nopphanat Anuphongphat, Komatra Chuengsatiansup, *Rural Doctor Good Governance and Health Politics*, 104-105.

²⁵ Racha Phuchong, Nopphanat Anuphongphat, Komatra Chuengsatiansup, 106-108.

²⁶ Suwit Wibulpolprasert, ed, *25 Years of Rural Doctor Movement in Thailand*, 121.

²⁷ Nuttarute Vongtangswad, "The dynamics of framing and mobilization of the rural doctor movement: conflicts and political transformation," 160.

²⁸ Suwit Wibulpolprasert, ed, *25 Years of Rural Doctor Movement in Thailand*, 128.

²⁹ National Archives of Public Health (14) SB 1.5/1.7, "Regarding the Association of Rural Doctors, Medical Student Clubs from 4 Institutions, Case of the Faculty of Medicine, Rangsit University."; Nuttarute Vongtangswad, "The dynamics of framing and mobilization of the rural doctor movement: conflicts and political transformation," 162.

³⁰ Nualnoi Treerat and Bank Ngamarunchot, *Politics and Power in the Universal Health Coverage System*, 70.

³¹ Suwit Wibulpolprasert, ed, *25 Years of Rural Doctor Movement in Thailand*, 125.

³² Chettha Sapyen, "A Study of the Rural Doctor Movement in the Policy Process of Health System: The Movement of Civil Society and its Contribution Toward Participatory Democracy in Thailand," 190-193.

³³ Chettha Sapyen, "A Study of the Rural Doctor Movement in the Policy Process of Health System: The Movement of Civil Society and its Contribution Toward Participatory Democracy in Thailand," 195-199

³⁴ Racha Phuchong, Nopphanat Anuphongphat, Komatra Chuengsatiansup, *Rural Doctor Good Governance and Health Politics*, 109-111.

³⁵ Komatra Chuengsatiansup, *Authority and Corruption: Decoding the Bureaucratic Culture of Public Health* (Bangkok: Amarin, 2003), 40.

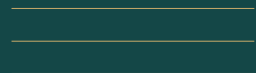
³⁶ Sombat Chantarawong and Rangsan Thanapornphan, *Love Thailand, Volume 1: History and Politics*, 56-60.

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- ³⁷ Chatree Charoencheewakul and Opiwan Nitayarumphong. *The Starlight of Faith: Sanguan Nitayarumphong*, 76-87.
- ³⁸ Prawese Wasi, *On the Path of Life: The Rural Doctor Movement in Thailand*, 354-360.
- ³⁹ Nualnoi Treerat and Bank Ngamarunchot, *Politics and Power in the Universal Health Coverage System*, 24-25.
- ⁴⁰ Wichai Chokwiat, *The Legend of the Gold Card: History of Thailand's Universal Health Coverage System* (Nonthaburi: Mitraphab Foundation, 2015), 41.
- ⁴¹ Interview with Professor Dr. Prawese Wasi, M.D., on May 29, 2022.
- ⁴² Interview with Professor Dr. Wijaa Phaanid, M.D., on June 22, 2022.
- ⁴³ Suwit Wibulpolprasert, ed, *25 Years of Rural Doctor Movement in Thailand*, 67.
- ⁴⁴ Nuttarute Vongtangswad, "The dynamics of framing and mobilization of the rural doctor movement: conflicts and political transformation," 179.
- ⁴⁵ Interview with Professor Dr. Prawese Wasi, M.D., on May 29, 2022.
- ⁴⁶ Phonsawan Juntarat, "The Participation of Non-Governmental Organization in Public Policy Advocacy: A Case Study of Universal Health Coverage Scheme," (Master's thesis, Faculty of Political Science, Chulalongkorn University, 2019), 47.
- ⁴⁷ Phonsawan Juntarat, "The Participation of Non-Governmental Organization in Public Policy Advocacy: A Case Study of Universal Health Coverage Scheme," 179-180.
- ⁴⁸ Royal Thai Government Gazette, "Health Systems Research Institute Act B.E. 2535" (1992) (Volume 109, Part 45G, Page 6, April 9, 1992).
- ⁴⁹ Nuttarute Vongtangswad, "The dynamics of framing and mobilization of the rural doctor movement: conflicts and political transformation," 181.
- ⁵⁰ Nuttarute Vongtangswad, 220-221.
- ⁵¹ Interview with Professor Dr. Prawese Wasi, M.D., on May 29, 2022.
- ⁵² Viroj Tangcharoensathien, 'Evaluation Report of the Universal Health Coverage System in the First Decade (2001-2010),' 49.



The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868-2002

Transforming economic crisis into
opportunities: The birth of People's
Constitution



Article 52 states, “Individuals shall have equal rights to receive standardized healthcare services, and indigent individuals have the right to receive medical treatment from state public health facilities without incurring expenses.”

Constitution of the Kingdom of Thailand B.E. 2540 (1997)

“

“As the drafting of the new constitution in its entirety this time is considered a starting point for political reform, opening opportunities for citizens nationwide to participate in the drafting process throughout. Therefore, this version of the constitution should be the ‘Constitution of Freedom’ for the people, by the people, and genuinely for the people, not a ‘Constitution of Power’ created as a pretext for seizing and utilizing state power limitlessly, as has been the case in the past.”

constitution drafting commission¹

”

The underlying mindset behind the drafting of the 1997 Constitution, often referred to as the ‘People’s Constitution,’ reflects the long-standing development of Civil Society in Thailand. This development began as early as the 1980s and evolved through the May 1992 events, ultimately establishing its foundation in the present era. Even though the country entered an economic crisis in 1997, known as one of Thailand’s most severe economic downturns, affecting the overall budget, health sector development did not come to a halt. On the contrary, health reforms continued to expand in various dimensions, such as the awakening of Civil Society forces, which played a defining role in shaping the political landscape. The National Health Act and experimental management in Ban Phaeo Hospital are intriguing examples. Thus, it is important to review how the 1997 economic crisis impacted the current healthcare context in Thailand.

Overview of the economic crisis in the year 1997 and its dimensions on public health

An Overview of the Economic Crisis Situation in 1997, commonly referred to as the ‘Tom Yum Kung Crisis’ by international media, was a result of the economic condition prevailing in Thailand prior to this. In the 1980s, foreign investors anticipated Thailand’s trajectory toward becoming a newly industrialized country (NIC), and this trend prompted the Bank of Thailand to encourage financial activities to flourish freely within market mechanisms. (with Bangkok International Banking Facilities-BIBFs) The financial development during this period was a significant transformation of the country’s financial system, the most significant

in Thai economic history. This included transforming Bangkok into a regional financial hub by relaxing interest rate restrictions and allowing foreign financial institutions to conduct business within the country. As a result, Thailand's economy saw substantial growth driven by both domestic and foreign private sector investments. However, such circumstances inadvertently set the stage for future crises. One such condition was the massive influx of foreign capital through commercial banks, leading to an increased level of risk for Thailand's financial institutions. A devaluation of the Thai baht would result in a rise in the value of foreign debt, a scenario that continued until 1994, leaving Thailand's financial stability somewhat fragile due to the burden of private sector debt exceeding foreign reserves.² The construction sector was one of the first businesses to show signs of slowing down, directly impacting the manufacturing sector that followed. This was particularly evident in the financial sector, especially among finance companies, which experienced the heaviest repercussions due to their high exposure to real estate debt. Concurrently, foreign investors began losing confidence in the Thai economy and deemed the baht to be overvalued. Consequently, starting from late 1996, foreign investors began to divest from the baht, causing a significant outflow of capital from the financial sector. To maintain the stability of the baht, the Bank of Thailand attempted to prevent its devaluation by using foreign exchange reserves to directly purchase baht from the market. In May 1997, the government allocated up to 10 billion US dollars to defend the value of the baht, becoming the costliest currency defense in Thai history. This effort led to a sudden reduction in net foreign exchange reserves, plummeting to only 2.5 billion US dollars from the original 24.3 billion US dollars at the beginning of May.³

After the currency protection measures taken in mid-May 1997, Thailand no longer had sufficient capital to continue defending the baht. This situation persisted until July when the Bank of Thailand announced a 'managed float' exchange rate policy. This policy significantly and consistently devalued the baht. On January 12, 1998, the baht reached its all-time low, with an exchange rate of 56.1 baht to one US dollar. Businesspeople who had borrowed money in foreign currencies, mainly in US dollars, faced a challenging situation due to the sharp depreciation of the baht. This depreciation exacerbated the burden of their dollar-denominated debt.⁴

The repercussions of the baht depreciation policy led to the government ordering the closure of a significant number of securities companies due to their substantial non-income generating debts resulting from imprudent lending to the real estate sector. Meanwhile, established banks, which had long played a pivotal role in Thailand's economy, faced severe stress arising from non-income generating debt, a consequence of loosely controlled and opaque lending practices. In numerous cases, there were instances of embezzlement and manipulation of the patronage fund system.⁵ In the industrial and manufacturing sector, there was a pronounced issue of severe working capital shortages leading to the closure of numerous businesses. Consolidation efforts and business alliances were often undermined by

debt issues, resulting in legal action leading to the collapse or instability of many enterprises, which were left vulnerable or gravely wounded.⁶ This economic crisis also led to significant social impacts, particularly in the form of widespread unemployment due to business closures across various industries. In 1997, approximately 4,941 Thailand-based establishments terminated employment contracts or closed down, resulting in a substantial loss of jobs for around 408,967 individuals. By 1998, the number of businesses that terminated employment or ceased operations increased to 5,827, while the number of individuals affected slightly decreased to 355,628. The aftermath of the economic crisis also showed correlations with increased suicide rates, mental health issues, behavioral disorders, and an uptick in individuals with psychological abnormalities during 1997.⁷

To address the crisis that occurred, the government led by General Chavalit Yongchaiyudh (1996-97) sought financial assistance from the International Monetary Fund (IMF). This move marked the inception of stringent risk management measures.⁸ After facing intense pressure from all sectors, General Chavalit decided to step down as Prime Minister, and that paved the way for Mr. Chuan Leekpai from the Democrat Party to assume leadership of the government once again (1997-2001). However, despite the change in leadership, the Democrat Party's approach remained aligned with the IMF's guidelines for problem-solving. This approach garnered strong criticism from various segments of society, including business, academia, NGOs, and the general public, particularly those in vulnerable positions who bore the brunt of the impact. These groups shared a common perspective that the government's focus on financial and banking sector issues was central to its policy, as stipulated in the IMF conditions. The government believed that if financial and banking sector issues were resolved, it would naturally lead to the recovery of other sectors. By contrast, those who disagreed with this approach argued that the government's policy neglected the 'real sector' and overlooked its impact on the majority of the population. They viewed it as favoring the wealthy and continuing on the pre-crisis path, which not only failed to solve the crisis but exacerbated its severity.⁹ As a result of the situation that required new alternative solutions to address the crisis, people from various sectors unexpectedly became allies, diverging from the path of following international organizations like the IMF and the World Bank as previous governments did.¹⁰ In this way, it was the structural economic context and economic crises like this that served as the crucial and decisive factors impacting the outcome of the first post-crisis election in early 2001.¹¹ The economy's impact on politics had consequential implications for healthcare policy, as can be clearly observed in the so-called 'Tom Yum Kung' crisis and its repercussions for the public health sector.

In the context of government health initiatives, it is evident that the 1997 economic crisis had significant implications for the Ministry of Public Health (MOPH). The currency devaluation resulting from the economic crisis, which saw the Thai baht depreciate from 4.8% in 1996 to 7.7% in 1997, led to budgetary challenges for the MOPH. The budget allocation for the Ministry in 1998, amounting to 62.6 billion baht,

experienced a net value decrease of 12.7% due to the economic crisis. Thailand had faced economic crises at both national and global levels in the past, such as the 'Oil Crisis' in 1973, which led to political turmoil between the United States and Eastern Bloc countries. Iran country, being a major oil-producing nation, experienced an oil shortage and subsequent increase in global oil prices. Shortly thereafter, the Iranian Revolution of 1979 added to the political instability between the Western and Eastern Bloc. The resurgence of Islamic culture in Iran significantly influenced global politics, particularly in Muslim-populated regions. These global political events had a direct impact on the world economy, causing a downturn along with persistent issues in the oil sector. With the added pressure on Thailand to rely more on loans and decreasing economic confidence during 1981-83, several banks and securities companies in the country faced financial difficulties. These economic crises directly influenced the reduction and reshaping of the MOPH budget. Consequently, they impacted developmental goals, leading to reduced budget allocations, community-level service expansion, and decreased health workforce production rates.¹² Nevertheless, the adjustments made by the MOPH administrators and operational teams to adapt to the situation had a limited impact on the health sector. For example, in 1983, despite the economic crisis, the MOPH still allocated budgets to community hospitals and health centers in rural areas, more than to hospitals in urban areas.

When faced with the economic crisis of 1997, once again, the Ministry aimed to prevent increased allocation of funds to various sectors. They aimed to maintain the existing or possibly reduced level of work. The Ministry implemented measures such as the 'tightening the belt' policy, as demonstrated in the 'Royal Decree on Healthcare Welfare (Version 7) of 1998,' to reduce healthcare expenses for civil servants. Simultaneously, the budget-cutting measures emphasized the principle of 'Good Health at Low Cost' to address budgetary issues arising from the economic crisis. This approach underlined the importance of using 'community-level services' as the starting point for healthcare, as these services are cost-effective and closer to the community than other healthcare facilities. Adapting to the economic crisis at the time, the Ministry's measures focused on prioritizing primary healthcare services. This was crucial as the economic crisis prompted more people to rely on government services, leading to some patients returning to public facilities due to reduced access to medical care in the private sector.

The expansion or contraction of private hospitals often fluctuated in response to the economic situation of the country and global market dynamics. For instance, during the rapid expansion of private hospitals in 1972, this was a result of economic policies encouraging private sector investment, support from the Board of Investment (BOI), and tax incentives. Similarly, during the late 1980s when the economy was booming, private hospital businesses flourished. However, before the 1997 economic crisis, the private hospital sector had grown significantly, increasing the number of beds from 9,974 and 1,094 doctors in 1987 to 29,945 beds and 3,244 doctors in 1997, nearly tripling in just a decade.¹³

Undoubtedly, when the economic crisis hit in 1997, the value of the Thai baht plummeted, and inflation rates soared. The reduced number of customers seeking services caused private hospitals to bear the burden of increased costs, especially due to escalating foreign debts. The private hospital sector was significantly impacted, with some facilities having to adjust the number of beds, close certain floors, convert them into clinics, or in the worst cases, shut down operations entirely.¹⁴ Large-scale private hospital networks that still managed to sustain themselves had to completely revise their strategies. These included financial measures to reduce costs (such as downsizing staff and salaries, cutting excessive expenses), market-oriented initiatives (entering foreign markets, offering specialized packages), and in some cases, integrating hospitals into the social insurance system to secure government support as working capital for temporary debt relief.¹⁵

Due to this, a key distinction between private hospitals and public ones is that the stability of private hospital operations often correlates with the fluctuations in demand dictated by the context of the times. In periods of economic growth, when people have increased purchasing power, the demand for services from private hospitals tends to rise accordingly. Conversely, during economic downturns when people have reduced purchasing power, private hospitals often encounter issues of financial instability. In contrast, the operations of public hospitals may not solely depend on demand but are influenced by government-established systems or policies and the direction of the political landscape.¹⁶ Undoubtedly, significant influences on health policy decisions abounded. This could be attributed to the fact that a substantial portion of government revenue primarily stemmed from taxes rather than profits. Furthermore, certain public hospitals were sustained by a combination of maintenance fees and central budget allocations. As a result, public hospitals did not need to grapple with selling healthcare products to survive in the market. This made economic factors merely one variable in the equation of change. The primary responsibility of public hospitals was to distribute assistance to the population to the greatest extent possible, and consequently, the state's health strategies were interconnected with necessity, each according to its context. For instance, during periods when there is a high demand for medical professionals due to the expansion of healthcare services and population growth, policies enforcing funding measures might be implemented. Similarly, in times when basic services are in demand due to the needs of impoverished rural communities, the state could adjust financial and budget policies to channel resources towards community-level and district-level healthcare establishments. This is due to the differences in objectives between private and public hospital management. This, in turn, leads to varied responses to economic and societal contexts between state and private hospitals. **Hence, during a period when private hospitals flourish due to economic growth, they might undergo a 'boom,' only to turn into a 'crisis' period for public healthcare (as the state's resources are drawn away, causing a lack of comprehensive services). Conversely, when private hospitals encounter a 'crisis,' it can translate into a period of 'prosperity' for state hospitals.** This notion of 'prosperity' could manifest in the return to using

state healthcare services, the establishment of community-based hospitals, or a temporary influx of medical personnel, although some events may yield short- and long-term effects differently. However, the underlying concepts and strategies that guide the adaptation or survival mechanisms of public health often have enduring effects on long-term health system development.

A. Economic crisis and the promotion of primary healthcare importance

During the period leading up to the crisis in 1997, the significant expansion of the economy in the late 1980s played a crucial role, prompting professional organizations and the MOPH to seek new approaches in healthcare system development. The growth of private hospitals was a key factor driving medical personnel towards urban areas. Alongside technological advancements in medical fields, the increasing popularity of specialized medical education attracted graduates who aimed for advancements in their careers. Simultaneously, the challenge of human resource distribution within the public healthcare system remained a constant issue that the government needed to address throughout various eras. This led to a dynamic interplay of power struggles between the public and private sectors. However, the problem of incorporating health centers successfully into communities, as part of a governmental system, remained unsolved.¹⁷ One aspect to acknowledge is that the issues of brain drain and insufficient physicians in frontline healthcare facilities have impacted the image of primary care services and the medical professionals working within these facilities.

Therefore, during this healthcare crisis period, a group of physicians recognized the need for promoting the concept of 'General Practice,' which is the core essence of primary care services. The redefinition aimed to reshape the attitudes of healthcare personnel, particularly physicians, to value general practice and realize its significance. During that time, while specialized medical education was gaining popularity, there was a need to reorient the mindset of healthcare professionals towards the importance of general practice. This was to counteract the trend of more physicians pursuing specialized fields. The segregation of general practice from the basic necessity-focused healthcare service helped draw attention to the significance of working in the initial stages of public healthcare. This matter was discussed through the National Medical Education Conference's 6th gathering in 1993, where it was agreed that the term 'General Practice' should be defined as:

“

“The provision of medical and public health services at the primary care level, utilizing integrated medical and sociological knowledge. It encompasses health promotion, disease prevention, disease treatment, and continuous health rehabilitation in a holistic manner, targeting individuals, families, and communities.”¹⁸

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In order to create a more distinctive identity, the faculties of medicine introduced a new terminology known as 'Family Medicine.' This was done to differentiate and elevate the status of general medicine. The rationale behind this was that an approach of integrated and blended care would help better understand the socio-cultural dimensions surrounding patients (such as being a part of families and communities).

Undoubtedly, when family medicine was applied through primary care services, three distinct characteristics emerged: continuity, integration, and comprehensiveness. It became evident that this perspective viewed individuals as part of a larger society, on one hand, aligning with the new definition of health as a holistic concept encompassing physical, mental, social, and spiritual well-being. On the other hand, it served as a countermeasure against viewing people solely as isolated entities, disconnected from society. For example, looking beyond just 'diseases' and 'treatment' in a reductionist manner was typical of the vertical approach of the medical industry. This is another reflection of using a crisis as an opportunity for adaptation and a platform for competing interpretations between reductionist medicine and holistic medicine. Thus, the term 'Family Medicine' evolved into a new specialized branch of medicine in 1998.

Consequently, following the economic crisis in 1997, it was an opportune time to advance family medicine and further enhance primary care services. The shift in people's healthcare utilization behaviors from the private sector to the public sector increased. This was because state-run healthcare facilities were more affordable. This trend was evident in the figures of outpatient services provided by health centers and community health facilities, rising from 34.6 million cases in 1996 to 40.4 million and 43.5 million cases in 1997 and 1998, respectively. This demonstrated a significant growth rate leap from 9% to 16.7% and 17.6% successively.¹⁹ With the surge of the population seeking healthcare services in significant numbers, state-run healthcare facilities had to find ways to adapt on a larger scale. This is because the workload had increased significantly, yet the government funding available had diminished.²⁰ Furthermore, the increase in the number of people seeking services during times of economic hardship not only highlighted the confidence that the population had in primary healthcare facilities over time, but also reflected the societal reluctance to fully accept and embrace them despite the consistent expansion of these services.²¹

Moreover, even though the economic crisis did not lead to a decrease in the number of state hospitals as significantly as private hospitals, it did stimulate another sector of the government to respond to the crisis in a similar fashion. The high inflation after the crisis prompted the government to reassess the capabilities of state hospitals and seek ways to reduce operational expenses. One of the measures adopted was the 'Privatization' of state hospitals, inviting private sector investment through corporate entities to share costs. The endeavor to adapt was driven by several rural physicians, who aimed to experiment with creating

semi-autonomous state hospitals in collaboration with both the government and private sector. This became evident through the case study of Ban Phaeo Hospital.

B. Banphaeo General Hospital and the utilization of the capitation system in the year 2000

The restructuring of the management system of Ban Phaeo Hospital in 2000 marked a transition of state hospitals from the traditional model to becoming ‘public organizations’ or alternatively referred to as ‘government-regulated hospitals’. This transformation was the first of its kind in Thailand, and aligned with the broader strategy of reforming the administrative system on a larger scale. The objective was to grant government agencies greater autonomy and flexibility to provide more efficient public services. Nonetheless, a significant innovation arising from the change in Ban Phaeo Hospital was the experimental budget reform. Previously, the hospital’s budget was primarily based on its own needs, but it shifted to allocating funds based on the population’s healthcare requirements within the service area, encompassing healthcare, prevention, and health promotion. On the other hand, this reform also aimed to grant the hospital the freedom to manage its budget without being strictly confined by government expenditure regulations. Therefore, the transformation process of Ban Phaeo Hospital can be regarded as a small-scale pilot of the per capita payment model and the establishment of a health security framework.

The idea of reforming state hospital management was part of a larger proposal, which involved advocating for the reform of the entire bureaucratic system that lagged behind and was slow to adapt to changes. This related to the challenges of central authority concentration and cumbersome processes. These issues were intertwined with the context of the digital age, which featured technology such as computers, data transmission, remote communication, and most importantly, the growing concept that the new administrative system should emphasize the reduction of the state’s role²² Emphasizing the decentralization of power and promoting transparency within the government system, as envisioned by General Chavalit Yongchaiyudh’s administration, a master plan for bureaucratic reform was introduced to expedite, equalize, and elevate the quality of life for citizens in accessing public services. The core principle of this approach was reform both in terms of the size and operation of state organizations. Underlying this reform strategy, the proposal for healthcare system reform became an integral part of the broader agenda. Specifically, the plan for healthcare system reform set out to address issues within three primary areas: the healthcare funding system, healthcare service provision, and health insurance system. One of the proposals in alignment with this strategic vision was the ‘reform and transformation of the state hospital management system’ aimed at solving issues in line with the aforementioned strategy.”²³

The study on the process of *'Departure from State Bureaucracy of the Private Organization: A Case Study of Ban Phaeo Hospital'* explains the transformation process of Ban Phaeo Hospital. After the economic crisis in 1997, the Health Systems Research Institute (HSRI) proposed a new model of state hospitals to the Asian Development Bank (ADB). Around the same period, the government conducted research on the direction of reforming the management system of state hospitals, with partial research funding from the ADB. The initial concept was to increase the autonomy of state hospitals while retaining the existing regulatory framework, without transforming them into profit-driven or corporatized entities. The term 'Autonomous Hospital' was introduced to describe this concept, aligning with the emerging idea of autonomous private organizations. This proposal was adapted to the concept of autonomous private organizations through the enactment of the 'Private Organization Act' in February 1999. The significance of this act is underlined by its assertion that when the government has plans or policies, especially for the establishment of public services, and it is appropriate to create new administrative units that differ from government agencies or state enterprises, aimed at maximizing resource utilization and efficiency, these units can be established as private organizations. This legal framework was established through royal decree based on this act.²⁴ This meant that it became a legal mechanism that transformed the proposal for a new format of state hospitals into a legitimate form, as private organizations or 'Autonomous Hospitals,' and served as a path for reforming the governmental system as planned.²⁵ Therefore, state entities transformed into private organizations represented a new form of organization that emerged amid the economic turmoil and the political and administrative changes. The manifestation of the aforementioned direction under the Private Organizations Act of 1999 is considered one of the new paths for reforming the Thai governmental system.²⁶ This can be seen as an opportunistic initiative that arose amidst the crisis, supported by a group of rural doctors who conducted research studies through HSRI.

Once the direction for reforming state hospitals became clear through the Private Organizations Act of 1999, the MOPH established a pilot project to transform a total of 7 state hospitals. These hospitals included Hat Yai Hospital, Khon Kaen Hospital, Saraburi Hospital, Yala Hospital, Nakhon Ping Hospital, Satun Hospital, and Ban Phaeo Hospital. Ultimately, Ban Phaeo Hospital became the only one transformed into a private organization. The government approved the establishment of Ban Phaeo Hospital as a private organization in September 2000, and operations commenced in October of the same year.²⁷ The MOPH's acceptance of the state hospital reform direction was not solely due to agreement with this proposal, but rather because hospital reform was part of the conditions attached to the International loan funding.²⁸

Therefore, the concept of the new state hospital aimed to reform the state hospital management system by decentralizing power, allowing hospitals to be flexible, responsive to local needs, and independent from central government control, without direct involvement in hospital internal management.²⁹ However, the hospitals still received funding from the state, but it was allocated as a lump sum general grant, not

divided into categories. At the same time, hospitals could also receive additional funding from providing services to other state agencies, such as the Social Security Office and the Health Insurance Office. The crucial point is that the government did not control how the budget was spent through bureaucratic regulations. This funding approach ensured that budget calculations were based on the hospital's performance, such as the quantity of services provided for each type.³⁰ It was also based on the population in the service area, which related to the goal of Ban Phaeo Hospital to establish a health insurance scheme for the population in the district. In this budget calculation process, they utilized a per capita payment model.

The most significant mission of Ban Phaeo Hospital after the administrative reform was to provide comprehensive and universal health services to every individual in the district, encompassing a basic package of services. This package included health promotion, disease prevention, basic public health services, rehabilitation, and medical treatment. It closely resembled the services provided by an annual health card that needed to be purchased. The hospital also managed patient referrals to higher-level healthcare facilities, and when patients were referred to regional/general hospitals or university hospitals, Ban Phaeo Hospital took responsibility for the expenses.³¹ The research team from the HSRI was responsible for calculating a suitable budget for Ban Phaeo Hospital to achieve comprehensive and universal basic health services. The net cost was approximately 782 baht per person in the district. This amount was inclusive of the budget allocated and supplemented by additional sources of revenue outside the budget. Therefore, it was believed that allocating the budget based on the population within the responsible area would help create a more appropriate resource allocation compared to a system that allocated budget solely based on the size of the healthcare facility, which may result in a larger budget for facilities with more staff. This budget allocation approach could lead to comprehensive and near-universal services that are similar to the benefits provided by health insurance cards.³²

HSRI analyzed budget allocation options suitable for Ban Phaeo Hospital, utilizing a 'per capita payment' model. This model is elaborately detailed in the article *'Budgeting for State-Owned Hospitals: The First State-Managed Hospital in Thailand - 782 baht per person, where does it come from?'* It explains that the budget allocated to the hospital must be used for providing public health services throughout the district. This encompassed services provided by both Ban Phaeo Hospital and health centers in the district. Individuals registered within the Ban Phaeo district were charged a service fee of 20 baht for each visit to the participating health centers. For patients seeking treatment at Ban Phaeo Hospital, those who were not residents of the district were charged 40 baht per visit, and in-patients were charged 100 baht for services. Patients who possessed the Universal Coverage for Thai Citizens (UC) card were entitled to services as per the card without incurring additional charges.³³ The implementation of the 'universal coverage' service model in Ban Phaeo District highlights a significant objective of the hospital. This

objective involves extending health insurance coverage to the population in Ban Phaeo District who do not have any existing health insurance. By creating a health service system comparable to the health insurance card system that residents outside of Ban Phaeo District must purchase annually, the hospital aimed to address this gap in health insurance coverage. Therefore, a crucial focal point that indicates the challenges in the implementation lies in the 'budgeting method. The budget of 782 baht per person per year for the hospital's support was calculated by the research team from HSRI based on two sets of data: (1) the disease rates of both outpatients and inpatients, and (2) the cost data per unit for both outpatients and inpatients. The calculation allowed for the separation of costs, revealing that Ban Phaeo Hospital (in the central region, outside municipal boundaries) had a medical treatment cost of 562 baht per capita and a preventive promotion cost of 149 baht, totaling 712 baht.³⁴

Table 10 Calculations of Budget for Healthcare and Health Promotion of the Thai Population, 1996

Source: Adapted from the budget for hospital operations under the first state administration in Thailand: 782 baht per capita, from where?, 14." Recommendations and background, 1994, 22.

Use of services in both public and private providers	National	Bangkok	Central Region		North		Northeast ^t		South	
			Municipal	Non-municipal	Municipal	Non-municipal	Municipal	Non-municipal	Municipal	Non-municipal
Outpatient (Visit/capita/yr.)	2.611	1.685	1.857	2.507	2.323	2.950	2.238	2.623	2.369	2.741
Inpatient (Admission/capita/yr.)	0.0584	0.0420	0.0533	0.0621	0.0652	0.0674	0.0508	0.0573	0.0521	0.0609
Inpatient *20 (weighted IP/using 20 time unit cost difference)	1.167	0.840	1.066	1.242	1.304	1.348	1.015	1.147	1.042	1.218
Total weighted morbidity	3.778	2.525	2.923	3.750	3.626	4.297	3.253	3.770	3.411	3.959
Operating cost/OP visit	158	250	200	150	200	150	200	150	200	150
Budget (baht/person/year) for medical treatment	597	631	585	562	725	645	651	565	682	594
Budget for health promotion baht/person/year) (20% of total capita)	149	149	149	149	149	149	149	149	149	149
total budget per capita	149	149	149	149	149	149	149	149	149	149

In this regard, the research team proposed an adjustment from the initial 712 baht for the case of Ban Phaeo Hospital. This adjustment was due to the hospital being under state supervision, which resulted in increased salary expenses, capped at a maximum of 50% of civil servants' salaries. During the process of reaching budget conclusions, representatives from the Ministry of Finance suggested increasing the rate to 712 baht due to the impact of increased labor costs. The HSRI research team calculated additional costs by assuming that all civil servants would receive a 1.5-fold increase in salaries. Additionally, the cost structure was adjusted, with 50% of costs being basic wages (impacted by the 1.5-fold increase) and the other 50% being other variable expenses unaffected by the 1.5-fold increase, along with 50% material expenses. The revised calculation led to a medical treatment cost of 633 baht per capita when combined with the preventive promotion budget of 149 baht, totaling 782 baht per capita.

Table 11 Calculation of Adjusting the Rate from 712 baht to 782 baht per capita

Source: Adapted from the budget for hospital operations under the first state administration in Thailand: 782 baht per capita, from where?, 14." Recommendations and background, 1994, p. 15.

	Proportion	Cost (baht)
Wages that are salaries of civil servants	0.25	150 baht per outpatient visit * 0.25 * 1.5 = 56 baht per outpatient visit
Other wages (overtime wages, other benefits, informal medical wages)	0.25	150 * 0.25 = 38 baht per outpatient visit
Material cost	0.5	150 * 0.5 = 75 baht per outpatient visit
Total	1	169 baht per outpatient visit
Ban Phaeo is sick with weight.		3.75
Medical expenses (baht/person/year)		169 * 3.75 = 633 baht
Health promotion budget (baht/person/year)		149 baht
Health budget (baht/person/year)		782 baht

When examining the process of constructing the identity of the hospital, the primary goal that Ban Phaeo Hospital aimed to achieve was to ensure that certain outcomes would materialize. These outcomes included healthcare management reform, a shift in budget allocation from central authorities, and notably, the endeavor to establish comprehensive health coverage for all individuals listed in the household registration of Ban Phaeo District. This effort can be considered a form of ‘social experiment.’³⁵ This is based on a culmination of diverse experiences that have been dispersed across various dimensions. In this regard, the transformation project of Ban Phaeo Hospital was a result of accumulated knowledge and the persistent drive for healthcare system reform that had been underway for a long time. Overall, it was rooted in the idea that the form of the hospital under state governance stemmed from the knowledge creation of HSRI, utilizing population-based budget allocation methods and budget calculation models drawn from the social insurance project. One of the key figures who played a pivotal role in calculating the crucial per capita budget for Ban Phaeo Hospital was Dr. Viroj Tangcharoensathien, the individual who proposed the budget figures for the social insurance project and introduced the concept of co-payment in the Health Card Project. All these experiences were once again experimented upon, this time using Ban Phaeo Hospital as the foundation. When questioned about the benefits of the Ban Phaeo case study, Dr. Wichai Chokwiat explained that, ‘... *the implementation of the Ban Phaeo Hospital model, which was able to provide comprehensive healthcare for just 40 baht, served as the foundation for Prime Minister Thaksin’s desire for a healthcare insurance system within the Thai Rak Thai Party’s platform, which led to a more cost-effective service value compared to Ban Phaeo Hospital, which charged 30 baht.*’³⁶ The Ban Phaeo project can be likened to a prototype for establishing a national health insurance system or the ‘30 Baht for All Ailments’ policy that would come to be.³⁷

The power of political reform and the People’s Constitution of 1997

To understand the origins of the 1997 People’s Constitution, one needs to trace back to the preceding trajectory of the concept of “Civil Society.” This concept emerged in the 1980s to explain social phenomena arising from transformations in society, politics, and economics. During this period, there was a dynamic social movement that operated outside the formal structures of the state and government, often formed loosely around common goals to achieve public interests. While Civil Society became widely recognized at that time, the definition of “Civil Society” varied among scholars and thinkers, such as “empowered society” by Thirayuth Boonmee and “democratic society” by Dr. Prawase Wasi. Consequently, the discussion about defining and understanding “Civil Society” was substantial. Even within the realm of public health, the quest for clarity regarding the concept of Civil Society was crucial. This clarity was sought to serve as a tool in driving the agenda of healthcare system reforms in the future.

A. Black May 1992: A significant legacy of increasing the role of civil society

Understanding the relationship between the concept of Civil Society and the realm of public health can aid in comprehending contemporary phenomena or approaches employed by pioneering doctors to strategize advancements in public health issues. Upon careful examination, it becomes evident that the public health sector perceived Civil Society as a distinct force, separate from the state and independent from private interests. It was seen as an informal establishment that operated based on shared relationships of equality and possessed an inherent set of values that worked to mitigate internal societal tensions. Dr. Prawese Wasi, in his work titled “Social Civilization,” most explicitly reflects this perspective. He emphasizes the significance of fostering a balance between State Power (government), Economic Power (corporate sector), and Social Power (community sector) to establish a harmonious society. The objective is for the Social Power sector to serve as an additional force that provides checks and balances both the State and Corporate sectors. This is essential because an excessive concentration of power in either of these sectors could be likened to a “social abyss,” which engulfs institutions and various social resources, disregarding the welfare and harmony of the overall community.”³⁸

However, the concept of social democracy is often challenged by an alternative interpretation, mainly advocated by the political economy perspective. This perspective argues that the expansion of the economy leads to the emergence of a “plutocratic politics,” driving the development of liberal capitalism as a fundamental factor. This, in turn, results in the rise of the middle class and business groups as significant influencers in shaping the democratic process within the country. This perspective does not distinctly differentiate between the middle class and business groups, believing that their political influence can liberate rural populations (which have traditionally been a crucial voting base) from the clientelism and corruption inherent in the electoral system. According to this way of thinking, connecting the rural economy with a free market in the urban setting could dissolve the essence of “community.” This is because the social mechanisms within rural communities are seen as obstacles to the democratic progress of Thailand (for instance, the notion that villagers trade their votes and exist within the patronage system of local politicians). The adoption of a market-oriented economy within these communities is believed to alleviate these issues. On the other hand, the endeavor to strengthen communities through their own cultural heritage might perpetuate these problems to some extent, even as efforts are made to create resilient communities.³⁹ Certainly, this perspective contradicted the “social democracy” concept put forth by other academics and even the public health community, who sought to strengthen communities beyond their state at the time.

Therefore, the May 1992 uprising (Black May) served as a catalyst for accelerating the articulation of the social democratic idea within the public health sphere, making it more distinct. Part of this might be attributed to the social mobilization of various sectors of the population in the 1987-96 decade, which

united students, laborers, civil servants, farmers, students, corporate employees, small business owners, and self-employed individuals. This massive movement could be seen as a process of reclaiming and revitalizing the essence of “democracy,” even though the violent events of May 1992 concluded with an agreement among prominent factions.⁴⁰ However, those events also acted as another thread that tugged, leading to the emergence of the people’s power phenomenon. This phenomenon played a role that facilitated the ongoing process of democratization, progressing steadily. This evolution ultimately culminated in the understanding that “social democracy” should be a force separate from the wings of the state and businesses, aiming to mitigate power imbalances and foster certain forms of equilibrium.⁴¹ For the public health sector, supporting this perspective was partly due to recognizing the significance of Civil Society in counterbalancing the power of private interests. It acknowledged that when private sector entities like business corporations, particularly in industries such as private hospitals and pharmaceuticals, engage in profit-seeking behavior that lacks ethical considerations, it can result in a burden on households’ healthcare expenses, perpetuating a trend. This can lead to the “Supplier Induced Demand” phenomenon, where an increase in healthcare supply drives demand. The competition among private businesses (such as the rise in specialized medical practitioners or investments in expensive technologies) can foster commercial relationships that burden consumers even when unnecessary, despite consent.

To prevent the public from being financially devastated by excessive healthcare costs and to avoid marginalizing disadvantaged groups in society, excluding them from politics or public spaces, reformist doctors viewed empowerment of the population as the most crucial solution. They believed this can be achieved by forming community-based Civil Society organizations (CSOs), including groups, foundations, associations, clubs, and NGOs. Grouping together allowed individuals with shared values to collectively safeguard public interests. Consequently, following the May 1992 events, Thailand witnessed a network alliance between doctors and the community, pushing for various issues, such as advocating funding for the MOPH in 1992 to support persons living with HIV/AIDS, groups or campaigning for Non-Smoking that eventually led to the enactment of the Tobacco Control Act in 1992, including the establishment of the “National Tobacco Control Committee.”⁴²



Figure 103 Dr. Uthai Sudsukh during a seminar on HIV/AIDS prevention and control by relevant educational institution agencies, held from November 6th to 8th, 1991.

Source: National Archives of Public Health, (13) C.NEG S.2.2/4.125, Dr. Damrong Boonyoen, November 1991 (Deputy Director-General of the Department of Health).

Therefore, it can be observed that the May 1992 events were a clear outcome that emerged from the latent power of the people that had been brewing for a period before (during the 1978-1988 decade). For instance, NGOs played a significant role in finding solutions to various issues faced by the public, especially those who were disadvantaged and struggling in rural areas.⁴³ Furthermore, the May 1992 events also caused the public health sector to assign a more prominent role to Civil Society. This is because the power of society had become a vital instrument in reforming the healthcare system, based on shared objectives. As Dr. Suwit Wibulpolprasert stated, *The key challenge in developing the 'third power' to create a society of health equity lies in fostering a collective consciousness within the society – encompassing the state, businesses, and communities – to seek harmonious ways to unite forces and collectively address health issues.*⁴⁴ Due to these reasons, the public health sector can be described as a field that recognized the importance of promoting Civil Society as an integral part of developing a multi-dimensional healthcare system. This included the promotion of power distribution, which became a significant gateway officially opening up space for Civil Society's involvement.

B. Framework of decentralization and the promotion of civil society participation

Until after the “Black May” incident and widespread corruption among politicians. The parliamentary system reinforced the concept of “decentralization” and promote more “participation” of civil society organizations (the principle of the privatization of Ban Phaeo Hospital was also a part). On June 9, 1994, Professor Marut Bunnag, Speaker of the House of Representatives from the Democrat Party There was an order appointing the Democracy Development Committee (DDC), numbering 58 people, to study, research and recommend political and administrative reforms in Thailand to be consistent with the democratic regime, with Dr. Prawase Wasi as the Chairperson. The full results of the study were published in September 1995 with the support of the Thailand Research Fund (TRF). This work became the initial framework for the drafting of the upcoming constitution. Many parts emphasized the “rights and freedoms of citizens,” and “role of citizens,” including further explaining that “non-government organizations (NGOs) are professional organizations in society that have high capabilities and roles in developing society and democracy in Thailand.

Later, the working group preparing the 8th National Economic and Social Development Plan (1997-2001) included content to support the growth of civil society organizations. One of the key players in the planning committee was Dr. Prawase Wasi, the Chairperson of the Rural Development Subcommittee of the 8th Development Plan, thus helping to open the way for civil society organizations to become an institution and participate in the development of the country by specifying that funds to be distributed directly to NGOs. This condition transformed power relations from the one in which the bureaucracy was the center of policy decision-making towards promoting decentralization to localities and communities.⁴⁶ Many of the proposals for political reform of the DDC and the spirit of the 8th Development Plan were forwarded to the contents of the 1997 Constitution emphasizing decentralization, participatory democracy, and reducing centralized power of the bureaucracy.

C. National Health Act: The Fundamental Health Legislation of Thailand with Public Participation (2000)

During the economic crisis, the 1997 Constitution of the Kingdom of Thailand, nicknamed the “People’s Constitution,” was the first to significantly strengthen the role of civil society organizations.⁴⁷ A key principle outlined in the constitution is the emphasis on public interest. To achieve this, new structures and rules were introduced to encourage public participation in decision-making, practice, and monitoring of the government and private sector activities. The Constitution contains provisions emphasizing public participation, such as endorsing state support for public involvement in political, economic, and social decision-making, allowing citizens to propose laws, and providing mechanisms to monitor government corruption. These constitutional mechanisms significantly influenced the reform movement in the health system.⁴⁸ Furthermore, **another crucial point directly related to health is in Section 3 on the rights and freedoms of Thai citizens. Article 52 states: “Every person shall enjoy equal rights to standard public**

health services, and the indigent shall have the right to medical treatment in public health facilities of the state free of charge.”⁴⁹ The article also discusses state-provided health services that are accessible and efficient, promoting participation from local administrative organizations and the private sector. This article clearly demonstrates the principles of equality, accessibility, and emphasis on participation.

During the same period when the concept of “civil society” was widely discussed in the public domain, the state sector also adapted to these changes. They introduced the idea of “Good Governance” as a key principle in the 1997 Constitution.⁵⁰ This legal intent promoted a greater distribution of power to the people. The main processes of this allocation include decentralization, participation, and checks and balances. These processes ensure that the promotion of public issues is lawful and that the ceiling of demands is not merely idealistic but connected to societal realities. Subsequently, the National Health Act was drafted, embodying the spirit found in the 1997 Constitution. It serves as a guarantee that the “power of the people” will be a significant factor in the genuine development of Thailand’s public health.

Moreover, the draft of the National Health Act integrates two main ideological waves resulting from the 1997 Constitution. The first one is the establishment of the “Health Assembly” to genuinely create a space for public participation in the development of the health system. Amidst the proposal to draft the National Health Act in 1999, the power of civil society organizations to find collaborative paths with the state in a democratic regime was evident, demonstrated through the “Demonstration of Health Assembly” in 2000. Subsequently, an informal “National Health Assembly” was held seven times between 2001 to 2007,⁵¹ although it was still informal since it was not yet legally recognized. The subsequent idea is “prevention is better than cure,” emphasizing health promotion and prevention over health treatment. This was the first time that preventive medicine and holistic health took precedence over curative medicine. The ideas of “Health Assembly” and “prevention is better than cure” were thus incorporated into the content of the draft bill of the 2000 version.⁵²

The draft of the National Health Act seemed to be of lesser importance in the political sphere. Although there were suggestions to draft it in 1999, and it was revised again in 2002,⁵³ as well as continuous discussions outside of the parliamentary politics every year through the (informal) National Health Assembly, it seemed to be consistently sidelined. Even though the Thaksin government promised the participants of the National Health Assembly in 2002 that the “government would propose the law on behalf of the people,” the draft remained pending for consideration by the health minister from late 2002 to 2003, for over 15 months. Observations were made by various parties that the draft National Health Act might overlap with the draft National Health Security Act,⁵⁴ which was the main policy of the government at that time. This resulted in a delay in the proclamation of the Act until 2007. Nevertheless, a significant event showing the role of the public in overseeing the state’s work, not long after the 1997 Constitution, was the fight to expose corruption in drug procurement in 1998.

D. Awakening and the Model of Civil Power in Scrutinizing the Operations of the Public Sector (Struggle for Transparency in Drug Procurement, 1998)

The movement to investigate corruption in the procurement of medicines and medical supplies by the MOPH originated from a collaboration between the Rural Doctors Society, the Rural Pharmacists Association, and a network of over 30 NGOs.⁵⁵ The underlying cause stemmed from a central government directive that instructed hospitals to purchase medicines from pre-designated companies at prices higher than usual. Initially, the movement to address this corruption emerged from the Rural Pharmacists/Doctors Association, which directly perceived the corruption (Dr. Wichai Chokwiwat is the one who set off the fireworks and led the movement). Later, this movement was joined by a network of NGOs. This corruption in medicine and medical supplies procurement formed a network that involved politicians, government officials, and private companies. The issue of corrupt practices in medicine was first brought to the public's attention in August 1998. Subsequently, several physicians working in community hospitals provided information. Notably, Dr. Pravit Liangsathapornwong, the Director of Uthai Hospital in Ayutthaya Province and Secretary-General of the Consumer Protection Foundation, and Dr. Yongyut Thammawut, Director of Patiw Hospital and President of the Rural Doctors Association in 1994, and Dr. Phusit Prakongsai, former President of the Rural Doctors Association in 1993.⁵⁶ These revelations emerged from the direct experiences of individual community hospital doctors. The rural pharmacists' groups also encountered issues and gathered information about corrupt practices, often in collaboration with community doctors.

The Rural Pharmacists' Association was directly involved in this matter as hospital pharmacists were responsible for managing the entire medication system of each hospital. This includes preparing medication lists, maintaining the hospital's drug inventory, procurement, specifying types, quantities, quality, and prices of medications that align with the available budget and needs. Consequently, medication procurement issues directly impact the ethical conduct of pharmacists. The Rural Pharmacists' group began noticing high-priced medication procurement around 1995. They later formed a group to exchange information about this issue. Dr. Samlee Jaidee was a central figure who led to the conclusion that there was corruption in medication and medical supplies procurement in various areas. In tandem with the pharmacists' movement, community doctors were also facing similar situations. This convergence prompted both rural pharmacists and community doctors to initiate a movement to expose corruption. In the initial stages, NGOs had limited involvement. The Rural Pharmacists' Association played a coordinating role in gathering information but had a lesser role in mobilization compared to the Rural Doctors' Association. Both the Rural Pharmacists' Association and the Rural Doctors' Association recognized that this corruption was a widespread, long-standing process across the country. It was often linked to transfers or sales of positions in various regions. Both doctors and pharmacists felt that they were being "compelled" to be part of the corrupt practices.

When the groups of doctors and pharmacists decided to expose this issue to the public, they began by collecting information and analyzing the corrupt processes and mechanisms. They aimed to make the public care about this issue consistently. In the early stages of the movement, they collected primary evidence and sought witnesses who could provide information about the corruption. They even proposed a project called “Witnesses of the Nation,” which aimed to encourage those involved in wrongdoing to come forward and share information under specific conditions guaranteeing their safety and legal protection. However, this project could not materialize as the Office of the Attorney General rejected the safeguards proposed by the doctors and pharmacists’ groups.⁵⁷

Nevertheless, examining medication corruption is like examining one’s own superiors. There was little inclination for those at the higher levels of the MOPH to genuinely investigate this corruption. Instead, they attributed the issue to receiving kickbacks in the procurement process. Some of those who exposed the corruption were subjected to investigative committees. These factors led to a movement that pushed NGOs to play a more significant role compared to governmental agencies. NGOs had more freedom to move because they didn’t rely on the bureaucratic system. This is unlike the doctors and rural pharmacists. The NGOs’ involvement in the anti-corruption campaign was facilitated by their good relationships with community doctors and pharmacists through collaborative public health development work. In this movement, the Consumer Foundation played a central role in driving the efforts of the 30 organizations. They coordinated communication, produced documents, served as a central hub for information, organized seminars, press releases, and meetings. However, the community doctors and pharmacists continued to have a role in gathering information to expose corruption directly. At the same time, the NGOs’ role was to generate pressure on the government to address the issue. This led to a joint statement and demands by the 30 NGOs on September 6, 1998. These demands included (1) Establishment of a committee to investigate corruption, and reporting directly to the Prime Minister, (2) Government protection for doctors, pharmacists, and officials involved in exposing corruption, (3) Resignation of the Minister of Public Health, Rakkiat Sukhonthawani, and the Deputy Ministers, Teerawat Siritanavankul, Chalermchai Lamsam, and (4) Resignation of Prakrom Wuthitham, Narong Saksakul, and Thawatchai Sunthornthep, respectively the Permanent Secretary, Deputy Permanent Secretary, and Assistant Permanent Secretary of the MOPH, to ensure transparency during the investigation.⁵⁸ The investigation led by Chairman Dr. Banloo Siriphanich revealed that there was indeed corruption involving both politicians and career government officials.⁵⁹ At first, the Minister of Public Health could not be held accountable. Until a committee was set up to investigate the facts with Mr. Wichai Chokwiwat was the chairman, so evidence was found against him. The Deputy Minister refused to resign but was urged by rural doctors so the minister finally resigned.

The movement of the NGO network in this instance followed the mechanism outlined in the 1997 Constitution, which stipulated the citizens’ power to scrutinize the state’s authority through Articles 303

and 304, wherein not less than 50,000 people can jointly register their names to demand an investigation into political corruption.⁶⁰ The collection of names took place from September 11 to November 18, 1998, and managed to accumulate a total of 52,554 people. This exposure of corruption had a widespread impact. As a result, the Minister of Public Health and the Deputy Minister of Public Health had to resign from their positions. Legal proceedings were initiated against the advisors to the Minister of Public Health and the private advisors of the Deputy Minister of Public Health. The Director-General of the Department of Health and several Regional Directors of Public Health were dismissed from their civil service positions. Health officials in five provinces – Ayutthaya, Nakhon Pathom, Chachoengsao, Phang Nga, and Narathiwat – were relieved of their duties. Multiple pharmacy executives were subjected to disciplinary investigations. Some politicians overseeing the MOPH were reassigned. Meanwhile, the anti-corruption movement also faced repercussions, with Dr. Wichai Chokwiwat, Miss Rosana Tositrakul, and the newspaper “Matichon” being charged with defamation.⁶¹ Dr. Yongyot Thammawut and Dr. Pravit Leesthaphong, who were among the first medical professionals to come forward with public disclosures, were appointed to a committee for investigating wrongdoing. Dr. Sanguan Nitayarumphong was investigated for being the organizer behind anti-corruption movement.⁶²

The resistance against pharmaceutical corruption marked the first instance where the Rural Doctors Society played a clear role in scrutinizing the activities of senior figures within the MOPH.⁶³ Because prior to this, since its establishment, the Rural Doctors Society had limited its scope of work, avoiding involvement in appointments and transfers, and attempting to avoid issues that could lead to conflicts with the central ministry’s service providers. However, in the case of investigating pharmaceutical corruption, it was like a “breaking point,” leveraging the strong alliance between the Rural Doctors Society and NGOs to jointly move forward and scrutinize high-level officials within the MOPH.⁶⁴ This essentially created cleared conflicts within the MOPH which could potentially hinder the reform efforts pushed from within.

However, it appears that the movement of the Rural Doctors Society and the network of NGOs had devised new strategies as outlined in the 1997 Constitution. What’s crucial is that the results of investigating pharmaceutical corruption led to proposals for the design of semi-autonomous organizations, such as suggesting a structure for committees involving proportions of the public sector, NGOs, and local governing bodies. These entities would have roles in oversight and policy-making, resulting in a fairer process. This, in turn, became the foundation for the design of healthcare reform organizations like the National Health Security Office (NHSO), Health Promotion Center (HPC), and National Health Commission (NHC), where committee compositions would draw from various sectors. This also marked a significant shift in the power dynamics within the healthcare system.⁶⁵



The political landscape during the 1987-96 decade, characterized by the May 1992 event, played a significant role in propelling the growth of Civil Society's role. Within the societal context and the public health domain, there was a growing interest in involving Civil Society in scrutiny and advocacy to influence the nation and reform the healthcare system. This trend is evident in the framework of the Draft Constitution on Constitutionalism (1994), the 8th National Economic and Social Development Plan (1997-2001), the 1997 Thai Constitution, and the (draft) National Health Act (1999), as well as the public participation trials in examining corruption in the MOPH's procurement of medicines and medical supplies (1998).

Nonetheless, if observed closely, all these developments took place during a period when the country was entering a "severe economic crisis." Undoubtedly, in the midst of the crisis, tasks and budgets related to public health were affected, leading to budget cuts and constrained resources. However, amidst this severe economic crisis, there were still many "opportunities" for healthcare system development. For instance, leveraging the focus on development and elevating primary care services, utilizing the momentum of Civil Society's awakening to experiment with state-run hospital development as seen in the case of Ban Phaeo, or the significant leap of institutionalizing Civil Society's role.

This journey progressed to the point where it even influenced the notion of basic healthcare rights for Thai citizens, officially enshrined in the 1997 Constitution. Fragments from several events were amalgamated into the core idea of the National Health Security Act. When the political scene's doors of opportunity opened with the triumph of the Thai Rak Thai Party in 2001, these efforts continued to shape the trajectory of healthcare reform.

Chapter 14

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⁴⁰ Puli Fuwongcharoen, *Thai Politics and Governance: Historical Development (1932 - 1997)* (Bangkok: Faculty of Political Science, Thammasat University, 2020), 533-539.

⁴¹ Kasian Tejapira, "People's Democracy Must Be Free from the State and Capital," in Supalak Ganjanakundee, *People's power: New Faces of Thai Democracy*, (Bangkok: Student Federation of Thailand, 1988), 25-28.

⁴² Suwit Wibulpolprasert, ed., "Society and Health Development: Academic Analysis," presented at the 1st Annual Conference of Health Systems Research Institute on "Reforming for Health: New Strategy for System Development," February 1-2, 2539, Royal Orchid Sheraton Hotel, Bangkok, Health Systems Research Institute, 1996, 2-19. <https://kb.hsri.or.th/dspace/bitstream/handle/11228/1689/hs0223.pdf?sequence=2&isAllowed=y>.

⁴³ Puli Fuwongcharoen, *Thai Politics and Governance: Historical Development (1932 - 1997)*, 562-564

⁴⁴ Suwit Wibulpolprasert, ed., "Society and Health Development: Academic Analysis," 18-19

⁴⁵ Democratic Development Committee, National Assembly, "Framework of Main Ideas in Compiling the Draft Constitution in Accordance with the Constitutionalism Approach: Part 1 Concerning the Monarchy, Part 3 Concerning the Rights of Citizens and the Oversight Organizations," (Bangkok: Government Public Relations Department, Office of the Secretariat of the House of Representatives, 1994).

⁴⁶ Nuttarute Vongtangswad, "The dynamics of framing and mobilization of the rural doctor movement: conflicts and political transformation," 193-195.

⁴⁷ For more details, see Duncan McCargo, *Reforming Thai Politics*, Nordic Institute of Asian Studies, 2002

⁴⁸ Nuttarute Vongtangswad, "The dynamics of framing and mobilization of the rural doctor movement: conflicts and political transformation," 201-203.

⁴⁹ Royal Thai Government Gazette, 'Constitution of the Kingdom of Thailand, B.E. 2540 (1997),' (Volume 114, Part 55, Page 1, October 11, 1997).

⁵⁰ For further details, refer to Borwornsak Uwanno, *Building Good Governance in Thai Society* (Bangkok: Winyuchon, 1999).

⁵¹ Komatra Chuengsatiansup, *Health Assembly: Philosophy, Concepts, and Spirit* (Nonthaburi: National Health Commission Office, 2012), 45.

⁵² National Health System Reform Committee, “Draft National Health Act” (Mountain-Moving Triangle Version), for Public Critique/Feedback (Nonthaburi: Office of the National Health System Reform Committee, 1997).

⁵³ Subcommittee drafting the National Health Act, National Health System Reform Committee, ‘Draft National Health Act B.E....Mountain-Moving Triangle Version For public hearing/listening to opinions’ (Nonthaburi: National Health System Reform Office, 5 October 2002).

⁵⁴ National Health System Reform Office, Draft Health Act, the path to well-being (Nonthaburi: National Health System Reform Office, 2004), 9.

⁵⁵ NGO Coordinating Committee on Development (NGO-COD), Thai NGO Coordination on AIDS, Network of People Living with HIV/AIDS, Foundation of Children, Thai Volunteer Service, Thai Holistic Health Foundation, Folk Doctor Foundation, The Komol Keem Thong Foundation, Industrial Pollution Study and Campaign Group, Foundation for Consumers, Rural Restoration Foundation, Arom Pongpangan Foundation, Thai Network on Community Rights and Biodiversity, Union for Civil Liberty, Consumer Rights Network, Alternative Agriculture Network, Dissemination and Promotion Development Committee, Northeastern Civil Society Organizations Coordination Committee, Spirit in Education Movement (SEM), Technology for Society Center, National Women’s Empowerment Project, Life and Nature Restoration Project, Alternative Agriculture and Consumer Project, Alternative Energy Study Group for the Future, Duang Prateep Foundation, Foundation for the better life of children, Consumer Association of Songkhla, The AIDS Access Foundation, Committee on Religious Affairs for Development, The Coordinating Committee of Primary Health Care of Thai NGOS.

⁵⁶ Nualnoi Treerat and Kanoksak Kaewthep, “Fighting Corruption: People’s Anti-Corruption Movement” (Bangkok: Political Economics Studies Center, Faculty of Economics, Chulalongkorn University, 2002), 59.

⁵⁷ Nualnoi Treerat and Kanoksak Kaewthep, “Fighting Corruption: People’s Anti-Corruption Movement,” 59–61; Associate professor Sumlee Jaidee Fund, Memorial service and cremation of Assistant Professor Pharmacist Sumlee Jaidee, Working Hard Quietly, Resting in Peace (n.p.: n.d.), 109-112

⁵⁸ Nualnoi Treerat and Kanoksak Kaewthep, 62–65.

⁵⁹ National Archives of Public Health, (24) SB 24.1.1/3 [5-8], “Investigative Report on the Allegations of Corruption by the Ministry of Public Health.”

⁶⁰ Nualnoi Treerat and Kanoksak Kaewthep, "Fighting Corruption: People's Anti-Corruption Movement," 56.

⁶¹ Interview with Rosana Tositrakul, June 15, 2022.

⁶² Nualnoi Treerat and Kanoksak Kaewthep, "Fighting Corruption: People's Anti-Corruption Movement," 74.

⁶³ Nualnoi Treerat and Kanoksak Kaewthep, 37.

⁶⁴ Prachatai, "Special Report: Revisiting Drug corruption case," Prachatai. October 31, 2004, <https://prachatai.com/journal/2004/10/977>.

⁶⁵ Nuttarute Vongtangswad, "The dynamics of framing and mobilization of the rural doctor movement: conflicts and political transformation," 206–7.



The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868–2002

The birth of a “model”
for developing countries and
the success in establishing
Universal Health Coverage

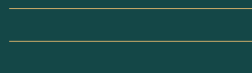




Figure 104 Image of citizens receiving comprehensive health insurance cards (2001)

Source: National Archives of Public Health, (13) C.NEG S.2.2/14.44, Presentation of Comprehensive Health Insurance Cards, Pathum Thani, March 2001.

After the economic crisis in 1997, significant changes were observed in the content included in the *"Constitution of the Kingdom of Thailand 1997."* It discussed important topics such as *"community rights," "grassroots democracy,"* and *"civilian participation in politics."* There were provisions that emphasized the involvement of the people, including requiring the state to support public participation in decision-making related to politics, economy, and society. It established mechanisms for citizens to propose laws, provided avenues for checking the misuse of state power, and created an atmosphere known as *"participatory democracy."* These constitutional mechanisms greatly influenced the movement for reforming the public health system.

Positive signals from the 1997 Constitution, being the highest institutional principle of the country after the economic crisis, led to a strengthened political environment under the framework of democracy. The Thai Rak Thai Party, founded by Prime Minister Thaksin Shinawatra in 1998, gained support from large business groups that had survived the economic crisis. It also received backing from private development organizations and rural activists, assisting in strategizing for electoral campaigns. The party advocated for fundamental structural reforms in the country, including addressing rural issues such as agricultural debt relief, village funds, and the *"30 Baht [to treat] All Diseases"* program. Simultaneously, the party promoted community empowerment and grassroots development.

The election results in 2001 showed that the Thai Rak Thai Party won with a substantial number of parliamentary seats, reaching 248 members. Within a year of the election victory, the policy of *"30 Baht for All Diseases"* was implemented. The first phase began in April 2001 in six pilot provinces: Pathum Thani, Samut Sakhon, Nakhon Sawan, Yasothon, Phayao, and Yala. The program expanded gradually and covered all provinces by October of the same year. It eventually extended to cover Bangkok in January of the following year (2002). However, one must consider the political context that facilitated this *"policy adoption."* It provided significant opportunities for reform-oriented physicians and the overarching idea of ensuring comprehensive healthcare for Thailand.

Political will and the *"30 Baht Treats All Diseases"* project: The birth of the Universal Coverage Scheme

The Thai Rak Thai Party officially registered for establishment on July 14, 1998, making it the first political party formed after the enactment of the 1997 Constitution. It achieved victory in the elections leading to the formation of the government in January 2001. The most significant context for the party's formation, policy design, and victory was the *"1997 Economic Crisis."* This major economic crisis led Thailand into a state of instability across various sectors, including economic recession, high unemployment rates, multiple financial institution collapses, export slowdowns, and declining foreign investments. Crucially, the

crisis deeply affected the people's livelihoods, and as the country transitioned into a period of government-led recovery, addressing the economic crisis became a top priority. When the country was in the midst of the crisis, the government chose to seek help from the International Monetary Fund (IMF) by agreeing to the conditions set forth by the IMF in exchange for financial assistance. However, the approach of adhering strictly to the IMF's stipulations was heavily criticized for being too stringent and inflexible in addressing the crisis.¹ Amidst a crisis of confidence in the government, then Prime Minister Chuan Leekpai decided to dissolve the Parliament. This decision subsequently led to the first election under the regulations of the 1997 Constitution. In the midst of such turbulence and political instability, public expectations escalated even further. Especially in this context, people were increasingly seeking new alternatives or fresh faces that could effectively address economic challenges different from those experienced under previous governments.² It was in such an atmosphere that Thaksin Shinawatra and the Thai Rak Thai Party chose to present a leadership image in politics characterized by successful business experience, policy proposals that were rational, and an image of a new and distinct political party from the ones that had existed in Thai society before.

A. Triumph of the Thai Rak Thai Party

Before entering the realm of politics, Thaksin Shinawatra, the leader of the Thai Rak Thai Party, was a highly successful businessman in the field of telecommunications and mobile phone services. His first political position was as the Minister of Foreign Affairs under a quota from the Palang Dharma Party in the Chuan Leekpai government during its first term. After the dissolution of Parliament, he emerged as the leader of the Palang Dharma Party, succeeding General Jamlong Srimuang as the head of the party, and participated in the election to become a member of the House of Representatives for Bangkok. He was elected, and was appointed to the position of Deputy Prime Minister under Prime Minister Banharn Silpa-archa. However, due to differing opinions, Thaksin resigned from both the government and the Palang Dharma Party. He then briefly served as Deputy Prime Minister during General Chavalit Yongchaiyudh's administration. These experiences led Thaksin to come to conclusion that to drive policies and legislation, a new political party would need to be established - one that could define the party's culture, set the direction for administration, and formulate election strategies according to genuine needs.³ The new Thai Rak Thai Party used the slogan *"Look Up to the Stars, and Keep Your Feet on the Ground"* to make Thai people aware that a new era had begun.⁴

In this context, when considering the groups of people who came together to form the Thai Rak Thai Party, they can be broadly divided into two main groups: Namely, the group of business tycoons and entrepreneurs, and the intellectuals, academics, and NGOs associated with the 'October Group.' The first group encompassed a diverse range of business entities that participated in founding the Thai Rak Thai Party. These include the media and mass communication business group of individuals like Prachai

Maleenont, the telecommunications and various other business ventures of Adisai Bodharamik, the group of business entrepreneurs related to automotive parts production led by Suriya Juangroongruangkit, and the CP Group, led by Dhanin Chearavanont. It can be said that the collaboration between Thaksin and the large business conglomerates has greatly elevated their advantage over other parties, particularly in terms of pooling financial resources for campaigning. As for the second group of party founders, consisting of the October Group, intellectuals, and NGOs,⁵ they played a crucial role for Thai Rak Thai by virtue of its potential to connect with grassroots populations across the country and garner support from intellectual middle-class individuals at the same time. This coalition had vital components for the establishment of the Party's broad base of support. Key individuals in this group include Phumtham Wechayachai, the founder of the Volunteers for Society NGO, and core groups of NGOs from around the country. Phumtham helped to inform the policy platform of the Party, and served as the liaison for Thai Rak Thai with various powerful NGOs to mobilize public participation in various forums. During this introductory phase of the Thai Rak Thai party, a key individual was Dr. Prommin Lertsuridej, a political activist who had been engaged in politics since his student years. He later served as the director of a hospital in Khon Kaen province. Dr. Phrommin then transitioned to work with the Shinawatra group as a managing director in the business development division of International Natural Resources Corporation (INRC) Limited. In 1993, when Thaksin founded the Thai Rak Thai party, Dr. Phrommin became an integral part of the policy team from the party's inception. Notable academics within the party include Somkid Jatusripitak, a former professor in the Faculty of Business Administration at the National Institute of Development Administration, and Dr. Thirapat Serirangsan, a lecturer in the Political Science department at Sukhothai Thammathirat Open University.⁶

The strategies employed to secure the victory in elections by the Thai Rak Thai party can be divided into three main approaches. The first strategy involved attracting former Members of Parliament with established constituencies to join the party. This strategy seemed to contradict the party's goal of creating a new political culture with clear ideology and professional management. However, on the other hand, Thaksin aimed to rapidly expand the Thai Rak Thai party to win elections. Therefore, he opted to bring in both politically savvy newcomers and former MPs with established voter bases into the party. The largest group of former politicians who joined Thai Rak Thai was the "Wang Nam Yen" faction led by Sanoh Thienthong, which had around 60-70 members of parliament under its affiliation. Another group was led by Somsak Thepsuthin, who received support from Thaksin and separated from the Social Action Party to bring around 25-30 members of parliament to Thai Rak Thai. A group led by Somsak Thepsuthin, who resigned from his position as the leader of the Social Action Party, brought approximately 15 members of parliament to Thai Rak Thai. Additionally, a group led by Sudarat Keyuraphan, which mostly consisted of MPs from Bangkok, along with some unaffiliated former MPs (around 20), also contributed to the party's strategies. The strategy of attracting former MPs from various political parties to join Thai Rak Thai was a crucial factor

that prepared the party to achieve its set goals. This was possible due to strong financial support from influential backers and an increased voter base resulting from the recruitment of experienced politicians from different parties.

The subsequent strategy involved creating a new image for the party leader and the Thai Rak Thai party itself. It can be observed that Thaksin Shinawatra was portrayed with a distinct image as a successful businessman, presenting a visionary outlook, offering clear solutions, and being decisive in addressing collective problems. Thaksin was presented as a highly accomplished businessperson with a strong economic standing, eliminating the need for any safeguards from corruption or makeover. This allowed for the introduction of a new selling point instead of relying on the old, criticized selling points that were no longer effective.⁷ These characteristics were never seen in any previous government leader. The Thai Rak Thai party also employed a political marketing strategy by utilizing the concept of market positioning. They positioned Thaksin as the “Deliverer” or the “Messiah,” offering the nation liberation from economic hardships. By portraying Thaksin as a wealthy global businessman, they argued that his status was suitable for solving economic crises, leveraging business expertise instead of legal expertise, unlike other political figures such as Chuan Leekpai from the rival Democrat Party who was a lawyer by profession.⁸ On the other hand, the strategic team established marketing positions that aligned with the party’s leader, through a populist policy approach that encompassed various societal groups. This approach aimed to ensure that a broad spectrum of the population from different segments benefited from such policies comprehensively. The intention was to create a distinct contrast with the policies of the rival Democrat Party.⁹ Therefore, even after being elected, Thaksin continued to apply his business background to adapt to the management of the governmental system, as stated during his first term as Prime Minister: “...we must adjust the administrative system to think in a way that prioritizes the people at the center of the government. As a businessperson, you would understand that in today’s world, any business that doesn’t focus on its customers cannot sustain itself in competition....”¹⁰

The final strategy that distinguished Thai Rak Thai Party from other political parties was the presentation of policies that were “clear” and “appealing” to the general public. At that time, the policy “30 baht treat all diseases” became one of the three major policies that were crucial to garner widespread support of the population.¹¹ This policy helped propel the Thai Rak Thai Party to winning the election with 248 seats and successfully forming a government on February 6, 2001.¹² For instance, as seen in prominent newspapers like “Naewna” and “Daily News,” which documented the atmosphere of the policy’s prominence during the Thai Rak Thai Party’s campaign in the 2001 election, it was stated that “*The Thai Rak Thai Party gained electoral support by making numerous promises to the people... Most recently, they announced that all citizens, totaling 62 million people nationwide, who seek medical treatment in hospitals, regardless of the illness, will only have to pay 30 baht per visit, covering both treatment and*

medication, until they recover...”¹³ This promise was most exciting and intriguing that captured the attention of people all across the country. Every sector agreed with this concept in principle, and felt that it would genuinely benefit the underprivileged members of the population.¹⁴ In the same vein, the newspaper “DAILY NEWS” blared the headlines that *“The policy that has generated excitement and captured the attention of the entire nation at this moment is the ‘National Health Insurance Policy: 30 Baht, Treat All Diseases, by the New Government!’”*¹⁵

However, before it became a policy for garnering votes, it can be said that Dr. Sanguan Nitayarumphong played a pivotal role in “pushing” and “promoting” the core concept of universal health coverage to various political parties.¹⁶ Not only the Thai Rak Thai Party, but also Dr. Paichit Pawabutr the former Permanent Secretary of the Ministry of Public Health (MOPH) (1992 – 1994) and a former colleague of Dr. Sanguan while working in Khon Kaen and at the MOPH, mentioned a period when Dr. Sanguan presented the concept to various political parties. *“[Sanguan] went to present it to several parties... Even the Democrat Party had the proposal, but they didn’t take it. When he presented it to Thai Rak Thai, they accepted it.”*¹⁷ In this regard, Aphisit Vejajiva, who held the position of Minister Attached to the Prime Minister’s Office during 1997-2001, which was a period of advocating Dr. Sanguan’s ideas, explained the significant reasons behind the fact that the Democrat Party could not respond positively to the proposal regarding universal health coverage as follows:

“

“Before [the policy] emerged with Thai Rak Thai, Thailand was still trying to recover from the economic crisis [of the late 1990s]. Thus, we proposed limiting the government budget and promoting financial discipline... The Democrat Party was concerned about the budget. After calculations, it was felt that we weren’t ready... The party didn’t explicitly disagree in principle, but saw that it wasn’t yet feasible. If we aren’t prepared, there will be consequences concerning the quality of care... anything that benefits the public. Political parties don’t often deny such proposals. However, if there was any mistake, it was that the Democrat Party was overly cautious. More cautious than if they had actually scrutinized the proposal itself.”¹⁸

”

Aphisit elaborated further that the Democrat Party recognized the importance of health development throughout its history. For instance, they supported the expansion of healthcare rights through segmented groups within the People’s Health Promotion Program (1992-1994). They established the National Health System Reform Office (2000) to research and draft the National Health Act. They promoted the delegation of power in the case of Ban Phaeo Hospital (2000). Furthermore, they initially pushed for the establishment

of the Health Promotion Support Fund Office (HPSFO) (starting in 2000, before the Democrat Party dissolved Parliament, and the policy was later continued by the Thai Rak Thai Party). Several health-related policies received support from the Democrat Party.¹⁹ Therefore, the concern regarding “budget” became a significant challenge that created uncertainty for the Democrat Party’s approach to universal health coverage.

At the same time, the key concerns of the Thai Rak Thai Party were not substantially different from those of the Democrat Party. Encounters and discussions between the healthcare reform group led by Dr. Sanguan Nitayarumphong and members of the Thai Rak Thai Party involved key thinkers such as Dr. Surapong Suebwonglee and Dr. Prommin Lertsuridej. In particular, Dr. Surapong was the “middleman” in connecting with Dr. Sanguan to give him a direct voice with the Thai Rak Thai Party leaders.²⁰ Dr. Surapong reflected on that period with the following observations:

“

“During the time when Dr. Sanguan presented his proposal to the Prime Minister on Christmas Eve (1999...As a businessman, he could easily gauge the budget and where the leeway came from. However, other parties might not have delved into the details...The various narratives depend on the type of mindset. If they wanted to do it, they would find ways to fund it.”²¹

”

Thaksin Shinawatra himself has recounted memories multiple times through various media channels, recalling the period when Dr. Sanguan Nitayarumphong presented the comprehensive health insurance concept to the Thai Rak Thai Party. Dr. Sanguan Nitayarumphong had passionately described the thorough approach to implementing comprehensive health insurance.²² Thaksin reflected about that period in the following way:

“

“Many political parties didn’t embrace this idea. But when Thai Rak Thai was newly established, and if there was an advocate that showed interest and pushed for it, the Party wanted to see the Thai people have access to comprehensive health insurance. They explained it to me, along with Dr. Surapong. We found it interesting, consulted further after the conversation about how to allocate funds, and there was a new budget management for the MOPH that was adjusted. So, we decided to make it a significant policy of Thai Rak Thai at that time, and up until today, the Thai people have been able to access comprehensive health insurance.”²³

”

Dr. Wichai Chokwiwat, who had been involved in discussions with Dr. Sanguan and members of the Thai Rak Thai party on certain occasions, explained Thaksin's decision-making process, which was swift and personally influenced. Thaksin himself stated that it had to be lower than [the fee charged by Ban Phaeo Hospital, which was 40 baht], so it was set at 30 baht. The decision for 30 baht was made on that day.²⁴ Dr. Siriwat Thiptharadol added that *'Thaksin is skilled and decisive, he makes quick decisions. He bought it right away. He gained popularity from the 30-baht policy, it's marketing... [at the same time] It was a good timing that this project emerged from his bold decision-making.'*²⁵ **Therefore, it must be acknowledged that the decision to 'buy' into the policy of the leader of the Thai Rak Thai Party and its use for political gain constituted a manifestation of political will. This significant instance marked the starting point for opening up space, allowing reform-minded doctors to actively push for the policy to materialize in practice.**

Once the party gained votes and successfully formed the government, urgent policies were proposed, especially those aimed at tackling poverty, recovering from economic problems, and addressing 9 key issues. One of the nine important points, as declared by Prime Minister Thaksin to the parliament on Monday, February 26, 2001, was 'Point 7: *"Establish a universal healthcare scheme to reduce overall expenses of the country and citizens in healthcare, with a payment of 30 baht per visit, and provide equal and accessible healthcare services for all citizens"*'.²⁶

Furthermore, in the subsequent statement, the administration of the Thai Rak Thai Party also expanded upon its goal to develop individuals holistically, encompassing physical, mental, and intellectual well-being. It aimed to strengthen society by focusing on public health and well-being. The government was committed to establishing service systems and safeguards for health, ensuring the overall well-being of the Thai population by reforming the healthcare system. This was intended to reduce the country's overall healthcare expenditures and the individual costs associated with healthcare. Additionally, it aimed to create a foundation for guaranteeing access to medical services and healthcare that met universal and equitable standards.²⁷



Figure 105 The image of Thaksin Shinawatra, during the initiation of the 30 Baht Treat All Diseases.

Source: National Archives of Public Health, (13) SF S.6/5.29, 30 Baht healthcare policy.

Therefore, in the overall context, it can be seen that before the emergence of the ‘30 Baht healthcare policy,’ which was derived from the goal of establishing a comprehensive health security for all the people of Thailand, as mentioned earlier, in the aftermath of the 1997 economic crisis, the movement regarding rights and the increasing role of Civil Society had a significant impact on the emergence of the comprehensive health security or the ‘30 Baht Treat All Diseases’ program. This is because it served as a catalyst, as evident from the spirit of both the 1997 Constitution and the 9th National Economic and Social Development Plan (2002-2006), which set the objective to expand health insurance coverage to encompass the entire population and uphold equity.²⁸ When the ‘fire’ of political acceptance within the Thai Rak Thai Party encountered the ‘fuel,’ it led to the emergence of the comprehensive health security policy in practice. In this way, the utilization of new market-oriented strategies and policies yielded results that contributed to the ‘victory’ of the Thai Rak Thai Party. Simultaneously, it became the ‘first step’ of success for the group of reformist physicians who advocated the ideas and methods behind it. Furthermore, it served as the ‘starting point’ for the country’s comprehensive health security system.

B. Universal Health Coverage or the “30 Baht Treats All Diseases” project in practice

After achieving victory in the January election and announcing policies in February 2001, the “30 Baht Treat All Diseases” became an urgent policy that the Thai Rak Thai Party was determined to initiate as swiftly as possible.²⁹ There is a group of rural doctors and Dr. Mongkol Na Songkhla who are nearby to follow up. The program was initiated with its first phase within the following two months, in April 2001, in six provinces: Phayao, Yala, Nakhon Sawan, Pathum Thani, Yasothon, and Samut Sakhon.³⁰ This initial phase of the project was carried out under the regulations of the MOPH concerning the establishment of the Universal Health Coverage (UHC) program in 2001 and the guidelines for the funding support of the

UHC program. The reason for selecting these provinces was that all six provinces had previously implemented Social Investment Program (SIP) projects funded by the World Bank, which allowed for a continuation of efforts from these earlier initiatives. A key figure in confirming the selection of these six provinces was Dr. Mongkol Na Songkhla, who was the Permanent Secretary of the MOPH at that time (2000-2001). He personally selected these provinces and ensured that they were ready for immediate implementation. Dr. Surapong Suebwonglee, then the Minister of Public Health, who played a role in implementing the policy, further explained the choice of additional provinces: *“The selection of the additional 6 and 15 [pioneer provinces] might be based on readiness and ensuring comprehensive coverage in every region. If we were to implement it in areas that are not ready, it might create more problems.”*³¹ Dr. Mongkol, who had outlined the guidelines, also assembled a team of doctors to assist in the pioneer areas. This team included Dr. Sanguan Nitayarumphong, Dr. Prateep Thanakitcharoen, and also Dr. Surapong Suebwonglee. In the initial phase of service provision, people were required to present a health coverage card called the “Gold Card,” which had been distributed to eligible individuals after a survey conducted by each province’s public health department. This system was put in place to ensure readiness. Starting from April 1, 2001, individuals could use the card to access services at any healthcare facility, paying a fee of 30 baht.³² Dr. Mongkol reflected on this period as follows:

“

“During the three-month period from late 2000 to early 2001, we were fully engaged, gathering together to brainstorm and discuss how we could benefit and make the most of the resources available. It was a time when we all came together to contemplate strategies and ways to manage the available funds. Eventually, we had to pool resources from various government departments to kickstart the initiative. Dr. Sanguan played a pivotal role in coordinating financial matters with the Prime Minister at the time. In the end, we managed to extend our efforts to every province, covering them all comprehensively. This narrative reflects our real struggle. Dr. Sanguan was the leader, and the others who followed him contributed significantly to the health coverage initiative throughout.”³³

”

From April 1st, just two months later, the Phase 2 of the project commenced on June 1st, 2001, expanding to an additional 15 provinces. These provinces included Nonthaburi, Saraburi, Sa Kaeo, Phetchaburi, Nakhon Ratchasima, Surin, Nong Bua Lamphu, Sisaket, Ubon Ratchathani, Amnat Charoen, Sukhothai, Phrae, Chiang Mai, Phuket, and Narathiwat. These were the provinces that willingly prepared themselves to join the initiative as pilot sites, having observed the success of the first phase's implementation.³⁴ Following that, in October 2001, the initiative was expanded until it covered all provinces across the country, in line with the intentions of Dr. Mongkol, the MOPH Permanent Secretary, who affirmed the goal of nationwide coverage by October. Speed was an imperative since Dr. Mongkol would have to retire in September of that year. He humorously observed that: *"I have to be grateful for being so old. If the Permanent Secretary had been someone younger, we might not have advanced so fast."*³⁵ Dr. Surapong mentioned that the UHC for the Bangkok metropolitan area would be implemented later, in January 2002, despite the initial plan to launch it in October 2001. This adjustment was made due to various challenges of Bangkok, where the healthcare system was complex and involved a higher proportion of specialized care for both patients and service providers. Additionally, there were issues with allocating the population to specific healthcare facilities, along with concerns related to budget allocation.³⁶



Figure 106 The image depicts a meeting discussing the guidelines for implementing the universal healthcare scheme on March 13, 2001. In attendance were officials from the MOPH, including Dr. Sanguan Nitayarumpong (on the left)
 Figure 107 Dr. Prateep Thanakitcharoen (on the right)
 Figure 108 Dr. Suwit Wibulpolprasert (bottom left).
 Figure 109 Dr. Mongkol Na Songkhla (Permanent Secretary of the MOPH at the time, on the left), and many other participants (bottom right).

Source: National Archives of Public Health, Document (13) C.NEG S.2.2/14.33, Main Guidelines for Health Insurance Meeting, March 2001.

At the same time, the previous healthcare welfare card known as “ Medical Welfare Scheme (MWS)” (blue card), which provided medical benefits to the general public, was discontinued and replaced with the UHC card (Gold Card), exempting destitute individuals from the 30baht co-payment for medical services. This new card would bear the letter “th” (pronounced as “tho”) in the upper-right corner. The official use of the blue card was terminated starting from January 1, 2002 onward.³⁷ Regarding the 500 baht healthcare insurance card, there was an order to cease its sale starting from May 2001.³⁸ It can be stated that the consolidation of the blue card program with the voluntary healthcare insurance fund into the Universal Healthcare Coverage (UHC) fund, ensured that the population of approximately 45 million people across the country would receive equal healthcare benefits.³⁹ Simultaneously, the fundamental rights to comprehensive healthcare gradually expanded throughout the country.



Figure 110 Image of citizens receiving the Universal Health Coverage (UHC) cards (2001).

Figure 111 the Universal Health Coverage (UHC) cards or Gold Card

Source: National Health Security Office, Reference Note (13) C.NEG S.2.2/14.44, UHC card distribution in Pathum Thani, March 2001.

Even though the MOPH had prepared facilities, service provision, and public relations efforts for the citizens extensively, the initial period did not only witness positive sentiments towards the UHC policy. Various issues were raised collectively in the media at the time. For instance, the set fee of 30 baht was considered relatively high and it was argued that it should be provided for free. Many voices from rural areas expressed concern about the 30 baht fee, stating that while it might be a small amount for urban residents, for rural people, 30 baht meant a substantial portion of their daily expenses, equivalent to meals for the entire day.⁴⁰ Media outlets presented news about the public's lack of confidence in accessing services, explaining that villagers still felt uncertain about receiving the same care as regular patients. Based on the numbers of service recipients in the 6 pilot provinces, where nearly 2 million people were registered, there were only slightly over a hundred people who used the UHC services on the first day.⁴¹ Also, there was the fact that people lacked confidence in community hospital treatment, which led to issues regarding cross-district/province service utilization and difficulty in accessing quality healthcare facilities.⁴² There was also an indication that the UHC system remained confusing due to additional charges imposed by service units or, in some cases, names being excluded from the system.⁴³

Given the demands from various healthcare providers, appeals were made to reconsider the 30-baht policy once again, as it was seen to limit the quality of patient care. For instance, sometimes there were materials, medications, or other equipment beyond the UHC-set standards that could be beneficial to individual patients. Thus, the feeling was that the government should allow healthcare facilities or doctors to present alternative options for patients to decide. In such cases, patients would have to bear additional costs beyond what the UHC covered. This was because a fee-for-service approach led hospitals to focus more on cost-cutting rather than emphasizing service quality.⁴⁴ However, it must not be forgotten that the aforementioned viewpoints emerged shortly after Thai society entered a significant transformation of the healthcare system and service delivery models that had not been prevalent before. Within the MOPH, led by Sudarat Keyuraphan, the Minister of Public Health at the time, there was no complacency. The MOPH accelerated public outreach efforts to inform people about the “30 Baht for All Diseases” program. This included disseminating documents titled “What will the people get with Health Coverage: 30 Baht Treat All Diseases? If you have doubts, this provides answers,” and the document “30 Baht Treat All Diseases: Towards Universal Health Coverage (UHC).”⁴⁵ In conjunction with the distribution of the “Gold Card,” there was continuous publicity effort.⁴⁶ Minister Sudarat conveyed the perspective of the early days of the new policy, emphasizing that it was not a simple change: “Initially, we introduced it in just a few provinces. We tried to work with the provinces that were willing to participate and agreed with us. At that time, we traveled every day, going everywhere to open our hearts, to understand the healthcare personnel across the country. I took personal responsibility to encourage and foster collaboration, aiming to establish a successful system...”⁴⁷



Figure 112 Minister of Health Sudarat Keyuraphan, promoting the “30 Baht for All Diseases” program.

Figure 113 Atmosphere while the Minister of Public Health is publicizing the 30 baht project to cure all diseases.

Figure 114 Public relations project: 30 baht treat all diseases in Pathum Thani Province (2001)

Figure 115 30 Baht campaign in Bangkok (2002)

Source: National Archives of Public Health, (13) SF S.6/5.29, 30 Baht for All Diseases; National Archives of Public Health, (13) SF S.6/5.30, Patients using the 30-baht card; National Archives of Public Health, (13) C.NEG S.2.2/14.44, Presenting Health Insurance Cards in Pathum Thani, March 2001; National Archives of Public Health, (13) C.NEG S.2.2/15.88, Providing Knowledge about 30 Baht to VHVs and Communities, January 2002.

In addition to communication and accelerating service unit expansion, another aspect that went hand in hand with the nationwide extension of rights was the establishment of task forces to oversee the transitional phase. These task forces were responsible for designing the structure and system of the project before the enactment of the National Health Security Act in 2002. During this period, the MOPH remained the primary agency responsible for managing operations during the transitional phase. A significant part of this effort was the formation of “10 Subcommittees,” tasked with studying the details, steps, and methods to be implemented in various aspects, as follows:

1. Subcommittee for Developing Benefit Packages and Financial Management
2. Subcommittee for Quality Standard Development
3. Subcommittee for Information System Management
4. Subcommittee for Public Relations and Complaint Resolution
5. Subcommittee for Service Network Development
6. Subcommittee for Developing the Supporting Infrastructure of the Main Health Security System
7. Subcommittee for Purchaser Development and Building Management Flexibility
8. Subcommittee for Human Resource Development within the System
9. Subcommittee for Knowledge Development to Enhance System and Project Evaluation
10. Subcommittee for Monitoring Draft Legislation of the National Health Security Act⁴⁹

The conclusions from the work of these 10 subcommittees were compiled and published as a book in May 2001, with revised and updated versions released in January 2002.⁵⁰ The publication was named “Guidelines for Establishing Universal Health Coverage in the Transition Period.” This publication served as a framework for stakeholders to use as guidance in implementing the policy, including objectives, principles, and key measures in policy execution.⁵¹

Another task was the issuance of regulations to govern the implementation of the pilot project in all 3 phases before the enactment of the National Health Security Act 2002, specifically the MOPH’s regulations regarding health coverage principles in 2001 (versions 1 and 2).⁵² These establish the principles, conditions, service entitlements, and various benefits within the scope of the pilot project and appointing a main “Health Insurance Committee” responsible for setting policies and operational standards in different areas, as well as controlling, supervising, and evaluating the implementation during the transitional phase. It also involved the consolidation of beneficiaries under various health welfare projects, such as the health coverage program for low-income earners and socially vulnerable individuals, health insurance cards, or any other health security frameworks provided by the state, all of which were brought under the purview of the MOPH regulations regarding the establishment of the UHC scheme, as stipulated in the MOPH regulations regarding the establishment of UHC 2001 (version 3).⁵³ The regulations mandated the establishment of “Provincial Health Insurance Committees,” which were responsible for formulating health policies and plans for the area to align with the central framework. They set criteria and allocated resources according to the guidelines set by the central UHC committee.

In June 2001, the “National Health Policy Committee” was established with the purpose of setting policies to facilitate the transition to Universal Health Coverage (UHC). The committee was responsible for creating framework plans, coordinating with all relevant sectors, conducting an evaluation of the National Health Insurance Act, researching operational guidelines for health insurance, and providing essential information for health insurance management. The committee also offered recommendations and advisory input to the Cabinet in terms of national policy concerning health insurance creation. The appointed committee members included well-known individuals such as Dr. Prawese Wasi, Jon Ungpakorn, Dr. Am Sayamwalla, Dr. Pairode Ningsanon, Saree Aongsomwang, and Dr. Surapong Seubwonglee.⁵⁴ In the early months of 2002, this committee proceeded to pass a resolution to establish 7 Subcommittees, each responsible for studying specific details in various areas, which included: (1) Subcommittee on Quality of Service Development (2) Subcommittee on Financial and Treasury System Development (3) Subcommittee on Service Network Development (4) Subcommittee on Citizen Empowerment and Protection (5) Subcommittee on Benefit Package Development (6) Subcommittee on Management Structure Development (7) Subcommittee on Health Insurance Information System Development. The proposals from these 7 Subcommittees were subjected to Public Hearings to gather input from various

stakeholders. They were also discussed during a major academic conference held at the Sirikit National Convention Center from August 26 to 28, 2002. The findings from these discussions were presented to the National Health Policy Committee for approval.⁵⁵ In this context, amidst various regulations, agencies, task forces, and subcommittees that were established, the role of the “UHC War Room” can be described as a vital “think tank.” Its significance extended from the selection of provinces for pilot projects, the formulation of service delivery models, and even encompassed budget calculations. This central hub played a crucial role in driving the transformation towards the creation of Universal Health Coverage (UHC) in this endeavor.



Figure 116 A seminar on the topic “30 Baht Policy: Thailand’s Universal Health Coverage” was held on March 30, 2001, featuring speakers such as Dr. Ammar Siamwalla, Dr. Surapong Seubwonglee, Dr. Sanguan Nitayarumphong, and Dr. Mongkol Na Songkhla.

Source: National Archives of Public Health, (13) C.NEG S2.2/14.33, Main Guidelines for Health Insurance Seminar, March 2001

C. Budget allocation for capitation payment and salary pooling

Another challenging aspect that goes hand in hand with pushing for universal health coverage (UHC) to be established in various regions across the country is the matter of budget management. As Sudarat Keyurapan mentioned, beyond the publicity efforts, “*The major decisions involved allocating the per capita budget and determining whether to consolidate salaries.*”⁵⁶ In this context, it is important to understand that the creation of the UHC through the 30-baht scheme was based on the principle of “sharing suffering, sharing happiness” among all members of society. This implied a system that

distributed the financial burden (Risk Sharing) arising from illness so that those who are healthy assist those who are ill, and those who are well-off assist those who are less fortunate. Consequently, the principle of sharing suffering and happiness within the UHC system must be implemented in a “comprehensive and obligatory” manner. This approach was a lesson learned from the weaknesses of the voluntary health insurance system, which led to issues with risk distribution due to the enrollment of only those who were already experiencing health problems or were prone to illness. Ultimately, this led to financial issues within the program. Therefore, the creation of UHC was closely tied to the concept of societal solidarity, which allowed people within the same population to mutually support each other, even without direct personal relationships, but based on their membership in the same community.⁵⁷

In order to design a sustainable system based on the principle of “sharing suffering, sharing happiness,” and ensure its long-term viability, three crucial components need to be considered: Policy Sustainability, Financial Sustainability, and Institutional Sustainability. Regarding Institutional Sustainability, in terms of policy sustainability, it began with the push to ensure the nationwide coverage of the UHC scheme or the “30-baht Scheme to Treat All Diseases” starting from January 2002. Then, the focus shifted to Financial Sustainability, which required careful planning from the outset. During the initial implementation in the 6 pilot provinces, the UHC War Room calculated the required per capita budget. Relevant stakeholders were involved in the budget calculation process, building on their experience from the previous Social Security Scheme project, leading up to the UHC. This remained the responsibility of Dr. Viroj Tangcharoensathien and the working group. Previously, Dr. Viroj had proposed a similar “capitation payment” budgeting model in the Social Security Scheme project in 1990.⁵⁸ He proposed a co-payment system between the government and the public in the Health Card project.⁵⁹ He also served as a member of the working group that proposed budget figures for the healthcare reform of Baan Phaeo Hospital in 2000.⁶⁰ Not to mention his extensive experience in healthcare finance.

Around April 2001, when the pilot project began, the budget figure of 1,202 baht per capita for the co-payment system started to appear in various media. It's important to note that this budget figure of 1,202 baht proposed by Dr. Viroj and his team was based on two types of raw data. The first type is “cost of medical treatment data,” which is broken down into 7 sub-costs. The second type is “healthcare utilization data,” divided into outpatient and inpatient services. The raw data of the first type encompassed seven sub-costs of medical treatment expenses, as follows⁶¹

- (1) **Cost per unit of health center** was based on a cost study of 55 health centers in Samut Sakhon Province in 1999.⁶² It was found that the cost per medical treatment was equivalent to 59 baht.
- (2) **Cost per unit of community hospital** was based on a cost study of hospitals in 15 northern provinces.⁶³ (Excluding Chiang Rai and Kamphaeng Phet) In 1999. It was found that the average cost per outpatient visit was 221 baht, while the cost per inpatient stay was 2,857 baht.
- (3) **The cost per unit of provincial hospitals** was based on a study of cost per unit of provincial hospitals across 92 locations nationwide in 1999.⁶⁴ It was found that the average cost per outpatient visit was 278 baht, while for inpatients, it was 5,424 baht.
- (4) **The cost of private clinics:** As there was no unit cost available at the time for private healthcare facilities, including both clinics and hospitals, the working group determined that the cost of community hospitals would serve as a proxy for the cost for private clinics, which was 221 baht for outpatients and 2,857 baht for inpatients.
- (5) **The cost of private hospitals** was based on the cost of provincial hospitals. The cost for private hospitals was 278 baht for outpatients and 5,424 baht for inpatients.
- (6) **High-cost treatment** expenses was based on data from the Social Security Scheme in 1999 and 2000, covering 8 different treatment methods.⁶⁵ It was found that the expenditure per insured individual in this case over the two-year period was 10 and 13 baht, respectively, when adjusted for the number of elderly individuals (who were not covered by Social Security). These elderly individuals had a higher likelihood of incurring expensive medical costs compared to the insured pool of individuals, accounting for 35% of the total. Thus, the cost was increased to 13 and 18 baht per person per year. Based on the above-mentioned calculations, the working group estimated the budget requirement for the UHC to be 32 baht per person per year.
- (7) **Emergency accident** expenses was based on the operation of the Social Security program during 1997 – 2000, and were found to be 29, 25, 26, and 25 baht per person per year, respectively. The working group estimated that the costs for emergency accident cases in the UHC would likely be similar, thus, they used the figure of 25 baht per person per year.

In summary, based on the raw data regarding healthcare treatment costs in all 7 categories, the calculation of individual cost components for each category can be determined as follows:

- Cost per unit of health center: 59 baht
- Cost per unit of community hospital: Outpatient 221 baht, Inpatient 2,857 baht
- Cost per unit of provincial hospital: Outpatient 278 baht, Inpatient 5,424 baht
- Private clinic cost: Outpatient 221 baht, Inpatient 2,857 baht
- Private hospital cost: Outpatient 278 baht, Inpatient 5,424 baht
- High-cost medical treatment cost: 32 baht
- Emergency accident case cost: 25 baht

- (1) **In the case of outpatient care**, referring to the survey conducted by the National Statistical Office in 1996, it was found that Thai individuals fell ill without requiring hospitalization at a rate of 4.3 times per person per year. The proportion of individuals who utilized healthcare services was 0.66, resulting in an average of 2.9 healthcare service visits per person per year. This usage was further divided into visits to health centers at 0.15 times, community hospitals at 0.13 times, provincial hospitals at 0.16 times, private clinics at 0.19 times, and private hospitals at 0.03 times per person per year.
- (2) **In the case of inpatient care**, using the same data source as outpatient cases, it was found that Thai individuals required hospitalization due to illness at a rate of 0.07 times per person per year. This utilization was divided into visits to community hospitals at 0.33 times, provincial hospitals at 0.49 times, and private hospitals at 0.18 times per person per year.

Both sets of raw data were used to calculate additional cost items, including “cost of health promotion and disease prevention services,” which was set at 20% of the benefits package for medical treatment. The estimated cost was 175 baht. The other cost item, “investment cost,” was set at 10% of the cost of medical treatment. The estimated cost was 93 baht.

Based on all the above data, these criteria were employed for calculations to determine the per capita budget for the population. The results were as follows: outpatient care for non-hospitalized patients at 574 baht, inpatient care at 303 baht, high-cost medical conditions (such as heart disease and cancer) at 32 baht, emergency care at 25 baht, health promotion and disease prevention at 175 baht, and a remaining

reserve budget of 93 baht. This reserve budget is earmarked for central funds to handle investments, unforeseen high-cost medical treatments, or emergency care. This is important as certain hospitals might face financial challenges and require a contingency fund.⁶⁷ However, the development of these aforementioned figures in practice was not without challenges, obstacles, and negotiations, as significant progress had to be made before arriving at these specific numerical values.

Starting from the historical context of the numerical calculations, it was found that during the initial stages of budget estimation, there existed not only the figure of 1,202 baht. Rather, diverse opinions emerged. For instance, Dr. Suphasit Panarunothai, a member of the public health finance team, was involved in contributing to the calculation of figures, but the outcomes varied. Dr. Suphasit recounted, “On that day, ‘Thai Rak Thai’ won. In January 2001, there was a meeting at Government House. On March 17, I proposed 1,500 baht, while Viroj countered with 1,200 baht. That day was like a tennis match. Eventually, the government chose 1,200 baht to implement the policy right away.”⁶⁸ While Viroj pointed out that the calculations were theoretically and methodologically accurate, they also utilized evidence from social insurance for comparison. Clearly, as the numbers diverged, disputes naturally arose to a reasonable extent. Therefore, “Capitation wasn’t thrown around like rose petals; there was an operational discourse, but it was Dr. Sanguan’s leadership that guided it.”⁶⁹ Furthermore, Dr. Viroj explained that when the capitation payment system was implemented, it led to another crucial point of contention that had both proponents and opponents. That is whether the aforementioned per capita budget should include or not include salary payments.

From the allocation of budget through a capitation-based approach, distributed according to the number of registered individuals utilizing healthcare services in each area, the UHC can be simplified as a “money follows patients” concept. The core idea behind distributing the budget in this manner is to anticipate that it will lead to changes in public health services that better meet the needs of the population. This approach allows areas with larger populations to receive a higher budget allocation. Consequently, healthcare facilities in these areas would have greater potential to pull various resources, including healthcare personnel, to the region. Conversely, areas with excessive resources compared to the population they serve would have their budget allocation shifted to the first type of area. This could limit their ability to further expand services due to budget constraints. The outcome of such a budget allocation approach results in a more even distribution of healthcare resources, of all types, to areas that genuinely require these services. Therefore, this foundational principle is a means to extend coverage and enhance the healthcare system without necessitating a substantial increase in budget.⁷⁰ One of the budget components that needs to be allocated according to the aforementioned principle is salaries.

In the initial stages of the UHC system, budget allocation on a per capita basis included incorporating personnel salaries as a part of the allocated budget for each province. This led to financial imbalances for provinces with a relatively large number of personnel compared to the local population. Specifically, the budget allocated on a per capita basis was proportionally allocated for relatively higher salaries, resulting in a smaller operational budget (some provinces have “negative” budgets). This imbalance caused challenges in funding operations and service delivery due to the lack of resources. Conversely, hospitals with fewer personnel but a larger population under their responsibility faced budget surpluses as the increased funds could not be easily converted into additional personnel. As a result, healthcare services remained constrained as before.⁷¹ The budget allocation system mentioned above was first implemented during Fiscal Year 2002, starting on October 1, 2001. This date marked the expansion of the “30 Baht Treat All Diseases” program nationwide. Today, this moment is considered the starting point of the capitation payment system, where personnel salaries were included in the healthcare insurance budget.⁷²

However, when evaluating the results of the UHC scheme between 2003 and 2004, it was found that including salaries within the capitation payment system led to at least two significant issues. Firstly, the integration of various budgets, including personnel salaries and other hospital expenses into this scheme didn’t consider the fact that healthcare facilities had responsibilities beyond providing medical care under the UHC program. Secondly, the most significant problem arising from this allocation method was the redistribution of budgets, which didn’t account for the actual healthcare resources such as personnel, infrastructure, beds, equipment, and various tools. Although efforts were made to reallocate these resources, the practical implementation was more challenging than merely transferring budget allocations. One of the outcomes was that some hospitals in certain areas received insufficient budgets to cover staff salaries.⁷³ The aforementioned issues are evident from the voices of some stakeholders, such as the perception that it may be a good allocation principle, but the problem lies in the “per capita cost of 1,202 baht for community hospitals. This can be well managed, while provincial hospitals face insufficient funds.”⁷⁴ This is further complicated given the fact that personnel distribution cannot occur within a short period or some personnel have family-related necessities that hinder their free mobility.⁷⁵

These challenges led to a proposal to redirect budget back to larger-sized hospitals, known as “salary separation,” which was suggested prior to its nationwide implementation in October 2001. The approach involved separating the salary component of MOPH hospitals from the lump-sum budget allocation, then consolidating these salaries at the provincial level. The remaining budget would then be allocated to hospitals based on the registered population. This approach resolved salary payment issues for larger hospitals with substantial personnel, but the problem was that this proposal contradicted the principle of allocating budgets based on population size. Some central project managers disagreed with this proposal. Eventually, a compromise was reached where each province could decide whether to adopt

this approach or not. Data from October 2001 indicated that more than half of the provinces chose to separate salaries from the lump-sum allocation and consolidate them at the provincial level.⁷⁶ In 2003, the MOPH transitioned to a method where the salaries of civil servants and employees within the Ministry were separated from the lump-sum budget allocation. Subsequently, the remaining budget was then allocated to healthcare facilities.⁷⁷ In the 10 years following the inception of the universal health coverage system, research conducted by the Health Systems Research Institute indicated that the equitable distribution of healthcare resources between provinces, although somewhat successful, faced challenges. This was primarily due to the lack of clear policies from the MOPH regarding the fair allocation of personnel, leading to the ongoing necessity of segregating personnel salaries when allocating budget resources on a per capita basis.⁷⁸ However, the issues surrounding budget allocation and salary consolidation continue to pose significant challenges, especially after 2002, when the National Health Security Office (NHSO) was established to manage budget allocation for eligible individuals under the UHC system. This necessitates an examination of the origins of the NHSO and other concurrent developments that occurred during the same period.



After facing the economic crisis, political strengthening within the framework of democracy emerged. The Thai Rak Thai Party, founded by Thaksin Shinawatra in 1998, advocated for structural reforms in the country's foundational systems. The party received support from NGOs and rural activists, prioritizing rural issues in their campaign strategies. The "Universal Health Coverage Scheme" or the "30 Baht Treat All Diseases Scheme," conceptualized and spearheaded by a reform-minded group of doctors led by Dr. Sanguan Nitayarumphong and his team. This platform played a significant role in the victory of the Thai Rak Thai Party in the 2001 elections.

Following the election victory and the introduction of the "30 Baht Treat All Diseases" policy in April 2001 across six provinces, its implementation expanded to cover all up-country provinces by October of the same year, and to the entire Bangkok Metropolitan Area in January 2002. Alongside this policy enactment, there were advancements in enacting two crucial pieces of legislation: the draft National Health Promotion Fund Act and the draft National Health Security Act. The first draft led to the establishment of the Thai Health Promotion Foundation (ThaiHealth), while the second draft led to **the formation of the National Health Security Office (NHSO)**. These offices played integral roles in driving the implementation of UHC.⁷⁹ While ThaiHealth played a crucial role in providing health promotion and disease prevention (P&P) services, it can be considered a concept that has evolved in parallel and alignment with one of the objectives of the National Health Security System. This system designates health promotion and disease prevention (P&P) services as benefits provided to all Thai citizens equally. As a result, during the period of advocating for the National Health Security Act, it became a favorable opportunity and another significant step in the advancement of the NHSO's efforts.

Chapter 15

¹ ThaiPublika, 15 Years of Economic Crisis 1997: Where is Thailand ?, 53.; Bukhoree Yeema, "Populist Policy Platform and Economic Power: The Political Economy of Thai Rak Thai Party's Election Success," 98.

² Kevin Hewison, Thaksin Shinawatra and the reshaping of Thai politics, *Contemporary Politics*, 16(2), June 2010: 119-133, 121

³ Watcharabon Buddharaksa, "The Thaksin Government's Attempts to Build Hegemony," (Master's thesis, Faculty of Political Science, Chulalongkorn University, Bangkok, 2006), 50.

⁴ Thai Post, "'Thaksin Shinawatra' New Face, Steps Forward After Dissolution of Parliament," NewsCenter, January 17, 1999.

⁵ Kritthep Somsanuk, Nattacharach Aengmahatsakul, Do it Right and Fear No Man: Dr. Suwit Wibulpolprasert (Bangkok: International Health Policy Program (IHPP) and Health Intervention and Technology Assessment Program (HITAP), 2013), 100.

⁶ Watcharabon Buddharaksa, "The Thaksin Government's Attempts to Build Hegemony," 50–52.

⁷ Daily News, "Thaksin Shinawatra, the Ace in the Political Game Reflecting the New Breed of Politician," NewsCenter, January 28, 2001.

⁸ Bukhoree Yeema, "Populist Policy Platform and Economic Power: The Political Economy of Thai Rak Thai Party's Election Success," 148.

⁹ Bukhoree Yeema, 157.

¹⁰ Ministry of Interior, Prince Damrong Rajanubhab Institute, Various Perspectives of Prime Minister Thaksin and the Development of Civil Servants (Document of Knowledge No. 2/2004) (D-Library | National Library of Thailand, 2004), 1, <http://164.115.27.97/digital/items/show/10380>.

9 Urgent policies include (1) suspending repayment of debts for small-scale farmers for 3 years, (2) establishing community and village funds of 1 million baht each (part of the "One Tambon, One Product" or OTOP policy), (3) establishing a People Bank to support low-interest loans for micro-enterprises, (4) establishing medium-sized and small-sized cooperative banks to develop existing and new business operators systematically, (5) forming a central asset management company to provide assurance to banks for loan, (6) developing state enterprises to be a key organization for economic recovery and revenue for the

country, (7) creating a comprehensive universal health coverage system to reduce overall expenses of the country and citizens in healthcare, with a cost of 30 baht per visit, ensuring universal and equitable access to standardized healthcare services, (8) accelerating the establishment of drug rehabilitation centers in parallel with suppression and prevention efforts, and (9) promoting citizen participation in prevention and suppression of corruption.

¹¹ In addition to the policy of 30 Baht Treat All Diseases, two other significant policies include 1 million baht for each village and a 3-year debt suspension for farmers.

¹² Online News, "'Thaksin' Tells History: The Beginning of '30 Baht Treat All Diseases,' 'Doctor Sanguan' Helps Over a Million People," Matichon Weekend, 2015, https://www.matichonweekly.com/hot-news/article_510532.

¹³ Naewna, "Introduction: 30 Baht Treat All Diseases," NewsCenter, January 13, 2001.

¹⁴ Naewna, "Introduction: 30 Baht Treat All Diseases."

¹⁵ Pongphan Boonlert and Dailynews, "Variety: True or Not... Peeja Sajab Raksa Hua Jai-Aids," NewsCenter, January 18, 2001.

¹⁶ Interview with Dr. Wichai Chokwiwat, May 17, May 23, and June 2, 2022; Interview with Dr. Siriwat Thiptharadol, May 20, 2022; Interview with Dr. Prateep Thanakitcharoen, June 6, 2022; Interview with Dr. Surapong Suebwonglee, May 27, 2022; Interview with Jon Ungphakorn, June 25, 2022. For more details, see Sanguan Nitayarumphong, Universal Health Coverage: Key Issues and Implementation Guidelines (n.p.: n.d.), and Sanguan Nitayarumphong, Suphasit Panarunothai, and Samrit Srithamrongsawat, Towards Creating Universal Health Coverage (Nonthaburi: Office of Healthcare Reform Project, (n.d.).

¹⁷ Interview with Dr. Paichit Pawabutr, May 30, 2022.

¹⁸ Interview with Mr. Abhisit Vejjajiva, May 26, 2022.

¹⁹ For further details, see Piyanart Worasiri, Revisiting Reform: The Thoughts and ideals of the Workers in the Healthcare Reform Movement, Volume 1 (Nonthaburi: National Health Commission Office, 2014).

²⁰ Interview with Dr. Prateep Thanakitcharoen, June 6, 2022.

²¹ Interview with Dr. Surapong Suebwonglee, May 27, 2022.

²² Online News, "'Thaksin' Tells History: The Beginning of '30 Baht Treat All Diseases,' 'Doctor Sanguan '

Helps Over a Million People,” January 19, 2022, https://www.matichonweekly.com/hot-news/article_510532

²³‘Ung Ing’ Presents the ‘Tony Woodsome Award’ to ‘Doctor Sanguan,’ the Pioneer of 30 Baht: Matichon TV (Youtube, 2022), <https://youtu.be/DSfRQw8mcrk>.

²⁴Interview with Dr. Wichai Chokwiwat, May 17, May 23, and June 2, 2015.

²⁵Interview with Dr. Siriwat Thiptharadol, May 20, 2015

²⁶Electronic Document Management System, “Policy Statement of the Cabinet of Prime Minister Thaksin Shinawatra to the House of Representatives on Monday, February 26, 2001” (Electronic Document Management System, February 26, 2001), 4–5.

²⁷Electronic Document Management System, “Policy Statement of the Cabinet of Prime Minister Thaksin Shinawatra to the House of Representatives on Monday, February 26, 2001,” 16–17.

²⁸Office of the National Economic and Social Development Council, “The 9th National Economic and Social Development Plan, 2002–2006,” Office of the National Economic and Social Development Council, 2001, Accessed August 1, 2023, https://www.nesdc.go.th/ewt_w3c/ewt_dl_link.php?nid=3784.

²⁹Amphon Jindawatthana and Suranee Pipatrotchanakamol, *Seeing Through 30 Baht Treat All Diseases: The Foundation of Universal Healthcare Coverage* (Nonthaburi: Academic Welfare Project Praboromara-jchanok Institute, 2004), 42.

³⁰Thai Post, “30 Baht Treat All Diseases, Trial Phase in 6 Provinces,” NewsCenter, February 22, 2001.

³¹Interview with Dr. Surapong Suebwonglee, May 27, 2015.

³²Daily News, “Pathum Thani Hospital Ready to Implement 30 Baht Treat All Diseases: Ensuring Affordable and Quality Medication,” NewsCenter, March 30, 2001.

³³Heart to Heart Foundation, *Notes from the Commemorative Event for Dr. Sanguan Nitayarumphong* (Nonthaburi: Heart to Heart Foundation, 2022), 9–10.

³⁴Daily News, “Saraburi Queue up for the 30 Baht Project,” NewsCenter, May 7, 2001; Naewna, “Surin Ready to process 30 Bant Treat All Diseases, Private Hospitals Participate,” NewsCenter, May 19, 2001; Daily News, “Upper Southern Region and Phuket Ready for 30 Bant,” NewsCenter, June 1, 2001; Daily News, “Phetchaburi Clarifies Eligible Participants in 30 Baht Project,” NewsCenter, May 17, 2001; Daily News, “Lan Na-Chiang Mai Ready to Pioneer 30 Baht Treat All Diseases project,” NewsCenter, June 12, 2001.

³⁵ Interview with Dr. Surapong Suebwonglee, May 27, 2015.

³⁶ Daily News, “30 Baht Treat All Diseases in Bangkok, Not in Time for October 1st, doing pilot project in inner Eastern zone,” NewsCenter, July 24, 2001; Suwit Wibulpolprasert, “The issue of 30 Baht Treat All Diseases and Healthcare Reform,” (Nakhon Pathom: ASEAN Institute for public health Development, Mahidol University, 2004).

³⁷ Naewna, “Former Low-income Card Holders Urged to Replace Cards with Gold Cards Before January 1, 2002,” NewsCenter, December 22, 2001.

³⁸ Pongpisut Jongudomsuk, e.d., *Until It Becomes Universal Healthcare Coverage* (Nonthaburi: National Health Security Office (NHSO), 2004), 21-22.

³⁹ Thai Post, “Disbanding the Health Card Fund for the Poor, Expanding 30 Baht for All Diseases Services,” NewsCenter, March 15, 2001.

⁴⁰ Daily News, “Nai Kamhaeng’s Finger Column: Even If You’re Rich or Poor, It’s Only 30 Baht,” NewsCenter, March 22, 2001.

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⁴² Thai Post, “30 Baht Treat All Diseases: Comprehensive Failure,” NewsCenter, December 31, 2001.

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The Art of Establishing Universal Health
Coverage in Thailand: From Past to
Present, c.1868-2002

The birth of the National Health
Security Office (NHSO)
as the “representative of the people”
in parallel with driving the Thai
Health Promotion Foundation
(ThaiHealth)

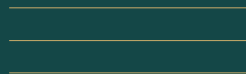




Figure 117 Dr. Surapong Suebwonglee, Dr. Winai Wiriyakitcha, and Dr. Sanguan Nitayarumphong at the Universal Health Coverage agenda meeting, January 2002.

Source: National Archives of Public Health, (13) C.NEG S.2.2/15.90, MOPH, and executives attending the Universal Health Coverage agenda meeting, January 2002.

During the period of expanding the national health insurance system, there was a push to empower organizations that supported various missions, officially backed by laws to ensure the stability and sustainability of operations related to the national health insurance for the benefit of the majority of the population, not merely as a politically expedient policy. One notable organization was the Thai Health Promotion Foundation (currently 'ThaiHealth'), established under the Health Promotion Foundation Act of 2001, with a crucial role in advocating, stimulating, promoting, supporting, and funding various agencies to drive health promotion. This aimed to encourage individuals to change behaviors, beliefs, and the environment, ultimately leading to a reduction in illness rates.

Subsequently, the National Health Security Office (NHSO) emerged, not long after, established under the National Health Security Act of 2002. This office was mandated to reform the public health system through financial measures. The NHSO's role as a "people's representative" was to manage and allocate health-related benefits and budgets within the national health insurance system officially. These developments were significant during the establishment of the Universal Health Coverage (UHC) insurance system in 2001 and the emergence of the NHSO in 2002. They confirmed that health wasn't just a matter of charity but a "right" for all Thai citizens, solidifying the idea that everyone should have access to basic, essential health care. This perspective is further explored through the examples of ThaiHealth and NHSO.

Another significant step of the ThaiHealth, one of the organizations in the "health-related" family (2001)

The establishment of the Thai Health Promotion Foundation, or ThaiHealth, was mandated by the Health Promotion Foundation Act in October 2001. It is a non-governmental organization operating under the supervision of the Prime Minister. ThaiHealth's mission includes advocating, stimulating, supporting, and funding various societal organizations to drive the process of health promotion, aiming to reduce illness and premature deaths. Simultaneously, it aims to improve the environment to enhance quality of life. The distinctive aspect of ThaiHealth lies in being the "principal funding source," which is a budget derived from 2% of alcohol and tobacco taxes.¹ ThaiHealth operates as a state organization but not a government agency, overseen by the Prime Minister. Its primary objective is to support initiatives that promote health and well-being, aiming to decrease illness rates and premature deaths while enhancing the living environment.

ThaiHealth is considered one of the four institutions in the S. family (i.e., which begin with the letter "Sor" in Thai), with the objective of reforming the public health system. The mechanism supporting ThaiHealth's reforms involves allocating resources to nurture the social sector, transforming it into a force driving public policies. Simultaneously, it also holds the responsibility of contributing to a preventive health care

system.² Before the establishment of ThaiHealth, efforts to distribute resources to social sector organizations by reform-minded doctors had been ongoing, especially during the 1980s. In this period, rural doctors began working in central positions within the Ministry of Public Health (MOPH). **It could be argued that the emergence of ThaiHealth was a response to the desire for “preventive medicine” and it solidified the role of the societal sector as an “institution” with stability driving this aspect.** However, ThaiHealth’s inception is intertwined with the social context’s development, knowledge formation, and attention given to various issues, such as understanding the health risks of smoking. This led to the necessity of controlling tobacco consumption through tax measures. The emergence of the idea of health-promoting organizations and the notion of “sin taxes” came together, utilizing the increased tax revenue from reduced tobacco consumption to fund health promotion activities. Understanding ThaiHealth’s emergence can’t be separated from comprehending the shift in direction and the evolving vision of healthcare system reform.

A. The idea of budget funding from sin taxes

The pivotal path that led to the emergence of ThaiHealth began with the campaign addressing the issue of smoking and its health impacts in the late 1970s (please refer to Chapter 7 for more details). In that context, numerous activities, organizations, institutions, and laws emerged to control smoking. For instance, the “Anti-Smoking Campaign” in 1986, the “Marathon Run Campaign for Non-Smoking” in 1987, and subsequently, the establishment of the National Committee on Tobacco Control (NCTC) in 1989, followed by the creation of the Tobacco Control Bureau (TCB) in 1990. These were significant efforts aimed at reducing smoking rates, marking the first instance of a state organization tasked with campaigning to decrease smoking rates. This eventually led to the enactment of the Tobacco Products Control Act in 1992 and the Health Protection Act for Non-Smokers in the same year.³ Therefore, the provisions regarding the ban on tobacco advertising and promotion, the development of campaign activities, the establishment of organizations, and the drive to enforce these laws were the essential foundations for the emergence of ThaiHealth. These aspects have been instrumental in shaping collective knowledge, bolstering the role of the societal sector, and enhancing the public’s experience in campaigns about the dangers of smoking. Simultaneously, the government intensified regulations controlling the sale and consumption of tobacco. Thus, the framework concerning the hazards of smoking and the necessity of reducing tobacco consumption was a shared consensus across all sectors and has become an undisputed societal norm today. These factors are akin to “old knowledge” that has gradually accumulated over time. However, the process of ThaiHealth’s emergence constitutes a synthesis of both this “old knowledge” and “new knowledge.”⁴ The new framework comprised the economic costs and the cost of addressing health problems. This included knowledge about sin taxes, knowledge about health-promoting organizations, and knowledge about fiscal laws and regulations. Together, they have effectively shaped a fair disposition towards channeling budgetary allocations from sin taxes into the Thai Health Promotion Fund.

Hence, the campaign against smoking has become the linkage between “health outcomes” and the “economic costs” required to address health issues associated with smoking rates. This knowledge is a significant foundation for the concept of investing in health, often referred to as “money talk.” What it says and how it says it can vary, but the clearest importance lies in the visible reduction of funds used for treating patients, which is crucial.⁵ There are international organizations and scholars working to generate knowledge and support the advancement of this issue in a principled manner. For instance, the World Health Organization is making direct efforts to promote health initiatives in Thailand through various means, including supporting knowledge creation, funding projects, and organizing international conferences. Additionally, the World Bank has released reports that underscore the importance of utilizing economics to study health-related issues, particularly concerning smoking. These reports highlight the economic repercussions tied to health problems resulting from smoking. Thai public health experts have also begun to apply economic frameworks to study smoking issues in order to compare outcomes and the costs incurred by the tobacco industry. Research institutions specializing in public health serve as knowledge hubs, central to advocating for sin taxes, and critical health-promoting organizations. In particular, during the period when Dr. Supakorn Buasai assumed the role of Deputy Director at the Health Systems Research Institute (HSRI), it marked a phase for HSRI that actively fostered movements aimed at creating a relevant “knowledge package” related to direct campaigning on sin taxes. This corresponds to emphasizing the significance of investing in health.⁶

With Dr. Supakorn’s interest in policies to reduce tobacco consumption, which dates back to his earlier years as a rural physician and continued during his studies in the United States at a time when there was opposition to the United States’ policy of promoting a free tobacco market in Thailand.⁷ Research opportunities on this issue arose later, and answers were obtained from research work dating back to 1993, indicating that imposing a tobacco tax is a necessary measure to slow the expansion of smoking. Lessons from various countries clearly point out that no country has been able to curb the expansion of smoking without utilizing tax measures. Even if other measures are in place, if cigarette prices remain low, those other measures will not be effective.⁸ These findings were presented to the MOPH and were subsequently implemented, leading to the introduction of the tobacco tax policy in the late 1993. This policy marked the first time that the government declared a tobacco tax not solely for revenue increase, but out of health necessity. The results of the tobacco tax implementation led to a rise in state revenue from 15 to 20 billion baht in 1994. Following this success, the tobacco tax was increased six more times. The persistence in pushing for these measures led to success, and it was assessed as “the first victorious step in promoting the tobacco tax policy.” This progress then paved the way for further movements to channel the increased tobacco tax towards health promotion. At that time, however, a clear direction was not yet established.⁹ However, at this juncture, the issue of reducing tobacco consumption appeared to have a promising and vibrant trend. That is because the government saw a substantial increase in revenue from

the tobacco tax. On the other hand, the idea of investing in health promotion had gradually gained traction and acceptance.

Nevertheless, the concept of an “earmarked tax” or “dedicated tax” that involves earmarking the collected taxes from alcoholic beverages, beer, and tobacco to be allocated for health promotion, as well as the notion of establishing health promotion organizations was a relatively new idea in Thai society at the time. This led to the Victorian Health Promotion Foundation – VicHealth of Australia becoming a significant model for organizational development in Thailand.¹⁰ VicHealth is a model health promotion organization that the World Health Organization recommends for many member countries to learn from, in order to adapt its working principles for implementation in each respective nation.¹¹ Dr. Supakorn, who had successfully advocated for the implementation of the tobacco tax in 1993, had the opportunity to meet Rhonda Galbally, the CEO of VicHealth, during an international conference in 1995. As a result of this meeting, both Dr. Supakorn and Bung-orn Rittipakdee were invited to represent the anti-smoking campaign and study the operations of VicHealth in July of the same year.¹²

VicHealth is a quasi-governmental autonomous organization with three main missions: (1) providing funding for activities in health promotion, safety, and disease prevention to raise awareness of the importance of good health; (2) promoting lifestyles conducive to good health through community-based initiatives; and (3) supporting research and development aligned with the aforementioned goals. VicHealth's revenue, collected from a 5% cigarette license fee, is distributed according to the organization's missions. Approximately 20-30% of the revenue is allocated to support health promotion, safety, and disease prevention activities, while another 40% is dedicated to promoting healthy lifestyles through community or school-based initiatives. Additionally, 20% of the budget is allocated to research support, and the remaining 10% is used for operational purposes.¹³ Overall, the budget received by the MOPH is subject to the final approval of the Prime Minister. This issue constitutes one of the limitations of VicHealth, where the allocation of the ultimate budget relies on the “discretion” of those in political power. This leads to an important lesson when designing the revenue structure for ThaiHealth, ensuring that the tax revenue is directly tied to health promotion to safeguard against the influence of political forces.

In August 1996, the World Health Organization supported funds that led to the establishment of a research team to draft legislation for the creation of a health promotion organization between HSRI and the Office of the Attorney General. The goal was to review laws of various countries regarding the establishment of health promotion organizations. Researchers from this project were attorneys from the Office of the Attorney General, and their research found that many countries had established organizations for health promotion, some funded by cigarette taxes or budget allocations. This study raised questions about the ethical integrity of using cigarette taxes to support health promotion organizations, as these funds were

used to address health or safety concerns of non-smokers as well. Crucially, this work did not support the notion of earmarking a fixed portion of cigarette tax revenues to the fund, as it went against budget allocation principles.

However, these criticisms did not widely circulate nor significantly impact the momentum of the movement. Between 1995 and 1996, those involved in advocating for health promotion organizations had garnered enough knowledge about such organizations to develop policy proposals and initiate the movement earnestly. This process ultimately led to the creation of ThaiHealth.

B. Driving the knowledge of HSRI (Health Systems Research Institute) to establish UCS.

In addition to the genuine interest of Dr. Supakorn Buasai, who was considered a key figure in the HSRI organization, in 1996, one could also observe the direction of movement and advocacy coming from HSRI itself. Starting with HSRI, there was a full-fledged academic conference titled “Reform for Health: New Strategies for System Development.”¹⁵ This conference served as a platform for sharing knowledge, experience, and expertise in health promotion. The event marked a significant step in the progression of the movement and was followed by further efforts to advance health promotion policies and practices. This conference served as a platform for introducing new policy agendas and initiating advocacy efforts, involving both political and social sectors, due to the participation of several key figures in the field of public health. Notable attendees included M.R. Jatumongkol Sonakul, the Permanent Secretary of the Ministry of Finance, who chaired the committee responsible for financial planning and implementation strategies for social finance plans. Additionally, Rhonda Galbally, the Director of VicHealth, was one of the presenters showcasing VicHealth’s work on the stage.

After the conference, Dr. Prakrit Vathesatogkit and Dr. Supakorn Buasai led the Director of VicHealth in meetings with Surakiart Sathirathai, the Minister of Finance, and M.R. Chatumongol Sonakul. As a result of these discussions, the MOPH assigned HSRI to study and develop proposals for health promotion organizations. Subsequently, HSRI organized a seminar titled “Establishing Support and Development Organizations for Health Promotion” on April 10, 1996, to discuss important issues such as the structure, responsibilities, roles, and funding sources of health promotion organizations. The conference facilitated the exchange of knowledge and the mobilization of support from diverse experts in various fields.

Its outcomes led to the formation of a working committee tasked with drafting the “Health Promotion Fund Act,” attempting to draw comparisons with similar organizational models that existed previously, such as the Research Fund Act of 1992 and the Public Health Research Institute Act of 1992. The proposed model for the “Health Promotion Fund Act” aimed to establish a legal entity organization under the jurisdiction of the MOPH, funded by the original budget allocation and supplementary funding allocated by the government from the annual budget, equivalent to at least 3% of the excise tax on cigarettes.

It can be observed that the proposed approach for the fund was not entirely new, as it still involved annual budget allocations from the regular process. However, it emphasized setting aside a specific percentage (at least 3%) of the excise tax on cigarettes for the purpose of health promotion, without direct ties between tax collection and the allocation of revenue to the health promotion office, bypassing the Central Budget Bureau and the regular budgeting process.¹⁶

The continuous advancement of knowledge in establishing health promotion organizations remained evident. On May 15, 1996, HSRI collaborated with the Faculty of Public Health at Mahidol University to organize a conference titled “Vision and Reform of Health Promotion in Thai Society.”¹⁷ In this conference, Dr. Prawese Wasi proposed the idea of establishing a Health Promotion Bureau using “sin taxes” as a means of funding. This independent organization would be tasked with stimulating genuine health promotion activities. Operating under the guidance of a committee, this freedom would result in agile, effective, and efficient work.¹⁸ Subsequently, HSRI collaborated with the World Health Organization to organize a conference on the topic “Regional Workshop on Organizational and Funding Infrastructure for Health Promotion” in November 1997.

The outcomes of this conference involving 10 participating countries highlighted the shared conclusion that there was a need to develop foundational structures and budgets to mitigate health risk factors related to behaviors and environmental conditions.¹⁹ In May 1998, HSRI organized another academic conference titled “Promoting Health: New Roles in the Era of Everyone.”²⁰ The participants proposed that health promotion is a “new public health paradigm.” The key proposals included three main points: (1) The primary health threats to Thai people arise not just from infectious diseases, but also from accidents, cardiovascular diseases, and cancer, which require significant societal resources for treatment. (2) These problems can be controlled and reduced through proactive health promotion efforts. (3) Effective health promotion beyond the government sector requires substantial participation from Civil Society. Many proposals from the meeting led to discussions about establishing health promotion organizations. Therefore, public advocacy and collaboration became another area where ideas about health promotion organizations were presented to various entities and networks to foster understanding and garner support. During the same period, the political mechanism was utilized to drive these efforts concurrently. An interesting point to note in the ThaiHealth initiative is that its development progressed rapidly around the same time as the NHSO (which wasn’t referred to as NHSO at that time) was being advocated for.

C. Driving through political mechanisms

In the political arena, the advocacy began in February 1996 when a pathway emerged to drive the establishment of health promotion organizations under the Banharn Silpa-archa Administration. An order was issued to create the “Policy Committee for Regional and Local Development, 1996.”²¹ One of the four subcommittees under the National Health Security Board is the “Power Decentralization Subcommittee,”

which presented the concept of “Social Finance and Treasury” aimed at utilizing financial and treasury measures to strengthen community organizations, distribute essential social services, and create health insurance foundations. The formulation of the “Treasury and Finance Master Plan” by the Power Decentralization Subcommittee served as a channel for the financial strategy of health promotion organizations and is one of the main strategies of the NHSO plan. Upon approval of the NHSO, the “Committee for Implementing the Treasury and Finance Master Plan for Social Welfare” was established in May 1996, with M.R. Chatumongol as the chairman. Nevertheless, even though the master plan included health promotion organizations, the concepts remained somewhat unclear. The plan merely suggested the encouragement of private sector involvement in taking responsibility for the country’s public health, without necessitating direct state intervention, but rather encouraging the government to allocate or support adequate financial resources.²²

While the initial push through the “Treasury and Finance Master Plan” within the Power Decentralization Subcommittee of the National Health Security Board did not make significant progress, in August 1996, the Subcommittee for Implementing the Treasury and Finance Master Plan for Social Welfare took a step forward. This subcommittee was tasked with developing proposals for the establishment of private institutions for public health and funds for health promotion and health insurance. Dr. Sanguan Nitayarumphong was appointed as the chairman, and Dr. Prakrit the vice-chairman. Other members of the subcommittee included Dr. Suphasit Pananarothai, Dr. Viroj Tangcharoensathien, as well as representatives from the Budget Bureau, the Ministry of Finance, and the National Economic and Social Development Board, among others. In simple terms, it can be summarized that the merging and joint meetings of the “Health Promotion Fund” and “Health Insurance” concepts occurred. While there were separate discussions in practice, when it came to the “Health Promotion Fund,” there were key figures driving and propelling the discussions. Prof. Dr. Prakrit (the advocate), Dr. Supakorn (the presenter to policy makers), and Bang-orn Ritthipakdee (the link to the social and media sectors) were the central figures in convening and driving the meetings.²³ However, with the underlying concepts and objectives of both the Health Promotion Fund and Health Insurance, they each played a supportive role in contributing to the greater good. As Dr. Prakrit emphasized (in the below quote), it is important to understand the goal of developing the Thai Health Promotion Fund, which would later transform into ThaiHealth:

“

“ThaiHealth works in tandem with the NHSO, with ThaiHealth providing support to the NHSO to prevent illnesses. This led to the idea of establishing a fund, allocating budget support. Looking at the example of Australia, we proposed that this project could assist the NHSO in creating a fund, without the government having to pay, but instead having tobacco companies contribute. It’s like riding the NHSO wave, although at that time the NHSO wasn’t named that, it was simply referred to as health insurance.”²⁴

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Therefore, the transformation of Thailand’s healthcare system through the initiation of key health insurance projects marked a significant turning point that prompted the government and society to recognize the tobacco issue more clearly.²⁵ As a result, the formation of this collaborative working group led to a genuine push for policy proposals in health promotion. The working group dispatched representatives to study the operations of health promotion organizations such as the Health Sponsorship Council (HSC) in New Zealand and VicHealth in Australia. That study tour aimed to understand organizational models, operational strategies, challenges, and constraints, with a focus on revenue sources, especially the use of “sin taxes” to promote health. The delegation comprised four members from the Ministry of Finance, the Budget Bureau, the Comptroller General’s Department, Dr. Prakit and Dr. Sanguan. The findings of this study led to the conclusion that the VicHealth model was suitable for replication in Thailand, wherein comprehensive health promotion activities are carried out by a coordinating organization rather than individual entities. However, it was proposed that health promotion funds should have a sustainable income base, which would be more reliable than relying on uncertain and politically vulnerable annual budget allocations. Therefore, it was suggested that tying funds from sin taxes to health promotion was a suitable approach. Additionally, establishing a health promotion institute was considered a worthwhile investment, as drawn from the experiences of VicHealth and HSC. In December 1996, the delegation presented a report to the Permanent Secretary of Finance to assess the feasibility of establishing a health promotion organization in Thailand. The report evaluated the potential benefits of investing in health promotion for three cases: accidents, smoking, and healthcare costs. At that time, the overall health budget was approximately 200 billion baht. The assessment estimated that successful health promotion efforts could lead to a 10% reduction in healthcare expenses, potentially saving up to 20 billion baht.²⁶

In March 1997, after presenting the report to the Permanent Secretary of Finance, the working committee following the master plan reached a resolution approving the proposal put forth by the working group regarding the cost-effectiveness of the investment. However, some committee members, such as Surakiat Satianthai, the Minister of Finance, agreed with the concept but remained skeptical about the method of collecting earmarked taxes for specific purposes. He believed that this approach could potentially undermine fiscal discipline.²⁷ At this juncture, although there were differing opinions regarding the linking of cigarette taxes to health promotion organizations, it was a positive trend that Thailand needed to establish an organization dedicated to health promotion. However, when changes in government caused progress to stall temporarily, until the government was reshuffled, the matter of health promotion organizations was brought up for consideration during a meeting of the working committee following the master plan for fiscal and social finance in April 1998. Abhisit Vejjajiva, as the Deputy Chairman of the committee tasked with bureaucratic reform, proposed the establishment of a health promotion organization according to this plan, with the status of a Royal Decree as a draft Non-Governmental Organization Act was being considered by the Parliament. Nevertheless, the key point of the draft Act for health promotion organizations proposed by Abhisit continued to specify that the income would come from the government as initial capital and annual subsidies provided by the government as appropriate.²⁸

During the same period unrelated to the aforementioned processes, the government established the “Fund for Campaigning Against Alcohol and Tobacco Consumption” to reduce pressure and impact from the policy of liberalizing the sale and production of alcohol, which might lead to increased alcohol consumption. Overall, tobacco was also considered a health-harming product. Dr. Prakit, who had been advocating for the establishment of health promotion organizations earlier, suggested merging the activities of the Fund for Campaigning Against Alcohol and Tobacco Consumption with the ongoing efforts of health promotion organizations in September 1999. During a meeting of the National Social Policy Committee chaired by Prime Minister Chuan Leekpai, with Dr. Prawese and Dr. Sanguan as committee members, the decision was made to establish the “Office of Health Promotion Support” and create a task force to study the merger of the two funds.²⁹ Before the “Health Promotion Support Fund Act” could be endorsed by the parliament, Thailand transitioned into the era of the Thaksin government. The Act was officially announced in November 2001, in line with the main funding source for the Thailand Health Promotion Fund. The funding was to come from taxes collected by the government from alcohol and tobacco producers and importers, at a rate of 2% of the tax payable. This provision is stipulated in Article 11 of the aforementioned Act.³⁰ Subsequently, it was the time for the National Health Security Act of 2002, which played a supplementary role and significantly propelled the establishment of ThaiHealth shortly thereafter.

Much before becoming the National Health Security Act (2002)

The establishment of the National Health Security Office (NHSO) under the National Health Security Act of 2002 is considered a manifestation of the “public financial management reform mechanism” aimed at overseeing the Universal Health Coverage (UHC) system. A key principle in creating a new organization to manage the primary health insurance system is the “purchaser-provider split,” which entails separating the roles of funding allocation and service provision. This means shifting the budget management authority away from the MOPH, as the service provider, and forming a new organization that represents citizens’ rights within the national health insurance system to purchase services from the MOPH. The newly established NHSO in 2002 was thus entrusted with two crucial missions: “negotiating service purchases,” a vital aspect of efficiently managing the National Health Security Fund, and controlling the public health service system to ensure citizens’ access to standardized and quality services.

Such a financial management reform necessitated NHSO to operate independently and free from the control of the MOPH. With NHSO acting as the government’s representative for purchasing and negotiating healthcare service costs on behalf of the public, the MOPH took on the responsibility of overseeing the production side. In principle, these two functions needed to remain separate and independent from each other.³¹ If making healthcare accessible to people was the goal of establishing the UHC, then creating the organizational mechanism of NHSO, supported by official legislation and including the design content within the “National Health Security Act,” can be likened to the “backbone” of the reform. This backbone ensures that the objective of creating a comprehensive, strong, and sustainable health foundation is achieved, rather than being merely a short-term policy aimed at gaining votes for any particular government.

Prior to the enactment of the National Health Security Act of 2002, there were three previous attempts to push for the fundamental legislation that underpinned this law. Each attempt was linked through the pivotal role of Dr. Sanguan Nitayarumphong, who orchestrated these connections and ultimately led to the creation of the National Health Security Act in 2002. The initial drafts of this act emerged during the years 1995-1996.

A. The first draft of the Act (1995-96) in the Working Group of the Public Health Committee

During the period when Dr. Sanguan was invited to serve as an advisor to the Public Health Commission of the House of Representatives, he utilized this opportunity to propose the idea of a national health insurance scheme. Subsequently, a working group was established to “draft” the health insurance legislation. This group was chaired by Somsak Kunngern, a representative from the Democrat Party of Khon Kaen province. The working group gathered representatives from various sectors, including the

Chart Thai Party, Thai Nation Party, government officials from the MOPH and the Ministry of Labor, as well as members of the legislative committee. Together, they successfully formulated the “Draft Health Insurance Act.” This draft legislation defined the compulsory basis for having health coverage, with contributions from both the public and the government into the National Health Insurance Fund. However, Dr. Sanguan did not achieve complete success in pushing for this draft legislation, as despite general agreement in principle among academics and various agencies, they believed that Thailand was not yet ready in terms of budget allocation. Hence, the draft health insurance act was put on hold, awaiting further adjustments, and it eventually became the foundation for the “Draft National Health Security Act” in 2002, in the subsequent years.³²

Although the initial draft of the health insurance bill during the 1995-1996 period did not progress, this experience provided important lessons for Dr. Sanguan, particularly in terms of the method of pushing for the main health insurance legislation “under the government system.” It made him realize that such efforts were primarily carried out within the realm of the bureaucracy, academia, and a minority of politicians, with the largest group that would benefit from the law having little involvement. If this group could understand and support this robust version of the legislation, it could transform into the most formidable proponents of the law.³³ For this reason, Dr. Sanguan took this idea and engaged in exchanges to seek cooperation with Civil Society organizations that had just found new avenues to drive various social policies through the 1997 Constitution. **When reaching this point, it became even more evident that the political atmosphere and the growth of rights and the movement of Civil Society after the 1997 financial crisis greatly influenced the formulation of the healthcare system direction in Thailand. One of these impacts was the incorporation of the content of the draft “People’s Version” of the bill into the process.**

B. The Draft version for the public

In the 1997 Constitution, apart from changing the principles concerning the state’s responsibilities in healthcare, explicitly defined as the “right” of the people to receive standardized and efficient healthcare services in Article 52 and continuously reiterated in Article 82, which specifies that the state is obliged to ensure the provision of “standardized and efficient” healthcare services, there is also a notable provision regarding the role of Civil Society organizations through the avenue presented in Article 170, which grants citizens the direct right to propose legislative drafts to the House of Representatives. This structural opportunity created a space in which Civil Society networks could actively participate and mobilize to propose fundamental healthcare legislation.³⁴ Dr. Sanguan, once again, played a role as a leader in sharing the concept of fundamental healthcare assurance with Civil Society organizations such as the AIDS Access Foundation, the Volunteer Foundation for Society, the Consumer Foundation, and others. This eventually led to the establishment of an organization that brought together a network of Civil Society groups, all with the common goal of advocating for the creation of Universal Health Coverage (UHC). This

initiative was known as the “Campaign for UHC.”³⁵ This involved the consolidation of healthcare development organizations and a network of 11 Civil Society networks, with Professor Jon Ungpakorn as a key leader. Jon Ungpakorn reflected on the starting point that led to the advocacy for UHC, stating the following:

“

“Before 2000, I worked at the AIDS Access Foundation. We encountered an ongoing problem that people couldn’t afford to buy medicine, even basic antiretrovirals or antifungal mouthwash. There were many deaths. So, we started fighting for access to medicine... We wanted access to medication and healthcare services. At that time, Dr. Sanguan was pushing for the concept of fundamental healthcare assurance... We conducted polls asking the public if they would want a healthcare insurance system without having to pay for treatment. The response was overwhelming, with people demanding it. Dr. Sanguan then met with us, and he presented the concept of creating healthcare legislation. He gathered enough like-minded people to join, and we started a working group representing NGOs to draft the legislation. At that time, we saw that Dr. Sanguan’s draft law was not yet comprehensive, and we wanted to be a part of it.”³⁶

”

In this legislative drafting process of the UHC advocacy project, led by Professor Jon Ungphakorn as the chairman, there was collaboration with numerous academics, legal experts, and consultants who possessed the necessary skills to form a team to draft the primary National Health Security Act. Notable figures such as Attorneys Nakorn Chomphuchat, Sureerat Treemakka, Pharmacist Dr. Yupadee Sirisinsuk, and others played significant roles in drafting the UHC legislation in the “Peoples’ Version.”³⁷ Dr. Yupadee emphasized the significance of drafting this version of the National Health Security Act, indicating that *“When we engaged in drafting this law, we had a long-term perspective in mind because if it’s just government policy, it might not have lasting impact. We wanted it to be enduring.”*³⁸ Apart from the drafting team, there was another team responsible for creating media and videos for dissemination and public awareness. While spreading news and preparing for the public’s acceptance of this draft of the National Health Security Act, there was a period during which the Thai Rak Thai Party embraced Dr. Sanguan’s ideas and incorporated them into their policy to gain support.

As for the content of this version of the “People’s Version” of the National Health Security Act, it was based on the template provided by Dr. Sanguan’s draft of the 1995-1996 version, as mentioned earlier.³⁹ However, there were some important principles that differed from the original version. For instance, the concept of “pooling health insurance funds” was introduced using state budget funds as the primary source, instead of the previous idea of “co-payment” that was proposed in the earlier version. Professor Jon confirmed this idea by saying, “In our version, it must be truly free, funded by taxes rather than collected from service recipients. However, in practice, there was a collection of 30-baht co-pay.”⁴⁰ Subsequently, the UHC Advocacy Project officially commenced its campaign to collect signatures on October 11, 2000, at the Parliament House, aiming to gather 50,000 names.⁴¹ Moreover, they were able to collect the names of those who supported this draft law, totaling 62,412 individuals. They could have gathered around 80,000 to 90,000 names, but approximately 20,000 names were removed due to not exercising their voting rights in the early 2001 elections.⁴² Subsequently, the draft of this Public Health Bill was expedited for consideration by the House of Representatives in November 2001. However, the process of verifying the names for the public version of the bill was relatively slow.

Nonetheless, another draft of the Public Health Bill proposed by the Thai Rak Thai Party underwent consideration, and several principles from this draft were subsequently applied. For instance, there was the concept of establishing two committees that could elect their own representatives without political interference to become the main committees for the Universal Health Coverage (UHC) system (the NHSO Board) and the Quality and Standards Control Committee for Public Health Services (the Control Board), or the proposal of a no-fault compensation system without the need for proof of liability, which has now become Article 41. Furthermore, during the time of external activity by the Civil Society organizations, it should not be forgotten that efforts were made to push for healthcare system reform through political channels. This resulted in the emergence of a “UHC system proposal” that contributed to further developing the drafting of the Peoples’ Health Bill.



Figure 118 Image of the meeting of the Committee/Working Group for the Social Collaboration Plan to Reform the National Health System, working on the academic aspect of healthcare system reform, 1st session/2000. On November 23, 2000. Participants included Dr. Prawese Wasi, Dr. Sanguan Nitayarumphong, Dr. Amphon Jindawatthana, Dr. Suwit Wibulpolprasert, Dr. Komatra Chuengsatiansup, Dr. Bancha Phongphanit, as well as representatives from Civil Society networks, such as Mr. Vichien Kuttawas and Ms. Rosana Tositakul, among many others.

Source: National Health Archives, (1) FP. SCH. 4.3/1, Seminar of the Healthcare System Reform Team, December 2-3, 2000, Pattaya, and the meeting of the Committee for Social Collaboration, November 23, 2000, Raddison Hotel, Bangkok.

C. Proposals for the Universal Health Coverage by the National Health Reform Committee and the Health Systems Research Institute

On May 9, 2000, the Cabinet during the Chuan Leekpai government passed a resolution approving the Prime Minister's Office regulations on the formation of the "National Health Reform Committee" (NHRC).⁴³

The Prime Minister is the chairman and the Director of the National Health System Reform Office is the secretary. While the "National Health System Reform Office" (NHSRO)⁴⁴ was established under the regulations of NHRC. The NHSRO's main mission is to draft "National Health Act" to be completed within 3 years and to build knowledge and strength of civil society and the media. One of the components of the process to draft the National Health Act was about "Health Financing". Due to this reason, the NHSRO collaborated with HSRI to establish a working group to conduct research and formulate a well-grounded proposal on this matter. This working group was named "UHC Policy Development Working Group of the Health Systems Research Institute," chaired by Associate Professor Dr. Ammar Siamwalla, an economist.⁴⁵

This included Dr. Sanguan himself, who was also part of this working group. Dr. Amphon Jindawatthana,

Director of NHSRO, recorded in his notes that *“During the initial phase of driving the National Health System reform (1999-2000)... we set the goal of creating the National Health Act to reform the medical and public health service systems... For this task, the Health Systems Research Institute supported a group of researchers led by Professor Ammar Siamwala... to synthesize knowledge and formulate proposals for this reform.”*⁴⁶ Additionally, it also comprised individuals who played roles in health financing, such as Dr. Viroj Tangcharoensathian and Dr. Supasit Pannarunothai, among others. Simultaneously, representatives from the “UHC Campaign” were also part of the knowledgeable members of this working group, including Dr. Yupadee Sirisinsuk, a pharmacist.⁴⁷ The report presenting the study outcomes of this working group was successfully completed and published around mid-2001 under the title “UHC Proposal.” This period coincided with the initial implementation of the “30 Baht scheme” for comprehensive healthcare services in the first six pilot provinces. The Minister of Public Health (Dr. Surapong Suebwonglee), who was a key force behind the development of this program, regarded this published report as the “Bible” of the 30 Baht scheme for comprehensive healthcare services.⁴⁸

The fundamental principle explained in the report “UHC Proposal” is that the implementation of the UHC policy should be a government-level policy, not limited to the ministerial level or below. Therefore, it must be enacted as a “law,” as without the authority of the law, changes can only be made on a small scale and lack sustainability.⁴⁹ While the core of service organization proposed in this report is the principle of “Purchaser-provider split,” which is an observation drawn from various UHC systems in different countries, where a system of market regulation is established. This system ensures that healthcare services are not provided freely to prevent market failure. For this reason, it is necessary to separate the relationship of interest between service purchasers and providers. The government takes on the role of being a large-scale service purchaser to control the market through its purchasing power, which prevents monopolistic power. The implementation of this approach involves the establishment of a National Health Insurance Fund, which must be separate from ministries or governmental bodies that own healthcare facilities. This separation is intended to eliminate conflicts of interest and allow the fund to negotiate with all types of service providers in a fair manner to maintain the public’s interests.⁵⁰



Figure 119 The image of the first meeting of the National Health System Reform Committee (NHSRC), held at the Government House on August 9, 2000. The presence of the Prime Minister, Chuan Leekpai, Emeritus Professor Dr. Ammar Siamwalla, Korn Dabbaransi (Minister of Public Health), Dr. Pairode Ningsanon, Dr. Amphon Jindawatthana (Director of the NHSRO), Dr. Suwit Wibulpolprasert, Dr. Prawese Wasi, Dr. Aree Valyasevi Dr. Wiput Phoolcharoen (Director of HSRI), Dr. Banloo Siriphanich, Kasama Worawan Na Ayuthaya, Professor Dr. Kasem Suwanakul, Abhisit Vejjajiva (Office of the Prime Minister), Sansanee Satiensut, Permanent Secretary of Finance, Permanent Secretary of the Ministry of Commerce, Permanent Secretary of the Ministry of Agriculture, Permanent Secretary of the Ministry of Higher Education, Permanent Secretary of the MOPH, Secretary-General of the Council of State, Secretary-General of NESDC, Director-General of the Budget Bureau, etc.

Source: National Health Archives, (1) FP SCH. 4.2/1, NHSRC 1st Meeting at the Government House on August 9, 2000



Figure 120 The image of the academic working group meeting for healthcare system reform in October 2000.

Source: National Health Archives, (1) FP SCH. 4.2/2, Universal Coverage: Will the dream come true for the Thai system, October 24, 2003

All of this demonstrates that prior to reaching the conclusion about the mechanism for healthcare reform to establish universal health coverage (UHC), there were at least three forms of movements related to the enactment of the UHC Act of 2002. These movements started with the initial draft of the UHC Act within the working group of the Health Assembly Secretariat and expanded into the realm of Civil Society organizations, resulting in a 'Peoples' Draft' of the UHC Act. Concurrently, academic work supported by political advocacy contributed to the development of the "Policy Development Working Group for UHC of the Health Systems Research Institute," leading to the creation of a proposal for the core system of national health insurance. All of these efforts have been built upon and evolved into the "preliminary draft" for the UHC Act which was presented to the Parliament by the Thai Rak Thai government.

National Health Security Act 2002

During the period of transition and implementation of the UHC program, the formulation of this policy was divided into two aspects. The first aspect involved the implementation of the 30 Baht scheme, which began in April 2001 in six provinces and was expanded nationwide within the same year. During this transitional phase, the operation continued under the umbrella of the MOPH. The second aspect was the establishment of a new organization to manage the core health insurance system in the long term. This required the enactment of a royal decree. Both of these aspects were carried out simultaneously between 2001 and

2002. For the “proposal” process of the draft UHC Act to the members of the House of Representatives, the first session commenced on November 15, 2001. Various drafts of the UHC Act were presented, including drafts from the government, four political parties, and a draft from the Civil Society sector, which included a list of citizens collected by the “Campaign for UHC” project since late 2000. Although the Peoples’ Draft could not be verified in terms of the names of the proposers, members of the House of Representatives presented this draft on their behalf. Following this, a process to appoint a committee of 35 ordinary members was initiated.⁵¹ Representatives from the “Campaign for UHC” project participated in this committee, consisting of five individuals: Saree Aongsomwang, Dr. Yupadee Sirisinsuk, Topong Kulkhanchit, Rakawin Leechanawanichphan, and Sureerat Treemakka.⁵²

During the 33rd session of the House of Representatives on November 15, 2001, it was found that among the six drafts of the Health Security Act, five of them were titled “Draft National Health Security Act...” The remaining draft, proposed by the Thai Rak Thai Party, was titled “Draft National Health Security and Public Health Service Quality Standards Act...” These six drafts were proposed by six individuals: (1) Dr. Surapong Suebwonglee proposed the Cabinet’s draft, (2) Dr. Poommin Leethiraprasert presented the Thai Rak Thai Party’s draft, (3) Preecha Musikul submitted the draft from the Democrat Party, (4) Amnuay Klangpha of Lopburi Province proposed another draft on behalf of the Thai Rak Thai Party, (5) Sittichai Kittitanesuan, a representative of Nakhon Nayok Province, presented the Thai Nation Party’s draft, and (6) Suwat Wannasirikul of Thonburi and Dr. Chonlanan Srikeaw of Chiang Mai, both affiliated with the Thai Rak Thai Party, were representatives proposing drafts from Civil Society.⁵³ In all of the draft documents, there are variations in details. For instance, in the definition of “service fee,” differences can be observed in the texts regarding the payment made by the service recipient to the service unit. These differences became evident in Section 1 concerning public health services, Article 5, where multiple versions converged in the direction that all Thai citizens have the right to receive standardized and efficient public health services. However, the variance lies in the Cabinet’s draft, which adds the phrase “*according to the country’s financial status.*” Several parties proposed the removal of this phrase. Regarding the section related to the establishment of the National Health Security Office, most agree that it should be a legal entity rather than a governmental agency, yet under the supervision of the Minister of Health.

Meanwhile, some drafts presented significantly divergent proposals. For instance, the Thai Rak Thai Party’s draft introduced different wording compared to the others. It specifically emphasized that vulnerable individuals, disadvantaged persons, and those who contribute to society (such as children, the elderly, monks, religious practitioners, disabled individuals, monks-in-training, novices, and individuals who contribute positively to the nation) should be able to access medical services without any charge, as they have historically been exempt. Another difference is that it suggested opening options for citizens from various funds to choose their preferred fund type. Moreover, the draft from Civil Society itself

presented several notable differences from the other versions. For example, it proposed a law that covered a single foundational health security act for all Thai citizens on an equal basis. This was due to the current complexity arising from numerous separated systems and management structures involving too many separate funds.⁵⁴ The proposal suggested that there should be no service fees charged and that it was the responsibility of the government. Alternatively, it proposed representatives from private sector organizations, selected through an election process, to present the proposal. This group consisted of 8 individuals, representing the highest number allocated for Civil Society involvement.⁵⁵ This version reflected viewpoints that were not viewed from a governmental perspective like other versions, and this diversity within the draft signified differing opinions or debates regarding the institutionalized legal provisions. It can be characterized as providing space for a wide range of opinions and presenting a vibrant array of viewpoints, as evident in the minutes of that Parliamentary session.⁵⁶

Subsequently, the process transitioned to the Parliamentary stage or representatives of the people who were nominated as members of the Standing Committee (House of Representatives) to carry out their duties of deliberation. The “Standing Committee on Health Insurance Bill ...” was considered, and several representatives who played a role in advocating for the system’s inclusion also participated. For instance, Dr. Sanguan and Dr. Surapong scheduled meetings a total of 22 times, from December 3, 2001, to March 27, 2002.⁵⁷ During this time, the Standing Committee organized public hearings on this legislation four times. The first and second hearings took place on February 22, 2002, in Khon Kaen and Chiang Mai Provinces. The third hearing occurred on March 1, 2002, in Bangkok, and the final hearing took place on March 5, 2002, in Songkhla Province. The House of Representatives deliberated on the second and third terms of the Health Insurance Act on May 15, 2002. The majority of the content closely followed the government’s draft, while some parts were expedited in the consideration process due to strong advocacy from Civil Society that had pushed for this matter previously. However, it is noteworthy that the deliberation process of this legislation saw a contrast in the level of engagement from different stakeholders. On one hand, the Civil Society’s efforts had significantly influenced and accelerated the consideration of the National Health Insurance Act, as they had been advocating for this issue for some time. On the other hand, the government officials in the MOPH and the majority of medical professionals had limited awareness or involvement, as the primary focus was on organizing the healthcare system to support the rapidly expanding 30 baht scheme during that period.⁵⁸



Figure 121 The atmosphere of the meeting on the topic of Universal Health Coverage at the Government House in January 2002 In the picture: Dr. Surapong Suebwonglee, Dr. Mongkol na Songkhla, Dr. Sanguan Nitayarumphong, and the Minister of Public Health.

Source: National Archives of Public Health, (13) C.NEG S.2.2/15.90, number 1/2545 the meeting on the topic of Universal Health Coverage at the Government House in January 2002

Figure 122 (In the middle row) Dr Pongpisut Jongudomsuk (President of the Rural Doctors Society, 15th Generation, 1992-93), Dr. Jadej Thammatacharee. (In the bottom row) Director-General of the Insurance Department, Emeritus Professor Dr. Ammar Siamwalla.

Source: National Archives of Public Health, (13) C.NEG S.2.2/15.90, number 1/2545 the meeting on the topic of Universal Health Coverage at the Government House in January 2002





Figure 123 Khunying Sudarat Keyuraphan, Minister of Health

Source: National Archives of Public Health, (13) C.NEG S.2.2/15.90, number 1/2545 the meeting on the topic of Universal Health Coverage at the Government House in January 2002

Figure 124 Dr. Viroj Tangcharoensathien (second person from the left) and Dr. Supattra Srivanichakorn (President of the Rural Doctor Society, 11th Generation, 1988, third person from the left).

Source: National Archives of Public Health, (13) C.NEG S.2.2/15.90, number 1/2545 the meeting on the topic of Universal Health Coverage at the Government House in January 2002



Even up to the level of consideration by the Senate, Civil Society organizations were able to send representatives to work within the Senate Committee, with a total of three individuals.⁵⁹ In this Senate level, there were differing opinions on three main issues. **The first issue** pertained to the direction of the comprehensive health insurance system, which might be divided into two sub-issues: (1) Whether it should be a “comprehensive” health insurance scheme or a health insurance scheme specifically for the “poor,”⁶⁰ and (2), Whether the main health insurance schemes for civil servants and social insurance should be incorporated into the project or not. Regarding the first issue, the conclusion was that the insurance in this version of the law must be “comprehensive,” not based on welfare policies. As for the issue of fund consolidation, the conclusion was to combine the management of these insurance schemes together, but with a time allowance. It stipulated that a royal decree must be issued to consolidate the CSMBS, and the Social Security Fund committee must approve the integration of the social insurance system. With these conditions, there was no easy path to consolidation of funds.

The second issue involved disagreements within the legislative assembly (House of Representatives) regarding the composition of the committees in the National Health Security Committee (Article 13) and the Quality and Standards Control Committee for Public Health Services (Article 48). This conflict arose from the fact that a certain group of professionals, especially physicians, saw that the proportion of committee members who were not professionals in the respective fields was higher than those who were. To address this, in the legislative assembly, the content was amended to increase the number of professional members by four from the Medical Council, Nursing Council, Pharmaceutical Council, Dental Council, and one representative from the Private Hospital Association. Additionally, around three other qualified individuals, likely to be physicians, were also proposed. As for the Quality and Standards Control Committee for Public Health Services (Article 48), the amendment aimed to increase the proportion of physicians to 13 and include approximately nine professionals from other public health-related fields within the total composition of 35 committee members.

The final contentious issue revolved around the matter of a 1% budget allocation for compensating medical malpractice and “third-party liability” in cases where there is a wrongdoer (Article 41 and 42). The divergent opinions stemmed from a certain group of physicians who were concerned about cases where patients suffered harm due to medical treatment, yet often lacked a process for recourse or compensation. To address this, Article 41 of the National Health Security Act stipulated that a fund must be responsible for these matters, allocating 1% of the healthcare budget for initial assistance in cases of treatment-related harm, whether or not there was a wrongdoer (i.e., no-fault). On the other hand, Article 42 outlined the fund’s ability to recover compensation from the wrongdoer. The intent behind these provisions was to potentially mitigate malpractice lawsuits. However, opponents argued that such provisions might increase the number of compensation claims and malpractice lawsuits. Subsequently, a group of physicians

demanded the removal of both Articles 41 and 42, or at least Article 42. It is important to note that since the late 1980s, there had been a noticeable increase in malpractice lawsuits in Thailand. This ongoing debate reflected the varying perspectives among physicians and contributed to the ongoing tension between groups with differing opinions. Despite discussions within the Legislative Assembly having suggested the removal of both provisions, ultimately, the Legislative Assembly passed this draft of the law while retaining the two aforementioned articles.⁶¹

Finally, the National Health Security Act was promulgated in mid-November 2002. This law led to the establishment of the “National Health Security Office” (NHSO) as the agency responsible for implementing Universal Health Coverage (UHC). The NHSO is composed of the National Health Security Committee and the Quality and Standards Control Committee for Public Health Services, which serve as organizations responsible for policy formulation.⁶² In one sense, this signified the emergence of “representatives of the people” who are responsible for managing and overseeing all aspects of health benefits and budgets within the national health security system.



During the expansion of services within the national health security system, there remained the need to continuously improve and seek the best ways to manage the system. Major issues still revolved around budget allocation on a per capita basis, and whether to include salaries or not. Concurrently, there was also a push for bolstering various supporting organizations and the establishment of legally recognized entities. For instance, the “ThaiHealth” organization was created with the ThaiHealth Promotion Foundation Act of 2001 to support health promotion efforts. This was followed by the establishment of the NHSO in 2002, supported by the National Health Security Act of the same year.

However, the process of implementing the national health security system for the benefit of the majority of the population was not an easy path. Designing the NHSO organization to oversee and sustain the system required intricate steps and the convergence of viewpoints from various sectors, including politics, academia, and Civil Society, throughout the drafting process of the National Health Security Act. The success that emerged was deeply rooted in the pivotal groundwork of coordinated orders and prepared knowledge. Long-standing relationships among stakeholders, the active engagement of Civil Society to voice diverse perspectives, and the persistent persuasion that led the political realm to open up space for pushing forward UHC, including the establishment of organizations like the NHSO with Dr. Sanguan Nitayarumphong, the ‘father of Thailand’s UHC,’ as its inaugural Secretary-General, were all outcomes shaped by the historical and political narrative of the entire Thai healthcare system. These achievements were the culmination of a journey that included trial and error in knowledge dissemination, the continuous evolution of healthcare facilities, the management of limited financial resources and budgets, and the perpetual challenge of human resources management. All these components converged into a significant and substantial achievement that has successfully brought about the realization of UHC for all Thais.

Chapter 16

¹ Parichart Siwaraksa, *The Birth of ThaiHealth Fund* (Bangkok: ThaiHealth Promotion Foundation, 2013), 2.

² Nualnoi Treerat and Bank Ngamarunchot, 'Politics and Power in the Universal Health Coverage System' (Nonthaburi: Health

Systems Research Institute (HSRI), 25.

³ Royal Thai Government Gazette, 'The Tobacco Products Control Act B.E. 2535 (1992)', (Volume 109, Section 38, Page 4, April 5, 1992); Royal Thai Government Gazette, 'the "Non-Smokers' Health Protection Act B.E. 2535 (1992)', (Volume 109, Section 40, Page 20, April 7, 1992).

⁴ Parichart Siwaraksa, *The Birth of ThaiHealth Fund*, 12–15.

⁵ Prakrit Vathesatogkit, *Lessons Learned: Guiding Society and Advocating Public Policies* (Bangkok: Action on Smoking and Health Foundation Thailand, 2017), 54.

⁶ Parichart Siwaraksa, *The Birth of ThaiHealth Fund*, 16–18.

⁷ Interview with Professor Dr. Prakrit Vathesatogkit, June 10, 2022.

⁸ Parichart Siwaraksa, *The Birth of ThaiHealth Fund*, 19–20.

Dr. Supakorn conducted research on "Demand Analysis of Aggregate Cigarette Consumption in Thailand, 1976-1981".

⁹ Parichart Siwaraksa, *The Birth of ThaiHealth Fund*, 22–23.

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¹⁴ Prakrit Vathesatogkit and Supakorn Buasai, "Health Promotion Fund: Opportunities in the Economic Crisis", *Chab Krasae*, Volume 3, Issue 11 (35) (1988): 6–8.

¹⁵ Health Systems Research Institute Newsletter, Article: "Opening the Health System in the Face of Health Reform", *Chab Krasae*, Volume 1, Issues 7-8 (January - February 1996): 1–5, <https://kb.hsri.or.th/dspace/handle/11228/4504?src=%2Fdspace%2Fhandle%2F11228%2F1%2Fdiscover%3Fquery%3D%25E0%25B8%2588%25E0%25B8%25B1%25E0%25B8%259A%25E0%25B8%2581%25E0%25B8%25A3%25E0%25B8%25B0%25E0%25B9%2581%25E0%25B8%25AA%2B%25E0%25B8%259B%25E0%25B8%25B5%25E0%25B8%2597%25E0%25B8%25B5%25E0%25B9%2588%2B1%26term%3D1&offset=8&firstItem=&lastItem=>.

¹⁶ Parichart Siwaraksa, *The Birth of ThaiHealth Fund*, 40–42.

¹⁷ Health Systems Research Institute Newsletter, Article: "Vision and Health Promotion Reform in Thai Society", *Chab Krasae*, Volume 1, Issues 11-12 (May - June 1996): 4–8, <https://kb.hsri.or.th/dspace/bitstream/handle/11228/4505/hsri-newsletter-v1-n11-12-may-june-1996.pdf?sequence=1&isAllowed=y>.

¹⁸ Prawese Wasi, "Forward", in Prakrit Vathesatogkit, *8-Year Recap of the Health Promotion Fund* (Bangkok: Health Systems Research Institute (HSRI), 2010), 3.

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Summary:

The art of establishing
Universal Health
Coverage in Thailand

Having reached this point in this historical review, the authors hope that the reader has grasped the key “turning points” in the history of medicine, public health, and the path of healthcare system reform, leading up to the creation of the Universal Coverage Scheme (UCS), a significant milestone that gave birth to Universal Health Coverage (UHC) in Thailand. Through an exploration of various crucial turning points from 1868 to 2002, significant observations arise. Amidst the challenges posed by global and national influences spanning politics, economics, and sociocultural dimensions, it becomes evident that individuals and stakeholders within the Thai healthcare system were compelled to make decisions that would shape the future of the system. These decisions gradually transformed into pivotal turning points in the history of medicine and public health, culminating in the emergence of comprehensive health assurance in the present day. The process of making decisions regarding complex, daunting, and provocative events of the past can be seen as an “art of reform,” an art that can be succinctly summarized in the following paragraphs.

The history of medicine and public health in Thailand is a vital foundation that has propelled progress and reforms towards the successful establishment of comprehensive health coverage. Starting from the establishment of large hospitals and small unit service facilities, as well as the provision of funding for the maintenance and care of all healthcare establishments since the 1880s the development has been ongoing. It began with the creation of hospitals such as Siriraj Hospital and others in Bangkok and its suburbs. Hospitals were established in distant provincial capitals, provincial (general) hospitals, and district (community) hospitals. Alongside these, there were also health centers at levels one and two, as well as midwifery centers, which transformed into both public and private healthcare service units in the early era of Thai society. When these service facilities required a workforce, the government expedited the process of training individuals, leading to the establishment of several medical schools. At that time, the ‘Department of Hospitals’ was established to manage and administer healthcare services. This evolution continued, eventually leading to the formation of the Ministry of Public Health (MOPH), responsible for promoting health, disease prevention, health protection, and health restoration, as seen in the present day.

Nevertheless, the foundational roots that resulted from a clear and notable adaptation and transformation during the late 19th century did not naturally emerge, but rather were influenced by external factors that shaped the mindset and direction of the public health sector. We cannot avoid mentioning the “Western influence and the globalization trend” that impacted various dimensions of Siamese (Thai) society from its early stages to eventually manifest as a Western-oriented phenomenon. This includes the “modern influences on medicine and public health,” such as the culture of building hospitals and medical practices like surgical techniques, anesthesia usage, vaccines, and more.

After overcoming the influence and the threat of globalization, external factors continued to shape Thailand's public health over an extended period. Despite varying contexts, these factors led to significant changes in various events. For instance, the “Cold War and American Influence,” which started after World War II (1939-1945), resulted in Thailand facing economic stagnation post-WWII. This was followed by the atmosphere of fear of communism during the decade following 1947, leading to a surge in hospital construction and the renovation of health centers throughout all provinces. The trend of hospital construction and the expansion of healthcare services to regional areas became distinct in the late 1950s and early 1960s. This aligned with the Thai government's vision, which allied itself with the United States to counter the communist threat. The government recognized the need to expedite rural development as “frontiers” to counteract communist influence. This led to an intensified effort in disease control, hospital expansion, bolstering community health, nutritional education, and more. Thus, the notion of “opening up rural areas” on a much larger scale than before became intricately linked with global politics, particularly in the context of the Cold War and the close relationship between the Thai government and the United States. Even as the tensions of the Cold War began to ease, international organizations led by the United States and other European countries still continued to influence Thailand's healthcare trajectory. The clearest example of this is the “Influence of the World Health Organization and the global healthcare trends.

In the late 1970s, the fundamental concept of comprehensive primary health care (PHC) became a crucial milestone in the direction of Thailand's healthcare system. This idea was influenced by global developments in 1978, combined with a period when the consciousness of being medical practitioners was in high demand due to the prevailing political trends. Thailand emerged as a crossroads for experiences in developing healthcare systems, which deviated from other developing nations. Consequently, the evolution of PHC in Thai society possessed certain distinctive features. A key factor was the rooted knowledge gained from pioneering projects focused on rural development, dating back to the late 1950s. During this period, the MOPH and various medical universities often received support from organizations such as USOM (United States Operations Mission), UNICEF, WHO (World Health Organization), and other bi-lateral and multi-lateral donors. Projects included iodized salt control, Ban Phai Project, Samerng Project, Non Thai project, Bladder Stone Project, Chonburi Provincial Health Development Project (promoting rural health in temples and churches), the Saraphee Project, Lampang Project, and more. Consequently, when embracing the principles of the WHO in the late 1970s to early 1980s, Thailand was able to extend and build upon the knowledge base from the “Rural Development Expo in 1957.” This led to significant success in the realm of comprehensive primary health care, marked by the emergence of new roles such as “Village Doctor,” Village Health Volunteer (VHV), Village Health Communicator, and the Folk Doctor Foundation. These initiatives empowered communities to take charge of their own health and simultaneously advanced both preventive and curative medicine.

In all of this, one must not forget the significance of the “domestic political environment” itself in driving transformative shifts at every critical juncture. This factor has played a pivotal role in propelling several leaps in Thailand’s history towards the establishment of universal health care (UHC). Notably, the act of “leadership” that highlighted the importance of Western-style medicine and public health by the leading class of Siam during the reign of King Rama V, serves as a prime example. Despite healthcare activities during the reign of King Rama V being developed in a form of public welfare, a majority of public health efforts received significant promotion and support, both overtly and behind the scenes, from various Siamese royal bureaus and the Chakri Dynasty.

When the Siamese Revolution of 1932 occurred, leading to the transition from an Absolute to a Constitutional Monarchy, the concept of public health underwent a redefinition, transforming it into a “state responsibility” that required more than just voluntary efforts. This shift led to an expansion and advancement of knowledge and activities related to public health even more extensively than before. For instance, the advancement of scientific knowledge (in health-related fields) deepened, attention to nutrition increased, the importance of clean drinking water was emphasized, and efforts were directed toward sanitation and public hygiene, including latrine facilities. The policy of establishing hospitals to showcase the country’s progress also held significant importance in the post-1932 political landscape. This is because the construction of hospitals along the border regions symbolized Thailand’s cultural advancement in the sub-region under the new political climate.

Then, as the seismic event of October 14, 1973 unfolded, the political atmosphere rapidly shifted, sparking discussions about social justice. This led many reform-minded physicians to feel compelled to improve medical education. The return to a democratic political framework shortly after October 14th allowed for swift progress in public health initiatives, driven by policies advocated by political parties in line with the democratic system. This also provided the opportunity for the emergence of the “Community-Based Health Care for Low-Income People” program, aimed at aiding the impoverished segments of society. This marked the beginning of Thailand’s health insurance system and efforts to reduce social inequality. In medical education, there were debates about creative teaching methods to improve medical curricula, focusing on a better understanding of rural areas. This allowed medical knowledge to be applied to assist people in remote regions far from the conveniences of urban centers. In terms of the central management structure of the country’s healthcare system, a significant reform took place in 1974, resulting in the decentralization of healthcare services to the regional level. This decentralization aimed to bring public health services closer to the people in the rural areas, which comprised the majority of Thais at that time.

Following the successful establishment of Thailand's first health insurance system, (the program for low-income people), the country saw significant progress in the restructuring of the MOPH, showcasing substantial advancements during that era. However, the development phase had to halt once again when the political cycle returned to a tense and exhausting condition. This was marked by the growing weariness with the role of the United States in Thai affairs, the repetitiveness of Thai political leaders, and the surge of socialist ideologies and widespread knowledge. These factors collectively drove society to seek solutions that aligned with a more compassionate direction, particularly toward groups such as farmers, laborers, and the general public, who all deserved equal rights and freedoms. Amidst the turbulent political climate, the event of October 6, 1976, emerged as a significant turning point. Despite the major political unrest at that time, it must be acknowledged that this crisis became a crucial motivating factor that propelled Thailand through the late 1970s and early 1980s, characterized by a semi-democratic system under a military regime. During this era, known as the "Technocratic Era," politics evolved toward a more utilitarian path, significantly benefiting the Thai healthcare sector. The guiding principle was the rapid development of rural living conditions, closely connected to the public health service system and the enhancement of quality of life. These aims were explicitly outlined in the 5th 5-year National Economic and Social Development Plan (1982-86).

The period from October 14, 1973 to October 6, 1976, was a transformative phase that gave rise to a "current of ideological thinking of the era." This is considered a shifting tide that significantly influenced the transformation within the healthcare sector. Many medical scholars and intellectuals (known as the "October Group") decided to venture out as "rural doctors" in remote areas of the country. They synchronized their efforts with the policies of the technocratic era. At this time, the vision of "Health for All" emerged, which not only addressed health issues but also began to encompass economic, social, and educational concerns. This laid the groundwork for the strategic linkage between rural development and the promotion of preventive medicine, which would later become the answer to the development of healthcare in rural areas.

The knowledge gained from working in unfamiliar rural areas and the necessity to survive in those conditions gave rise to a solidarity of shared experiences of doctors in rural settings. Relationships were formed between doctors in rural regions and those working in central areas, as well as among rural doctors themselves. Additionally, connections were established between rural doctors and various NGOs that contributed to local development. These relationships eventually evolved into a driving force that propelled various aspects of public health in Thailand. This was aimed at delivering health services to the population's hands. These relationships also played a role in building the "strength of the societal sector," that would further propel health reforms later in the late 1980s. Consequently, during the period of 1967-77, political, economic, and sociocultural crises in the country spurred developments in the health sector. These

developments progressed in an inter-linked fashion, consisting of the power to generate relevant knowledge, the power of social movement, and the power of political involvement, akin to the concept of the “triangle that moves the mountain.”

Indeed, the period from the late 1960s to the late 1980s can be characterized as a time of consolidating knowledge and experience of reform-oriented doctors and rural physicians. This encompassed education and engagement, from within the confines of universities to hands-on practices, primarily in rural areas. Subsequently, as some rural doctors chose to return and work closer to the headquarters of many national agencies, studies were conducted to assess the readiness of healthcare facilities, leading to broader system development. Continuous generation of new knowledge through data analysis, experimentation, and practical implementation became a norm. This encompassed exploring financial and budgeting systems, comprehending the developmental cycle, and more. All of this collective knowledge has been forged and etched onto the historical trajectory of building a universal health insurance system over the years.

The initial set of knowledge began with the application of the concept “ignorance leads to suffering,” encompassing dimensions of knowledge, economy, and health. This was combined with Buddhist economics to design solutions for the issues of impoverishment and inequality. The experimentation with the “Basic Minimum Needs” aimed to measure the actual poverty level in rural communities and provide the essential means for a decent life aligned with their community and regional needs. Promotion of roles such as the “Village Doctor,” VHV, Village Health Communicator, and the Folk Doctor Foundation aimed to empower villagers with health awareness. Another significant endeavor was the establishment of community hospitals and health centers in every district, accelerated by the government to bridge the societal gap between urban and rural areas. One strategy was to create primary healthcare units (sub-district level) to ensure easier and more comprehensive healthcare access for villagers. Eventually, an observable increase in the number of district-level healthcare units emerged in this era, reflecting the government’s dedication. As part of this evolving knowledge journey, understanding the dearth of manpower within the healthcare system was imperative. Efforts were made to study and experiment with welfare systems, service provision, budget allocation, and various health insurance models to mitigate financial risks. These analyses extended from social welfare for civil servants, projects like “30-baht Healthcare Scheme,” and the development of social security systems, to the Ayutthaya Project and Health Care Reform Project. The cumulative insights gained from these pilot projects culminated in the design of the Universal Coverage Scheme (UCS) as the template for the national healthcare system.

The entirety of this knowledge set stemmed from experiences and experimentation aimed at identifying strengths and weaknesses. To be sure, it relied not only on the medical sciences but also encompassed diverse disciplines such as public health, prevention, sociology, economics, and medical anthropology, to name a few. This diverse spectrum of knowledge contributed to finding comprehensive solutions within the healthcare system. Ultimately, the group of reform-minded physicians managed to innovate healthcare system reforms by emphasizing the importance of a “big picture” perspective or a holistic and systematic approach. This translated to acknowledging that physicians bore the responsibility for comprehensive patient care, encompassing physical health, mental well-being, socio-economic profile, politics, the environment, and even the patient’s human rights. This went beyond treating isolated instances of illness and delved into the broader context of patient care. Hence, Thailand’s journey towards Universal Health Coverage (UHC) is rooted in a long history of intellectual groundwork, supported by evidence-based studies and an openness to adopting new ideas for improvement. Empirical evidence showcasing the progress in knowledge forms the essential foundation for building UHC. A pivotal player in this landscape is the independent organization known as the Health Systems Research Institute (HSRI). This institution was created under a royal decree, signifying its significance in advancing the UHC initiative.

As noted, the process of generating knowledge within HSRI followed the conceptual thinking of the “Triangle that Moves the Mountain” theory. This meant that the knowledge produced by HSRI must be applicable, goal-oriented, and practical in nature. For instance, studies on health economics systems and the promotion of Diagnosis-Related Groups (DRGs) were employed to develop comprehensive health coverage principles. The initial formation of this knowledge triangle was led by a group of physician-academics who have effectively produced results. Subsequently, the focus shifted towards seeking processes for integrating this knowledge into the social fabric (the second vertex of the triangle) and finding means to influence political/powerful entities (the third vertex). The successful integration into both the societal and political domains was achieved through leveraging the political, economic, and social currents of the country, which, in turn, provided another impetus for the reform-minded physicians.

During that time, the political, economic, and socio-cultural landscape of Thailand continued to evolve rapidly and remained a driving force for change. The reform process for the healthcare system that followed from the late 1980s to the late 1990s was greatly influenced by the events of the May 1992 uprising, which sought to preserve the path of democracy. This event served as a catalyst for generating knowledge focused more intensely on the issue of “health rights”. Simultaneously, the social sector (i.e., Civil Society), inspired by the political events, began advocating for human rights and developing community groups that grew into strong organizations. The sphere of public health also started paying attention to involving the Civil Society in examining and pushing for the country’s development and healthcare system reform. The good relationship established between rural doctors and the Civil Society since before the late 1970s

facilitated the integration of the social sector into these efforts. Consequently, Civil Society started recognizing the growing connection between human rights and health, as demonstrated in the drafting of the Constitution along the lines of Constitutionalism (1994), the 8th National Economic and Social Development Plan (1997-2001), the 1997 Thai Constitution, and the (draft) National Health Act (1999). These events were followed by the citizen-driven movement to investigate corruption in the procurement of medicines and medical supplies by the MOPH in 1998. Therefore, political factors served as a strong impetus, helping the social movement to grow stronger and more influential. This movement safeguarded the collective interests and principles of human rights, including health rights. Starting from the late 1980s, the Civil Society began to increasingly play a role in societal development alongside the government. This transformed it into a new social force that played a robust role in pushing for healthcare system reforms. This eventually led to the drafting of a people's Constitution in the early 1990s, serving as a key to unlock the door to the creation of UHC in the years that followed.

If we observe the significant progress that has occurred in the field of public health in recent times, we will find that many advancements took place during periods when the country was facing a “crisis.” Similarly, during times of economic crises, such as the financial crisis of 1997 (one of the largest financial crises in Thai history), it is noteworthy that several advancements occurred. Despite the fact that budgets for healthcare were affected by these events, resulting in budget cuts and the need to operate under constraints, amidst this severe economic crisis, healthcare reformists were able to perceive numerous opportunities for the development of the healthcare system. Seizing these opportunities encouraged the government to refocus on the importance of development and elevation of primary healthcare services. This approach harnessed the social momentum to experiment with the development of state hospitals, exemplified by the case of Ban Phaeo Hospital. This strategy pushed the role of social sectors to formal institutional status and even led to the concept of seizing opportunities driving the idea of accessing essential health services as a fundamental right of being Thai, which was officially enshrined in the 1997 Constitution. Once the knowledge framework was established and connected with the societal sector, healthcare reformists continued to move forward, seeking opportunities to engage with the political sector. The political arena's opportunities opened up with the victory of the Thai Rak Thai party in 2001, which led to the realization of the Universal Health Coverage concept.

The policy of the “Universal Health Coverage Scheme” or the “30 Baht Treat All Diseases Program” was conceived by a group of reform-minded doctors led by Dr. Sanguan Nitayarumphong. This policy played a crucial role in the electoral victory of the Thai Rak Thai party in the 2001 elections. After their victory in 2001, the policy of “30 Baht for All Diseases” was initiated in April 2001, initially implemented in six provinces, then rolled out up-country by October of the same year. The program eventually encompassed the entire Bangkok metropolitan area by January 2002. During the expansion of the UHC system, there was a continuous need to refine and seek the best management practices for the future. Major issues still

revolved around budget allocation, which was addressed by the reform-minded medical team who participated in designing and establishing the initial UHC blueprint. At the same time, they designed organizations to support various tasks and laid down formal legislative frameworks to accommodate the system's needs. This can be seen through the establishment of the "Thailand Health Promotion Foundation (ThaiHealth) under the 2001 Health Promotion Fund Act, which then led to the creation of the National Health Security Office (NHSO) in 2002, supported by the National Health Security Act of 2002.

However, the implementation of a sustainable national health security system, which was designed for the benefit of the majority of the country's population, was not a straightforward path. The creation of the NHSO to oversee the UHC system was a complex endeavor. This can be seen from the processes and methods used to reconcile diverse perspectives from all sides, including the political, academic, and societal sectors, through the drafting of the National Health Security Act. The success that ensued was largely due to the strategic use of command and preparedness, retaining the knowledge base, knitting enduring relationships among stakeholders, drawing in the broader society to participate in the discourse, influencing the political sector to open the space for pushing UHC, and finally designing the organizational framework of the NHSO, with Dr. Sanguan Nitayarumphong, the 'father of UHC' in Thailand, assuming the role of the first Secretary-General of the NHSO.

From the winding path that all this progress traversed, especially with the leadership role of Dr. Sanguan Nitayarumphong, alongside doctors and healthcare personnel in rural areas, senior reform-minded doctors and professors, government officials, administrators, policy makers, planners, and academics both within and beyond the public health sector, the evolution of medicine, public health, and various health systems has been driven. This has led to another key conclusion that the successful establishment of UHC requires "leaders of each era" to initiate and drive the process of knowledge creation, foster collaboration within the medical community and other sectors of society, advance knowledge through trial and error and, beyond having leaders, the timing must be carefully chosen, and the prevailing winds of momentum considered. All of these tasks involved in establishing UHC required an element of "artistry" throughout. Hence, the title of this volume, "The Art of Establishing Universal Health Coverage in Thailand: From the Past to the Present (1868-2002)," aptly reflects these intricate processes.

The authors would like to conclude with a small note that the significant achievements during the period 2001-2002 were just the beginning of a much larger endeavor. The ongoing effort to establish long-term stability for the UHC system requires pushing forward and navigating the storms of politics, economy, and society in various dimensions, particularly the challenges that emerged after 2002. However, the resolute establishment of the UHC principle in 2001 and the emergence of the NHSO in 2002 stand as symbolic affirmations that every Thai citizen should be entitled to receive essential healthcare services that are "comprehensive, equitable, and of high quality," as a fundamental right of their humanity.

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The shift in perspective on healthcare, from being seen as a matter of "charity" to a "right", ensures that everyone in Thai society can access basic health services in a "universal" and "equitable" manner.

This is a significant conclusion of the evolution of Thailand's public health from the year 1868 to the establishment of the Universal Coverage Scheme (UCS), which eventually became the foundation of the Universal Health Coverage (UHC) in 2002. This serves as a model for health security systems in developing countries worldwide.

The Art of Establishing
Universal Health Coverage in Thailand:
From Past to Present, c.1868-2002



