

The triangle that moves the mountain: nine years of Thailand's National Health Assembly (2008-2016)



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The triangle that moves the mountain: nine years of Thailand's National Health Assembly





Executive summary

The health reform movement which kicked off in the late 1990s in Thailand created a socio-political environment which was conducive to more open citizen-state engagement. In addition, the public increasingly demanded more participation and consultation in policy-making.

A sufficiently long and sustained period of collective citizen consciousness was cultivated in subsequent years, culminating in the first NHA in the early 2000s. Each of the NHAs since then have served as learning experiences for both citizens and the state to improve upon for the next round.

The NHA is only one mechanism for greater citizen-state engagement following the National Health Act which passed in 2007. The NHA's success lies partly in the fact that it is well embedded into a larger reform and stakeholder engagement process which prioritizes population capacity-building and fostering civic consciousness.

Overall, the major strides achieved since 2008 on the development, institutionalization, and constant fine-tuning of the NHA is commendable and can inspire other sectors and countries to follow suit. The power of various stakeholder groups coming together have been impressively harnessed in the National Health Assembly process. The lesson to be learned is clearly that the potential of citizen's voice to offer concrete policy options is remarkable when appropriate channels and fora are offered.

The NHA has allowed the different stakeholder groups to understand each other's points of view much better through dialogue, and has helped foster respect for very differing takes on the same issue. The way in which different stakeholders discuss and debate with each other in a real attempt at consensus thus represents a reformed modus operandi in policy dialogue.

Nevertheless, the biggest challenge facing the NHA in the future is ensuring a strong and sustainable link to decision-making and the highest political circles. The current weak link to policy-making poses great risks to the credibility of the NHA as an institution. Modalities must be found to make NHA resolutions high priorities for the Thai health sector; this will make the NHA more relevant, and bring in more and diverse stakeholders into the active participatory process.

The scope of this case study did not allow for an in-depth assessment of NHA's influence and impact on policy. However, it is highly recommended to do so as a follow-up to this study, which would be beneficial in the reflection on how to concretely improve policy uptake.

The 3 'triangle that moves the mountain' stakeholder groups (explained in more detail in the background section of this case study) coming together to complement each other is a huge strength of the NHA. Very few other mechanisms exist which brings these particular health stakeholder groups together. This feature gives a solid stakeholder-wide buy-



in to all NHA resolutions which should be given its due value by policy-makers. The NHCO should thus invest time and resources in working with government institutions to co-design a policy uptake strategy.

That being said, the NHA must be lauded for its mature process which has been

well refined over the years. It can thus be used as a model for other sectors to implement the concept of participatory public policies. Indeed, the lessons learned from the Thai NHA can be extremely useful not only within Thailand but throughout the region and for other Member States of the World Health Organization.



Introduction to this case study

This endeavour took place with the dual objective of contributing to both the Thai national reflection process to review 9 years of the NHA, as well as to WHO's programmatic work stream on providing normative guidance to countries on participatory health governance mechanisms.

As to the former objective, several internal evaluations on specific NHA-related issues have been conducted during the course of the last 9 years, as evinced on the NHA web site and existing documentation. As the NHA approaches its 10th anniversary, it was deemed timely and necessary to examine the NHA process more thoroughly in order to evaluate what works well and less well and reflect on what can be improved or done differently.

As to the latter objective, WHO and Thai colleagues agreed that the NHA process was invaluable as a potential point of orientation to guide other countries in similar ventures. In addition, there is a dearth of NHA documentation in English, an important pre-requisite for dissemination of the NHA experience beyond Thai borders.

WHO has been receiving increasing requests from Member States for technical support for population consultations. This case study is one crucial step in a work programme which will culminate in guidance material for WHO Member States on how to engage with the population for input into health sector decision-making. The focus of this study is thus on the process itself, i.e. the 'how' of consulting with and engaging the population on health issues. The scope explicitly does not include an impact assessment, for which a different methodology would be required; yet it is acknowledged that such an assessment would be extremely useful and, indeed, represents one of the main recommendations of this study.



Background

History

In 1988, the National Epidemiology Board in Thailand convened the first “National Public Health Assembly” in Bangkok, with the aim of facilitating exchange on health between top administration officials from nearly every ministry in the country¹. It was a remarkable achievement for the time, even if the principal focus was on increasing cooperation between government organizations only. It served as a stimulus for reflection on how an ideal health system would look like in Thailand.

A few years later, in 1992, the Ministry of Public Health created the Health Systems Research Institute (HSRI) to promote health research, and undertake evidence generation and analysis on which interventions work well (or do not work well) in the Thai health sector. In the late 1990s, by being able to provide concrete options for policy dialogue, the studies conducted by the HSRI underpinned calls for health system reform.

At the same time, civil society organizations (CSO) working on health began to grow and expand its network with the primary health care movement in the early 1980s and 1990s. The Ministry of Public Health was the first government entity to provide funding to civil society, in the recognition that these groups were instrumental in operationalizing the primary health care concept. The term ‘participatory public policy formulation’ began to be used with more frequency

by civil society actors, as well as other health stakeholders. The realization that the right to health also included health promotion and prevention led the HSRI to coordinate a series of studies on how best to put this in practice in the Thai cultural landscape.

Concerted action by government, academia, and civil society and its partners (including media), led to the Health Promotion Foundation Act in 2001. It created the landmark Thai Health Promotion Foundation which to this day funds health advocacy and promotion with revenue derived from 2% excise taxes levied on tobacco and alcohol. A large proportion goes to civil society organizations and has been pivotal in building civil society capacity to participate more meaningfully in policy dialogue.

This coincided with the passage of the National Health Security Act in 2002 which was a major milestone in the government’s earnest quest towards universal health coverage (UHC). The UHC vision for Thailand was a cornerstone of health reform; it was bolstered by HSRI’s available evidence and civil society advocacy. CSO networks even submitted their own draft version of the National Health Security Act², attesting to their unified front and growing capacity.

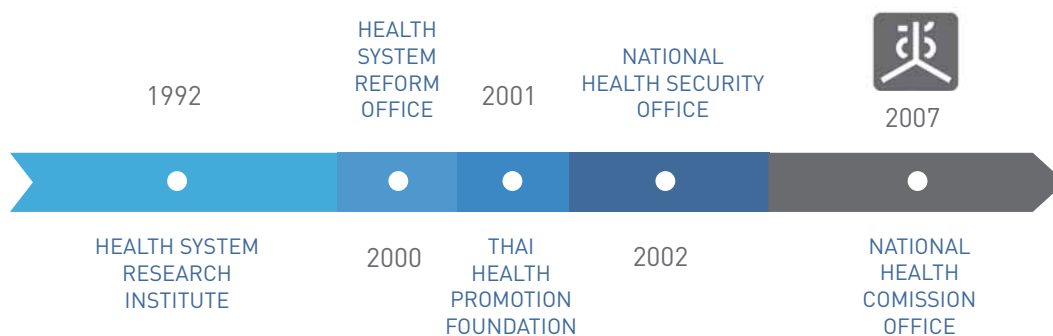
UHC policies based on the National Health Security Act led to major structural changes to the Thai health system as well as to financial and fiscal reforms. Around the same time, the Health Systems Reform Office (HSRO) was created to

bring the various health system changes under an 'umbrella' piece of legislation addressing overarching health system reform (and not only 'health security'), with a time-limited mandate¹ to draft evidence-based policy recommendations and broker consensus around them.

The idea of an overarching health law came from the need for a paradigm shift to provide a foundation for the reform – a shift from health being predominantly within the sphere of the bio-medical and the curative to health being holistic in nature, encompassing the social and spiritual determinants of health.

HSRO's first year (2001) aimed at building the knowledge base and mobilizing civil society in the reform movement³. Various forums were organized to foster debate and dialogue and to get a sense of the population's perception of the nation's health problems. The second year saw the development of a draft framework for a National Health Act, which was based on an evidence review by the HSRO as well as input from the multiple public deliberations. The draft framework was subject to further extensive open debates and deliberations. A draft National Health Act followed, which was subject to scrutiny at a national health assembly⁴.

Figure 1: Health system reform in Thailand: a timeline



¹ The HSRO's initial mandate was 3 years but was extended to 7. It was abolished with the National Health Act in 2007



Through the sheer plethora of forums, meetings, conventions, and conferences at different administrative levels of the country, public discussion on health slowly became the norm rather than an exception. This new public space became the underlying pillar of what later became the National Health Act in 2007 (see figure 1); this act secured participation as the basic orienting principle and practice in health policy-making in Thailand. The National Health Act conceived the National Health Commission Office (NHCO) with the mandate to hold yearly assemblies. The National Health Commission Office also took over some of the functions of the HSRO as its mandate was completed. The head of the HSRO became the Secretary-General of the NHCO.

The National Health Assembly was officially born.

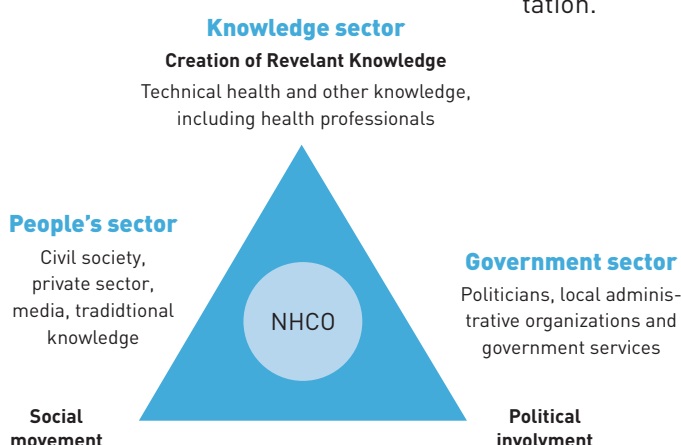
National Health Assembly (NHA) concept

The NHA's foundation is the concept of the 'triangle that moves the mountain' (see figure 2), the vertices of the triangle representing government technocrats, policy-makers and politicians (referred to often as the 'government sector'); civil society, communities, and the population ('people's sector'); and academia, think tanks, and research institutions ('knowledge sector')^{II}. The core principle of the NHA is to bring together the three groups represented by the triangle corners to combine top-down and bottom-up approaches to achieve progress and reform.

NHA resolutions are passed on consensus and are not binding for policy-makers and service providers. Rather, the NHA aims to achieve influence and compliance through the legitimacy its broad stakeholder base lends to its resolutions. Indeed, the principle reason for the creation of the NHA was the fact that policies which were crafted solely by politicians or administrators were not seen as legitimate after governments changed. The lack of continuity in policies and poor ownership by the population led to half-hearted implementation, if at all. The NHA was a mechanism created in the quest to increase inclusive ownership of policies and thereby also improving implementation follow-up.

The triangular approach aims to create synergy through the constant interaction and exposure between the 3 different groups within the structured environment of the NHA process and its clear objectives. The NHA is thus meant to be a tool to put in practice public participation in policy formulation and implementation.

Figure 2: The triangle that moves the mountain⁵



II Presentation by Jiraporn Limpananont, December 2014



National Health Assembly governing bodies and administrative set-up

National Health Commission (NHC)

The National Health Commission was established by the National Health Act in 2007. Its official responsibility includes advising the Council of Ministers (otherwise known as the Cabinet) on policies and strategies related to health; steering the NHA and Provincial Health Assemblies; and actively promoting the process of healthy public policies (for example, by supporting Health Impact Assessments). It also serves as the steering body for the National Health Commission Office.

The National Health Commission meets every 2 months, and has 39 members with the 3 angles of the triangle equally represented. More than half of the Commission do not come from the health sector, attesting to the true intersectoral approach taken to health. Members sit on the Commission for a 4-year term. They come from the government sector representing several ministries (Ministries of Public Health, Social Development and Human Security, Natural Resources,

Agriculture, Interior, Environment, and Industry); local government; civil society; academia; professional associations (medical, pharmacy, nursing & midwife, etc); media; and the private sector. These are just examples of the 39 groups which are given a fixed seat at the Commission. Each group self-selects a Commission member; the process for each group is determined by the group themselves and varies across the groups – some are elected and others are nominated.

National Health Commission Office (NHCO)

The National Health Commission Office acts as the secretariat of the National Health Commission. It is led by its Secretary-General and has a staff of 92 people (2017) including those working specifically on developing the NHA agenda, following up on resolutions, supporting provincial health assemblies, building capacity of constituencies, monitoring and evaluating the NHA, and working on advocacy and communication for participatory policy-making. In addition, the NHCO's support staff work on human resources, finances, information technology, auditing, procurement, and general administration.

The NHCO Secretary-General is selected by a body called the Executive Board as stipulated in the National Health Act. It consists of a representative from the NHC, Ministry of Public Health, a CSO, and media. In addition, an academic



health expert, an academic policy and strategy expert, an expert in administration and management, and the sitting Secretary-General complete the Executive Board. The Board accepts applications for the Secretary-General post and manages a classical selection process including reviewing application files and conducting candidate interviews. The Board makes a recommendation to the National Health Commission who accepts or rejects the selection. In practice, the Executive Board's recommendation is usually accepted.

Besides the preparatory work for the NHA, the NHCO undertakes advocacy work amongst different constituency groups and in provinces to encourage engagement with the Assembly and raise awareness about the process and possibilities of participation.

National Health Assembly Organizing Committee (NHAOC)

The National Health Commission appoints the President of the NHA Organizing Committee. The selection of the president involves deliberations regarding potential candidates' ability to moderate discussions with opposing views. The respect and standing of the candidate for NHAOC president is also a factor for selection. An attempt is made to rotate the president position between the different constituencies and groups; for example,

to date, the presidency has been held by a government agency representative, an academic, a Chamber of Commerce representative, a civil society representative, etc. Gender balance is also taken into consideration.

In consultation with the Secretary-General of the NHCO, the NHA Organizing Committee president has the mandate to appoint the other members of the committee. The NHAOC oversees the entire process of the NHA. The National Health Act stipulates that a maximum of 40% of its members can come from government departments and agencies, although it is often less. The composition of the NHAOC is supposed to reflect the triangle concept with diverse membership from different population groups and profiles.

The NHAOC receives proposals for resolutions and jointly decides which ones will be taken forward for study within the drafting groups of the NHA (see below). Proposals to the NHA Organizing Committee can be submitted by anyone or any group, and must show collaboration with other triangle groups. For the 9th NHA in December 2016, 29 proposals were received, and 4 were deliberated upon at the NHA.

The NHCO provides seed funding for the drafting groups to then develop their resolution topics further. The NHA Organizing Committee keeps tab of progress on all drafting groups and oversees them.



Drafting Groups of the National Health Assembly

Drafting groups are tasked with writing background papers as well as the draft resolutions on topics selected by the NHAOC. The background papers and draft resolutions are made available via the NHA website, and disseminated directly to stakeholders to inform discussions before the NHA. Public hearing forums of all topics with their background documents and draft resolution

are held, after which the revised version is sent out again to all stakeholders. The National Health Commission Office also distributes media materials such as brochures and animation videos with simple key messages to make the topics more easily understood.

Some topics may be postponed to the next NHA if the drafting group, in close coordination with the NHAOC, decides that evidence is insufficient or more time is needed to refine the arguments and build consensus. For example, in 2016, one of the 5 topics namely solid waste

management was dropped for debate at NHA 9 to give stakeholders more time to make the resolution more robust.

The drafting groups are composed of those who have submitted the proposal (for example, a civil society organization), as well as those who were consulted and requested to give input to the proposal (for example, a relevant ministry department or a research institution who might have assisted in explaining the evidence base on the topic). The drafting groups must have representation from all triangle constituencies, and many strive to include a wider range of actors or secure strong representation from specific groups based on the topic at hand. For example, a proposal on essential medicines would explicitly target the private sector and pharmaceutical companies, but those stakeholders may be less relevant for other topics.

NHCO-defined constituency^{III} groups

Within the broad NHA triangle corners, the NHCO defines specific constituency groups with an assigned number of representatives. Each NHCO-defined constituency group organizes its own consultation process to select its representatives to raise their concerns in the NHA.

Participants attend the NHA in their capacity as representatives of a constituency group. Individuals wishing to attend

must thus first join a constituency group. In general, the NHA is extremely diverse in its stakeholder base, with representation from government, think tanks, academia, civil society, communities, and private sector.

The number of NHCO-defined constituency groups increases each year according to the resolution topics addressed at the annual NHA. No group is ever removed from the list; new groups are added each year as relevant. For the NHA 9 in 2016, there were 280 constituency groups.

National Health Assembly process

No one constituency has a privileged role in the NHA process when compared to another. The aim of the NHA is to ensure complementarities of the varying points of views by giving every representative access to the NHA process where every attempt is made to put all sides on equal footing (through capacity-building, awareness raising work, etc., organized by the National Health Commission Office).

All constituencies at the NHA thus have equal speaking rights. After the initial plenaries, the agenda items are discussed in parallel sub-committees. Resolutions can be passed only by consensus so in case of disagreement, the agenda item is subject to deliberation again until a consensus is reached. If

^{III} The NHCO refers to a constituency to mean a group of people, organizations, agencies or a network who are united behind common goals and objectives and undertake joint activities consistent with those objectives.

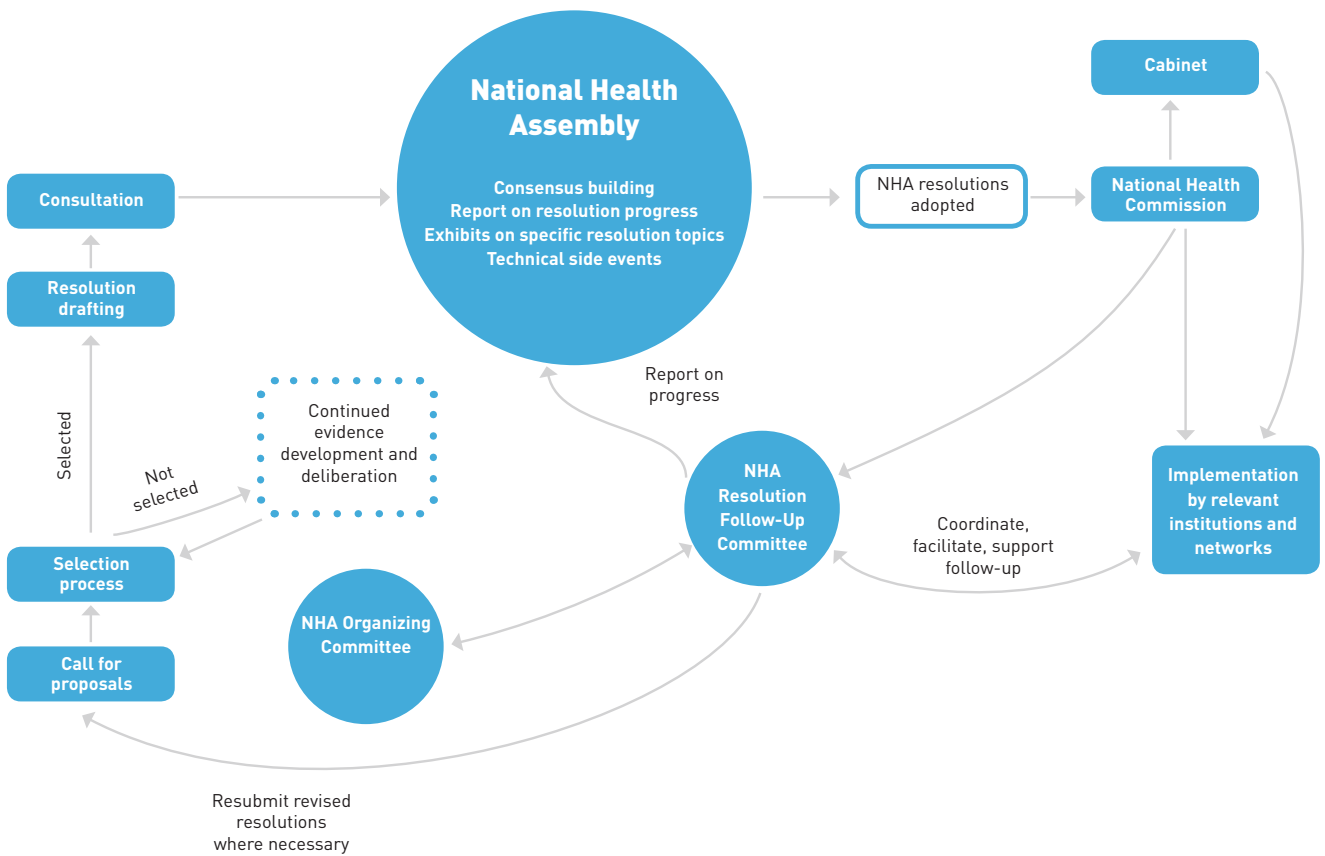
consensus cannot be reached, an ad-hoc drafting group may be established during the NHA to allow further discussion and possible modification of the resolution.

Voting is not possible at the NHA. If, after re-deliberation and re-drafting, a consensus cannot be reached, the agenda item must be deferred to the next NHA to allow more time for consultation and consensus-building. This has occurred once to date, on the issue of prevention of health and social impacts from international trade.

NHA Resolution Follow-Up Committee

The National Health Commission established the NHA Resolution Follow-Up Committee in 2010 to work in parallel with the NHA Organizing Committee. The NHA Resolution Follow-Up Committee is tasked to facilitate driving the resolutions into action and following up on the implementation of NHA resolutions⁶.

Figure 3: The National Health Assembly set-up and process





Methodology of this case study

This case study included a document review of existing English-language literature on Thailand's participatory governance processes and specifically on the National Health Assembly. In addition, a literature search was done for citizen consultation theories of change to get a better sense of what other programmes might have hypothesized regarding why consultation processes achieved or did not achieve their objectives. Nine key informant interviews were conducted in Thailand and 2 focus groups were held in Bangkok and Chacheongsao province. This review also includes the views and experiences of the authors within the context of the National Health Assembly and the work of the National Health Commission Office.

The document review and the discussions around the theory of change contributed to a coding framework which was applied on the key informant interview and focus group transcripts. Five of the authors coded the transcripts; each transcript was coded by 2 people and cross-checked for concurrence in a 2-day workshop held in Geneva in April 2017. In the few cases where codes were different, a discussion took place and consensus found. The coding process helped identify additional major themes and confirmed those which were already in the coding framework. The results of the analysis are further elaborated upon in subsequent sections of this case study.

Results

This section highlights the principal lessons which can be drawn from 9 years of NHA experience in Thailand, based on the methodology described earlier. Overall, the NHA has been a success in terms of its objectives of increasing participation in public policy-making and ensuring that health is not viewed narrowly within curative care only. The reasons behind this success are explored below. Of course, there have been important challenges as well, the most pertinent one being the continuing poor links to real policy-level decision-making; this and other challenges are dealt with in later sections of this case study.

Lessons learned and factors of success

- 1. The National Health Assembly has been an extremely useful platform for bringing together a wide and inclusive range of stakeholders to discuss complex health challenges on a regular basis. It is recognized as a national public good.**

It was widely acknowledged across the board that most NHA stakeholders would not normally come together otherwise and thus, the annual NHA provides a significant impetus to convene together and jointly address matters of concern. It is notable that many stakeholders admitted that widespread scepticism by all sides prevailed when the NHA was initially launched, mainly with regard to its use-

fulness and ability to influence decisions. However, despite lingering challenges in linking NHA to policy- and decision-making, stakeholders recognized the clear added value of the NHA process, specifically in their own work, and generally in advancing on public health goals in the country.

Particularly when it came to more complex health problems, the NHA was used and appreciated as the vehicle for policy dialogue. For example, the NHA was the main platform used for stakeholder dialogue on issues where the health sector's reach was limited and inter-sectoral collaboration was required. In fact, reaching out to other sectors was one the rationales behind the creation of the NHA. Dr. Amphon Jindawatthana, former Secretary-General of the National Health Commission Office, summarized it succinctly: *"We established the office of national health commission chaired by the prime minister, not by the ministry of public health, because we saw that that ideation of health comes from every sector"*.

When looking at the resolution topics over the last 9 years, one is indeed struck by the complexity of the health issues addressed: asbestos-induced pathologies, medical tourism, antimicrobial resistance linked to antibiotic use in food animals, access to basic care for stateless people, and more. The proposed solutions to these problems have involved several government ministries, the Board of Industries, the private sector, pharmaceutical companies, and many, many oth-



er stakeholders who were convened in a structured and coherent manner around the National Health Assembly process.

The NHA's utility value also lies in the fact that those very complex issues are unpacked with the available evidence on the one hand, and population views and expectations on the other. By bringing together academia as well as civil society and communities with government entities, the NHA allows practical feasibility considerations to be adequately elaborated and agreed upon.

Access to population views and opinion has made the NHA especially attractive to some groups such as the private sector, parliamentarians, political parties, and media. Specific and targeted feedback from the public on topics close to the population's heart is invaluable information for many. The media, for example, has often taken information from the NHA process, and broadcasted the issue for better understanding by the public⁷. In essence, the NHA helps to frame citizen views and enables to some extent the operationalization of citizen demand.

2. NHA has contributed to empowering and enabling the 'people's sector' to take on their civic duty and meaningfully engage with the health policy-making process

At the beginning of the National Health Assembly, the platform was used mainly by CSOs, and much less by government, private sector, academia and others, to

bring forward issues of their interest. It was primarily perceived to be a platform for civil society to voice complaints and concerns. More than one key informant characterized the NHA in its beginning years as a 'complaint platform' rather than a 'solution platform'. Also, civil society did not have, until the advent of the NHA, any other real way to engage in health policy-making as it remained principally in government hands. This was the first opportunity accorded to civil society by government to contribute to decision-making.

The initial years of the NHA saw civil society spending a large part of their time pointing fingers mainly at Ministry of Public Health departments whom they felt should have done things differently. Most Ministry departments reacted defensively and showed themselves as unwilling to collaborate. Compounding this atmosphere of criticism was the reality that many of those criticized were not in the position to change anything without support from higher government circles. Many key informants recalled the extremely heated atmosphere of the initial meetings between the three 'triangle' constituencies, some even describing it as a 'battleground'. However, over time, many government officials interviewed acknowledged that civil society had learned to organize and coordinate amongst themselves, and had started collaborating more closely with academia. The latter point is significant as it meant that community organizations "*became more mature. They don't go and complain anymore. They come with the*



evidence and knowledge^{IV}. This earned them an increasing level of respect and standing over time, and is a direct consequence of having a platform and an event, the NHA, to work towards as a goal every year. In essence, the NHA process helps all stakeholders think through solutions to problems, rather than focusing solely on the problems themselves.

The emphasis on solutions has also brought community groups and civil society to own up to the multi-stakeholder nature of roles and responsibilities, including their own. Many key informants mentioned that the NHA process has led to civil society taking on key roles in the implementation of resolutions, and in general, contributing more to attaining public health goals. The focus group discussion yielded the same conclusion, with the group stating *“If this channel [did] not exist, there is no chance for local people to propose various issues. So it is beneficial for us. Besides, it is also the development of people”*.

The allusion to the ‘development of people’ is also fruit of vastly improved internal coordination amongst community groups and civil society. The NHA essentially helped reinforce, and in many places, create, a tight network of citizens and community members with a stake in the same topic, and forced those diverse viewpoints to converge into a common stance to be expressed jointly at the NHA. Civil society’s strength comes with a unified stance which the NHA process has encouraged and helped solidify.

IV Quote from a government key informant

3. The NHA is not just a yearly event but a continuous process convened and led by the National Health Commission Office. The attention accorded to the process by the NHCO, more than to the 3-day event itself, has allowed the NHA to steadily improve in quality over the last 9 years.

The emphasis on the NHA process is demonstrated by the resources with which the National Health Commission Office is privileged to operate – its staff strength working directly or indirectly on the NHA is currently 92, although it began with much less personnel. These are the kind of resources needed to drive the continuous dialogue with the population around the evidence on key health sector issues. In addition, the steady funding to civil society from the 2% levy on tobacco and alcohol sales is not to be underestimated. It allows civil society organizations and community groups to build long-term capacity and institutionalize their structures over time.

A central aspect of NHCO’s role is capacity building of all parties, especially the ‘people’s sector’. Building expertise and dialogue skills has improved the quality and constructive nature of stakeholder input over time. This is not to be underestimated as the strength of the NHA process depends heavily on moving from a more confrontational mode -- characterized by complaints and venting of frustration primarily on the side of civil society, and defensiveness mainly from the government



side – to a solution-oriented consensus attitude where (acceptable and accepted) decisions can be taken.

The NHA has allowed the policy dialogue to be characterized by continuity which also means that topics which are subject to dialogue stay visible even if no hard solution is found. A case in point is the topic of asbestos; a NHA 3 resolution in 2010 recommended a ban on the substance. Despite an initial Ministry of Public Health endorsement and support from the Ministry of Industry, the ban is yet to be issued by the Thai government. Various reasons, including a reversal of the Ministry of Industry's position on asbestos, have blocked implementation of the 2010 resolution. However, the topic is far from forgotten. The National Health Commission's NHA Resolution Follow-Up Committee obliges all unimplemented resolutions to be examined on a regular basis, convening relevant parties to examine ways to advance on the issue. Even if the ban is not in place, other actions such as consumer education campaigns are happening, in the recognition that awareness of asbestos risks among the Thai population is low, and more grassroots pressure may need to be created to move the issue forward. As the National Health Commission Office staff mentioned, *"But, for the asbestos itself, actually it's progress[ing] but it's not yet reached the goal and outputs that we expected. But, we can move on that [to] some extent. It can go to the policy level...[and] to the cabinet and we have a dialogue with the Ministry of Indus-*

try even though it [has] not progress[ed] in the sense of banning."

Indeed, one of the NHCO's key tasks is monitoring follow-up on resolutions and driving them to action. Creating the NHA Resolution Follow-Up Committee in 2010 was crucial for ensuring the link to real health sector decision-making. It has also brought more legitimacy to the National Health Assembly process as resolutions are not left hanging after they have been passed. The Committee allows for a formal process where follow-up action on the resolutions are examined and stakeholders are brought together to constructively find a way to advance on the issue at hand. Although there is still much room for improvement here, it has proven to be a crucial step at re-igniting stakeholder enthusiasm and willingness to invest in the NHA process.

4. Much of the NHA's longevity and success can be attributed to its firm entrenchment into a much broader reform movement.

If the whole country is going in the general direction of restructuring and change, it is much easier for the health sector to go along with that wave. The NHA in Thailand was never an isolated event, it was always embedded in the work of the Health Systems Reform Office's (HSRO) mandate before 2007 and then an integral part of the National Health Act of 2007. Both the HSRO and the National Health Act came with a greater willing-



ness to try new and innovative measures. The National Health Act created a number of government health institutions whose governing body includes civil society and communities, and whose founding charter allows more flexibility and less bureaucracy in terms of decision-making. It is within this context that the National Health Assembly process should be understood – more precisely, its key role in contributing to a reformed way of working in the health sector. This context also facilitated the view that the NHA is a long-term, continuous process which must be nurtured and improved over time.

When the National Health Act passed in 2007, the HSRO had already spent several years conducting health assemblies⁸, albeit without a legal framework underpinning it. Those years gave health sector stakeholders the time, practice, and sufficient exposure to dialogue which helped the NHA mature considerably by the time it was more officially launched. Working concepts, objectives, procedures, selection of participants, and networks had the time to be refined. Many concerns by critics were progressively addressed and/or relayed and acceptance for the approach and process were slowly increasing. It was then likely easier to anchor such a complicated process such as the NHA into the Thai health system architecture due its relative level of advancement and recognition, at least in political circles, by 2007.

NHA's just place within a larger reform effort means that the NHA enjoys high-level political support, as well as the status and resources associated with it. The political support is complemented by broad-based civil society support, making it difficult for any politician to oppose it entirely. This does not mean that political support does not wane with some governments and resurge with others; however, overall the National Health Commission is chaired by the Prime Minister (or his/her substitute), regardless of which government is in power, attesting to the visibility and prominence that the NHA as an institution can claim.

5. The National Health Act has given the NHA a solid anchoring in the legal architecture of the country, and thus, a sustainable long-term perspective.

The National Health Act was a landmark piece of legislation that passed despite a significant level of opposition from those wishing to keep the status quo at the time. The National Health Act essentially enshrined the idea of participatory national governance into the health landscape at the time. More significantly, it gave participation a budget, and made it mandatory for government health stakeholders to come together with non-government stakeholders and engage in a dialogue. As one government employee put it, *“There are many factors that the government acknowledged [regarding] the value*



and usefulness of the dialogue or National Health Assembly. One, it is the law, but not only the law from the National Health Act, but also the constitution that gives the importance to public participation". Many key informants admitted frankly that, especially at the beginning, the 'dialogue' was organized and conducted mainly because they had to spend the budget line – and not necessarily because they felt that there was an added value to their work. However, being forced to talk to each other for a certain period of time with a certain level of regularity led to a greater mutual understanding for each other's viewpoints, even if both sides continued to disagree. In addition, respect was fostered; a key point here is the hard-won respect for differing views, without which joint solutions are difficult to craft.

The National Health Act has also allowed the NHCO and the NHA to become institutionalized fixtures in Thailand, despite changing governments and politics. To fulfil the mandate of the National Health Act, the NHCO spends approximately 1.3 million USD to fund both the 3-day Assembly as well as the entire year-long preparatory process and resolution follow-up activities. To put this into perspective, this amount is a minuscule percentage of total government health expenditure (which was 14 billion USD in 2012⁹), but has huge leverage.

6. A few key figures who championed the value of participation as well as the NHA process have acted as change agents over the years and played a pivotal role in the NHA's institutionalization.

During their lifetimes, these change agents have climbed up to key positions over time and contributed greatly to the institutionalization of the NHA and overall health reform efforts. Interestingly, they have come from different parts of the 'triangle which moves the mountain', i.e. some were civil society activists, others were prominent figures in government, and still others were in academia. Interestingly, even the government figures were often described as 'apolitical' and 'respected by all sides' regardless of whether Thailand had a military or civilian government. Some of the change agents spent part of their careers as activists or academics, then switched over to government, or vice versa, thus enabling an understanding of the different groups from within. As one of the change agents who was interviewed put it: "*So we jump[ed] in ... at that time trying to link Ministry of Public Health and National Health Commission Office*"; this quote demonstrates how the change agents from their different positions linked up their respective institutions and brought them closer together.



7. NHA is a key vehicle for bringing evidence more strongly into policy discussions

As one critical angle of the 'triangle that moves the mountain', academia and think tanks, or the 'knowledge sector', is given an equal place besides civil society/communities and the government in the tripartite NHA governance structure. The NHA process also puts heavy emphasis on deliberation and discussion on proposed NHA resolution topics, with the aim of bringing together a wide range of people who have a stake in the subject matter, but also in order to sufficiently study the feasibility and practicality of any potential solution. Dialogue and debate need material for discussion; hence, it is a virtuous cycle as more structured dialogue demands more evidence analysis.

Evidence is the crucial piece both at the topic proposal stage as well as when solution options are debated on. When a topic proposal is accepted, the drafting group receives funds to concretize the issue at hand and anchor it more strongly in evidence. If the group is unable to establish sufficient evidence, or is unable to gather sufficient information to concretize the issue further, the proposal is tabled until the following NHA, thereby giving the group more time to collect the evidence. This system favours stakeholder groups who have already closely examined the evidence, are able to demonstrate a clear evidence base on their topic, and offer

potential solutions. It gives civil society and community activists a huge incentive to partner with academia and think tanks before advocating for their topic area.

The NHCO has invested heavily in capacity-building of communities and civil society, especially for evidence analysis. The NHCO's capacity-building work began within the context of health reform which emphasized participatory public policies. As mentioned earlier, part of this reform involves a steady stream of funding managed by the Thai Health Promotion Fund. This fund provides resources for civil society organizations and think tanks focused on health issues to gather evidence and conduct advocacy work. Many of the strongest civil society organizations (CSO) with their own research departments are entirely funded by the Thai Health Promotion Fund; many have managed to build excellent capacity over the years, and with it, powerful and coherent voices for health promotion at the NHA. They have built up respect and a certain standing in the Thai health sector landscape, mainly because of the robust evidence base they are able to give their issues at forums such as the NHA. It has also helped modify perceptions of civil society work being simply 'hot-headed activism' to rational and reasonable demands.

The NHCO works very closely with these CSOs by having them on various drafting groups where their knowledge and proximity to communities is valued





and brought in. In addition, the NHC0 draws many lessons from the way these stronger, more established community-based organizations work to help build capacity of weaker, less well networked organization in the provinces. The NHC0 conducts several training workshops every year, and also provides seed funding for civil society partnerships with local academic institutions.

With civil society and the research community strongly encouraged to join forces under the NHA model, government institutions end up also following the firm emphasis on knowledge and evidence. Many have realized that evidence clearly help legitimize policies. The NHA has thus pushed health policy-making into a more evidence-led sphere. One could argue that politics, then, has also been forced to give evidence the prominent place it rightly deserves.

8. NHA resolutions are better implemented when all relevant stakeholders and implementing bodies are brought into the process from the very beginning, i.e. during the resolution drafting stage itself.

Many key informants mentioned that the quality of the NHA process had improved over the last 9 years. One of the concrete results of this were more actionable and feasible resolutions – a simple review of resolutions from the last 3 years vis à vis those from the first 3 years of the NHA

reveals that even the resolution wording was left vague and relatively unclear on follow up in the early years. Over time, the resolution wording is more precise, makes a clear point, and is linked to concrete follow-up action. One of the main reasons cited for this improvement was the lesson learned after the first few NHAs that stakeholders who might potentially implement the resolutions should be involved in the resolutions drafting process itself. Bringing in implementing bodies at an early stage of the NHA process not only won their buy-in and ensured joint ownership of the resolution, but it also encouraged a full reflection on how the resolution would be implemented, how much resources were necessary, and whether it was actually feasible in the short term or not. This facilitated a more precise wording of the resolution and more concrete actions to be committed to as part of the resolution itself.

One of the NHA's major advantages is the complementarity of the diverse groups and constituencies gathered together. Including all relevant constituencies from the very beginning of the NHA process leverages that very advantage and forges a joint vision towards implementation. The spirit of this common path which is created through the NHA process is aptly reflected by the following statement from one key informant: *“Initially, some people just sit in and listen, but after a while they can start exchanging ideas. The assembly creates participation and ownership”*



Challenges and room for improvement

The NHA has come a long way since 2008. Yet important challenges persist which should be addressed sooner rather than later in order for the NHA to remain relevant and find a firm foothold in policy-making. These challenges, and possible avenues for solutions, are elaborated upon further below.

1. Thorough follow-up and implementation of resolutions, and their integration into health policies and decisions, remains a key challenge

Implementation of resolutions is perceived as poor and too slow across the board. Part of the problem is the inherent complexity of issues brought to the NHA, which is why they are debated at the NHA in the first place, in the hope of finding common ground for a solution. However, resolutions are not binding; they are meant to express the consensus of the large stakeholder base of the NHA, giving it that weight for consideration and implementation within policy circles. Many key informants observed that, while government participation is visible and present at the NHA, it is not at a high enough level for decisions to be taken based on resolutions. At the moment, it seems that operational-level government technical cadres are active in the NHA process; decision-makers from higher up the hierarchy may thus need to be courted and actively brought

into the process by the NHCO to ensure high-level backing of resolutions. One key informant deplored, *“the government sector...it is impossible...to command them or order them. Sometimes you have to beg them to do according to the resolution. It is very hard to do like that”*.

The fact remains that NHA resolutions are not always priorities for action at the national decision making level, despite the NHA’s systematic and broad stakeholder consensus approach¹⁰. In essence, political will determines how far the NHA topics enter into policy spheres. A range of several other factors, only some of which are within the control of the National Health Commission, largely influence whether or not the resolutions are taken up further for proper implementation. For example, government agencies still do not attach as much importance to the NHA process as they do to their own internal policy-making processes; the former and the latter are not yet well integrated.

Most civil society and community networks generally do not lead on policy implementation per se – first and foremost, government does, and without their follow-up actions, the *raison d’être* of the NHA can easily be called into question. Realizing this, a permanent NHA Resolution Follow-Up Committee was called a few years back which has opened up a crucial avenue to ensure better implementation on resolutions. Key informants from civil society and the private sector mentioned that a waning enthusiasm for the NHA had been revitalized with the creation of this committee.



The NHA Resolution Follow-Up Committee's role is to convene the right stakeholders who are needed for resolution follow-up and regularly review all unimplemented resolutions or parts of resolutions. The Follow-Up Committee has managed to re-ignite the discussion with various parties on issues going as far back as the first NHA in 2008. It also ensures timely submission of progress review reports on every single resolution and has established clear content requirements for those reports. These reports are seen as positive for moving the agenda forward by all sides.

Nevertheless, the NHA Resolution Follow-up Committee needs to be given more prominence and the NHCO as its secretariat more resources to work more closely with government entities to support them in their own internal processes and be given a clear mandate for coordinating high-level policy dialogue around resolution-related matters. The work of this Committee must be placed at the heart of the NHCO's activities as it will ultimately determine the NHA's rightful place in health sector policy-making.

A study specifically looking at the impact of NHA resolutions, as well as the internal government policy-making processes they were linked to, or supposed to be linked to, could be very useful to better understand where the bottlenecks are in linking with the NHA process.

2. The diversity of approaches and beliefs of constituencies make NHA difficult but necessary

In a way, this challenge will remain with the NHA at all times. NHCO's task here is to ensure that this challenge is constantly overcome. The NHA system relies on consensus (it is not a majority vote system) which means dialogue is imperative and some (any) consensus must be found on the actual Assembly days. This is obviously not always easy with the constituencies' different vantage points and assumptions about the others. The diplomacy skills of the drafting group, committee and sub-committee chairpersons are of utmost importance in this context where a common solution must be found which participants are happy with. Recognizing this, the NHCO has generally taken great care in selecting its chairpersons and should continue doing so.

The NHA process forces people with different ideas on the same issue to express those very different ideas and merge them together into something which is akin to a solution. Many key informants and focus group participants affirmed that the NHA forced them to examine other viewpoints and helped them better understand where other opinions came from. Simply put, many stated that the NHA "helps change people's mentality". However, this is not easy and is gradual, the path towards that convergence of



ideas, or 'mentality change' is rocky, with many detours along the way. The NHCO needs to continue managing this, and not lose sight of this critical task.

Politics sometimes blocks the straight path towards resolution implementation, discouraging community groups and civil society. The NHCO's task is extremely arduous as it seeks to keep all parties actively involved, enthusiastic, with a belief that the NHA system will help advance all of their causes.

3. Representativity of constituencies is a challenge. Increased capacity and coordination skills are necessary within constituencies to select the right representatives

The NHA model is built on the notion that different constituencies and population groups are adequately represented, and come to the Assembly with a constituency-wide coordinated viewpoint. In reality, this is not always the case with all groups. A focus group participant complained accordingly, *"These representatives must bring the opinion of the group that they are representing, not just their own opinion"*.

Representatives are self-selected within the constituency which means that the stronger constituencies with more capacity do better representative selection. Capacity-building initiatives of the National Health Commission in this re-

gard will take on a decisive role here as it will determine the quality of the representation and hence, the quality of the NHA.

For example, as alluded to previously, various universities and academic institutions are grouped into a constituency but they may have little interaction with each other. Hence, this grouping probably needs to be thought through again as academia's participation seems more representative of other hats which academics are wearing (civil society, think tanks) rather than the academic hats.

With regard to provinces and community organizations, those with high capacity, means, and influence tend to have their voice solidly heard. One focus group participant complained that the same people showed up at the NHA, and those were the ones active in the committees and sub-committees as well, as they were well-endowed with skills and resources. A key informant summed it up by saying *"Besides, the National Assembly is half closed. That is, we are accustomed to most participants... Currently, approximately 50% of the participants we meet are the [already] existing [ones]."*

Those with lower education levels and less free time on their hands were only heard if their local CSO networks were able enough to reach out to them and pro-actively bring in their voice. There still remain many provinces and topic



areas where the poor, vulnerable, and marginalized are not heard enough, and where careful outreach work would benefit both these groups and the NHA process overall. A well-reflected analysis of who are not participating, and why, would form a sound basis for designing this outreach work. In addition, one key informant suggested targeted focus groups for low-income, less educated, marginalized, and vulnerable groups; the results of these targeted focus group discussions would feed into the drafting group deliberations. The idea is to put these less advantaged groups in an atmosphere where they might feel more at ease to express themselves in their own language. Currently, the drafting groups tend to be dominated by technical jargon, often leaving less articulate members feeling daunted and silenced.

4. The role of academia, or the 'knowledge sector', could be leveraged more smartly to fulfil the objectives of the NHA

The added value of the 'knowledge sector' in the current NHA format is during the resolution drafting process; their input into the National Health Assembly drafting groups is crucial for understanding the evidence and lending legitimacy to the topic. During the actual 3-day NHA event, however, their input is, at the moment, minimal. At present, academia's participation in the NHA seems to be mostly in support of CSOs' and/or government's agenda.

Many of the key informants from the 'academic sector' who were interviewed explained that they attended the NHA as





civil society or think tank participants. In fact, all of the 'academic sector' interviewees wore different hats, and moved fluidly between civil society organizations and academia. It seems that most of the 'knowledge sector' does an excellent job of providing and explaining the data and information on an agenda set by others. Most of the academics and researchers themselves saw their role as explaining the complex evidence and translating academic language into everyday parlance. Indeed, CSOs undoubtedly need academia to translate their messages from lay terms to more scientifically rigorous language which is more respected and accepted. However, academia's NHA input seems to be focused solely on that role, without going much beyond it.

The challenge therefore is ensuring that academics participate in the NHA with their own institutional viewpoint as well. As one of the angles of the 'triangle that moves the mountain', it is a crucial constituency in the NHA. However, it is telling that their presence in the 3-day NHA event has been decreasing over time. This demonstrates the importance of their role behind the scenes, during NHA preparation, and during the drafting groups; it also attests to their lack of a clear role when it comes to expressing their own institutional view. One academic key informant plainly stated, *"When we analyse the academia [during the NHA event], most of them, just like me, work with the civil society, not in the name of [an] academic organization"*.

This case study, with all its due limitations, found that researchers interested in moving their research topic forward on a practical level do not use the NHA as a vehicle to do so. Instead, they seem to reach out to CSOs instead. A potential reason for this could be that 'academia', or the 'knowledge sector' is just as heterogeneous as the other 2 constituencies on the triangle, yet are currently allocated seats at the NHA as if they were a homogeneous group. Far from it, academics do not seem to be a unified, well-coordinated community in the Thai health sector like the CSO community have come to be over time. Yet, the modality through which academia's voice is expressed at the NHA assumes as such. The NHA's huge added value comes in the diversity and complementarity of viewpoints, and the opportunity to dialogue constructively and find consensus despite differences. It seems that not all academics who work on a particular field are included in the NHA process; the NHA is currently losing out on their potential valuable input. One interviewee bluntly commented *"There are many researchers working on the given issue who do not join the NHA and give their point of view"*. One academic key informant lamented that *"We don't have the mechanism to get consensus [amongst ourselves] before [the NHA]"*. This internal coordination is exactly what civil society and community-based organizations have been doing heavily, strengthening their capacities on the way, and presenting a united view to the NHA. This same mo-



modus operandi might not only benefit the 'knowledge sector' with cross-learning and exchange, but also underpin the NHA resolutions' knowledge base in stronger evidence which includes debate amongst the full range of actors working on a given topic.

5. National and provincial health assemblies must be better linked in order to reap the benefits of both for all administrative levels of the country

The Provincial Health Assemblies (PHA) were seen as very useful, especially by the province-level focus group, to address issues of local concern with local solutions. The NHCO spends much of its staff time and resources working with provincial CSO networks and provincial government to build capacity and assist in setting up and organizing a PHA. Yet the focus has strongly remained on dealing with provincial level issues and brokering a consensus through the PHA platform for solutions. It was acknowledged that this was necessary in many instances where the issues were, indeed, province-specific, with little relevance beyond provincial borders. However, more than one key informant felt that it was a missed opportunity to not use that in-depth knowledge and trust gained at provincial level to relate local problems to national ones where relevant. Many interviewees mentioned that other provinces and districts could profit from bringing provincial issues to national level; it would also ensure that the different

provinces addressing similar issues are coherent in their solution to the same problem. One informant reflected, "*I don't think the provincial policy [should be an] isolated policy...[it] should not be separated from the national assembly. I don't think so. They are separated because of the working structure of NHCO. They should [be] concern[ed] about this.*" It boils down to the fact that issues which are raised at provincial level are often relevant beyond provincial borders and hence need the NHA to connect the discussions with relevant national-level resolutions. By doing so, the PHA gains in value and relevance for all.

Another compelling reason to bring the two institutions closer together is the simple fact that much of the implementation of NHA resolutions take place at provincial level. It is ironic that much of the resolution follow-up involve working arrangements at provincial level and sometimes even a recommendation for a provincial-level resolution. Here, a concrete modus operandi could include joint and concomitant (where practical) preparation of a NHA and PHA resolutions with joint follow-up arrangements where there is overlap in the solutions implemented.

6. There remain some population groups who still do not participate enough in the NHA

Both key informants and the focus groups highlighted the relatively low voices of less educated, poor people in the NHA.



As mentioned earlier in this report, their input into the NHA depends heavily on the inclusiveness of the networks in their provinces. In provinces where the networks are strong and outreach is done regularly, their voice is likely well heard. However, in other areas, their thoughts and views may not make the passage over to those who will bring it up to the NHA. In addition, in drafting group meetings, the poorer, less educated members tend to be silent in the face of daunting technical jargon. The barriers of more academic-style writing loom large when resolutions are drafted. As one interviewee put it, *“They know their problem very well but they cannot write it in an academic way and propose it to the NHA”*. Finally, an aspect brought up especially by the provincial focus group was that practical considerations of time and availability is a challenge for poorer sections of the population for whom ‘participation’ happens on the margins of their ‘real lives’.

The NHCO should continue to invest in capacity building of regional (and other weaker) CSO networks, using the stronger regions for cross-learning and facilitation. For the drafting groups, as suggested above, separate sessions to obtain feedback from more silent populations can be considered. Separate sessions have the advantage of participants feeling ‘amongst themselves’ and thus more free to express themselves in lay language on the issues at hand. Regarding the lack of time and availability of poorer sections of society, more active outreach might be needed, i.e. going to

where they are to seek their input rather than the other way around. Perhaps studying how stronger provinces address this issue is a good starting point to learn from.

Another population group which many interviewees said needed some attention was actually the government sector. Here, not only higher-level government participation from the health sector is meant but also more active input from non-health government entities who have a stake in health. This has markedly improved since the first NHA but there is still considerable room for improvement, especially when it comes to resolution follow-up.

The issue of unorganized lay participation came up a few times during the course of the interviews. The NHA is dependent on coordinated networks or groups of people who rally around a cause. What about those who are not formally part of those networks and wish to have their voice heard independently? It may not be practical to accord a large number of seats to these individuals but it may be important to reflect on whether or not this type of participation is possible, and if so, how.

Lastly, almost all stakeholders interviewed regretted the low motivation and participation levels of the private sector. It was universally recognized that there is a large divergence in viewpoints and interests between the private and public sectors and that this must reduce in order to enact policies for public good. Yet, having the NHA process engage more





meaningfully with the private sector is seen as a challenge by the private sector itself. The private sector stakeholders interviewed were aware of the NHA process and had participated several times. Those who had experienced the NHA process at least once seem to see its added value but relayed that it is extremely difficult to motivate their peers to spend their time on something which does not bear any obvious fruit. Industry representatives did, however, strongly state that if the resolutions were binding or if there were an unequivocal policy link, the interest amongst their peers to participate would surge.

7. There is an acute need to raise awareness on the NHA process, how it works, and how it can be of benefit to different stakeholders

Many people simply have not heard of NHA and do not know one must access it through certain networks and civil society organizations. One interviewee affirmed, *“I joined the NHA as an observer because I didn’t know NHA at that time. I didn’t even know that I was one of the constituencies. I didn’t know...that I was listed in the network. So many organizations do not know, just like me”*. The NHA existence should be made more widely known to begin with. In addition, information campaigns can be stepped up to make people aware of the fairly complex NHA process. Even within the 3 groups of the

‘triangle which moves the mountain’, many stakeholders are unaware of how exactly the NHA works and where a good entry point would be for their issues. The NHCO is cognizant of this and conducts information sessions but they can be increased and expanded in the stakeholders they target. In essence, a larger budget and resources for communication and outreach might be helpful for taking meaningful stakeholder participation to a new level.

8. Despite large strides made since the first NHA, evidence gathering and analysis skills remain a challenge with weaker capacity constituencies (some CSOs, poorer provinces, etc.)

This issue is linked closely with the earlier point made on communities and local people who are shut out of discussions because they are not fluent in technical language. While the ‘people’s sector’ tends to propose topics based on lived experiences and expectations, bringing them together with academics and others allows for linking those experiences with an evidence base for those issues. However, understanding and analysing the evidence is not necessarily the forte of community organizations. The NHCO should thus continue to build evidence analysis capacity and ensure a good match of ‘people’s sector’ issues with the right academics and think tanks.

Discussion

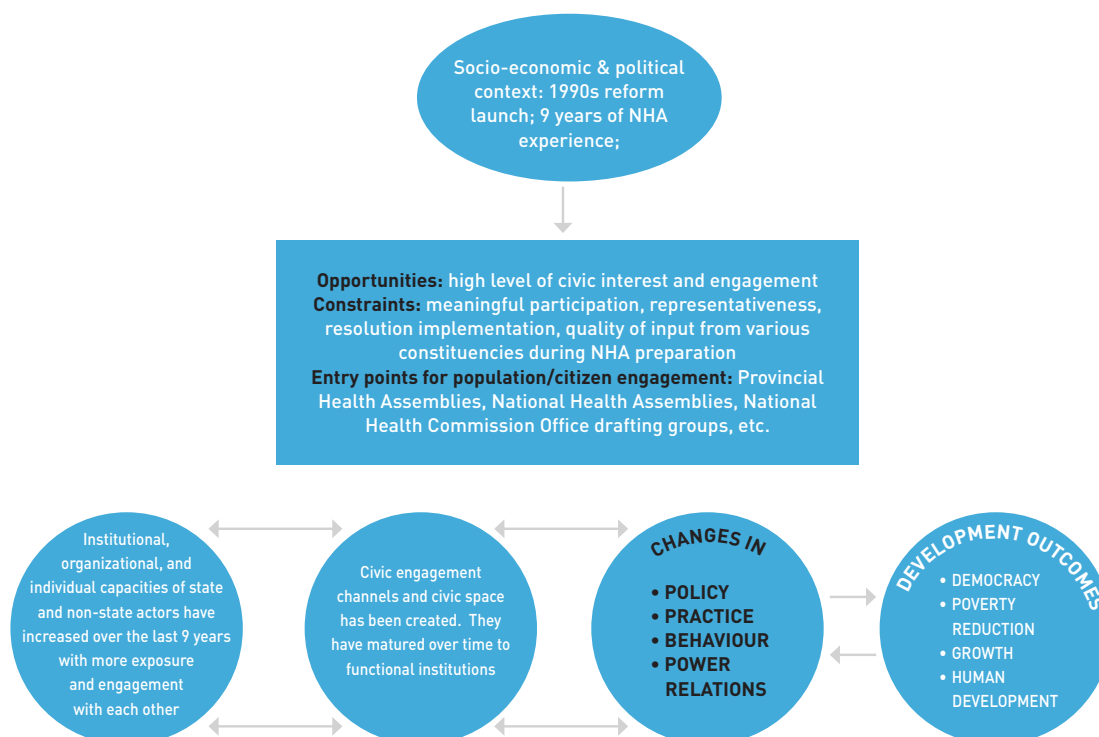
The health reform movement which kicked off in the late 1990s in Thailand created a socio-political environment which was conducive to more open citizen-state engagement. In addition, the public increasingly demanded more participation and consultation in policy-making.

A sufficiently long and sustained period of collective citizen consciousness was cultivated in subsequent years, culminating in the first NHA in the early 2000s. Each of the NHAs since then have served as learning experiences for both citizens and the state to improve upon for the next round.

A window of opportunity presented itself post-coup d'état in 2006 where the Minister of Public Health, who believed in the NHA process, was influential in the military government. The National Health Act, despite opposition and a reluctance to change the status quo, passed through Parliament. This led the way for a further decade (till the present) of experience and learning through the NHA.

The NHA is only one mechanism for greater citizen-state engagement following the National Health Act. Its success lies partly in the fact that it is well embedded into a larger reform and stakeholder engagement process which prioritizes population capacity-building and fostering civic consciousness.

Figure 4: Theory of Change for 9 years of National Health Assemblies in Thailand¹¹





Overall, the major strides achieved since 2008 on the development, institutionalization, and constant fine-tuning of the NHA is commendable and can inspire other sectors and countries to follow suit. The fact that the NHA is a pillar which cannot be bypassed for some health topics is testimony to the influence of what many Thai policy-makers termed 'soft power' in interviews. The power of participation and the power of constituencies coming together can be seen live in Thailand every December at the National Health Assembly. The lesson to be learned is clearly that the potential of citizen's voice to offer concrete policy options is remarkable when appropriate channels and fora are offered.

The NHA has allowed the different constituencies to understand each other's points of view much better through dialogue. Dialogue has helped foster respect for very differing takes on the same issue, a respect which was not necessarily present when the NHA began and mistrust was more rampant amongst the different parties. This is not to say that this has completely disappeared; what has changed is the way the different stakeholders, mistrustful of each other or not, discuss and debate with each other in a real attempt at consensus. It goes without saying that this is enormously difficult and tense at times, and thus represents an inherent challenge of the NHA which must be constantly monitored and managed.

"Ordinary people have access to national health issues [now]", said one of this

study's key informants, reinforcing their newfound awareness that the Thai government has, indeed, provided an enabling environment which allows citizens to contribute to policy-making, each with their unique point of view. Slowly but surely, a new working culture for society may be setting in, one based on dialogue and consensus. Such a change in mindset takes time. The NHCO has been wise to view dialogue as a long process, not a one-off event, involving several meetings and possibilities to listen and exchange, allowing space for reflection and exposure to different ideas which have time to take root and grow.

Nevertheless, there remain considerable challenges ahead, some which pose great risks to the credibility of the NHA as an institution. Working on ensuring a strong and sustainable link to decision-making and the highest political circles will make the NHA more relevant, and bring in more and diverse stakeholders into the active participatory process. Unless and until what are called 'hard power' and 'soft power' processes, or internal government policy-making processes and NHA-type participatory approaches, are more closely integrated and linked, NHA resolutions will remain poorly implemented. A separate impact evaluation study could be useful here, which would examine hard power processes more closely to bring potential recommendations as to how best bring hard and soft power closer together.

In addition, reaching out to the poor and most vulnerable more actively, as well as



the private sector, will be demanding and require proportionally more resources -- as is often the case when trying to reach the last mile. Rethinking how the 'knowledge sector' participates and brings in their own institutional intelligence will require an outreach strategy with academia.

Examining how representative the NHA representatives are of their allocated constituency group might necessitate a new format for the NHA. Since correct representation is the backbone of the underlying philosophy of the NHA, it is a pressing matter not to procrastinate on. Spending some thought on how to raise general awareness among relevant stakeholder groups on the NHA as a process and institution might help reach out

to those who are not represented well, as well as to many others who already belong to constituencies but do not actively participate.

The 3 triangle groups coming together to complement each other is a huge strength of the NHA. Very few other mechanisms exist for health sector issues which brings these particular groups together. The type of knowledge gleaned from those who are living the issue and have an opinion based on their experience is invaluable when put together with those who are approaching the issue more technically. The NHA is thus special in that it brings experts and non-experts together which has helped craft viable solutions and should continue to do so in the future.





Limitations

This study was based solely on a review of 8 English-language documents and 2 Thai language documents summarized into English, joint development of a theory of change, 9 key informant interviews, and 2 focus groups. Mining the Thai language literature in more detail would have been enormously useful and presents a limitation to this study. In addition, due to time constraints, field observations of provincial health assemblies and drafting group meetings were not undertaken as planned.



Conclusion

Thai health systems development has benefitted greatly from the NHA institution by improving civic consciousness and amplifying citizen's voice. It has also led to a tacit acknowledgement by many government actors that they are not the sole owners of the solutions to Thai health sector challenges. The improved quality of dialogue and consultations linked to shifts in mind-set of officials and citizens over time has led to an increased understanding and respect for each other's views and a more balanced perspective reflected in consensus-based resolutions. The NHA has also contributed to the discernible change in the perception of health as solely within the purview of biomedicine. A more holistic concept of health is now anchored in the government discourse as well as civil society activism.

That being said, health challenges which particularly need targeted intersectoral action and broad population buy-in are especially suited for debate in the NHA format. Many government officials thus appreciated the existence of this platform which facilitates such discourse ('soft power') but also mentioned that some topics which are clearly health-specific in nature and which enjoy broad support from all stakeholders – the quintessential example being vaccination campaigns – can be designed and decided within the Ministry of Public Health without a long, participatory process ('hard

power'). The point here is that participation as a fundamental value of public policy is necessary but need not mean that straightforward and simple policies with no contention need to be subjected to a process such as the NHA – it would take away precious NHA time from the really contentious or complex issues and would not add any extra value. What would add real value is a firm link between the 'hard power' and 'soft power', which in essence is the National Health Commission with its high-level access to the President's Cabinet as well as the NHA Resolution Follow-Up Committee. As mentioned earlier in this case study, those links are not yet firm enough and will need some specialized and targeted action if the NHA is to remain relevant.

The Thai government's efforts to bring all participants on an equal footing with regard to their input into the NHA is admirable. As the former Secretary-General of the National Health Commission stated, *"We come from different groups of society, but when we work together, we are on [an] equal basis, not that the professionals have a very high status. We have the process that [any one] of us can propose [an] issue of concern and we have the committee or sub-committee to oversee [that]"*. This effort includes long-term capacity building of civil society, communities, and provincial networks, as well as awareness raising activities. However, this case study has demon-



stated that these efforts should be stepped up within certain constituencies, such as academia, private sector and non-health government entities.

The NHA can be used as a model for other sectors to implement the concept of participatory public policies. Indeed, the lessons learned from the Thai NHA can be extremely useful not only within Thailand but throughout the region and for other Member States of the World Health Organization.





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