Deliberative Action:

Civil Society and Health Systems Reform in Thailand

Health Systems Research Institute,
and Society and Health Institute, Thailand

Report of a Rockefeller Foundation Supported Project:
The Roles of Civil Society and Health Systems Reform

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Acknowledgement

Health systems reform movement in Thailand was a collective learning experience. In the past three years, the reform initiative has gradually expanded to include a wide range of civil society organizations to participate actively in rethinking and redesigning national health systems. Among the wide variety of actors in the reform movement, what were percieved as the object of reform, what are the desirable characteristics of new health systems, and how to achieve them was diversely viewed from different perspectives. More importantly, the dynamic process of reform that has been unfolded in the past three years could be interpreted differently from varoius viewpoints. This report is not intended to claim to be an absolute, undisputable interpretation of what has been happening in the health systems reform movement, for any interpretation is always situated and rendered from a specific standpoint, and therefore is always contested and subjected to endless reinterpretation from differing viewpoints.

This report was the result of an action-research project entitled "The Roles of Civil Society and Health Systems Reform," which was generously supported by the Rockefeller Foundation. The support made it possible to put into operation the concepts, ideas, and strategies, which would otherwise impossible to realized. The project has become a collaborative effort among various civil society organizations, state agencies, as well as academic institutions. On behalf of Health Systems Research Institute, Health Systems Reform Office, and the Society and Health Institute, I want to express deepest gratitude to the Rockefeller Foundation and numerous active citizen as well as various civil society organizations that have contributed greatly to the ongoing health reform movement in Thailand. It was hoped that the effort during these three years of enthusiastic endeavor would create a long lasting civic tradition in the domain of health policy and action.

Health systems reform, as well as other social reform, is not a one-time endeavor. Rather it is an endless continuous process of changes to solve new problems, to create new possibility, and to achieve new health status. The reform initiative in Thailand has not completed and will never be completely accomplished. New situations will turn up, new problems emerge, and new visions of good life will inspire and renew the attempt of ordinary citizen to join in ther collective effort to build a just, peaceful, and healthy society. Hopefully, this report will be an inspiration for further actions and a small contribution towards a stronger civil society and a healthy collective life here in Thailand and elsewhere.

Summary

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Civil Society and Health Systems Reform in Thailand

This report provides an account of civil society movement and health systems reform in Thailand. As an attempt to depict and explain lessons learned from the effort to promote the roles of civil society in shaping the future of Thai national health system, the report offers a background review of how the health systems reform movement in Thailand was initiated, what were the guiding principles, and how its working strategies played out in the three years reform process, extending from the year 2000-2003. To better understand the roles and contributions of civil society in social changes, the report provides a summarizing review on concepts and theory on civil society. It defines civil society as "an autonomous sphere of social interactions in which active individuals and groups form voluntary associations and informal networks and engage in activities with public consequence."

The three years of health systems reform movement aimed at creating a broad-based reform movement to achieve two strategic objectives: (1) The restructuring of institutional arrangement through legislative action, and (2) The forging of a new collective health consciousness. To achieve these two objective, a triangular approach was employed as the reform working strategies. There are (1) Creating knowledge base for reform, (2) Social mobilization and civil society movement, and (3) Political engagement and the creation of legal framework. These working strategies were translated into stages of action in the three years reform movement facilitated by the Health Systems Reform Office (HSRO) and the National Health Systems Reform Committee.

The first year of implementation aims at building up knowledge base and creating an infrastructure for the mobilization of civil society in reform movement. By the end of the first year, various forums were organized to inaugurate the dialogue on health problems among stakeholders. In the second year implementation, the initial framework for health reform was proposed in order to kick off the deliberation. Extensive debates on the proposed framework were encouraged. Hundreds of forums and workshops at various levels were organized to scrutinize the framework. By the end of the second year, a draft of the national health bill was introduced taking into consideration the ideas and suggestions gathered from the debates. Following hundreds of local, provincial, and regional forums, a national health assembly was

organized to revise the final draft of the bill. The third year was the year of promoting health initiatives in accordance with the bill, which was waiting to be approved by the Cabinet and the House of Representative.

The analysis of the reform process suggests that the most important aspect of mobilizing civil society in health systems reform was the creation of civic deliberation process. Various forums, meetings, conventions, and conferences at various levels created much needed spaces for the public to deliberate on how health and medical predicament should be understood and what should be the most important changes to achieve the desirable health systems. In order to engage the broadest range of social actors and civil society organizations to participate in the reform process, it was realized that the way health was conceptualized needed to be expanded from a biomedically oriented definition to health towards a more holistic, inclusive, and multidimentional definition. In the process of reform, health was consequently redefined to emphasize not only biological and psychological aspects but, more importantly, social and spiritual aspects of wellbeing and wellness. Various activities aimed at expanding and redefining health concept were provided as working examples in this report.

The report also gives detailed accounts of how concepts of health systems reform and civil society mobilization were translated into practices. Particular emphasis was on civic engagement and the creation of deliberative function of health system governance. It was in the deliberative processes that active citizen were empowered and the status quo was challanged. Health, as it was percieved and deliberated in civic forums, was not so much an individualized, depoliticized state of being achievable solely by individuals adopting personal healthy lifestyle, nor by passively following official authority or bureaucratic policy. Rather, health was viewed as socially determined and public policies that often greatly affected health were too important to be left alone to bureaucrats, politicians, and experts. It was this shift on the view of health and politics away from conventional model to one that embraced the active roles of citizen that could be said to be the true object of reform in Thailand's health systems reform movement.

The report ends with a set of recommendations on strategies to enhance the roles of civil society in health reform. It suggests that in order to involve greater spectrum of civil society organizations in health reform, the concept of health as well as the framework for reform need to be expanded and more inclusive. Policy processes and legitimate health actions also need to be percieved in a more pluralistic manner. Coordination mechanism to encourage collaboration between civil society organizations and national agencies is crucial

and the coordinating body must be flexible and able to work in a less structured, more informal way. Information and data base on existing civil society organizations is also crucial. The report also suggests that creating knowledge and understanding on civil society and health through research is essential for creating long term policy and strategy for a greater role of civil society in health and social changes.

Chronology of Events

Health Systems Reform Movement in Thailand

January 2000.

Broad of Health Systems Research Institute (HSRI) approved the establishment of Health Systems Reform Office (HSRO) as an interim office to coordinate the national health systems reform movement.

February – July 2000

Commission works to review and synthesize 15 issues of existing body of knowledge on health system and health sector reform. The process of review aimed at creating knowledge base for a broad-based health reform movement and the drafting of the national health act.

March 2000.

Senate Commissioners on Public Health presented the "Health System of the Nation" proposing a health system reform in accordance with the new constitution.

July 2000.

The Office of the Prime Minister issued a regulation on National Health System Reform, B.E. 2543. Accordingly, the National Health Systems Reform Committee was set up with the Prime Minister as chairperson. The purpose of the committee was to reform the national health system by passing national health act within three years.

August 2000.

National Health System Research Conference on "Civic Deliberation towards Health of the Nation" was organized. More than 1,500 participants participated in discussions on the problems of national health system, health situation and trends, and the desirable health system. Twelve civic groups organized separate forums to express their views and share their experiences on various aspects of health systems.

August – November 2000.

Research and technical groundworks were undertaken to create a strong knowledge base for health system reform.

November – December 2000.

An initial conceptual framework for national health system was published and distributed.

January – August 2001.

More than 500 workshops and forums were convened at various levels for individuals, organizations, civic communities, and public agencies to develop consensus on basic values that citizens felt should be on the reform agenda.

September 1-5, 2001.

Health Reform Bazaar was organized for civil society organizations to share and exchange their views and experiences. Technical sessions as well as the domonstration of a civic forum in form of National Health Assembly were convened.

More than 150,000 people came to the Bazaar and participated in various activities during the event.

A declaration proposing principle ideas and concepts for health system reform was drafted during the assembly and was handed to Deputy Prime Minister who attended the closing ceremony.

October – December 2001.

A draft of main content in the national health bill was produced and widely distributed among networks of civil society organizations.

February – April 2002.

550 district civic forums were convened to discuss the draft main content of the national health bill. More than 40,000 people participated in the process.

April – May 2002

The first draft of the National Health Bill was produced. Contents derived the technical review taskforces as well as from district civic forums were utilized as input for the drafting of the bill.

June – July 2002

Provincial health forums were organized in all provinces to discuss the draft of the bill. Forums for specific issues of concerns were also created to discuss specific topics. More than 100,000 people participated in these forums.

August 8-9, 2002.

National Health Assembly 2002 was convened. 4,000 participants discussed and made a final effort to round off the bill. Prime Minister Thaksin and Health Minister vowed to process the bill according to the wish of the assembly.

September 2002.

The National Health System Reform Committee approved the final draft of the bill.

October 16, 2002.

The bill was processed to the cabinet.

November 2002.

A national campaign for the bill was organized. 4.7 million signatures were gathered and presented to the speaker of the Parliament to show popular support of the bill.

December 18, 2002.

The bill was considered by the screening committee before presenting to the cabinet. Representative from the Ministry of Public Health request a month time to discuss with corresponding agencies.

January 2003.

A group of doctor from private for-profit hospital lobbied for blocking the bill. They were afraid that the bill would prohibit the operation of for-profit hospitals.

January 13, 2003.

A consultative meeting was convened to resolve controversial issues. Consensus was reached and the draft bill amended. The final draft was completed and was in the process of waiting for the approval of the cabinet.

June 3, 2003.

The cabinet extended the working period of the National Health System Reform Committee and Health System Reform Office for another two years to continue working for the bill to be put into effect.

August 2003.

National Health Assembly was organized to illustrate how local agenda should be linked to national policies. More than 2,000 participants from various civil society organizations participated in the conference.

December 2003.

The bill has not been processed to the cabinet.

February 2004.

A plan to launch a popular campaign in order to gather 50,000 signatures to support the bill was conceived. The new National Constitution grants a possibility for civil society to directly propose a new law to the National Parliament without the approval of the government.

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Introduction:

Civil Society and Health Systems Reform in Thailand

Reconceiving health reform

The founding of Siriraj Hospital as the first public hospital in 1888 marked the beginning of the transformation of health and medical care in the history of the Kingdom of Siam. Although it took several more decades before Western-styled medical care was accepted by the public, the establishment of modern hospital and medical school at Siriraj Hospital had laid the foundation for the new health system of the nation. In decades that followed, modern medical knowledge not only changed how sicknesses were cured, but also transformed the way health was defined and conceived. Most importantly, it has changed the structure of power, transformed the authority of the state, established the dominance of medical professional, and altered the roles of individuals, families, and communities in dealing with both individual and social health problems (see Komatra & Chatichai eds. 2545; Thaweesak 2543, 2545).

Prior to the establishment of Siriraj Hospital, the state played limited roles in providing health care or medical welfare for general public (Pensri 2528). Health and healing was the sole responsibility among families and members of the communities, relying mostly on local healers whose skill and knowledge could hardly be considered a profession. In such a historical context, the inauguration of freely available medical care for general public could be considered an unprecedented progress, a reformation of the nation's health care system so to speak. Under enormous support from the government and extensive technical assistance from abroad, modern medicine and modern health care system gradually replaced traditional systems of healing (Chanet 2545). Presently, modern medicine has become the main resort for health and medical problems and public medical facilities has been the major provider of medical care in Thailand.

During the past few decades, Thailand has witnessed a progressive development in the country's health situation. National health indicators have shown significant improvement. The life expectancy at birth of Thai people has markedly increased. Infant mortality rate and maternal mortality rate have been greatly improved. Various infectious diseases were either controlled or eradicated. Health care facilities have been expanded to cover both urban and

rural areas. This achievement of health development in Thailand, however, came with a high price tag. Thailand has spent approximately 250 billion baht annually on health expenditure, with a 10-percent yearly increase (Ministry of Public Health 2002: 52). While a number of old problems have been successfully dealt with, new and more challenging problems are lurking on the horizon. Preventable diseases, for example, accidents, AIDS, dengue hemorrhagic fever, leptospirosis and tuberculosis are still threatening the health of the nation. Additionally, non-communicable diseases such as diabetes and cardiovascular diseases as well as other behavior related health problems have become new challenges to the dominant biomedical approach and hospital-based health system (Ministry of Public Health 2001).

One of the main problems of conventional approach in health development is that health has been individualized as well as narrowly conceived of as the result of medical intervention. This medicalization of health and its emphasis on curative aspects has accelerated medical expenses and led many countries to initiate the reform of their health care systems. Attempts have been made in many countries on reforming national health care financing in order to contain cost while providing a better coverage of care for the population (see Sanguan & Mill eds. 1998). Medicalization of health is, however, not only costly but also inadequate in addressing the complex interplay of physical, socio-cultural, economic, and political factors that greatly affect health at individual and collective levels. Achieving health and well-being of the population requires more than the reconfiguration of medical care and changing its financing system.

If health is perceived of not as the result of medical cure, but rather as a state of individual and collective well being inseparable from its socio-political contexts, then the object of reform might be quite different from what has been viewed in healthcare reform movement, a movement that has been spreading out all over the globe in the past few decades. The object to be reformed is not as much "healthcare system" as "health system" in a broadest sense. In other words, it is not healthcare system per se that needs reform, rather the systems and processes at various levels which affect personal and collective health are what need to be reformed. Such a health system reform (HSR) approach calls into question various aspects of health system unscrutinized by conventional healthcare reform (HCR) approaches. How health is conceived, defined, and achieved outside healthcare domain as well as how systems related to health are constructed and maintained also needs to be reconsidered.

Perceiving health as the result of dynamic interplays of bio-psycho-social factors requires that reform of health sector is not restricted to "healthcare system" and "healthcare financing" that concerns only with the equity, quality, and efficiency of health care delivery

system. How can we go beyond the restricted conventional approach in reforming health sector and create a reform process from a broader perspective? Is it possible to create a reform movement that would transform health in a more holistic manner? What is the health reform agenda that enables cross-sectorial dialogue and greater public involvement to reshape the nation's health system? How can health system governance be reorganized to invite broadest range of actors into health policy processes and actions? It was with these concerns and considerations that a reform initiative was launched in Thailand in 2000 for "HEALTH SYSTEMS REFORM".

Thailand's Health Systems Reform Initiative: Toward a New Approach in Health Reform Movement

On May 9, 2000, the Thai government approved a proposal establishing a platform for national health systems reform. The proposal calls for the appointment of National Health Systems Reform Committee (NHSRC) to address the problems in current health systems of the country. To bypass bureaucratic hurdle, a secretariat office called National Health Systems Reform Office (HSRO) was set up as an autonomous agency independent from cumbersome bureaucratic administrative procedure. The aim was to reform the nation's health systems through the promulgation of the "National Health Act" which would serve as the master legislative framework for the new health systems. The process was expected to be completed within three years.

It was realized at the very beginning that wide-ranging public deliberation and people's participation was critical for building consensus on various aspects of the new national health system to be established. Involvement of public, private, and civic sectors, however, was considered crucial not only because consensus has to be achieved, but because of a strong conviction that collective learning process was critical for reinventing health system. This underpinning idea of public deliberation and collective learning was greatly influenced by the spirit that informed national political reform during 1997-1998. The resulting nation's new constitution has since symbolized the transformation of Thai political ethos toward a stronger participatory form of democratic governance.

The primary goal of reform initiative was aimed at mobilizing the broadest range of public to actively participate in the process of rethinking and enacting on the nation's health system. This was to ensure that changes in health system would be in accordance with people's will and expectation. From professional associations, non-governmental development agencies, local community organizations, to various others in civic sectors,

engagement of these civil society organizations was achieved through provincial meeting, district forums, grassroots community discussion groups, as well as regional workshops and national assembly. These interactive learning processes to shape reform agenda were assisted by various technical working groups and researchers coordinated by the Technical Subcommittee under the National Health System Reform Committee.

During the past three years, dialogues on health and the deliberation of health system culminated into a strong, broad-based reform movement. Recommendations and policy options to be incorporated in the national health systems reform agenda and the National Health Act were scrutinized and debated among concerned civil society organizations. Reciprocal exchanges of ideas and information between the NHSRC, its taskforces and subcommittees, and various stakeholders took place in hundreds of forums. The National Health System Reform Office (HSRO) has been instrumental in encouraging the participation and learning processes among various sectors of civil society in the reform process. While a great number of consensuses have been reached, some more complex and controversial issues were still in the on-going processes of debate and negotiation.

The Objectives

This document reports on lessons learned from the effort to promote the roles of civil society in shaping the future of Thai national health system. It was the result of a research program entitled "The Roles of Civil Society and Health Systems Reform." The three years project was supported by the Rockefeller Foundation with the following objectives:

> To establish coordinating mechanisms and two-ways communication networks among various civil society organizations, researchers, and research institutes in order to facilitate participation and mutual learning among concerned parties on the issues of health systems reform. The coordinating mechanisms and networks will serve to mobilize and gather ideas, expertise, and opinion of various groups on the issues of health systems reform.
>
> To conduct research studies on the roles and contribution of civil society in health reform movement as well as their potential capability and possible contribution to the building of a new national health system.
>
> To document the reform processes in order to draw lessons and experiences derived from the involvement of civil society in health systems reform movement. Lesson learned and experiences derived from the engagement of civil society in health reform movement will be analyzed to build up a framework for a better understanding of the roles and contribution of civil society in shaping reform agenda and health action.

This report analyzes experiences of mobilizing civil society and health reform movement in Thailand. It aims at providing accounts and an assessment of lessons learned during the period of three years reform effort (2000-2003). Although the roles and contributions of civil society organizations in social changes have been increasingly recognized, we are hopeful that lessons learned and experiences gained from health reform initiative in Thailand would contribute to a better theoretical understanding of the roles and potential of civil society in health reform in the Third World countries.

Concepts and Theories on Civil Society: A Summarizing Review

Historical Evolution of the Concept

Before the eighteenth century, the terms "civil society" and "state" were almost synonymous (Keane 1988a: 35-38). In Europe, civil society began to differentiate from the state in the late eighteenth- and early nineteenth-centuries (Seligman 1992: 15-58). The flourishing of international commerce in the time had created a new politically active middle class in Western Europe. With gathering places such as salons and coffeehouses in urban township and the invention of the press, a new public sphere emerged and new forms of associational life began to take shape (Habermas 1989). Prior to such political development in Europe, commoners under ancient regime could only relate to public affair through their compliance with state's order, for the state was the only legitimate actor that could claim to represent public interest. The emergence of public sphere and politically active middle class had changed the relationship between private and public. For the first time, individual citizen could have an autonomous idea and distinguish their public interest from that of the state. This historical development had eventually laid a firm foundation for later democratization of Europe.

The distinctive historical context of Northern America has made the development of American civil society unique. Alexis de Tocqueville observed that in the early 19th century the associational life and voluntary associations in American society was central to its democratic equality. "Americans of all ages, all conditions, and all dispositions constantly form associations," wrote Tocqueville.

> They have not only commercial and manufacturing companies, in which all take part, but associations of a thousand other kinds, religious, moral, serious, futile, general or restricted, enormous or diminutive… Wherever at the head of some new undertaking you see the government in France, or a man of rank in England, in the United States you will be sure to find an association (Tocqueville 1947: 106).

As pointed out by Barber (1995), Tocqueville's account revealed that American society of the early 19th century comprised not two but three sectors: government, markets and civil society. Civic activities were prevalent and individuals thought of themselves as citizens and their groups as civil associations in which they worked together to achieve common good.

Current interest in the concept of civil society was stimulated by political changes and the democratization of Eastern Europe. Concisely, Eastern European political changes were characterized by dictatorial regimes being challenged by small, self-organized, pro-democratic groups. These seemingly diffused, isolated organizations grew into a well-connected, autonomous network that finally liberated Eastern Europe. In this political transformation of Eastern Europe, the idea of civil society was partly influenced by political thinking of Gramsci, an Italian Marxist (see Garty, ed. 1989; Bernhard 1993; and Nagengast 1991). Departing from Marxist orthodox, Gramsci conceptually divided society into two parts, political and civil, and stressed the dialectical relation between them. The state, or political society, according to Gramsci, was the coercive institution of administration whose functions based much on the logic of force. "Civil society," in contrast, was made up of those institutions, both public and private that relied on shared values, ideas, and meanings rather than simply by naked force (Nagengast ibid.: 213; Babblio 1988; Gramsci 1971).

In a neo-liberal political tradition, interest in "civil society" or "The Third Sector" has grown out of the disillusionment with the government or state machinery. The nation-state, long considered the sole institution representing the nation, was challenged by complicated problems that transcend national boundaries. Eric Hobsbawm, a noted British historian, opines that, as the world entered the twenty-first century, nation-state was put on the defensive stance against a world economy it has little power to control.

> [The] very fact that, during the era of its rise, the state had taken over and centralized so many functions, and set itself such ambitious standards of public order and control, made its inability to maintain them doubly painful (Hobsbawm 1994: 576-577).

The dissatisfaction with government has culminated in the call for "less government" on the one hand, and "reinventing government" on the other (Osborne & Gaebler 1992). Daniel Bell, a leading political sociologist, posits that "the national state has become too small for the 'big' problems of life… and too big for the 'small' problems" (Bell 1989: 55). For Bell, the demand to a renewal of civil society is "the demand for a return to a manageable scale of social life."

While skepticism towards the state was increasing, suspicion towards transnational corporations was also on the rise. Korten's work (1995), entitled *When Corporations Rule the World*, warns how global financial institutes and transnational corporations, in pursuing their wealth, could do more harm than good especially to the disempowered developing world. The distrust and discontentment towards global financial institutions such as the World Bank, the IMF, and WTO was expressed in the vigorous protests by various global civil society organizations as well as by organizational efforts such as: the Jubilee 2000, a worldwide movement to cancel the debt of impoverished countries by the new millennium; Fifty Years is Enough, U.S. Network for Global Economic Justice, a network working to bring about changes in the policies and practices of the World Bank and the IMF; and Third World Network (TWN), which focuses on global inequality, health, and human right.

It is clear from the review above that the existence and essence of civil society has evolved greatly during the long history of human society. The definition of "civil society" has also changed over time, which much reflects the political circumstances of each epoch in which the term was defined. What makes the "civil society argument" remarkably interesting is that it is a concept commonly used by various schools of political thought. "Civil society" was seen to be a critical component useful as a corrective measure to other account of the good life and democratic society. The civil society argument, as pointed out by Michael Walzer (1992), "is directed as a critique of both the left (too wedded to government action in the pursuit of distributive justice) and the right (too unconcerned about the destructive impact of competitive markets on the fabric of associational life)." The general appeal of civil society derives largely from common agreement that civil society was the building block of democracy and a better system of governance (see Keane 1988b; Putnam 1993; Clark1991).

Defining Civil Society

Although there are differences among various civil society arguments, these differing theoretical orientations do shared some common notions on the characteristics of civil society. Such characteristics include civil society as a realm of social interaction that is autonomous, voluntary, democratic, and private-for-public. Michael H. Bernhard (1993), in his book on the origins of democratization in Poland, points out that historical evolution of "civil society" is marked by the creation of alternative "sphere of autonomy" in the late eighteenth century. He writes:

> [This] sphere of autonomy, which I will call the "public space," was created between the official public life of the monarch, the state, and the nobility, and that of private

> and/or communal life. In time, a range of associations and organizations (voluntary, professionals, cultural, social, and trade union), political parties, social movements, and communication media (the press and publishing) came to populate it (Bernhard 1993: 3).

According to Bernhard, these autonomous organizations were able to organize themselves outside the official political sphere and compelled the state to recognize and respect their existence and thus radically alter the power relation in the political system as a whole.

The autonomy of civil society, as its other name "The Third Sector" signifies, is defined in relation to the first two sectors: State and market. Oliveira & Tandon, in their article entitled "Institutional Development for Strengthening Civil Society", define civil society as

> [The] web of associations, social norms and practices that comprise social activity different from activities of the institutions of the state (such as political parties, government agencies, or norms about voting) or the institutions of the market (such as corporations, stock markets or expectations about the honoring of contracts) (Oliveira & Tandon, eds. 1994:6).

Bratton, building his ideas on Putnam's formulation, refers to civil society as "the sphere of social interaction between the household and the state which is manifest in norms of community cooperation, structures of voluntary association and network of public communication" (Bratton, cited in Soccorso 1994: 7). Civil society is characterized by participatory process. "It comes into being when people construct a sphere other than and even opposed to the state... including, almost always unsystematically, some combination of network of legal protection, voluntary association, the forms of independent expression" (Soccorso 1994: 8).

Other definitions stress slightly different aspects of civil society as important characteristics. Cohen and Arato, for instance, define civil society as "a sphere of social interaction between economy and State, composed above all of the intimate sphere (especially family), the sphere of associations (especially voluntary associations), social movements, and forms of public communication" (Cohen & Arato 1992: ix)

Civic Practices Network offers another definition, stressing the networking aspect of civil society. "Civil society refers to that sphere of voluntary associations and informal networks in which individuals and groups engage in activities of public consequence" (Civic Practices Network, online at: www.cpn.org/sections/tools/models/civil_society.html). Civil society is," as Barber argues, "public without being coercive, voluntary without being private" Barber (1995). Similarly, Rubem Cesar Fernandes sees civil society or the Third

Sector as consists of "private organizations and initiatives aimed at the production of public goods and services" (Fernandes 1994a: 343). He proposes a simple scheme to distinguish between private and public realm, which is adapted and shown below.

Agents		Ends		Sector
Private	for	Private	=	Market or Business
Public	for	Public	=	Government or State
Private	for	Public	=	Third Sector or Civil Society
Public	for	Private	=	Corruption

(Adapted from Rubem Cesar Fernandes 1994a: 342)

To sum up, one can define civil society as **"an autonomous sphere of social interactions in which active individuals and groups form voluntary associations and informal networks and engage in activities with public consequence."**

Although the concept of civil society was originated as a Western political idea, it can be used as a conceptual tool to understand the emerging "private, nonprofit organizations" or "the Third Sector," which has increasingly influenced health and social development in many parts of the world today. In forging a broad-based health systems reform movement in Thailand, civil society was situated at the center of the movement. It was a strongly held conviction that the roles of civil society and civil society organizations were crucial in creating a healthy health system reform in which dialogue and deliberation is the key to create a consensus of what is good for individual as well as collective health.

Research Questions

To ensure that lessons learned from the reform movement were fruitfully collected, research process was designed as part of the reform and proceeded along as the reform process progressed. As a qualitative research, an extensive set of research questions was formulated at the outset as a guideline broad enough to cover interesting issues that might be encountered as the research evolved. The research questions were grouped into three main areas as follow:

(1) On the concept and theory of civil society and health:

What is a tenable theoretical understanding we can draw from Thailand's unique experience of civil society movement in health systems reform? How "civil society," as a

theoretical concept, is understood and enacted from the points of view of various actors in health systems reform movement? How is the concept of civil society useful in conceiving a reform movement? What are the relationship between civil society, public policies, and health reform?

(2) On the strategies and approaches to strengthen the roles of civil society:

From the understanding of the roles of civil society gained from Thailand's health systems reform experience, what are strategies or working models that would help to facilitate and further strengthen the roles and contribution of civil society in health and human development? What are the strength and/or weakness of civil society in the realm of health? What are the prerequisites for the strengthening of the roles of civil society in health system reform?

(3) On civil society and health governance:

From lessons learned through the participatory process, what are critical functions of civil society in health policies and actions? How does civic engagement influence reform agenda and reform processes? What are the roles of civil society in creating stronger democratic governance in health systems? How can civil society best contribute to the functioning of new health systems and health systems governance?

These core questions guided the study and the analysis of the reform processes. The findings from review of situation, literature reviews, and case studies were synthesized around these research questions to arrive at a clearer understanding of the relationship between civil society and health system reform. Researches were conducted employing qualitative approach and using the following materials and method.

Framework and Methodology

The research program of which this report was the partial result was created in parallel to the health systems reform movement. Research works were undertaken in accordance with the way reform processes unfolded. According to the reform plan, the first year of implementation aimed at building up knowledge base and creating an infrastructure for the mobilization of civil society in reform movement. By the end of the first year, various forums were organized to inaugurate the dialogue on health problems among stakeholders. The issues raised in the forums were recorded and used as input for the analysis and formulation of framework of reform.

In the second year implementation, the initial legal framework for health reform was proposed in order to kick off the deliberation. Extensive debates on the proposed legal

framework were encouraged. Hundreds of forums and workshops at various levels were organized to scrutinize the framework. By the end of the second year, a draft of the national health act was introduced taking into consideration the ideas and suggestions gathered from the debates. Following hundreds of local, provincial, and regional forums, a national health assembly was organized to revise the final draft of the bill. The processes of debate and deliberation were observed and documented. The third year of reform was the year of promoting health initiatives in accordance with the new national health act, which was waiting to be approved by the Cabinet and the House of Representative.

This report based on the result of three years study of reform movement. It took ideas, concepts, work processes, and examples from the reform movement as objects of its studies. The research procedure of this study, however, was not a detached but participatory process in which researchers of the program actively engaged both in continual dialogue and in action throughout the reform process. It was our strong conviction that there were no objective, neutral, and value-free assessment and only an epistemology based on practice and direct engagement that we can appreciate as well as appraise a process aimed primarily at social change.

Materials and Method:

At the outset, a technical working group was appointed to facilitate and coordinating ongoing research works on civil society and health systems reform. Regular technical workshops have been held among members of the working group to assess the situation, formulate work plan, conduct necessary research studies, as well as supervise ongoing research and case studies. Experiences grained during the three years of engaging civil society in health reform movement was systematically analyzed and synthesized to formulate a tenable theoretical understanding of the roles and potential contribution of civil society in shaping health policies and social changes.

This report was the attempt to provide a comprehensive review of situation, traces the development of the movement, analyzes the experiences gained from the reform efforts, and gives systematic recommendations for the future development of the roles of civil society in health and human development. Other than the review, interview, and case studies, a series of technical seminars were regularly organized to discuss and develop deeper understanding of ongoing health reform movement within contemporary Thai socio-political contexts.

The process of regular technical meetings was designed so as to ensure that parties involved in reform movement had a chance to share their perspectives with researchers and to

learn from their own experiences. In the last year of the program, four regional workshops were held to invite various parties to reflect upon their experience on health development and reform.

The working process of the Health Systems Reform Office has been systematically documented to reveal how an organization determined its vision, mission, and strategies in working to mobilize participation and to strengthen the roles of civil society in determining the future of health systems. It was expected that lessons learned from experience in civil society movement and health systems reform would provide a strong basis for synthesizing a sound theoretical understanding of the roles and potentials of civil society in health and social change in Third world context.

Overview of the report

This report provides a detail account of health systems reform movement and the ways in which civil society was engaged in the reform process. It aims at analyzing and evaluating Thailand's experiences on the strengthening of the roles of civil society in health systems reform movement. Special emphasis was put on developing the understanding of changing roles and relationship between civil society and the state in shaping the new health awareness and health practices in Thailand. The report is organized into five main parts. Other than this first part of introduction, the following second part of the report provides a historical background of Thai politics and the evolution of health systems in Thailand. It also gives an account on the emergence of civil society and the growing roles of civil society in the domain of health care and health development. The third part provides a review of global experience on health sector reform. It argues that in the worldwide health care reform movement the roles of civil society deemed to be absent. Civil society was absent in health care reform in a double sense; civil society was not only missing as a topic in health care reform debate, but it has also been missing as an actor or political force in shaping health care reform agenda. The forth part of the report provides an account of health systems reform movement in Thailand. It begins with a discussion on the guiding concepts and working strategies that gave a strong emphasis on the involvement and mobilization of civil society to create a broad-based reform movement. The later section examines how the ideas, concepts, and strategies were implemented. The fifth and final part of the report looks forward from current situation and provides some practical suggestions on ways and means to encourage and strengthen the roles of civil society in health and social changes. It also suggests some research questions for creating a better understanding on civil society and its potentials.

2

Background

Political Development and the Evolution of Health Systems in Thailand

The political landscape and emergence of civil society in Thailand

This section explores current political landscape and examines an emerging civil society in the dynamics of contemporary Thai politics. Review and historical analysis of political development of Thailand reveals an increasing role of civic sector in Thai society. In fact, in the Seventh International Conference on Thai Studies held in July 2001, some 700 social science scholars from around the world gathered in Amsterdam and convened under the theme: "Thailand: A Civil Society?" Terms such as "civil society," "citizenship," "public sphere," "collective consciousness," and "civic virtue" have been appearing in the Thai semantics and increasingly being employed by social activists, media, and academicians in contemporary political discourses (see Suwit ed. 2540; Anuchat & Krittaya 2542; Yuthana & Sunita 2543).

In a book edited by Chris Hann and Elizabeth Dunn (1996), *Civil society: Challenging western models*, Hann, following Adam Seligman (1992), identified three distinctive ways in which the notion civil society was used: Firstly, it was used as political slogan, powerfully employed in an ephemeral usage against the state. Secondly, it was used as "a positive, analytic term" for the analysis in empirical research. Although the term has been gaining academic interest in the past decade, some viewed it as confusing and redundant, too vaguely without any strict definition. In the third sense, civil society was used as a normative concept, a desirable social order employed to judge how "good" or "democratic" a society was. Various articles in the book revealed that how the term civil society was used and how its relation to the state was perceived largely depended on socio-political and historical circumstances.

Although the actual definitions of these terms may vary among different people, most of them share the idea that the concepts such as civil society suggest new ways of political action and democratization process. In stead of viewing official politics and representative democracy as the only means for social change, civil society movement in Thailand seeks to create alternative political spheres and strengthen the roles of people in "public politics" (see Chaiwat 2547). From grassroots community organizations to national movements, various

civil society organizations are making their presence felt and trying to make a difference in people's social and political lives. Current situation in Thai politics can be characterized by an increasing public demand for participatory democracy and increasingly recognized roles of civil society.

The following discussion is divided into four parts. The first part provides a historical background of Thai political development. It traces the current political situation to the commencement of a modern Thai nation-state. The historical review reveals how a Kingdom under an absolute monarchy has been gradually transformed into a "bureaucratic polity" and eventually emerged as a democratic nation. Against these historical contexts, the second part examines the evolution of civil society and the roles of civil society organizations in Thailand. From elitist charitable function, civil society organizations have been increasingly diversified. The third part of the analysis explores Thai health system through the historical evolution of modern medicine in Thai society. It traces the history of medicine from when it was first introduced during the colonial encounter to its roles in the building of modern Thai nation state. The analysis ends with a discussion on current health systems governance and the emerging roles of civil society in the field of health governance. It can be said that health was an important arena in which civil society organizations actively and successfully establishing their roles and their constituencies.

Part 1

Thailand: The Politics and Economy of Modern Thai State

The colonial encounter during the reign of King Mongkut (Rama IV, 1851-1868) and King Chulalongkorn (Rama V, 1868-1910) marked the inception of the nation-state of Thailand. The increasing pressure of colonial powers of Britain and France had forced the royal court of Siam to cautiously transform the Buddhist kingdom of Siam into a modern nation-state. The colonial pressures had culminated into the signing of Bowring Treaty in 1855, in which the British envoy Sir John Bowring persuaded King Mongkut to open the country for foreign trade. From the time of the Bowring Treaty on, Siam was increasingly integrated into an international order and the world market (Keyes 1987; Ingram 1971).

The commencement of Siam as a nation-state was characterized by political reform; economic changes and an augmentation of highly centralized bureaucratic system (see Riggs 1966; Siffin 1966; Tej Bunnag 1976; Wyatt 1969). This transformation resulted in the formation of the new class of bureaucrats and eventually led to the 1932 coup commanded by

young bureaucrats, military officers, and civilian figures, most of whom were educated in Western countries (Stowe 1991: 9-22). The coup transformed the absolute monarchy into a constitutional monarchy, and founded what Riggs (1966) called a "bureaucratic polity" in which commoner officials were placed in the cockpit of political power. Although the initial intention of the coup was a democratic reform, democratization was hindered by the clash between civilian and military fragments of the government. Military rule eventually overcame and took control of the state in the next following few decades.

During 1960's, with the Thai economy being increasingly integrated into the world market, the state's developmental policy under Sarit's military regime started promoting cash corps such as jute and cassava in rural area. Natural forests throughout the country were invaded and cleared for cash corp. In the meantime, under the influence of The World Bank and The United States, Sarit's regime turned state policy towards privatization. The formation of a new middle class of entrepreneurs and massive governmental investment in the construction of economic infrastructures paved the way for the modernization of Thai economy. However, it was not until the last two decades that Thailand has witnessed an amazingly rapid transformation of its economy and society.

From a predominantly agrarian society, Thai economy has turned towards industrialization and enjoyed an exceptionally high growth rate over 20 years. The national Gross Domestic Product (GDP) has exhibited continuous growth averaging over 7% per annum (The World Bank 1984). More dramatically, Thai GDP increased more than 10% per annum from 1988-1990. The sustained economic growth was achieved predominantly by rapid industrialization, an increase in foreign investment, tourism, and a growing export-oriented manufacturing sector. Thailand's optimistic economic outlook was so promising that in 1982 the World Bank's economists published a report suggesting that Thailand, among other 12 developing countries, was a "second tier." It would be likely to emerge as one of the NICs (Newly Industrialized Countries), following the footsteps of the original four NICs in Asia: Hong Kong, Singapore, South Korea, and Taiwan (quoted in Tan 1993).

Although the exceedingly rapid growth has generated a fourteen-fold increase in the national income and an average eight-fold increase in per capita income over the two decades during mid 1970 to 1990s (The World Bank 1984), this optimistic outlook obscures several serious problems. For one, Thailand's income distribution and poverty profiles remain major concerns. Although household income has steadily increased in real terms, the Gini Coefficient (an index indicating disparity of wealth) has widened from 0.426 in 1976 to 0.500 in 1986. The disparity has resulted in less than 20% of the entire population appropriating

more than 50% of the national wealth. Furthermore, the percentage of the population below the poverty line showed no sign of improvement over the same period (Hutaserani S. et al 1988).

Thailand and the Global Political Economy

A closer look at Thai economic development reveals that the agricultural production has been declining in its contribution to the country's exports since the 1960s. In 1971, agricultural exports accounted for 62% of all exports, of which manufactured goods accounted for only 10%. By 1988, while manufactured goods accounted for 66% of all exports, the share of agricultural exports fell to 28% (Tambunlertchai 1989). The decline of the agricultural sector has further accelerated in the past few years. In 1990, the share of the agricultural sector dropped to 15% (Yongyuth and Somsak 1993:208). Unmistakably, aggressive governmental policy towards industrialization was increasingly influenced by the global political economy. Under the mainstream development paradigm, Thailand's successful growth-oriented economic strategies relied heavily on foreign capital inflows and foreign investment.

In 1997, the overheated economy of Thailand melted down, pulling along a few other Asian economies. Facing the mounting crisis, one that was considered the most damaging since the World War II, the government was forced to devalue the baht currency against the US dollar. Within a year after the first sign of economic crisis, the depreciation of the currency decreased the value of the baht by almost 100%. The Thai government was compelled by the severity of the crisis to request a bailout package of 170 million dollars, as a loan from the World Bank and the International Monetary Fund, to ease the liquidity of the market (Pasuk & Baker 1998). Although the effect of the economic downturn hit first and most intensely on the industrial and financial sectors, its ripple effect was eventually felt by rural communities who had little buffering mechanism to cushion the austerity measures imposed by the International Monetary Fund and the World Bank.

Yet the economic crisis has its positive side. In the course of crisis development, it has become clear that the crisis facing the nation in fact had its deepest roots in the corrupt politics that are predominant in the Thai political landscape. The growing middle class who, in the past two decades, have prospered like never before and now see their wealth evaporating in front of them, rigorously demanded political reformation. Middle class white-collar workers gathered on the streets demanding political change. The new constitution drafted by an independent assembly, despite the fact that it proposes various progressive measures, which would cripple the power of those who presently enjoyed their political

privilege, was approved by the national House of Representatives. This new constitution, dubbed as "People's Constitution," induced drastic changes in the Thai political landscape and open up new era of citizen's participation and deliberation in political affair.

A New Political Ethos and the Emerging Civil Society

The emergence of civil society as a social institution and the relationship between civil society, political society and corporate society is historically contingent. In other words, the development of a civil society depends on historico-political contexts and differs from country to country. As mentioned earlier, before the 18th century, the terms civil society and state were almost synonymous. In Europe, civil society began to differentiate from the state in the late 18th and early 19th century when the flourishing of international commerce created a new politically active middle class (Keane 1988a; Habermas 1989). With gathering places in the marketplace and the invention of the press, a public sphere had emerged in Western Europe. In Northern American, as Tocqueville's witnessing accounts suggested, associational life and voluntary organizations were a way of life and building blocks of democracy in 19th century America. Current revitalization of the concept was partly stimulated by political changes and democratization of Eastern Europe, the decline of nation state, and the skepticism of globalization in current age of global economy.

Although civil society has become a concept employed by a variety of social actors in every part of the world in the past decade, the emergence of civil society and its relationship to political and corporate society, as well as how the term civil society was discursively employed, largely depends on specific historical circumstances. In the case of a middle-income country like Thailand, a country typified by its rapid economic transition and industrialization, what is the accurate reconnaissance of the existence of civil society, its strength, and its relation to the state? Akom Chanangkura has conducted early investigation of this issue. Akom's article "Thai Bureaucratic Capitalist State: An Essay on State and Civil Society in Thai Capitalism" is cited in Thanes Arpornsuwan's analysis of state and politics in Thailand:

> Blurred demarcation between civil society and political society is expressed in the forms of relationship deeply embedded in Thai bureaucratic system, namely, paternalism, nepotism, and a highly hierarchical, ranked system of relation. Even on the level of basic understanding, Thai people are not aware of the distinction between the state and society. They seem to wrongly assume that society is the state and vice versa (Akom, cited in Thanes 1992:208).

Chai-anan (2535) offers an explanation on this phenomenon by pointing out historical evolution of the modern Thai State. Chai-anan contends that the formation of the modern Thai state was a response to the external challenge from colonialism. The expansion of colonial power threatened the sovereignty of the Siam court. The modernization process has been a response to this threat and thus was mainly a process of strengthening the state machinery to maintain a stronger grip on political power and sovereignty. The focus of modernization was on creating a more effective centralized bureaucratic body, which would secure the state's authority over its territory. It has been a state-building process and not a nation-building one.

According to Chai-anan, the consolidation of the Thai State machinery and the centralization of governmental organization have created a monopolistic bureaucratic polity. Civic organizations outside the realm of the state have been disdained. Chai-anan compares the Thai situation to that of Europe and Britain. He notes that in the process of state formation in Europe and Britain historically, there was a co-evolution of an economic sector to the extent that civic sector developed and was able to take a decisive role in political evolution and eventually overturned the absolutist regimes. In the case of Thailand, the Thai state developed without this concomitant growth in the civic sector. However, the last decade has witnessed drastic changes in the Thai political and economic scene. Rapid economic growth has accelerated and increased the role of middle class in Thailand.

In the May 1992 political upheaval, the middle class gathered and protested against the military junta, and eventually cast out the coup leader from the premiership. News reporters called the mob the "mobile-phone mob", for participants of this political demonstration carried with them their pocket mobile phones that they used to describe the situation to their friends and families. Previous descriptions of Thai society as a "bureaucratic polity" have been challenged by Anek Laothammatas, who posits that the Thai state has been transformed from a bureaucratic polity into a state of "liberal corporatism" or "social corporatism." Such a transformation was marked by the emergence of a powerful middle class in Thai politics and the consolidation of economic sectors (Anek Laothammatas 1992).

Coinciding with Anek Laothammatas' analysis, Therayut Boonmee, a prominent social activist, proposes a ground breaking analysis of Thai politics and suggests a strategy for social change which takes into account a crucial role of "civil society" (Therayut 2536). He points to an emerging civic consciousness, expressed in popular and professional movement in the last few decades. This movement, according to Therayut, is more diffuse in its character, emphasizing popular involvement rather than highly centralized, hierarchically

organized movements as were popular among socialist-minded activists during the 1960's and 1970's. This civic movement is also characterized by the emphasis on local initiatives and the empowerment of organizations outside the realm of the state such as NGOs, business firms, and professional organizations.

According to Therayut, the existing national ideological construction, namely "nation" or "chat," which has been employed by the state to promote nationalist loyalty and social cohesion has lost its compelling power and become irrelevant. Therayut contends that "civil society" as an ideological construct has been emerging and replacing the old nationalist construct. The ongoing process of institutionalization of "civil society" will eventually cultivate "sustainable political development." Therayut spells out four steps towards the strengthening of civil society, which include the emergence of collective consciousness at the societal level, the formation of various civic organizations, the crystallization of civil society as an ideology, and the institutionalization of civil society. Therayut suggests that in the last three decades, Thai society has been in this third step, where "civil society" was emerging as a new political ideology.

Part 2

The Emergence of Civil Society in Thailand

Historical evolution of Thai civil society

The emergence of civil society as a distinctive social institution from that of the state deeply depends on a nation's historical circumstances. In the Thai historical development, non-state actors have only recently become a relatively active political force. As shown by Anek Laothammatas' account, it was only in the late nineteenth century that the business associations became politically powerful enough to influence the state's policies. Anek Laothammatas posits that the Thai state has been transformed from a bureaucratic polity into a state of "liberal corporatism" or "social corporatism." Such a transformation was marked by the emergence of a powerful middle class in Thai politics and the consolidation of economic sectors (Anek Laothammatas 1992).

According to Habermas, the political situation in Europe during the Eighteenth century was marked by an emergence of a public sphere in which the affluent middle class engaged in debating public issues. It was within this public sphere that civil society came into existence. It would be mistaken if we considered the advent of the Thai civil society as purely the construction of middle class only in late nineteenth century. Various accounts on Thai

historical development indicated that non-state actors in the domain of public affair were quite natural phenomena in pre-modern Siam. Of utmost important was the role of the Buddhist Order, or the Sangha, as a center of people's social and moral life. Buddhist monasteries around the country were the places where people came together to realize their collectivities. Not only religious activities in terms of merit making and ritual ceremonies, but also various other cultural and charitable events took place in the monasteries. In fact, most rural monasteries played important roles in providing education, both religious and secular/occupational, for the communities.

Other than the Buddhist monasteries, the early form of philanthropy was organized by members of royal family. In 1890, the national Red Cross Society was established by Queen Rama V, Somdej Phrasripacharindhra. The first orphanage was also setup by a member of royal family in Bangkok. In 1904, King Rama V and his courtiers setup the Siam Society as a philanthropic association. In addition to these elitist initiatives, there was also a variety of ethnic and religious organizations. Of most prominent were Chinese clan associations. They provided necessary food, accommodation, as well as medical and social welfare for the immigrant Chinese who had come into the Kingdom. In fact, a few of the earliest hospitals established in Thailand were those started by Chinese philanthropic association (Thienfa Foundation's Hospital and Hua Chiew Hospital, for instance). In addition, other religious groups also sought to provide humanitarian aid. Western missionary groups also came to the Kingdom and set up hospitals. The McCormick Hospital in Chiengmai was in fact the first hospital in the Kingdom. Bangkok Christian Hospital and the Mission Hospital were also among the early missionary effort to render medical assistance for local people. These efforts were particularly prominent after the World War II.

According to Amara (2545), the evolution of the civic sector in Thailand can be viewed as three phases. The first phase was during after the WW II to the period when the military had a strong hold on the country's government affair. The second phase can be conceived of as being in the period when pro-democratic movement that resulted in the end of military regimes in Thailand. The third period was after the promulgation of the new constitution, which was popularly called "People's Constitution."

The First Period: After the World War II and during the Military Regimes

Most of the non-profit organizations during this time confined their roles in the areas of social services and charitable activities. There were only a small number of such organizations and most were run by the elites of Thai high society. These organizations

provided supports and services for disastrous victims, scholarship for poor students, and donation to hospitals for the disadvantaged. There were also a number of Chinese clan associations whose roles were to provide support among members of their clans. Some of the Chinese clan associations were viewed with suspicious by the military government. It was suspected that these organizations were associating with and influenced by the Chinese Communist regime. Other than these organizations, local Buddhist monasteries played important roles in providing support for the destitute. A few other religious groups existed and played limited roles typically among their small circles of followers.

The Second Period: The Era of Political Struggle for Democracy

In the early 1970s, the dictatorship regime of military junta came under strong challenge for the pro-democratic movement, which had gradually gained political momentum and popular support. The October 14th Popular Uprising ousted the military junta and opened up a new era of political participation and democratization. A variety of people's organizations emerged including labor organizations, farmer associations, student organizations, as well as various other social groups. The active political movement came to a standstill after the crackdown and massacre of October 1973. After a brief halt, civil society organizations resumed their ideological pursuit. The period of 1980s saw a surge in number of non-profit organizations. This growth coincided with the commencement of interest and policy emphasis on rural development. A great number of organizations started their work in community development and gradually expanded to the area of environment, children, and health. The advent of "Primary Health Care Movement" contributed greatly to the increasing roles of civil society organizations in Thailand.

The Third Period: The Emergence of Strong Civil Society

The 1980s decade witnessed rapid economic growth and industrialization of the Thai economy. The proliferation of Thai economy spurred the growth of the middle class in Thai society. Business associations became much more assertive and eventually exercised strong influence in the government policies. When the military coup took over the power from a corrupt government and later on turned out to be detrimental to democratic principle, the middle class hit the street in one of the biggest protests in Thai history. The military junta was ousted and a civilian government was set up. The following half a decade has witnessed an extraordinary economic performance, which ended shockingly by the financial crisis in 1997.

When the Thai economy collapsed in 1997, the middle class stratum came to the forefront to demand for a new system of governance. Middle class white-collar workers gathered on the streets demanding political change. The new constitution drafted by an independent assembly, despite the fact that it proposes various progressive measures, which would cripple the power of those who presently enjoy their political privilege, was approved by the national House of Representatives. In the process of drafting the new constitution, civil society organizations such as community organizations, NGOs, and concerned academicians, from grassroots initiatives to national organizations joined hands and created forums to deliberate on how the new architecture of democratic governance should be. These civil society organizations became strong change agents, forging a new political sphere, a sphere of deliberate citizenship in which the voices of the excluded can be heard and extreme asymmetrical power relations can be more effectively challenged.

Part 3

Thai Health System and the Evolution of Modern Medicine in Thailand

The following analysis explores the evolution of Thai health system through the history of modern medicine in Thai society. The analysis, however, does not aim as an exhaustive review of the Thai medical history. Its main objective is to demonstrate the relationship between health, medicine, the state, and civil society, which have evolved within specific socio-political contexts. As will be demonstrated by the following analysis, current system of national health governance was the result of counteracting multi-leveled historical forces each with its own agenda. From the early days of colonial expansion to the age of globalism, the interplay of medical knowledge, professional authority and the state was critical force that influenced and shaped society's health as well as its power structure.

While the colonial powers employed medicine as an instrument of control and domination, medicine was also appropriated and employed by the state to lend legitimacy to its expanding roles among its citizen. In the development era, illnesses and diseases became a pretext for the increasing roles of the state as the champion of development. Medicine and health care were on the top of developmental agenda of most the developing countries. While medicine and health care was used to legitimize and extend the power of the states, poor health and the unequal access to medical care has prompted the desire for equity and social justice. Medicine was therefore as much an institution for social control as a realm of competing political action. It will be clear by the end of the analysis that, in the context of

emerging civil society and civic politics in Thailand, health has become a strongly contested domain in the nation's transition from representational democracy to participatory democracy.

The first part of the following discussion examines historical evolution of modern medicine in Thailand. It traces changes and transformation of medicine and health system since pre-modern Siam to the establishment of western medicine in modern Thai nation state. It will be clear that current health system governance was the result of a long evolution, which took place in specific socio-political contexts. The emerging civic health movement must be understood within such historical contexts as well as within the changing contexts of current Thai politics. The analysis will then proceed to examine health situation in Thailand. It should be noted that although many health indicators have improved in the last three decades, the problems of non-communicable diseases, health problems related to developmental policies, as well as issues related to health governance have become more concerned. The analysis concludes by examining how health has become a major sphere for civic communities and civil society organizations to realize their political subjectivities and to achieve active citizenship. This analysis will be a contextual background to better understand health systems reform movement in the following chapters.

Historical Evolution of Thai Health System

Health and Medicine in Pre-modern Siam

Prior to the introduction of western medicine into the kingdom in the 19th century, traditional health system of Siam was an eclecticism of multiple indigenous healing traditions (see Suwit & Komatra eds. 2530). Systemic knowledge and practices of healing existed only among *"mau luang"* or the house doctor of the royal court, while commoners generally relied on *"mau chalueysak"* or local healers whose knowledge and skill was more of a wise person than of a professional. The ideas of public health and organized system of health care were inconceivable under traditional system of knowledge and social organization. In ancient pre-modern Siam, the roles of the sovereign confined primarily to the protection of its subjects from external intrusion. With regard to internal affairs, state apparatus was developed and employed only in so far as it was necessary to ensure royalty and social orderliness.

To better understand how medicine and health care featured in pre-modern Siamese lives we need to look into the pre-modern social organization of the Kingdom. The socio-political organization of pre-modern Siam was characterized by the *sakdina* system, a system of ranking in which the entire population was organized into hierarchical order. The system drew the dividing line between two major social strata: "upper class person" and "lower class

person". It was estimated that the small ruing stratum were no more than 2,000 persons out of an estimated two million population of Ayutthaya period (Chai-anan 1976; cited in Turton 1980: 253). While among the royal family and courtiers, the royal doctors *(mau luang)* were available for treating ailment with various forms of traditional medicine, common folks, or the lower class persons, relied on folk doctors *(mau chalueysak)* for their health problems. The state played little role in everyday health and medical problem of the ordinary folk.

Only when there were massive outbreaks of epidemics that threatened peace and security that the state took on an active role. Certain ritual ceremonies were performed to wrath off the epidemics, which were conceived as attacks by evil spirits (Pensri 2528). Although no system of health care was organized for common folks, the royal court played instrumentals role in gathering and systematizing medical knowledge. In a number of occasions, medical knowledge was inscribed and displayed for the public (see Vichai 2545a: 56-58). With limited roles of the state in public health, most health problems were taken care of by families and communities relying on home remedies and traditional medicine. Early missionary records indicated that there were a variety of indigenous healing practices, such as midwifery, herbal medicine, massage, and spiritual healing, resorted by households in the communities (Bradley 1865; Beyer 1907; McFarland 1928).

Medicine and the Colonial Encounter

Although the arrival of western explorers can be traced back much earlier, it was during the reign of King Mongkut (Rama IV, 1851-1868) and King Chulalongkorn (Rama V, 1868-1910) that the colonial encounter was at its most intensified period. By the latter half of the nineteenth century, European powers were aggressively pursuing their colonial conquest into this part of the world. Siffin describes the Siamese situation in the nineteenth century thus:

> With Burma humbled by Britain and with British authority established at Penang and the Straits Settlements, with the China ports smashed open, the surge of Western activity posed a growing threat to the security of Thailand (Siffin 1966: 46).

It was within this colonial context that the modernization of Siam must be understood. The Colonialist Britain was forcefully making its way into India, Burma, Malay, and parts of China, while the French were penetrating Vietnam, Cambodia, and Laos in an even more aggressive and belligerent manner. Modern systems of knowledge and institutional practices such as historiography, medicine, architecture, astronomy, and archaeology, as pointed out by various writers (Asad 1973; Bhabha 1985; Stocking 1987), were part of colonial practices.

Medicine and missionary doctors occupied a special place in the history of colonial encounter for medicine was the technology par excellence for proving the superiority of western colonial knowledge.

One of the most important medical doctors who came to Siam during the reign of King Rama III was an American missionary, Dr. Dan Beach Bradley. Keen in introducing various western technologies to the Kingdom, Dr. Bradley was the first who established printing and ran a press in Bangkok. His periodical, "Bangkok Recorder," became a public media that spurred various scientific debated among Siamese elites. He also introduced vaccination and demonstrated modern medical surgery by amputating an arm of a monk who was seriously wounded by a firework explosion. Although it was a successful operation and modern medicine was increasingly appreciated by local people, it was not until the reign of King Rama V, or King Chulalongkorn that the first medical hospital under the royal patronage was initiated. The establishment of Siriraj Hospital in 1888 opened up a new chapter of medicine and health development in Thailand.

In addition to establishing modern medical facility, as modern knowledge of health and medicine became increasingly accepted other health interventions were also initiated during the reign of King Rama V. Immunization for smallpox was introduced while various laws and regulations were promulgated to ensure public hygiene and sanitation. New state department was set up in 1888 to administer public health and medical affair. Together with the set up of Siriraj Hospital, medical training program was initiated. In the early period, Siriraj Hospital and medical school incorporated both western and Thai traditional medicine. Fifteen years later, in 1907, traditional medicine was removed from Siriraj Hospital and the medical school curriculum because of it's allegedly lack of standardized practices and conflicts between western and traditional doctors.

It can be said that the introduction of modern medicine in Thailand, together with the pressure from the colonial power, has resulted in the expansion of state's roles in provision of medicine and healthcare. Colonial knowledge and power has transformed the traditional system of sovereignty into a benevolent state at the expense of traditional medicine being neglected and abandoned. Healthcare system has consequently become the domain of western medicine and increasingly biomedicalized.

Medicine, Modernity, and the Nation-State

Three decades after the set up of Siriraj Hospital, a passing-by Rockefeller Foundation representative, Dr. V. G. Heiser, on his travel to China, was asked to visit and

comment on the Siriraj Medical School. His straightforward answer that "… it was in the most appalling state ever seen..." prompted King Rama VI, who was educated in the West and regarded himself as champion of modernization of Siam, to make radical changes to the Kingdom's health care system. These changes not only affected the outlook of how health care was organized but it also marked the beginning of professional medical authority. The first licensing bill for medical profession was approved into law in the following year of 1923. Through Prince Songkhla, who was residing in the United States at the time, Prince Chainaat, Commander of the medical school asked Rockefeller Foundation for assistance to upgrade the medical school to reach the international standard. Rockefeller Foundation was willing to assist in improving medical school if the government agreed to invest in creating a professional career and build infrastructure so that graduated doctors could work in a good hospital-based environment. When these conditionalities were met, Rockefeller Foundation continuously poured in resources for thirteen years, making it one of the biggest assistant programs ever to create professional career for doctors (Chanet 2545).

With the establishment of medical school and high quality medical hospital under royal patronage and assistance from the Rockefeller Foundation, medicine in Thailand has become a prestigious profession and held an unbridled power over health and health care of the country. It can be readily seen that under the professional authority of medical establishment, biomedical worldview was soon to become dominant in health development discourse. However, during the 1890 the role of modern medicine was still limit. Bamrasnaradur gave an account that the establishment of modern hospital was not widespread prior to the 1932 coup led by young bureaucrats (Bamrasnaradur 2500). Early statement made by the coup leaders stated clearly the goal of expanding health care to the larger population in accordance with the democratic principle of equity.

The role of medicine in nation building was most evident during the Phibulsongkhram regime. Marshal Phibul put great emphasis on the development of medical care and public health in his policy statement (see Rong 2520). His aim was to build Thailand into a great nation state comparable to western super powers. He strategically organized ballroom dancing to promote marriage among single people, provided incentive for couple to have more children, built Women's Hospital and Children Hospital to ensure that mothers gave birth safely and the children survived. Phibul also imposed "State Convention" on people's behavior such as eating nutritious food, personal hygiene, sleeping habit, and physical exercise. Using modern medicine as its basis, Phibul's strategic mission was to strengthen the nation by escalating its population. The plan was to increase Thai population from 18 million

to 40 million. His speech in the inaugurating ceremony of establishing the Ministry of Public Health stated this idea clearly.

> A nation consists of some hundred thousand households, depending on whether it is a great or a small nation according to the size of its population. If a nation has only a small population, it is a small nation… The first step of making a great nation is to increase the population….
> Nation building depends in part on public health. Because the more public health and medicine progress, the stronger our nation will be. The population would increase in both quantity and quality… Presently we have only 18 million population, or 36 hands for work, which are too little for building a nation. If we have 100 million populations, we will have the power of 200 hands to work. This will make our nation a great super power (Bamrasnaradur 2500: 62-63)

In the process of nation building, medicine played a critical role in enforcing the power of the state. The instrumental use of medicine as political tool for the nationalistic movement necessitated the centralization of health care system. As a result, medical institute came under an even stronger patronage of the state far more than it was under the ancient regime.

Health and the Development Paradigm

After World War II, the international politics was transformed into the confrontation of capitalism and communism with the greatly expanded roles of the nation-state. Following the success of the "Marshall Plan," an international project called "development" was conceived. "Development" has become the reason of the state particularly for third world, or "developing" countries. However, this development discourse, to a certain extent, has been exposed and criticized as an attempt to cover up political inequity and the asymmetrical power relation. James Ferguson, for instance, in his study of development projects in Lethoso, maintains that development was discursively constructed as "antipolitic machine" working to cover up the political root cause of poverty and suffering in Nepal (Ferguson 1994). It disguised and redressed the problems of power relation and exploitation into the lack of development. In this development discourse, health has become one of the most prominent domains in which development work was exhibited. Developmental discourse in the field of health reached its peak during the primary health care (PHC) movement, which by the end of 1970s has become a global development agenda (WHO 1981).

Thailand was one of the many countries in which serious attempts were made to implement primary health care policies. Village health volunteers and village health communicators were set up in most villages in Thailand. At the peak of the policy the number

of village health volunteers were more than 50,000, while village health communicators were approximately 500,000, ten times more than the volunteers (see Thavithong et al. 1988). Eight elements of comprehensive primary health care were strongly advocated by various international organizations such as the World Health Organization and the UNICEF. The eight elements were later expanded into ten elements in Thailand, which included nutrition, health education, clean water supply, sanitation, immunization, prompt treatment of common diseases, availability of essential drugs, maternal and child health, mental health and dental health. The last two were later added as it was found to be common problems.

There have been a number of evaluative studies of primary health care looking at how village health volunteers and various groups were set up to conduct developmental activities during the heyday of primary health care (see Thavithong ed al 1998; and Morgan 1993). It was found that the roles of these community organizations were mostly to cooperate with the health agencies to implement health activities. They hardly had any role , either in decision-making process to determine what were to be done or how to do them otherwise. Rather they were participating in prearranged activities, which were derived from a universally standardized primary health care handbook. Lynn Morgan, in her study on community participation in Costa Rica found that, contrary to what was supposed to be the case; there was little participation in the policy process. Rather, Morgan showed that primary health care was used as political symbolism to gather votes and to render legitimate other hidden policy agenda (Morgan 1993).

It can be said that primary health care movement has successfully created new social spaces in which laypersons could have certain roles to play in health development. Instead of viewing the public as passive recipients of health services, the policy and its implementation permitted laypersons and the communities to partake in various developmental activities to improve their health. The participation, however, was permitted only in so far as it did not get in the way of policy decision-making. In other words, it was participation in the implementation processes rather than in the political processes of deliberating and determining how to improve their health. It was clear that despite various interpretations of primary health care movement from various political inclinations, a high sight of the process strongly revealed that the way in which people's participation in primary health care was conceived and executed was "implementation without deliberation."

Part 4

Health Governance and Civil Society

Current Situation of Health and Health Governance

Health indicators and epidemiological profiles suggested that Thailand has made considerable progress in health development. A remarkable decline in population growth rate and gradual rise in life expectancy triggered Thailand demographic transitions. The demographic transitions have created a change in Thai population age-structure from that of a broad-based, pyramid-like shape in 1970 to a columnar-based form. Thailand's infant mortality rate has also declined from 125 per 1,000 live births in 1960 to 26.1 per 1,000 in 1996, indicating a remarkable improvement (Ministry of Public Health 2001: 3). However, an obvious disparity exists between urban sector (27 per 1,000) and rural sector (41 per 1,000) (Yongyuth & Somsak 1993).

Official reports also indicate that epidemiological transitions took place in Thailand. Infectious diseases and parasitic diseases, as well as nutritional deficiency have sharply reduced. The Expanded Program for Immunization (EPI) has successfully led to the decreasing incidences of diphtheria and tetanus neonatorum. Tuberculosis and malaria ceased to be major health treats. Although infectious diseases were no longer the leading causes of death, diarrheal diseases and respiratory tract infections were still the leading causes of illnesses that bring people to health facilities. Post-transitional problems of non-communicable, chronic degenerative diseases were emerging as a new threat to the health of the nation. Accident, cardiovascular diseases, and neoplasm were the three leading causes of death in Thailand (Ministry of Public Health 2001). The most concerned public health problem of Thailand currently was the re-emergence of infectious diseases such as tuberculosis, malaria, filariasis, Dengue, and leptospirosis and other newly discovered diseases such as SARS and Avian Flu (see Vichai 2545b: 312). Occupational and environmental related health problems were also on the rise (Ministry of Public Health 2001).

During mid 1980s to mid 1990s, the spread of HIV infection in Thailand has been a major health threat in the history of Thai public health. Thailand was one of the most severely afflicted areas to the extent that it can be described as the epicenter of AIDS epidemic in Asia. Thailand, to a large extent, has been successful in the containment of AIDS epidemic due to an extraordinary concerted effort between state agencies, non-governmental organizations, as well as grassroots community organizations. During the AIDS epidemics, there was a tremendous increase in the number of non-governmental organizations working at various levels in the fight against HIV/AIDS. Effort of the non-governmental organizations to reach

for the marginalized and to fight against social stigma of people living with AIDS has been widely recognized (see Lyttleton 2000: 116-119).

In 2001, with the new government led by Prime Minister Thaksin Shinawatra, a universal coverage scheme for health care was introduced. More than 40 million people have been registered since. The scheme provided basic benefit package for all Thai citizens. Although it helped to increase equality and accessibility to medical facilities for those who have been left out in the past, the scheme cost the nation 31 billion baht. In addition, as the scheme's main focus was on reforming the country's health care system, priority was given to the financial and curative aspects of medical care with less emphasis on other dimensions of health. Overemphasis on biomedical model of health and the concern over cost-effectiveness made it impracticable for laypersons and non-professional organizations to participate in the reform effort. If health was defined in a broader sense than accessibility of medical treatment, it was possible to envision an active participation and lively deliberation from a broader range of actors.

It should be noted that although medical facilities, curative services, and disease prevention, to a certain extent, have been highly developed in Thai health system, health promotion has been comparatively lagged behind. The Ottawa Charter's five main areas of health promotional activities have been slowly and unevenly developed. At the personal and community levels, various measures were relatively successful since the implementation of primary health care. However, interventions at the macroscopic level, such as the attainment of healthy public policies, were extremely ineffective. As the nation was moving toward rapid industrialization and urbanization, the impacts of development policies and projects could be felt on every facet of life. Reports on factories releasing polluted water, chemicals, air and noise pollution have been routinely heard. Mega-development project such as dam construction and industrial estate have become not only the major sources of health problems but also the main cause of social conflict and violence.

Thai Health System and Its Governance

From the historical evolution of Thai politics and health system discussed above, we can readily draw a number of conclusions. Firstly, it can be clearly seen why current health system of Thailand was heavily constrained by curative medicine and bio-medical model of health. The strong support from the State and the influence of Rockefeller Foundation helped to create solid foundation upon which allopathic medicine was established (Chanet 2545).

The domination of curative medicine was evidence at the very beginning of the modern history of Thai medicine.

In 1924 Prince Songkhla, the father of the current King of Thailand, attended a meeting to reorganize medical education. Prince Songkhla just graduated from Harvard University with a degree on public health. Because he was not qualified as a medical doctor, he was ridiculed by other medical doctors for making comments on health policy. The incident prompted him to leave Siam, returned to the United States to further study medicine, and became a medical doctor. Prince Songkhla was later named the Father of Thai Modern Medicine. The incident suggests that very early in the history of medicine in Thailand, medical doctor has become an exclusive social class. As the professional authority further consolidated, medical doctors held an absolute power on how the health systems should be organized. This professional sovereignty set the stage for succeeding development in which the Thai health systems have been heavily dominated by biomedical worldview, which has permeated the whole society in less than half a century.

It should be noted that the biomedicalization of Thai health system was also in part reflected in the decision made when health care system was first started. There were two different views on how the health care system and health manpower should be created. The first view was proposed by an advisor from the Rockefeller Foundation to produce few medical doctors in medical school with highest standard comparable to those in the West. The second idea was to create more medical doctors capable of using appropriate level of technology and made it more accessible for the public. Although there were a few strong advocates for the second idea, eventually the first idea that emphasized the standard of excellence was adopted (Wariya 1984). Such a policy set the trend of privileging advance biomedical standard at the expense of equity and accessibility. It also gave a strong legitimacy to professional authority as the overseer of technical standard in medical advancement.

The rise of professional authority was closely tied to the consolidation of bureaucratic power. The bureaucratization of development has created the exclusivity of official policy process. Furthermore, medicine and health were largely employed instrumentally to accentuate and legitimize the state's power to control its citizen. This was particularly prominent during the Phibulsongkhram regime where reproductive health helped to endorse nationalist policies to increase the size of population (see Kongsakol 2545). In addition, during the height of the Cold War in 1970s, medicine and health programs were instrumentally employed by the Thai state to secure its authority and legitimacy in the

borderlands (see Komatra et al 2547). For the early days in Siamese history when the state played limited role in providing medical care and health welfare to the populace, medicine and health development has become a prominent mission and the reason of the state. Professional authority was, therefore, a crucial source of legitimacy of the state 's power.

From the above discussion, it can be concluded that the existing health system has been biomedically predominated. Such a paradigm perceived and defined health in accordance with biomedical worldview and thus focused mainly on diseases and biological interventions. This predominantly reductionistic view has practically precluded interdisciplinary efforts in achieving health. Once health was interpreted strictly in biomedical model, disciplines other than biomedicine were rendered irrelevant. Psychosocial and spiritual dimensions of wellbeing, for instance, have been ignored. In such a paradigm of thought, involvement of stakeholders outside the domain of medical professional was unlikely. From a civil society's perspective, however, health, as with other public affairs, must be understood as the result of collective deliberation and action, not a sole responsibility of medical experts.

The health system governance in Thailand has relied exclusively on official structures and bureaucratic policy processes. The bureaucratization of health made health development an exclusive domain of medical professional and public health bureaucrats. Although, in the past two decades, there was an increasing number of civil society organizations engaging in health development issue, the extent to which these organizations were able to have any impact on the policies and practices of state development mechanism has been limited. Health bureaucracy in Thailand was characterized by a strong centralized planning system in which communities and civil society organizations were expected to collaborate with the pre-determined policies and projects. Even during the height of primary health care movement the idea of people participation had been more of "people cooperation" in state's development ideology rather that people partaking in political decision-making on how their health predicament should be interpreted and addressed. In other words, participation was on implementation and not on deliberation.

The Emerging Roles of Civil Society in Health Governance

Although the emerging role of civil society was a recent phenomenon, there were evident of civic tradition and philanthropy early in Thailand's modern history. Health was an important domain for such activities. The Thai Red Cross Society, for instance, played important roles in taking care of war victim. The royal orphanage house also concerned itself

with health and wellbeing of the orphans, while various elitist housewives associations during the 1980s worked not only to promote high culture among their members but also provided health care and welfare for the destitute (Benjamas & Suraphol 2545: 16). During the development era in 1960s, non-state actors actively engaged in various field of development especially in the field of health. The United Nations declared "the Decade of Development" and, with financial and technical assistance from the first world nations particularly the United States, supported development agencies and volunteer organizations to work in community development program.

Of particular importance were the Population Development Association that contributed greatly to family planning and population control. Rural development initiative by Dr. Puay Aungphakorn was a significant chapter in the role of civil society organizations in development. The integrated approach adopted by the project helped to place health problem in its proper context. It was during this Decade of Development that civil society organizations working in the field of health had multiplied. Most of these organizations worked with local communities at the grassroots level. A number of them have been active in the field of health such as providing health care to the poor, running child survival programs, advocating the use of herbal medicines and indigenous healings, as well as encouraging organic farming and alternative agricultural practices as a healthier way of life.

Some high profile non-governmental organizations worked at national level. A number of consumer groups were extremely active, working both in consumer education and consumer right advocacy. Also greatly noticeable was the anti smoking activist group, which has been exceptionally successful in its campaign. In addition, professional associations were more active and played important roles in the field of health development. The Rural Doctor Association, the Community Pharmacist Association, and the Network of Community Health Workers, for instance, have been working to encourage professional contribution to the health of the poor particularly in rural areas. These organizations engaged in public policy processes in various ways including public education, running campaign on specific issues, advocating legislative changes, as well as working as political watchdog (see Suwit 2546).

During the 1980s and 1990s, economic expansion created a growing stratum of middle class in business sector. A number of organizations in the corporate society have been increasingly active in initiating programs for public service. Examples of such programs are *Krongkarn Ta Wises,* a campaign project for better environment; Think Earth Project; Central Department Store's strong support for anti-smoking campaign; Creative Media Foundation with strong support from Bang Chak Petrochemicals; and Population and Community

Development Association's Thailand Business Initiation for Rural Development project (TBIRD). Most of these initiatives could be said to be concerned with health in a broader sense. Although some of these initiatives were viewed as a thinly veiled public relation ploy to create good commercial image, quite a number of them did and continued doing decent work up to the present.

The roles of civil society organizations have been increasingly diversified in the past three decades. In addition to providing service and support for those who needed, non-governmental organizations gradually expanded their role and work in protection of right and advocacy, knowledge generation, as well as provision of alternatives and exit options. Tobacco consumption control, environment preservation, consumer protection, as well as promotion of alternative health have been main areas in which civil society organization take active roles. One of the most important events in recent history was the eruption of 1998 Drug Scandal in the Ministry of Public Health. The Scandal also brought into attention of the media and general public by the Rural Doctor Society and other non-governmental organizations.

The exposure of the corruption brought about a critical awareness among concerned parties of the deep-rooted cultural practices that made possible this biggest scandal in the history of the Ministry of Public Health. Media coverage had been extensive. The ex-minister of public health was recently sentenced to jail for his wrongful conduct. Although the Rural Doctor Society and other NGOs have been praised for their courageous conduct in alarming and exposing the abusive administrative practice, and thus public interest had been protected, a number of people are paying attention to what long lasting structural changes such an exposure would make in the realm of public health governance. It is clear, however, that the role of civil society organization on creating a transparent and participatory process of health governance has been increasingly realized.

3

A Review

International Experiences on Civil Society and Health Sector Reform

Health Sector Reform and the Absence of Civil society

This section examines why civil society has been largely missing from health care reform. Although in the past decade civil society has been a vital social force in shaping various domains of public policies, the roles of civil society has strangely disappeared both as a topic in the debate about health care reform and as an actor in shaping health care reform agenda. The paper maintains that the absence of civil society in health sector reform was not only owing to political reasons but the way of thinking about health in our modern culture precluded the roles of civil society and inhibited civil society from effectively participating in health sector, and particularly health care reform debate.

Politically speaking, incursion of civil society into the reform affairs could be perceived as a threat to the prevailing power structure of health care politics. It was a well-known fact that medical establishment and medical professions, pharmaceutical companies, state bureaucracies, and the insurance industry have long dominated health care industry. In developing countries, state bureaucracies and medical professionals, often under the cloak of state officers, seemed to have unbridled power over medicine's public policies. Within this existing power structure, it was unlikely that unsolicited player would be an acknowledged new comer or regarded as significant actor in the field.

It is clear that there was political reason for the absence of civil society in health care reform, but there could also be cultural reasons beneath the obvious political explanation. The review of international experience on health care reform suggests that cultural characteristics of the reform process have practically inhibited civil society from playing greater roles in shaping reform agenda. These cultural barriers were deeply rooted in the conventional perception of health and in the unquestioned framework of health sector reform. In debate about health care reform, health has been defined and interpreted strictly within biomedical framework, while the strategic task of reform has often been narrowly conceived of as merely changes in health care financing and improved accessibility of medical services.

Within this interpretive framework, economics and biomedicine have become the rules of the game and the reform of health care system has been restricted for those who

knew how to play. Such a narrow framework left little space for the roles of civil society as partner in determining the desirable health systems or as potential contributor in building society's health and well-being. To create a broad-based health reform movement, it was crucial to begin with an open platform that encourages public deliberation rather than a rigid framework that restricted political participation and hindered the roles of the public at large.

The following review is divided into two parts. The first part examines the emerging roles civil society played in health and human development in the past decade. With the increasing political roles of civil society as background, the analysis proceeds to examine the strange disappearance of civil society in health care reform. Dominant approaches and practices in health care reform were critically examined to reveal the reasons for the absence of civil society. A few exceptional cases of health sector reform with strong involvement of civil society will be discussed as possible examples of alternative approaches.

The growth of civil society organizations

The growth of civil society was a global phenomenon. In the past two decades, private non-profit organizations have dramatically increased in many parts of the world in developed and developing countries alike. In African Continent, private non-profit organizations increased from 1,506 organizations in 1985 to more than 20,000 in 1994. In Kenya alone, non-profit organizations increased from 125 in 1974 to more than 400 organizations in 1988 while in Zimbabwe the number raised from 376 organizations in 1980 to 1,506 in 1985. In the Middle East, non-governmental organizations in West Bank and Gaza strip increased from 272 organizations in 1987 to 440 in 1992. In Jordan, the number raised from 221 in 1980 to 587 organizations in 1992. In Tunisia, the number increased more than two folds form 1,886 organizations in 1988 to 5,186 organizations in 1991.

In Eastern Europe, more than 70,000 civil society organizations were set up during 1992-1997. In Western Europe, private non-profit organizations were also growing. In one-year period of 1987 alone, 54,000 non-profit organizations were established in France, while the average rate of increase of non-profit organizations in France has been 10,000 - 12,000 a year during 1960s. In Britain, the spending in non-profit organizations' budget increased from 7.9 billion pounds in 1980 to 12.6 billion pounds in 1986, while donation for philanthropy from private sector increased 221 % in the United States and the growth rate of non-profit organizations was 160 % during 1967 - 1985. In addition, since 1984 more than 40,000 private non-profit organizations were set up each year in the United State (Data from

Anheier & Seibel eds. 1990; Oliveira & Tandon, eds. 1994; Weisbrod 1988; and Ben-ner & Gui 1993).

These civil society organizations were not only increasing in quantity, but their influences were changing the ways national and global enterprises were carried out. Some of these organizations were much more effective than the inter-governmental mechanism and the nation state. Some environmental conservation organizations had much more budget than many countries. Green Peace International and World Wildlife Fund, for instance, had the annual budget of 100 million US dollars and 200 million US dollars respectively in 1992 while the United Nations' total budget allocated for environmental protection in the same period was only 75 million US dollars.

On a global level, financial support provided to NGOs from international funding organization increased almost twofold from US$3.6 billion in 1983 to approximately US$7 billion in 1990 – the equivalent of 16 per cent of total bilateral aid flows (Williams 1990; Clark 1991, cited in Farrington et al, eds. 1993: 5). Recent report by the Johns Hopkins Center for Civil Society revealed that in the United State, Europe, and Latin America, the non-profit sector has become a major economic force with a US$ 1.1 trillion in expenditure employing close to 19 million full-time equivalent paid workers (Salamon et al. 1999).

Not only the financial support for nonprofit organizations was increasing in the last two decades, these organizations have become much more effective than many international bureaucracies have been. Amnesty International and Human Right Watch, for instance, have created great impact and have already changed state human right practices in a number of countries. Green Peace International's media facilities and communicative networks were extremely effective; it even had it own satellite link. Through their extensive communicative networks, the organization could send out its photographs to newspaper and circulate video news spots to television broadcasting stations in 88 countries around the world within hours (Wapner 1995: 321). Their activities were publicized in international mass media as much, if not more than, any UN agency or transnational corporate.

The burgeoning role of civil society organizations at the global level has never been more prominent. McGrew points out that in 1992, some 15,000 organizations actively engaged in creating an international civic network and at the same time expanding their roles in many international forums such as the Rio's Earth Summit, the Vienna's Human Right conference, Copenhagen meeting on social development, and Cairo's International Conference on Population and Development. A landmark event has been the global meeting on women in Peking in 1995 in which NGOs organized a parallel meeting to advocate their

own agenda. The meeting by NGOs received more attention from international mass media than the UN official meeting. As observed by Bogert of Newsweek, "… in the long run, the U.N. may be just a midwife at the birth of a new transnational society" (Bogert 1995: 15).

The role of international NGOs were now even more prominent and clearly critical in influencing global agenda, which has been dominated by the World Bank and the IMF. In The Third World Trade Organization Ministerial Conference in Seattle, the World Economic Forum 2000 in Davos, the Tenth UNCTAD Meeting in Bangkok, and the World Bank & IMF Annual Meeting in Washington, D.C., international NGOs have been joining force in negotiating with the global financial institutions for a more humanistic approach in economic development (see Korten 2000).

Roles of Civil Society in Health Development: International Experiences

In the realm of health development, a rough estimate in 1991 suggested that most of the 10,000 to 20,000 Southern NGOs were working to promote people's health and covering a population of 100 million people in developing countries (South Center, United Nations 1996, cited in Jareg & Kaseje 1998:820). The roles of non-governmental organizations working in health and health-related field were diverse. In the early period, most voluntary associations worked in health field provided humanitarian medical services. Over time, NGOs have evolved and performed various tasks ranging from providing basic health services, independent health and environmental monitoring, early warning, information gathering, or providing alternative solutions to health and social problems. The report of the United Nations' Commission on Global Governance, Our Global Neighborhood, acknowledges that

> More and more, NGOs are helping to set public policy agenda – identifying and defining critical issues, and providing policy makers with advice and assistance. It is this movement beyond advocacy and the provision of services towards broader participation in the public policy realm that has such significance for governance (The Commission on Global Governance, reprinted in Boston Research Center for the 21st Century 1995: 56-57).

In attempting to account for the roles and contribution of civil society organizations in health development, Gill Walt suggests that the roles of civil society organizations could be roughly categorized into three groups: support and services, policy and right, and knowledge and research (Walt 1998: 4). In another attempt, Nyangg' oro (cited in Jareg & Kaseje 1998: 819) describes three roles of non-governmental organizations:

- Exit option refers to the role of NGOs as creating and providing parallel health, political, and economic systems. Such a role can also be perceived as providing alternative means to health, social and political development.
- Voice option refers to the role of NGOs as advocate and negotiator. NGOs with this role engage the State in dialogue for the purpose of addressing inefficiencies, corruption, and bad policies.
- The third role is that oscillate between the "exit option" and the "voice option" according to the circumstances.

By combining Walt's and Nyangg' oro's suggestions, four categories can be proposed to account for the roles civil society organizations perform in the realm of health and social development, namely support & services; alternative & exit option; right & advocacy; and knowledge & research.

1. Support and Services

These have been the original roles performed by voluntary associations. Most early voluntary associations were ethnic associations and concerned mostly with the welfare of fellow ethnic. They provided humanitarian support or medical and social services. In present situation, the main providers of public services were the states. However, NGOs still had the role of replacing the state when the state machinery has collapsed. Examples of this were the Integrated Health Program of the Somalia Red Crescent Society; the Church's health and development activities in the Democratic Republic of Congo; and the Integrated Health and Development Program in Afghanistan (Jareg & Kaseje 1998: 820). In addition, NGOs were more multitasking and more efficient in reaching the disenfranchised or hard-to-reach groups. A good example of service-based organization is Hogar de Cristo found in Santiago, Chile by the Jesuit priest Alberto Hurtado in 1944. In 1992, this "charity corporation" had 37 offices distributed around the entire country and provided daily care to about 7,200 children, 2,900 adults, and 2,000 old people. It kept an old people's village made up of 110 houses, donated by construction companies. There were 40 shelters for destitute people in 30 cities (see Fernandes 1994b: 52). Services provided by civil society organizations have also diversified, ranging from basic welfare and health services, to information gathering, and even to help establish relationships and trust necessary to bridge political gaps.

2. Alternative and Exit Options

In the health realm, there have been an increasing number of civil society organizations working in alternative life-style and alternative health. Some of these organizations were creating parallel health systems and offering new choices for people who were not satisfied with conventional medicine. Some were not directly concerned with health

in a bio-medical term. However, they could be considered as health-related and concerned with social or spiritual well-being rather than physical well-being. Organic farming, environmental conservation, sustainable agricultural development, and literacy program could create positive health impact. Organizations that offered alternative therapy could also serve specific interest group and provided psychosocial care to complement biomedical treatment.

3. Right and Advocacy

Right- or advocacy-based organizations were easy to identify because of their visibility in political arena. These civil society organizations were working to changing policy and practices and their influence has been recognizable. Among right-and advocacy-based organization, environmental groups such as World Wildlife Fund, Friends of the Earth, Greenpeace, Conservation International, and Earth Island Institute were particularly visible and effective. On health issues, there have been a number of high profile consumer's right organizations in many countries. The most prominent ones are the Ralph Nader's consumer group and Health Action International (HAI). Health Action International was a nonprofit, global network of health, development, consumer, and other public interest groups located in more than 70 countries and working for a more rational use of drugs (Kim et al, eds. 2000: 408). In Asian and Pacific region, one of the most prominent consumer right groups was the Consumers International's regional office for Asia and the pacific located in Penang, Malaysia. The organization was formerly known as the International Organization of Consumer Union, or IOCU. This international network of consumer organizations was established twenty-five years ago and now has its head office in London and regional offices in Malaysia, Chile, and Zimbabwe.

4. Knowledge and Research

In 1989 Ralph Nader's Public Interest Research Group (PIRG) and the Natural Resources Defense Council (NRDC) organized a massive outcry about the use of Alar on apple after a research study finds that the chemical create cancer risk 240 times greater than those declared safe by the U.S. Environmental Protection Agency (Wapner 1995:327). The use of research result and massive campaign pressured the Uniroyal Chemical Company to cease producing Alar not only in the U.S. but also aboard. Knowledge and information has become instrumental and increasingly important in creating changes. More and more civil society organizations were engaging with research and information gathering activities. A good example of these organizations was the Worldwatch Institute. Worldwatch was best known for its annual State of the World report, published in 27 languages. It also produced

Vital Sign, which tracked such key indicators as global temperature, fish catches, population growth, and military spending, and World Watch magazine, with articles distributed to nearly 100 leading newspapers around the world. State of the World was a textbook used in more than 1,300 U.S. college and university courses (see Keating 1994: 94).

The roles of civil society organizations in various aspects of health and human development have been apparent. In health care reform, which has emerged as an important agenda for social reform across the globe in the past decade, however, civil society organizations have been strangely absent both as a topic in the debate of health care reform and as a noticeable player in shaping the reform agenda. The following section will discuss and examine why the roles of civil society has been limited.

Current Approaches in Health Care Reform

In most countries, attempt to reform health care system was mostly generated by concerns of increasing health expenditures and the rising number of people who did not have access to basic medical care. Although the public could easily relate to the justification for reform, the process of reform has been mostly developed and carried out by professional policy makers and politicians without engaging the public. In a number of third world countries, international organizations have also played critical roles in starting and implementing the process of health care reform. Aid agencies as well as international financial institutes demanded reform as part of the conditions for assessing aid, loan or economic rescue package.

In most of these cases, it was clear that the driving force of health sector reform came from above. While the preceding review indicates that health was one of the domains in which civil society organizations have been actively involved, it was quite puzzling that in health care reform of most countries civil society has not been featured, neither as an active player in shaping the reform agenda nor as potential resource for creating a better caring system. To understand the absence of civil society we will look at current approaches in health care reform to see how the way health care reform was put into practice hindered the role and contribution of civil society.

Health Care Reform and the Politics as Usual

Official politics has always been perceived as the sole instrument for change in attempt to reform health care system. This conventional approach, however, was not a guarantee that health care reform effort would produce result. Even in countries with a time-

honored political system, polarized politics and power play could generate resistance to changes that would devastate reform process. As have been written extensively, health care system and medical establishment has been dominated by medical professionals, state bureaucracies, pharmaceutical companies, and health insurance industry. Attempt to change the status quo inevitably challenged the existing structure of power and invited resistance. Adolfo Martinez Valle (2000), for instance, in his political analysis of Mexico's health care reform, pointed out how interest groups influenced both the policy making process and the outcome of reform effort. The restructuring of Mexico's health care has failed because the Mexican Institute of Social Security has managed to oppose successfully the changes that threaten its hegemony in the Mexican health sector.

Not only the politics within a health sector tended to curtain off changes from the outside, public understanding of health care reform also contributed to the confinement of reform to the realm of official politics. The case of health care reform in the US during the Clinton's administration was a good example. Although at the beginning, Clinton's pledge to reform health care system won popular support and contributed significantly to his victory in presidential campaign. The public endorsement of reform was record high (Skocpol 1995: 67). The role of civil society and American citizen, however, has ended at the election ballot box of 1992.

As Clinton became president, health care reform has become a political problem left in the hand of presidential taskforce rather than a civic question to be deliberated by the public. As described by Paul Starr in his article entitled "What happened to health care reform?" (Starr 1995) health care reform in the United States was highly politicized within the contexts of ferocious partisan politics. While the Democrat was splitting in their detailed differences, Republicans was aiming at confounding and impeding any issue that symbolized the president's agenda. The sharp partisan politics was to the point that it raised doubts about the possibilities for rational discussion and political compromise among elites (Weir 1995:104).

A reform effort starting with a forty-year high public support came to a tragic end virtually by the absurdity of "the politics as usual". A nation with great civic tradition, as indicated in Tocquilville's witnessing account, the United States has evidently succumbed to the malaise of partisan politics. The 1993-1994 Health care reform effort in the US was a typical case of the lacking of civic engagement. As forcefully pointed out by Jennings and Hanson (1995),

> … the American way of conducting public policy debate and civic discourse has failed to cope with the challenge of health system reform. The Great Health Reform debate of 1994 was, in Daniel Yankelovich's apt phrase, "the debate that wasn't" (Yankelovich 1995). The public was misinformed and frightened by the debate and finally estranged from it.

Jennings and Hanson, citing Mills (1959), went on saying, “a large majority of Americans saw serious flaws in the health care system, but their sense of "personal trouble" was never translated into the comprehension of a "public issue." It was not a coincidence that contemporary accounts of American politics as observed by keen political scientists found that, as the civic tradition in the US was on the wane, American people have become “the disengaged” (Starr 1994) and are now “bowling alone” (Putnam 2000).

The Economic Discourse of Health Care Reform

A dominant motif repeated throughout worldwide health reform has been that of economic discourse. In this discourse, health care reform was transformed into merely the reform of health care financing system. From AAPCC (Adjusted Average Per Capita Cost) to ZSB (Zero-Sum Budgeting), puzzling technical terms and acronyms used in the economic discourse of health care reform confounded and daunted participation of “lay organizations.” Moreover, this discourse equated health care as just another economic activity. According to Kaiser Permanente, the managed care company in California and Texas, health care reform was "… mostly a matter of applying what's known about payment incentives to specific circumstances". Within this economic framework, it was not surprising that debate on health care reform has focused primarily on financing. This perspective has limited the possible roles and contribution of civic organizations because it based on the assumption of health care as commodity and services to be provided by medical experts. Rather than viewing health care mainly as a public commodity to be distributed, the Civic Practice Network advocates the view of health care as a public work to be shared.

> Public work means an occasion of common endeavor and shared problem-solving that involves both providers and patients, and that takes place in the context of a larger community. We have trouble seeing public work in this sense in our society, even when it is right before our eyes. We suffer from civic myopia, perhaps in health care matters most of all. We do not see well because we are looking through ill-fitting glasses (Kari et al. 1994)

Economic conceptual framework was useful in health resource management but the underpinning assumption of this perspective reduced the complex set of relationship within a

health care system into the single axis of "provider" and "purchaser." Citizen was reduced into "consumer" whose expected role was to maximize benefit by maintaining market choice. Again, Nancy Kari and her colleague pointed out that:

> Operating within such a conceptual framework, the recent health policy debate has been largely cast as a choice between allocation guided by government regulation versus allocation guided by a competitive market influenced in part by interests of pharmaceutical companies, hospital corporations, and private insurers. However, the underlying privatized notion of health care as a commodity that is privately consumed by paying (i.e. insured) individuals remains unquestioned… The language and assumptions that remain bounded by rights and economic goods constrain our political imaginations, narrow social roles, and conceal the civic and public aspects of health (Kari et al. ibid.)

Reductionistic Biomedical Worldview

The reductionistic worldview of biomedicine forced health care reform to focus narrowly on curative aspect of health. This disease-oriented approach capitalized on the sense of vulnerability and the fear of unpredictable danger of illnesses. Politically, it was an approach guarantee to win popular support. More importantly, it did a great service to the dominant sectors in health care system, namely medical professionals and the pharmaceutical industry, whose prime benefits came directly from curative activities of health care system. It can be said that the econocentric and the reductionistic biomedical approach in health care reform reinforced each other. Viewing health care reform as a matter of restructuring health care financing forced the reform debate to focus on medical expenditures and thus on curative aspect and bio-medical care. It was not surprising then that the World Bank has shown extraordinary interest in "Investing in health." Data from the analysis of World Bank activities in the pharmaceutical sector worldwide using 77 staff appraisal reports revealed that 16% of the total World Bank health, nutrition and population budget, approximately US$ 1.3 billion, has been committed to loans or credits supporting pharmaceutical activities during 1989-1995. Most of this amount, approximately US$ 1.05 billion, has been committed to procurement of drugs and medical equipment (Falkenberg and Tomson 2000).

The concentration of reform on costs and financing thus inevitably compelled the reform process to adopt the biomedical model of health. This reductionistic view of biomedicine not only reduced the complexity of health and well being into merely the malfunctioning of biological process, it also individualized health by proposing a view of health as something attainable through personal undertaking. This approach failed to address adequately the collective aspects of health particularly critical in health promotion and prevention of diseases. If we started with a definition of health that was not predetermined by

biomedical view by approaching health from a more holistic manner, we would have a totally different way of going about reforming our health care system, a change that would greatly enhance the necessity of having civil society participating in the reform process. To create a civic approach to health care reform required a dramatic change in the way we collectively think about health and the change in collective definition of health required more than just the official policy process and the conventional division of labor in the reform process.

To achieve health in this framework needs the involvement of the whole society rather than just the reconfiguration of health care financing and accessibility of quality care. It is only by involving civil society in the process of reform that issues left out by conventional approach such as change of health-related behavior, community's role in taking care of the sick and the elderly, change of the relationship between care providers and patient, and the redefinition of the roles of the state and citizenry can be effectively addressed.

What we need, then, is an entirely different policy process. We can consider the existing policy process as a classical modernist approach to problem solving. Beginning with a grand theory of health care reform as rule-abiding, objectively measurable phenomena, this modernist visionary proposes to reform health care system in accordance with the grand narrative of economic rationality. Just as it has been in developmental economics, arguments in reforming health care financing are deduced from a great universal theory with which health care system and all parties are constrained. Its application of the general to the particular is devoid of any experiencing life-world where civic engagement could be connected. This approach could be said of as being characteristics of modernist institutional practice and typical of modern nation state's official policy process. A civil society perspective would start with the lived experiences of people and the intersubjective understandings they developed in real living situations. This paradigmatic shift would better serve the dialogical nature of reform process and revolutionize it from a one-way implementation of predetermined ideas and conceptions. A more democratic, pluralistic policy process will redirect our way of dealing with our collective well-being. As Kari et al (1994) put it:

> Throughout the 20th century, as large government agencies and corporate structures have grown, a new stratum of managers and technical specialists has emerged who draw their basic metaphors and language from science. This contemporary "culture " of professionalism, evident in most disciplinary areas, emphasizes rationality, methodical processes, and standards of "objectivity" in place of public deliberation and active citizenship. Today, experts define and diagnose the problem, generate the language and labels for talking about it, propose the therapeutic or remedial

> techniques for problem-solving, and evaluate whether the problem has been solved. There are few opportunities for citizens to learn the skills of public action, deliberation and evaluation through which ordinary people move to the center of public problem-solving and everyday politics (emphasis original).

Rethinking Alternate Model for Health Reform

Although civil society's role in health care reform has largely been inconsequential, the absence of civil society in health care reform was not absolute. There have been attempts and, to some extent, successes in making health care reform a civic question. Some efforts to enhance the roles of civil society organizations (such as the Clinton's plan to increase the role of "group" or "conglomerations of health care consumers" in neighborhood organizations and workplace as building block of new health care reorganizations) failed to materialize. There were, however, other positive examples of civic engagement in health care reform. To give an example of these cases, the following section provides brief accounts of the Oregon Health Decisions initiative in the United State.

The case of Oregon Health Decisions was illustrative of civic involvement that helped shape the reform agenda of Oregon health plan. It was well known that reaching an agreement on various aspects of health reform agenda (e.g. universal coverage, a basic minimum benefits package, equitable funding, and freedom of choice) was a daunting task in any reform attempt. The critical factor that helped make Oregon health reform successful was that Oregon Health Decisions, a nonpartisan grassroots group, had developed methods for getting citizens to deliberate respectfully and responsibly at community meetings about what they wanted from health care system. The organization held hundreds of community meetings and two statewide health care parliaments in the 1980s.

These public deliberations had become the heart of the reform and helped to prepare the ground for a state reform process beginning in 1989. The process was successful in that it included most stakeholders in their public deliberations. The result was that the Oregon health reform had gained strong support from the broadest array of local and state groups: senior and disabled, poor women and children's health advocates, medical and nursing associations, insurance company and small businesses, and the hundreds of thousands of others who had previously been left uninsured. (See detailed account available at www.cpn.org/sections/topics/health/stories-studies/ohd.html.)

Other than the initiative of Oregon Health Decision, there were a number of increasing local initiatives to forge a wider participatory process of local grass-roots communities and civic organizations in determining the desirable health care system.

However, these initiatives were more of an exception than a rule. As Hoffman recent work demonstrates, campaigns for health reform in the United States were dominated by elites more concerned with defending against attacks from interest groups than with popular mobilization. Moreover, grassroots communities and civic organizations in the United States seemed to suffer from the fragmented vision and unable to connect to the bigger picture of health care reform. Civic organizations working in the labor, civil rights, feminist, and AIDS activist movements have concentrated more on pressing issues and incremental changes rather than on transforming the health care system as a whole (Hoffman 2003).

With the review above as a background, the following sections will examine the experiences of health systems reform in Thailand. As mentioned earlier, the concept and approaches in launching health systems reform in Thailand gave strong emphasis on involving and mobilizing civil society in reforming the national health systems. The following analysis aims at providing example and explanation of how the reform was organized and what lessons can be drawn from the experience of Thailand.

4

Thailand's Experience

Civil Society and Health Systems Reform

Introduction

The following section presents the concepts, ideas, and working processes of health systems reform movement. It will first describe the ideas behind the reform movement and provide some background contexts of the setting up of the National Health Systems Reform Office (HSRO), which was the coordination mechanism for the reform. The HSRO was created with two strategic objectives: (1) Restructuring institutional arrangement through legislative actions, (2) Forging a new collective health consciousness in Thai society. To achieve these strategic goals, working strategies were formulated through a set of three-pronged strategies known as "The Triangle that Moves the Mountain." Each component of concepts, ideas, and working processes will be discussed in detail in this chapter.

Guiding Concepts and Working Strategies

> "Conventional medical and public health approaches have failed to bring about health or well-being. Although advanced technologies are available in modern medicine, they led to the problem of high cost, inequity, and financial catastrophe. Medical technologies cannot solve emerging social ailment, or health problems that are caused by social pathology. In fact, the structure of our current public health system is arranged to deal with diseases caused by biophysical origin and not with socially originated health predicament. As a result, health care has been a passive system waiting for those who have already got sick to come to get medical treatment instead of proactively reaching out to bring about health and well being.
>
> Health must be understood as well being both in physical, mental, social, and spiritual senses. Health, therefore, is embedded in every aspect of human and social development. Health, and not GDP or any economic outlook, should be perceived by all as a national ideological goal. Health includes and transcends economic development… Health systems reform therefore equals a reform of the meaning of life. In other words, a reform of how we perceived as a worthy life and what we should hold as ultimate aim of our existence."

The preface of a book documenting the initial effort of the Health System Reform Office written by Professor Dr. Prawase Wasi, one of the pioneers and advocates of social reform in Thailand, captured the essence of health systems reform movement in Thailand, a movement that has been going on for more than three years. During these three years (2000-2003), the Health System Reform Office has been working to engage various civil society

organizations, academic institutions, public agencies, as well as political institutions to foster a healthy dynamics of health reform processes. It was an undertaking guided by a set of conceptual principles and well-thought working strategies. The result of three years movement seemed to indicate that health system reform in Thailand has become a broad-based civic movement and has been gaining momentum. However, as will be evident in the chapters that follow, these principles and strategies were far from being passively accepted or adopted by stakeholders, rather they were contested, challenged, and altered in accordance with specific contextual circumstances.

The question of how to build a healthy working relationship that would enable synergy between private, public, and civic sector has long been wondered about by social theorists in various fields. Dodge (1992), for instance, studied forms of interactions and linkages as crucial aspects of intercommunity governance, while Bebbington & Farrington (1992) investigate the possible ways of collaboration between governmental organizations and non-governmental organizations in agricultural development. In the field of health, which was conventionally viewed as dominated by professional authority and highly specialized form of medical knowledge, it was extremely interesting to see how the reform processes would encourage "laypersons" to participate in health policy and action and to reclaim their autonomy. The following account details and analyzes the working experiences of the Health System Reform Office as the coordinating mechanism of health system reform in Thailand.

The Birth of Health System Reform Office

In the year 2000, the Ministry of Prime Minister Affair's order pronounced the setting up of Health System Reform Office, HSRO. The pronouncement stated that:

> Presently, the national health system is incapable of bringing about an acceptable level in people's health and quality of life. The situation is in discordance with the spirit of national constitution. Action should be undertaken to reform the nation's health system in order to strengthen the quality of the health system and contain cost, and to draft a bill that will be the main legislative framework for the reform.

The decree proposed a "National Health System Reform Committee" to oversee the reform process with the Health System Reform Office as its secretary. Although the Health Systems Reform Office would initially be supported by governmental budget, it was formed as an autonomous body astoundingly unbound by bureaucratic rules and regulations. The missions of HSRO were stated as follow,

1. To create a collective movement toward the transformation of the society's way of thought about health from "fixing ill health" to "creating good health" so as to achieve health for all in the society.
2. To support academic and technical activities for creating bodies of knowledge on critical issues relevant to health system s reform.
3. To mobilize civil society by supporting activities that encourage participation of people, communities, civil society, and various stakeholders in critical issues of health system reform.
4. To support and develop relevant and acceptable measurements for the reform of health systems. Such measures are to be included in the national health act, which is to be drafted during the reform process.
5. To coordinate and engage political society, state bureaucracies, and other organizations to join force in pushing for the reform of national health systems.

The National Health Systems Reform Committee and the HSRO were contemporary organization and were initially assigned a three-year period to promulgate the natio nal health act. It should be noted that an ordinary process of drafting of a bill would probably take up an average time somewhere between a few months to a year. The idea behind the prolong process of drafting national health act was that it was not the outcome of passing the bill through the national legislative body, but the process of deliberation that was the most important part of the reform process. To encourage participation and deliberation, not only the time frame was extended, but the scope or the conceptual framework was also broadened. The framework set up at the outset of the reform defined health and health system in a very broad sense. Health was defined as *"a dynamic state of physical, mental, social, and spiritual well being*". In addition, health system, according to the decree, was *"a whole range of systems relative and integrative to the health of the nation including all factors related to health, be it individual, environmental, economic, social, physical, or biological as well as internal factors from health service systems.*"

Strategic Objectives of Health Systems Refo rm Movement

Health care reform experiences around the world exhibited a strong top-down, expert-led, legally sanctioned approach. Although there were some success stories, the frequent failure of most reform attempts indicated that health reform needed more than just an imposition of new system through legislative execution. Health system was a complex whole with multiple dimensions and multiple domains, all connecting to one another. Transformative and sustainable changes in any complex system could never take place simply by means of imposition and imperious coercion. Imposed changes and coercive structure most likely ended up being a new monstrous regime in place of the old one. More

importantly, as Albert Einstein was often quoted saying, "We cannot solve problems by using the same kind of thinking we used when we created them." In addition to the much-needed structural changes, what was indispensable in reform of complex social system was collective learning process, a process of transformative experience that would change the way health was conceived, interpreted, and acted upon.

Required changes for the new national health systems were therefore consisted of two complementary components. These two components made up the objectives of the reform process.

1. The restructuring of institutional arrangement through legislative action

The first main objective of the reform movement was to bring about changes in the structure of national health system. The new constitution and the shift towards stronger democratic governance in Thai society called for a new system of governance in all social sectors. Accordingly, existing structural arrangement of national health system needed to be revised for better health system governance. As revealed in the preceding discussion, existing official policy processes, relying solely on state agencies to implement the predetermined health policies, excluded civic participation and required more transparency. What was needed was a platform that would perform the deliberative function of health system governance. In restructuring the national health system, which consisted of many interconnected subsystems, a legislature was needed to reorganize existing institutional arrangement. However, it was considered inadequate simply to impose structural changes through a new legislature drafted by commissioners and experts working behind close door. Changes in the institutional "hardware" needed an accompanying change in society's "software" to make the reform complete. A second component was therefore needed to complement structural changes.

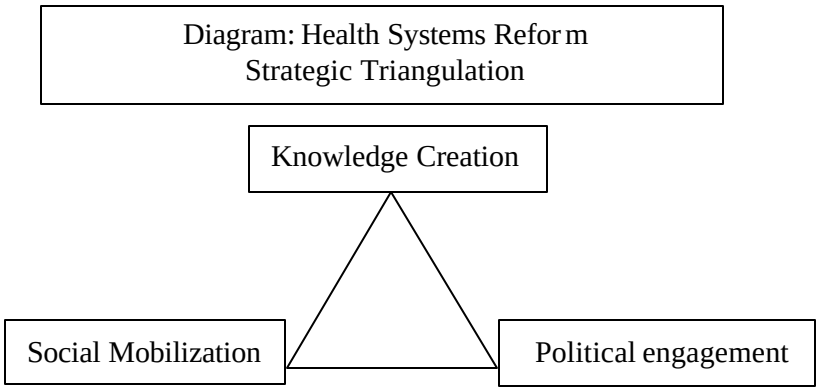
2. The forging of a new collective health consciousness

The way health was acted upon depended not only on individual motivation but also, to a great extent, on how health was collectively understood and imagined. In the biomedical model, health was understood as the result of medical intervention and, therefore, was better left to medical experts to determine. In addition, health has always been compromised in public policies for materialistic or economic advantage. Without a strong collective consciousness that give health a priority, health would never be placed high on developmental agenda. It was therefore crucial to make health and well being a shared vision among the public. The enactment of a new health legislature must go together with the

forging of new collective health consciousness. The drafting of national health act was aimed as a learning process in which civil society came together to rethink and recollect a collective pledge to achieve health. The new consciousness would not confine to the domain of jurisdiction, but it must also become the spirit of civil society, a spirit that would inform various civic activities even outside the domain of official authority. This second objective of the reform movement therefore aimed at a transformative change in the realm of civic consciousness.

Working Strategies: The Triangle that Moves the Mountain

To achieve the two strategic objectives, a set of working strategies was formulated. Building on prior experience of forging a national movement for political reform, which resulted in the promulgation of the new constitution, Dr. Prawase Wasi, an architect of social reform, devised the strategic triangulation of knowledge creation, social mobilization, and political engagement (see diagram). This was known as "the Triangle that Moves the Mountain," a set of three-pronged strategies to bring about changes in difficult social issues. According to the strategies, the first strategic mission was to compile and review existing knowledge on various aspects of health and health systems.



Knowledge generated through the process would be prepared in the forms that were useful for empowering potential actors and enabling collective learning for health systems reform. To enable the broadest participation of stakeholders in the reform process, it was considered critical to create knowledge base of health reform not only from conventional biomedical and public health perspectives but also from various other points of view. A broad, multidisciplinary body of knowledge was necessarily for supporting a board-based social mobilization. Sound and solid technical knowledge of health and health systems was

also viewed as a prerequisite for a successful engagement with political establishment to facilitate formal changes in the national health systems through legislative action.

In accordance with these working strategies, the National Health Systems Reform Committee (NHSRC) appointed by the Prime Minister set up four taskforces to work on each strategy:

1. Technical Taskforce, working on building up knowledge base and management of relevant knowledge for reform;
2. Civic Mobilization Taskforce, working to engage and encourage participation of civil society in reform movement; and
3. Mass Media and Communication Taskforce, working to ensure that the public was well informed
4. Legal Taskforce, working to develop legislative framework and to draft the new health act by incorporating desirable features of health system gathered from deliberation in various civic forums.

The works of these taskforces were expected to culminate into the drafting of the National Health Act, a legislative framework for a new national health system. The aims of the first two years of implementation were to build up knowledge base as well as to create a platform for carrying out reform processes. Critical areas of knowledge that would suggest new ways of conceptualizing health and health system components were identified. Potential researchers were engaged to prepare groundwork in respective areas. The purpose of this process was to expand the conceptual framework of health reform initiative in order to create more spaces for various civil society organizations to participate in the reform process. The third year of implementation focused more directly on linking local health agenda identified during the deliberation to national policy processes and on the approval of the draft bill by the national legislative body. The following section provides accounts of how these three strategies were executed and realized.

Creating Knowledge Base for Reform

The prime focus of this strategy was on knowledge production and management. It aimed at creating knowledge that would serve as a solid foundation for the reform processes. Knowledge in this regard not only confined to bio-medical knowledge or public health statistics. Rather, knowledge was defined in a broader sense with an aim to enhance collective learning, public deliberation, and the rethinking of health and health systems. Two parallel research programs were set up to review and synthesize relevant knowledge for

reform. While the first program focused on the institutional arrangement and structural configuration of health system and its various subsystems, the second program, 'Society and Health Program', aimed at providing broader philosophical and theoretical understanding of health and healthcare. It was perceived that conventional notion of health and medicine needed to expanded so as to invite broader stakeholders and those outside the domain to biomedicine to participate in a more meaningful way in the reform initiative.

Social Mobilization and Civil Society Movement

To encourage broader participation of civil society in health systems reform movement, various mechanisms and measures were developed and taken. The highlight of second year implementation were the National Health Assembly which was organized on August 8th-9th, 2002 at the Bangkok International Trade and Exhibition Center and the nationwide campaign to gather 5 million signatures of supporters for the new national health act. On working towards these two highlights, a series of civic forums, workshops, conventions, and district/provincial assemblies were organized. In addition, the "Reform Forum," a newsletter aimed at connecting various movements toward health systems reform, was published by Health Systems Reform Office. The meetings at various levels as well as the newsletters served to engage larger public and to build up consensus on the desirable health systems among various people.

To encourage participation of grassroots organizations, district forums were organized by various civic groups in collaboration with local health agencies. Five hundred and fifty forums took place at the district level during the second year of implementation. These forums were places where local health issues were discussed, information exchanged, and suggestions made to assure that the new health systems would be relevant to local health agenda. At the provincial level, all provinces organized provincial forums for town residents and civic groups to discuss and voice their opinions as well as to deliberate on the proposed legal framework for the new health systems. At these district and provincial levels, there were more than 50,000 people participated in the forums. Participants came from 3,300 organizations around the country. The process of consultation and civic participation created a unique broad-based civil society mobilization. These district and provincial forums culminated into the National Health Assembly on August 8th-9th, 2002 in which almost 4,000 participants gathered and expressed their support for the reform.

Public forums have become not only process of consultation and debate over health problems, but also process of collective learning between communities, civil society

organizations, and health agencies. Civic initiatives and deliberative action in tackling health problems were enthusiastically exchanged between participants in public forums. In addition, it was through these forums that a new form of public life was organized. People from different organizations who shared similar concerns came to know each other and started building up network of cooperation. In a sense, the forums have become civic infrastructure within which deliberative action and collaboration between civil society organizations became possible.

Political Engagement for Legislative Reform

Engaging political institutions to support the new health systems was considered a crucial mission for the reform process. The organization of the National Health System Reform Committee itself was a platform for political engagement. The committee was chaired by the Prime Minister with Ministers and Permanent Secretaries from various Ministries as its members. Other than this officially appointed committee, various other working groups, taskforces, workshops, seminars, and civic forums provided platforms for political participation. The first national seminar on "The Desirable Health Systems for Thai People" was participated by Minister of the Prime Minister Office as well as many leading senators and members of parliament. Since the very beginning of the movement various political leaders, political representatives, as well as members of the senate were invited to participate and contribute their ideas to the reform movement in various forums.

One of the most important dimensions of engaging political institutions to support the reform was the process of promulgation of the national health act. The process of drafting the new health act started with the development of legal framework for the new health system using the process of continuing discussion among health experts, legal experts, political leaders, as well as representatives from civil society organizations. By the end of second year, the draft of the national health act was completed. It provided working definition, clarification of related concepts, explanation of the rights and duties of the state and citizenry, description of various components of national health system and their functions, and accounts on structural arrangement and working mechanism of desirable health systems. The draft was handed to the government and in the process of consideration and approval of the Cabinet before handing it over to the Parliament.

The following section provides detailed analysis of how the guiding principles, ideas, and strategies of reform were transformed into practices.

Health Systems Reform: From Principles to Practices

1. Creating Knowledge Base for Health Systems Reform

Creating Knowledge Base for Health Systems Design

The Technical Taskforce was appointed by the National Health Systems Reform Committee at the outset to work on creating knowledge base for reform. The duty given to the taskforce was to set up a research program in order to develop a serviceable body of knowledge for the designing of the new architecture of health systems. The taskforce identified fifteen research topics as crucial for rethinking and reinventing health systems. Most topics concerned mainly with the structures, processes, and subsystems within the comprehensive national health system. The aim of the review was not to determine once and for all how the new national health systems must be configured. Rather, the aim was to provide a solid technical support for civic deliberation in order to create a well-informed public debate on the new health systems. Topics of the review were classified into five groups as follow:

Policy Processes and Structural Organization of Health Systems

Review of concepts and practices in health systems reform.

Structure, systems and processes for healthy public policies.

Health impact assessment and participatory public policy process.

Medical technology assessment system.

Health security and universal coverage of healthcare

The roles of public, private, and civic sector in healthcare.

Structural and organizational arrangement of national healthcare system

Systems for the protection of consumer and patient's right.

International experiences on universal coverage: Lessons from 10 countries.

Health Promotion

Self-care at individual, household, and community levels.

The roles of mass media, health promotion, and health system development.

School health program and students' health behavior.

National system for health promotion.

Disease surveillance, prevention, and control

Framework for the reform of national disease prevention and control

Surveillance system for disease prevention and control

Health Service System

Primary care system under the universal coverage scheme

Integrating indigenous/alternative medicine in national health service system

Health manpower development

Health service quality and hospital accreditation system

Emergency medical service system

Financing national health services

Health service for the disabled

Health service for the elderly

Information and knowledge management

Health and medical information system

National health research system

Research and development in pharmaceutical and medical technology

Potential researchers who have been working in relevant areas of research were identified and commissioned to conduct the reviews. The idea was to review and assess not only concepts and theories in respective areas, but to examine concrete case examples of various ideas and approaches. It was expected that the case examples would be particularly useful for encouraging and helping public dialogues in order to get through the abstract ideas. In addition, the commissioned researchers must also suggest necessary structural changes and institutional arrangement that would enable the new health system to work according to the recommendations. Suggestions on specific legislative arrangement from the reviews of similar legislatures from relevant international experiences were also requested. These requirements were made explicit in the Terms of Reference and the agreement accepted by each researcher or research team.

The processes of review and research of these topics were organized deliberately for broad participation and for collective learning experience of concerned parties. Seminars and workshops were organized to identify and refine the essential research questions. Concerned civil society organizations as well as academicians and politicians were invited to participate in the continuing dialogue, which led to the acceptable conclusion in each area of research. The research results were produced not as the final verdicts of each problem areas. Rather, they were produced as to be used as "input" for further discussion and deliberation among wider networks of concerned civil society organizations in various civic forums.

The reviews and analyses were also compiled and used to produce a technical report, "Principles, Objectives, Mechanism, and Critical Issues for Health Systems Reform and the Drafting of National Health Act". The paper was used as conceptual tool to stimulate discussion and as a tentative idea for further elaboration. During the first two years, a number of technical workshops and conferences were organized to scrutinize reports and review results. In addition to workshops and conferences on specific issues, there were also a number of workshops and conference to consider the overall health systems as well as to discuss how the reform initiative should proceed. These workshops and conferences were:

- Workshop on "Health Systems Reform" on December 25-26, 1999 at Mercure Pattaya Hotel, Chonburi Province.
- Conference on "Partnership on Health Systems Reform," at the Ministry of Public Health, on March 3, 2000.
- Meeting on "The Desirable Health Systems for Thai People" at Siam City Hotel, May 3, 2000.

The meeting on "The Desirable Health Systems for Thai People" at Siam City Hotel was particularly important. It was the first meeting aimed at stirring up public attention on the problems of health systems and raising the issue of health systems reform. More than 200 participants including researchers, health administrators, social and political leaders, as well as media people participated in a discussion on current health system and desirable characteristics of new health system. The meeting was chaired by Professor Prawase Wasi and was broadcasted live on national television for broader public. Using an open format, the meeting helped to bring out voices and concerns of various aspects of the existing health systems. Most importantly, the meeting created a consensus, a shared vision and a sense of ownership at the very beginning of the reform initiative. The event has become a watershed for the reform movement. The result of the meeting was published into a book. In addition, the video recording of the meeting was edited and used as input for many subsequent meetings.

To ensure a broader involvement of public, six meetings were organized after the first meeting at the regional level. The aim was to encourage wider pubic discussion and to better understand regional needs and demands for health reform. To foster mutual effort among local civic groups at the very beginning of the reform process, the Health Systems Reform Office worked closely together with local civil society organizations to co-host the following events:

- In upper northern region, the meeting was organized in Chiengmai with the participation of 188 people from various governmental and non-governmental organizations. The meeting was co-organized by local radio broadcasters.
- The lower northern region meeting was organized on August 3, 2000 in Amarin Lagoon Hotel in Pisanulok Province. 449 participants from eight provinces participated in the meeting. Local organizers were Foundation for Pisanulok against AIDS and Indo-China Crossroad Institute.
- Upper northeastern meeting was organized in Khonkaen Province with 224 participants from 11 provinces. Organizers of the meeting were Khonkaen Hospital and Udon Provincial Health Office. The meeting was broadcast live on FM 99.5 that covered all major provinces in upper northeastern region.
- Lower northeastern meeting was held in Nakornrajsima Province at Sima Thani Hotel. 442 participants from eight provinces participated in the meeting.
- In the Upper South, a meeting was organized in collaboration with Walailuk University and the Network of Southern Civil Society. 155 participants from seven provinces participated in the meeting that was broadcast on national television channel 11 covering all the southern provinces.
- The sixth meeting was organized for southernmost provinces. It was organized in collaboration with the Network of Civil Society Organizations in Narathiwas Province.

There were also numerous small meetings and technical workshops at the Health Systems Research Institute for topics related to health systems reform. These meetings, workshops, consultations, and conferences culminated in the National Conference organized by the Health Systems Research Institute on August 15-17, 2000 at the Bangkok International Trade and Exhibition Center (BITEC). The conference entitled "Civic Deliberation towards Health of the Nation" was participated by more than 1,500 participants from all over the country.

National Conference: Civic Deliberation towards Health of the Nation

The conference aiming at creating a shared idea of health systems reform was organized as a three days event, each day with special emphasis on each aspect of the "Triangulation that Moves the Mountain" strategies. The conference started by the presentation of an analysis of the nation's health situation and trends as well as the results of

a meeting on "The Desirable Health Systems of Thai People" in the morning. In the afternoon, twelve civic forums were organized to discuss specific issues according to geographical concerns as well as specific problem groups. There were forums for the northern, the south, the northeast, and the central region, as well as forums for the health of the poor, the elderly, women's health, workers' health, urban health. Special forums for professional associations and health personnel were also held for community nurses and pharmacists. There was also a forum discussing health innovation that explored various community and hospital initiatives on medical care and health development.

The second day focused on presenting the results of the review research and relevant knowledge for reform. Most of the fifteen review topics mentioned earlier were presented and discussed. In addition, some interesting emerging issues were also included. The objective is to create an interactive learning process between researchers, people, and civic associations from various social sectors. Forums were organized in ways that encouraged the discussion and the expression of different viewpoints. The issues presented and discussed included the following topics:

- Mass media and health reform
- Healthy cities: Environmental Issues and Health
- Health Promotion Fund
- Disease prevention and control
- Healthy public policies
- Self care
- Decentralization and health system
- Health security and universal coverage of healthcare
- Primary care and family practitioner
- Information and communication network for health
- Healthy ways of life and lifestyle
- Indigenous healing and self-reliance
- Consumer right protection
- Participatory hospital governance
- New social movement for health
- Grassroots economy, community saving, and health development
- Green marketing and health promotion
- Community empowerment for health

- Reforming emergency medical care
- Legal measure and health

The conference was conducted in an open format, inviting people from academics, grassroots communities, non-governmental development agencies, health personnel, as well as representatives from various civil service agencies to deliberate on what researchers proposed. The final day wrapped up the conference by looking forwards and proposing ideas and concepts on how legislative measures, civil society moblization, as well as governmental support should be enlisted to strengthen the reform of health systems.

Expanding Health Concept, Broadening Alliance for Reform

To broaden knowledge base for further reform movement, attempts were made to expand the operational definition of health. The broadening of health concept was meant to widen the scope and prospect of civil society participation in health reform movement. It was clear that the biomedical model of health that emphasized the role and authority of specialized experts and medical high technology discouraged the active role of common citizen. The process of "de-medicalization of health" began with a technical workshop to identify crucial areas of knowledge that would provide new framework for the broader interpretation of health. Five main areas were identified as important themes for the groundwork preparation:

- History of Thai Medicine and Health Systems
- Philosophy of Science and Medical Paradigms
- Humanizing Health Care: Primary Care and Health System Reform
- Civil Society and Health Development
- Health and Human Right

Working groups on each of these areas were formed and groundwork (such as situational analysis, identifying potential researchers and actors, review of existing body of knowledge, setting up research agenda, and creating collaborative networks) were undertaken. The detailed ideas and implementation in each area are as follow.

(1) History of Thai Medicine and Health Systems

In order to forge a reform movement that built on lessons learned from the historical evolution of Thai health system, a program on "History of Thai Medicine and Health Systems" was created and a thematic review was undertaken. A national workshop was

organized to assess the existing works in the field as well as to set up research agenda on further researches. Forty participants including medical historians, researchers, archivists, and health system administers were invited to participate in the workshop on August 17, 2001. Four recently comple ted studies on the history of medicine in Thailand were presented at the workshop as case illustrations to stimulate discussion. They were:

- "Politics and Socio-Economic Transformation of the Thai Health Care System" by Chanet Wallop Khumthong of Chulalongkorn University,
- "Changes and Evolution of Local Medical Systems in Northern Thailand" by Malee Sitthikriengkrai of Chieng Mai University, and
- "The Life and Work of Professor Dr. Sem Pringpruangkaew" by Santisuk Sophonsiri of the Thai Holistic Health Foundation.
- "Important Reforms of Health Care System in Thai Society between 2431-2543 B.E." by Vichai Chokwiwat of the Ministry of Public Health.

Assessment of the existing knowledge of the history of Thai medical systems suggested that little attention has been given to this field. Other than a handful studies of the evolution official medical institutions, there has been no attempt to examine systematically various historical dimensions of health systems in Thailand. The workshop suggested that a program on historical studies of Thai health and medical system should include not only history from official perspective but also historical experiences of people, local communities, as well as history of various indigenous systems of healing co-existing in Thai society. Attention should also be paid to social and political consequences of changes in medical systems to better understand the long-term effect of reform processes. It was proposed that not only retrospective studies of the history of Thai medicine and health systems were crucial, but also a prospective approach was also important. The workshop suggested that an archive on Thai health systems must be set up to systematically compile official documents and records in order to facilitate further research and interest in the field of medical history and the history of health systems in Thailand.

The result of the technical workshop was published as "State of Knowledge in Health and Medical History of Thailand" (see Komatra & Chatichai eds. 2545). It includes research agenda as well as listing of useful bibliographies in the field of medical history. In addition, a proposal to build an archive on Thai health systems was in the process of being approved by the Ministry of Public Health. It was expected that the archive will be built in the fiscal year 2005 and will be able to start working within a year afterward. Other than providing

systematic accessibility to the collected official documents on health, medicine, and health care, the archive will also provide support on researches and historical studies as well as other scholastic activities.

(2) Philosophy of Science and Medical Paradigm:

Expanding the Operational Definition of Health

Prevailing health definition was based on a biomedical model of health, which stressed biological factors as the determinants of health. Such a model was strongly influenced by reductionistic and dualistic paradigm of physical science. It downplayed psychosocial and humanistic dimensions of well being. Narrowly perceived definition of health has led to a restricted approach in achieving wellbeing, which often relies on high technology and costly biomedical interventions to solve health problems. At the same time, it limits the roles in which non-medical actors and communities could participate in health policies and actions.

In order to expand the knowledge base for broader participation, eight areas of research were identified as crucial for a shift toward a new paradigm of health that takes into account biological, psychosocial, as well as spiritual dimensions of well being. It was expected that a new concept of health that expands to include multiple dimensions of well being could facilitate further cross-border collaboration. The eight areas include:

- Death and Dying
- Health and Humanity
- Alternative / Complementary Medicine
- Alternative Paradigms in Local Health Cultures
- Holistic Paradigm in Family Medical Practice
- Health in an Ecological Perspective
- Spiritual and Aesthetic Dimensions of Health
- Health and Learning Experience

The justification and criteria of selecting each topic was based not only on the significance it has on how the new health system could be imagined, but also on the possibilities it had on creating broader alliance for health system reform movement. During the first two years, potential researchers in each area were identified. A technical workshop was organized in Ayutthaya Province on August 22-24, 2001 to discuss and draw out strategic plan in each area. The workshop was participated by fifty participants including clinician in palliative care unit, philosophers, social scientists, health and medical professionals, journalists, health system researchers, educators, NGO workers, and artists.

There were short paper presentations, technical discussions, and the formulation of strategic plan of action on each area. Groundworks in each area were undertaken and the outputs were presented in various forums. The proceeding of the August 22-24, 2001 workshop on new health paradigms was published and widely distributed (Komatra, Nongluk, and Pot, eds 2545). The eight working groups in each area served as focal points for the networking of researchers and research institutions interested in working in each area.

The following are brief descriptions of the significance and activities undertaken in each area of research.

Death and Dying

It has been estimated that more than 70% of health and medical expenditure in the United States were used during intensive/high tech critical medical care in the last six months of life. The fact that modern medical institutions contained little knowledge with regard to dimensions of death and dying other than biological was due to its paradigmatic assumptions. Dominant medical paradigm put great emphasis on extending life to the extent that death and dying has become a taboo subject among health professionals. In addition, death and dying was perceived as an archenemy of medicine. Some argued that medical war against death and dying was in fact a zero-sum game. Other went further to stress that struggling against death and dying could create unnecessary suffering and could be extremely costly. Understanding death and dying was therefore crucial and have important implication on health reform movement. To better understand the problem, a review project was undertaken to examine the following issues:

- Situation of death and dying on various sectors in society
- Local knowledge and cultural practices on death and dying
- Legal approaches to death and dying including euthanasia, and
- Knowledge and skill needed for health professional in working with terminal patients and their families.

The result of the review became groundwork for the formulation of a comprehensive program on "Dying in Peace and Spiritual Health" which will be supported by the National Health Promotion Fund.

During the drafting of the National Health Act, the right to die peacefully and dying with dignity became a heated debate. Situation as well as knowledge on existing experience in approaching the issue turned out to be crucial for the informed debate. Although the issue has not yet reached a consensus, it has been a healthy debate embracing various viewpoints

ranging from legal to religious orientation. The debate was recorded and published into a book entitled "The Right to Die Peacefully with Dignity" (HSRO 2546). It was generally agreed that the issue of peaceful death and dying with dignity was an important subject, which needed a continuing dialogue before any specific consensus could be reached.

Health, Diseases, and Humanity

Diseases and illnesses have ramifications far beyond individual physical bodies. Xenophobia, stigmatization, accusation and other forms of dehumanization of patients have been known for sometime. The understanding of the interactive processes between health, medicine, and humanity was crucial to the prevention and rehabilitation of unnecessary adverse consequences of disease and illness. A review of situation and existing body of knowledge was needed in order to develop a framework for further actions. Such an understanding would bring closer together health and humanistic sectors in health reform movement.

A review project by the Center for AIDS Right was undertaken, using the problem of AIDS and people living with HIV/AIDS as examples of how dehumanization processes operated. The result provided framework for the drafting of the new health system act. It also provided groundwork for further developing of practice guideline for health professional as well as non-governmental organization's workers.

Alternative / Complementary Medicines

Medical pluralism has been an important characteristic of most health systems in the world. In the past few decades, alternative health and complementary medicine have become increasingly popular in Thai society. More than 200 organizations including self-help groups, alternative health advocates, non-profit organizations, and modern medical hospitals were involving in promotion and application of alternative medicine in patient care. Alternative medicines were different from allopathic medicine not only in their methods of restoring and maintaining health but also in their conceptual and organizational aspects of how health was perceived and how caring systems were organized. Models for the integration of appropriate alternative medicines could only be developed with an understanding of the differences between various explanatory models of health and illnesses in different systems of healing.

An important aspect emphasized in the review was on epistemological differences between various medical paradigms of alternative medicines. As the process of reform unfolded, indigenous healers and practitioners of alternative medicine became increasingly

active in finding a place in the official national health system. The understanding in the review process contributed importantly to the debate and the drafting of the new national health bill in order to integrate traditional / alternative healings into national health systems.

Health Paradigms in Local Health Cultures

Local cultures affected health through cultural practices and cultural contexts within which human interaction and behavior took place. Local cultures provided structures of meaning that served as frameworks for the interpretation of illness experiences. Local health cultures also provided communities with health resources such as healers, knowledge on herbal uses, and health maintaining and restoring techniques. Indigenous health concepts and medical practices often had different cosmological and epistemological assumptions. An understanding of local cultures and indigenous systems of knowledge existing in Thai society would help to adapt health systems to make them relevant to local cultural contexts.

As the reform initiative also gave strong emphasis on self-care, the understanding of local health cultures and social behavior related to health became crucial. The task of bridging difference between biomedicine and indigenous understanding of health and healing was easier said than done. The difficulty was not on how to re-conciliate between differing methods of disease treatment, rather it was the huge differences between the distinctive ontological and epistemological assumption of reality that needed to be bridged. The review revealed the underpinning principles of local health cultures and proposed a continual dialogue across disciplines to facilitate cross-cultural understanding.

Holistic Paradigm in Family Medicine

There was a surge in the interest in family practice in Thailand recently, particularly after the implementation of a universal coverage scheme of health care. This was partly due to the attempt to strengthen networks of primary care providers that would provide holistic and integrated care at the community level. The creation of family practice and primary care unit, however, seemed to pay more attention to form and quantity rather than content and the quality of care. Nonetheless, there were a number of interesting cases of community hospitals that took holistic care seriously and became active in developing practice models for primary care service and family practice. Local sub-district administrations have shown their clear interest in investing on this new development. An exploration and review of these examples was conducted to examine how holistic care can be promoted, particularly with the support of local sub-district administrations.

Health in Ecological Perspectives

New ecological movements, such as deep ecology and eco-feminism construed health as an integral part of ecological and spiritual wellbeing. There has been an increase in Thailand not only in ecological awareness but also in the number of organizations working in environmental and ecological issues. Linking health with ecological concerns has become strategically critical. The groundwork in this area sought to assess current situation and to develop framework and common language to connect health reform and ecological movement. A group of researchers and activists was formed to review the situation and build up technical understanding and relevant framework to facilitate future work in this area.

The review was aimed at providing groundwork on ecological perspectives of health. The result of the review not only included theoretical understanding of the field, but also provided case examples of how health was alternately perceived and realized through organic agricultural practices and alternative natural resource management. Active individuals and organizations in the field were also listed. The information was remarkably useful both for the reform process and for the networking of people working in this area.

Health, Spirituality, and Aesthetics

In the dominant paradigm of biomedicine, health was defined and conceived as a state of normal bodily functions and biological processes. Mind and body were viewed as separate entities. In the world of bio-medical reality, therefore, the multiple dimensionality of life has been reduced to its materialistic or bio-physiological dimension. Epistemological assumption of modern science has precluded the possibility of inquiring into the realm of existential experiences mainly because they cannot be objectively examined. Studies in new scientific paradigm seemed to offer a new path of inquiry for the purpose of redefining health. Holistic paradigm and the science of complexity proposed that in a complex system the whole is always more than the sum of its parts. Spirituality and humanity are a few of the emergent properties of complex organism of human biological system. Such characteristics of the whole cannot be reduced or understood by the property of its elementary parts. Spirituality seemed to be more and more realized as an important aspect of wellbeing.

Spirituality was not necessarily religious or otherworldly. Spiritual fulfillment can also be rooted in a secular world and non-religious ideology. Feminist activists, people who worked in ecological conservation groups, anti-nuclear movement, charitable organization, development agencies etc. in seeking to fulfill their vision of a good life can also be considered as being on their own spiritual quests. Health and spiritual life was closely

connected but hardly acknowledged in modern medical science. A framework to assess and build up the idea of how spirituality was important to health and well-being would help to facilitate the collaboration of religious groups in various knowledge traditions in seeking a more humanistic way of addressing human illness and suffering.

The review resulted in a report addressing various epistemologies and the shift toward a more holistic approach in life science. Although the important of spiritual dimension of health were well accepted by various parties in health systems reform movement, some consensus and reconciliation was still needed for differing religious orientations particularly on terminology used in official document. However, the review was useful in situating various viewpoints on spirituality and health in a wide theoretical perspective. It was therefore possible to conceive a continuing dialogue between differing knowledge traditions for further understanding and development in the field of spiritual health.

Health and Learning Experience

Health education and professional education of health and medical personnel have been based on a didactic model of learning. Just as patients needed to be "educated" in conventional model, medical professionals needed to be "trained". Lessons learned from various self-help groups, particularly people living with AIDS (or PWAs) and cancer survivor groups, suggested that there was a critical distinction between "education" and "learning". In health and medical education, emphasis has been given to "teaching" and "educating" in which professional authority and experts had acquired the correct answers to health and medical problems to impart on patients of medical students.

The new pedagogy and alternative educational models emphasized horizontal approach in learning processes in which various parties engaged in dialogical relation to realize their own potential. Technical skill, important as it were, was secondary to learning skill and self-mastery. Knowledge on existing conventional practices and how to apply a new pedagogical approach in forging a new learning society in health was of critical import. Review of situation and the creation of working group to examine and identify key actors in this field were undertaken. The review result was particularly useful for the debate on how to define spiritual health as well as how to apply the concept to specific health policy or program, such as spiritual health impact assessment of developmental project.

(3) Humanizing Health Care: Primary Care and Health Systems Reform

Although one of the most important elements in health system reform was the creation of universal coverage scheme of health care, it was impossible to implement universal coverage scheme without a strong network of primary care providers. As mentioned earlier in the historical review, the evolution of Thai national health systems has been strongly dominated by biomedical model, emphasizing high technology and specialized medical care. In such circumstance, creating primary care system required understanding and support from a wide range of health professionals. The objectives of this program therefore aimed at:

1. Building a vision of primary care among various health professionals.
2. Sharpening working tools to strengthen holistic approach in primary care.

The new vision of primary care needed a new structural arrangement within the existing system and had to be forged through the interactive learning processes among various stakeholders. Otherwise, changes in the structure of health care organization would invite strong resistance from existing professional organizations. Current employment of the concept defined primary care merely as "gatekeepers" and relied on the reform of financial mechanism to enforce structural change in support of primary care. So far, such an approach has proven to produce unfavorable result. This project proposed to interpret primary care with great emphasis on community health, stressing cultural and human dimensions of health and caring. To actualize this vision of humanistic primary care, tools to strengthen holistic approach were therefore critical. The following activities were implemented during the first two years of the reform.

1. A review of current knowledge and existing operational models on primary care. Emphasis has been given to community components in primary care service. Various approaches to community work, not only in health development, but also in other domains of community development work were reviewed and evaluated.
2. The preparation and production of community work fieldbook. Anthropological concepts and tools were adapted and applied to help local health workers to better understand cultural components and human dimensions of health and illness. In February 2001, the first draft of the handbook was completed. To introduce the handbook to health administrators and primary care workers, a launching seminar was organized on February 19, 2001 with more than 700 participants participated in the event. Seven hundred copies of the fieldbook were distributed for testing and evaluation.

3. A number of workshops to refine the tools and their applications as well as workshops for training of trainers were organized to promote the use of the tools. By the end of the second year, more than thirty training workshops in twenty provinces have taken place.

The fieldbook was later published as "*Community Approach: a Field Book on Anthropological Tools for Community Work in Primary Care*," a 200-page handbook on how to apply anthropological tools to community health work. It provides a clear scope of primary care work and its relations to other institutional care. The handbook has been generally used to train primary care providers to understand social and cultural dimensions of health and to be able to work better in providing holistic care.

(4) Civil Society and Health Development

The main focus of this research area was to provide groundwork as well as to document the ways civil society involved in the national health systems reform process. It aimed at generating from the working experience knowledge on the roles and potentials of civil society on health systems reform and health governance. The following activities were undertaken to document and analyze how civil society was engaged and the ways in which civil society organizations participated in reimagining and rebuilding health systems at various levels.

1. Review of situation and relevant literatures

Systematic reviews of circumstantial situations and existing literatures on the relationship between civil society and social movement on the one hand and health/social changes on the other hand were undertaken. Six topics were selected for systematic review:

- Current Thai politics and national health systems reform
- "Social capital" and its interpretation in health reform movement
- Health and participatory democracy: A profile of Health Systems Reform Office
- Concept and practices in traditional Thai social life
- Public space and civic practices in everyday life
- Tools and methods in the strengthening of civic tradition in Thailand

A group of researchers was formed to undertake the review. The conceptual framework resulted from the reviews were presented and discussed in a series of small informal workshop organized among concerned academicians and civil society organizations.

2. Engaging research institution and researchers

To invite broader participation of senior researchers and academicians in higher educational institutes in the research process, potential contributors were identified and commissioned to write research papers on various issues related to the development of civil society at global, regional, and national perspectives. The contributions of senior researchers included the following topics.

1. Representative Democracy vs. Participatory Democracy: The Future of Democratic Governance, by Chaiwat Thiraphan.
2. Transnational Civil Society Networks and the New Social Movements, by Amara Phongsapit.
3. Globalization, Globalism and Its Impacts on Civic Politics, by Surichai Wankeo.
4. Civil Society and Health Sector Reform: A review of international experiences, by Komatra Chuengsatiansup.

The understanding generated from these commissioned research papers was helpful in situating civil society mobilization and health reform movement in a broader theoretical perspective. The reviews and research papers were distributed and used in various technical seminars among researchers and people from civil society organizations. Most of the reports will be published and made available (mostly in Thai language) in June 2004. They will be important inputs for the national seminar on civil society and health movement, which will be organized by the Health System Reform Office in September 2004.

3. Development of research network

Four regional research networks were established with collaboration of regional research institutes. Common research framework was employed to gather relevant information during the process of provincial and district forums. Researchers from Chiengmai University's Faculty of Nursing, Khonkaen University's Research and Development Institute, Songkhlanakarin University's Faculty of Pharmacy, and Local Development Institute conducted research on the process of forming provincial forums in the north, the northeast, the south, and the central region respectively. For collecting information on district forums, 80 researchers were recruited and a one-day workshop was organized to train local researchers on research framework and data collection. Data collected both from the provincial and district forums were gathered and analyzed to assess the strength and weakness of civil society organizations and civic practices in Thailand.

4. Creating Database of Civil Society Organization

From data collected from provincial and district forums, a database on civil society organizations was created. During the first year of reform, twelve networks of civil society organizations in 69 provinces were identified. In addition to these area-based organizations, there were 14 issue-based networks of grassroots organizations already engaged in the reform process. To better understand the situation of civil society organizations and their potential roles in health reform, four regional seminars were organized in Chiengmai, Roi-ed, Nakhon Sridhammaraj, and Khonkaen. Participants of these workshops were researchers from local research institutions and representatives from grassroots organizations. Aside from further identifying research agenda and potential researchers, the seminar aimed at assessing the performance and capacity of civil society organizations in each region.

During the three years of interactive reform process, information on civil society organizations as well as their potentials was regularly updated. By the end of the third year, similar regional seminars were organized to reassess the situation. Researchers and representative of civil society organizations who have been active in reform process were invited to reflect on their experiences. From the information gathered from these interactive processes, twenty interesting cases of civil society involvement in health systems reform were identified and systematically investigated as case studies.

5. Case studies

As a research program consisting of several studies, research design and methodology was fashioned to enable collaboration and synthesis of the country's experience. To account for a wide variety of civil society organizations engaging in health systems reform movement, twenty interesting cases of civic engagement were identified Detailed investigations of these twenty case studies were undertaken. As mentioned earlier, there have been a vast number of civic groups and organizations engaged in the process of health systems reform. Learning from experiences of these movements was crucial to understand how the process of reform unfolded and how consensus was reached or conflict settled. Twenty case studies were systematically investigated using common framework and standard data collecting method. The twenty case studies were:

- Nakorn Pathom Province in Central Thailand
- Yasodhorn Province in Northeastern Thailand
- Kalasin Province in Northeastern Thailand

- Songkhla Province in Southern Thailand
- Pichit Province in Northern Thailand
- Trad Province in Eastern Thailand
- The case of Forum of the Health of the Poor
- The case of Women's Health Movement
- The case of community radio and health movement
- The case of AIDS and health reform
- The roles of NGOs and health reform
- Dongyai Community and health development
- Indigenous medicine network and health reform
- Network of the disabled and physically challenged people
- Consumer protection and community governance
- Youth Assembly and Health
- Network of Community Health Workers
- Community Nurse Association
- Community Forestry Conservation
- Organic Farming and Alternative Agriculture Movement

(5) Health and Human Right: Creating a Framework for Reform

Although it has been known that violation of human right often caused damaging effects on health and wellbeing of individuals and society, little systematic understanding of the interrelation was available. This program set out to explore the relationship between health and human right in order to build a workable conceptual framework to integrate human right and health system reform. The ultimate goal of this initiative was to place right to good health and good health care on national human right agenda. During the first year of the program, four areas of work have been identified as initial step for groundwork preparation:

Situational Analysis of Health and Human Right in Thailand

A group of researchers and social activist were formed to review current knowledge and situation on health and human right in Thailand. In addition to documentary review, field research was also undertaken to examine local situations as well as local perspectives on the issue of health and human right. Topics of inquiry were concepts and theoretical relation between health and human right, comparative analysis of western and local perspectives on human right, and violation of human right associated with medical discourse and practices. It

was expected that the review would help to establish the national health act on a solid theoretical understanding of human right.

Health Reform and the Health of the Poor

Health of the poor has not fully been appreciated as the issue of human right. To guarantee that the voice of the poor will be heard during the process of health reform, the Forum for the Health of the Poor Project was created. Four regional meetings with grassroots organizations working with the poor as well as people from poverty-stricken communities both in urban and rural areas were organized. During the meetings, health issues from the perspective of the poor have been raised. Four issues of critical significance have been identified and investigated. They included: (1) Food system and food security among the poor; (2) Economic and financial aspects of health from the perspective of the poor; (3) Health security among the urban poor; and (4) Public policies and their impact on the health of the poor. The result of the review was used as input for the process of drafting national health act.

AIDS as Basic Human Right Issue

To advocate human right in health arena it is crucial not only to voice the concerns but also to make available tools and method for health professionals and development workers to use in their daily practice. To make available practical ways of working on this issue a group of human right activists who have been working on the issue of AIDS was formed to review the situation of how the systems worked to protect basic human right in medical practices. Case studies were conducted to gather the experience of human right violation. Practical ways and means to help these cases would be drawn to write a handbook on health and human right for health personnel and development worker.

The five major areas of work to create knowledge base for health systems reform were undertaken during the first two years. By the end of the second year, the Health Systems Research Institute organized the "National Conference on Social Health" to disseminate and discuss what have been found and proposed from the review.

National Conference on Social Health: Founding Public Space for Rethinking Health System

In the following year of 2002, studies previously undertaken were mobilized to stimulate discussion and stir up new imagination among concerned parties. The Centennial Conference of Health Systems Research Institute, organized during August 5th-7th, 2002 at

Bangkok International Trade and Exhibition Center (BITEC), served as the focal point for the collective learning and rethinking of health definition and concepts. The conference was organized under the theme: "Creating Social Health towards a Peaceful Society" aiming at interjecting a concept of health that is not individualized. The main concept, which was used as the organizing theme of the conference, proposes to define health from a social perspective (see box below). Throughout the conference, the theme "social health" was echoed in various discussions to bring home the idea that creating health as a collective well being is creating a just and peaceful society.

National Conference on Creating Social Health towards Peaceful Society
August 5 -7, 2002, Bangkok, Thailand

The aim of the conference was to create a collective learning process and broadening the concept of health. The theme of the conference "Creating Social Health towards Peaceful Society" was reiterated in "the main concept," a conceptual proposition disseminated and used as the guiding idea for the conference. It stated:

The Main Concept

Health is socially determined. People living in a good society get sick less often and when inevitably get sick healing is more obtainable. A conscientious society possesses less health threats and restoring ill health, as a collective effort, is less of a burden for individual sufferer. It is well established knowledge that, in an exploiting society, health of the people deteriorates, families and communities flounder, environment depreciates resulting in deprivation, violence, and suffering. Health or well being of people, be it physical, mental, social, or spiritual, is, therefore, a direct outcome of a society: good health comes from a good society, that is a society which is equitable, reciprocal, respecting humanity, and peaceful. Achieving health of a society is therefore impossible without realizing that health, in the final analysis, is collective.

In a society as wealthy as the United States of America, the center of the world economy, for instance, epidemiological data reveals clearly that diseases are socio-economically distributed. Infectious diseases such as AIDS and Tuberculosis, or chronic non-communicable diseases such as malignancy, hypertension, and diabetic are far more prevalent and devastating among marginalized groups and those belong to lower social class. Black and Spanish American in particular suffer most severely from these epidemics. In societies around the world, preventable and curable diseases, be it AIDS, tuberculosis,

malnutrition, pneumonia, hypertension, or diabetic, are still prevalent among the poor, minority, women, and those who are on the receiving end of power structure. Diseases and health problems therefore resemble to social suffering in the sense that they are not accidentally occurred and not evenly distributed among social classes in society. Diseases are socially created and are distributed along the fault lines of society. While diseases, ill health, and suffering are concentrated at the margins among the poor and the disfranchised, health and medical resources are mostly concentrated at the center among the rich and the advantaged. Creating health and creating a just society are therefore one and the same.

But the root causes of social suffering run deeper than most of us realize. The creation of a good society needs more than equal distribution of resources. Resource will never be sufficient for the needs and greed of a few men or a few nations. Human societies need a whole new way of thought for the collective liberation of social suffering, a way of seeing that emphasizes oneness among people and societies before and beyond the crude instinct of exclusivity and individual survival. This new vision has to be not only convincing in a rationalistic sense, it has to be spiritually inspiring and conscientiously motivating to mobilize all sectors in the society into the great learning process. A paradigmatic change from competition and conquest to compassion and community needs a reinvention in the arts and sciences of living together, a reinvention for the transformative appreciation of common humanity and the beauty of simple human relations. A society is a complex whole with multiple dimensions and multiple domains all connecting to one another. Transformative changes in a system as complex as a human society can never take place simply by means of imposition and imperious coercive power, or else imposed changes and coercive structure would end up being a new monstrous regime in place of the old one. What is really needed is a revolutionary learning experience for all sectors and all societies to embrace a new collective consciousness that connects all people and all societies as one.

The Thai health system has been incarcerated by a dualistic and reductionistic view, which conceives health problems merely as a biological malfunctioning of individual bodies. Although such a view is in due time sufficient in solving certain physical diseases for a few, it is hardly adequate for the creation of health and well-being for all. Because health is not only socially determined, it is collective. When humanity is viewed as one integrated whole, health for a few is hardly health at all. In this collective sense, health is thus the direct outcome of the state of a society. A global society where superpowers dominate and mercilessly take advantages of even the poorest countries under the name of free trade, a society where consumerism is worshipped and materialism eclipses spirituality and humanity,

a society where modernity is glorified over local identity and cultural dignity, a society where culture of terror is norm and violence is the sole mean of conflict resolution, a society where life is discounted and nature disenchanted, a society where families depreciate and communities disintegrate, in such societies where collective well being is impossible, health is never to be achieved. Health and humanity has to be conceived of as one, if collective well being of humankind is to be realized.

Health and human well-being is not to be achieved through reductionistic intervention. Rather, health as a collective state of well being is achievable only through collective effort in which society as a whole -- from individual persons, families, communities, as well as various local, national, and global social institutions -- engages in transformative processes. All sectors and all levels of the society need critical learning experience for the collective growth of new consciousness and compassion. This transformation is a Herculean task far too great to be left in the hand of any single mechanism or methodological exclusivity. It can only be brought about by the processes of interactive learning through action in which all parties and stakeholders are invited to participate, to realize their potential, and to appreciate their contributions, for fundamental changes are required not only in structural dimension but also in spiritual and mental dimensions.

The conference to be held in August 5-7, 2002 provides an opportunity for those engaged in health and humanity to come together to renew our commitment, to inspire and to be inspired, and to learn and to collectively reflect on issues that concern us all so deeply. The conference organized under the main theme of "Creating Social Health toward Peaceful Society" will mark the beginning of the second decade of the Health Systems Research Institute, a new decade dedicated to realizing an imagined destination of collective well being of common humanity.

Among more than 2,000 participants who joined the conference were governmental health officers, health administrators, researchers and academicians, non-governmental organizations' staff, and people from grassroots community organizations. In the conference, various technical issues were discussed to explore the new interpretation of health, which could be more appropriate than the conventional biomedical interpretation. The conference was organized in three different formats: plenary cessions during the opening and the closing events; technical seminars on specific issues; and training workshop on tools and methodologies for health reform. Each session addressed the importance of social dimensions of health and proposed alternative views of health and medicine. Some of the issues presented and discussed in the conference were:

Plenary sessions:

- Peace and Health
- Global Capitalism vs. Global Community
- Creating Social Health towards Peaceful Society
- Society and Collective Well Being

Technical seminars:

- History of Thai Medicine and Health Systems
- Death and Dying: Health Dimensions from Spiritual & Religious Perspectives
- Primary Care and the Humanization of Medicine
- Health and the New Medical Paradigm
- Energy, Health, and People's Power: Energy Policies for People's Health
- Consumer Choice in Health Market
- Indigenous Wisdom: Folk Medicine and Social Health
- Family Health: Back to the Foundation
- Health at Workplace: Living and Working in Harmony
- Food System and Food Security
- Creating Peace and Social Health, Stop Violence against Women
- Globalization and Its Impacts on Local Communities
- Healthy Communities and Local Empowerment
- Universal Coverage and Social Equity
- Waste Management: Role of People and Community Participation
- Agriculture and Spirituality: New Linkage of Food Production and Health
- City, Travel, and Health
- Health Dimension in Small and Medium Sized Enterprises

Training workshops:

- A Workshop on Living and Dying Peacefully
- Health and New Ecological Consciousness: A Meditation Workshop
- Health Public Policies: Health Impact Assessment as a Tool for Healthy Society
- Health and Peace: A Training Workshop on Non-violent Conflict Resolution
- Child Development: Training on Tools and Method
- Training for Trainers on Anthropological Tool for Community Primary Care
- Long-term Research Capability Strengthening

The evaluation of the conference strongly showed that learning experience and the sharing of knowledge during the conference had successfully introduced an awareness of a new health concept, a concept of social health that sought to differentiate itself from the conventional disease-oriented, individualized, and reductionistic health definition. The conference was immediately followed by a national assembly to discuss the legal framework of new health system. The assembly was organized in an informal atmosphere to enable people from all social sections to participate. Local health initiatives were put on display as part of the exhibition to show how local communities could be encouraged to take charge of their own health. Representatives from civil society organizations participated in discussing and suggesting ways to improve the proposed legal framework. Legal experts, health experts, and people from grassroots community organizations exchanged their ideas through a well-prepared group of facilitators. At the end of the conference, the Prime Minister came to the closing ceremony. The resolution of the assembly was handed to the Prime Minister who pledged to support the promulgation of the new national health bill as a mean to lay down a solid foundation for the new health systems in Thailand.

2. Social Mobilization and Civil Society Movement

Engaging Civil Society: The Implementation of Reform Strategies

With the review of concepts and practices on creating knowledge base for the reform as the background, this section of the report examines in detail the implementation of working strategies in mobilizing civil society in the reform process. The process of civic engagement and the increasing roles of civil society in the domain of health policy and action must be understood within the larger political contexts and the continuing transformation of health systems discussed earlier. The strategy and experience of social mobilization and civil society movement discussed in this section will reveal how civic engagement strengthened the deliberative function in health governance.

HSRO, Civic Mobilization, and the deliberation of HSR

As mentioned earlier, in building a board-based social movement for health system reform, the Health Systems Reform Office, or HSRO, was set up to work as a coordinating body. Three strategic missions were identified as critical for forging a successful health reform movement. The first mission of creating a workable body of knowledge to enable a knowledge-based reform has already been discussed in the preceding chapter. The second and third strategies were: (1) Social mobilization and civil society involvement in the reform initiatives, and (2) Engaging political society to ensure structural changes through legislative arrangement. This section will examine the process of mobilizing civil society and civic engagement that aimed to foster public involvement in health system reform. Of particular emphasis was the ways working relationship between civic groups and HSRO as a coordinating mechanism was developed and sustained.

It should be noted that this working relationship was by no mean ideal and void of conflict or suspicion among various sectors. The interesting point was the way conflicts and disagreements were handled and resolved. As will be evident by the end of the analysis, civic participation was mobilized by creating a new social space, a space within which various sectors in the civil society could deliberate on how health should be understood, what were the desirable health systems, what were the objects of reform, and how reform processes should be carried out. Such deliberation of health system reform was possible only through the cultivation of healthy working relationship, a relationship that respected diversity, valued inclusiveness, and tolerated difference.

Public Forums and the People's Health Assembly

The constitution of 1997 has become a symbolic representation of new politics in Thailand. It marked a transformation from representational democracy to participatory democracy in the Thai political system. In the spirit of new political consciousness, the process of designing the new health system was carried out to ensure the broadest possible range of participation. The existing system of health governance, as mentioned in the preceding chapter, emphasized the implementation of predetermined program of health development. Such an approach precluded any meaningful participation of the public in the processes of policy decision-making or program design. In other words, what was meant for communities to participate was implementation and not deliberation. It was against this logic of restrictive democracy that the civic deliberation of health systems reform was carried out.

In an attempt to move away from the restriction of representative democracy towards a more inclusive mode of deliberative democracy, it was realized that mechanisms and processes that would open up spaces in which the public can participate were needed. It was towards this objective that a range of public forums at various levels was created.

As mentioned earlier, at the very beginning of the reform process, a brainstorming session was organized in Bangkok. It was entitled "The Desirable Health Systems for Thai People." Active citizen from all parts of society including religious sector, labor organization, professional association, political society, business sector, alternative health advocate, community organization, mass media, human right advocate, and academic sector participated in a discussion on current health systems and desirable characteristics of new health systems. The meeting was chaired by Professor Dr. Prawase Wasi and was broadcast live on national television program. The result of the brainstorming was later published and distributed for further debate.

After this first meeting, six regional meetings were successfully organized in order to broaden the participation at the regional level. These regional meetings were the result of collaboration between HSRO and local civil society organizations that co-hosted the events.

1. In upper northern region, the meeting was organized in Chiengmai Province with about 200 participants from various governmental and non-governmental organizations. The topic was "Giving Back Health Knowledge to the People." The meeting was chaired by well-known local activist and was co-organized by a group of local radio broadcasters who broadcast the meeting to local communities.
2. The lower northern region meeting was organized on August 3rd, 2000 in Pisanulok Province. The meeting was entitled: "Reforming Health System: Step One, Reforming

the Way of Thought." Almost 500 participants from eight provinces participated in the meeting. Local organizers are Foundation for Pisanulok against AIDS and Indo-China Crossroad Institute.

3. Upper northeastern meeting was organized in Konkhaen Province with 224 participants from eleven provinces. The meeting topic was "Way of Life, Way of Health for Northeasterner." Organizers of the meeting were Khonkaen Hospital and Udon Provincial Health Office. The meeting was broadcast live on regional radio station that covered all major provinces in upper northeastern region.
4. Lower northeastern meeting was held in Nakornrajsima Province at Sima Thani Hotel. The title of the meeting was "Decentralization and Local Administrative Agencies." 442 participants from eight provinces participated in the meeting. The event was organized by provincial health administrative office.
5. In the Upper South, a meeting, entitled "From Health Consciousness to Maintaining equilibrium of Life," was organized in collaboration with Walailuk University and the Network of Southern Civil Society. 155 participants from seven provinces participated in the meeting. The meeting was broadcast on national television covering all the southern provinces.
6. The sixth meeting was organized for southernmost provinces. It was organized in collaboration with a local civic association and the network of 45 civil society organizations in Narathiwas Province. More than 300 participants gathered to discuss on the issue of "Spirituality & Religious Value: The Driving Force for Health Systems Reform."

These regional meetings started off a continuing dialogue between the Health Systems Reform Office and civil society organizations around the country. In each of the meetings, respected public figures as well as local leaders played crucial roles in stimulating local public to voice their opinion. The ideas and expectation during the three years of the reform movement were also discussed. In the following years, thousands of community and provincial meetings were organized to stimulate the public to rethink health systems. These meetings created a new space for active citizen to participate in shaping the reform agenda.

The First Year of Civic Engagement:
Creating Forums, Inventing Public Space to Rethink Health System

In the year that followed, more than 500 forums were organized at various levels of the society. A booklet proposing initial conceptual framework for the reform was published

in February 2001 and used to initiate debate and discussion. It was also used as an educational tool to launch learning processes in various civic forums. Most of these forums were held among civil society organizations in collaboration with local health authorities. In August 2001, additional six sub-regional forums were organized in the provinces of Phitsanulok, Ratchaburi, Khonkaen, Surajthani, Songkhla, and Surin. By the end of the year, more than 40,000 participants attended the forums to learn and deliberate on their health problems and solutions. In addition, the "Reform Forum," a newsletter aimed at connecting local movements and sharing ideas on health systems reform was published. The meetings at various levels as well as the newsletters have served to engage larger public and to build up consensus on the desirable national health systems among various sectors in society.

The first year of civic engagement was wrapped up by a gathering event in which civil society organizations came to share their ideas and exchange their experiences. The event was called "Health Reform Bazaar." Technical sessions were organized for health experts to discuss and share their views on health system reform with local civic associations. These technical sessions were held along side the National Health Assembly in which delegates from civil society organizations put forth their views and opinions on the agenda of health systems reform. Not only was this first assembly of civil society organizations aimed as an experimentation and demonstration of how health policies would be deliberated in civic forum, but also the voices expressed by these organizations were recorded and summarized. The result was used as the basis for developing legal framework for the national health act, which was published and widely distributed by the end of the first year.

The Second Year of Civic Engagement:
Civic Deliberation and the Creation of Legal Framework

The second year focused on generating more debates on the legal framework of the reform. Based on the proposed outline of the new legislature, additional civic forums were organized with an emphasis on district and provincial levels. The aim was to discuss the relevance of the framework for practical issues with which local communities and groups were facing. This second year was kicked off by five regional forums organized to deliberate specifically on "national health policy processes," which was an important element to be included in the drafting of national health bill. Debated in the regional forums were issues such as the composition of national health committee, the process of selecting representatives from civic communities, and the design and functions national health mechanisms. It was also suggested that national health assembly should be organized annually and health

assembly on specific problems should be held whenever necessary. These suggestions were collected and used to revise the working framework for national health act.

When the first draft of the national health act was on the way, a series of training workshops were arranged for district facilitators who would help to organize district meetings to deliberate on the draft bill. Four regional training workshops were held in the North, Northeast, South, and Central/Eastern/Western regions. There were a total of 263 participants from all 76 provinces. Participants of the workshop were informed of the concepts and design of the bill, how the structure of the draft bill was developed, and how each component of the bill was drawn up, as well as how to organize district meetings so as to encourage participation and deliberation on the bill. Five issues were initially proposed as possible examples for more extensive debate in district meetings, namely, health policy process, factors threatening health and healthy public policies, consumer protection, primary care system, and the roles of local indigenous healing practices. These were only suggestive issues to be discussed The agenda for each district meeting, however, must be determined by local participants.

District Forums and the Deliberation of Health System Reform

By the end of the following six months, 526 district forums were organized with the total of 27,222 participants participated. It can be said that the organizing of district meetings have encouraged local people to rethink and reclaim their active roles in determining how the national health system should be. The process of deliberation was an active learning process that people came to understand themselves as active citizen and not just passive subjects of the state. This civic education was evident in how the process brought about deep contemplation and collective reflection of health problems among participants. Reflection on issues such as the values of local indigenous healings or the social origins of diseases, and the needs of healthy public policies was a conscentization process that not only revealed deep-seated problems and their taken-for-granted root causes but also the unobserved roles of ordinary people as active citizen.

In addition, forums on specific topics of concern such as women's health, health of the disabled, contract farming and agricultural use of pesticides, social and health impact assessment, and health of the poor, for instance, were also organized. These forums culminated into the National Health Assembly 2002, which the main focus on deliberating the draft of national health bill. Workshops and forums were arranged according to specific issues raised during the district and provincial forums. The closing ceremony of the National

Health Assembly 2002 was presided over by Prime Minister Thaksin Shinnawatra who, standing in front of a cheering crowd, vowed to process the bill to fulfill the wish of the assembly.

The Third Year of Civic Engagement:
Connecting Local Agenda with National Policy Processes

As the process of drafting the national health act was well underway, the third National Health Assembly has less to do with the legislative aspect of reform. Rather, the focus was on creating an alternative space so that local health agendas and initiatives could be expressed and shared among participants. To prepare for the 2003 assembly, provincial and regional forums were encouraged to select specific issues that were important to health and well-being of the region. These regional themes were debated at the provincial and regional forums. They then were placed on the agenda of the national assembly in order to connect local health concerns with the national policy processes. Themes derived from regional forums and were deliberated at the national health assembly were:

1. Theme from the northern region: Agricultural policies and practices and their impacts on health; Traditional knowledge and indigenous healing systems.
2. Theme from the northeastern region: Healthy public policies; Healthy agricultural policies and practices.
3. Theme from the central region: Holistic health care; and water resource management and energy policy.
4. Theme from the southern region: Religion and women's health; Tourism and health impact.

Conclusions derived from the assembly covered a broad range of issues. The forum on agricultural policies and practices noted that health impacts of agricultural practices were usually related to food safety, which concerned mostly on safety of the consumers. The forum suggested that the concern must be expanded to cover farmers' safety, as it was evidently clear that there have been extremely excessive use of chemical fertilizers, pesticides, insecticides, and weed killers in agricultural practices. The forum proposed that a ban should be imposed on the importation of excessive agricultural chemicals. Whereas the forum on holistic health care proposed that the development of primary care system must be emphasized. In addition, pluralistic medical system, which has long existed in Thai society, must be better harnessed by making them work together in a more integrated and complementary way.

The forum on religion and women's health paid special attention to how a cultural and gender-sensitive healthcare system could be devised. Participants from the southern region of Thailand, who were mostly Muslim, suggested that more female medical personnel were needed especially for providing care that was gender specific. While the forum on tourism and its impacts on health argued that sustainable natural resources management and health were two sides of the same coin. Local citizen must have more say on the use of local natural resources. Public hearing as well as social and health impact assessment of policy, plan, and implementation of tourism promotion must be established as means for participatory healthy public policy process.

The forum on traditional knowledge and indigenous healing systems proposed a new system of governance in order to put traditional medicines and indigenous healing on par with modern biomedicine. It was suggested that since traditional medicine and indigenous healing were entirely different systems of knowledge, each with its own distinctive epistemology, the system of governance must be sensitive to their philosophical differences. Using modern scientific epistemology in order to validate or to raise the standard and quality of indigenous healing system was amount to cutting off the feet to fit the shoes. Forum on water resource management and energy policy as well as forum on healthy public policy advocated decentralization of public administration, stronger public participation, and more transparency in the way public policies on natural resource management were formulated.

An interesting feature of the 2003 National Health Assembly was that local themes were presented through folk performances. In these presentations, local dialects were used as media for voicing health issues as well as for entertainment purpose. In addition, traditional ritual ceremonies were also employed during the opening and closing session of the assembly. The employment of local culture had significant effect of enabling country folks to express their views. For one, conventional way of debate and discussion with its emphasis on verbocentric expression could be viewed as privileging central Thai-speaking, well-educated middle class. Local languages and cultural performance allowed those who were not native to central Thai dialect to be more comfortable and confident in expressing their views in the ways they were familiar. Joni Auodeurchao, a leader of Karen ethnic hill-tribe remarked that the use of local languages at the convention symbolized a fresh new way of looking at health:

> There are many ways that health could be thought of. In fact, there are many healths for many people. For us Karen people, health is being able to feel confident in what you are. When you don't feel humiliated by your own culture or ethnic background, that is health.

Civic Forum as a Parallel Public Sphere:

An Analysis of National Health Assembly

Twelve years ago, on September 12-15, 1988, the first national health assembly was organized in Thailand at the Ambassador Hotel in Bangkok. Considered by many as a landmark of Thailand's health policy development, the assembly was the first time when high-level policy makers and political leaders not only from health but also from various sectors outside the conventional public health domain gathered and discussed issues facing the health of the nation. The opening ceremony was presided over by Princess Sirindhorn and attended by Ministers from various ministries including the Ministry of Education, Ministry of Interior, Ministry of University Affair and others.

More than 1,000 participants participating in the assembly were mostly health policy makers, administrators, researchers, and officers from various ministries. The assembly discussed and debated issues including the national health policies, health manpower development, people participation, medical technology assessment, health resources procurement and allocation, and strategies for children health development. The event was considered an extraordinary achievement because, for the first time in the Thai public health history, it exemplified the much-praised concept of multisectorial collaboration in health policy development.

In 2000, twelve years after the first national assembly, another national health assembly was organized. Although organizers of the two assemblies were closely related, the events were remarkably different. The latter assembly was attended not so much by state officials and policy makers. Rather, the majority of participants were from grassroots community organizations, development NGOs, professional associations, charitable foundations, and various other kinds of civil society organizations. The highlights of the assembly were placed on the roles of local initiatives and civil society organizations in shaping and carrying out health reform agenda.

The shift from an assembly of decision makers in official policy processes toward non-state actors was significant; it signified a drastic transformation in politics and governance in the domain of health system in Thailand. The national health assembly of the year 2000 has become a newly invented social space in which the deliberative function of governance could be realized. The following analysis will examine the processes that brought about the new social spaces and how the new spaces thus created served as a public sphere, a sphere by which the official politics of exclusion was challenged and transformed.

To better appreciate the significance of this newly invented public sphere, a brief theoretical review of the notion of public sphere will be provided in the following section. It will also raise a few interesting questions regarding the significance of "alternative spheres of autonomy" within the domain of health, a domain which, in less than half a century of modern medical history in Thailand, has been transformed into a "technical sphere" predominated by professional authority and specialized medical experts. To illustrate how such new social spaces were created, a case example of indigenous healer's network will be discussed to demonstrate the process. It will be evident that the new social spaces in which civil society organizations populated served not only for the valorization of civic consciousness and political subjectivity, but as a much needed deliberative function of governance in health system.

On the Notion of Public Sphere

Studies on political subjectivities and social movement have provided insights on the changing politics from representative democracy towards more participatory form of democratic governance. Various studies in this field pointed to the importance of alternative discursive space as a pre-requisite for any contestation of existing politics of exclusion. Fraser (1992), for instance, posited that "subaltern counterpublics" was instrumental for those who were excluded by the mainstream political processes to be able to get their voices heard. Fraser's argument was based on her conception of multiple public spheres in which she argued against Habermas' thesis of "bourgeois public sphere". In his thesis, Habermas investigated the emergence of "public sphere" in the eighteen-century Europe and demonstrated that it was a critical period of European democratization.

According to Habermas' account, the emergence of a "bourgeois public sphere" first took place in eighteenth-century England. At the time, the trading and oversea commerce was at its height. The middle class merchants and entrepreneurs had accumulated their wealth and become politically active. The new centers of sociability found in places like salons and coffee houses as well as the invention of printing and periodicals such as the *Tatler*, the *Spectator*, and the *Examiners* created a new social space in which the activities of the state could be scrutinized. According to Habermas this public sphere in the eighteenth-century was

> casting itself loose as a forum in which the private people, come together to form a public, readied themselves to compel public authority to legitimate itself before public opinion. The publicum developed into the public, the subjectum into the [reasoning] subject, he receivers of regulations form above into the ruling authorities' adversary" (Habermas 1989: 25-26).

This new sphere was created within the tension between "town" and "court." The term public had resumed its new meaning, from a narrow sense as synonymous with "state-related" to a domain of judgment. It was within this public sphere of civil society that public opinions were formed. "Whatever was submitted to the judgment of the public gained Publizität (publicity)" (Habermas ibid: 26). The emergence of critical public eventually led to the attainment of freedom of speech and expression. However, according to Habermas, this bourgeois public sphere was rapidly decline by the "re-feudalization" as the state became stronger while the free press such as newspaper and periodicals was controlled by the increasingly commercialized system of mass communication.

It should be noted that Habermas' "inquiry into a category of bourgeois society" was an attempt to trace the origin of public opinion. Public sphere, according to Habermas, was a domain of social life that led to public use of reason. His idea that a consensus could be reached and public opinion formed through debate was later developed into his thesis on "communicative action." In a sense, Habermas viewed public sphere as an "ideal speech situation" in which all participants in the public were free to debate and have equal opportunities to do so. This normative notion of public sphere was criticized by many as ignoring the unequal access and uneven ability to participate in the mainstream public among those who are marginalized and excluded.

There was a strong contestation particularly among feminist scholars who argued that women were and still are systematically excluded from the bourgeois public sphere. Nancy Fraser (1992) suggests that it was better not to consider public sphere in a single, normative manner. In order to maintain that public sphere was not something monopolized by the bourgeois, we must instead perceive of multiple public spheres. Notion such as "subaltern counterpublics" was proposed to differential public space of resistance from the dominating mainstream public sphere. In other words, public spheres were not single but always plural. In addition, among these multiple spheres of publicness, there were always spaces of contestations and negotiation in which those who were excluded and discounted by the mainstream public produced and circulated their counterdiscourse.

In the sphere of health and medicine where the power and authority of medical establishment dominated, attempts to reclaim this technical sphere from medical experts took many forms. The movement on women and reproductive health was a forceful effort to reclaim autonomy of women from the androcentric medical practices. Recent upsurge of alternative medicines was another instance of such reclaiming of technical sphere. This

chapter explores how these alternative spheres of autonomy were created in the process of health systems reform. Such alternative spaces served the deliberative function of governance that has been so far absent in the existing structure of health system administration.

Civic Forums and the Alternative Sphere of Autonomy

The creation of civic forums and community meetings was crucial in the process of engaging various sectors of society in reform movement. By participating in this discursive space, ordinary people could learn and transform into active citizen. This was particularly evident in the case of indigenous healers, who, for the most part of Thai medical history, were left out and ignored by official policy and authority. The following section provides a detailed analysis of indigenous healers network to illustrate how civic forums as an alternative sphere of autonomy could serve as an arena for the realization of political subjectivity.

The Case of Indigenous Healers Network

Since the introduction of modern medicine in Thailand, indigenous healing traditions have been on the wane. Various forms of indigenous healing have been struggling for survival with little policy support from the state. Among the variety of indigenous healings, only the classical medicine of the central Thai that has been legally accepted, albeit with little support. In the past few years, although classical medicine has received increasing support by the state, the variety of "indigenous healing" and "ethnomedicines" from other cultural background did not receive equal opportunity. If "Thai traditional medicine" could be said to be marginalized by modern medicine, "indigenous medicines" were even more so; they were struggling at the outer margin with slightest recognition and support from the state authority.

Practitioners of traditional medicine must pass the licensing examination in order to practice traditional medicine. However, the examination was based on specific medical textbooks that were mostly about classical Thai system of healing. Indigenous healers from different ethnic and cultural backgrounds were hardly able to pass the examination with their distinctive systems of indigenous knowledge. Without a license allowing medical practices, indigenous medicines were discarded and their systems of knowledge increasingly irrelevant. It was within this context that indigenous healers in various regions in Thailand found out that health systems reform movement might serve as an instrument for the revitalization of their indigenous systems of healing. This case study examines the effort of indigenous

healer's organizations to make their voices heard and to shape the legislative framework of the new pluralistic national health system.

The Origin of Indigenous Healers Network

Effort to revitalize indigenous medicines started in the early 1980. The Herbal Medicine for Self-Help Project founded by Komol-kheemthong Foundation, a high profile non-governmental organization, and the Traditional Massage Revival Project by Foundation for Health and Development were among the pioneering attempts. At the time, there was a movement among non-governmental development organizations to strengthen and encourage the use of "local cultures" and "indigenous systems of knowledge" in community development work. Collaboration between developmental agencies, researchers, community health workers and indigenous healers in northern region of Thailand has culminated into *"Association of Indigenous Healers of Phya Mengrai District"* in Chiengrai Province. In the following years, further collaboration with neighboring Phayao Province expanded the organization into the *"Association of Indigenous Healers of Chiengrai & Phayao Province,"* the first indigenous healers' organization with members and activities transcending provincial border.

AIDS epidemics that severely hit Northern provinces in the 1990s has brought public attention to the association. Witnessing the mortality of AIDS victims who were left without any effective remedy, indigenous healers offered what they perceived as possible remedies for the sick. Northnet Foundation, a non-governmental organization, was one of the early efforts to organize indigenous healers in order to provide what was seen as "holistic care" for people with HIV/AIDS. Within a span of two years, forty more of such indigenous healer's organizations were established. The urgent need to rescue their fellow villagers from life threatening disease has made it necessary for indigenous healers to share and exchange their experiences. This necessity not only greatly enhanced the networking of indigenous healers but also lent a great degree of legitimacy to the revitalization of indigenous systems of knowledge.

In the Northeastern region, the effort of non-governmental development agencies to reserve natural forest brought into attention the importance of herbal medicine, ethnobotany, and ethnomedicine. In the past, there have been isolated efforts to promote the use of herbal medicine by individual healers. The support from non-governmental development agencies helped to link them up and encouraged collective action. In late 1990s, 250 indigenous healers from seventeen provinces met in Mahasarakam Province to from the "Council of

Northeastern Indigenous Healers." The aims were to create a forum for exchange of ideas and information as well as to increase their roles and visibility among public. The council consisted of twelve associations of indigenous healers and has been actively advocating indigenous healing and herbal medicine since. Cooperation with provincial health authority and research institutes further enhanced the roles and strengthened the networks of collaboration among indigenous healers.

Associational Power: Shaping National Agenda

Through their participation in various collective activities, indigenous healers gradually learned how to further strengthen their effort to revitalizing indigenous healing. In the past, their associational life was mostly confined to their local communities. When they came together and discovered broader issues of common concern such as legislative problems, policy hindrance, or deforestation, they felt the need to get organized. The new socio-political situation demanded an extension of the scope of their associational life beyond what it used to be. With the assistance of non-governmental development agencies, organizations of indigenous healers expanded their roles from providing support to their members to advocacy roles.

When the movement toward health system reform started in 2000, network of associations of indigenous healers was already making a start. A group of researchers was commissioned to work with indigenous healers on situational analysis and to propose recommendations for reform. Three meetings were organized in the North and the Northeast in which more than 100 participants including indigenous healers, community development workers, health officers, and researchers convened to discuss how to include the revitalization of indigenous healings and ethnomedicines (and not just Thai classical medicine of central region) into the reform agenda. The consultation resulted in four main recommendations:

1. Existing potentials of pluralistic medical systems must be recognized and further developed to make them useful and able to work together for the health of people.
2. Decentralization is a prerequisite for the revitalization of indigenous medicines. It will enable local authorities to adopt and adapt locally available indigenous medicines to suit local need.
3. Local communities must maintain its rights to reserve and revitalize indigenous medicine and local systems of knowledge as well as to manage, develop, and make use of local indigenous medicine and medicinal herbs.

4. The government must designate "National Committee on the Development of Thai Indigenous Health System" under the national health council to direct policy and be responsible for the support and improvement of indigenous medicines.

Civic Forum, Story Sharing and the Politics of Collective Empowerment

Although it will need some time to convince national health authority to accept such recommendations, the process of deliberation was the first time indigenous healers came together and collectively realized their common predicaments and purposes. The forums and public deliberation of policies toward indigenous healing became a site in which their political agenda was conceived. While the mainstream political sphere nullified the existence of indigenous healers, these discursive spaces enabled them to reclaim their autonomy, to speak for themselves, and to transform themselves from object being acted upon into subject acting upon the world. By sharing their stories in working to revitalize their indigenous system of knowledge, local healers found out what were the problems they were working against. A story recounted by an indigenous healer of the northeast region was an example of how he worked against the system, which was structurally detrimental to indigenous system of knowledge:

> A few years ago, I set up a school of indigenous knowledge in my hometown in a northern province. I reported to the official because I wanted the school to be properly registered. Governmental officials came to me and ask if my school has enough room for students and teacher's offices and courtyard for student. They also wanted to know what the teacher and student ratios are. Are the teachers qualified and do they have teaching license? I said my school is different from ordinary school because we are teaching in our indigenous ways. The official said it is illegal to set up a school without complying with the state's regulation. If I want to call it *"rong rian"* [a school], I have to conform to the state's regulations. I figured out my school couldn't operate that way and decided to call it in local term for school, "*hong hian*," instead of in official central Thai language *"rong rian"*. Just to keep it away from the prohibitive law.

The rules and regulations may be appropriate for modern system of schooling, but indigenous apprenticeship and schooling was an entirely different affair. Because state's legislatures only regulate *"rong rian,"* they did not apply to his *"hong hian."* By changing the name to local dialect, he was free to operate without being subject to the state's rules and regulations, while he could maintain his indigenous identity at the same time. The school has been operating since and providing apprenticeship not only for indigenous healing but also for indigenous music and performance, woodcraft and sculptures.

The sharing of stories and narratives was particularly meaningful among those whose political existence was excluded. One of the main questions being asked in the forums of indigenous healers was "Why is health an exclusive domain of modern medicine and the state?" In the processes of exchanging ideas, it has become increasingly realized that the fading indigenous medicine was not because it was less effective. There were a number of ailments that indigenous healing could in fact complementing modern scientific medicine. The problems were much more subtle.

The domination of modern medicine was not only in the legislature, state policies, and in the way national health system was organized. It was also in the language, explanation, and classificatory scheme tightly entwined in social stock of knowledge. An indigenous healer said in a seminar, "When we use a foreign terminology, we are not only using a term but we are also employing their way of thought." Other added, "Those who hold the explanation hold the power." It was not surprising that most of the forums of indigenous healers were hold in local languages to challenge the imposing power of official language. Within this alternative discursive space in which the dominant discourse lost its commanding power, indigenous healers reclaimed their ability to speak for themselves.

Forums and meetings among indigenous healers, developmental agencies, and local health authorities also reduced the estrangement among each other. Dialogue and informal exchange could greatly enhance trust and reduce intolerance. In the past, encounters between indigenous healers and state health officers often resulted in dissension due to mistrust. Many indigenous healers were prohibited from practicing their arts of healing because local health authority considered them as illegal and superstitious. After a period of regular meetings, there was an increase of mutual understanding and rigid application of rule and regulation against indigenous healing was gradually transformed. Indigenous medicine for self-care, complementary care and psychosocial support, and healing practices performed by members of recognized associations, for instance, has become more acceptable. In a sense, there was a trusting relationship developed out of informal exchange and dialogue. This trust, which some theorists considered as a form of social capital (see Coleman 1988; Putnam 2000), enabled further collaboration and collective action.

The Challenges: Facing Controversies, Creating Consensus

Although the aim of the deliberation was to build consensus, the deliberative processes also brought about a number of controversial issues. Three of them were of particular importance. One of the controversial issues was about the notion of spiritual health.

As an attempt to expand the working definition of health it was suggested during the drafting of the bill that health should better be defined as "a dynamic state of complete physical, mental, social, and spiritual well being" instead of just "a complete state of physical, mental and social well-being". There were some scholars, monks, and representatives from religious organizations who did not feel comfortable with the use of the Thai term *"sukhapawa tang jitwinyan"* or "spiritual health" in the new definition of health. Their concern was that the Thai term *"jitwinyan"* which was generally employed to mean "spirituality" was allegedly inconsistent with the Buddhist etymology. Representatives from the discontented groups participated in the assembly and strongly protested against the use of such term. They wanted to remove it from the legislature and use other term instead. Other religious groups as well as many other Buddhist groups had no objection for the term.

As the term *"sukhapawa tang jitwinyan"* has become increasingly recognized and accepted by various civic and religious communities, the dispute posted a dilemma for National Health Systems Reform Committee. It has been generally agreed that concept such as spiritual health was much needed to signify a crucial dimension of well-being missed out by conventional health concept. But, on the one hand, after a long and persistent attempt to encourage the use of such concept and the term *"jitwinyan"* has been relatively accepted and fairly successful in conveying the message across both secular and non-secular sectors. On the other hand, it was considered offensive to a group of devoted Buddhists. How could this dispute be resolved? Voting was by all means not considered an appropriate way to reach consensus. Employing a non-confrontational, peaceful conflict resolution, the National Health Systems Reform Committee proposed to organize a consultative workshop to resolve the problem.

Representatives from various religions were invited to seek an appropriate solution in a meeting chaired by a well-respected member of the Privy Council. In the consultation, the chair started by reminding everyone that the aim of health systems reform was to enhance health of the nation by working together. Attempts should be made to work out any conflict of idea and to reach consensus, but at the same time respect and tolerance towards diversity and difference was also critical. Everyone was invited to express his or her pros and cons of the use of *"jitwinyan"* as a conceptual term. Participants were also invited to propose alternative terms for the concept. A number of terms were suggested and the meeting debated on each term. By the end of the process, the consultation came to a conclusion that the offensive term *"jitwinyan"* be replaced by the word *"panya"* or "wisdom". Although those who have been using the term *"jitwinyan"* were disappointed, they agreed on the use of the

new term that could be embraced by all. Once the agreement was reached, the new term was proposed to the legal body to be used as a substitute.

Other two controversies were the issues of death and dying and for-profit health care industry. In the case of death and dying, controversy sprang out from different interpretation of an article in the draft bill stating everyone has the right to "die in peace with human dignity" (article 24, Draft of National Health Bill). Hearings were organized to clarify the issues. The processes of reaching consensus were long-drawn-out and not rushing for conclusion. Although there were certain issues of the controversies that could not be compromised, such subtle processes of consultation created conducive environment that enabled each parties to respect and learn from between different perspective. The point of deliberation and public debate was not just to finalize or settle dispute, but more importantly, it was a collective learning process for civil society to appreciate the dialogical nature of decision-making that would enable a win-win solution.

3 Political Engagement for Legislative Reform

Active Citizen and Official Authority: Defying Medical and Political Model

Conclusion from the forums clearly demonstrated the potentiality of health as an issue around which civic associations and grassroots communities could work together to realize their collective capacity. Most suggestions and conclusions from various forums aimed at changes in broader context and macro-social policy instead of viewing health from an individualized and medicalized viewpoint. It is noteworthy that it was the official authorities and medical establishments that could not catch up with the conclusions and suggestions from civic forums. Official representatives from health bureaucracy were at lost when they were invited to express their views. Ministerial representatives often viewed participants as "lay persons" passively awaiting "health experts" to tell what to do. They often tried to use the forums to "educate" participants.

A number of examples were at hand. A representative from the Minister of Public Health, for instance, was invited to give his response to the conclusion from the forum. Instead of acknowledging and responding to the ideas proposed by the forums, he used his thirty minutes to teach how one should eat clean food, do exercise at lease twice a week, get enough sleep at night, and avoid being emotional in order to stay healthy. An official from the Ministry of Agriculture was quite taken aback as participants presented the problems of excessive use of agricultural chemicals and asked his opinion about the banning of agricultural chemicals importation. He said he did not expect to be asked such a serious question. Another high-ranking health official tried to argue how successful health development in the past has been and, in order to achieve more, people should feel grateful and comply with what state officials said.

It can be said that while civic politics tried to redefine health and establish an active role of citizen, official authority was trying hard to stick to the old biomedical model of health and the clientelistic model of politics. Health was perceived and deliberated in the forums not so much as individual health achievable solely by adopting healthy lifestyle, nor by passively following official authority. Rather, health was viewed as socially determined and public policies that greatly affected health were too important to be left to bureaucrats, politicians, and experts. It was the shifting on the view of health and politics from conventional model to one that expands health definition and embraces active roles of citizen that could be said to be the true object of reform.

Engaging Political Establishment: The New Political Environment

During the three years process of reform, representatives from various political parties, politicians and members of the House of Representative were invited to participate in various workshops and conferences. The National Committee on Health Systems Reform, chaired by the Prime Minister was expected to serve as a critical link between public deliberation and official policy process. The necessity of engaging official politics and involving political establishment was the need for the draft national health bill to be approved by the National Parliament. In order to do so, the draft bill has to be accepted by the government. In the course of the reform, however, changes in the ruling political party has resulted in delay of legislative process.

The first general election after the new constitution became effective resulted in a government drastically different from the earlier ones. Thaksin Shinawatra, a telecommunication tycoon, with his newly found Thai Rak Thai Party, received overwhelming support and came into his premiership in 2001. The populist policies, which gathered supports from various social strata and sustained the popularity of his administration, had expanded the roles of the state beyond previously conceived. In the first year of Thaksin regime, the government constructed low price houses and condominiums for sale to low income people, selling economically priced desktop and notebook computers, providing low cost life insurance, setting up community fund for loan, subsidizing small and medium sized enterprises, and providing universal access to health care.

While the state was currently expanding its roles as a welfare state, business and economic sectors are boosted by Thaksin's dual track economic policy, what was known in a self-aggrandizing term, "Thaksinomics." The approach was a simultaneous two-pronged strategy of strengthening local economies through promotion of small and medium sized enterprises and local communities' product along with greater expansion of export, inviting more direct foreign investment, and creation of global strategic partners. The outcome has proved to be successful with the GDP growth exceeding the estimate and the economic outlook was once again one of the best in Asian countries.

While economic development was generally considered as gaining increasing strength, social and political development was relatively less impressive. Human right record of the country came under critical scrutiny when thousands were missing in the war against drug led by the government. Some were reported as allegedly executed without legal trial. Those who did not agree with certain aspects of state policies were hastily excluded and marred in bad faith. Politically active non-governmental organizations that were critical with state's policies

were accused of being paid by ill-wished foreign agencies to blemish the government's credibility. Academicians who came out to criticize the way the country was run and the conflict of interest in the government were strongly ridiculed by Prime Minister Thaksin. Some were threaten by mysterious phone calls. In this new political context, the expected role of civil society organizations was to comply and cooperate without questioning the rightfulness and lawfulness of the state's policies, or so it seemed.

The Way Forward: Beyond Representative Democracy

Although at the National Health Assembly in 2001 Prime Minister Thaksin Shinawatra presided over the closing ceremony of the assembly and promised to process the draft bill through parliamentary approval, some changes in the bill worried him. As a Premier with strong an entrepreneurial ideology, an article in the bill prohibiting capitalist exploitation of health care was perceived as contradictory with governmental policy. In addition, bureaucratic and professional politics was also opposing some structural changes that were viewed as detrimental to the status quo. However, the draft bill was approved by the National Health Systems Reform Committee by the middle of the third year of reform plan. At present (December 2003) the bill has been delayed and waiting to be considered by screening body before seeking further approval of the Cabinet.

As a measure to release pressure from the National Health Systems Reform Committee and its wide-ranging civic alliance, the government has extended the reform plan from three years to five years. An extension of two years work period for the National Health Systems Reform and the Health Systems Reform Office was granted. Although an extension was welcome by many civil society organizations, a number of politically active civil society organizations have become more skeptical with the government. They were finding new ways and means to get the bill through the National Parliament. Strategies to engage politicians and member of the National Parliament were discussed. Leaders of the reform were in the process of negotiation with the government.

One important development was a campaign launched to gather popular support of the bill. According to the new Constitution, ordinary citizen can propose a bill directly into the parliamentary process if there are 50,000 persons supporting the bill. Although the procedure requires 50,000 signatures, the organizers of the campaign expected to get 500,000 signatures to show strong support from the public. The closing stage of the campaign would coincide with the new general election in 2005. The civic network that, for the last three years, has been working together was not very optimistic about the outcome, however, argument has

been made that what was most important was not the outcome. Rather, in a long-term prospect of achieving true democratic form of governance, the process of creating structures of associational life and norms of civic community was far more critical.

Towards this long term prospect, emphasis must be given not only on the outcome of having the approval of the bill, for at this historical stage of Thai political development, the domain of official policy process and party politics was not where civil society could be effective. In countering the exclusive domain of official policy process, it was strategically important to create alternative social spaces in which political subjectivity and a sense of active citizen could be valorized and sustained.

Civic Politics, deliberative democracy, and the alternative social spaces

Civic forums and national health assembly can be viewed as social spaces in which political subjectivity can be valorized. These social spaces provided opportunities for people to realize their political potential and in due process transform themselves into active citizen. These forums drew together people from various civic communities and helped them to elaborate their common purposes, to negotiate their interest, as well as to assert their autonomy. It was through their discursive participation within this alternative political sphere that individuals were transformed into active citizen. To be sure, such alternative spheres of autonomy required distinctive terms of engagement in which differing opinions were not only tolerated but also acknowledged with a strong collective conviction that it was only through dialogue and reciprocity that humankind could learn to achieve their collective well being. It is by engaging civil society in the deliberation that health system reform was firmly grounded in a solid civic foundation.

In the transition from representational democracy to direct democracy in which citizens take active roles, reform processes need to provide people with opportunity to participate, to deliberate on what their believe are the problems, how should the problems be viewed, what are the relevant policies and how best these policies be implemented. Such deliberation must be carried out under conditions that are unfettered by dominating power structure. Community meetings, civic forums, and assemblies provided alternative public spaces in which citizen could make a different in how health system should be configured and how reform processes should be. It was a step toward the realization of deliberative democracy.

Deliberative democracy, as the Civic Practice Network succinctly states on their website:

> rests on the core notion of citizens and their representatives deliberating about public problems and solutions under conditions that are conducive to reasoned reflection and refined public judgment; a mutual willingness to understand the values, perspectives, and interests of others; and the possibility of reframing their interests and perspectives in light of a joint search for common interests and mutually acceptable solutions.

The alternative public spaces created by various civic forums not only useful for the deconstruction and reconstruction of health concept and health system. More importantly, they were instrumental as civic educational tool, a tool by which communities could come together and learn to play active roles as citizen. It was through this learning process that a shift from a previously unaware political subject into a self-conscious civic actor with a public mind took place. Again, as the Civic Practice Network puts it:

> It is thus often referred to as an open discovery process, rather than a ratification of fixed positions, and as potentially transforming interests, rather than simply taking them as given. Unlike much liberal pluralist political theory, deliberative democracy does not assume that citizens have a fixed ordering of preferences when they enter the public sphere. Rather, it assumes that the public sphere can generate opportunities for forming, refining, and revising preferences through discourse that takes multiple perspectives into account and orients itself towards mutual understanding and common action (http: www.cpn.org).

In looking at how a sense of citizenship and political subjectivity was valorized, we can see from the examples above that building a deliberative democracy required the construction of a new discursive space, a space that helped to transform persons into active citizen. Civic forums and community meetings created much needed space for individuals to come together and realize their collective action. It was this transformation for isolated, individualized life into an associational life of active citizen that was the core of health systems reform movement in Thailand.

5

Conclusion and Recommendations

Reform as the Deliberative Construction of Active Citizen

Lessons Learned

Reform, as oppose to revolution, has been understood as an attempt to introduce changes from above. Reform advocates were mostly technocrat, aristocrat, bureaucrats, or politicians who wanted systematic and, to some extent, structural change in accordance to their elitist standpoint. More critical activists viewed such an approach as a top-down approach, imposing an elitist view and using people only instrumentally. At the same time, radical change such as those achieved through revolution seemed to create more problems than providing answer. Even for those on the left of political spectrum, the radically forced changes has been increasingly problematized. The vision of Italian Marxist, Antonio Gramsci, was most influential in this regard.

In theorizing on revolution in Europe, Gramsci pointed out that in advanced capitalism, political control was achieved as much through popular "consent" as through "force". Based on this insight, Gramsci distinguished two fundamental forms of political power: "domination" (direct physical coercion) in the realm of state and "hegemony" (consent, ideological control) in the realm of civil society (Boggs 1978:39). The development of a skilled labor, the role of the mass media, the availability of more sophisticated techniques of ideological control, the importance of knowledge and education in advanced capitalist societies, all required the state to increasingly build its authority upon hegemony rather than force.

In so theorizing, Gramsci proposed a "war of position" as a main strategy for social change in advanced capitalist society, in contrast with Lenin's notion of "war of movement." What was meant by Gramsci's "war of position" was the long-range contestation of cultural-ideological hegemony for the gradual shifting in the equilibrium of social forces. Politics in Gramsci's sense was thus more of "moral-intellectual" and "cultural-ideological" rather than "political" in the narrower sense of struggle for seizing of state power, as connoted by Lenin's "war of movement."

What made the "civil society argument" interesting was that it was a concept situated in between and is commonly used by various schools of political thought. "Civil society" was seen to be a critical component useful as a corrective measure to the accounts of the good life

proposed by the left and the right. It argued for participatory democratic governance with an enthusiatism toward radical change not only at national but also at the global regime. The civil society argument, as pointed out by Michael Walzer (1992), "is directed as a critique of both the left (too wedded to government action in the pursuit of distributive justice) and the right (too unconcerned about the destructive impact of competitive markets on the fabric of associational life)."

This report provides an account of civil society and health system reform in Thailand to demonstrate how a broad-based civic movement was attempted. From the review and analysis above, we can readily see that the roles and potentials, and even the meaning of civil society, were obviously contingent to the histoical and political contexts. In the case of Thailand, the changing historical contexts and the evolution of Thai politics in the past few decades were relatively conducive to the growth of non-state actors. The emerging public sphere has been increasingly populated by civil society organizations of various shapes and sizes. As defined in the outset of this report, civil society in current situation in Thailand could be imagined as "an autonomous sphere of social interactions in which active individuals and groups form voluntary associations and informal networks and engage in activities with public consequence."

The three years of health system reform aimed at creating a broad-based reform movement to achieve two strategic objectives: (1) The restructuring of institutional infrastructure through legislative action, and (2) The forging of a new collective health consciousness. The analysis of the reform process suggests that the most important aspect of mobilizing civil society in health system reform was the creation of civic deliberation process. Various forums, meetings, conventions, and conferences at various levels created much needed spaces for the public to deliberate on how health and existing medical predicament should be understood and what should be the most important changes to achieve the desirable health system.

In order to engage the broadest range of social actors and civil society organizations to participate in the reform process, it was realized that concept of health itself needed to be expanded from a biomedically defined concept towards a more holistic, inclusive, and multidimentional definition. Health in the reform process has been redefined to emphasize not only biological and psychological aspects but, more importantly, social and spiritual aspects of wellbeing and wellness. The broadened concept of health enabled the involvement of broader stakeholders into the deliberation of reform process.

It was in the deliberative processes that active citizen were empowered, the seemingly unproblematic status quo called into question, and the new meaning of health generated Health, as it was percieved and deliberated in civic forums, was not so much an individualized, depoliticized state of being achievable solely by individuals adopting personal healthy lifestyle, nor by passively following official authority or bureaucratic policies. Rather, health was viewed as socially determined and inseparable from collective wellbeing and social justice. Public policies that often greatly affected health were too important to be left alone to bureaucrats, politicians, and experts. It was this shift on the view of health and politics away from conventional models to ones that expanded the operational definition of health to embrace the active roles of citizen that could be said to be the true object of reform in Thailand's health system reform movement.

Recommendation on Enhancing the Roles Civil Society in Health Policy and Action

Expanding the Framework of Health

The biomedical definition of health precludes the involvement of stakeholder from a broader social and economic development and poverty alleviation in health development. The expansion of operational definition of health in health sector reform from a disease-oriented, curative approach to a more holistic approach will broaden the scope of possible participation of civil society. Framing reform process from the perspectives of health promotion and caring of chronic illnesses will reemphasize the role of family, community, neighborhood, and other grassroots organizations. A new concept of health that expands to include multiple dimensions of health can facilitate further cross-border collaboration. Expanding the concept of health is thus a prerequisite for broader participation of health reform.

Pluralization of policy processes and actions

Most health reform effort relies on what can be called "official policy process" in which the process of policy formulation, planning, and the implementation of national health reform policy are undertaken exclusively within the structural organization of public health bureaucracy. As Jareg et al point out, the grand vision of "Health for All by the Year 2000" launched by WHO in 1978 could never be fulfilled by governments working on their own. NGOs, with their experience of working with the dispossessed and difficult to reach groups, had to be the core alliance to accomplish such an important goal. The same can be said with health reform. Civic engagement and public deliberation of health reform can be useful to overcome the limitation of official politics and representative democracy. It is a move to

broaden the platform in which civil society and active citizens can participate more directly and variously in public affair.

Encouraging Collaboration between Civil Society and National Agencies

Experiences from Thailand's health systems reform movement strongly suggested that collaboration between civil society and health reform agency was critical. In a sense, this cross-border collaboration has to transcend differences in organizational cultures. Various actions could be taken to promote this cross-cultural collaboration between them.

Coordinating mechanism

Focal points for the coordination of civil society organizations are needed to facilitate the collaboration. Sigrun Møgedal of Center for Partnership in Development offers this practical remark on collaboration and partnership between government, corporate society and civil society.

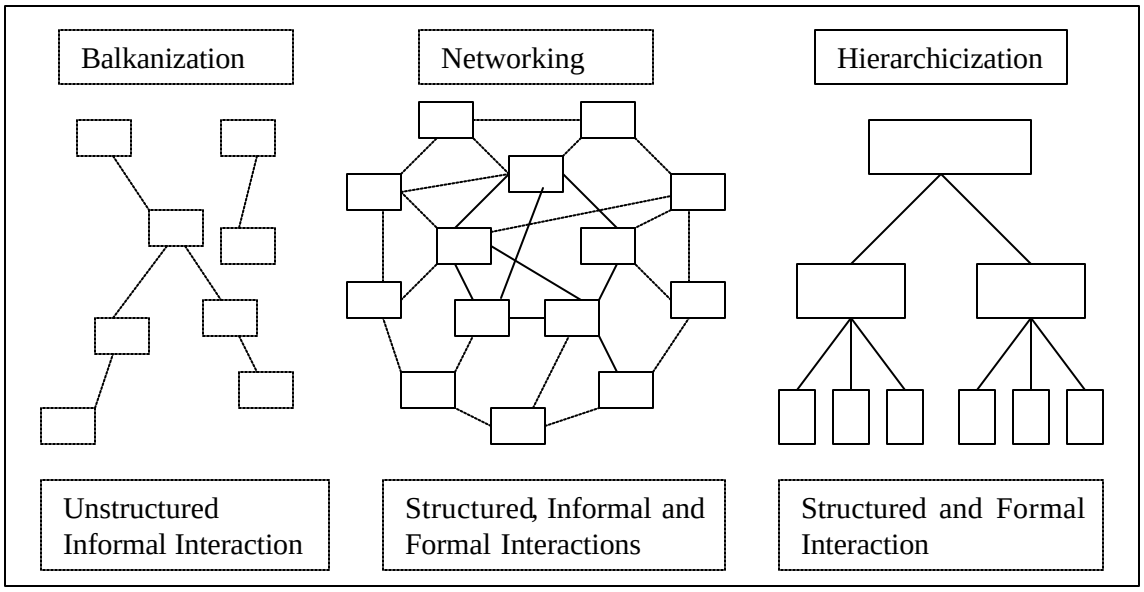
> Partnerships between civil society, governments and donors for agreed purposes can also obviously be constructive and effective, but may represent constraining co-option and should not by design be understood to be harmonious. Civil society cannot easily become contracted by any outside agent of development and change without loosing its specificity and potential. Community mobilisation and organisation in free democracies can be enabled but not prescribed (Møgedal 1998: 8).

Collaboration and coordination between organizations can take various forms ranging from a rigid top-down bureaucratic relationship on the one hand to a loosely structured networking on the other. In civil society, where voluntary organizations are mostly autonomous, relationship between organizations (among civil society organizations and between civil society and the State and market) is fluid and informal. Forms of collaboration and coordination can be grouped roughly into three models of interaction and linkage: balkanization, networking, and hierarchicization (see diagram below).

Among these models of inter-organizational relationship, networking has become common mode of collaboration and coordination in civil society. Balkanization refers to interorganization linkages in unstructured and informal ways. Each organization contains its own autonomy and interactions are mostly bilateral. Networking refers to interactions and linkages between organizations in both formal and informal way, usually not bilateral and involving more than a few organizations. Each organization might have its own objectives but come together in order to set common agenda or to accomplish certain tasks.

Hierarchicization refers to formal and structured ways of interaction between organizations in which organizations lower in the hierarchy are under command and receive order from higher organization, a typical bureaucratic relationship. Interaction and linkage in

civil society fall mostly into the networking model. Before formal collaboration and coordination can be reached in civil society, trust, acquaintance, and a sense of shared purpose must first be established through informal engagement (Bebbington & Farrington, eds. 1992).



(Three Models of organizational interaction and linkage. Adapted from "Alternative Models for Intercommunity Governance," William R. Dodge 1992: 406-407)

Information system

Creating information base to facilitate the cooperation with civil society is crucial particularly where little coordination previously exists. Building an information base of civil society is, however, not the cataloging of civil society organizations or listing their addresses. A strategic information base is not only consisting of sets of data on each organization, but, more importantly, the strategic linkages and key connections each organization has and the common goals shared by a cluster of organization. Compiling this strategic information cannot be accomplished simply by looking into the directories and annual reports of the organizations. Rather, it should be done by actually participating in the activities carried out by these organizations to understand the organizational culture of civil society organizations.

Clear policy and plan

The need for a clear policy and plan has been recognized as a prerequisite for achieving intended objectives. Clear policy and plan not only helps to set the direction and coordinate actions, but they also help to mobilize the needed resources and personnel. It is recommended that close and frequent consultations especially in the forms of informal meeting, courtesy visit, and open dialogue with related civic groups are organized in the

policy formulation and planning processes. It should be kept in mind that the roles of civil society in health can be "collaboration" "correction" and even "confrontation." An over-optimistic view of mutual collaboration is not realistic.

Encouraging dialogue between civil society and international agencies.

As countries are increasingly incorported into the global economy, local civil society organizations will need to work more closely with transnational civil society organizations. The Greenpeace, World Wildlife Foundation, Transparency International, for instance, have set up their regional and country office in many parts of the world. At the same time, the global regime of freetrade and transnational corporations have increased their presence in every region. Just as with politics and economic, health has become simultaneously global as well as local issue. It is more crucial than ever for local civic initiatives to coordinate and form network with not only transnational NGOs, but also other global institutions. Linking local NGOs' initiatives to the global agenda needs continuous dialogue between agencies of the U.N. system, multilateral financial institutions, and funding agencies. These global institutions have different strengths and weaknesses as Gill Walt's tabulation below illustrates.

Organizations	Perceived Strengths	Perceived Weaknesses
World Bank	Financial resources, policy advice, and technical assistance Links to ministries of finance and planning	centralized, weak country offices (staff in Washington) narrow economistic approach to health perceived as Western dominated and ideologically driven
UNICEF	effective at operational level resources at country level strong country offices (85% staff at country level) advocacy role	too driven by New York and narrow goals sustainability of initiatives vertical approach to health
UNFPA	resources strong advocacy role (family planning) limited technical capacity effective procurement service	small, undergoing paradigm change from rigid population control to reproductive health subject still vulnerable to political differences
UNDP	broad development orientation close ties to government coordination role	diverse competence at country level poor on advocacy because of ties to government
WHO	technical and scientific knowledge network of experts links with ministries of health	weak at country level two-third staff (of 5700) at central or regional level

Source: Gill Walt 1996:28

The roles of international NGOs and emerging global civil society are increasingly prominent. International NGOs can help raise global awareness and monitor the compliance of corporations and nation states on various issues. Baby Milk Action, for instance, works to promote legislation and practices in line with the WHO's International Code of Marketing of Breast Milk Substitutes. Other organizations perform different roles such as challenging international financial institutions or development agencies to rethink their policies and practices. These different forms of interaction and relationship can be more constructive by encouraging continuous and open dialogue between different perspectives.

Promoting research

Civil society and other related concepts are new and the theory of civil society and health is still in its infancy. Although it seems to be a useful conceptual tool, the concept which emerges from specific historical contexts need to be adapted to local setting. Information necessary for policy formulation and cooperative effort is difficult to find. Promoting civil society and health as a field of research inquiry will help to create much needed knowledge base for further collaboration.

Research Questions

Research studies are needed to build up knowledge base in order to enhance the roles and performance of civil society in health. The following recommendations are four groups of research questions, which are important to refine the idea of civil society, assess the profile of civil society, and configure the relation of civil society and health. The four groups of questions are theory of civil society and health; basic information and profile of civil society organizations; strategies and approaches in broadening the alliance for health in civil society; and tools and technical know-how in strengthening civil society.

- **Theory of civil society and health**

1. What are the differences in the definition of "civil society" among different school of thought and political ideology? What practical implications do these different theoretical orientations have in the relationship of civil society and health?
2. As a concept derived mainly from Anglo-American political thought, how can the concept of civil society be applied in non-Anglo-American contexts and how useful is this "foreign" concept for strengthening participation of various sectors in health development in developing countries?

3. What are the basic assumptions that inform existing policies, plans, and actions in health development? How can the concept of civil society help as a corrective measure to existing policy and practices in health development?
4. What is the theory of health development and how can "health" and "health system" be defined in ways that are more inclusive and open to civic participation?
5. What new theoretical and conceptual understandings can be generated and synthesized from lessons learned from various civic movements (such as environmental conservation, women's movement and human right movement) worldwide and how can they apply to health actions ?

- **Basic information & profile of civil society organizations**

1. What are the existing civil society organizations (e.g. community organizations, people organizations, voluntary associations, and non-governmental organizations, etc)? How many and which of the existing organizations are active?
2. What is the geographical distribution of these organizations? How are these organizations distributed in various areas of interest and in different area of health problems? Which areas of social policy and action could civil society organizations have strong or weak roles or contribution?
3. What are the existing coordinating mechanisms between health sector and civil society? How effective are the existing coordinating mechanisms?
4. Through which existing mechanisms is civil society related to governmental agencies and to corporate society?

- **Strategies and approaches in strengthening the roles of civil society**

1. What are the strategic problems in the existing health development paradigm? How can the idea of civil society as a strategy be applied to broaden participation and multisectoral cooperation for health development?
2. Who are the strategic alliances in different areas of health development and how can strategic relationships among these alliances be created?
3. What are critical linkages or interfaces between governmental organizations and civil society organizations in specific areas of health problem? How to strengthen the linkages and interfaces between them? What are the alternative organizational forms that could facilitate better collaborations?

4. What are the "leverages" by which civic initiatives can be scaled up and linked to national and global agenda?

- **Tools and technical know-how in strengthening civic sector**
  1. What are the existing tools and techniques for the assessment and evaluation of the roles of civil society organizations in the realm of health development?
  2. How effective are the available models of civic education? In what settings are various forms of civic education most effective?
  3. What are the strengths and weaknesses of the available community organizing tools such as Future Search Conference, AIC (Appreciation, Influence, Control) method, Consensus Organizing Model, and other soft techniques used in community organizing activities?
  4. What are the training needs of various categories of health workers, which will help facilitate cooperation in civil society? How many training packages are needed for different settings of health development?

Concluding Remark

Civil society, and other related ideas and concepts, can open up new ways of thinking about social changes and thus new possibilities for people's participation in development. But it should not be seen as a "magic bullet" capable of solving all problems in health and human development. It seems, however, that the world is currently witnessing dramatic changes in both local and global political landscapes. Current political ethos is characterized by increasing public demand for democratic governance and the increasing roles of civil society in shaping development policies and practices. Health, as an integral part of human and social development, is an excellent ground to cultivate new forms of collaboration and to enrich civil society's creative and innovative capabilities of which it has already demonstrated its initial potentiality. However, with its strengths, civil society also has its weaknesses. It is only in working together with mutual respect that the government, corporate society, and civil society can learn from each other, realize their strengths and weaknesses, and reach their distinctive potentiality.

To imagine a greater role of civil society in health care is to change the way we think about health and public affairs. David Korten, in his analysis of global civil society, maintains that the emerging roles of global civil society were an unfolding of cultural struggle. What was being fought out is not a struggle to change the way wealth (or

commodity) has been distributed, but a struggle to fundamentally change the ways we think about good society. As Korten succinctly states,

> Although the public face of the struggle is political, its roots are cultural and its resolution will depend ultimately on the outcome of a deep global shift in cultural values—of which the global democracy movement is one manifestation (Korten 2000).

The same can be said about health reform. Current approaches in health sector reform cast the debate in the rigid framework that reduces health to medical service and reduces citizen to passive client awaiting services handed out to them by "health care providers." Health from a civic perspective requires a new way of thinking about health and how we bring about changes in our collective well being. From a civic perspective, health care reform is not about making a decision on an either-or choice between health as public goods provided by the Market and health as welfare provided by the State because at both ends of this spectrum health care was still viewed as a commodity (a service) to be dispensed and consumed by subdued individuals. Instead of viewing health as commodity or service, we need to be able to see health as "a state of individual and communal wellness and well-being, a state attained both through actions one takes in life and through relationships, structures, and communal fabric the connect people" (Jennings and Hanson 1995: 9). The shift of our fundamental understanding of health is a prerequisite of a new possibility to unleash the potentials of civil society in creating a healthier personal and communal life.

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