Struggling Along the Path to Universal Health Care for All

Dr. Sanguan Nitayarumphong

National Health Security Office (NHSO)
200 Moo 4 Jasminne International Tower,
Chaengwattana Road, Pakkred District
Nonthaburi 11120, Thailand
Tel. 66 2831 4000
Fax. 66 2831 4004
www.nhso.go.th

Production Credits
Publisher: National Health Security Office (NHSO)
Editors: Sanguan Nitayarumphong
Cover Designer: Verachai
Artworks: Suphattra Poonneam
Printing Office: Komol Keemthong Foundation Publishing

Printed in Thailand
ISBN

First Published 2006 2,000 copies

Table of Contents

Dedication

To My beloved family: Dr Opiwan, Nong Ploy and Nong Phuen

Forwards

A government's primary mission is to take care of its people, educating them and providing them with opportunities to improve their lives.

The national health security policy, or 30 Baht for All Treatment program, initiated by the government is rooted in the principle that all men are born equal. As such, each has one vote when ballots are cast, and so too, each should have equal rights to health care access. All government policies must respect this, while aiming to reduce people's expenses and increase their incomes to improve their quality of life.

The government now provides health security to more than 49 million Thai people who previously had no guaranteed access to health services. Whenever I visit people in the 75 provinces, I receive reports that 90 percent are pleased with the program. Over the past three years, the program has succeeded because of the dedication of many people. I must thank all those health professionals and everyone else involved for making this possible in such a short period of time. I especially want to thank Dr. Sanguan Nitayarumphong for his crucial

role, and for documenting the process in this valuable book.

This book chronicles the events and the complex social and political dynamics surrounding the development of the national health security policy, what the government now calls 30 Baht for All Treatment. It provides an excellent explanation of the ideological principles that shaped a more clear and practical approach for policy changes to ensure the health of Thai people.

I am confident that this book will provide its readers with knowledge and understanding of this important policy as well as inspire all of us to strive further to improve Thai society.

Prime Minister
Dr. Thaksin Shinawatra

The National Health Security Act is one of the best things to have happened to Thailand. Although many people participated and contributed to its development, the most important was Dr. Sanguan Nitayarumphong. He has been on an exhaustive journey comparable to The Long March. His experience in navigating such a difficult road, *Strugging Along the Path to Universal Health Care for All,* provides a valuable lesson for the public.

Dr. Sanguan's mind is always exploring opportunities to improve care for the poor. As a student, and immediately thereafter during his time in rural hospitals, he experienced their tremendous suffering, especially when they fell ill. His heart began to fill with the desire to do more, prompting him to attain the wisdom to do so. With some of the fundamentals of public health theory in hand, he went on to actively engage in experimentation on many fronts. From methods to improve delivery of health services, to more efficient financing schemes, along with new approaches to management and administration, his efforts caused him to become the most knowledgeable person in the field of national health security reform. In any country, health care reform is an extremely difficult undertaking, akin to moving a mountain. Dr. Sanguan has moved this mountain for Thailand, using knowledge, patience and hard work.

The achievement of any difficult task deserves to be recorded. This book documents for the Thai public how our national health security scheme evolved. We still have many mountains to move to achieve a just society. I hope Dr. Sanguan's book will inspire people who want to work to reduce suffering and to improve people's lives, to do so with knowledge and wisdom. And hopefully, along with other efforts to heal our world, we can heal ourselves, since we and the world belong to one another.

Professor Dr. Prawes Wasi
1975 Magsaysay Award Recipient

Health security for all means a publicly managed system to provide equitable access to health care to everyone in society. It is based on the belief that health care is everyone's right. Access is not determined by the amount of money in one's pocket. In many countries, national health security has been achieved by people engaging in long struggles and campaigns; Thailand is no exception.

Here, the principle of universal health security was first applied in 1990 with the establishment of the Social Security Fund. It was the result of an extended struggle by the labor sector led by then Labor Department Permanent Secretary Dr. Nikom Chandraravitoon. However, the Fund provided benefits to just eight million people. It excluded workers in the agricultural sector as well as those engaged in informal employment. It was not a universal system.

The arrival of real universal health care in Thailand occurred following passage of the National Health Security Act of 18 November 2002. But this policy too has many lingering weaknesses and problems. Service quality and resource distribution are not yet satisfactory. The public still lacks sufficient opportunities to participate in the scheme's management. And efforts are afoot to abandon the scheme even though it remains in its infancy. Nonetheless, we still must regard the scheme as a great step for the country. Hopefully, its ongoing

development will further move the scheme toward benefiting the majority of the country, as was intended from the start.

Who are the people behind this achievement?

Dr. Sanguan Nitayarumphong and his small team in the Public Health Ministry have for a long time been leading the call for universal health care as part of an ambition to realize a more equitable society. But they lacked support from the Ministry's leadership. Although they drafted a national health security bill in 1997, it took another five years and the help of many more people before a version of it became law.

Also critical were the people comprising the eleven networks of non-governmental organizations representing the interests of HIV/AIDS sufferers, the disabled, women, alternative agriculture, the urban poor, organized labor, informal labor and consumer rights. They embraced Dr. Sanguan's idea and, with his team, launched a public information campaign in 2000 that reached a broad segment of society. They educated people, drafted a revised national health security bill, and collected 50,000 signatures to require Parliament to take up the bill as mandated by the Constitution. Unfortunately, it took the Parliament eight months to verify the legitimacy of all these signatures. In the meantime, the Thai Rak Thai Party proposed their own bill, which sailed through the parliamentary approval process. Fortunately, representatives from the people's sector were invited to consult on the Thai Rak Thai Party's bill by both the lower house and the senate.

Prime Minister Thaksin Shinawatra is the person who made national health security for Thailand a reality. It began with his party promoting 30 Baht for All Treatment as part of their campaign platform. The party then won the largest percentage of votes in the 2001 general election, becoming the core of a new coalition government. Thereafter the party proposed its national health security bill to Parliament, and won approval in 2002. Regardless of their motivations for supporting the policy, the Thai Rak Thai Party deserves credit for its courage. I especially would like to acknowledge Dr. Surapong Seubwonglee. He brought Dr. Sanguan's and the peoples' organizations' proposal to the Thai Rak Thai Party, and encouraged the Party to incorporate it into their policies.

Former Senator Jon Ungphakorn
2005 Magsaysay Award Recipient

Preface

The major objective of the National Health Security Act is to ensure access to quality health care for all. It aims to eliminate all barriers to access, especially economic and geographic ones. The current government adopted this policy, now commonly known as 30 Baht for All Treatment. The words *for all* signify the policy's vast impact on the population. This policy created widespread public discussion and debate on a number of complex issues and questions: Are the 30-Baht Program and the National Health Security Act the same? Will the Program create a long-term economic burden? Is the Program sustainable? Whom should the Program cover? Should the Program provide benefits to all middle and upper income populations, as opposed to exclusively serving the poor? Would it be unfair if the Program serviced higher income groups? Will the Program deter the availability and use of new medical technologies?

This book is an anthology of commentaries I submitted over a four-month period to the weekly news magazine *Matichon*. My primary intent with these pieces was to outline and review the development process of a public policy initiative

which had tremendous impacts on the population. I also wanted to illustrate how such a policy depends on the collective physical and intellectual efforts of all stakeholders.

These writings, of course, were my retrospectives alone, as someone who was intimate with the process from the beginning. I hope their assemblage into this book will provide a vivid depiction of the ups and downs in the process of shaping a major public policy, the sequential impacts along the way, and the role and influences of the various stakeholders who made it all possible.

We've seen many how-to books for business. I feel that it is now time for a how-to book on social policy. While one person may be able to rely on their own capabilities to attain success in business, accomplishments in the social arena require partnerships and collaboration to stimulate action from various parts of society. The universal health insurance policy represents an excellent case study.

I deeply thank the three people who contributed forwards to this book. They embody the three main pillars necessary to address major challenges in society. Prime Minister Thaksin Shinawatra, the government leader, represents the pillar of political power driving national policy. Dr. Prawes Wasi, the highly respected senior citizen, represents a pillar of knowledge and wisdom. Finally, Former Senator Jon Ungphakorn represents the pillar of civil society. The power of these three pillars must be harnessed to work collaboratively in solving difficult problems.

I especially thank all those friends and colleagues who gave me advice and suggestions to improve the writings contained in this book: Dr. Prasert Plitpolkanpim, Dr. Supapol Aimmethawee and Khun Chulaluck Pukert of Matichon Group, who edited the book. I also wish to thank the translation and editing team who helped work on the English version of this book.

Last but not least, I would like to warmly thank my beloved family: Dr. Opiwan, Nong Ploy, and Nong Pheun, who are always there by my side giving me courage and moral support.

I sincerely hope that his book will provide encouragement to all those facing difficulties when engaged in efforts to improve our society.

Dr. Sanguan Nitayarumphong

Chapter 1: Dreams are the Guiding Light

Imagination is more important than knowledge.
Albert Einstein

The world looks so bright when you are 20. Life is fun; you are ready to embrace goodness, and your dreams are just waiting to be realized. I was a young medical student then, and it became my aspiration to ensure everyone on earth had a health care system to rely on should they become ill. This was during a critical period in modern Thai history. From 1971–1973 university students became more socially and politically active. We talked about social injustices, the plight of the poor and the lack of democracy under our military dictatorship.

Coming from an urban middle class family, I knew little about the lives of poor people. So when I took part in student-organized rural development camps, a popular form of activism at the time, it was a very eye-opening experience. I came to realize that poor people were not poor because of

laziness as so many of us were led to believe. On the contrary, they worked extremely hard. They led simple lives, often with barely enough food to survive from one day to the next. I had no idea that when they became sick, seeking medical help required a lengthy trip from the village, sometimes upwards of two days. Worse still, upon arrival they might not be able to afford the treatment.

Books and publications circulating at the time further exposed me to a host of ideas about ways to improve Thai society. The article "From Womb to Tomb" by the late respected scholar Dr. Puey Ungphakorn epitomized the direction many students felt society should take. He stressed the importance of quality of life, reinforcing how much happiness could be achieved by giving everybody access to basic services such as education, health care, and other ingredients to sustain a strong family. Dr. Puey insisted that these needs could easily be fulfilled if society merely placed a greater emphasis on sharing with one another. Providing a good quality of life from our mothers' wombs to our tombs, he argued, would also go a long way toward furthering peace.

Inspiration also came to us through music and poems. John Lennon's "Imagine" caused us to wish for a stronger sense of camaraderie and an end to the killing throughout the world. Don Quixote's "Man of La Mancha" caused us to wish for "The Impossible Dream" or the "Ultimate Dream" as the Thai version was titled. Student activist Vitayakorn Chiangkul penned an inspirational poem with the now famous line, "Let's bring down the stars from the sky and sew them into a mat for the poor." His desire to create a better society in which people share with, and care for, one another was shared by many.

Beginning my adulthood amidst this atmosphere made me eager for the day I would become a professional. I saw myself walking along with like-minded people all working to build a better society–joining my peers in the medical profession in a journey that would someday end with the establishment of a health care system for all.

I started to pursue my dream while still a student. I joined other activists in producing the university's newspaper. When Kukrit Pramoj's government proposed the idea of free medical treatment for the poor, the opportunity surfaced for me to publish articles about health security. I contacted respected scholars Dr. Prasan Tangjai and Dr. Sant Hatirat to write for us. Both were medical professors who regularly published articles on social issues. Their views on achieving universal health care were my first lessons, the first bits of the knowledge I needed to begin to fulfill my dream.

As students social activism reached its height in 1973, an ideological struggle in Thai society emerged. On one side were those frustrated that the majority of people did not benefit from the current socioeconomic/political system and were seeing their quality of life deteriorate. They cited countries with mature capitalist systems, such as the United States, which still had many poor people and a high degree of economic inequality. On the other side were those willing to accept the way things were, fearing that were Thailand to try to get rid of these inequities by embracing a socialist model, people would lose their freedoms to a more authoritarian government akin to what was the Soviet Union at the time.

I too wanted to see a more just society in which people were not left behind, but I also wanted to ensure we preserved people's rights and freedoms. Simply put, I wanted the best of both capitalism and socialism. I learned that in Sweden, Denmark and West Germany, political parties under the banner of "social democracy" were winning elections. These parties took a middle path. They supported economic competition, but worked to avoid the social pitfalls of American-style capitalism. They supported strong welfare programs for the poor including housing, health care, unemployment insurance and support for small enterprises, while at the same time not compromising civil liberties.

I remember a medical researcher who was conducting an opinion survey asking the students which country we most hoped to visit. I assumed his motivation was to better understand, and thus prevent, the increasing problem of brain drain caused by Thai medical doctors moving to other countries. I recall I answered Sweden, mainly because it exemplified the benefits of the social democratic system. I also knew that Sweden had a universal health care system. And while I accepted that Thailand might not be as rich and developed as Sweden, I felt that we should not allow ourselves to lag too far behind. So I asked myself a question, "How can we embrace a common dream to make Thailand's public health services comparable to those of Sweden and other developed countries?"

Chapter 2: Motivation without Money

Economists taught us about utility: personal gain is man's motivation to act. Religion leaders taught us to believe in the spiritual power of good deeds: fostering a kind heart is far more important than monetary or other tangible benefits. Maoists also taught us that we need kind hearts and sharing to create an equitable society, but contrary to religious leaders, Maoists advocated shaping these attitudes through cultural revolution and violent means: changing the existing environment, social habits and beliefs so that the mind serves the people and becomes a common asset.

When I was a medical student, it was an extremely dynamic time for social and political debate. There seemed to be so much I could learn, and I trust others in university at that time felt similarly. It was one of the best times in my life. Were we able to recreate that same learning atmosphere today that students had from 1971–1976, absent the social and political atmosphere that led to violent

clashes amongst those with differing ideologies, we would have substantially more graduates with good hearts eager to serve the public.

Students then were highly conscious of their role in serving society. Motivated by a strong frustration with the repercussions associated with the prevailing development strategies, many students protested against the direction in which the capitalist system was steering the country. They opposed what they saw as a trend toward a selfish, individualistic society in which the rich exploited the poor, and the country lost its social capital of caring, sharing and kindness.

Students wanted a more equitable and caring society. To achieve this, most realized substantial change would be inevitable. However, there was a divergence in approaches toward realizing this change: one emphasizing peace in the spirit of religion, and one embracing the spirit of violent revolution.

Thai society has now learned that violence was not the right path. Even had this approach prevailed and a communist system been established, such states have faded and failed elsewhere, and mainstream capitalism now dominates. Many people believe capitalism's monetary rewards can certainly provide a strong motivation for change, and without such financial stimulus societies may take much longer to develop and to become more livable. However, my student activist lessons taught me that money is not the only driver of development within society. Other non-financial incentives, especially a desire and enthusiasm to work together to improve society, are even more important. This was demonstrated to me once my initial medical training was completed.

As part of our obligation as medical students, we were required by the government to help alleviate the shortage of doctors in rural areas. This was something many of us accepted happily, as it embodied the type of social awareness and practice we were demanding as students. At the time, graduates from nearly every discipline were highly motivated to serve society, especially in rural areas. Even though it was not required of them, many young dentists, pharmacists, nurses and medical technicians joined us doctors in the rural clinics and hospitals.

Following graduation in 1977, I was assigned to fulfill my service at the Rasi Salai District Hospital in the northeastern province of Si sa ket. Many other young graduates were posted to this hospital. Most also came from urban middle class families, but were nonetheless extremely enthusiastic about our opportunity to improve the level of rural health care.

We worked happily together like brothers and sisters, and thought of ourselves as members of the rural families we served. We may have come from different backgrounds, but we were all committed to a strong team spirit. We greatly respected one another, were quick to lend a helping hand, never argued nor competed, and easily forgave mistakes.

When our paths cross now, nearly three decades later, we routinely comment on how the spirit of cooperation during those years made them the best of our professional lives. We experienced firsthand the value of helping to improve the lives of others, and the happiness and joy this brought to us all. We learned that this was something money could not buy, and was indeed of a higher value and fostered a stronger driving force for us and for society.

The strength of our health team was also a result of the mix of new graduates from various medical disciplines and our enthusiasm for solving social problems. This was the case for rural hospitals all over the country at the time, such as those in the districts of: Pratire, Sung–nern and Dan Khuntot in Nakhon Rachasima Province; Sichol in Nakorn Si Thammaraj; Hod in Chiang Mai; Prakonechai in Buri Ram; Dan Sai in Loei; and Kranuan in Khon Kaen.

Members of these health teams did not only encourage one another to develop their district hospitals, but they also inspired visiting students and medical technicians to do the same. As a result, this period marked a crucial step in the development of Thailand's public health system, all thanks to the dedication of the young health professionals involved.

Their incentive was not money. They were happy just working hard as a team to achieve a common goal to improve rural society. They had a desire to make a contribution they could be proud of, one which would also give them the joy of accomplishment. They hoped that society, especially the younger generation that would follow in their footsteps, would recognize their efforts.

Unfortunately, this favorable learning atmosphere did not persist. While the social awakening amongst the students from 1971–1976 was rewarding, both personally and for rural health practitioners as a whole, the momentum could not be maintained and continues to decline to this day.

Chapter 3: Young People and Infinite Inspirations

Inspiration comes from various sources. Some people are inspired by what they see, others by what they hear or read. It's inspiration that turns an ordinary man into a millionaire or a student into a professor.

Social activism peaked between 1971 and 1976. Thereafter, students continued to develop strong social consciousness, but they no longer engaged in political organizing. Their social interests remained most pronounced in their outreach to rural projects, especially following natural disasters.

I too maintained my commitment to rural health by working at a small district hospital. My colleagues and I would often receive visiting students, some studying medicine, some not. Their main desire was to gain experience and inspiration from senior physicians, so we shared with them our ideas and knowledge. In return, their warmth and enthusiasm routinely inspired us, and re-ignited our own fire.

I remember well one occasion when four groups of

students converged on our hospital simultaneously. There were about 50 medical and nursing students. They outnumbered our patients as our small hospital had only 40 beds. One evening they asked me to lead a discussion. I was highly impressed–if not slightly taken aback–by the topic they proposed: "The meaning of life." I doubt many young people today would care to tackle such tough philosophical questions. But such ambition and soul-searching was typical of students at that time, who were often exploring how they could best benefit the lives of other people.

Though relatively small, our hospital was quite well staffed, including pharmacists, dentists and lab technicians. We could provide comprehensive medical services including blood analysis and other complicated laboratory services comparable to larger provincial hospitals. Our treatment was well respected, thus highly sought by people both within and outside the district. Our patients' trust provided us an immense source of encouragement and caused us to work that much harder.

Incidents arose, however, that gave us second thoughts about our level of effectiveness. There were certainly many problems we could not address because they were beyond the area of public health. There were other problems, though, like our need to better comprehend the decision-making process employed by people in the villages, that sometimes pointed to further avenues for improvement.

One incident I will never forget involved a woman who turned her back on our hospital to seek treatment elsewhere for her sick child because she was unsure if she could afford the hospital fees. I encountered her on my way back to the hospital from town. Through a heavy downpour I saw a woman holding a child waiting for public transportation. I picked them up and she told me her child was ill. It appeared to me that her child might have pneumonia as it was panting. I told her the van we were in was a hospital vehicle and we were heading there next. I assured her that her child would receive excellent treatment.

But to my astonishment, when we arrived at the hospital and she disembarked from the van, she turned around and walked away. I asked her why she did not enter the hospital and allow her child to receive treatment. She replied that she had only Bt30. She planned to take the child to a nearby clinic where a local health practitioner would charge her only Bt20 for an injection. This would still allow her enough money for her return trip home.

I explained to her that her child was too seriously ill to be cured with only one injection. I told her that it was our hospital's policy to provide free care to those who could not afford to pay. After my assurances that she would not be burdened

financially, she finally concented to have her child treated at our hospital.

Such experiences raised our awareness that even if we provided excellent treatment, respected people's treatment choices, and were flexible with our fees, particularly for poorer patients, we still might be unable to administer to some people's need to the level we would like.

So we began to realize that in order to increase access to our services we should consider factors beyond geographical limitations, including: economics, cultural beliefs, as well as a lack of knowledge about the potential severity of an illness and its proper treatment. Even if a hospital is nearby, if the care is unaffordable, people will seek care elsewhere regardless of its quality. Similarly, if hospital care is both physically and financially accessible, people may still seek care from ungualified providers because they have an established trust in those providers. Some prospective patients also might have greater confidence in alternative services, such as those from a shaman or a practitioner of traditional medicine. Therefore, we should not simply be proud that our hospital is popular among the patients it serves, but work to improve our ability to reach all those who could actually benefit from our services.

My experience with that mother and child forced me to realize that people could unnecessarily lose their lives to treatable illnesses. Pneumonia can generally be managed with Western medicine, and hospitals are the appropriate destination for treatment. It saddened me to think about how many people, like that child, could be facing death from what is a simple and curable malady, but unlike the child, do not receive the treatment they need.

Conversely, common afflictions like a cold or diarrhea should be treated by community clinics, traditional medicine and local chemists, thus not burdening hospital service. Only by better understanding the real social and economic factors within the local context in which we operate, can we do a better job delivering services. Merely successfully treating those patients who find their way to the hospital is insufficient. Moreover, we cannot sufficiently meet public health needs solely from what we learned at the university. We must go beyond medical sciences, and take a more holistic approach. As the case of the sick child illustrated, diagnosing and treating the patient was not the problem, it was helping the patient's family overcome financial barriers to obtain the treatment that allowed the patient to recover.

Having experienced these impediments to available medical care, our hospital team became even more inspired to pursue all opportunities to improve our capacity to deliver health services.

Chapter 4: The World is Larger than What We See

Ancient wisdom tells us that if we have not seen a sea, we will not know how narrow the river is. We must break away from our regular routines and surroundings to realize that our own rivers are truly narrow.

It took me some time before I fully grasped the truth within this teaching. As a young doctor in the early 1980s I was fully content working with my new colleagues. We had grown into a family which I had no desire to leave.

There was a growing trend at the time for doctors to study abroad. I could not comprehend how such an experience would substantially expand my knowledge. I reasoned that such overseas medical training would largely revolve around making better use of drugs and medical technology that Thailand had little money to import. I also assumed that exposure to other countries' public health practices would address environments, cultures and lifestyles

far different from our own, and thus be of little practical use in my work here. As a result, in 1982 when I was offered a fellowship at the international program within the Public Health Department at the Institute of Tropical Medicine in Antwerp, Belgium, I declined. Two year later, however, I conceded to the trend, accepted their offer, and thus began to witness for myself how this world was much larger than the one I had known.

The organizer of my program, Professor Van Balen and Professor Mercencier, had ambitious expectations: to "change the world." The well-designed program had a specific emphasis on strategies to refocus the job of primary care physicians to treat patients, not just their illnesses. They taught us a holistic approach involving assessing the physical, mental and familial factors affecting a patient's well-being. The program also reinforced that such an approach requires that primary care providers establish strong links with higher-level providers through an efficient referral system.

There were already examples of such practices throughout much of the developing world, including Latin America, Africa and parts of Europe. These case studies provided tools and techniques applicable to improving health services in other poor countries. My Thai colleague in the program, Dr. Ravinan Sirikanokwilai, and I were truly inspired and anxious to improve Thailand's public health system when we returned home.

In 1989 we jointly developed what was called the Ayuddhaya Project. We collaborated with our professor and two other freinds, Dr.Wim Van Delberg and Dr. Pierre Daveloose from Belgium, whose change-the-world ambition fit well with our dream of improving Thailand's health care system. They were especially keen to participate because their program did not yet have an Asian case study. Our experiences with this initiative ultimately laid the foundation for the 30 Baht for All Treatment universal health care program that is now the Thai government's flagship public health policy.

The Ayuddhaya Project followed in the footsteps of a small pilot project to improve the public health system in the Khun Han District of Si Sa Ket Province in the Northeast. Three years later we established a larger pilot project at the provincial level in Ayuddhaya. In 1996, the Ayuddhaya Project began to be transformed into something even more ambitious. Incorporating lessons from the Ayuddhaya Project's two pilot projects, two other public health initiatives, and health care reform projects in other countries, the Health Care Reform Project was created, spanning a number of provinces across the country.

The Ayuddhaya Project had three principle components:

1. Financing reform

Money is often a major obstacle to people's access to health care. While over the years various administrations have provided some form of free care to the poor, in practice many truly poor people have had no access to these services. Additionally, middle-income patients who can afford basic care often have difficulty shouldering the financial burdens associated with more serious illness.

We chose to change this system by implementing a flat rate payment-per-visit fee structure. While each visitor would have to pay something, it would be a one-time charge regardless of the ultimate level of treatment required. For example, an appendicitis patient who came to the community health center with severe stomach pain would be referred to a hospital for definite diagnosis and treatment. He or she would receive an operation if necessary, and hospitalization until they were ready to be discharged. For such an episode the patient would pay one affordable flat rate.

It was our hypothesis that this system would reduce people's hesitance to seek early hospital treatment. This would benefit both the patient and the hospital. Serious illnesses were more likely to be caught early, reducing patient suffering and avoiding the higher hospitalization costs associated with delayed treatment. Beyond the tangible benefits of access, confidence and affordability, the flat rate system also reinforced the principle of sharing. When everyone pays the same rate regardless of the illness and its severity, the mildly ill patients share the burden of the more seriously ill patients.

The rate under the Ayuddhaya Project was Bt70 per visit. Project staff derived the rate through discussion with the community, with the objective of ensuring the Project's financial sustainability. Ultimately though, health facilities that charged the Bt70 flat rate did require some additional government subsidies to balance their budgets.

2. Service delivery reform

Local health centers registered each person residing in the areas served by the pilot project. These centers served as families' primary care providers. In addition to treating ill patients when they arrived at these facilities, health practitioners took a proactive approach and undertook home visits to assess physical and mental health. It was the project's aim to address all stages of an illness: prevention, treatment and rehabilitation. Strong administrative and professional links were also

established between the local health centers and larger hospitals to facilitate referrals, and reinforce patient confidence in the efficiency of a single, comprehensive system.

3. Community–provider relationship reform

In our conventional health care system, patients interacted with doctors or nurses only when they reached an examining room, so they did not feel their health centers belonged to them. Even efforts by practitioners to go out and meet patients in their communities failed to provide patients a sense of ownership in their local health facility. Communities cared little about their facility's financial or administrative problems, especially if they lacked confidence in the quality of services delivered.

But get the community involved in decisions effecting their local health facility, and they will develop confidence in it, and a commitment to its long-term sustainability. In the case of the Ayuddhaya Project, the community consultation to obtain consensus on the Bt70 flat rate fee was well received. Two years later, when ongoing evaluations revealed that the fee should be raised to Bt100 per visit, communities again agreed. They had been involved in the evaluations and recognized that the facilities required additional revenue. This action validated the communities' strong support for quality services and raised their sense of ownership of it. This in turn encouraged providers to develop their services further to better meet the needs of the community.

These core components of the Ayuddhaya Project have now been widely disseminated to other areas in the country. As a result, our experience and knowledge have grown accordingly. This stands in stark contrast to my narrow thinking of ten years earlier, when I was comfortable that what I was doing then was right and that there was little more to be learned from others. I recognized that this limited view was an obstacle to learning, and had I not overcome it, an obstacle that would have prevented me from achieving my goal of developing universal health care for all.

Chapter 5:
A True Friend is a Gift for Life

Society today is so open. And aided by technology, we can meet many more people than our predecessors. But how many of these are true friends, the ones who will stay with us in good times and bad?

Following my field work, some five years after my return from Belgium, my colleagues and I went our separate ways. I returned to Bangkok to start a family. Others fanned out to various provinces and did the same. Alongside our new domestic commitments, our social consciousness and eagerness to reduce people's hardship continued to burn inside, fueled by that tremendous experience we shared working together in rural communities.

Although we became stationed in different provinces, we regularly sought opportunities to meet and share experiences, often led by Dr. Prawes Wasi, a well-known social thinker who

served as our mentor and the nexus for our network.

We continued to share a common goal to improve society's access to health care. Our approaches to achieve this, however, became more varied. This was not surprising given that we then had greater diversity in our professional experiences and working environments, coupled with differing perspectives on the relative importance of career advancement, professional reputation and social acceptance. These divides would sometimes drive us apart, but not so much that we failed to realize the benefits of what we could learn from one another.

As a young doctor, I became more familiar with group dynamics and various strategies to harmonize and moderate competing ideas and personalities. Misunderstandings and opposing viewpoints within our group never escalated to serious conflicts because each of us was honest and had a common aim to work for the public interest. We continuously reinforced in each other a shared commitment to remain sincere, forthring and responsible in our efforts to serve the public interest. The group process itself also promoted greater mutual understanding and strengthened our own intellectual and creativity capacities.

I later came to realize that despite this experience, my group management skills were still raw, and in need of refinement and polishing. This opportunity came when I helped to establish the "Sampran Forum" in 1986. Many of my friends, colleagues and advisors within the public health sphere were interested in organizing a working group to resolve an escalating debate that was affecting us all.

Growing disagreement had emerged on how best to quantify Basic Minimum Needs (BMN), a common exercise when addressing rural development problems. Historically, the BMN was derived through a survey process initiated by central agencies in Bangkok, then undertaken by provincial administrations with input from the public. A variety of data was collected. Everything from water quality to medical needs to economic infrastructure was assessed to help the central agencies determine priorities.

To many people this remained a viable approach. Others, however, wanted to see the process driven much more by local people. Detractors felt the survey process differed little from traditional top-down government planning, which they felt mistakenly ignored the value of allowing communities to think for themselves. They also challenged the methodology of imposing just one survey format, likening it to offering free t-shirts in just one size where not everyone will want one. Better to teach people how to assess their own needs, and to develop strategies to meet these

needs, than to continue advocating the one-size-fits-all policy, the opponents argued.

The Sampran Forum was conceived as a platform to discuss this issue with the intent to establish agreed upon protocols for measuring BMN. While trying to establish the Forum's format, we sought advice from our longtime mentor, Dr. Prawes. He observed that it might be difficult for the group to resolve this difference, and that structured attempts to do so might only stimulate additional conflicts, especially given the level of ego among the participants.

If a forum was to be established, he suggested that it serve as a mechanism to share experiences and lessons on a range of issues, and allow each participant to contribute to and take from it what they could, without trying to force consensus on any issue. He advised each participant to apply the approach they believed to be best, and to cease debating which might be right or wrong.

Once the Forum's concept was transformed from that of an intellectual boxing ring to a platform for learning, its monthly meetings got under way. Presentations were given on a wide range of topics, all of which provided practical lessons we could use in our individual work. There were ongoing topics as well as those addressing new and emerging issues. When discussions revealed an issue was of particular importance, members were often assigned to follow up and report their progress at a future meeting.

The Forum became a continuous means to improve our intellectual capabilities. A prime example of this occurred in 1990 when the Social Security Act was announced by Prime Minister Chatchai Choonhavan. This new law's principle component was medical services for private sector workers. Since the law was to be enforced nationwide and would have a major impact on the health service system, the Forum immediately took action to initiate extensive research on the policy.

Coincidentally, Dr. Viroj Tangcharoensathien, a Ph.D. student from the Health Economics Program at the London School of Hygiene and Tropical Medicine, had already been researching this issue. He had just returned to Thailand as the Forum took up the topic. He and I made presentations analyzing the new law's potential impacts. I was then head of the planning division at the Public Health Ministry. We reviewed experiences from other countries that had implemented similar schemes. We concluded that the social Security Act would have extensive repercussions if designed inappropriately. It was feared that it could evolve into a two-tiered system for Thailand with higher quality medical care available to those who could afford to pay and poorer quality care available to

those who could not pay, and eventually cause the fund's collapse, as had occurred in several Latin American countries.

I was therefore encouraged by the Forum to work closely with the Department of Labor, then under the Interior Ministry, which was to be responsible for the new Social Security Office. Our principle objective was to ensure that the program was designed appropriately and had a solid path to achieve effective implementation. That turned out to be the most significant turning point in my life. It afforded me a tremendous opportunity to move closer to realizing my dream of creating health security for everyone in the country, even if at the time I was not fully confident as to how I could actually achieve it.

My ongoing lessons from the Sampran Forum, together with the encouragement of Dr. Prawes and my friends, contributed to me developing a much broader understanding of various health insurance models. I eventually became fully involved in each of the country's health insurance-related projects.

My relationship with the Forum was as if I had met true friends, or "Kalayanamitr," with a common goal to help society. It was a wonderful gift, enabling my knowledge to grow, but most importantly, giving me the opportunity that would eventually lead to fulfilling my dream of universal health care for all.

Chapter 6: Just Steer, No Need to Row

Our actions are the products of our thinking. Positive results are often grounded in good thinking and analysis. Conversely, negative results often have their roots in incomplete information, bias and haste. Rightly or wrongly, our thinking has the power to affect our lives, property, businesses and society. Thailand has many examples, particularly the 1997 economic crisis. If we have learned our lesson, we will have corrected what was wrong by first understanding the problems-by thinking better-then by doing better.

Working within the public sector tended to bias my views. I was confident that the government was better positioned to meet social needs than was private enterprise. I believed that the public sector's role was to serve the society, while the private sector's role was profit-making for the self-interested. This view did not begin to change until 1990 when I helped to develop the foundation for the health insurance component of the newly established Social Security Office.

My motivation for assisting with the program came from two directions. First, my colleagues and I agreed that this initiative was so important that we should try to involve ourselves from beginning to end. Second, my late professor, Dr. Nikom Chandraravitoon, who had finally succeeded in his 30-year effort to establish a social security system for workers, was a major inspiration. So when I was formally asked to lead the implementation of the health services component for the Social Security Act, the choice was easy.

I began by coordinating efforts within the Interior Ministry, which was responsible for implementing the Act. At that time, the Ministry did not yet have a medical doctor to administer the health program for the Social Security Office. Because of my ongoing position as Director of the Department of Health Planning at the Public Health Ministry, I was warmly received by key officials involved with implementing the Social Security Act, especially Deputy Director of the Department of Labor Amporn Junnanon and Dr. Amphon Singhakowin who became the first Secretary General of the Social Security Office. Their enthusiasm made my job much easier. Furthermore, while it was my original intention when accepting the invitation to do my utmost to help them make this new program succeed, which I certainly did, I learned so much that I often felt it was they who were helping me. I later went on to apply much of what I learned to the development of other public health insurance programs.

When the Interior Ministry first announced the Social Security Act, the Interior Minister informed the public that he planned to construct and administer new hospitals to serve the patients receiving this new insurance. The Interior Ministry was following an established pattern to build its own hospitals, as many other ministries–such as Defense, Finance and Agriculture–had done for their staffs.

Although the Interior Ministry maintained one of the largest public sector payrolls, with staff spread throughout the country, their employees had to use other ministries' hospitals. Now that the Social Security Office was to be established inside the Interior Ministry for the purposes of providing private sector workers with government-administered health insurance, the Interior Ministry felt delighted that he could finally build the Interior Minister its own hospitals.

Planning to erect new hospitals was also a natural reflex to an age-old government practices of building infrastructure whenever a major policy was passed. There always had to be new building to house the new employees to carry out the new policy. While this might have been acceptable when the government was small and state agencies were

relatively independent, many argued that such practices needed a fresh look.

The public health system, for example, had changed significantly. The existence of the Public Health Ministry itself was testament to that. No longer was public health just an administrative office within the Interior Ministry, but a separate ministry altogether, with its own expanded network of health facilities to serve the needs of the whole population, including medical schools and hospitals. Simultaneously, and in conjunction with the strong economy, there had been extensive growth within the private health care sector. It was therefore argued that the Interior Ministry should not focus on establishing new hospitals, but should instead develop mechanisms within the broad network of existing infrastructure to deliver services for people covered by the new Social Security Act.

Indeed, the old approach to public administration that allowed individual ministries to take on wide-ranging responsibilities had created a system that was now clumsy and inefficient. The government had become bloated, squandered valuable tax revenues, and still fell short of meeting the public's needs. This culture also made the public sector extremely rigid and incapable of adjusting to changing environments or new social problems.

The new trend emerging within public administration circles was for agencies to reduce their size by delegating work to other agencies and to the private sector. The idea was that agencies should shift their role from trying to do everything, to focusing on guiding policies and establishing stakeholder networks to carry out these policies. If Thailand is a boat, the public sector should steer, and leave the rowing to the people, non-governmental organizations and the private sector. This would allow public services to be delivered more efficiently and with fewer resources. Additionally, by including stakeholders in the development policies of the country, the private sector and peoples' organizations would grow stronger, further benefiting society.

As a result of this debate, the Interior Minister faced an uphill battle with his hospital proposal. The Medical Committee* appointed by the Social Security Office opposed the plan, as did I, consultants with the International Labor Organization, various professional medical associations, public hospital administrators and public medical schools. This opposition eventually forced the Interior Ministry to abandon his plan to

* The Medical Committee included: Chairman Dr. Pirote Ningsanon, Former Permanant Secretary of the public Health Ministry; Deputy Airfield Marshal Kitti Yensudjai, Director of the Air Force's Medical Department; Dr. Wichai Chokewiwat, Secretary Generral of the Medical Council; Dr.Surapong Amphanwong from Private Hospitals Association; Dr. Aroon Paosawad, Dean of the Medical Faculty Siriraj Hospital; and Professor Dr.Rungtham Ladplee and myself as members.

construct new hospitals. Instead, the Social Security Office was directed to recruit and support a network of existing hospitals and other heath facilities to deliver health services to Social Security clients. The office's role was to create incentives for hospitals to participate, and to develop and monitor service standards to ensure patients received quality care from all facilities under contract with the Social Security Office.

The Social Security Office saved a substantial amount of money and time by not building hospitals. Its potential administrative requirements were also greatly reduced by avoiding costly and complex hospital management responsibilities. The advantages of steering as opposed to rowing were illustrated clearly during and after the 1997 economic crisis. Although some of the contracting hospitals went bankrupt, social security medical services were not interrupted as new contracts were signed with other hospitals. There is no question that had the Interior Ministry tried to steer and row the boat with new hospitals, the social security program would have collapsed. Instead, the system continued to flourish, accumulating a budget surplus of nearly 100 billion baht.

So while much of the country was suffering from bad decision making, here was an excellent example of the value of getting one's thinking in order before launching into one's work.

Chapter 7: Imagination Plus Wisdom Yields Reality

An intelligent mind passes through three stages. The first is attentive listening to one's teachers. The second is careful thinking and deep reasoning. The last is meditation practice until our mind is clear and fully understood.

Buddhadasa Bhikku

I gained tremendous experience taking part in the development of the medical benefits component of our social security program. I learned to develop a sustainable financing mechanism for a major health care program employing capitation–the use of fixed prepayments per patient covered by contracted health care facilities. I learned how to establish and maintain a national network of hospitals and private clinics. And I learned the importance of gaining patient confidence by providing hospital choices, while employing budgeting techniques to ensure patients received quality care including costly treatments such as heart surgery and neurosurgery.

Two colleagues whose guidance was particularly helpful at that time were Dr. Viroj Tangcharoensathien and Dr. Supasit Pannarunotai, who both received their Ph.D.s in health economics from the London School of Economics. In addition to our collective work with the new social security program, we were all engaged in efforts to improve existing health insurance policies. Dr. Viroj was examining methods to reform the long-established health benefits program for government employees, the Civil Servant Medical Benefits Scheme whose annual budget was Bt15 billion. Dr. Supasit's interest was reforming the Health Card Scheme, a system in use by ten million people involving the purchase of a card for Bt500 entitling them to full medical coverage for one year. I was working to improve the Health Welfare for the Low Income Program, which had grown to serve 24 million people-nearly half the country's population.

We built strong connections with academics and researchers whose interests were public health security. Within the faculty of economics at Thammasat and Chulalongkorn Universities we worked with Dr. Sirilaksana Korman, Dr. Dao Mongkolsamai, Dr. Pleonpit Satsanguan, Dr. Tienchai Kiranan and Dr. Somkid Kaewsonthi. From the Thailand Development Research Institute Dr. Mattana Pananiramai was very active, as were a number of academics at the National Economic and Social Development Board (NESDB). We convened a number of meetings, the most important of which was in 1993, which marked the start of the national health insurance movement in Thailand.

The meeting took place in the resort town of Hua Hin in Petchaburi Province. The focus was Thailand's public health financing. The forum was coordinated by Dr. Buranat Samutarak, who taught at Chulalongkorn University's Faculty of Medicine at the time, and later became a secretary to Prime Minister Chuan Leekpai. The meeting was widely attended. A number of international experts participated, most notably, Dr. William Chiao from Harvard University who was invited by the NESDB in collaboration with the World Bank. He aided in our national health financing analysis. The meeting concluded with a blueprint for reshaping health care financing into a universal health insurance program.

For my colleagues Dr. Viroj and Dr. Supasit and me, this blueprint set us to work modifying and aligning each of our programs so they too could be seemlessly incorporated into a single national health security policy. And for Dr. Buranat the success of the conference led him to later become one of the key drafters of the National Health Security Act, which is in use today.

Our strategy for health insurance reform did not evolve from meetings and discussions alone. As

described in Chapter 4, we had begun a project in Ayuddhaya Province that provided practical experience for shaping a new national policy. The objective was to upgrade the quality of, and increase community access to, local health care facilities. We began in 1991 with the Wat Indra community under the direction of Dr. Yongyuth Pongsuparp. In 1994 we expanded to the Pom Petch community under Dr. Seksan Chavanadilert. By 2000 the project encompassed all districts in Ayuddhaya for which Dr. Taweekiat Boonya-pisarncharoen served as the chief provincial doctor.

The principle component of the experiment was to test a new financing mechanism. With the consent of community members, we established a single Bt70 fee per visit regardless of the severity of the illness or length of stay necessary for recovery. We wanted to determine if a Bt70 payment (in conjunction with a continuation of existing government subsidies) would be sufficient to provide complete care. The project was smoothly implemented, warmly received and showed favorable results. In 1995, with support from the European Union, it was expanded to six more provinces.

In 2002, when the National Health Security Act was implemented, the accumulated experience and skills attained from these pilot programs allowed the community health programs in these provinces to rapidly adapt to the new system. The only major difference under the new law was that the patient fee was reduced to Bt30 per visit, which correspondingly required an increase in government payments to some hospitals.

In developing our program, we also benefited from the experiences of other countries with universal health coverage. For example, in advance of implementing their program, Taiwan sent a large number of medical personnel to the United States for training. So we too began sending more doctors abroad. With the help of Professer Anne Mills, at least 20 students enrolled in graduate studies in health economics at the London School of Hygiene and Tropical Medicine. Another 40 students attended the Institute of Tropical Medicine in Antwerp, Belgium with the assistance of Professr Van Balen and Professor Mercencier.

We learned how Colombia utilized assistance from Harvard University in analyzing various approaches to organizing its national health security program. We also carried out several macro-level analyses examining various financing options, some in collaboration with the Health System Research Institute of Thailand and the Asian Development Bank. All of this was put to use by an academic team under the leadership of renowned economist Dr. Ammar Siamwalla, with coordination from noted public health expert Dr. Supakorn Buasai, in

preparation of the initial draft of a national health security program and associated impletation plan for Thailand.

In the Philippines, we saw how peoples' movements played a major role in securing their national health security program. We were therefore appreciative of the campaigning assistance we received from public health activists mobilizing support for national health security, especially Jon Ungphakorn, who went on to became a senator.

When the Hua Hin meeting concluded, we were very pleased that we had finally laid out a plan for universal health coverage. But those pages would have been useless absent these other assets, especially the on-the-ground experiences in Thailand and abroad. Collectively, these ingredients helped establish a cohesion between planners and researchers that eight years later resulted in the completion of Thailand's National Health Security Act.

Chapter 8: Strive with Patience

I was fortunate to have an opportunity to learn from several prominent people who exemplified what it meant to devote one's life in the quest to solve social problems. Dr. Nikom Chandraravitoon's 30-year campaign led to Thailand's Social Security Act, and Dr. Hatai Chitanon and Dr. Prakit Vateesatokit spent 20 years reversing the rate of smoking among Thai people. Their determination to bite firmly into an issue has been a major source of inspiration for many still grappling with Thailand's social problems.

While there was seldom a shortage of support for the concept of universal health care in Thailand, most people felt the program was a luxury only rich countries could afford. To openly advocate such a policy in Thailand was seen by one's peers as publicly embracing fantasy for the purposes of self-promotion, in other words a stubborn, egotistical act. This atmosphere of pessimism has undermined many worthwhile initiatives. Typically, those social innovators who have persevered have endured painful experiences and lonely journeys battling opposition from all sides.

There was full agreement amongst groups that participated in the 1993 Hua Hin meeting that the blueprint for universal health care developed there should be put into practice. To achieve this we accepted that major changes had to be made to existing health security programs. Such reforms would have to be embraced by policy makers, and the Hua Hin blueprint should serve as their guide.

In 1991 Dr. Amorn Nontasut, Permanent Secretary of the Public Health Ministry, created the Health Security Office, which was responsible for implementation of the Health Card Scheme and the Health Welfare Scheme. He invited me to be its director. I was reluctant given my commitment to my work with our project to reform health care. I eventually agreed, however, anticipating that the new position would afford me greater leverage and latitude to improve the overall system.

The Social Security Office, then in its fifth year, was moving health care policy in the right direction, but it was time that the Health Card Scheme and the Civil Servant Medical Benefits Scheme to follow suit. The introduction of the Health Card Scheme in 1983 represented a bold step for the Public Health Ministry. The Ministry hoped it would play a major role in fulfilling their objective of *Health Care for All by 2000*. Under the project, an individual or a family could purchase a health insurance card for Bt500 and receive full coverage for one year. The Public Health Ministry contributed Bt500 per card sold to subsidize the system. Although bureaucratic difficulties hindered the program's ability to meet its year 2000 objective, Dr. Amorn and his subordinates Dr. Niwat Thepmanee and Dr. Rujira Suriyawanakul continued to channel their energies into the Health Card Scheme until it evolved into an important component of the emerging national health security program.

My experience with the Social Security Act taught me that for an initiative to be sustainable it must be backed by legislation. Universal health security would have to become the law. My opportunity to pursue this strategy surfaced in 1993 when I was invited to serve as an advisor to the Committee on Public Health in the House of Representatives. Right away I began advocating for a national health security law. The committee was enthusiastic and established a task force to draft the law. MP Somsak Khun-nguen from the now-defunct Sereetham Party served as chairman, and he was joined by MPs Nipa Pringsulka and Komkai Polabutr from the Democrat Party, and Vitoon Karuna from the Chat Thai Party. Representatives also came from the Public Health Ministry, Labor Ministry, Social Welfare Office, and Bureau of National Legal Affairs Office. In 1995 after more than ten meetings, we had a draft bill for the nation's first universal health care law. This bill would eventually form the basis of the law we have today, but not without a struggle.

We circulated the draft bill for comments, followed by a series of public hearings. Opponents came forward with the then familiar analysis: the law is an excellent idea, just not for Thailand because we lack the resources to finance it. This chorus included many of my colleagues, who up until this point were quite supportive, but now with a bill on the table, were backing down, saying Thailand was not ready and encouraging further field work and study.

But some colleagues with extensive public health management experience like Dr. Damrong Boonyuen and Dr. Suwit Wibulpolprasert were firmly on my side. They saw no reason for delay, feeling confident that sufficient experience had already been attained through the pilot projects. To them, the enactment of the law was just another logical and necessary step in the effort to establish universal health care for all.

Unfortunately, a reshuffling of senior management within the Public Health Ministry dried up what was once strong support for the law. This, combined with a sufficient level of opposition from the academic community, stalled the bill. Initially, all of us involved in the bill's drafting were extremely disappointed, but after reflecting on the years and even decades it took for other valuable initiatives to be embraced by society, we resolved to press on. The frustration I experienced then caused me to understand more deeply the Buddhist teaching of *ubekkha*. This was first introduced to me by the venerable monk P. A. Payutto during my time as a monk. I could now see why this teaching was a component of the four principles for successful endeavor, and was the most difficult to practice. Most people, the revered monk said, interpret it simply as non-attachment, the principle of allowing our desires to pass through our minds without embracing them. *Ubekkha* goes further, to allow our ego (our self) to remain detached from events, but to maintain our effort toward achieving our task. We should not become attached to feelings of encouragement or discouragement, what other people may think or say, just put our egos aside and allow the mind to focus on the work that needs doing.

So following our defeat, we reviewed what we had learned. Wisdom told us to be patient and to accept that more work lay ahead. Should new obstacles emerge, we would recall the principle of *ubekkha*, not feel burdened by them, and continue on our journey to realize universal health care for all.

Chapter 9: No Cronyism, No Favoritism, Just Work for the People

Valuable advancements in Thai society often are stymied by petty political rivalries, nepotism, or fear of losing face. Public servants routinely allow their own ambitions to trump the public interest. Worthy initiatives launched by one administration are often cast aside by the next because those who start projects typically receive more attention than those who complete them. Bureaucrats can be so focused on not offending those who got them their jobs, and trying to extend similar favors to their own friends, that very little creative space exists for serious policy making. I often wonder how much more developed Thailand would be if all government officials put the people first.

After we failed to win that first round of debate on the universal health care bill, I had my own debate about what went wrong. Was it true that Thailand lacked the capacity to manage a universal health

care program? Was the bill's drafting process confined to such a select group of stakeholders that it was incapable of gaining the public's trust? Similarly, was the public review process focused too much on technocrats, academics and politicians at the expense of the voices of those who would actually benefit? Had underprivileged groups such as the disabled or HIV sufferers been involved, could that have tipped the balance? Lastly, did we fail to present sufficient information and analysis to demonstrate the program's capacity to succeed?

The answer to all these questions might have been yes, but in my quest to develop a new strategy for reviving interest in universal health care, I decided to ask a more basic question: How had other social activists succeeded? I had to look no further than the political reform efforts led by Dr. Prawes Wasi, who spawned a social movement leading to the adoption of a new constitution 1992.

His strategy differed from ours. Instead of working with a small group to pass a bill into law, he took advantage of growing public frustration with the devolution of the political process and employed that as his catalyst for reform. He first led a research team to develop a draft constitution based on an exhaustive review of constitutions from other countries. He then took this document directly to the public with a series of public hearings. These efforts heightened people's enthusiasm for reform, which spawned a social movement culminating in the adoption of a new constitution.

I decided to adopt a similar approach. I would compile additional information from other countries to strengthen our comparative analysis supporting Thailand's capabilities to implement a universal health care program. I would then share these findings with peoples' organizations across the country. We looked at lessons and experiences from Canada, Germany, Japan, the Netherlands, the Philippines, Singapore, South Korea, Sweden, Taiwan, the United Kingdom and the United States. We prepared an updated economic analysis to further demonstrate the project's financial viability. We organized public forums, study tours and international conferences to obtain input and build public support. We had extensive discussions with civic groups to ensure their views on health security were addressed by the bill. We promoted the theme of *No cronyism, no favoritism, just work for the people*, to reinforce that this bill was about people helping people, not politicians helping themselves at the people's expense.

We approached NGOs such as AIDS Access Foundation, the Thai Volunteers Service Foundation, the Consumer Protection Foundation, as well as the Democrat, Chat Thai, Sereetham and New Aspiration political parties. Once founded,

we also worked with the Thai Rak Thai Party.

Many NGO leaders and academics became active in promoting the bill. Jon Ungphakorn from AIDS Access Foundation assisted me in working with NGOs involved with HIV/AIDS. Dej Pumkacha from the NGO Coordinating Committee introduced us to their broad network of NGOs working with children, women and residents of urban slums. The late Dr. Thiranart Kanchana-aksorn of Chulalongkorn University's political economy group organized an important seminar allowing us to strengthen support from academics.

Several politicians were also critical in spreading the word about the merits of the bill. Chat Thai Party's Prayuth Siripanich invited me to present the bill to his party members. Deputy Finance Minister Chaturon Chaisaeng was encouraged to see that if implemented properly, universal health care could actually save the country money, a welcome opportunity as Thailand was in the throes of a major economic crisis.

This new approach paid off. In 2002 the government adopted the National Health Security Act. Looking back on this success, two things stood out. First, the people's sector provided the driving force. Under the leadership of Jon Ungphakorn, the NGO Coordinating Committee and its network of more than 100 organizations were determined to put the national health security bill under the nation's spotlight. Spearheaded by Saree Ongsomwang, Rakawin Leechanawanichphan and Yuppadee Sirisinsuk, a campaign was launched to organize public participation in the legislative process. More than 50,000 signatures were gathered in support of the bill. This achievement meant the bill could be submitted to Parliament as a People's Bill, requiring debate and a vote. This was only the second time in Thai history the public had placed a People's Bill before Parliament. The first was the Community Forest Bill.

Second, we built unanimous support within Parliament. When the bill was discussed by the House of Representatives, six other versions were offered by the political parties and other stakeholders. But the MPs from both the government and opposition parties worked closely to iron out the differences. Opposition MPs Abhisit Vejjajiva, Dr. Buranat Samutarak and Dr. Uthai Sudsuk assisted Public Health Minister Dr. Surapong Seubwonglee to complete the final bill, which was passed unanimously. While the language in the law included a number of amendments to the bill drafted one year earlier, the bill's principle components remained unchanged.

Thailand now has universal health care for all because there was universal involvement from the public to demand it. I sometimes wonder if I should

be thankful that we did not win that first debate on the bill back in 1995, because had we prevailed, I may not have learned how effective and valuable it is to develop and implement a truly *public* policy. If Thai politics could better embrace the collective spirit of that process, of putting the needs of the people first, there is no telling how many more of the country's problems we might solve.

Chapter 10: Obstacles Point to Victory

With a pure mind, my strength doubles.

I mentioned earlier that I was fortunate that my medical education occurred during a period of heightened student activism. The importance of a strong social consciousness was ever-present in our discussions, and a frequent theme of commentaries, books and music. But stray too far off-campus and the real world could shatter a student's altruism. A home-stay visit with rural farmers to better understand their problems could become an inquisition about a student's political agenda. Such encounters could instill a sense of hopelessness among young activists. To counteract discouragement, a number of sayings extracted from songs and poems became popular: "Even amidst humiliations and suffering, people stand firm in the face of challenge," or "The candle must melt for the light to shine. What will we leave behind when our life is gone?" These helped to remind

us to be patient and accept that achieving our dreams would not come without adversity.

Perseverance was a common theme in discussions with my mentors. Former Public Health Minister, Dr. Sem Prinkpuongkaew, whom we often referred to as Father Sem, told me once, "Obstacles point to victory," overcoming them gives us strength and brings us that much closer to our goal. Dr. Prawes Wasi would continuously remind me that, "Big endeavors are bound to confront strong opposition. Success does not come without obstacles."

My advocacy for universal health care certainly proved to me the wisdom of these words. Many people involved with public health programs were extremely resistant to the idea of universal health care. Their reticence, however, stemmed not from any reasoned criticism of the actual proposal, but to change generally. They knew some of the their programs might undergo significant reforms, and were uncomfortable with any change regardless of its merits. This proved to be a major hurdle.

My challenge became somewhat less daunting following passage of the 1990 Social Security Act. This policy demonstrated that the public health community could successfully accommodate major changes. Health care providers learned to become comfortable with the capitation-type payment system where hospitals received annual payments for each insured person in their service area, regardless of whether these people ever sought treatment from the hospital. This differed significantly from all other public insurance programs operating at the time, where budgets allocated to public hospitals could be somewhat arbitrary and heavily influenced by politics. Opposition to the new billing approach subsided as familiarity with it increased.

But this positive lesson was not enough to dampen protests to the reforms sought through the National Health Security Act. Unlike the Social Security Act, which created an entirely new administration serving previously uninsured clients, the National Health Security Act would bring about reform of existing programs, and thus was far more imposing on established political and bureaucratic territory. The programs included: the Health Card Scheme, which Dr. Supasit Pannarunotai was attempting to improve; the Civil Service Medical Benefit Scheme (CSMBS), for which Dr. Viroj Tangcharoensathien had been developing reform recommendations; and the Health Welfare Scheme, in which I had become involved.

Of the three, the Health Welfare Scheme was the largest. First established in 1975 by then Prime Minister Kukrit Pramoj as the Health Welfare for the Low Income Program, it was expanded in 1992 by Prime Minister Chuan Leekpai to serve children

under the age of 15, the elderly, and the disabled. The annual budget swelled to Bt7 billion, serving 24 million people. Although the Health Welfare Scheme served the greatest number of people, its per capita expenditures were dwarfed by those of the other program. The Health Welfare Scheme provided only Bt290 per person per year. The Health Card Scheme provided Bt500, but each insured family paid a Bt500 annual fee, so the total was Bt1,000. The new Social Security Office also provided about Bt1,000 per person per year, and the CSMBS was considerably higher, providing upwards of Bt2,000 per person per year.

Such marked differences in the per capita spending between the Health Welfare Scheme and other insurance programs began to create a two-tiered system of coverage, where quality of care was affected by a program's resource availability. Many of those involved in the Health Welfare Scheme were young, elderly or disabled. These populations required more medical services than people served by the other public programs, who tended to be able-bodied adults active in the workforce requiring far less medical treatment. Additionally, although eligible for publicly supported health care, many people on the rolls of the other government programs would seek treatment from private physicians. As a result, these programs had far more money to spend on the relatively lower percentage of patients who actually used them, than the Health Welfare Scheme did.

The Health Welfare Scheme's Bt7 billion annual budget was clearly insufficient. To make matters worse, influential politicians caused disproportionately large percentages of the budget to be directed to their own constituencies, leaving even less for those in the remainder of the country. Such corrupt behavior deeply frustrated many public sector workers, but they could not intervene for fear of losing their jobs.

The experiences gained with the capitation financing structure employed by the Social Security Office provided a model for removing politicians from the Health Welfare Scheme's budget allocation process. The money would directly follow the people. A province with one million people, and Bt300 per person designated as the amount of government support for coverage, ensured that Bt300 million would be distributed directly to a province's participating health facilities. Such a straightforward and transparent allocation process greatly improves budgeting efficiency, while also restoring equity and good governance.

I worked aggressively to convince the government's Central Budget Bureau (CBB) to broaden this method of budgeting beyond the new Social Security Office to include the Health Welfare Scheme. Thanks to positive support from CBB Deputy Director Pornchai Nutsuwan, the CBB agreed to make the change. To ensure efficiency and further guard against corruption, we also

sought new regulations within the Finance Ministry specifically for this revised allocation approach.

Unfortunately, when news about our effort to establish these new regulations reached more influential bureaucrats and politicians, I was summoned to a meeting by the Secretary of the Public Health Minister. He made it clear that I should abandon my campaign, or otherwise be prepared to lose my job. Later another high-ranking officer within the Public Health Ministry similarly instructed me not to interfere.

I chose not to yield to the pressure. Although discouraged about the need to battle with my superiors, I firmly believed that what I was doing was right, and stood my ground. Thailand was recovering from the 1997 economic crisis at the time, therefore I expected that the Thai people would be receptive to my efforts to improve the efficiency of health care financing. It astonished me that even during such tumultuous economic times various influential people fought to preserve their ability to extract a disproportionate share of the health care budget for their own benefits. This resistance only encouraged me to push harder for the new regulations. I was prepared to resign once the regulations were approved, as my desire to work amidst those fighting so strongly against me had diminished greatly, but this did not prove necessary.

The new regulations were adopted in 2001. They mandated that the Public Health Ministry's budget committee include several people from outside the Ministry to ensure the Health Welfare Scheme's budget was allocated according to the new capitative framework. I recruited a number of people whose reputation for honesty and transparency was well received by the committee. They were very experienced working with those populations covered by the Health Welfare Scheme: Dr. Banlu Siripanich worked with the elderly and was also a children's rights advocate; Wallop Tangkananurak worked with underprivileged children; and Sommai Parichatr was the President of the Thailand Press Association.

Even with these more stringent procedures in place, attempts to manipulate the process persisted. An unsubstantiated request of Bt1.4 billion emerged from the cabinet to, "assist the increasing number of low-income people resulting from the economic crisis." Senior politicians felt confident that this supplemental budget could be authorized through other channels employing less scrutiny. Fortunately, some Public Health Ministry officials could no longer tolerate such blatant corruption during a major economic crisis and campaigned against the supplemental budget. In the process, they exposed a major scandal involving drug procurements within the Public Health Ministry. The issue captured headlines for nearly a year. Some in the Ministry

misunderstood me to be the person responsible for leading the anti-corruption campaign that ultimately uncovered the scandal. They spread rumors, produced leaflets, and made false accusations to the media in an effort to discredit and destroy my career. I eventually was left with no other choice but to sue one of the newspapers. The case was settled after the newspaper printed an apology.

I was not interested in receiving undeserved credit for exposing the scandal, but was proud of my contribution to weed out corruption generally from our health insurance programs. This proved to be a very painful experience especially since the accusations and misunderstandings in the media caused me to lose the trust of some friends and colleagues whom I greatly respected.

I knew I could endure the struggle, however, because I recognized I was merely putting into practice the lessons Father Sem and Dr. Prawes had reinforced earlier to stand firmly and fight all obstacles, because otherwise there can be no victory.

Chapter 11: The Triangle that Moves a Mountain

The greatest satisfaction in life is achieve a goal that benafits others. Goals that only benefit oneself yield rewards that disappear rapidly.

Dr. Prawes Wasi is one of Thailand's most widely respected social reformers. His successes in mobilizing civil society to reduce political corruption by passing a new constitution and to catalyze new approaches to public health management have significantly advanced Thailand's development. He points to what he calls *the triangle that moves a mountain* as the key to overcoming obstacles to achieve meaningful reform. The triangle is formed by three elements all working together to create a powerful wedge to move society: thorough knowledge of the problem to be solved; enthusiastic people to form a social movement to draw attention to the problem; and political support within the legislative arena to resolve the problem.

Unfortunately, it is a rare occurrence in Thailand when all three elements are available, thus impeding action on a wide range of important issues. For example, it is widely known that traffic accidents are the second leading cause of death in Thailand. The public is also well aware of potential mechanisms and policies which could be adopted to dramatically improve traffic safety. However, neither the public nor politicians have been motivated to tackle the problem. Sometimes when politicians have acted to address a social problem, such as poverty reduction, these programs have been ineffective because they were developed without an attempt to understand the complexities of the problem or to engage those affected–in this case poor people–in formulating the corrective measures. Many other examples exist where knowledge was strong and public involvement was high, but reform was practically unthinkable because of a lack of political support, as occurred during the beginning of the 1997 political reform efforts. Only when all three elements are mobilized to complement one another, can a formidable force result in making changes to improve society.

While working to establish what became Thailand's 30 Baht for All Treatment universal health care program, we built a triangle to move the opposition's mountain. The knowledge element was established through research both domestically and internationally, along with the experience gained in our pilot projects across many provinces including Ayuddhaya, Nakhon Rachasima, Payao and Songkhla. The viability of our proposal was no longer in doubt. The public mobilization element was achieved by involving groups across many sectors, and culminating with the gathering of 50,000 signatures, as required by the constitution, to compel Parliament to act on the proposed law. But when we began working to firmly establish the third and final element, political support, we realized that yet another ingredient would be necessary, responsible leadership.

We recognized that a strong political leader may champion reform, yet reject sound analysis as to how it should be achieved. They could instead advance solutions based on their personal feelings and motivations, resulting in political actions that fail to solve the problem. Furthermore, enacting worthy policies on paper absent a strong leader to ensure their implementation will also greatly limit reform. Prime Minister Thaksin Shinawatra demonstrated the importance of this additional dimension, most notably through his support for health care reform.

Leading up to the January 2001 general election, myself in partnership with a number of academics from different institutions pitched our health care reform proposal to several political parties, particularly those which had already pledged that

universal health care for all was among their party's priorities. I had the opportunity to meet Dr. Thaksin Shinawatra, the leader of Thai Rak Thai Party, in 2000. Dr. Surapong Seubwonglee, who was helping to craft the Party's health policy, introduced me. I was asked to propose a health policy which I thought would not only be of interest to Thai Rak Thai, but other political parties as well. I proposed two policies. The first, advanced by academics, was a revenue-generation scheme to finance public health programs through what we called a *sin tax*- taxes on cigarettes, alcohol, and possibly state-sponsored lotteries. The second was the implementation of our universal health care for all proposal. Dr. Thaksin expressed strong interest in the latter. Ever since his years as a criminology graduate student in the United States during the late 1970s, he had a desire to see the level of health care in Thailand raised to what he observed while completing his Ph.D. in Texas. As a medical professor, Dr. Surapong Seubwonglee was equally intrigued, especially since he had been following health care reform initiatives in the United Kingdom.

Having previously presented our proposal to several other political parties, it was particularly gratifying to have the opportunity to present detailed information to a political party that was so seriously inclined to support it. I did not anticipate that this party would win the upcoming election and eventually form a one-party government. I later recalled how lucky I was that during that meeting with Dr. Thaksin, I also had a chance to meet Dr. Somkid Jatusripitak and Dr. Pansak Winyarat, two key party members. Dr. Somkid went on to become the Finance Minister of the new government. Their victory and support allowed the universal health insurance program to materialize overnight.

I felt fortunate that establishing universal health insurance was Dr. Thaksin's primary interest, yet I also knew that to achieve this, drastic changes in the public health arena would be necessary and might not come easily. Nonetheless, I was confident putting forward my views on how the policy should be implemented because the Thai Rak Thai Party had campaigned on the theme *think new, act new.*

1. New health care financing

Our research revealed that implementing universal health coverage could largely be achieved through our existing resources. At the time, total health care spending in Thailand was approximately Bt250 billion annually, 65 to 70 percent came from patients' own pockets, and approximately 30 to 35 percent from the government. These expenditures were growing at a rate of approximately 8 percent a year, outpacing that of the economy as a whole. The findings of a working group headed by leading economist Dr. Ammar Siamwalla, in conjunction with the Asian

Development Bank, were that the government would need to budget about Bt100 billion to finance universal health care. At the time, this exceeded by Bt30 billion what the government was spending on related programs that would be replaced by the new system. To eliminate the shortfall, we proposed that a collective financing mechanism be developed to replace the individual out-of-pocket payment systems then in use. Such a tax could easily generate an adequate level of revenue for financing the universal health care for all policy.

2. New budget allocations

Today we recognize that health care service can be more efficient when they focus on people instead of hospitals. Historically, however, the allocation of public health budgets focused primarily on hospitals and related health care facilities. These decisions were strongly influenced by political and economic forces, concentrating spending in urban areas, even though there were many highly populated towns in rural areas with more substantial public health needs. For example, the remote Nongbualumpoo Province had one doctor responsible for more than 25,000 people, while the ratio in Bangkok was in the neighborhood of one doctor per 1,000 people. The number of hospitals serving similar-sized populations varied dramatically as well. Si Sa Ket Province's poverty-stricken district of Kantararak had only one 90-bed hospital to serve 200,000 people. Pang-nga and Singha Buri provinces each served some 200,000 people as well, but instead of only having one hospital like Kantararak, Pang-nga and Singha Buri provinces each had six hospital. In addition, one of the hospitals in Pang-nga and one of the hospitals in Singha Buri had more than 100 beds. Maintaining the allocation method that created this inequity would never provide adequate health care in many areas. An *act new* budget allocation would be necessary, based primarily on the size of the population served.

3. New health care delivery models

Health care at the time could best be characterized as delivering *repairing services*, or curative care, to ill patients. There was little interest in *health building*, or preventative care, to reduce the potential for illness. Private medical clinics had a vested economic interest in sick patients, as their financial returns were far higher for delivering curative care than for teaching prevention. Public donations, a common form of supplemental revenue for health care facilities, were primarily solicited for building new hospitals or adding patient rooms, not for research, disease prevention education, physical exercise training or vaccine development. A new concept of health services needed to be introduced, where both the public

and physicians were interested in illness prevention, not merely treatment once illness occurred. This shift needed to occur throughout the public health sector, including providing financial incentives for private clinics that promoted good health, and redirecting private donations to preventative health programs.

These three *think new, act new* examples represented only the beginning of the changes necessary to successfully implement universal health care for all. For example, medical professionals would have to become more flexible; instead of forcing patients to conform to their routines and office hours, they needed to create an atmosphere of convenience and easy access. Likewise, hospitals accustomed to working on their own would have to integrate into a larger network of health facilities. We were not just implementing a new system, but completely transforming the culture and practice of the existing system to make it more accessible, affordable and equitable while still delivering quality service.

Were it not for the leadership of the Thai Rak Thai Party, these changes may still have been a long way off. Their commitment to universal health care, and ambition to instill an attitude within the government of openness to new approaches, are what ultimately enabled what is now known as the 30–Baht Program to be delivered to the Thai people.

Chapter 12: The 30-Baht Message

Think like a wise man, but communicate in the language of the people.

William Butler Yeats

I have always had a passion for literature and languages, but never fully appreciated the importance of language in mobilizing popular support. During my years advocating for health care reform I observed many social thinkers who, on the contrary, were masters of communication. They routinely coined new terms to capture people's attention, and simplified complicated concepts with new expressions that quickly gained acceptance.

Some phrases evolved into powerful slogans that contributed to major changes in society. Dr. Prawes Wasi's *triangle that moves a mountain* was one such maxim. It became known universally as the framework for overcoming obstacles to achieve difficult reforms. He could have simply said *three factors* in reference to his practice of unifying knowledge of an issue, public organizing and political support, but *triangle that moves a mountain* was far more engaging.

Similarly, Dr. Chai-anant Smudavanija's term *loganuwatra* as a translation for globalization and Thirayuth Boonmi's use of *dhammarat* to imply good governance, stimulated widespread discussion on concepts which were relatively new to Thai society. Employing words that placed these terms in a Thai context as opposed to relying on literal translations was key to accelerating their use. They have since evolved into the terms *logapiwatra* and *dhammapiban*, and have become standard Thai vocabulary.

Examples also emerged in the public health lexicon. In 1977, the World Health Organization introduced the campaign slogan, *Health Care for All by 2000*, inspiring countries worldwide to improve access to health care. Development agencies, including the World Bank, Japanese International Cooperation Agency and the Canadian International Development Agency incorporated this slogan when outlining their own objectives for providing technical and financial assistance to public health programs. Despite criticism that the goal was unrealistic, its presence nonetheless contributed to advances in health services in both developed and developing countries.

In Thailand this campaign inspired the Public Health Ministry to embark on a number of initiatives to expand access to primary health care. New district and community hospitals sprang up across the country as did other health facilities. A program for recruiting and training a network of health volunteers at the village level was also implemented. Mechanisms were devised to improve coordination among the Education Ministry, Interior Ministry, Agriculture Ministry and Public Health Ministry (the four principle ministries responsible for rural development) to provide basic minimum needs for all people. The clarity of the challenge *Health Care for All by 2000* rallied health care professionals in a manner not previously witnessed it Thailand, a testament to the power of the right words at the right time.

This phenomenon was again observable during the development of the universal health care policy. Stakeholders had many discussions in an attempt to develop an effective message that could communicate the benefits of this policy to the pubic. We discovered that the phrase *universal health care* did not resonate well with lay people, creating confusion as to the purpose of the policy. Then Dr. Surapong Seubwonglee, who helped to write the health care policy for the Thai Rak Thai Party, simplified the concept with the phrase, *30 Baht for All Treatment*. Deployed during the 2000-2001 election campaign, this slogan clearly conveyed what people could expect from a national health insurance policy: visit a hospital, pay Bt30, and all other fees would be financed by the government; no one would be left out.

The 30-Baht slogan was not without controversy. Some people considered it to be nothing more than an election pledge that would never be honored. Others chose to offer competing reform proposals. But it was undeniable that the slogan stimulated public discussion on the desire for a universal health care system, and that major reforms would be forthcoming, marking an important milestone in Thailand's public health history.

Following the Thai Rak Thai Party's election victory, the Public Health Ministry was immediately charged with implementing the 30-Baht Program. This effort was led by Public Health Minister Sudarat Keyurapan and Deputy Minister Dr. Surapong Seubwonglee in cooperation with Permanent Secretary Dr. Mongkol Na Songkhla, and Deputy Permanent Secretary Dr. Suwit Wibulpolprasert. We began in April 2001 in six provinces, expanded to 15 provinces two months later, and within one year had reached all 76 provinces.

Health facilities throughout the country had to make many adjustments and improvements. New mechanisms for public-private partnerships were established across the health care sector. More than 1,000 community health centers were established providing people much greater access to health practitioners and preventation care.

I had never envisioned the 30-Baht Program's implementation occurring over such a short period of time, feeling a three-year time frame would be more appropriate. Indeed, such rapid and extensive changes inevitably generated criticism. Upon reflection, however, the fast-track approach was probably vital to the Program's survival. As the renowned social critic, Nithi Eoseewongse, stated in one of his writings on the policy, "if we don't do it fast, we may not have a chance to do it at all."

From the beginning, it sometimes seemed like we were in a race to get the policy in place before the opposition's mounting momentum could stop the new program in its tracks. The political leverage from the election victory which enabled the swift transition from a policy on paper to care in the hospital carried with it latent resistance from the election campaign. Many still saw the policy as unfounded, arguing that it remained nothing more than a populist scheme to secure votes. Concerns grew that the Program would become a major budget burden. Fears also arose that the government would steer resources away from other popular insurance programs like the Social Security Scheme or the Civil Servants Medical Benefits Scheme. Additionally, the Program's publicity and low cost immediately drew more people to seek medical treatment, which resulted in higher workloads for health care providers. The stress amidst this shorthanded work environment was

exacerbated by the need to fulfill the patients' expectations built up during the election campaign. As a result, in just a short period of time, the 30-Baht Program became the most controversial public health reform program in Thailand's history.

While not completely analogous, I remember thinking at the time of the failed efforts of United States President Bill Clinton to deliver on his 1992 campaign pledge to provide universal health care. Once in office, widespread resistance from the pharmaceutical industry, health insurance companies and professional medical associations never allowed his initiative to get beyond a draft proposal. Although our program had moved into the implementation phase, I still feared it might ultimately suffer a similar fate.

Ironically, however, university surveys showed that despite these concerns, the public ranked the 30-Baht Program among their favorite government policies. The findings also revealed a tremendous level of patient satisfaction with the services received. This was the feedback that kept us going during the Program's infancy, after which we sought solutions to some financial and human resource concerns so that the 30-Baht Program could eventually become widely accepted.

Chapter 13: Positive Thinking: the Power of Life

A winner always sees a stone before him as a ladder.

There was a period in 1997 when I was responsible for international affairs for the Public Health Ministry. I frequently traveled to World Health Organization meetings, especially to their headquarters in Geneva and their regional office in New Delhi. During most visits to India I shopped for English-language books because the selection was extensive and the price inexpensive relative to Thailand or the other countries I visited. On one occasion I noticed Norman Vincent Peale's book *The Power of Positive Thinking*. The book's jacket revealed how an optimistic outlook is often all that one needs to overcome many of life's difficulties. For those problems where a strong attitude alone is insufficient, he advises us to look forward to the skills and experiences gained in weathering these more turbulent of life's storms, and to the heightened confidence we will have to face even tougher challenges in the future.

Thailand's rebound from the 1997 economic crisis was a case in point. Had the public remained pessimistic, focusing solely on blaming and complaining, the nation's recovery would have been far more rocky. On the contrary, the country's desire to constructively address the crisis enabled the resolution of a litany of lingering problems within Thai society which otherwise might remain with us today.

My struggle to implement universal health care followed a similar path. Each obstacle I encountered offered a lesson in ways to adjust my strategy and attitude to better promote universal health care for all. The vital step we took to embark on a broad-based consultation process with peoples' organizations and political parties evolved only after a period of considerable frustration in failing to build public support. Had we recognized earlier the importance of working with this broad spectrum of society, many conflicts and obstacles to the Program's adoption could have been avoided. Of course, had we not maintained a healthy outlook in the face of our many setbacks, we would have been consumed by them, and the 30-Baht Program would never have seen the light of day.

Persisting with this single-mindedness also proved critical once the 30-Baht Program was implemented as a flagship policy of the newly elected Thai Rak Thai government. While pleased that the Program would be rolled out quickly, we knew this would also create many headaches. Easing these growing pains was difficult enough, but as their existence helped to fuel post-election opposition to the policy, our burden was much heavier. By reinforcing the benefits to the country that would be achieved once this new system was in place, and not being drawn back into debates about the Program's merits, especially amongst detractors within the Public Health Ministry, we maintained just enough momentum to avoid the Program's collapse during those early years of implementation.

We continued to emphasize that we would be greatly increasing the efficiency of our health care system, while also bringing down costs. Health care spending had been growing at a rate of approximately 8 percent annually with no real improvements in services or access. After absorbing some start-up costs, once the 30-Baht Program was firmly in place, public health budgets would grow more modestly at just 2-3 percent per year. More importantly, Thailand would have universal health coverage, and for a price that was much lower than in other countries. Thailand would be investing just 4.4 percent of its Gross National Product (GNP) on health care, whereas other countries with universal health care-such as the United Kingdom, Canada and South Korea-were spending in the neighborhood of 8 percent of GNP

on health care. Interestingly, the United States, which now invests nearly 14 percent of its GNP in health care, still leaves nearly one in six Americans uninsured.

We encouraged our opponents to look positively on the health care reforms then taking place to South Korea. Like Thailand, South Korea had suffered a significant economic downturn as a result of the region's 1997 financial troubles. Also like Thailand, South Korea was instituting a host of new public policy reforms, including a national health insurance program. Operationally, their task was far more daunting, attempting to integrate nearly 200 separate programs into just one national policy. They too faced considerable opposition, especially from labor unions and professional medical associations. But by 2001, the new policy was in place and they were on track to ensuring that all members of their population had access to health care.

At the same time we discouraged people from giving too much attention to the abbreviated universal health care campaign of newly elected President Bill Clinton in the United States. We stressed that his effort failed because, unlike in Thailand, the Clinton administration had not worked slowly to demonstrate how such a program might work, nor did his staff work to build support amongst key stakeholder groups, particularly physicians and the pharmaceutical industry.

During the implementation of the 30-Baht Program, I was mindful of those interests that challenged the Korean and US schemes. I was prepared for opposition from private hospitals, labor unions, multinational drug companies and medical associations. I did not discount their arguments as unwelcome noise or groundless criticism, but looked at how we could translate their concerns into constructive priorities to aid in the Program's implementation. It was our objective to satisfy the concerns of all stakeholders as best we could.

Many urban hospitals, for example, were rightly quite nervous. Their budgets had swelled under the more politically driven public health budgeting process. They were not keen to now have their budgets determined by a strict formula based on the size of the populations they served. This shift from a hospital-centered to people-centered allocation program would be particularly beneficial to small hospitals in the North and Northeast, where large populations had been served with few resources. Their windfall would come at the expense of hospitals in urban areas, provoking strong protests from staff members. We responded to this with special transitional funds to ease these bloated hospitals into the new budgeting process. We also designated a number of urban hospitals as *centers of excellence* for particular medical specialties, such as cancer and heart centers, and allocated additional funding accordingly to ensure

Thailand remained current on technological advances in all disciplines.

We more easily calmed the concerns of labor unions and others about how the 30-Baht Program would impact the existing public insurance schemes. People had become quite comfortable with the new Social Security Scheme, as well as the Civil Servants Medical Benefits Scheme which had been in place for several decades. Once it was clear that we would not be transitioning away from these programs, as occurred in Korea, these constituencies became less vocal.

The general misconception that the Program was merely a low quality service for the poor, swiftly put in place to win political favor for the newly elected Thai Rak Thai administration, was a bit more difficult to overcome. This created a significant morale problem among physicians, which was aggravated by their general confusion surrounding the new administrative procedures and treatment guidelines. In some cases this indeed led to poor-quality treatment for patients.

There was also little we could do for the foreign drug companies. The fact was, locally produced generic drugs were much cheaper, and with tighter budgets, hospitals could no longer afford such unnecessary luxuries.

The aggregate stress of attending to these matters, on top of the pressure to quickly get the Program under way, tended to foster an atmosphere of chaos. It often took all of our energy just to respond to the crisis of the day. This apparent turmoil at the management level, combined with confusion surrounding the new procedures and guidelines to be followed by each facility, added to the discontent among health care practitioners. All this became a focus for the media, further magnifying the negative image of our new program. For example, extensive criticism came from middle class urbanites, who had not actually used the system, assuming that since it was put in place to serve the poor, the service itself would be substandard. Their low utilization was in turn seen as a demonstrated failure of the 30-Baht Program.

We carried on undeterred. Tremendous encouragement was found, as discussed in the previous chapter, in the opinion polls conducted by several different institutions. All consistently affirmed the satisfaction of those patients who actually used the 30-Baht Program. We pointed out how unrealistic it was to assume that a program of this scale, implemented so rapidly, could be absorbed without encountering problems. These difficulties were acute and transitional, we pointed out, and would abate with time. We stressed our welcoming of criticism from medical professionals, and how their courage to challenge a government policy

would only help us to solve these initial problems more quickly, putting the system on a faster track to universal acceptance. We noted that the resistance from labor groups was a healthy sign of civil society trying to ensure protection of valued welfare schemes already in place. This attitude helped us to establish effective communications with the unions, and to convince them that their fears were unfounded.

We knew that it would take a positive view to yield positive change. Crises were viewed as opportunities to find solutions to problems, the resolutions of which would only make the 30-Baht Program stronger. This attitude was not only necessary, but it created a spirit of happiness amidst chaos, clearly revealing to me the *power* Norman Vincent Peale featured in those 250 pages now available in some 40 languages.

Chapter 14: The Three Mountains: Challenges to Sustaining the 30-Baht Program

The purest and highest achievements are those works which bring happiness to their creator and their fellow man.

Venerable P. A. Payutto

It was our application of Dr. Wasi's social change theory *the triangle that moves a mountain* which allowed the 30-Baht Program to evolve from paper to government practice. However, we quickly learned that until such a program is firmly established and the desired change achieved, the three elements of this triangle must be managed continuously: further knowledge about how to improve delivery of services must be constantly cultivated; popular support for the program must be maintained; and confidence in the political decision-making apparatus must not be allowed

to wane. To achieve this we identified three internal mountains we needed to overcome to permanently secure the 30-Baht Program to the foundation of our public health system.

1. Assuring quality care

The most important gauge the public will use to assess the value of universal health care is the standard of service they receive. A lack of quality treatment would eventually cause people to turn their backs on the system and lead to the 30-Baht Program's collapse. While opinion polls during the Program's first two years reported increasingly favorable ratings as it improved and evolved, we still were not yet at the level of service we had envisioned. For society to develop full confidence in the scheme, we emphasized greater advances in both the personal and the technical quality of service. We wanted to eliminate criticism that the scheme was just a second-class health care service. Hospital staff were reminded to be courteous and attentive, and higher standards were sought for timely and accurate diagnosis, and efficient and effective treatment.

2. Job satisfaction for health care providers

The universal health care system would not have survived without quality personnel. We had to sustain worker confidence, while at the same time asking them to sacrifice and commit to this new scheme despite operational difficulties and public criticism. The new system had created tremendous skepticism and confusion among health care providers about job security and their ongoing access to contemporary medical technologies. It was our job to demonstrate to them our commitment to meeting the needs of health care personnel, and our recognition that they were the driving force that would make or break the 30-Baht Program.

3. Effective management

The public wants to see quality service, but without an excessive tax burden. They want a system which is transparent, accountable and incorporates public participation. They want to see problems addressed swiftly amidst an atmosphere of ongoing improvements. They do not want to see poor budgeting procedures forcing systemwide cutbacks, or the inefficient allocation of resources amongst facilities leading to localized problems. They want the equitable and efficient system that was promised if they are to have the confidence to preserve it.

We knew that our ability to overcome the issues the three mountains represented directly affected the sustainability of the 30-Baht Program. Failing

to address any one of the three could have led to the Program's termination. Indeed, during our first two years, we struggled with each one, routinely fending off problems in an effort to build confidence amongst all stakeholders. There were doubts about the quality from the public, discontent among health care professionals due to increased workloads, and insufficient budgets for some hospitals. Nonetheless, our *triangle to move a mountain* remained intact. We sustained support from civic groups, preserved a strong commitment from politicians to keep the Program going, and strengthened our knowledge base to tackle problems and improve the overall management apparatus.

Had we been more passive, and not continued pursuing the same strategy during implementation that won us passage of the policy two years earlier, the Program would have collapsed. Despite their support for universal health care, physicians and nurses would have lost their patience and left. Service quality would have plummeted, and the public would have lost all confidence. We have yet to summit the three mountains, but through our experience and dedication, we have climbed ever higher, and the 30-Baht Program is becoming stronger as a result.

Chapter 15: We are the Society and the Society is Us

I now understand that my welfare is only possible if I acknowledge my unity with all the people of the world without exception.

Leo Tolstoy

Noble Peace Prize recipient Lec Walesa, who led the fall of communism in Poland, rallied behind the term solidarity. It was the moniker for his trade union, and later his political party, which saw him become Poland's first democraticallyelected president. Originating from the French word *solidarité*, it has been employed worldwide by peoples' movements to promote equity, justice and compassion amongst one another. This concept is not new. In many Eastern cultures, such attitudes have for a long time been the glue holding communities together. And in the West these sentiments have helped to evolve social welfare programs. Unfortunately, with global trends increasingly supporting individualism, the principle

of working together to improve our collective welfare has become more difficult to advance.

The availability of universal health care exemplifies a healthy stage in a society's development. The whole notion is based on the principle of taking care of each other through risk pooling and benefit sharing. The collective effort functions because those with the ability to contribute more resources to support the services do, and those who may not be able to contribute at all are still entitled to receive care. Despite all the evidence supporting the potential for, and benefits of, health care for all, it is surprising to see how many countries resist efforts to take care of their own citizens.

Most developed countries, including Germany, the United Kingdom and Japan, established a universal health care policy decades ago. As their economies evolved, countries like Taiwan, South Korea and Chile followed suit. Even Columbia, with its political and drug-related turmoil and a lower GNP per capita than Thailand, now has universal health care for all. With Thailand's long-standing culture of sharing, as set forth in the Buddhist tradition, it would seem that implementing universal health care could be achieved with little difficulty. This was not to be. It was a challenge solely to get people to accept that, no, Thailand was not too poor, and indeed could afford to provide health care for everyone.

We looked at the two prevalent methods for financing the system. The first involved direct contribution to a specific health insurance fund based on people's ability to pay, and where the poor could be exempt. Germany, Japan, Taiwan and Columbia employ this strategy. The second was more indirect, where health care programs are financed from a country's general tax revenues. As tax rates are generally progressive, here too, the system would primarily be financed by those with upper and middle incomes, yet all would receive care. The United Kingdom and Canada employ this mechanism to finance their universal health insurance programs.

Regardless of the financing technique chosen, this commitment to greater unity and equity benefits everyone: the poor have access; the middle class obtains treatment that will not bankrupt their families; and the rich appreciate that the program helps to reverse the exponential rise in health care costs. However, financing must be sufficient to maintain service quality, or else the middle and upper income users will stop supporting it. This in turn will force budget cuts to service providers, causing them to lose confidence and abandon the system.

While reviewing these financing options, several issues kept resurfacing relating to the form Thailand's universal health insurance program should take.

1. Should the new system exclusively serve the poor?

It was argued by some people that those in middle and upper income groups did not require universal health care because they could afford medical treatment on their own. Others added that the wealthy would emerge better off if they were allowed to receive care, because their relative contribution to the program would still be much less when compared to the percentage lower-income groups would have to contribute from their annual earnings.

If the wealthy were not active in the system, some people feared the quality of care could not rise above a second-class service standard, especially as the poor lack a sufficient political voice on their own to ensure they receive an appropriate caliber of care. This scenario would eventually affect middle and upper income patients, once they found themselves burdened with an unaffordable catastrophic illness causing them to turn to the universal program for treatment. At that point, they certainly would want quality care, so why not pay into and use the program regularly, so that everyone can benefit from it every day.

2. Decreased competition among health care providers would compromise Thailand's access to advances in medical science.

I certainly understood the merits of this argument. When looking at the capitation payment scheme for hospitals, it is clear that it encourages managers to more efficiently meet patient needs and government standards, but may not necessarily provide hospitals sufficient revenue for upgrading equipment or training physician in new procedures. However, it is also arguable that Thailand already maintained a large gap when it came to access to high quality medical treatment, especially between urban and rural areas. As noted earlier, the number of doctors per capita in Bangkok was 25 times greater than in some provinces. Eight of the nation's 17 heart centers were in Bangkok, indicative of the technological imbalance the capitation system was designed to remedy. The problem was not the absence of state-of-the-art treatment, but how to maintain it while improving its distribution. When recognizing that urban and rural areas are part of the same society served by the system, this concern loses validity. Urban hospitals will not benefit by leaving rural hospitals with substandard equipment and overworked staffs, as more patients will migrate to the cities, crowding urban facilities and affecting their services.

3. Other countries have had problems.

While universal health care has been under way in the United Kingdom, Japan and Canada for some time, it has not been without controversy. There has been growing dissatisfaction, and even calls to abandon their universal health care systems. Why would Thailand want to follow a similar path?

Opponents were pointing to the skyrocketing impacts on national budgets that were frustrating taxpayers in the United Kingdom and Canada relative to the quality of treatment they felt they were entitled to receive. Proponents argued that many in the United States were calling for universal health care because so many poor people lacked access to health care of any form, particularly within African American communities. The infant mortality rates among African Americans was twice that of the white population. The reemergence of such inequities was certainly one reason why no political parties in either the United Kingdom or Canada advocated abandoning their systems. Therefore, the relevant issue for Thailand was whether we wanted to have a health care system reliant on an individual's ability to pay, as in the United States, or a more equitable and compassionate system, as in Europe and Asia.

These debates created a significant level of confusion within Thai society about what universal health care was and was not. Not surprisingly, these differing perceptions were generally influenced by one's level of knowledge of health care, and by which of the many disparate sources of information one learned about the proposal from. Had we been able to ensure everyone had access to the same knowledge and information, disputes would have been resolved more easily, as most people were in agreement on the main goal of improving access to health care for all.

Too often we look at a problem as only affecting other people. We do not see it as our own. This impedes our ability to employ a holistic approach to find a solution. If we accept that we are all connected to, and therefore responsible for, all problems in our society, we–in solidarity–can more easily solve them. This perspective was vital to Thailand's decision to embark on the universal health care journey, and this perspective must be sustained if we are to ensure the long-term viability of the 30-Baht Program it produced.

Chapter 16: No Greater Benefit than the People's

Take your benefit second, your fellow man's benefit first.

HRH Prince Mahidol, Father of HM the King

Thai medical school graduates are well acquainted with the famous quotation above by the late HRH Prince Mahidol, himself a medical doctor and recognized as one of the founders of modern medicine in Thailand. Dr. Sud Saengwichian, Dr. Uay Ketusingh and Dr. Aree Walayasevi are among the nation's top medical professionals putting these words into practice. If all medical professionals followed their example, medical care in Thailand would have advanced significantly, already benefiting the vast majority of the population.

When implementation of the 30-Baht Program began, there were many confused and divergent opinions about how this should occur, not only among medical and health professionals, but

society as a whole. The wide spectrum of views was comprised of an amalgamation of insular opinions reflecting people's backgrounds and working environments. There was little interest in considering issues beyond one's own needs before cementing a stance on the Program. The resulting friction would have been trivial had people been more flexible, sympathetic and compassionate. However, when one's priority is the defense of one's own interests, win-win solutions are nearly impossible to achieve. Selfishness, therefore, became a significant threat to the success of the 30-Baht Program.

As discussed previously, a primary node of contention about the 30-Baht Program was the shift from a more politically driven process for allocating resources amongst the nation's hospitals, to a capitation approach, where funding is based principally on the number of people in a hospital's service area. Those in rural areas, who lacked the essential resources and manpower to meet the health care needs of the vast populations they were responsible for, were extremely supportive of the new approach. Conversely, those who worked in large urban or teaching hospitals feared budget cuts were on the horizon that would preclude them from continuing to operate on par with their peers in countries elsewhere in the region. These doctors did not want Thailand to fall behind in medical technology, diminish our ability to graduate quality physicians, or compromise our capacity to advance medical science.

These two groups supported only those components within the 30-Baht Program that addressed their needs, and opposed all those which did not. Both groups had valid concerns and were genuinely committed to the welfare of the Thai people. Had they applied HRH Prince Mahidol's principle of seeking benefits for the commons first, they would have found that their interests were not mutually exclusive. They could have worked constructively together, recognizing the Program's potential to fulfill their respective expectations.

Another dispute centered on the pace of implementation for the 30-Baht Program. Some people believed it should be introduced immediately even if many details had yet to be resolved. As implementation progressed, they argued, the Program could self-adjust in response to problems, while still moving forward toward achieving its goal. Any delays in its introduction could lead to a loss in momentum, and ultimately failure. Others preferred extensive preparations to address all foreseeable contingencies to avoid chaos and confusion once implementation began. They worried that absent comprehensive planning, the Program's implementation might generate unexpected and undesirable results. Here again, had both sides

chosen to look beyond their own egos and to the Program's mission to help everyone, a mutual understanding could have materialized, and a common course could have been charted.

Fostering a more cooperative approach was further hampered by competing ideologies as to whether the delivery of medical services should, or should not, adhere to a pure business model. Some in the medical field felt that medical services are a public right, and that their availability should not be commercialized. Government involvement was also necessary, they argued, to prevent unethical practices. Of particular concern were doctors who might encourage unknowing patients to consent to unnecessary and expensive procedures, or to use nonessential prescription drugs, forcing both the patients and society to bear the burden of higher health care costs.

Others viewed the delivery of health care as comparable to any other professional service, where competitive businesses should be able to operate within the free market. Government intervention, they pointed out, leads to inefficiencies that drive costs up and the quality of care down. Competition among providers is necessary to stimulate demand for higher quality care and the medical advances necessary to provide it.

Both ideologies' arguments were valid. Most people do want an ethical health care industry, and they also want access to good, contemporary medical treatment. The introduction of the 30-Baht Program aimed to accommodate both. Providing health care benefits to the people was our primary goal, and we wanted to encourage competition amongst providers to help preserve an atmosphere for ongoing improvements in treatment. Unfortunately, while we were committed to this approach, several factors beyond this ideological debate made the task even more difficult.

Leading up to the 1997 economic crisis, Thailand's medical sector was booming. In both the public and private sectors, new hospitals were built, older ones expanded, and new equipment purchases were on the rise. This rapid growth was most pronounced in large cities such as Bangkok and Chiang Mai. Once the economic bubble burst, most of these hospitals faced significant financial difficulties resulting from outstanding debt. In some areas the number of hospital beds greatly exceeded demand. The introduction of the 30-Baht Program could help to improve their financial situation, as many more people would become eligible for treatment. However, those managing public health facilities regarded the prospect of the government contracting with private hospitals as a threat. They opposed sharing limited public funds with their private sector counterparts. The reality was that

regardless of what we chose to do, a surplus of beds would remain, and facilities in both sectors would continue to be affected by the economic downturn.

Another complication was the insecurity among medical professionals. Shortly after the 30-Baht Program got under way, I participated in a meeting where medical professionals were discussing the Program's impacts on the medical industry. I was quite disheartened with the discussion's tone, which was entirely negative. All I heard were analyses about the financial damage the Program would cause to their private practices, and how doctors' incomes would suffer. I sympathized with concerns for preserving profitable medical practices, since at that time my own family clinic was having difficulty making ends meet. This, however, was an ongoing problem many of us faced, and the introduction of the 30-Baht Program was not going to affect things one way or the other. What I found most appalling was that their one-sided, self-interested thinking could not allow them to open up and welcome the benefits the Program would bring to people throughout the country. They acted as if the Program was designed with the sole purpose of harming their private practices. The emotions fueled by these inflated, negative perceptions were so strong I found it nearly impossible to convince any of them that their concerns were largely unfounded.

Such insecurity resulted in many medical professionals resisting anything related to the Program. Even measures designed to help doctors were opposed, such as a mechanism to reverse the growing trend of medical malpractice litigation. This had become a major problem for physicians, not only in terms of time and money, but lost credibility. The Medical Council itself was so frustrated with the increasing damage this issue was causing the medical profession, that it convened a task force to address it. Chaired by the highly respected medical professor, Dr. Witoon Ungpraphan, and later myself, the group examined how Thailand's experience with malpractice claims compared to other countries, and what if anything other countries were doing to address the problem.

His team discovered that the United States, with its free-market model, delivered high quality service and generated the highest rate of medical malpractice claims in the world. Multi-million-dollar awards to patients were becoming commonplace, doctor's malpractice insurance premiums were skyrocketing, and many attorneys were becoming millionaires themselves by specializing in medical malpractice litigation. Despite these trends, the United States had yet to institute any substantial reforms.

Finland on the other hand, which was also grappling with a rise in malpractice claims, developed a

special mechanism similar to those established for labor arbitration. Committees were appointed to help adjudicate, negotiate and settle patient–doctor disputes, and a central fund was available for administering compensation. Both patients and doctors were satisfied with the new system, as evidenced by the dramatic reduction in the number of malpractice claims that went before the courts. New Zealand now operates a similar program.

A survey of Thai doctors revealed that they too favored a mechanism for out–of–court settlements, and were very much in need of consultants who could help negotiate such agreements with disgruntled patients.

The Medical Council approved, in principle, the establishment of a fund to assist with patient claims so that both doctors and patients could avoid litigation. But the Medical Council did not have the resources to operate such a fund. When the national health security bill was drafted, I proposed that a compensation fund be included. We succeeded, and when the Act was passed in 2002, the fund was to be implemented along with the 30–Baht Program.

Despite the obvious benefits to doctors, many were resistant, feeling the fund was a move by Thailand toward the American model of bolstering patient rights and thus encouraging excessive compensation. They would not accept, that in fact, the fund's objective was entirely the opposite: to prevent what was happening in the United States, where doctors were at a high risk of being sued. I suspect that some of these detractors were so insecure about the integrity of their own medical practices, that they feared anything that drew attention to the topic of malpractice compensation.

I tried hard to understand all these misconceptions and misunderstanding relating to the fund. I recognized that for many medical professions, the emergence of the 30–Baht Program represented a significant step to empowering patients. It was understandable that with rising awareness of patients' rights, medical professions felt less freedom in their practice due to the fear of being sued. Because of these changes, my team and I would often be criticized by our peers. All I could do was to remind them of HRH Prince Mahidol's words, "Take your benefit second, your fellow man's benefit first" and to cultivate the willpower and the patience to continue the effort to establish universal health care for all.

Chapter 17: The Future Challenge: Solidarity in Thai Society

I remember an astronaut once remarked how he was profoundly changed by his journey into space. Seeing the Earth as that small, fragile ball shimmering blue against the dark vastness of space had altered his view about the importance of achieving world harmony, where regardless of race, religion or sex, humans coexisted peacefully with one another and their environment. Our planet is a coalescence of diversity, however we too often fight this notion with nation-building, religious fanaticism, resource degradation and war. If only we could truly grasp the interdependence of our coexistence and employ the concept of solidarity to care more for one another and other species, our world would be a more peaceful, happy and healthy place to live.

To fully realize the potential of the National Health Security Act, it would be helpful if all competing

stakeholders–medical professionals, public health experts, public administrators, and NGOs–removed their hats and become one homogenous group of common citizens in need of health care. They then would place the attainment of benefits for the people as their top priority, working collaboratively on strategies to provide universal access to quality health care.

Our initiative to provide health care for all is very courageous; some have characterized it as reaching for the stars. Encouragement, cooperation and patience are needed from all stakeholders. Similarly, everyone must learn to compromise and sacrifice details for the sake of the broader goal of health care for all. Mistakes will be made for sure, but those who do no wrong do nothing, After all, Rome was not built in a day. Competing opinions are necessary to stimulate improvements and innovation, but they must not become barriers to cooperation and progress. We absolutely need constructive dialogue in such a vital change process, but it should be aimed toward broadening the intellectual foundation bridging our plan to action, not sparring to achieve selfish and insignificant victories. Moreover, conflicts that do arise must not be allowed to fester, as such divisions will come at great cost to the people.

The debate surrounding Article 41 of the National Health Security Act helps to illustrates how such problems can arise. This provision of the Act requires one percent of those budgets allocated by the National Health Security Office to contracting hospitals to be deposited into a fund to service patients' malpractice claims. This obligation is designed to help offset the risks, to both health care providers and patients, associated with medical procedures. Even under the best of circumstances, with the best–trained professionals, medical complications can occur that are of no fault of the doctors. Should a patient become harmed, they should feel confident that a resolution, including any appropriate compensation, will be achieved as quickly as possible. Health care providers too must have confidence that they can administer appropriate care without fear of legal action being taken against them.

The fund acts as a mediator to protect both parties in the event of a complaint. Health care consumers and providers must respect that there are risks on both sides, and must be willing to work within the compromise framework of the fund's complaint resolution mechanisms. However, if the fund is used by patients principally as a means to extract large settlements for dubious claims, or by physicians to fight against any compensation whatsoever, then it will lose its credibility as a neutral instrument for offsetting risk. Such a development could lead to further deterioration in doctor–patient relationships, and potentially

escalate the types of legal confrontations the fund was designed to eliminate.

Another example where lack of solidarity can prove problematic pertains to criticism by the media and technical experts. In an open society, it is almost obligatory that such an important endeavor as universal health care–with significant and extensive impacts on the population–be the object of critiques. This is especially true given that the policy was regarded by many as principally a political ploy to secure an election victory. As a result, much of the initial attention given to 30 Baht for All Treatment was quite negative. However, this publicity raised some important questions leading to positive contributions that improved the 30-Baht program. Unfortunately, portions of the debates between health professionals and academics were often misinterpreted by the media due to their limited understanding of the concepts and details of the Program. The media too often showcased new criticisms based on old misconceptions. This of course further confused the public. It also exacerbated existing debates, muddying even further the Program's public image.

Overall, so long as the media and academics keep the best interests of the country in mind, their reporting and analysis will contribute to an increasing awareness as to the benefits of the 30-Baht Program and ways in which its implementation can be improved. The same must be said of all stakeholders, as it is the lack of such solidarity amongst interested parties to put the mutual benefits of the people first that represents the most serious threat to Thailand's universal health care policy.

Another obstacle which may impinge on the success of the 30-Baht Program is the rising rate of health services utilization. With health care now more convenient and financially accessible, demand has risen, making larger public health budgets inevitable. Given public financing limitations due to budget constraints, service quality cannot be maintained without other sources of revenue. The same applies to the need for resources to strengthen wellness and disease prevention programs. People's solidarity to help garner new resources is crucial. Therefore, we must remain aware of the interdependence among different social and economic groups. In anticipation of public financing constraints, higher and middle income earners must be open to a progressive financing structure which guarantees the quality of service everyone desires, and still protects those who lack the ability to pay. Essentially, a dedicated tax for universal health security is needed, as has been adopted by most developed countries.

Greater cooperation will also be needed to address other obstacles, including: conflicts between larger hospitals and smaller health care facilities with respect to patient referral practices; conflicts between public and private hospitals; and the continued imbalance of health care resources between urban and rural areas.

Whatever problems we encounter, all of them can be resolved if we allow the principles of social solidarity to overcome our individual interests that too often prove divisive. This was the philosophy that spawned the idea of universal health care for all three decades ago, and must remain the guiding tenet for this dream to be fully realized.