

PEOPLE'S PARTICIPATION

OF THE UNIVERSAL COVERAGE SCHEME (UCS)
IN THAILAND



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GLOSSARY

STAKEHOLDER IN UNIVERSAL COVERAGE SCHEME

Stakeholders in universal coverage scheme include agencies related to national health security such as government agencies, experts, professional councils, health care providers, patients, local administrative organizations, and non-government organizations

NON-GOVERNMENT ORGANIZATIONS (NGOs) IN UNIVERSAL COVERAGE SCHEME

NGOs in Universal Coverage Scheme include non-profit private organization registered with the National Health Security office and implementing activities for the following groups; a) children and adolescents, b) women, c) elderly, d) disabled or mental health patients, e) HIV or other chronic disease patients, f) labor, g) populous communities, h) agriculturists, and i) minorities.

PEOPLE PARTICIPATION IN UNIVERSAL COVERAGE SCHEMES

People participation in universal coverage scheme provides the opportunity for people to engage in policy related to health benefits package and to monitor the allocation of public health resource whether it is used for the optimum benefit of the public.

GOVERNANCE IN UNIVERSAL COVERAGE SCHEME

Governance in Universal Coverage Scheme refers to the interaction between stakeholders to solve problems and to improve national health security system. The National Health Security Act allows people to govern health security system by engaging in the National Health Security Board and the Standard and Quality Control Board.

PUBLIC HEARING

The annual public hearing is set up with health care providers and beneficiaries to collect opinions and suggestions toward the improvement of health security system. The public hearing will be conducted in the regional level with 13 regions and in the national level.

PEOPLE'S HEALTHY SECURITY CENTER

People's Healthy Security Center is not located in health unit and operated by people living in the community or civil society organization. The missions of People's Healthy Security Center include informing people about universal coverage scheme, handling complaint, monitoring quality of health care, and other works related to people.

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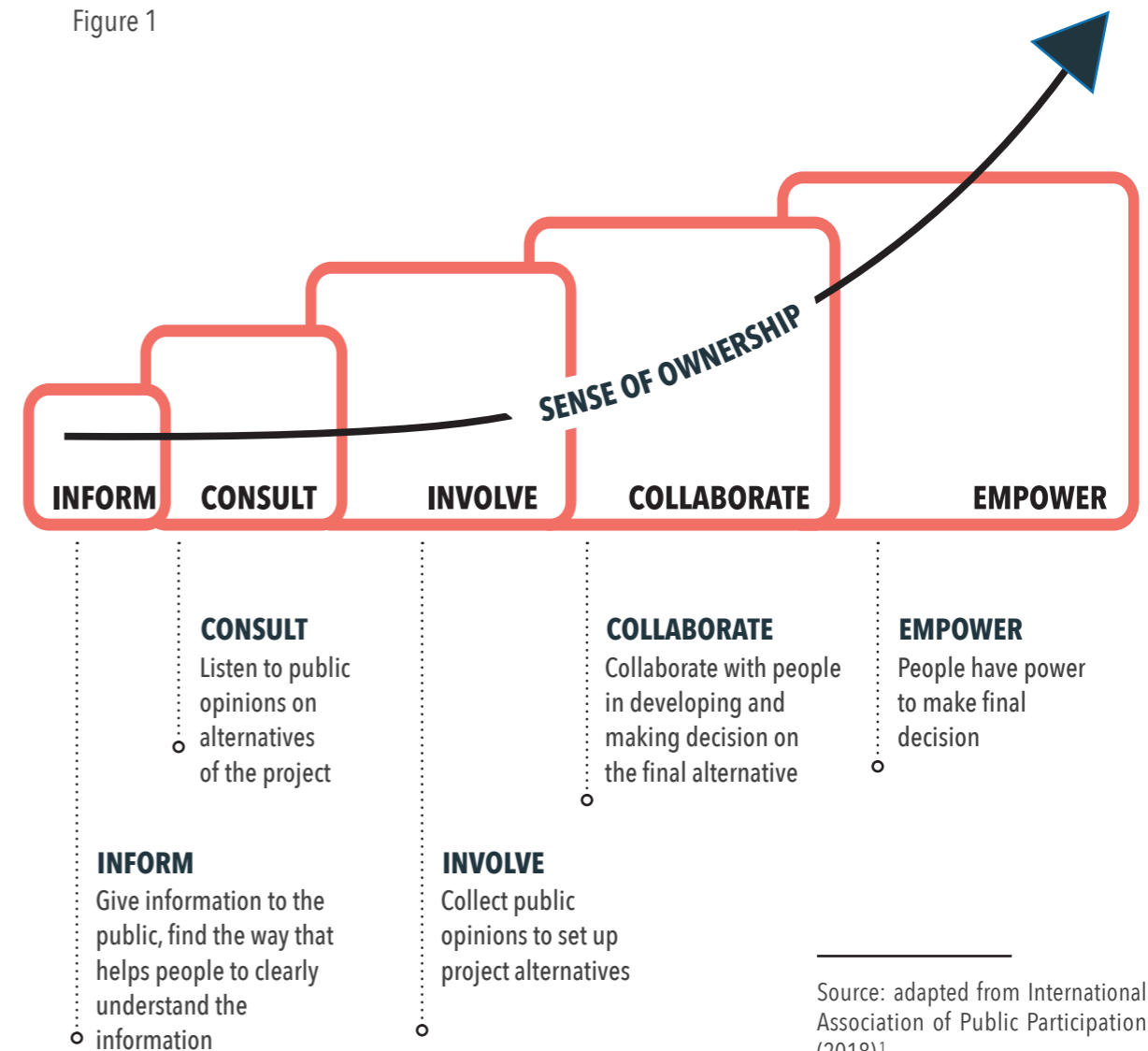
INTRODUCTION

People participation is a key success of achieving universal coverage scheme in Thailand. In additions, public participation is one component of good governance. People have engaged in universal coverage scheme since policy formulation stage until policy implementation stage. The unique of public participation in Thai universal coverage scheme includes the engagement of people in all levels (Figure 1); inform, consult, involve, collaborate, and empower¹ which enable sense of ownership in universal coverage scheme.

This book is aimed to distribute knowledge and understanding on people participation in universal coverage scheme in Thailand. The contents in this book include people involvement in policy formulation, people involvement in policy implementation, result of people participation in universal coverage scheme, challenges, facilitating factors, and way forwards of people participation in Thai universal coverage scheme.

SPECTRUM OF PUBLIC PARTICIPATION

Figure 1



Source: adapted from International Association of Public Participation (2018)¹

2

PEOPLE PARTICIPATION IN POLICY FORMULATION

People participation in health system development in Thailand started from the Alma Ata declaration of World Health Organization in 1978 which targeted “health for all by the year 2000”. Primary health care was a major strategy to achieve that target.^{2,3} In practice, the Ministry of Public Health has implemented primary health care by establishing public health reporters and public health volunteers in every village.³ This was capacity building of the villagers to participate in public health which was very important root of Thai public health system development.

There is a long history of NGOs participation in health system. The government had a policy to force medical students to intern in the rural area since 1968.⁴ Consequently, the doctors had realized about the difficulty of people in rural area and deeply understand about public health inequality.⁵ The 14 October 1973 incident awakened the awareness of democracy and equity. Many non-government organizations were established.⁶ The rural doctors founded rural

PEOPLE PARTICIPATION IN HEALTH SYSTEM DEVELOPMENT IN THAILAND STARTED FROM

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doctor union in 1976 which changed to rural doctor association in 1978 and registered as rural doctor foundation in 1982. The Coordinating Committee for Primary Health Care of Thai NGOs was founded in 1983⁵ and later the consumer protection bureau was separated to register as Foundation for Consumers.⁷ In 1992, Health Systems Research Institute was established to generate knowledge which was the important factor to reform health system.⁸ These health NGOs were essential to move Thai health policy.

The first attempt to push the national health security law was in 1995 when Dr Sanguan Nittayarampong worked

THE FIRST ATTEMPT TO PUSH THE NATIONAL HEALTH SECURITY LAW WAS IN 1995 WHEN DR SANGUAN NITTAYARAMPONG WORKED WITH THE SENATE STANDING COMMITTEE ON PUBLIC HEALTH TO DRAFT

“HEALTH INSURANCE AND HEALTH SERVICE STANDARD B.E.”.

with The Senate Standing Committee on Public Health to draft “Health Insurance and Health Service Standard B.E.”. The draft was finished in 1996. The principle of this draft bill was to establish mandatory health insurance which co-paid by people and the government.⁹ This draft bill was approved by the Senate Standing Committee on Public Health but there was no action after that due to lack of political pressure.¹⁰ Moreover, the government officers did not support this draft bill and the parliament was dissolved.¹¹

The constitution of the Kingdom of Thailand B.E.2540 allows 50,000 eligible voters to submit a petition to the president of Parliament to consider draft bill.¹² Dr Sanguan Nittayarumpong convinced the NGOs and Civil Society Organizations (CSOs) to support universal coverage scheme.

Finally, the experts and 11 CSOs (children network, woman network, disable network, consumer network, HIV/AIDS patients network, elder network, slum network, alternative agriculture network, Southern village bank, community welfare group, formal workers group, and informal workers group) had moved universal health coverage agenda together since 2000 under “campaign for universal health coverage”.^{10,13,14}

The CSOs have established working group to draft the bill on national health security for the reason that 1 in 3 of the ad hoc committee in the bill reading would be the representatives of CSOs. Consequently, the content of the law would remain the initial intention of the public bill. Jon Ungphakorn from AIDS Access Foundation was a key man of this working group¹³. This people draft bill was improved from "Health Insurance and Health Service Standard B.E. ...", drafted by Dr Sanguan Nittayarampong. The principle of the bill was still to provide essential health care to all Thai people. However, the source of budget has been changed from co-payment to the government budget.⁹ Other important contents included integrating all health security funds within 2 years, 8 representatives of CSOs and liability compensation.¹⁵

1 IN 3
OF THE AD HOC COMMITTEE
IN THE BILL READING WOULD BE
THE REPRESENTATIVES OF
CSOs

On 11 October 2001, the CSOs set up a forum at the Teachers Council of Thailand to announce their intention to collect 50,000 names of eligible voters to push national health security bill. Dr Sem Pringpuangkeo, Dr Prawase Wasi, Jon Ungphakorn and Dr Sanguan Nittayarumpong had engaged in this forum. Moreover, the CSOs had disseminated the information of national health security to people via the public forums and collected the name of almost 60,000 eligible voters. The people's draft bill and name of eligible voters were proposed to the president of the parliament on 26 March 2001.

Due to the delay of the inspection process to check eligibility of names collected, the people's draft bill could not be proposed to the parliament in the due date of 22 November 2001.⁹ The CSOs put hard effort to coordinate with political parties to propose people's draft bill to the parliament for them.¹³

However, at that time the political parties also had their own draft bill. Finally, Doctor Cholnan Srikaew, a rural doctor and the Thai Rak Thai parliament member from Nan Province proposed the draft bill for the CSOs.^{9,13}

On 22 November 2001, total 6 draft bills on National Health Security Act were proposed to the parliament. Among these 6 draft bills, one was from the government, four were from the political parties, and the last one was from Mr Suwat Wannasirikul and Dr Cholnan Srikaew who proposed the people's draft

THE CSOs PARTICIPATION IN THE AD HOC COMMITTEE WAS VERY IMPORTANT TO KEEP THE PRINCIPLE OF PEOPLE PARTICIPATION IN MANY ARTICLES OF THE LAW

bill for the CSOs. The members of the parliament approved the principle of all six draft bills and appointed for the law commission.¹⁶ The representatives of CSOs had engaged in the ad hoc committee for the first reading and the second reading of the law.^{13,16,17} The CSOs participation in the ad hoc committee was very important to keep the principle of people participation in many articles of the law.

Although the constitution of the Kingdom of Thailand B.E.2540 allows 50,000 eligible voters to submit a petition to the president of Parliament to consider draft bill, the process of petition was complicated. The copy of identification card and housing registration were required to verify the voters. In additions, the communication at that time was not as convenient as at present. Total 12 draft bills from public were submitted to the president of national legislative assembly under the constitution B.E. 2540. Two draft bills were considered in the national legislative assembly. Only National Health Security draft bill from people had gone through the legislation process and finally enforced by law. Since people had actively engaged in every step, the 2002 National Health Security Act is really owned by the public.¹⁸



3

PEOPLE PARTICIPATION IN POLICY IMPLEMENTATION

When the National Health Security Act has been enforced, people still continue participating in the structure and process of universal coverage scheme. This participation is the intention of 2002 National Health Security Act which indicates that "Health service system essential to health and sustainability shall be organized to meet the medical treatment standard. There shall be a control and monitoring organization implemented with the participation of public and civil sectors in order to establish an efficient medical treatment system throughout the country".¹⁹

3.1

STRUCTURE OF PEOPLE PARTICIPATION IN UNIVERSAL COVERAGE SCHEME

After the enforcement of the 2002 National Health Security Act, "National Health Security Fund" has been established to manage public health services in the public health units. There are two levels of work under this law. People have involved in the implementation of both two levels (Figure 2).

1

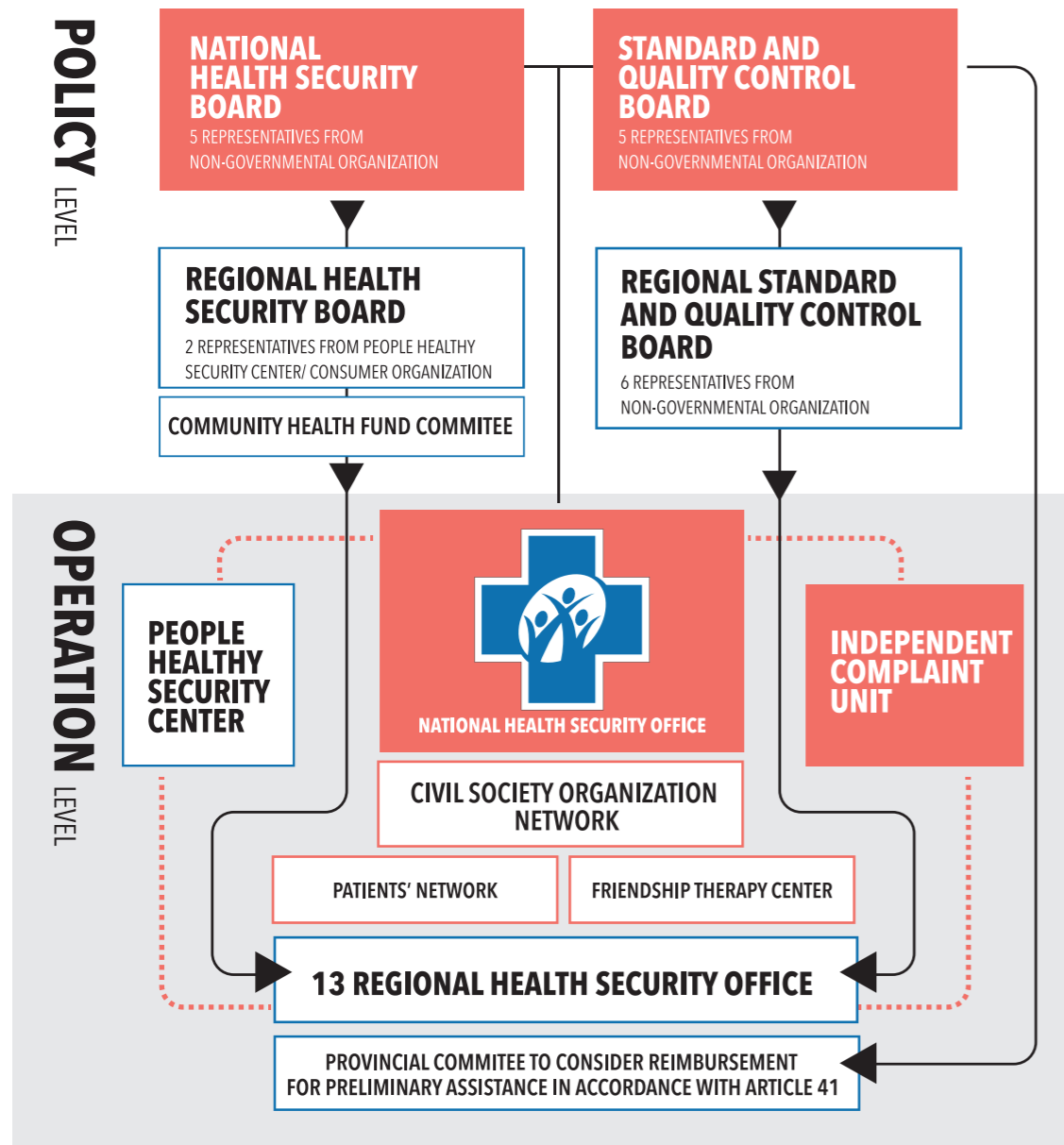
The policy level includes national and regional policy making process in the national and regional level. People have been engaged in the national committee and sub-committee.

2

The operation level includes the National Health Security Office (NHSO) that is responsible for administration of the board, fund management in accordance of the rules prescribed by the board, and other duties assigned by the board. The civil society works with NHSO in national and regional level to give knowledge about universal coverage scheme, to expand people network, to protect rights of members via independent complaint unit and People's Healthy Security Center. The objectives of this collaboration is to enhance people understanding, to enable access to health care, and to protect rights of patients.

STRUCTURE OF PEOPLE PARTICIPATION IN THE UNIVERSAL COVERAGE SCHEME

Figure 2



1

STRUCTURE IN THE POLICY LEVEL

The administration in the policy structure is divided into national and regional level.

In the national level, two national boards are appointed by law. One is "National Health Security Board" responsible to address policy, fund management criteria, payment regulation, type and scope of benefits package, and other criteria related to health insurance. The other national board is the Standard and Quality Control Board, responsible to control the quality and standard of health security system.

The 2002 National Health Security indicates that five representatives of non-governmental organization shall be in the National Health Security Board and the Standard and Quality Control Board. The five representatives shall be elected by non-governmental organization implementing activities for the following groups; 1) children and adolescents, 2) women, 3) elderly, 4) disabled or mental health patients, 5) HIV or other chronic disease patients, 6) labor, 7) populous communities, 8) agriculturists, and 9) minorities.

In additions to the structure indicated in the law, the national health security system decentralizes administrative power to the regional level. The Regional Health Security Board is appointed by the National Health Security Board while the Regional Standard and Quality Control Board is appointed by the Standard and Quality Control Board. These two regional boards include the representatives of people. Two representatives from healthy security center and consumer organization are the composition in the Regional Health Security Board. Six representatives from non-governmental organizations and public health volunteers are the composition in the Regional Standard and Quality Control Board.

2

STRUCTURE IN THE OPERATION LEVEL

NHSO has been established under the law to manage national health security fund in accordance of the rules prescribed by the National Health Security Board. Previously, NHSO was responsible to buy drug and medical equipment. However, the study found that centralization of drug and medical equipment purchasing was ineffective. As a result, NHSO decentralizes power of purchasing to the regions. The regional office can manage, purchase, and provide health service in accordance of the context and regional resources. The decentralization leads to effective resources allocation.²⁰ Therefore, the structure of national health security office divides the administration into 13 regions. Each region is responsible for group of provinces. Civil Society Network, People's Healthy Security Center and Independent Complaint Unit are established in all provinces to give information about universal coverage scheme to the people and to control standard of medical service unit. The decentralization enables participation in the area. In additions, there are patients' network and friendship therapy center to encourage patients and families.

3.2

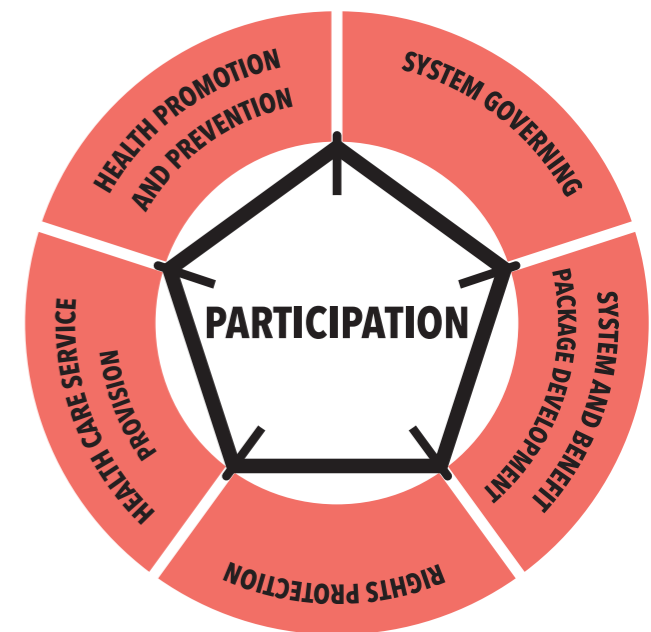
PEOPLE PARTICIPATION IN UNIVERSAL COVERAGE SCHEME

People are important component in national health security system since universal coverage scheme covers health insurance of almost 48 million people. Consequently, people have engaged in both policy and operation level of universal coverage scheme.

The 2002 National Health Security Act intents to reassure participation from all stakeholders. Thus, NHSO opens the opportunity for public to develop universal coverage scheme in order to response real needs of people.²¹

PEOPLE PARTICIPATION IN UNIVERSAL COVERAGE SCHEME

Figure 3



Overall, people participates in universal coverage scheme in 5 aspects; system governing, system and benefits package development, rights protection, health care service provision, as well as health promotion and protection (Figure 3).



PEOPLE PARTICIPATION IN SYSTEM GOVERNING

GOVERNANCE REFERS TO THE ADMINISTRATION WITH GENEROSITY, VALUES, AND INTEGRITY OF HUMAN. THE GOAL OF GOVERNANCE IS TO GENERATE MUTUAL BENEFIT OF GOVERNOR AND PEOPLE.

When considering the content in the law and the implementation of NHSO, people play important role in managing national health security fund and controlling health care quality and standard (Figure 4) as described follows;

1

PEOPLE PARTICIPATION IN MANAGING NATIONAL HEALTH SECURITY FUND

According to the 2002 National Health Security Act, people involve in managing national health security fund in national, regional, and local level as described below;

In the national level, the law indicated that five among thirty committee in the National Health Security Board shall be representatives from non-governmental organization. The intention of this law is to allow participation from people who can reflect the real need of public. The non-governmental organization representatives in the National Health Security Board have pushed health policy for the optimum benefit to the public. Having non-governmental organization representatives in the board facilitates people empowerment which is the highest level of public participation.

In the regional level, the regional sub-boards are appointed to manage national health security in the region and to response health problems in the area. One composition of the regional committee includes representatives of NGOs. The duty of regional committee is to govern regional health policy in accordance of health problems in the area.

In the local level, the community health fund has been established under the National Health Security law. The community health fund is managed by the representatives of local administrative organization and local people. The committee of community health fund has power to approve budget for the projects that consistent with the objective of fund and appropriate with the local health need. The examples of projects under the community health fund include health promotion and prevention activities in sub-district, health data base, health strategy and plan, and collaboration with hospitals to provide health promotion and prevention for people in sub-district.

2

PEOPLE PARTICIPATION IN CONTROLLING QUALITY AND STANDARD

According to the 2002 National Health Security Act, people involve in controlling quality and standard in national, regional, and local level as described below;

In the national level, five representatives from the non-governmental organizations engage in the Standard and Quality Control Board to control the quality and standard of health unit, to propose reference price of medical treatment, and to address criteria for complaint consideration.

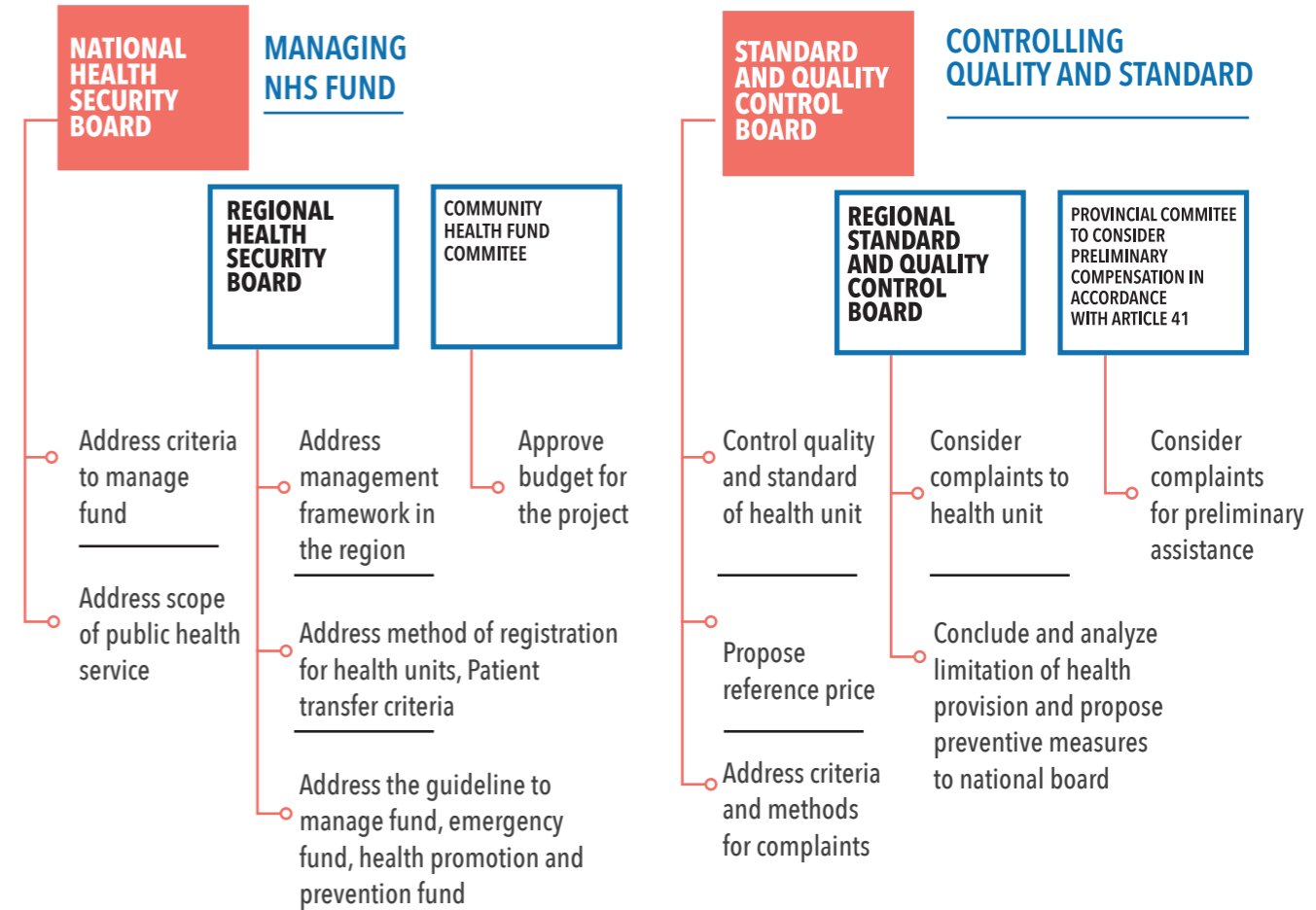
In the regional level, the Standard and Quality Control Board appoint the regional standard and quality control board to consider the complaints in the regions, to summarize and conclude limitation of public health service, and to conduct report for the national board.²²

In the provincial level, the provincial committee is appointed by the Standard and Quality Control Board to consider reimbursement for preliminary compensation in accordance of Article 41 in National Health Security Act. The provincial committee is authorized to consider whether the complainer should receive preliminary compensation for damage or injury caused by any service provided by the health care unit. The consideration of reimbursement is based on damages and economic status of patients.²³ The provincial sub-committee includes at least three experts as well as equal number of representatives from hospital and beneficiaries. This preliminary compensation not only relieve the burden of patients, it also reduces conflict between doctors and patients.²⁴ Chaweewan Lorsirikul and Chanapol Sriruecha²⁵ found that the patients were satisfy with the preliminary compensation and felt that the payment was impartial. Moreover, the study of Sriruean Deepoon and Vilailuk Chaimongkol²⁶ confirmed that the preliminary compensation led to reduction in conflict and termination of complaints in maternal and child health.

In summary, people participation in system governing is shown in Figure 4.

Figure 4

PUBLIC PARTICIPATION IN GOVERNING UNIVERSAL COVERAGE SCHEME





PEOPLE PARTICIPATION

IN BENEFITS PACKAGE DEVELOPMENT

VIA PUBLIC HEARING WITH HEALTH PROVIDERS AND BENEFICIARIES

Article 18 (10) of the 2002 National Health Security Act indicates that the National Health Security Board shall conduct annual public hearing with the health providers i.e. doctors, nurses, and other public health personnel as well as patients. The objective of public hearing is to collect opinions to improve quality of universal coverage scheme. The public hearing is the strength of universal coverage scheme because it creates “sense of ownership” and encourage people engage in improving national health security system.²⁷

The first public hearing was conducted in 2004. In the first few years, the National Health Security Board indicated the issues for public hearing and only one public hearing was set up in Bangkok. After that, the form of public hearing has been changed; for examples public hearing in 4 regions and Bangkok.

“

There are many steps in public hearing. NHSO designed form and issues of public hearing, then proposed to National Health Security Board for consideration. After public hearing, the proposals would be proposed to the board and some proposal would be selected to develop new benefits package. In the first few years, HITAP would conduct feasibility study and assessment. After that the benefits package would be proposed to sub-committee for consideration and to the national health security board for approval. After approval, the financial sub-committee would conduct more study. Although the benefits package is worth for investment, the new benefits package would not be addressed until the health units are ready to provide the service.

”

Content from the interview
“General Public Hearing with health service providers and beneficiaries”
in NHSO²⁸

In 2013, the National Health Security Board announced the regulation for annual public hearing with health care providers and beneficiaries to indicate framework for public hearing process.

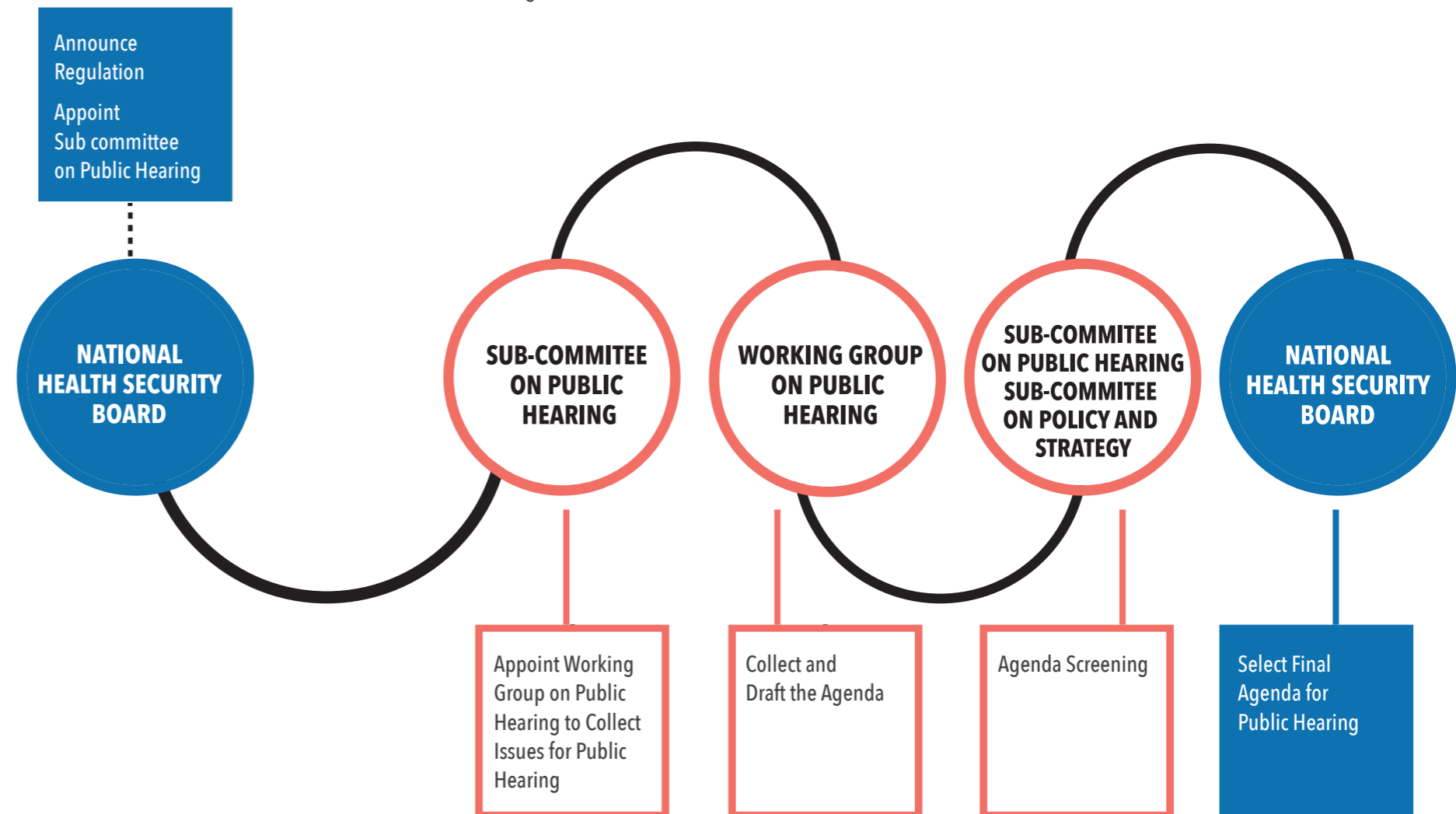
In 2015, the National Health Security Board announced the second regulation on public hearing process to revise criteria of public hearing.²⁷ After that, the form of public hearing is the same pattern every year.

At present, the process of annual public hearing starts from the announcement of the National Health Security Board on regulations for public hearing. Then, the National Health Security Board will appoint the sub-committee on public hearing to draft the agenda for annual public hearing. The agenda for public hearing is collected from the meetings with public health personnel in the hospital, the management level of the hospital, the representatives from government sector, and the representatives from civil society. The agenda of public hearing in each year are different.²⁸

The agenda setting for annual public hearing is summarized in Figure 5.

ANNUAL PUBLIC HEARING AGENDA SETTING

Figure 5



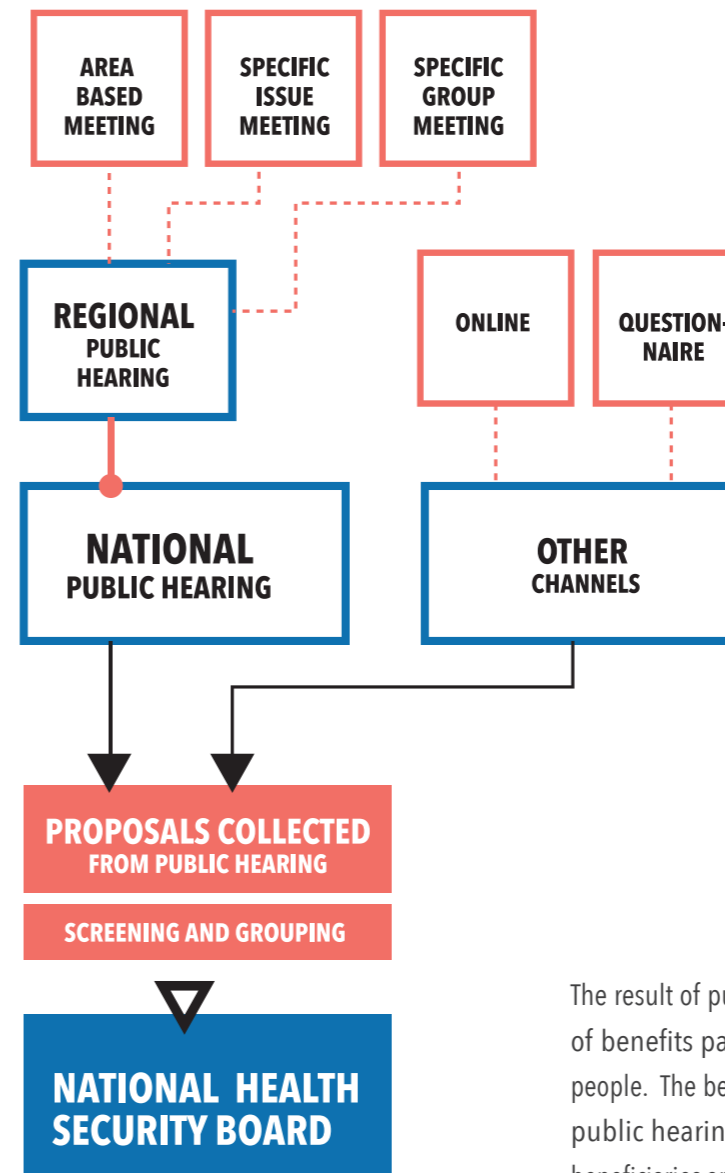
The public hearings start with the regional forum at 13 regions; then followed by the national public hearing in Bangkok. For the regional forum, each regional office will assign working group to design form of public hearing and to select target groups that fit the issues of public hearing. The target groups of public hearing must be varied and cover health care providers, patients and families, civil society, experts, and representatives from local administrative offices. The Regional Health Security Board and the Regional Standard and Quality Control Board are the co-host of the regional public hearing. The regional office is able to design the numbers and patterns of regional public hearing which are mostly suitable to the local context. If the problems raised in regional public hearing can be solved under the regional authority, the regional board will proceed immediately. If the problems raised in the regional public hearing need the national authorities, the proposals will be transferred to the National Health Security Board for further consideration.

After the regional public hearings were conducted, all proposals obtained from the public hearings were separated into short terms (quick win) and long terms issues. The quick win issues will be proposed to the National Health Security Board for immediate consideration. The National Health Security Board will appoint ad hoc committee to work with the long terms issues.²⁸

The process of annual public hearing with health service providers and beneficiaries is summarized in Figure 6.

PROCESS OF ANNUAL PUBLIC HEARING WITH HEALTH SERVICE PROVIDERS AND BENEFICIARIES

Figure 6



The result of public hearing leads to the development of benefits packages that really meet the needs of people. The benefits packages developed from annual public hearing with health service providers and beneficiaries are shown in Section 4.2.

Besides the annual public hearing, people can propose for new benefits package to the universal coverage scheme via the national health assembly.



PEOPLE PARTICIPATION

IN RIGHTS PROTECTION: COMPLAINT HANDLING

VIA CUSTOMER SERVICE CENTER AND INFORMATION DISSEMINATION VIA PEOPLE'S HEALTHY SECURITY CENTER

The 2002 National Health Security Act indicates the principle that include people to participate in handling with complaints regarding the problems of universal coverage scheme health service.

In the initial stage of universal coverage scheme implementation, Dr Sanguan Nittayarampong; the first NHSO secretary general, emphasized and developed mechanism to protect patients' rights and to enhance people participation.²⁹ The two mechanisms include right protection and people participation promotion.³⁰



RIGHT PROTECTION

NHSO has established "customer service center" to handle with the complaints and to protect beneficiaries. A call center 1330 is centralized at NHSO headquarters to provide information services to UCS members and to manage complaints. When a call center has implemented for a while, it was found that most of complaints included misunderstanding of system as well as miscommunication between doctors, nurses, public health staffs and patients. There were little complaints regarding national health security. Most of incidents happened in the hospital. Thus, the customer service center has been established in the health care unit to give suggestions and to assist patients. The customer service center is a channel to create understanding of universal coverage scheme and to build good relationship between doctors, nurses, and patients. In 2018, there were more than 800 customer service centers all over the country.³¹



PEOPLE PARTICIPATION PROMOTION

In the beginning stage of universal coverage scheme, NHSO has worked with CSOs to conduct forums in 8 regions to introduce the national health security and to search for networks to work with NHSO. The result of forums found that people needed the agencies or coordinating centers in the area to give information about universal coverage scheme. As a result, "People's Healthy Security Center" was firstly established in 2005 to give information about universal coverage scheme, to handle the complaints, and to responsible for other duties. The People's Healthy Security Centers have been operated by CSOs. The centers are not located in the hospital or any government places. The centers must be operated by people who live in the area or civil society organization.³² In 2018, there were 146 centers in the provincial, district, and sub-district levels. There are also centers for specific issues such as labor, child, elder, and chronic diseases.³⁰

By the approval of the quality and standard control board, some People's Healthy Security Centers have been registered to "the independent complaint unit" under article 50(5) of the 2002 National Health Security Act. The independent complaint unit is the autonomous mechanism to complain and to call for action related to the problems of universal coverage scheme.³³ In 2018, there were 122 complaint units in 77 provinces over the country (except Mae Hongson Province).

NHSO focuses on the cooperation of all mechanisms to raise people understanding on universal coverage scheme, to solve the problems, to handle the complaints, and finally to improve quality and standard of health service (Figure 7).

COMPLAINT HANDLING MECHANISM IN UNIVERSAL COVERAGE SCHEME

Figure 7



PEOPLE PARTICIPATION IN HEALTH CARE SERVICE PROVISION

The 2002 National Health Security Act intends to involve people in providing health service and in supporting the health care units. The patients help each other by sharing experiences of treatment, giving knowledge, and advising about benefits package in the universal coverage scheme. The supports from patients will enhance the effectiveness of treatment and will heal the mind of both sides. When people engage in health service provision, people would understand about the universal coverage scheme and public health care system. The sense of ownership is also increased. Consequently, people will be eager to engage more in proposing health policy in the future.

A Comprehensive and Continuous Care Centre (CCC Centre) is an example of public participation in health care provision. The collaboration between civil society and government expanded considerably in 2002 when Thailand obtained financial funding from

the Global Fund to support HIV/AIDS patients to access drug, to establish patient support system, and to prevent and reduce new infection.³⁴ Later in 2005, Thai Government Pharmaceutical Organization (GPO) developed anti-retroviral drug (GPO-vir) at low cost. Consequently, Antiretroviral Therapy (ART) was introduced to UC benefits package in 2006. As a result, HIV/AIDS patients are able to access to drug from all public hospitals.³⁵

Although HIV patients could access to drug easier, there was a discrimination to HIV patients in some health care units due to lack of human compassion.³⁶ The discrimination might discourage patients to take medicines regularly and reduce the effectiveness of treatment. Saowakon Oonkatepon; Kittikorn Nilmanat; and Praneed Songwathana³⁷ found that social support and self-valuation had a positive relation with medication adherence. As a condition of fund provision,



PEOPLE PARTICIPATION IN HEALTH PROMOTION AND PREVENTION VIA THE COMMUNITY HEALTH FUND (CHF)

Global Fund required CSOs to ensure medication adherence and to prevent drug resistance.³⁴ Consequently, Thai Network of People Living with HIV/AIDS (TNP+) together with AID Access Foundation (ACCESS) and Medecins Sans Frontieres (MSF) had developed new form of patient's participation in health care provision to HIV/AIDS patients so called "Comprehensive and Continuous Care Centre (CCC Center)". HIV patients collaborate with the clinical team in community and provincial hospitals to give suggestions to the patients, to provide consultation on living with family and community, and to follow up treatment at patients' homes³⁸⁻⁴⁰.

Global Fund has supported CCC Centers since 2009. When the Global Fund grant expired, the National Health Security Office has committed to supporting all individual CCC Center costs.³⁴ CCC Centers is a proactive innovation to provide effective health care to HIV/AIDS patients.

According to the National Health ACT B.E.2550 (A.D.2007), health means the state of human being which is perfect in physical, mental, spiritual and social aspects, all of which are holistic in balance. Social determinants of health such as ineffective political system, low-quality food, air pollution, environmental pollution lead to health problems. At present, public health problems are complicated and cannot be solved by only medical treatment. It is highly essential that local administrative organization participate in solving health problems in the community.⁴¹

Therefore, article 47 of the 2002 National Health Security Act indicates that NHSO shall cooperate with local government organizations to manage the national health security system in local areas by receiving budget from the Fund in order to enable local participation in health activities.⁴²

To translate the obligation in the law into practice, NHSO has invented "Community Health Fund" (CHF) since 2006. The voluntary measures were applied to encourage local administrative organizations to organize health promotion and prevention in the community. The local administrative organizations have to co-pay to the community health fund with the NHSO.⁴³

The CHF opens opportunity for local people to propose for health promotion and prevention projects in their community under the criteria prescribed by NHSO.⁴⁴

People participate in CHF management in 4 steps; participation in planning and making decision, participation in implementation, participation in benefit, and participation in monitoring. The stakeholders engaged in CHF include CHF committee, civil society organization, and other networks. Participatory management leads to decentralization and participation from all related sectors.⁴⁵

In 2018, the CSOs network had developed the curriculum to promote role of the CHF board to support people to conduct community health plan. The objectives of this curriculum included to give knowledge to the local CSOs and CHF board about the principle of universal coverage scheme and CHF, and to give training to conduct health plan and project proposal that able to solve public health problems in the community.

4

RESULT OF PEOPLE PARTICIPATION IN THE UNIVERSAL COVERAGE SCHEME

4.1

RESULT OF PEOPLE PARTICIPATION IN SYSTEM GOVERNANCE

The CSOs have strongly involved in the National Health Security Board and the Standard and Quality Control Board as well as other sub-committee such as the Regional National Health Security Board, the Regional Standard and Quality Control Board, and Community Health Fund Committee. This is raising level of people participation in the country. Previously, only the government fully allocated the public health resources. Allowing people to participate in the committee level enables good governance in public health resources allocation for the optimum benefit of the public.

4.2

RESULT OF PEOPLE PARTICIPATION IN BENEFITS PACKAGE DEVELOPMENT

NHSO has set up public hearing with health care providers i.e. doctors, nurses, and public health personnel as well as patients, government officers, local administrative organization, and civil society organization. Many UC benefits packages were developed from the proposals from public hearing as shown in Figure 8.

BENEFITS PACKAGE DEVELOPED FROM THE PROPOSALS GATHERED IN THE ANNUAL PUBLIC HEARING

Figure 8

BENEFITS PACKAGE

DEVELOPED FROM THE PROPOSALS GATHERED IN THE ANNUAL PUBLIC HEARING

Increase benefit and budget in rehabilitation fund

Primary health care support

Medical services for patients with HIV/AIDS (antiretroviral drugs, laboratory test, voluntary counseling & testing, condom)

- Thai traditional medical service
- Cancellation of 30 Baht co-payment
- Disease management

- Renal replacement therapy for end stage renal disease patient
- Cancellation of 2 times a year limit of emergency coverage

- Access to high cost drug and drugs in national drug list E(2)
- Seasonal influenza vaccine for elders above 65 years old and 7 chronic diseases patients
- Methadone replacement therapy for drug dependences

2004

2005

2006

2007

2008

2009

2010

Access to orphan drugs and drugs in the national drug list

2011

- Cancellation of 15 days limit of psychiatric patients treatment
 - Diabetes mellitus and hypertension screening
 - Liver transplantation in children
 - Heart transplantation
-

2012

- Integration of emergency health care service for all insurance schemes
 - 30 Baht co-payment for hospitals with more than 10 beds
-

2013

- Integration of medical service in government insurance schemes for HIV/ AIDs end stage renal disease patient
 - Cancellation of 500 Baht copayment for Hemodialysis (HD)
 - Revision of criteria for patients with HIV to start treatment for ≤ 350 cells/ mm² of CD4 count and extension of drug items
 - Revision of criteria for no-fault liability compensation
-

2014

- Stem cell for leukemia and lymphoma (except Thalassemia patient)
 - Extension of targets for season influenza vaccine (more than 4 months pregnant female and 6 months - 2 years old child)
 - Announcement of criteria to support local health fund
 - Access to national drug list E(2) for early stage of breast cancer/ hepatitis C 1,2,3,6// HCV and HIV co-infection/ leukemia and lymphoma
 - Revision of criteria for patients with HIV to start treatment immediately for any CD4 count
-

2015

- Unlimited coverage for baby delivery
 - Extension of rights to access 18 items of drugs
-

2016

- Community long term care
 - Services for patients with chronic mental illnesses
 - HIV prevention
-

2017

- Pap Smear
 - HPV vaccine for students in primary school year 5
 - Extension of target for seasonal influenza vaccine under the condition of national drug list
-

2018

- Colorectal cancer screening
- Bangkok local fund for health promotion and prevention

In additions, people can propose for new benefits package via the national health assembly. The examples of benefits packages developed from the National Health Assembly (NHA) are described as follows;



HEALTH CONSTITUTION

NHA 1, resolution 1: Health constitution is a common intention and obligation of society. Health constitution is the country direction for health policy, strategy, and operation. NHSO follows health constitution to frame the operation. For example, the strategy for universal health coverage (2012-2016) indicated that "all people living in Thailand shall be covered by national health security".⁴⁶



THE ESTABLISHMENT OF FUND FOR PEOPLE WITH CITIZENSHIP PROBLEMS IN FISCAL YEAR 2010

The establishment of fund for people with citizenship problems in fiscal year 2010 was a result of NHA 1, resolution 8 on equity in essential health care access. The provincial administrative organization supported establishment of the rehabilitation fund in accordance of NHA 3, resolution 2 on equity in health care access of disabled people.⁴⁷

4.3

RESULT OF PEOPLE PARTICIPATION IN RIGHTS PROTECTION

The independent complaint units, People's Healthy Security Centers, and civil society network have been established to protect rights of UC members in proactive and reactive way. In proactive way, People's Healthy Security Centers promote rights of people to access essential health care in universal health coverage scheme. In reactive way, the centers also collect complaints related to problems in accessing health care in the area. The operation of People's Healthy Security Centers enables public participation by disseminating the information, increasing understanding of universal coverage scheme to people, handling complaints, solving problems, and enhancing good relationship between health service providers and patients.

The People's Healthy Security Centers lead to the effective mechanism of people participation and strong network. People can actively involve in the committee in regional and national level. In additions, People's Healthy Security Centers are responsible for collecting opinions and suggestions to improve health care system and health benefits package via forums. The representatives from the People's Healthy Security Centers have to propose these opinions in the annual public hearing. The result of their proposals in the public hearing led to the development of new benefits packages. People's Healthy Security Centers also actively join the important movements that lead to new benefits package development such as drug Compulsory Licensing (CL), kidney disease benefits package, heart disease benefits package, mental health care, heart transplantation, and liver transplantation in children younger than 18 years old.³²

The principle of independent complaint unit is to be a mediator between health providers and patients to avoid confrontation. The missions of the independent complaint unit are to explain about rights of patients in universal coverage system and to assist patients when they do not receive the appropriate health service. The result of independent complaint unit is the mutual understanding between patients and health units which consequently improve the quality and standard in both policy and operation level.

4.4

RESULT OF PEOPLE PARTICIPATION IN HEALTH CARE SERVICE PROVISION

The consequence of public participation in health care service provision is that more patients access to health care service.

The CSOs have been closely participated in providing health care service to HIV/AIDS patients via CCC Centers. The volunteer patients have worked with health care units to provide consultation, to visit patients at home, and to follow up the treatment to prevent drug resistance. The HIV/AIDS patients have occupation and access to health information from experienced patients who really understand the situation of patients. In 2017, NHSO supported more than 170 CCC Centers over the country.⁴⁸

4.5

RESULT OF PEOPLE PARTICIPATION IN HEALTH PROMOTION AND PREVENTION

The study of Ratanasak Yeesarnpak, Krit Khunluk & Thanusith Sukserm (2016)⁴⁵ proved that the CHF led to decentralization and participation from all stakeholders.

One good example of successful innovation of CHF is “excellent happy home ward”; a collaboration of health professional network, patient’s families, and the community to provide holistic health care service for chronic patients and the elders.^{49 50} The municipality installed telephone networks and CCTV and linked this communication network to the operation unit at the municipality. The operation unit can connect to the volunteer networks in the community and professional teams. The GPS system was installed to check the point of incident immediately. In additions, the municipality collected database of transportation routes in the community. With accurate database, the ambulance can access the patient’s house and bring patient to the hospital quickly.⁴¹

CHF has been expanded over the country. In 2017, some 7,736 among 7,776 local administrative organizations had involved in CHF. Total 1,233 million Baht were co-paid by the local administrative organizations to support health promotion and prevention projects in the community.⁵¹

5

FACILITATING FACTORS/ CHALLENGES OF PUBLIC PARTICIPATION IN UNIVERSAL COVERAGE SCHEME AND WAY FORWARDS

5.1

FACILITATING FACTORS OF PUBLIC PARTICIPATION IN UNIVERSAL COVERAGE SCHEME

The factors that facilitates public participation in Thai universal coverage scheme include capacity building and empowerment of civil society organization, the authentication of public participation in 2002 National Health Security Act, and government support especially supports from local administrative organization, hospital, and Ministry of Public Health.

1

CAPACITY BUILDING AND EMPOWERMENT OF CSOs

In the initial stage, the public health CSOs such as sterilization association, family planning association, population and community development association, and folk doctor foundation implemented wide range of health activities from health care development to rights protection.

Later, the CSOs linked public health issues with other social problems and started working in network form. The common directions of CSOs were to solve health inequity and to reform financial system for national health security. The CSOs played active role in Thai health care system.

After 2002 National Health Security Act has been enforced, the civil society has actively engaged in policy development, health service provision, health information dissemination, complaint handling, and health care mediation. The capacity of CSOs has been strengthened through their active commitment in the implementation of universal coverage scheme.

2

THE AUTHENTICATION OF PUBLIC PARTICIPATION IN 2002 NATIONAL HEALTH SECURITY ACT

Rights of people to participate in universal coverage scheme are validated by article 5, article 6, article 7, article 8, article 13 (4), article 18 (3)(7)(9)(10) (13), article 41, article 47, article 48 (8), article 50 (5)(7)(9) and article 59 in the 2002 National Health Security Act. Vibrant authentication in the law obligates NHSO to develop mechanism and innovation to enable public participation. In additions, the law addresses that the result of public participation shall be considered to improve universal coverage scheme.

3

GOVERNMENT SUPPORT

Since the Ministry of Public Health cannot provide coverage health care service, the collaboration with CSOs is essential. Networking and flexibility management of the CSOs can response to dynamic public health problems. In additions, the CSOs can provide health service that the government cannot do such as abortion.

Since 1990, the Ministry of Public Health (MoPH) offered budget and provided equipment, place, and human resources to civil society organizations. The objectives of MoPH support were to enable the CSOs to work in according of health promotion and prevention, environment, primary health care, Thai traditional health and herb, consumer protection, disability and marginalized people protection.

5.2

CHALLENGES OF PUBLIC PARTICIPATION IN UNIVERSAL COVERAGE SCHEME

The public and CSOs put hard attempt to engage in universal coverage scheme. However, health literacy of people is still low and insufficient to response dynamic health risk factors. People are not aware of sickness from their inappropriate consumptions and lifestyles. For instances, obesity, diabetes mellitus, and high blood pressure are caused by unsuitable diet and lack of exercise. Alcohol drinking leads to accident and unwanted pregnancy.

Although the 2002 National Health Security Act empowers local community participation to manage their own health in accordance of social determinants of health concept, most of health projects under CHF were aimed to response general health problems such as high-blood pressure monitoring, diabetes mellitus, and elders' health care. Health innovations to solve dynamic public health problems are still limited. Also, there is no clear target and long-term plan for CHF. Most of projects under CHF included small scale health care provision as well as health promotion and prevention activities that immediately responded to existing problems. There is lack of consideration to the threatened factors which could affect future health status.

5.3

WAY FORWARDS

In order to sustain participation in universal coverage scheme, it is essential to build up capacity of CSOs; especially the inaccessible to health care groups. The strong engagement of civil society will reinforce the universal coverage system.

The collaboration between CSOs, professional organizations, and local administrative organizations is needed to develop community health master plan. The consistency of community health master plan should be a criteria to approve the projects under CHF in order to generate significant impacts to health status of people in the community.

6

CONCLUSION

People has actively engaged in every step of universal coverage scheme since the petition of draft bill. The members of the civic group were drafted onto the parliamentary commission set up to consider the first and the second reading of the bill, which later became the National Health Security Act. When 2002 National Health Security Act has been enforced, the civil society has continued engaging in governing universal coverage scheme including decision making process, right protection, health care provision as well as health promotion and prevention. The continuity of public participation in all levels leads to "people's sense of ownership" to the universal coverage scheme.



**PEOPLE'S
SENSE OF
OWNERSHIP**

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