

Chapter 10

Participatory Development of Healthy Public Policy and Statute on National Health System

1. Meaning and Evolution of Public Policy

In the past, “policy” was understood that it was an issue undertaken only by the government and state agencies. As a matter of fact, “policy” is drawn up all the time in each society and every policy created will have an impact on a large number of people. Thus, policy is a matter that every one is to be involved in as the world has progressed a great deal. Transboundary transfer/communication of knowledge and information as well as social complexity has made people begin to express the needs to have and exercise the right to choose the rule including policy that might affect their livelihood or community. The role of the central government begins to decline in importance; policy is not confined only as a political policy of various political parties, governments, ministries, and departments; rather, policy can also be formulated by the popular sector, the private sector, the community and society. Thus, this kind of policy should be called “public policy” which means **“direction or guide that the entire society has deemed or believed that actions should be carried out in such a direction”** without any written statement from the government or state agency.

An analysis of public policy in Thai society in the past has revealed weaknesses in the policy process resulting from:

1.1 People’s inaccessibility to public policy process. The people were excluded from the process or had just an opportunity to perfunctorily learn about it. The 2007 Constitution of Thailand has tried to close this gap with a provision in Section 87(1): “The state shall promote public participation in the determination of public policies and economic and social development planning both at national and local levels”.

1.2 Imbalanced importance given to various values and dimensions. Importance tended to be chiefly given to economic dimension favorable to certain groups of people, while the majesty lost an opportunity and were disadvantaged. For example, the policy on industrial estate development for “Map Ta Phut” which benefited non-resident investors, while local residents had to cope with health-deteriorating pollution, changes in livelihood, and society overwhelmed with non-local cultures, resulting in problems related quality of life of children, youths and family members.



1.3 Public policy created with the lack of inadequate technical evidence. Such a policy was especially the one set according to the information or data obtained from some groups of people that benefited from, but did not take into account the impact on other aspects such as policies on energy and building a power plant in the locality.

1.4 Lack of impact assessment and consideration of various options. There were no mechanisms and methods for impact assessment in various aspects; nor were there several options. More importantly, there was no public participation in the policy formulation process such as the water management policy that focused on supporting the industrial sector resulting in a fight for water from the community and agricultural areas rather than getting together to appropriately share and utilize limited resources.

1.5 Lack of systems for monitoring and evaluation of public policies. There have been no such systems especially for the created or implemented policies until negative impacts have occurred cumulatively and become serious and chronic without any problem resolution or policy revision as appropriate.

Prof. Dr. Prawase Wasi has mentioned about three evil deeds (akusala-kamma) in public policy resulting in “policy corruption”, which include:

- 1) **Lack of knowledge** – resulting from wishful thinking, conflict of interest, lack of information/evidence, and lack of rational consideration.
- 2) **Lack of wide-scale participation** – policy formulated by only a few people without the broad participation of stakeholders, but affecting the people of the whole country.
- 3) **Lack of morality** – lack of ideology for righteousness and all people’s benefit, but for the benefit of certain people or groups.

On the contrary, a good public policy process should be based on three good deeds as follows:

- 1) **Intellectual process** – using the evidence or facts that have been analyzed to obtain “knowledge” so-called knowledge-based policy formulation.
- 2) **Social process** – as the policy will affect all people that are stakeholders in society, the society should play a role or take part in the process of learning and policy formulation in a transparent manner.
- 3) **Moral process** – the public policy process should have the ideology for righteousness and maximum benefit for all members of society without any vested interest for any particular group.

The key element of public policy formulation is the “**process**”, i.e. the **participation of all concerned in society** is needed for sharing/exchanging information and knowledge, drawing up public policy directions, jointly implementing the policy, following up on policy implementation, and reviewing/revising the policy on a continuous basis. It has to be accepted that the movement for the participatory action in public policy formulation in Thailand has resulted really from the awareness and drive of the popular sector or civil

society, outside the public sector. The role of civil society in public policy process has been so extensive that there has been an impact on the formulation and monitoring of public policy, which previously was confined only to relevant state agencies. That reflects the fact that certain groups in society have more realized the importance of “public” than “personal” interest. Recently, the factors that have accelerated and empowered the civil society participation with the public sector in the public policy process is the provision of the 1997 Constitution, which is regarded as one of the most democratic constitutions and resulted from the joint movements of the people and academics in the participatory democracy for political reforms since 1992. The constitution contained a clearly stated provision that urged Thai citizens to give importance to, and recognize, the basic right of human beings and also give rise to the empowerment of various civil society organizations.

2. Participatory Development towards Healthy Public Policy

In 1998, the primary health care strategy was adopted in the Alma-Ata Declaration of Health for all by the year 2000 and became the beginning of major health care reforms, shifting from centralized health systems towards the expansion of community hospitals and subdistrict health centres as well as village health volunteers assisting in providing health care for villagers. A major campaign using various formats was conducted on tobacco control by public and private sector agencies including non-profit organizations for the mass media, academics and lawyers. The campaign deployed the social marketing strategy against cigarette smoking and the Ministry of Public Health played a lead role in the enactment of significant laws: the Tobacco Product Control Act of B.E. 2535 (1992) and the Non-Smokers’ Health Protection Act of B.E. 2535 (1992). In addition, there have been movements on healthy cities, healthy schools and healthy workplaces. The major occurrence resulting from health system reforms during the period 1978–1996 was the opening of space for the people outside the state and health sectors to participate in health programmes; and the definition of “health” has been expanded beyond the issue of “disease”.

The implementation of various public policies has had an impact on health and well-being, positively and negatively, directly and indirectly. For example, agricultural development policies focusing on yield enhancement with wide-scale utilization of growth-stimulating chemicals and pesticides. Despite increased yield and income, such practices have a direct impact on farmers’ health, chemical contamination, and consumers’ safety, as well as on environmental pollutions so-called “poisoned land”. On the contrary, the implementation of public policy gives the importance to health and well-being as called “healthy public policy” emphasizing the creation of health security. For example, the public policy on transport gives the importance to road safety and the agricultural promotion policy gives the importance to pesticide-free agriculture.

“Healthy public policy means a direction or guide that the society has collectively deemed or believed that the policy should be implemental with an explicit concern for health and the society is prepared to be accountable for the health consequences of such policy; meanwhile, the policy aims to create health-enhancing social and physical environments and make health choices accessible for citizens to lead healthy lives.”



Both terms (healthy public policy and public health policy) might be confusing among some persons concerned as they have different but related meanings. Healthy public policy has a broader meaning related to all development efforts in society, while public health policy deals with the policy for the implementation of public health programmes and is thus important for the improvement of people's health. However, that is not sufficient to prevent and control health impacts from public policies and other health threats. For example, under the government's policy on universal healthcare, during the New Year and Songkran (Thai New Year) festivals there are a large number of road traffic accidents and injuries and every injured case has the right to medical service at any state hospital. But that is regarded as short-term problem solving, thus, at present, many state agencies, public benefit organization, academics, private sector agencies and the general public have urged the government to pay attention to formulate public policy on issues that are the root causes of problems, i.e. developing mass transit systems, improving road safety conditions, creating driving disciplines among motorists, enforcing the anti-drunk-driving measure; controlling alcohol advertisements and sales, etc. They are broader than public health policies but important for health and related to a large number of people outside the health sector.

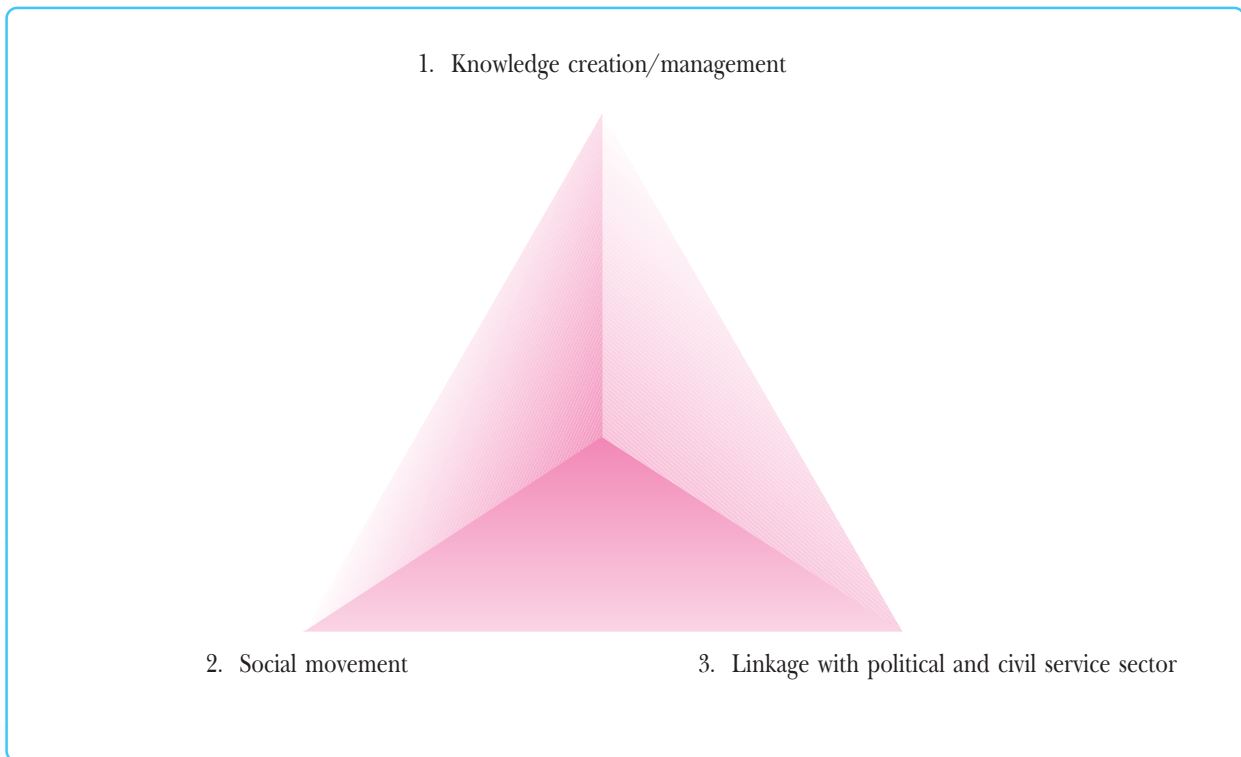
Professor Prawase Wasi mentioned about the public policy process that "It should not be a shortened process of making recommendations to be proposed to policy-makers, but the emphasis should be on participatory learning by all sectors concerned so as to reach social understanding, social value and social practice, taking the recommendations as a by-product. The creation of a good healthy public policy should be a **"Participatory Public Policy Process"** or PPPP with the participation of all sectors according to "the triangle that moves the mountain" strategy (Figure 10.1) introduced by Prof. Wasi including three principal sectors:

1) Technical and professional sector, including academics from educational institutions/ universities and policy research funding agencies (such as the Thai Research Fund, the Health Systems Research Institute, and the National Research Council of Thailand), health professionals and other relevant persons.

2) Popular and social sectors, including civil society organizations, the mass media, non-governmental organizations, private sector agencies, elderly persons groups, disabled persons groups, children and youth groups, and disadvantaged groups.

3) Political and civil service sector, including state agencies (ministries and departments), representatives of independent organizations (the National Economic and Social Advisory Council and the National Human Rights Commission), political sector (cabinet members, members of parliament), and local government organizations at all levels.

Figure 10.1 The “triangle that moves the mountain” strategy



Source: Prawase Wasi, 2002.

The initiation of public policy process may be undertaken from any of the angles or sectors, but with a real participatory action involving the receipt of information and participation in thinking, planning, decision-making, implementation, benefit-taking, monitoring/evaluation and examination of the healthy public policy, not just organizing a meeting to inform the people attending such meeting. In this process, each sector can exert their capability in support of the policy development. For example, the technical sector can play a key role in the creation of wisdom or knowledge which is the foundation for synthesizing a good policy, while the popular sector, including the private sector and the mass media, can play a key role in the monitoring effort, informing or warning the society as a whole to be aware of any health-affecting project or a policy that will be implemented in the locality, or suggesting which new policy should be created and then actively participate with the technical and policy-making sectors in developing a public policy using the interactive learning through action approach. Such undertaking is to be done without my egocentric feelings, emotion and obstinacy. Another key element in this effort is respecting and valuing other people’s knowledge. The policy-making sector has to sincerely respect the value and equality of the popular sector participating in the process; meanwhile, the technical sector has to be open to different opinions, not always regarding their own knowledge as correct. The popular sector has to listen to different views for careful consideration. If the public policy process moves along amidst the atmosphere of valuing and knowledge sharing, there will be a process of knowledge management leading to intellectual innovation of a high-quality healthy public policy that is timely agreed upon by all sectors concerned.



3. Development of Mechanisms for Participatory Healthy Public Policy: From “Primary Health Care” towards “Health System Reform” and “Nation Health Act”

The beginning of health system reforms in Thailand was the formation of a health community that grew up along with citizen politics after the 14 October 1973 incident such as the Coordinating Committee on Non-Governmental Organizations for Primary Health Care, the Rural Doctors Foundation, the Folk Doctor Foundation, and the Consumer Protection Foundation. One of the factors that helped strengthen the health community was the primary health care in 1977 that enhanced the experience in health system management in the popular sector to become networks, which, even though not being large ones, later became diverse and expanded to the protection of rights. In 1986, the declaration of the Ottawa Charter at the first international conference on health promotion was the new era of health promotion that clearly gave importance to the strengthening of community action and the creation of healthy public policy. When the 1997 Constitution of the Kingdom of Thailand was promulgated, the participatory development of healthy public policy began to be seriously undertaken under the flag of health system reform.

Since 1990, the trends of health sector reforms have began all over the world due to several causes such as rising medical care costs, lack of health security for the people, and poor quality of health care. The reforms focused on medical service system chiefly using financing measures. For Thailand, **health care reforms had a major difference in that they emphasized social movement and empowerment in joining technical, social and political forces.** The new and desirable health system of Thailand focused on **disease prevention and health promotion**, adjusting the thinking system and operating structure to be holistic in nature, **distributing the roles and strengthening the capacity of the people, communities and society to jointly take responsibility** for health care even from the personal behaviour level to health policy-making and health management at the community, local and national levels.

In 2000, the Senate Standing Committee on Public Health prepared “A Report on National Health System” with recommendations for health system reform according to the 1977 Constitution of Thailand, including the overall picture of the desirable health system and clearly proposing the drafting of a National Health Act for use as a major health legislation for people’s health development in the long run. That was the first time for the term “Health Systems” was officially used in a broader meaning than the term “Public Health Systems” that was previously used. As a result, the process of Thai health system reform was formally established as per **the Regulation of the Prime Minister’s Office on National Health System Reform on 31 July 2000**, deploying the coordinating mechanism of three major sectors: the people, technical and political sectors, so-called “the triangle that moves the mountain” strategy. According to the regulation, the National Health System Reform Commission was chaired by the Prime Minister and composed of representatives from the three major sectors, **and the National Health System Reform Office (HSRO) was established under the Health Systems Research Institute (HSRI)** to serve as the secretariat in undertaking national health system

reform efforts and getting the National Health Act passed as the major health legislation for Thai society.

Under the direction of Thai health system reform with the “building health leads fixing health” policy, the focus was on changing the way of thinking about health among all Thais and urging them to realize the right to health, i.e. health is a matter for everyone, not waiting to be provided by the state, and is broader than “disease” and “organ”. *Health deals with “the entire system interconnected holistically having an impact on the health status of the people throughout the country and all health-related factors, namely personal, environmental, economic, social, physical and biological as well as health-care system factors”*. The health system reform movement utilized the National Health Act drafting process as a tool to mobilize cooperation and opinions from all sectors. Thus, the drafting of the legislation was both the process and the target, which was different from the previous law drafting process. For almost 8 years of the law drafting, more than 1,000 public hearing forums were organized with more than 3,000 networks and more than 100,000 participants from health community networks, state agencies and health professionals taking the lead role. Finally, the National Health Act passed the third reading of the National Legislative Assembly on 4 January 2007 and came into force on the date of its publication in the Government Gazette Volume 124, part 16 A, on 19 March 2007.

The National Health Act, B.E. 2550 (2007), was regarded as the first law of Thailand that was prepared with public participation throughout the 8-year period from start to finish. The Act has become a new tool for society to have a mechanism for all sectors to work on health and jointly create healthy public policy through various modes especially The “**National Health Commission (NHC)**” chaired by the Prime Minister and comprising 39 members from 3 sectors (13 members each), namely the technical and professional sector, the state/political sector including independent organizations and local government organizations, and the civil society and community sector, with the **National Health Commission Office (NHCO)** as secretariat.

The 2007 National Health Act has created at least 4 kinds of tool for participatory development of healthy public policy as follows:

3.1 Statute on National Health System. According to the National Health Act, Section 25(1) prescribes that NHC has the duty to prepare the **Statute on National Health System** for use as a framework and guide for setting policies and strategies (including principles, targets and measures) and implementing national health programmes, as a tool for projecting future scenarios and directions of that health system as jointly agreed by the society and for all agencies to use in formulating their healthy public policies without any policy conflicts, as detailed in section 4 of this chapter.

3.2 Health assembly. The 2007 National Health Act provides that “health assembly” is a process open to all sectors in society to work together through the use of technical knowledge and unanimity, sharing knowledge for creating a good healthy public policy, and transforming the policy into concrete achievements, through the government, state agencies, partner organizations or communities.

Health assembly is a product of the innovative health system reform process. The report on knowledge synthesis related to mechanism and process for formulating health system reform policy and



strategy, especially healthy public policy, prepared by Assoc. Prof. Dr. Churnrurtai Kanchanachitra, suggests that “**health assembly**” be organized as a *forum for the popular sector and all other sectors concerned to comment on government policy from the first step of concept formulation, policy recommendation, and policy implementation*. The development of health assembly progressed in parallel with the health system reform process. In 2001, a “health system reform forum” was held as a demonstrative health assembly; and in 2002, forums of provincial health assembly, area-based health assembly, issue-based health assembly, and national health assembly were formally held, focusing on informing the participants and getting them to take part in drafting a law. Public hearings were held in all 4 regions of the country and then 526 forums on “Uniting forces towards National Health Act” were held at the district level before preparing the first draft of the National Health Act. After that, forums for provincial health assembly were held across the country to comment on the draft health legislation. In such efforts, a system was drawn up for determining the proportions of participants, based on the principle of the composition of the participants in the process that translated the triangle that moves a mountain strategy into action. Of all the participants, not more than 15% each were from the civil service and political sector and the technical/professional sector, and 70% were from the popular sector.

The health assembly process has continually progressed from a forum of commitment in 2002 when the national administration publicly announced its support for the draft legislation. On the day of receiving the draft National Health Act, the prime minister said “...when it is the people’s desire to have a National Health Act, which will make the national health issue not become the issue of any particular sector or the government, which is correct. As I am on the Cabinet, having the duty to do as the majority of the people desire and for the majority, the government will accept this matter for further action in the administrative and legislative processes.” In 2003, the conceptual framework was set as a slogan “Using knowledge and love to jointly seek the way forward”. The health assembly for that year emphasized technical actions and friendly dialogues with rationalization and listening to all sectors. In 2004, the national health assembly was able to draw up a clear policy and strategy recommendation and the National Health System Reform Commission (HSRC) could submit the “Recommendations for Formulating Health Policy and Strategy”, as endorsed by the 2004 National Health Assembly, to the Cabinet for review and approval. In that year, more than 80% of the forums of local health assembly undertook action on the issue of food and agriculture for health as the issue-based health assembly had been working on such an issue since 2003; and theme for National Health Assembly was “Food and Agriculture for Health: Threats from Chemicals”. In 2005–2006, the themes for national health assembly have gone beyond the issue of public health to well-being and sufficiency economy. Meanwhile, project proposals were accepted from interested groups of people that wanted to organize forums of area-based and issue-based health assembly to confirm the principle that health assembly is a “public space” that is not confined to any particular group.

According to Section 3 of the National Health Act, B.E. 2550 (2007), “**health assembly**” means “*process in which the public and related state agencies exchange their knowledge and cordially learn from each other through a systematically organized forum with public participation, leading to suggestion of healthy public*”

policy or public healthiness.” There are three types of health assembly as prescribed in Sections 40–45 as follows:

1) **Area-based** health assembly – organized for a particular locality or area with a certain boundary such as a provincial health assembly, a regional health assembly, or a river basin health assembly.

2) **Issue-based** health assembly – organized for a certain public issue such as a health assembly on agricultural chemicals or a health assembly on overweight and obesity.

According to Section 40 of the Act, both types of the above-mentioned health assemblies can be organized by the people or networks in the public or private sector with the support of the National Health Commission Office (NHCO) as per the criteria and procedures prescribed by the National Health Commission (NHC). A recommendation from any health assembly for a state agency to implement or use in formulating a healthy public policy, the law requires that such a recommendation be submitted to NHC for further action as appropriate.

3) **National health assembly** – according to Section 25(3), NHC has the duty to organize a national health assembly at least once a year to develop healthy public policy at the national or locality level that requires special attention and then push for a concrete action. The law requires that NHC set up a National Health Assembly Organizing Committee (NHAOC) to take charge of such matter including setting criteria and procedures so that the assembly will be held in a systematic manner, with adequate technical back-up, creative and broad public participation for creating the acceptance of all sectors.

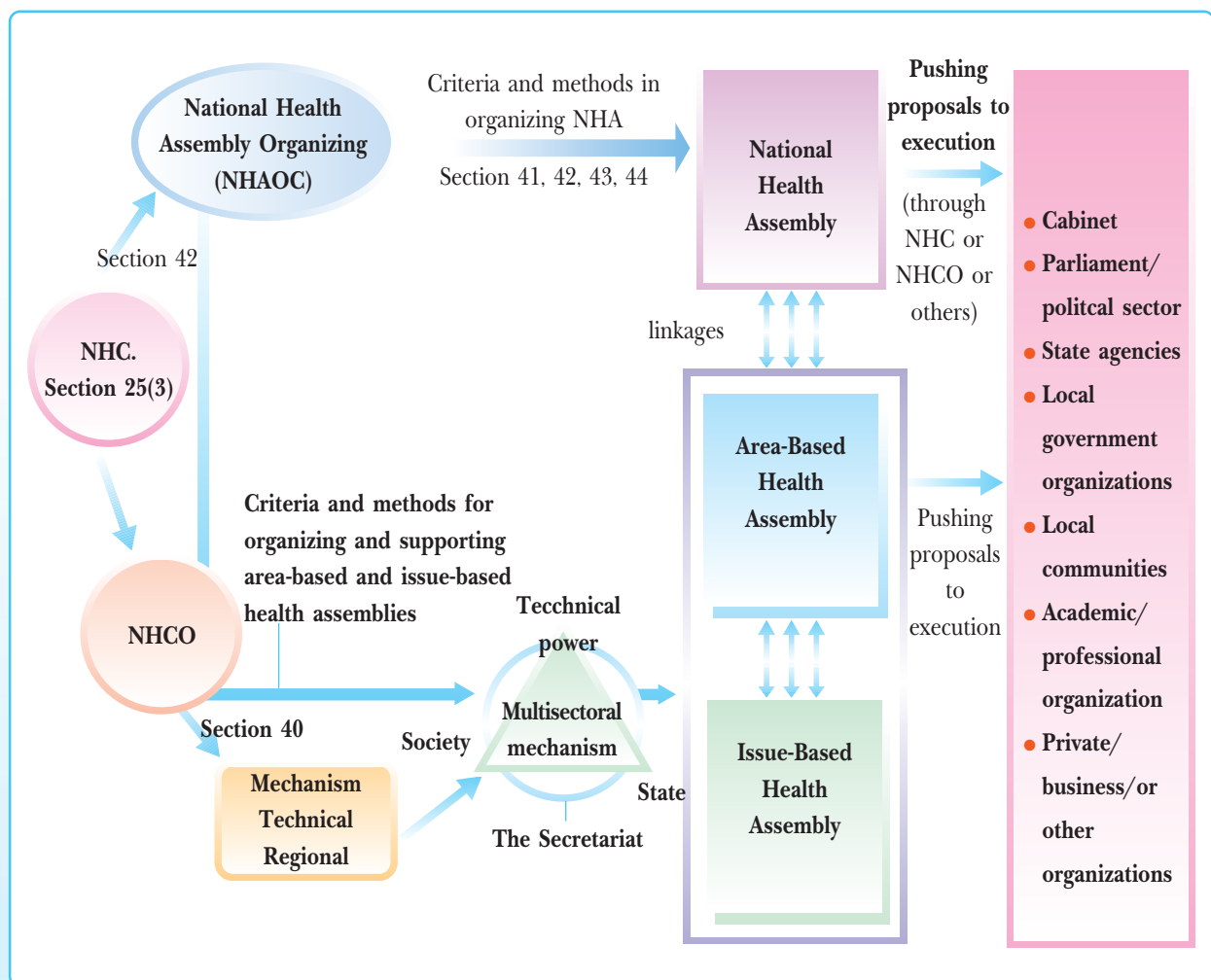
The First National Health Assembly (NHA) was held at the United Nations Conference Centre, Bangkok, on 11–13 December 2008 – the first one organized under the 2007 National Health Act. In organizing the assembly, NHC appointed Dr. Suwit Wibulpolprasert as the chairperson of NHAOC based on the format, process and system for management of the World Health Assembly, which has been organized continuously since 1948, to the extent possible in the Thai context. So, the format and process were different from those for the previously held national health assemblies. Regarding the participants at the assembly, in addition to assigning groups according to the triangle that moves a mountain strategy, constituencies were established: 178 networks in 2008, 180 in 2009 and 182 in 2010; the representatives of such networks only were eligible to attend and voice their opinions in the assembly. The opinions expressed were then regarded as those of their networks, not individual opinions as previously practised. The agenda of the assembly was prepared systematically; the issues to be proposed for specified period, especially for NHAOC to review and draft the resolution, according to the established criteria; and a meeting for comment on such a matter was held to reach a consensus for finally preparing the NHA resolutions in a systematic manner.

As for the Second and Third National Health Assemblies, the process was praised and valued by society and gained more attention from various state agencies as noted by their participation on the NHA Organizing Committee as well as in the resolution drafting process and making comments in the assembly. The major focus of the NHA is the creation of mechanism and process for all sectors to reach a “consensus” in setting public policy without voting on any particular matter.

The desirable images of NHA in the future are as follows:

- 1) Being a process that is significant and powerful with faith, joint ownership and social acceptance.
- 2) Being a system that is feasible with the participation of all sectors.
- 3) Linking with health assemblies on specific localities or specific issues as well as the public policy processes.
- 4) Focusing on healthy public policy issues at the national and international levels or significant local issues.
- 5) Having resolutions or recommendations that can be effectively implemented.

Figure 10.2 Systems and mechanisms for health assembly



Source: Health Assembly Bureau, NHCO.

The National Health Assembly in the new model is a new tool in society that needs to be continuously developed in the future based on at least three challenges as follows:

- 1) Do the representatives of the groups and networks attending the assembly really represent their groups/networks and are their opinions acceptable to their groups/networks?
- 2) How does NHA move to ensure the implementation of the resolutions?
- 3) How to develop the capacity of the groups/networks in the health assembly process, especially in the areas of developing policy recommendations, considering resolutions at the NHA, and advocating their implementation?

The fact that the 2007 National Health Act requires that the government supports three types of health assembly regularly every year is because it has been recognized that the health assembly process is the key to health system development in response to the changing situation in a timely manner, especially in the following aspects:

- 1) Health assembly is a significant tool for the participatory healthy public policy development.
- 2) Health assembly is a social movement process that values all participating partners to work together on health, not just holding a meeting on an ad hoc basis.
- 3) Health assembly is a public space for all sectors to work together creatively according to the participatory democracy principle.

At present, it has been accepted at the international level that the health assembly process is a social innovation of Thailand, which has progressed considerably and needs to be further developed ceaselessly.

3.3 Health Impact Assessment (HIA)

The HIA of public policy is a new tool prescribed in the 2007 National Health Act and the development of HIA tools also took place during the same period as that for health system reform. However, there are some differences as the HIA process had been developed and used in some other countries with WHO's technical support for Member States.

In 2001, for the first time the technical information related to HIA was presented in connection with two public policies: HIA on contract agriculture and farming and the Eastern Seaboard Development Project. One of the recommendations on national health system reform before closing the NHA was that: "In the national health system, there must be an HIA system for various public policies and there must be a concrete system to manage the health impacts from public policies". In 2002, HSRI pushed forward "healthy public policy" and proposed that "HIA" be used as a tool, which had a linkage with the drafting of the health legislation in how to prevent or resolve the problems that had happened or would be happening. There were participatory learning processes with civil society organizations and non-profit organizations in organizing provincial health assemblies in different localities such as the Map Ta Phut industrial zone in Rayong province, the Songkhla Gas Pipeline Project, and the area with water pollution in Nakhon Nayok province. Raising such



issues at the NHA created a heated debate as they were issues with high levels of conflict. That was regarded as the beginning of a good learning process for healthy public policy development, especially the importance and necessity of preparing technical background paper for rational discussion.

Until 2007, the social mobilization and learning in Thailand had made many sectors to learn of the term “HIA” and Section 67 (paragraph 2) of the 2007 Constitution also prescribes that:

“Any project or activity which may seriously affect the quality of the environment, natural resources and biological diversity and health shall not be permitted, unless its impacts on the quality of the environment and on health of the people in the communities have been studied and evaluated and consultations with the public and interested parties have been organized...”

Moreover, Section 10 of the National Health Act prescribes that:

“In the case where there exists an incident affecting health of the public, a State agency having information relating to such incident shall expeditiously provide and disclose such information and the protection thereof to the public.

Section 11 of the Act prescribes that:

“An individual or a group of people has the right to make a request for an assessment and to participate in the assessment of health impact resulting from a public policy.

An individual or a group of people shall have the right to acquire information, explanation and underlying reasons from state agency prior to a permission or performance of a programme or activity which may affect his or her health or the health of a community, and shall have the right to express his or her opinion on such matter.”

Moreover, Section 25 (5) of the Act prescribes that NHCO has powers and duties “to prescribe rules and procedures on monitoring and evaluation in respect of national health system and the impact on health resulting from public policies, both at the policy-making and operational levels”.

During 2007–2008, the NHC expedited the endorsement of the new tool, beginning with NHCO’s establishment of a working group chaired by Dr. Wiput Phoolcharoen to draft a system, mechanism and criteria for HIA related to public policies which were approved by the First NHA in 2008. Based on the resolution, NHC appointed a committee on development of system and mechanism for HIA chaired by Dr. Wiput Phoolcharoen and also established an HIA Coordinating Unit (HIA Co-Unit) to serve as the secretariat of the committee. The HIA system and mechanism was drafted based on technical review and lessons learned in other countries and consultations as well as public hearings with all concerned in the public, private, academic, and popular sectors, including operators of private businesses and officials of non-profit organizations; and the final version was approved by NHC in October 2009.

To date, NHC has issue **the Notification of NHC on Rules and Procedures on Assessment of Health impact Public Policies, B.E. 2552(2009), dated 8 November 2009**. That means HIA is a tool that has been legally recognized.

According to the Notification, HIA means “**a participatory learning process of society in the**

analysis and forecast of positive and negative impacts on people's health that might result from one or more policies, projects or activities, if implemented during the some period of time or in the same locality, through the application of various tools and participatory processes as appropriate to the decision-making beneficial for the people's health in the short and long terms".

And according to the intent of the National Health Act's chapter on rights and duties related to health, HIA should be carried out based on seven principles: (1) democracy, (2) fairness, (3) appropriate use of information and evidence, (4) practical appropriateness, (5) cooperation, (6) holistic well-being, and (7) sustainability.

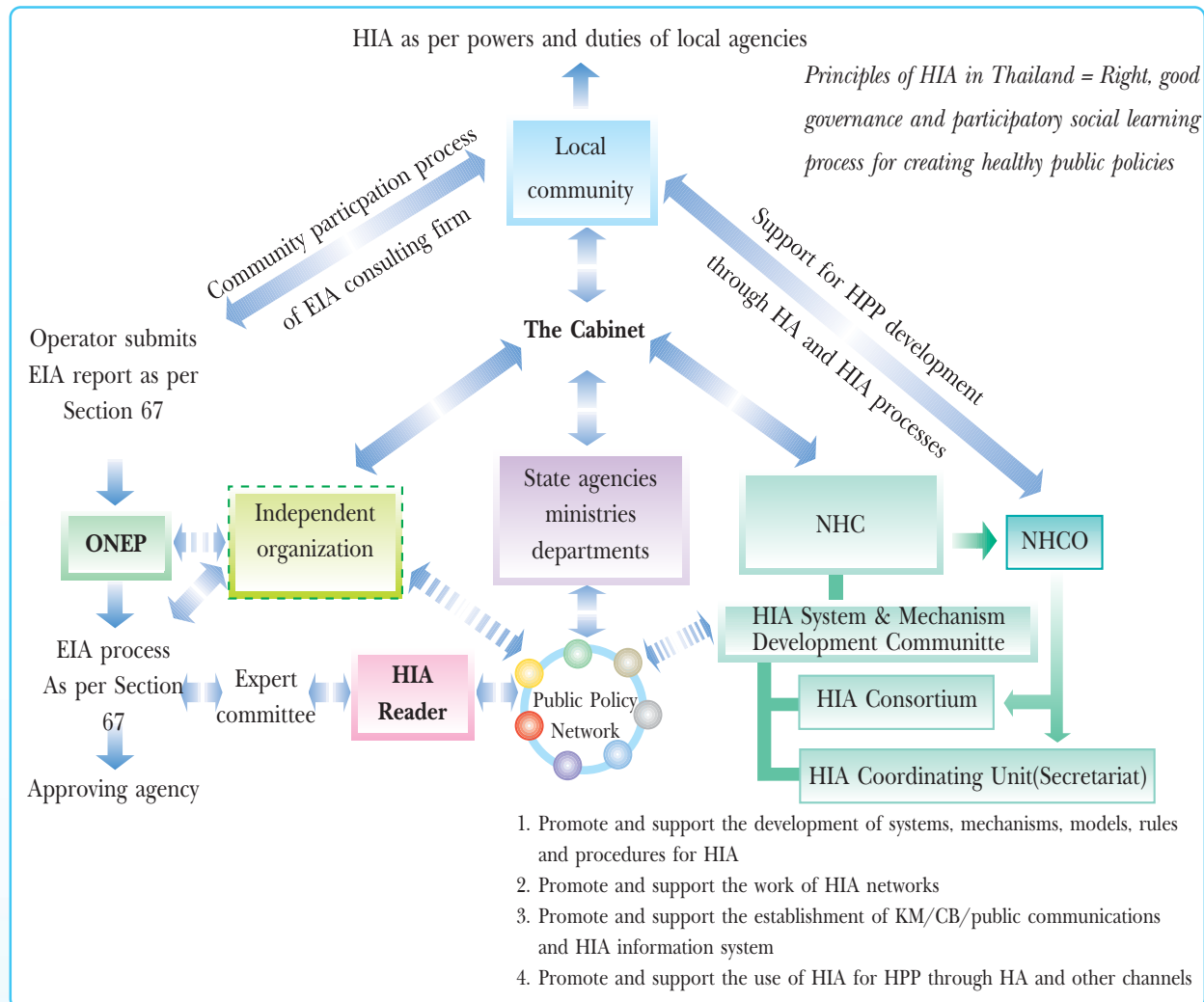
Based on the above principles, the projects and activities that should undergo HIA are classified into two aspects:

1) Projects and activities with the types and sizes as stated on the list of projects/activities possibly having a serious impact on the community and their HIAs have to be carried out as per Section 67 of the Thai Constitution.

2) Development planning activities that might have a serious impact on community health in the future, namely: city planning and improvements possibly leading to projects/activities that will have a serious health impact in the future; regional planning (such as regional development strategic plan); transport network planning; electricity generating development planning; mineral/mining development planning; farming/cultivation of genetically modified organisms; large-scale agriculture; operations related to dangerous substances; toxic waste and radioactive substances; free trade or international agreements as per Section 190 the Thai Constitution; and planning to implement a project/activity in any areas that should be conserved such as water catchment areas, class 1 river basins, and wetlands of national and international significance.



Figure 10.3 Linkages of systems and mechanisms for health impact assessment in Thai society



Source: HIA Coordinating Center, NHCO.

Notes: ONEP = Office of Natural Resources and Environmental Policy and Planning, Ministry of National Resources and Environment

EC = Expert Committee

NHCO = National Health Commission Office

While developing the HIA rules and procedures, NHCO also supported communities, academic networks and state agencies to use the HIA tool in real-life situations for developing public policies as the tool had been designed according to the social participatory process. That was for all sectors to participate in the review of health impacts that might occur and then in the assessment and management of such possible impacts. The local communities that actually used the tool on an experimental basis are: Bang Saphan district in Prachuab Khirikhan province where a full-scale steel production plant is located; the impact assessment of agricultural use of large amounts of chemicals in Bo Ngoen village in Pathum Thani province; the impacts of handicraft industries in Ban Thawai in Chiang Mai province; and the impacts of global warming in Kula Ronghai Field in the Northeast.

But the case that has made the HIA tool well-known the most in society is the impacts of industrial development in Map Ta Phut, Rayong province. The case study was started on 9 April 2007 when the Eastern People's Network handed over a letter to the Secretary-General of the NHC, requesting that an issue-based health assembly be held, according to Sections 5, 10 and 11 of the 2007 National Health Act. The purpose was to seek ways to resolve conflicts and build up the community's capacity to take part in the local public policy process, leading to health equity for the residents in Map Ta Phut subdistrict and other areas in Rayong province. Later on, NHCO supported the Healthy Public Policy Foundation (HPPF) to implement the project, including data search and conducting issue-based and area-based health assemblies until 14 policy recommendations could be submitted to NHC for Rayong provincial development in August 2008. In addition, NHC agreed to appoint a committee, chaired by Thanphuying Dr. Suthawan Sathirathai, President of the Good Governance for Social Development and the Environment Institute to study, support and monitor the implementation of NHC's proposals.

During that period of time, on 3 March 2009, the Rayong Administrative Court passed a verdict which says on the last page that: *"the defendant has to notify that the entire area under the jurisdiction of the Map Ta Phut Municipality and those of Noen Phra, Map Sa and Thap Ma subdistricts of Mueang Rayong district and Ban Chang subdistrict of Ban Chang district are designated as pollution control zones for the operations related to the control, abatement and elimination of pollution as required by law. The action is to be accomplished within 60 days as from the date of this verdict"*. In the details of the verdict, it refers to the provision of Section 5 of the 2007 National Health Act, which prescribes that: "A person shall enjoy the right to live in the healthy environment and environmental conditions" as well as the NHC's resolution of 1 August 2008. Later on, the National Environment Board passed a resolution to declare the areas under jurisdiction of the Map Ta Phut Municipality and surrounding subdistricts as the pollution control zone on 30 April 2009.

As for the NHC's resolutions to be submitted to the Cabinet on 19 May 2009 for consideration, the Cabinet passed a resolution for relevant agencies to adopt the three policy recommendations related to the impacts of industries in the Map Ta Phut area according to the NHC's resolution as follows:

- 1) Relevant state agencies shall disclose the information on health impacts from industries and disseminate the ways to prevent the impacts and ways for health promotion during the pollution period to the public rapidly and continuously.
- 2) Relevant state agencies shall develop plans and operating procedures for preventing and mitigating industrial hazards and draw up plans for the prevention and mitigation of chemical accidents at the provincial level.
- 3) NHC shall support the development of central mechanism for operations and strengthening of the popular sector using the area-based health assembly process.

Regarding the other two recommendations, i.e. (1) the government shall review/revise the Rayong provincial development guidelines with the participation of local residents throughout the process and (2) the government shall delay the expansion and construction of new industries in the Map Ta Phut and Ban



Chang areas, by establishing guidelines and processes for making decisions on approving/permitting such expansion or building in accordance with Section 67 of the Thai Constitution, the Eastern Seaboard Development Committee, chaired by Deputy Prime Minister (Mr. Korbsak Saphavasu), was assigned to consider. Later on, the committee agreed to all the five recommendations and directed that all relevant agencies/organizations undertake the following:

- 1) Endorsing the conceptual framework for Rayong provincial development in a balanced and sustainable manner.
- 2) Reviewing the Rayong provincial guidelines for balanced and sustainable development and revising it in accordance with the conceptual framework on such a matter.
- 3) Establishing good-quality and thorough systems of basic economic and social service.
- 4) Drawing up a plan of action for reducing and eliminating pollution in the pollution control zone.
- 5) Delaying the expansion and building of new industries in the Map Ta Phut area and taking action in accordance with Section 67 of the 2007 Constitution; and expeditious actions were to be undertaken by the Office of the Council of State, the Ministry of Public Health, the Ministry of Industry, and the National Health Commission Office.

In June 2009, 43 members of the Anti-Global warming Association and the public jointly filed a lawsuit against the state agencies that allowed 76 new industries to resume their construction even though such industries might have a serious negative impact on the community as per Section 67 of the Constitution. In December 2009, the Administrative Court suspended the construction of 65 projects and allowed 11 projects to proceed. And after further consideration, the court allowed another 19 projects to proceed; so, the remaining 57 industries were still awaiting the court's decision.

The most recent dispute occurred when the four-party committee, appointed by the prime minister and chaired by Mr. Anand Panyarachun to expeditiously resolve the issues according to Section 67 of the Constitution, prepared recommendations on 18 projects that might have serious impacts on the environment, natural resources and health, but the National Environment Board announced that only 11 projects were under such a category. However, when taking the announcement as the criteria for reviewing the applications, it was found that most of them were not the projects that might cause serious impacts to the community. At the NHC meeting, the proposal on criteria for project review was considered as proposed by the relevant technical review committee and working group and finally made recommendations for the Cabinet's endorsement. The Cabinet resolved that the National Environment Board and the Subcommittee on Decision of Complaints Related to Projects that Might Cause Serious Impacts on the Community were to adopt the results of the study and aforementioned recommendations for revising the announcement.

According to the developments and actual cases in society, it is noteworthy that HIA, as a participatory and multidisciplinary process in society, has a boarder dimension than medical and health dimension, as it covers holistic well-being and uses a positive approach, not just undertaking for granting or not

granting any approval. It is an intellectual process, rather than legal or authoritative measures, for joint academic and social learning purposes and assessing the health impacts on the people and community resulting from public policies of the government, private sector entities, local agencies and the communities. The process would lead to the determination of alternatives, making decision on such alternatives, seeking ways to minimize such health impacts for the well-being of the people and community.

3.4 Tools for Other Forms of Healthy Public Policy Development

Tools other than that proscribed in health laws include the establishment of specific mechanisms of NHC and support for the operations of networks and other organizations.

Between 2007 and 2010, four committees were established by NHC to develop healthy public policies as follows:

1) Commission on Human Resources for Health. The commission is tasked with the implementation of the Strategic National Plan on Human Resources for Health, 2007–2016, which was approved by the Cabinet as proposed by MoPH. The first Chairperson of the Commission was Prof. Dr. Kasem Wattanachai and the current chairperson is Dr. Mongkol Na Songkhla. The secretariat includes the director of HSRI, the director of the Bureau of Policy and Strategy, the director of the Human Resources for Health Development Office (HRDO), and representatives of NHCO.

The policy-related achievements of the commission include the comments given on the guidelines for developing a health workforce requirement plan and a public sector health development project, the solution of health workforce problems in Southern border provinces, and the national health system statute, and the preparation of proposition on the Medical Error Compensation Bill, proposed by MoPH, and the appointment of the patient-doctor relationship enhancement subcommittee, chaired by Dr. Suphan Srithamma.

2) National Commission on Traditional Wisdom Development. The Commissions duty is to oversee the implementation of the National Strategic Plan for Thai Wisdom and Thai Healthy Lifestyle Development, 2007–2011, as approved by the Cabinet and proposed by MoPH, under the chairmanship of Dr. Vichai Choekivivat with the secretariat including a deputy director-general of the Department for Development of Thai Traditional and Alternative Medicine, HSRI director, director of the Thai Health Institute and a representative of NHCO.

Major policy-related achievements of the Commission include the appointment of a subcommittee on development of Thai traditional medicine hospitals (the first prototype hospital was established in Sakon Nakhon province with the collaborative efforts of the clerical and non-clerical sectors including Rajamangala University of Technology Isan Sakon Nakhon Campus and local government organizations in the province, and the participation in 2009 as a co-host in making policy recommendations that were strategic goals and the 2009 Statute on National Health System through an issue-based health assembly held during the National Herb Expo; the proposal was adopted as a resolution of the 2nd National Health Assembly in the agenda on “Development of Thai traditional medicine, indigenous medicine and alternative medicine as a major health-care system in parallel with the modern medical system.



3) **Commission on Studies of Health Impact from International Trade.** The commission was appointed by NHC as per the resolution of the 1st National Health Assembly under the agenda on “public participation in formulating policies on free trade negotiations” chaired by Mrs. Sirina Pawarolanwittaya, a NHC member from the private sector. The commission has the duty to promote and support all sectors’ participation in studies and monitoring of international trade negotiations and examination of positive and negative impacts resulting from the stipulated agreements. The purpose is to improve the agreements in the future and provide compensation for any damage that would occur. This mechanism is independent of the government’s existing trade negotiation mechanism but linked to each other. The secretariat of the commission includes the secretary-general of the National Economic and Social Development Board and Dr. Churnrurtai Kanchanachitra, vice president of Mahidol University.

4) **National Health Information Commission.** The commission is now in the process of getting established to oversee the implementation of the Strategic Plan for Health Information Development, 2010–2019, as approved by the Cabinet and chaired by Dr. Somsak Chunharas; its secretariat includes officials to be assigned by HSRI, MoPH’s Policy and Strategy Bureau and the National Statistical Office.

This national mechanism is different from other national committees in that it will consist of officials or representatives from three sectors (state, academic/professional and popular/private) which will jointly work, without using any legal mechanism and authoritative power, based on their technical expertise, together with the secretariats of other commissions, on a multisectoral basis, NHC will not play a key role in the operation of this commission; rather, it will provide support with facilitative functions.

In addition to the aforementioned commissions, there are other tools or modes for public policy development as follows:

1) Public policy development through networks such as the network for policy on agriculture and food for health which has been developed from the network on drafting the national health legislation. The network consists of representatives from state agencies, academics, non-governmental organizations, and the health community. In the past, the network could develop proposals for consideration as resolutions of the First National Health Assembly, particularly on the agenda for “agriculture and food during crisis”. After that, the network continued working on creating knowledge and coordinating with various agencies to advocate the importance of food security, community organic agriculture, and the role of local government organizations in supporting the sustainable agriculture system.

2) Public policy development through cooperation with two academic institutions:

(2.1) Technical cooperation with Khon Kaen University (KKU). Under the 2008 KKU-NHCO cooperation agreement, KKU’s Research and Development Institute is the lead agency in collecting the information or knowledge about the impacts on the Northeast (Isan) resulting from public policies, especially on five issues, namely: (1) KKU: a community of well-being; (2) Khon Kaen: the city of well-being; (3) the Northeast and food security; (4) the Northeast and human/social security; and (5) water management for the Northeast. In 2009, public policies were presented to the KKU community on “good areas and at-risk areas” on

campus; and the community also participated with the Khon Kaen network in formulating public policy on city of well-being.

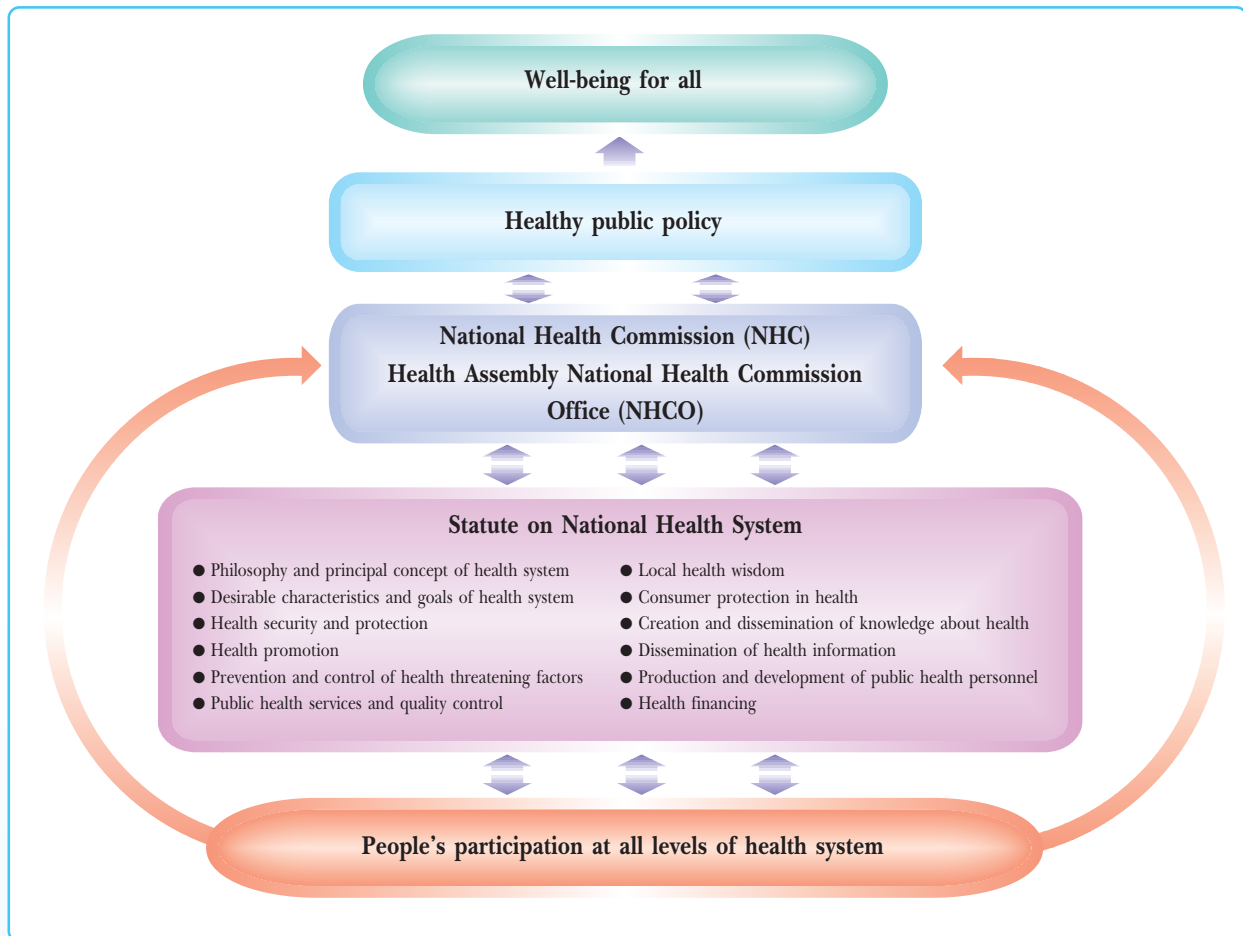
(2.2) Technical cooperation with Mahidol University in developing a healthy public policy towards being the wisdom of the land. In 2009, four public forums, called “Salaya Dialogue” were organized to exchange ideas on healthy public policies: (1) pandemic influenza H1N1 2009, which later on became recommendations on the emerging disease together with MoPH’s Department of Disease control, Ministry of Agriculture’s Department of Livestock Development, and the Ministry of Natural Resources and Environment, which were included on the agenda of, and approved by, the 2009 National Health Assembly for further action; (2) medicines in Thailand are very expensive and many Thais have no access to essential drugs; (3) looking at impacts before thinking about compulsory licensing (or CL of certain drugs); (4) the future of Thailand after the global crisis: regional cooperation towards society of good livelihood; and in 2010, another three forums of Salaya Dialogue were organized on: (5) health knowledge gap to policy; (6) teenage pregnancy (*mae wai sai*)...a big problem to be jointly tackled; and (7) universities and Thailand reform. Moreover, a talk was held on obesity as a silent threat for Thai children. The results of the forums were reported to the University Council that was much interested in the matters.

In 2010, linkages have been initiated among the Thai Health Promotion Foundation, the Health Systems Research Institute, the International Health Policy Program, the Social Research Institute at Chulalongkorn University, and the National Health Commission Office. At the beginning, the Social Inequity Reduction Network (SIRNET) was established to create knowledge and awareness of social determinants of health, leading to a policy for reducing health status gaps in society through participatory movements with all sectors.

4. Intent and Acquisition of Statute on National Health System

“Statute”, or *thammanun*, according to the Thai Dictionary of the Royal Institute, B.E. 2552(2009), mean a law dealing with the organization of an agency such as the Act on the Organization of Military Court and the Statute or Law on the Organization of the Courts of Justice. By the same token, despite the fact that the original intent of the drafting of the National Health Act, the entire law was meant to also serve as the statute of the health system. However, when the draft law was being reviewed by the Office of Council of State, especially Chapter 6 on policy and strategy guidance for health with details on desirable health systems such as those on health promotion, prevention and control of health threats, public health services and quality control, and others, totalling eight issues, it was deemed that having such details in an Act would have more disadvantages than advantages because such systems should be dynamic like other systems that might change according to social context and situations at the community, national and international levels. So, the entire chapter 6 was deleted but prescribed that NHC has the duty to prepare the “Statute on National Health System” for use as a framework for setting health policy and strategy as well as a guide for health programme operations of the country. The National Health Act, Section 47, prescribes that the statute has to cover at least 12 issues as shown in Figure 10.4.

Figure 10.4 Essence of the National Health Act, B.E. 2550 (2007)



Source: Bureau of Health Statute and Public Policy, NHCO.

In this connection, Thailand is the first country in the world that has developed a statute on health system that is legitimate and endorsed by law.

4.1 Status of the Statute on National Health System. According to Section 48 of the National Health Act, the Statute that has been approved by the Cabinet shall be binding upon state agencies and other relevant agencies in the performance of activities under their powers and duties. But more importantly, in the social context, the Statute is regarded as the social commitment and references for setting directions and targets proportion of health systems of the country in the future. So, the process, essence, and translation of statute into action are **the social mechanisms and processes that are linked with the movement for participatory development of health systems** in response to the needs and benefits of all sectors.

4.2 In the process of drafting the Statute, the law requires that NHC took into consideration the ideas and recommendations of health assemblies and then submit the draft Statute to the Cabinet for approval, submit it to the House of Representatives and the Senate for acknowledgement and then get it published in the Government Gazette. The law also requires that, for the Statute to be suitable for the changing

health situations, it has to be reviewed/ revised let least **every five years**. After the law came into force, the process for drafting the Statute was undertaken from 2007 to 2009 as briefly stated below:

1) **In 2007**, NHC appointed the “Working Group on Development of Systems and Mechanisms for Drafting a Statute on National Health System” whose duties were to draft the systems and mechanisms, with the participation of various sectors to the extent possible, aiming to make the statute

2) **important and valuable**, thus, the systems and mechanisms had to be **accepted** by various participating organizations since the beginning of the process, through **participatory and systematically organized** public forums, opening to all ideas/comments from the drafting of the 2007 National Health Act. The draft systems and mechanisms were presented to a forum on “Movement and participatory learning of the statute drafting process”, organized at the UN Conference Centre, Bangkok; and the draft was endorsed by the forum which was attended by more than 1,000 participants.

3) **In 2008**, the year of Statute drafting, in January NHC appointed the Statute Drafting Committee, chaired by Dr. Bunloo Siripanich having the secretariat comprising the NHC secretary-general, HSRI director, and director of MoPH’s Policy and Strategy Bureau. Later on, six working groups were established comprising representatives of various state, academic, professional, private, popular sectors; and the secretariat also had officials from various partners/agencies such as the Health Insurance System Research Institute, the National Health Foundation, the Thai Health Institute, the Health Consumer Protection Programme at Chulalongkorn University, and the Department of Health.

The Statute drafting was undertaken for the entire year beginning with a workshop for members of the committee and working groups on defining the scope, process, essential matters and timeframe of the Statute; and finally, the timeframe of the first Statute was set for the **long-term health system to end in the year 2020**. After that, the working groups undertook a situation and knowledge review of each issue, followed by public hearings and drafting the essential matters for each issue in May and June, which were publicized in the mass media for the people to learn of the Statute. The second workshop was then held to formulate the philosophy and principal concept as well as desirable characteristics and goals of the health system to be used for writing the details of each chapter.

Between July and August, each of the subcommittees began drafting each chapter of the draft Statute; 8 public forums were held to reach a consensus agreement on the future of the health system, which was an innovation of public dialogue with more than 400 participants. The first draft of the Statute was widely presented and discussed at 75 provincial public hearings in August through October including specific group discussions with approximately 3,000 participants; totalling, more than 10,000 participants attended the public hearings throughout the drafting process. After that another workshop was held to review the essential matters and revise the entire draft so that everything was consistent as the second draft which was submitted and approved by the First National Health Assembly on 11–13 December 2008. However, some observations from the NHA were given to the Statute Drafting Committee for further revision.

4) **In 2009**, the year of success in preparing the Statute, after the Statute Drafting Committee



had finalized the Statute, as per NHA's observations, in January, the draft Statute was submitted to NHC for review and endorsement for submission to the Cabinet. And on 30 June 2009, the Cabinet approved the Statute on National Health System, B.E. 2552 (2009), with no alternation and after that the Statute was acknowledged by the Senate and the House of Representatives on 7 and 10 September, respectively, and then came into force upon its publication in the Government Gazette (Volume 126, Special issue 175 D) on 2 December 2009.

5. Statute on National Health System, B.E. 2552 (2009)

The first Statute covers the timeframe for the overall health system of the country until 2020 and contains 12 chapters (111 Sections). Chapters 4–12 deal with subsystems ranging from health system through health financing, each was written in the same format including the principles, objectives and measures for use with no rigid binding or implementing methods because the Statute is not a programme or project. Another important principle of this Statute is the fact that **local partners or networks can establish their own health statutes** as far as they do not contradict the provisions of the Statute on National Health System.

5.1 Essential Matters of the Statute by Chapter are the following:

Chapter 1: Philosophy and basic concepts of the health system. Health is a basic right of the people and the health system is part of the social system and part of the national security system. The health system must give high importance to health promotion leading to sustainable well-being and self-reliance of the people; and all sectors must jointly push forward the national development from consumerism towards the path of sufficiency economy.

Chapter 2: Desirable characteristics and goals of the health system. The health system must be based on the principles of virtue, ethics, humanitarianism, good governance, knowledge, and wisdom.

Chapter 3: Provision of health security and protection. Health security and protection must cover all the people living on Thai soil and all the factors affecting health, not being confined to ensuring access to public health services.

Chapter 4: Health promotion. Health promotion must be undertaken to create holistic well-being for the entire society, primarily aimed at decreasing morbidity, disability, and untimely death, and cutting health-care spending, in accordance with the concept “health promotion comes before health repair”. The objectives are to develop participatory healthy public policy process and empower the communities regarding health-care capability, covering at least 80% of all subdistricts throughout the country.

Chapter 5: Prevention and control of diseases and health-threatening factors. The aims are to create the solidarity of relevant agencies in preventing and controlling diseases and health-threatening factors, to develop the surveillance system, and to use the tax measures, by encouraging people's participation in all the efforts as well as decentralization and capacity building for the community to carry out certain activities such as health impact assessment.

Chapter 6: Public health services and quality control. The primary-care system has to be

supported so that its quality and dignity are accepted, respected, and trusted by the people, the services are to be provided by family physicians or health-care providers through the humanized health-care system in a concrete manner. **And the state should not support or give any tax incentive and investment privileges to any business-oriented health services.**

Chapter 7: Promotion, support, use and development of local health wisdom, Thai traditional medicine, indigenous medicine, and other alternative medicines. The people are to be supported to have the right to choose and access various medical care systems on an equal basis. The health-care system is to include traditional Thai and herb-derived drugs in the National List of Essential Medicines, i.e. at least 10% of all drugs are traditional or herb-derived drugs, establish at least one model Thai traditional medicine hospital in each region of the country, and have in place a system, mechanism and adequate budget for local wisdom development.

Chapter 8: Consumer protection. Urgent action is to be taken to establish an independent consumer protection organization in accordance with the Constitution; and there must be in place mechanisms for the surveillance and inspection of goods and services with public participation so that the products and service offered are of high-standard and quality, safe and fair for all in an equitable basis. And there must be a system of efficient and appropriate compensation for damages that may occur as well as a system for consumer protection against any negative impacts resulting from international agreements and relevant laws as provided in the Constitution.

Chapter 9: Generation and dissemination of knowledge about health. Public policies must be drawn up from a comprehensive, adequate and reliable knowledge base whose sources must be publicly disclosed. Thus, state agencies and relevant sectors have to invest and play a role in the generation, management, communication and dissemination of health knowledge.

Chapter 10: Dissemination of Health information. Such an effort must be impartial, fair and comprehensive through appropriate channels so that the people can understand and use in making decisions on health behaviours leading to well-being, while being protected to receive correct and adequate health information.

Chapter 11: Formation and development of public health personnel. The state has the duty to formulate policies and plans on the production, development and distribution of public health personnel in an equitable manner so as to meet the needs of the country, while ensuring that they have good quality, ethics, good social-conscience and sufficient numbers to provide public health services to the people in collaboration with other health-related personnel in a multidisciplinary manner.

Chapter 12: Healthcare financing. This effort aims to create equity in benefiting from state health services, reduce the proportion of national health spending, decrease the number of families suffering from economic crisis resulting from a high medical-care cost, increase the tax rates for business-oriented health-care businesses or health-deteriorating products, and support the establishment of community health funds.



5.2 Benefits for Thais from the Statute. One of such benefits is the reference on the direction and goals of the health system that is the social commitment for the future. Thus, after the Statute has been prepared and enacted, it would be valueless if nothing is done to transform the principles, concepts, objectives and essence in the Statute into action to see concrete achievements. All agencies, organizations, institutions, communities, people of all localities, levels and networks, including popular sector's networks, civil society organizations, communities, local government organizations, professional organizations or individuals, academic institutions, educational institutions, state agencies at the ministerial, departmental, or divisional level, private sector agencies, businesses, non-governmental organizations and non-profit organizations can make use of the Statute. If all agencies and networks implement their programmes according to the framework of the state, the health system of the country will have a clear direction, suitable for such a period of time, which can be revised after various contexts are reviewed at least every five year. The guidelines prescribed in the Statute are not fixed or non-revisable, but during a certain period of time, the health system of the country needs a clear direction so that the achievements of development efforts will be tangible in accordance with the principles and suitable goals for such a period.

5.3 Examples of the use of the Statute. The commitments of state and other relevant agencies required by law are the following:

1) Using the Statute as a **reference in designing plans related to health at all levels** such as the National Economic and Social Development Plan, the 11th National Health Plan (being formulated), and the Strategic Plan of the Health Systems Research Institute, 2011–2015.

2) Transforming the Statute's essential matters including directions and goals into the national administration plan and 4-year plans of action or annual plans of action of state agencies, and using some content in the Statute as a reference for developing policies, programmes/projects as well as budget request proposals.

3) Creating policies and goals in a concrete manner for action by policy-making agencies of the government, national committees or agencies responsible for certain issues such as setting directions and goals of the government or political parties, and the National Drug System Development Committee for inclusion of certain traditional Thai drugs and herb-derived drugs in the National List of Essential Medicines.

Regarding the use for **social and community benefit**, the entire Statute what can be used including the concepts, principles, goals and directions, or its certain parts can be used such as some of the goals or measures for developing local health systems as follows:

1) Using the Statute as a guide for developing an area-based health statute. To date six areas have done so, namely: **Cha-lae Subdistrict Health Statute** in Singhanakhon district, Songkhla province, led by the Cha-lae Tambon (subdistrict) Administrative Organization (TAO) and being the first area-based health statute of the country, and **Sung Men District Health Statute** in Phrae province, led by the district hospital and being the **first** district health statute of the country. In 2010, another four area-based health statutes were established for Rim Ping Subdistrict Municipality in Lamphun province, Mueang Mo TAO in Phrae province,

“Cha-lae” is a small subdistrict in Singhanakhon district, Songkhla province, with a population of about 3,000. The subdistrict enacted the first area-based health statute in the world under the leadership of Mr. Khunthong Boonyaprawit former chief executive of Cha-lae TAO, who had been asked: “How can we get the TAO committed to allocating budget for implementing the subdistrict health development plan on a continuous basis and cause the subdistrict’s residents to practise what has been written in the plan?” And then, the participatory process for drafting the health statute was initiated using the knowledge about health from academics from educational institution located in the locality. Subcommittees were set up to undertake various functions, namely statute drafting, public communication and participation campaign, public hearings, and follow-up/evaluation. Finally, the Health Statute Bureau was established to coordinate all the processes and activities including the long-term implementation of the statute. The Cha-lae Subdistrict Health Statute was enacted

The essence of the Cha-lae Subdistrict Health Statute, B.E. 2552 (2009), includes the following:

Section 5. The general standard of practice of Cha-lae residents is to observe item 5 of the Five Precepts (of Buddhist Teachings) and at least another item of the rest of the Precepts.

Section 10. Control the odour, solid waste, night-soil, sewage, noise, dust, light, smoke and vehicle speed so that they are at the suitable levels jointly established.

Section 23. There shall be a professional nurse and a dental nurse at the proportion of 1:5,000 or as per community’s needs.

Section 45. Support the marketing and consumption of the products of Cha-lae’s residents

Section 51. The Cha-lae TAO has to allocate budget for the implementation of the Cha-lae Subdistrict Health Statute in the amount of at last 20% of all of its annual revenue.

**** Mr. Khunthong was assassinated on 25 November 2009.**

All the aforementioned health statutes have the same feature, i.e. using only the principles of the Statute on National Health System, but the essence was based on the concrete goals and actual health status information and needs of the localities in drafting the statutes with the participation of all sectors. And then the long-term scenario of the community health system in the future could be drawn up for use as the guiding principles in determining the programmes and activities of the subdistrict development plan in accordance with the jointly agreed upon directions.

2) The use of certain specific goals, measures or issues of the statute in developing guidelines for programme operations or movements to achieve concrete results of certain groups or organizations working specific issues such as marginalized people’s health, Thai traditional medicine, women’s health, child health, adolescent health, and health of the disabled and the elderly.

The movements mentioned above require collaborative actions of all sectors and a higher level of cooperation than that obtained during the past two years of statute drafting, to date, NHC has set up two committees, one on follow-up support and evaluation of the implementation according to the Statute on National Health System, chaired by Dr. Banloo Siripanich, and the other on health system research development for supporting the Statute on National Health System, chaired by Prof. Dr. Vicharn Panich, to serve as a mechanism for creating strategies for translating the Statute into action through knowledge management, creating essential knowledge and social mobilization as well as evaluation and making recommendations for drawing up the next statute.

