Introduction

Public participation in health policy development has grown significantly in high income countries since the Ottawa Charter for Health Promotion in 1986. The concept of ‘healthy public policy development’ was first raised in Thailand in the mid 1980s but took shape in the late 1990s at a time of constitutional change. Since then, decision-makers in Thailand have made great strides to encourage a participatory response to health through the auspices of the National Health Assembly (NHA), created as a result of the National Health Act 2007.

A participatory and multi-sector response to health recognises that all of society, including sectors not normally associated with health, have a shared responsibility for improving health, and that health can also become a driving force for social and economic development. The WHO Health in All Policies (HiAP) is an approach which enables and encourages all sectors to take the health implications of their decisions into account and to work together towards the development of public policies which improve population health and health equity.

Ottawa Charter 1986:

“Health promotion goes beyond health care. It puts health on the agenda of policy-makers in all sectors and at all levels, addressing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.”

The NHA in Thailand is the first political body of its type in South East Asia to embody the concept of a HiAP approach to public policy development. Using Thailand (2013)’s analysis of the first 5 NHA’s (2008-2012), in particular the main constituencies involved and the different
stages of the policy development process, two components emerge as being intrinsic to the success of the NHA: (1) engagement mechanisms which enable and foster intersectional dialogue, and (2) knowledge which is important to manage conflict and build trust between constituencies, and as the essential ingredient in the formulation of resolutions. The case study also identifies some of the key challenges which need to be addressed for NHA resolutions to be put into action by all sectors.

Background - the emergence of an inter-sectoral response to health

The policy change window

Traditionally, the policy process in Thailand is heavily centralised with limited opportunities for information-sharing, coordination and collaboration among sectors. Public involvement in health policy development took shape after the 1997 Constitution was enacted. This was the first constitution to be drafted by a popularly-elected Constitutional Drafting Assembly and included a number of features such as the decentralisation of government and recognition of human rights, including the right to public health. Such features were also included in the 2007 Constitution of Thailand [1,p,15]. Even though decentralisation has been slow [2.p,347], these contextual factors which emerged with the Constitution are important as they perhaps shed some light on why a participatory response to health emerged at this time.

In addition, despite doing well in many areas including communicable diseases, an essay by Wasi written in 2000, ‘Triangle that moves the mountain’ identified that, at this time, the Thai health system was in crisis with increasing rates of health expenditure as well as challenges in access to quality healthcare [3. p,107]. Wasi outlined the need to move away from an ‘ill-health-oriented’ system towards a ‘good-health-oriented’ system. He recognised that responsibility for ‘good-health’ would lie with ‘all sectors of society’ [3.p,108]. It was, perhaps, also within this context that the need for a National Health Act, which would stipulate the role of all sectors, came about.

HiAP “…An approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity.” WHO working definition prepared for the 8th Global Conference on Health Promotion, Helsinki, Finland, 2013

The National Health Act 2007

In 2000, with a mandate to draft the National Health Bill, the National Health System Reform Committee and the National Health System Reform Office were established to steer health systems reform in Thailand. The drafting process was participatory in nature with over 400,000 participants from various sectors and organisations taking part in over 500 brainstorming sessions.

The National Health Act 2007 incorporates a definition of health not merely as the absence of disease or infirmity, but as a state of complete physical, mental, spiritual and social well-being [4]. The Act established the National Health Commission (NHC) which is chaired by the Prime Minister and consists of Ministers from various sectors (as appointed by the PM), representatives from local government and the private sector, as well as the President of the National Economic and Social Advisory Council and the President of the National Human Rights Commission [4]. Two key duties of the NHC are:
1. ‘to organise a national health assembly and support the organisation of a health assembly in a specific locality or on a specific issue’

2. ‘to provide, promote or support the process of health policies and strategies development for continuity of performance of activities and public participation from all sectors’ [4].

The Act specified the organisation of a health assembly in a specific locality or on a specific issue (i.e. it can be organised locally, nationally or by area). The NHC is responsible for organising a National Health Assembly and for the appointment of a National Health Assembly Organising Committee (NHAOC) which has responsibility for drawing up of NHA rules and regulations, organising the NHA forum, inviting participants and considering applications to participate in the forum [4].

The NHA - Health in All Policies in action

The National Health Assembly is the first political body of its type in South East Asia to embody the concept of a HiAP approach to public policy development.

The NHA convenes each year and provides an arena to facilitate dialogue for inter-sectoral health, to ensure participation in policy development and is a place where all sectors can work together to develop policy resolutions to some of the biggest public health and public policy challenges.

Thailand (2013), reviewed the experiences of the first five NHA (from 2008-2012). Using its findings, the following section outlines the main constituencies involved in the NHA and their participation at the different stages of NHA policy development. In doing so, various engagement mechanisms are identified which have enabled inter-sectoral collaboration and the role of knowledge to facilitate trust and manage conflicts between constituencies. It also sets out some of the challenges which need to be addressed for NHA to reach its potential where inter-sectoral policies are all translated into action.

Constituencies of the NHA

The participatory principle of the NHA is based on Wasi’s (2000) approach structure known as ‘Triangle that Moves the Mountain’ where ‘the mountain means a big and very difficult problem, usually immovable’ [4, p.106]. The Triangle, as illustrated in Figure 1, consists of: (1) Creation of relevant knowledge through research, (2) Social movement or social learning and (3) Political involvement. In essence, each power relies on the other to ‘move mountains’. Related to the NHA, the Assembly provides a structure which can empower the public (social movement) with relevant knowledge to be involved in the political process which tends to have the resources and authority which are needed in development. The inverse is also true, ‘politics without knowledge and social movement will not do’ [4, p.107].

Thailand 2013, also inferred that this approach structure was used to ensure that the constituencies which were invited from all over the country to participate in the NHA represented the 3 main powers of the ‘Triangle’ as illustrated in Figure 1. They include:

1. Delegates from knowledge sector (research institutes, technical institutes, and professional councils)

2. Delegates from people sector (civil society including NGOs and business related agencies)

3. Delegates from political sector (government agencies, local administrative organisations, independent regulatory agencies and political parties)
Thailand 2013, added a fourth constituency: delegates from provincial constituencies.

The inclusion of provisional constituencies is apt given that they would be implementing the policy which is being developed (see figure 1).

A working group was appointed with responsibility for ensuring that the NHA is representative of all constituencies. During the first 5 NHA’s, participation increased each year from 178 constituencies in the first NHA to 234 in the fifth NHA in 2012. More specifically, during the first NHA there were only three business representatives but by the fifth, there were 12.

Thailand 2013 also identified that the ability of the NHA to make effective policy was challenged by the fact that some representatives lacked the authority to support or approve NHA resolutions. In the case of ‘Prevention of Health Impacts from Free Trade Agreements’, for example, the representatives from the people sector, such as NGOs, had the authority to take decisions and present the opinions of their organisations to the NHA. In contrast, representatives from government agencies, such as the Ministry of Commerce, and representatives from the business sector, did not have the authority to act and had to consult with more senior level officials before giving an opinion. Although it is not clear why this was the case, it is a useful observation as it identifies a factor which could hinder the ability of the NHA to be more than just a forum for information sharing.

**National Health Assembly - engagement mechanisms for inter-sectoral dialogue**

The following section sets out the different stages of the NHA policy development process and identifies the mechanisms which have been established to foster inter-sectoral engagement and participation between all constituencies at each stage of the policy process (figure 2).

**Agenda setting**

The NHA policy development process begins with the submission of proposals or issues of concern to the NHAOC. During the first 5 NHA’s, proposals were submitted from specific sectors, such as the ‘Medical Hub’ proposal which was submitted
by the business sector, from specific organisations, and also from area-based health assemblies. The ‘Mental Health and Suicide’ item, for example, was proposed by an area-based health assembly network in the northern region.

Each year over 50 proposals are submitted. The NHAOC applies 4 criteria for the prioritisation and selection of proposals to be included as agenda items:

1. Emergency
2. Nationwide impact
3. Public interest
4. Possibility of the issue succeeding to implementation.

Thailand 2013 noted that during the first 5 NHA’s issues with complexity requiring inter-sectoral action had a high tendency to be selected as agenda items. It was also observed that issues from the provinces, mostly submitted by groups or area assemblies, had a high propensity to be accepted as they had a tendency to better meet the criteria. In contrast, proposals submitted from the knowledge sector, mostly by individuals, had the lowest rate of being included in the NHA agenda.

Within the agenda setting stage, workshops are set up as formal engagement tool to facilitate discussion between groups which have submitted similar proposals, with the aim of merging their proposals (see Figure 2).

**Drafting Resolutions - the role of knowledge**

Once the agenda is set, the next stage is to draft resolutions. For each agenda item, a Technical Working Group (TWG) is established and provides a formal arrangement for all stakeholders, including those who proposed the issues and representatives from each of the constituencies, to participate in drafting the resolution (see figure 2). The process takes between 4 and 6 months.

Evidence based policy has been highlighted by Thailand 2013 as being the most critical ingredient for the TWGs to formulate draft resolutions. As with the ‘The Triangle that can Move the Mountains’ structure, academic contributions are seen as critical to provide the necessary knowledge to empower the public (people sector) to be involved and inform the political process. Likewise it is important to politics to ensure that evidence based resolutions are created. In the case
of agenda item, ‘Sustainable Development Plan of Southern Region’, for example, data compiled by community members that reflected their cultural, environment and economic situation, was used to inform the draft resolution. Evidence has been seen as such a crucial factor in policy development that civil society organisations who take part in the NHA have increased their knowledge capability to fill information gaps and give their positions legitimacy (Thailand 2013).

Thailand 2013, also emphasised the important role of knowledge as a way of managing conflict and building trust between constituencies. For example, the ‘Medical Hub Policy’ introduced by the government as a dual track policy with ‘Universal Health Coverage’, created tension between the business sector and civil society. The business sector supported the medical hub as a way of generating revenue for Thailand. In contrast, civil society and consumer protection NGOs raised concerns that the medical hub would lure physicians away from the public sector hospitals, reducing quality and access for medical care for Thais. In this situation, knowledge became an important vehicle to steer and try to manage this conflict. Accordingly, the NHAOC endorsed a Chair of the TWG from the Health System Research Institute and the secretariat team from the International Health Policy Program, both research institutes. An agreement of the working groups to only use technical and evidence-based information from reliable sources also helped to minimise tension between groups with differing views.

Before the draft resolutions are submitted to the NHA forum, they are brought to a wider public hearing through different channels including the internet, direct mail, and through more formal mechanisms such as public hearing forums (see Figure 2). At a local level, for example, Provincial Health Assembly’s comprising of representatives from the Triangle are used to garner views, gain public opinion and finalise positions. In a similar way to the WHA, a regional voice is agreed in a Regional Health Assembly to solicit a regional position.

The NHA Forum - the adoption of resolutions

A 3-day process, the NHA forum is a further opportunity for consideration and discussion of items among representatives before they are adopted in a Plenary Hall.

The forum begins with the adoption of the NHA agenda items by all constituencies in a Plenary Hall. Agenda items to be considered are then divided into 2 groups and are run by 2 subcommittees in separate rooms (see Figure 2). Agenda items to be reported as a progress report are run by another subcommittee elsewhere. Each constituency has 3 minutes to discuss and propose its opinions on each agenda item. Similar to the WHA, a drafting group can be appointed if agreement cannot be easily reached in the subcommittee. In the first NHA, for example, item ‘Universal Access to Medicines’, was discussed in a drafting group for 17 hours before the resolution was adopted by the subcommittee and finally the NHA.

Before returning to the Plenary Hall for adoption, resolutions are first adopted by subcommittees. The NHA resolutions, once adopted, belong to all society. They are subsequently passed and endorsed by the NHC and then to the Cabinet for consideration.
Implementing resolutions, monitoring and evaluation

Once resolutions are adopted, the NHCO, as a secretariat to the NHAOC, is responsible for informing and discussing with the relevant constituencies their roles and expected responsibilities. All NHA resolutions are submitted to the Cabinet for either acknowledgement or endorsement and subsequent implementation by the relevant departments, ministries and agencies [5, p.8]. The monitoring and evaluation of resolutions is undertaken by the ‘Committee for the monitoring of the Implementation of NHA Resolutions’, created by the NHC. There is also a channel, started in NHA 2012, for constituencies to propose a revision of previously adopted NHA resolutions if needed [5, p.8] (see Figure 2).

Thailand 2013 pointed out that one of the biggest challenges to the effectiveness of the NHA during the first 5 assemblies was that some government agencies did not recognise its legitimacy which made implementation of resolutions, even those adopted by the Cabinet, very difficult. For example, the resolution ‘Making Thailand Free from Asbestos’ was adopted by the NHA and subsequently approved by the Cabinet. The resolution agreed that Chrysotile is not allowed in any products able to be produced from Chrysotile substitutes. However, the Ministry of Industry is yet to implement the resolution and has asked for Thai specific epidemiological evidence of cancers and diseases caused by asbestos. Thailand 2013 hinted that the Ministry viewed the policy through an economic lens and the impact it would have on industry, rather than a HiAP approach which takes into account the health implications of decisions. This example underlines the need, as shown in the ‘Triangle’, for continued research to inform resolutions, a mechanism for managing conflicts.

Thailand (2013) also outlined a number of examples where non-health sector agencies clearly recognised the importance of a HiAP approach and are actively engaged in the implementation of resolutions with other sectors. In the case of ‘Control of illegal Health Product Advertisements’, for example, the resolution was adopted during the fourth NHA but it was only acknowledged by the Cabinet. Despite this, a memorandum of understanding between the Thai Food and Drug Administration, Office of the National Broadcasting and Telecommunications Commission, Office of the Consumer Protection Board, and Consumer Protection Police Division has been created to draft a plan with the technical support from the knowledge sector and with the active participation of consumer protection NGOs. At the time of writing (Thailand 2013), the organisations were holding regular meetings with the aim of controlling misleading health product advertisements in Thailand [5, p.9].

Conclusion

Thailand’s NHA is a clear example of a HiAP approach to policy development in action. Thailand (2013) describes the experiences of the first 5 NHA’s and shows how it has provided a space for all constituencies to be actively involved in ‘healthy’ policy development. It has been shown that engagement tools, such as workshops, working groups and forums, are vital for inter-sectoral dialogue and to scrutinise the legislative process to ensure that good policy is developed. Knowledge has also been shown to play a critical role in managing conflicts and building trust between constituencies, and giving legitimacy to the policy positions of people sector delegates. It has been the essential ingredient in the formulation of resolutions (Thailand 2013).
At the same time, Thailand (2013) recognises that the NHA is still evolving and there are a number of challenges which need to be addressed for NHA to realise its potential where all sectors (particularly non-health agencies) recognise the authority of NHA and the value of developing ‘healthy’ public policy. Further work is needed to ensure that: (1) representatives who attend the NHA have the authority to make decisions on behalf of their agencies, (2) there are sufficient engagement mechanisms available to build trust and confidence between constituencies, and (3) a monitoring structure is in place to monitor policy impacts and outcomes of resolutions over the longer term, which can also be used to inform future policy development and provide data to show the success and benefits of a multi-sector approach to policy development.

References

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