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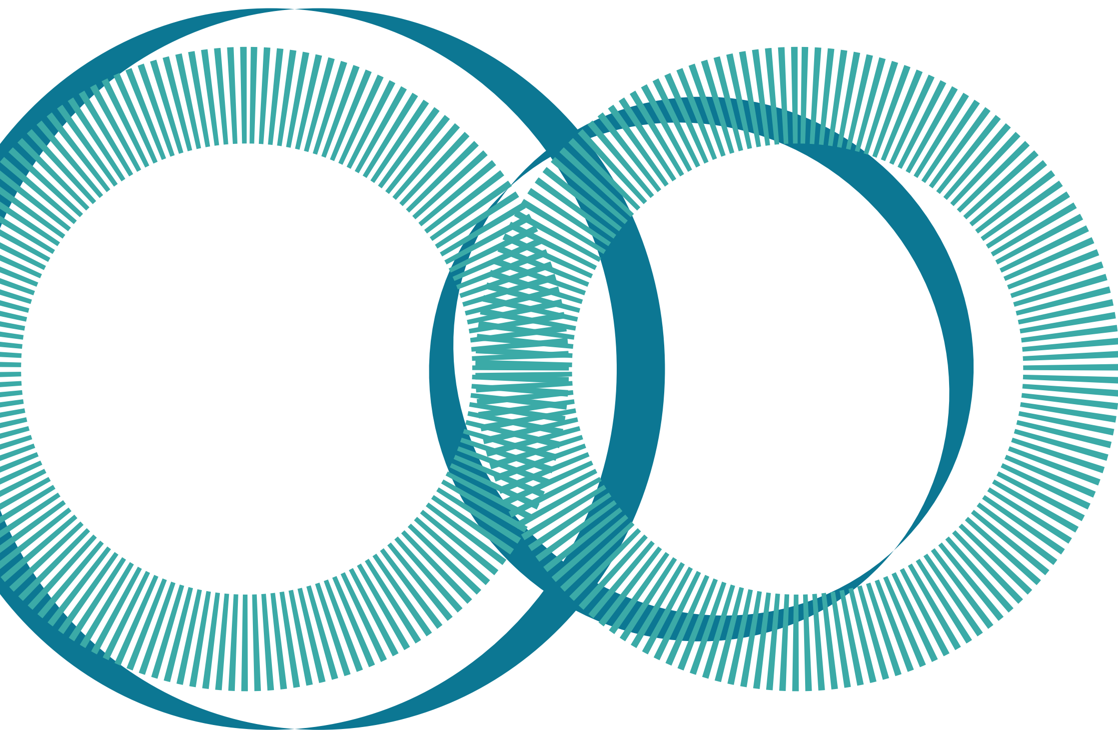

***I don't want you to be only a doctor,
but I also want you to be a man.***

HRH Prince Mahidol of Songkla

INTRODUCTION

LOCAL IS GLOBAL IS UNIVERSAL

KANITSORN SUMRIDDETCHKAJORN

Everything under the sun seems nowadays to affect everybody under the sun. For those less inclined to agree, a review of any recent year's news should lend support to the notion that geographic border is becoming irrelevant when it comes to a ray of hope or a life threat.

To name but a few examples, there's the perennial extreme weather that spares no region; early last year the Ice Bucket Challenge fund-raising scheme had spurred a world-wide following; the Fukushima meltdown since March 2011 has ignited debates on the future of nuclear power; countries in Europe, America and Asia are espousing the bike-sharing program; more public spaces are declared smoke-free; and trans-fat are declared *non grata* in most eateries.

Sieges of all kinds—infectious, military, ethnic, religious—will never fail to wreak psychological havoc on netizens, local denizens and world citizens; the Occupy Wall Street will continue to spawn other Occupy movements across the globe; the political, military and security ramifications from the 9/11 are seeing no hope of abating; and the Great Recession in all its manifestations is being felt far and wide.

And then, of course, there's Ebola.

If anyone needs further convincing that a situation, even in the remotest of corners, can send ripples to the farthest reach of the planet, and in a single day to boot, they need look no further than at the outbreak of the merciless virus in West Africa.

Not only does the sweeping ravage illustrate how a local problem can turn virulently and speedily global with just one connecting flight, it also points out how the robustness, or lack thereof, of one country's health system to cope with the onslaught of cases can have repercussions as massive as they are global.

The extent to which local issues can cast global concern, either through vicarious feelings, shared experiences or a foreboding of potential imminence, is reflected by the recent Pew Research Center study that examined public opinion in 44 countries. Religious and ethnic hatred, inequality, the spread of nuclear weapons, environmental problems, and infectious diseases figured among their greatest perceived threats facing the world.

But events need not cross borders to be global. From one hemisphere to another, one country's predicament or Eureka moment can capture the soul, animate the spirit and activate the corpus so long as it is shared, like a Venn diagram, by other countries.

Income disparity is a case in point. As long as social class exists, there is no escaping it wherever one lives. And yet, the place where one lives does have a powerful influence on how wide the income gap is, according to José Antonio Ocampo whose "Time to Create a Fairer World" article in the New York Times states that location determines four-fifths of today's global income disparities.

Where one lives does matter a great deal to one's wellbeing. And wise leaders are looking to fix this discrepancy so their citizens anticipating their dotage would not find themself wishing they were born elsewhere. With rapid ageing being witnessed across the globe, however, most leaders have no luxury of procrastination and are thus striving to put in place a formula (Chapter 1) that is amenable for a nation-wide scale-up. Such initiatives, of course, require multisectoral community engagement for long-term sustainability, to achieve which various community-governed processes (Chapter 2 and Chapter 3) have been attempted with varying degrees of success.

Where one lives does matter a great deal to one's wellbeing. But even in the richest of nations, there is only so much the state can do before its coffer is exhausted. High-cost care (Chapter 4), the bane of any insurance scheme, can deplete the state's largesse in no time while providing health

coverage for migrant workers (Chapter 5) now that borders are porous and native labor is scarce will only aggravate the country's financial burden further.

With every project thus clamoring for their share of financial support, appropriating even a small proportion of the tax levied on cigarettes and alcohol, as Thailand has done à la Australia's VicHealth for its health-promotion drives (Chapter 6), should be attractive for both cash-strapped and cash-flush countries.

All of these go to show how the mission of public health has evolved since the mid-19th century.

Granted, the discipline has always held true to its tenet of maintaining and improving the population health through collective actions. There is never any less of the focus on underserved populations, as is apparent in the Millennium Development Goals (MDGs) whose deadline in 2015 hopes to see some achievement in poverty reduction.

The ultimate goal too has never budged from its aspiration to combat subnational, national and supranational iniquity. The London International Development Centre Commission's proposal for the post-2015 health-goal setting, for instance, indicates intragenerational and intergenerational equity as one of its guiding principles. This corresponds neatly with Ocampo's call for strong international cooperation in, and improved national distribution of, funding, educational quality, social protection and, most significantly, values that place equity at the centre of the social contract.

The increasingly recognized connotation of wellbeing (think: health in all policies) also implies that 'health' in public health is not exclusive to the medical or biological sciences, but tightly woven into the social, economic, environmental, political and cultural threads that make up the tapestry of life. So much so, that any loose thread left unfixed can eventually cause the life fabric to fray. And when it does, there's no telling what sort of calamity will ensue. Political upheaval, military uprising, economic collapse, social unrest, and what not—everything is possible.

But while the outreach of public health has extended across borders and oceans, the nature of the transaction is shifting, according to the viewpoint of the Consortium of Universities for Global Health Executive Board, published in the June 6, 2009 issue of the Lancet. More emphasis is placed on the synergy of diverse societies and health dimensions; greater international ownership; and sustainability against all odds.

The global omnipresence of many local issues makes real partnership of states, sectors and disciplines the only effective way to go. And thanks to our increasing

interconnectedness and changing power dynamics, the constant interchange of experiences is such that a free flow of ideas and aids between developed and developing countries is becoming the norm.

Depending on the situation, these aids and ideas can flit and float, like the air we breathe, through fortressed walls, barbed wires and miles of oceans to reach peoples in both high and low places. Or, like the air we breathe, they can build up into a gale-force wind to deliver the required elements to the target in a fast, wholesome and coordinated manner.

It used to be that expertise went solely from north to south. Now it moves in every direction of the compass. Inasmuch as we survive through combining forces, we should make sure all the helpful elements harmonize and reinforce one another.

Because we are culturally diverse, it does not follow that we do not share values and traits as human beings. Because the Earth is patterned with crisscrossing lines of borders, it does not follow that each country is a closed system.Stripped of all demarcations, countries simply coalesce into landmasses on waters.

The world, to paraphrase that famous refrain from the upbeat American folksong, is made for you and me. We all have a stake in making it a healthy, secure and equitable place.

We are not alone.

And because we are not on our own, it does follow that we should be one ■

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CHAPTER ONE

THAILAND POST 2015: AN EMERGING DEMAND FOR LONG-TERM CARE THE LAM SONTHI MODEL

SUKJAI CHAROENSUK
PANARUT WISAWATAPNIMIT
SIRIKUL KARUNCHARERNPANIT

Dr. Santi Lapbenjakul and formal community caregivers visit Aunt Maew

A formal community caregiver checks Aunt Maew's blood pressure

"I wouldn't have been here today if it were not for Dr. Santi and his care team," Aunt Meaw said with smile. Helpless after being hit by a stroke, Aunt Meaw recalled her experience. "Six months ago, I became paralyzed...I was hopeless...Her husband also reflected his difficulty to balance the breadwinner and caregiver roles. "She couldn't help herself at all. I didn't know how to deal with it. We were new to this community. Our children all worked far from here, and I had to work for both of us. Sometimes, she had to wait several hours before I could clean her. I was so helpless and hopeless that she would get any better."

This issue of dependent patients and hardship for family members is becoming a big problem in Thailand and promises to gain greater magnitude in the face of the aging society.

LONG-TERM CARE: A CHALLENGE OF THE ELDERLY SOCIETY

Among Southeast Asian countries, Thailand has moved up the ranks to become the second country in the region (next to Singapore) with the most aging population. The National Statistic Office reported in 2013 that the population aged over 60 in Thailand was 13.2 percent, or roughly nine million of the total population. The aging of the population gave rise to an epidemiological transition from the 'disease of poverty' to the 'disease of wealth.'

Traditionally, the family has occupied the dominant role in providing care for the disabled and elderly. However, with family members having to maintain jobs far from home, taking care of the dependent elderly has become a challenge.

THE STARTING POINT FOR THE LAM SONTHI MODEL

Aunt Maew's husband recalled that "one afternoon, Aunt Anong who has experiences in caring her bedridden mother and is a formal community caregiver of Lam Sonthi came to my store and found my wife. She discussed about my wife's situation to her supervisor at Lam Sonthi Hospital. We felt like there was light at the end of the tunnel."

Since then, Aunt Maew was registered as a dependent patient in Long-Term Care (LTC) of Lam Sonthi Hospital.

The LTC initiative was established in 1996 by Dr. Santi Lapbenjakul, Director of Lam Sonthi Hospital. He came up with the idea after finding abandoned disabled and elderly patients during one home visit.

He understood how the family didn't want to leave the elderly alone, but needed to earn money. The number of dependents that he had found made him realize that the problem would continue to grow, given that Lam Sonthi

was an aging society with 13.6% of the population aged over 60.

To solve this problem, the role of health care providers should no longer be passive. Active strategies and infrastructure are needed for the district, with the development of the service that involves community participation.

Dr. Santi Lapbenjakul

Dr. Santi and his staff worked closely with both local health and non-health sectors, which supported his idea and created the motto of "Lam Sonthi People will never leave others behind." Since then, the LTC in Lam Sonthi has engaged all community sectors to work towards the main goals: reduce the number of the elderly who are dependent; decelerate death of the elderly that are partially or totally dependent; and enable the healthy elderly to care for themselves and maintain a healthy lifestyle.

A meeting between health and non-health sector, presided over by Somporn Chatpaiboon, Assistant Chief Executive of Subsomboon Subdistrict Administrative Organization

INTEGRATING ALL PARTIES

There are two channels for registration: hospital or community. The LTC coordinating committee then formulates a care plan. Patients' houses are checked by the hospital's health care team, with parts of house modified as needed by technicians, family members and/or neighbors with funding from the Sub-district Administrative Organization (SAO).

The LTC coordinating committee also examines health in all aspects and plans a holistic care approach. data is sent to the district case manager, who meets with the community team to formulate an individualized program, assign a formal caregiver, and assign other personnel from related sectors for their contributions.

Any problem that arises from the caretaking is reported to the case manager, who meets regularly with members to review cases, analyze problems, and improve

the LTC process. All information is reported weekly to the LTC coordinating committee.

Care-team meeting

Care-team meeting with Dr. Santi Lapbenjakul

THE LAM SONTHI APPROACH

The main LTC services include health and social care. The holistic approach provides continuum care with a focus on the three Bs (Brain, Bone, Body). Care and activities are adjusted for each person's functional ability and dependent level. For totally dependent patients, multidisciplinary team comprising Lam Sonthi Hospital, primary care center, and a community caregiver will work together towards providing housing modifications, physical therapy, emotional support, and nursing care (e.g. urine catheterization, feeding, oxygen therapy). Frequency of home visit is set according to health needs.

Social service focuses on social welfare, costs of living, housing budget, environmental modifications, and career plan.

There is a synergy between the family, the health sector, and the social service. The LTC plan includes family members as part of the team. All aspects of life, including suffering and happiness, are considered.

House modifications for the elderly

Formal community caregiver feeds an elder

Formal community caregivers help with rehabilitation

FORMAL COMMUNITY CAREGIVERS

In the Thai society, family members traditionally look after their parents and elderly relatives. However, the limitations posed by their occupations have made this increasingly difficult. Formal community caregivers at Lam Sonthi came into being for this purpose.

Aunt Anong, a formal community caregiver for Aunt Maew, talked about her activities. "When Aunt Maew was incapable of doing anything, I helped her daily with the showering, feeding and rehabilitating. When she was better and her husband could look after her, I visited her occasionally to keep her company while her husband went out to earn their living."

There are currently 23 formal community caregivers in all six SAOs of Lam Sonthi. Volunteers are trained by Lam Sonthi Hospital on hygiene care, basic physical examination, and capillary-blood sugar testing. Their knowledge is reviewed after each home visit. They are assigned cases from the case manager and follow the care plan.

Compensation from SAOs of 5,000 – 6,000 baht per month is small when transportation and other expenses are taken into account. However, money is not the main reason for these caregivers. "I'm so proud that I can help Aunt Maew and other dependents to be independent," said Aunt Anong.

Care team, including formal community caregivers, visit a dependent elderly

Formal community caregivers

Not only are they satisfied with their work, the local authorities and community folks also appreciated their dedication.

Somporn Chatpaiboon, Assistant Chief Executive of Subsomboon SAO said, "A formal community caregiver is praised for their pureness of spirit even though they get very little in terms of monetary rewards."

OUTCOMES OF THE LAM SONTHI MODEL

Thanks to the Lam Sonthi model, all 2,270 dependent elderly in Lam Sonthi have received LTC with participation from all sectors in the district. The local authorities have pledged to their financial support.

Thongchai Mongkolkaew, Chief Executive of Nong-Ri SAO, said, "The budget for the LTC and community caregivers will increase according to the demand. We have plan for this."

Based on the Bathel Index of activities of daily living, the number of dependent elderly has decreased (Figure 1) The quality of life of the dependents and family members has also increased.

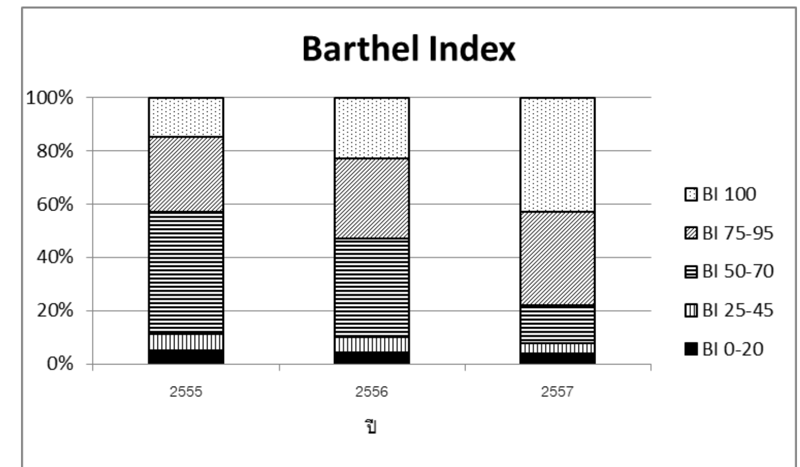

Figure 1 Bathel Index of dependent patients of Lam Sonthi from 2012 – 2014

KEY SUCCESS FACTORS

- Active involvement of both health and non-health sectors
- Sharing of experiences and tailoring of plan according to the financial, social and cultural context of the district
- The crucial role of community caregivers as the focal point between the family and the care team

CHALLENGES FOR LAM SONTHI LONG TERM CARE

- Well-defined roles and responsibilities of each sector should be clarified.
- Suitable arrangement should be considered for dependents who live alone.

FUTURE PLAN

Dr. Santi expected that "LTC will become one of biggest issues for Thai people. Policy makers and strategists should consider LTC and quality of life of elderly."

In the statement made by Professor Rajata Rajatanavin, the Minister of Public Health of Thailand on October 20, 2014, preparing the health work force for the elderly society figured among the ten policies he planned to launch.

The Lam Sonti model could be a role model for other districts in the country to follow.

LESSONS LEARNED

Participation from all levels of organizations and people in the community is crucial to solving complex health issues such as LTC. As to which sector should start it in the community and how to sustain the collaboration, these issues must be considered at the very beginning. Systematic planning is needed to achieve the ultimate goal of equity in population health ■

Aunt Maew

Aunt Maew, her husband, and the care team

"Now I can walk again even if it's not as good as it was. Dr. Santi and his care team from Lam Sonthi Hospital and the community have given me a new life."
-- Aunt Maew.

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Special thanks to Dr. Santi Lapbenjakul, Director of Lam Sonthi Hospital; Thongchai Mongkolkaew, Chief Executive of Nong-Ri SAO; Ms. Somporn Chatpaiboon, Assistant Chief Executive of Subsomboon SAO; Mr.Chanwit Khumwong, Health Officer of Lam Sonthi Hospital; Aunt Maew and her husband; and Aunt Anong for their support and information for the article.

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CHAPTER TWO

PROVINCIAL HEALTH ASSEMBLY MOVING TOWARDS GOVERNANCE BY NETWORK

SUPAPORN WANNASUNTAD
ANCHALEEPORN AMATAYAKUL

"[Teen mums] lack knowledge about sex. They don't know how to protect themselves from pregnancy."
-- Ms.Kalapungha Chosivasakul, a nurse practitioner at Nong Muang hospital.

"Adolescent pregnancy is the greatest challenge. If we don't do anything, the problem will continue."
-- Mr. Thongbai Kreuakum, Chief Executive of Chonsomboon Subdistrict Administrative Organization

In 2009, according to data from Nong Muang Hospital, the prevalence of adolescent pregnancy in the district was 33.3 percent, much higher than the goal of 10 percent set by the Ministry of Public Health, and higher still compared to the prevalence of 18.1, 18.3, and 17.5 percent, from 2007-2009, respectively. Moreover, the majority of these adolescent mothers often left their babies with their grandparents, as observed by Kalapungha Chosivasakul, a former nurse practitioner at Nong Muang hospital, who has been working very hard to solve adolescent pregnancy in Nong Muang.

Kalapungha decided to approach Prakhrubaidika Songphon Chayananto, the abbot of Srirattanaram Temple, who is highly respected by Chonsomboon townsfolk, about the problem and asked if he could do something. At first, the abbot was not sure if he could help since it was not the role of the Buddhist monk. But after much deliberation, he decided to get involved by inviting several key persons of Chonsomboon, such as the Chief Executive of the Subdistrict Administration Organization (SAO), the Director of Nong Muang Vittaya School, the Village Headman, a housewife group, healthcare providers, and the residents, to learn about the problem from Kalapungha. The discussion at that time came to no conclusion.The general thinking was that, there was no way to stop teenagers having sex.

Prakhrubaidika Songphon Chayananto, the abbot of Srirattanaram Temple, has invited several key persons to discuss teen pregnancy in Chonsomboon

With much perseverance, meetings were arranged several times until everyone agreed to solve this problem.

"Adolescent pregnancy is the greatest challenge. If we don't do anything, the problem will continue," said Mr. Thongbai Kreuakum, Chief Executive of SAO.

Once the key persons agreed to tackle teen pregnancy in Chonsomboon subdistrict, the root of the problem was analyzed through concept mapping and responsibilities were then assigned to related authorities. The abbot, for instance, taught teenagers on morals

via Buddhist principles. SAO Chief Executive arranged an awareness program on adolescent pregnancy for teenagers. Health care providers provided sex education for teachers and students. The school director added sex education and life skills into the curriculum. The police and village headman patrolled the at-risk areas at night.

Prakhrubaidika Songphon Chayananto teaches morals via Buddhist principles

Mr. Dissapol Chamchan, Director of Chonsomboon Health Promoting Hospital, teaches sex education to students

Mrs. Surin Maneechay, Nurse Practitioner at Nong Muang Hospital, trains student leaders on teen pregnancy prevention

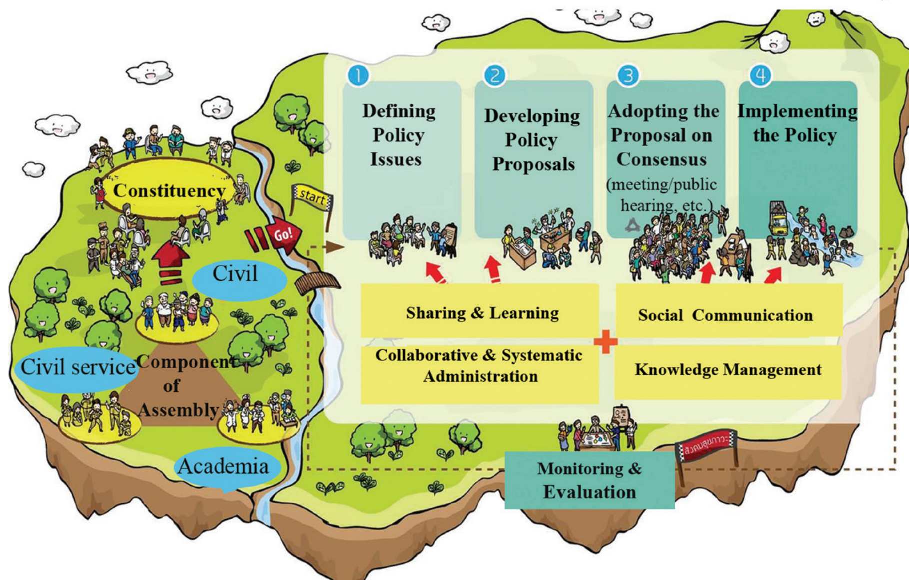
The success of Chonsoomboon's management of adolescent pregnancy is due largely to the strength of the leader and high commitment and participation of every sector in the community.

HEALTH ASSEMBLY FOR PUBLIC POLICY

The national health assembly is designed as a tool and a learning process that allows the civil-service sector, academia, and civic sector to share knowledge and work collaboratively on health-related public policies. There exist three types of health assembly in Thailand: 1) local health assembly (provincial or regional); 2) issue-based health assembly, (e.g. food safety, adolescent pregnancy); and 3) national health assembly. The first two assemblies are arranged by the public sector, the civic sector, and other networks with support from the National Health Committee. The national health assembly is responsible for organizing an annual assembly to advance health policies at the national and local levels.

Section 40 of The National Health Act 2007 promotes people to arrange local or issue-based health assembly by setting an organizing committee composed of the civil society, academia, and the civil service in equal numbers; to define policy issues; and develop policy recommendations for adoption by consensus.

After policy implementation, the assembly monitors and evaluates the progress in a systemic and collaborative manner and communicate the proceeding to the townspeople.



Health assembly process

PROVINCIAL HEALTH ASSEMBLY LOPBURI

More than ten years ago there was an initiative of the health networks in Lopburi to promote “Healthy Life, Livable Province”, by organizing meetings of various groups for their consensus and action. These groups later formed the Lopburi Provincial Health Assembly Organizing Committee.

In 2013, the Provincial Health Assembly (PHA) analyzed the local situation and define the top three problems to solve, namely teenage pregnancy, game addiction in children, and food safety.

The Lopuri provincial health assembly committee and stakeholders meet to define health policy issues

Academic, civic, and civil service sectors work together to develop policy proposal for teen- pregnancy prevention

A public hearing on strategies to prevent teen- pregnancy

Regarding teenage pregnancy, the PHA placed priority on teenage pregnancy prevention with collaboration from all sectors. with a three-year strategic plan (2013-2015) to prevent teenage pregnancy. Several media outlets were used to raise awareness of the problem and available preventive methods.Organizations under the Ministry of Education, Ministry of Public Health, Ministry of Social Development and Human Security, provincial administrative organization, private and the civil sector in Lopburi worked together as a large network to enhance awareness on teenage pregnancy of educational administrators, teachers, student's parents, and people in the community, and developed a network of sex educators within and outside the school system.

Since Lopburi and Chonsomboon shared an interest on teen pregnancy prevention, Dr. Kasak Tekhanmag, Associated Professor of the Faculty of Humanities and Social Sciences, Thepsatri Rajabhat University and Director of the Narai Institute for Development and a member of Lopburi Provincial Health Assembly Organizing Committee, Miss Phonthida Veangson, a public health technical officer, and Mr. Punya Yongying, a faculty member at the University of Phayao, introduced the idea of using health assembly to resolve teen pregnancy to key persons of Chonsomboon and asked if they wanted to be part of the health assembly network.

The collaborative work in Chonsoomboon to prevent and control adolescent pregnancy was remarkable for its success in promoting reproductive health at the subdistrict level, and encouraging other assemblies to the cause.

First, Nong Muang district chief offcier appointed the district health assembly committee (DHA) to monitor adolescent pregnancy in Chonsomboon. They set the goal to reduce adolescent pregnancy in Chonsomboon to ten percent within three years (2010-2013) using the "Egg-Yolk Strategy" which compares adolescents to the yolk, the community to the egg white, and the government to the eggshell, reflecting the need of collaboration from all sectors.

After setting adolescent pregnancy as their policy issue, the committee reviewed the situation, analyzed the causes and brainstormed practical solutions. Policy recommendations were developed, proposed to the public, and adopted by consensus.

Several activities aimed to reduce adolescent pregnancy were set and implemented for adolescents in Chonsomboon, with excellent collaboration from every sectors, such as arranging a program for students in Nong Muang Vittaya School to encourage them to focus on their future, their life goals and their values and arranging "a warm-family camp" for female adolescents to spend time with their parents and vow to behave. Sex education and life skills to prevent teenage pregnancy were delivered to adolescents by teachers. Groups of student leaders for teen-mom prevention were trained to convince their friends to be aware of teen-pregnancy. Health care providers and teachers visited adolescent moms at home to advise the moms on childcare. In addition, the teen-moms who left the school were invited to share their experience with their peers.

After Chonsomboon is proposed as an exemplary subdistrict for reproductive health, several strategies and policies set by the Provincial Health Assembly, such as campaigns and media to raise awareness of adolescent pregnancy among educational administrators, teachers, parents, and adolescents, and training teachers that add more fruitful outcomes and adopted by five nearby subdistricts.

Warm Family Camping

A home visit on teen mum

Student leaders for adolescent pregnancy prevention

In 2013, more partners on the provincial level were involved. The Primary Educational Office of Lopburi developed a school program to provide age-appropriate sex education for students and the Lopburi Provincial Public Health Office arranged a "counseling clinic" and "heartfelt adolescent center" to promote life skills and reduce risky behavior in adolescents.

Pamphlet developed to provide information on teen-pregnancy prevention

Adolescent counseling clinic

The district health assembly committee led by the abbot of Srirattanaram Temple reflects regularly on their achievement and opportunities for improvement. The evaluation was sent to the district chief officer. Data from Nong Muang Vittaya School showed that the prevalence of adolescent pregnancy had reduced continuously from 18.5 percent in 2010 to 14.8, and 1.2 in 2011 and 2012, respectively. It was no surprise, then, that Chonsomboon received the health assembly award.

LESSONS LEARNED

- Multisectoral involvement allows all parties to share resources
- Public policy can be proposed by people in the community as long as they can participate in the decision making.
- The health assembly is one of the powerful tools to make well-informed health policies.

• A key person who is highly accepted by all parties can attract support from all sectors.

• High commitment of the network's members ensures success.

CONCLUSION

The story of Chonsoomboon shows how the civic, academic, and civil service sectors work collaboratively through the health assembly on the local issue of adolescent pregnancy. Similarly, the provincial health assembly of Lopburi embraces a greater network of adolescent pregnancy prevention to work on the issue at theprovincial level ■

Dr. Sirichai Limsakul, Chief Physician of Lopburi Health Office, Prakhrubaidika Songphon Chayananto, chairman of the District Health Assembly Committee, and members of the adolescent pregnancy prevention network

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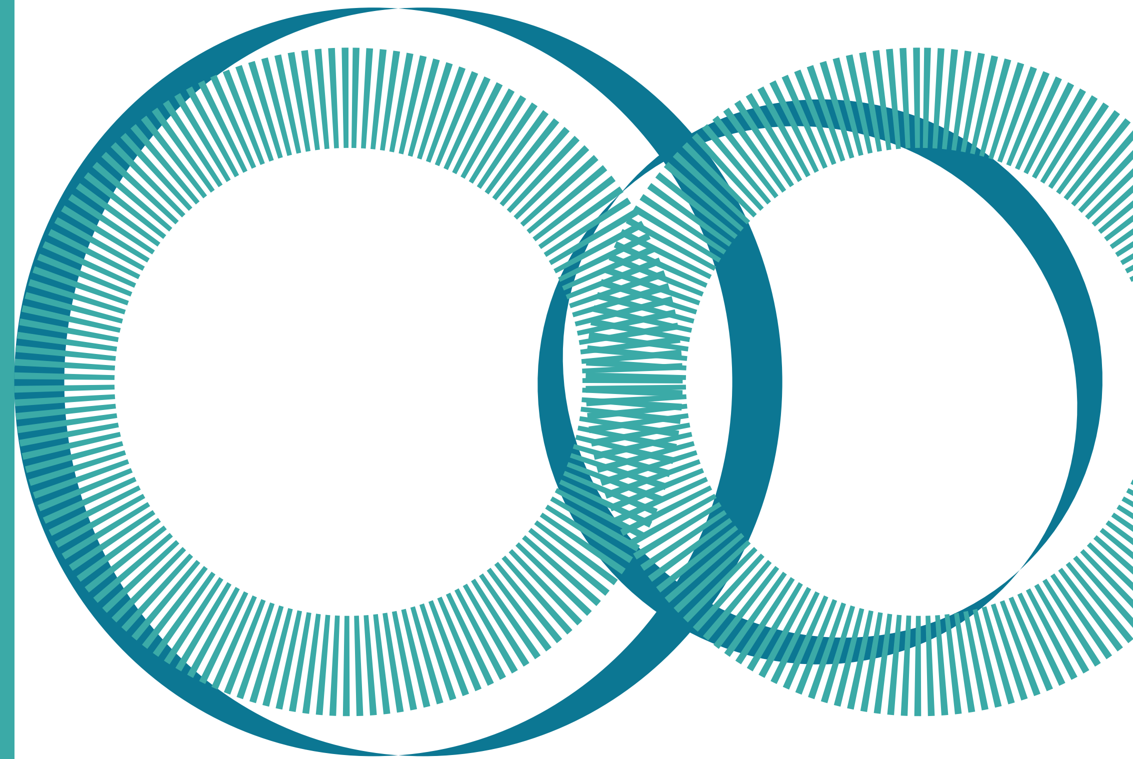
- Mr. Promp Jantana, Director of Ban Chonsomboon School
- Ms. Kalapungha Chosivasakul, a former nurse practitioner at Nong Muang hospital
- Ms. Phonthida Veangsong, a public health technical officer of Muang District Health Office, Lopburi



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CHAPTER THREE

HEALTH STATUTE: NETWORK GOVERNANCE ON THE COMMUNITY LEVEL

THONGSOUY SITANON
PORNRUEDEE NITIRAT

Nongyow is a large agricultural subdistrict in Chachoengsao. Similar to other agricultural areas in Thailand, pesticides have been widely used here; as a result, the problem of pesticide residues in the blood has been of great concern to the community. Yet, reducing pesticide use through such strategies as creating an organic farm was rarely apractised. Apart Hence, Apart from the farm of Mr. Wirat Prongjit, who established an organic farm due to health concerns with chemical farming, it was almost impossible to find any organic farm in Nongyow.

Agriculture area in Nongyow Subdistrict

Mr. Wirat Prongjit, an organic farmer

"I was the first person who dared to change. My neighbors thought I was crazy. I don't mind. I followed my strong intention to build an organic farm. When the community health statute decided that the food safety was one of its resolutions, community members began embracing the idea of organic agriculture, and my farm was selected as a learning area" said Mr. Wirat Prongjit, an organic farmer.

Like other areas in Thailand, chronic illness, dengue hemorrhagic fever, drug abuse, and pesticide residues have been on the increase in Nongyow. The approach the community took to solving these health issues is unique with the passage of the subdistrict health statute, in which a cross-community agreement was established as the key mechanism to address public health concerns.

HEALTH STATUTE DEVELOPMENT AT NONGYOW

The Nongyow health statute was modeled on the National Health Statute, at the initiative of Mrs. Panida Mingsamorn, Director of Bantonna health promoting hospital, with the help of the National Health Commission Office through assembly meetings on several topics that aimedto generate a united force towards community well-being.

Director of Ban Tonna Health Promoting Hospital, Mrs. Panida Mingsamorn

Director Mingsamorn recognized that the health statute could promote health equity to communities in the twelve villages in her charge. Along with the chief administrator of Nongyow Subdistrict Administrative Organization, she disseminated idea of health statute to encourage community participation. With strong support from the health promoting hospital, local government, community leaders, and community networks, the health statute was adopted to address community health. The governance process connects everyone in the community to work together to achieve a common goal.

With collaboration from people of all levels, villagers were eager to become involved in developing the first health statute, which they believed could become a tool for community health improvements. The statute allowed them to identify their needs and manage the health of the community, rather than merely acting upon national policies that might not address their needs. The drafting process took several months, involving everyone in the community to ensure that the contents were correctly and comprehensively defined.

Community meetings

FROM COMMUNITY MEETINGS TO COMMUNITY HEALTH STATUTE MOBILIZATION

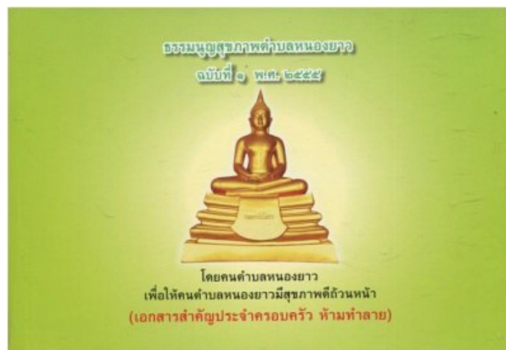
Regularity of community meetings was the most important factor for the success of the health statute development. At the meetings, health issues raised by each village were discussed at the steering committee composed of trusted community leaders. Common health issues were agreed and prioritized, while other issues were discussed for inclusion or exclusion from the statute.

Finally, the '2011 Health Statute of Nongyow Subdistrict,' drawn from the actual needs and cooperation of Nongyow people, was formulated, containing 13 sections in accordance with the national health Statute, as follows:

1. Philosophy and principal concept of health system;
2. Desirable characteristics and goal of health system;
3. Provision of health security and protection;
4. Health promotion;
5. Prevention and control of diseases and health hazards;
6. Public health service and its quality control;

7. Promotion, support, use and development of local wisdom in respect of health,Thai traditional medicine, indigenous medicine, and other alternative medicines;
8. Consumer protection;
9. Creation and dissemination of knowledge in respect of health;
10. Dissemination of health information;
11. Production and development of public health personnel;
12. Health financing;
13. Office of health statute

During the three years since the statute's enactment, all 13 sections have been addressed. Some sections appeared to be outstandingly successful, four of which are mentioned here.



Health Statute

Section 3
The Provision of Health Security and Protection states that community needs to

- replace the use of chemical substance with the organic one; and
- encourage all sectors to collectively prevent and monitor health hazards

Mr. Wirat Prongjit is a pioneer of organic agriculture in the subdistrict. His farm was gradually transformed from being a chemical farm to an organic farm before the health statute was even developed. When this health issue was raised, his organic farm gained community attention. In 2011, his farm was completely changed to an organic farm, following King Bhumibol Adulyadej's sufficient-economy philosophy. Various sorts of plants have been cultivated to ensure year-round products and income. He also set aside a plot in his land for raising animals.

Sufficient economy: Poverty removal

With the health statute, Mr. Wirat's farm became the point of interest from which the community people could learn. Mr. Wirat disseminated his idea of food safety and life security to promote a holistic approach to community health. Consequently, his farm has now become 'the learning center of sufficient-economy application for a better life.'

Section 7

Promotion, Support, Use and Development of Local Wisdom in Respect of Health, Thai Traditional Medicine, Indigenous Medicine, and Other Alternative Medicines states that

• Nongyow local governor must promote and improve the use of Thai traditional medicine and other alternative medicines that support community's lifestyle, culture and beliefs to conceive future self-reliance; and
• community provides a Thai traditional medicine clinic, encourages herb planting and usage

Without any hesitation, Bantonna health promoting hospital began to foster the use of Thai herbs as recommended by the Ministry of Public Health for certain symptoms and diseases such as sore throat and flatulence. Their benefits and safety were widely communicated.

The local government also provided financial support to local people to study Thai traditional medicine and Herb products have been produced for use and business inside and outside the community.

Section 8

Consumer Protection

states that community needs to

• develop a learning process to enhance consumer's competencies;
• create a mechanism to monitor and verify the quality of products and services; and establish a sub-district center for customer's compliance

Village health volunteers and community leaders took action after the statute enactment. They regularly examine toxins in raw and cooked food in the market. Customer protection is a good tool to empower the community and increase their capacity to make a big change.

"We often check food toxins such as formalin and sodium hydrosulfite. When we found contaminated food, we told the sellers and asked them to stop selling it. We also spread this information throughout the community to warn the people and urge the sellers to improve the quality of their food. This strategy is very effective because sellers do not want to lose their customers," said Ms. Somprom Boonnoon, Head of Village Health Volunteer and Assistant Village Headman.

Section 12
Health Financing
states that

- community co-operative, village fund, and other financial institutions should support health promotion activities in community; and
- community health fund should be established by governmental, local, and civic sectors

Health financing was a tool to promote community collaboration for health care accessibility. Typically, the annual physical examination under the universal health coverage does not include special laboratory investigations.

But with the village two-baht saving fund (established under the statute), community members can have those tests if the need arises.

"Being concerned about our health, we persuaded people to pay two baht per person per month for specific checkup. Two baht is very little money. We just wanted community folks to contribute to their health, too", said Mrs. Panida Mingsamorn, Director of Health Promoting Hospital.

For the first three years of Nongyow statute, benefits conceived by community members included safer food, continuous use of Thai herbs, and coverage of health screening. Nonetheless, the statute is a soft law, making compliance uncertain.

Community power

In conclusion, health statute is a social tool to encourage community involvement in improving their health and well-being. Its horizontal networking approach has brought some degree of health equity through improving community strengths, correcting its weak links, and implementing novel ideas. Although the articles in the whole statute have not been completely carried out, there are monthly meetings for progress monitoring and revision. The second statute will be enacted in the near future, with lessons learned from the first statute taken into account to ensure that the statue will be a proper tool to foster health for all in Nongyow ■

Acknowledgments

Special thanks to Mrs. Panida Mingsamorn, Director of Bantonna Health Promoting Hospital for valuable information of the Health Statute Development.Special thanks also to all community informants in Nongyow Sub-district, for sharing their knowledge and experience in health statue establishment and implementation in this area. Finally, special thanks to excellent collaborative networks including The National Health Security Office, the public health office of Panomsarakahm disctrict, Chachoengsao Province, Nongyow subdistrict administrative organization, partnership networks in the community such as community volunteer groups, government institutions, and private organization—Osotspa.

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CHAPTER FOUR

MANAGEMENT OF HIGH-COST SERVICES IN NONTHABURI

WILAIPORN KHAMWONG
SUPARPIT VON BORMANN
SUNANTA THONGPAT

High-cost services pose an enormous challenge for governments and hospitals. The management of universal health care coverage in the Central Chest Institute of Thailand and Pranangkloa Hospital illustrates that substantial progress is being made in supporting patients and enhancing their quality of life. Access to good health care provides patients with peace of mind, especially when facing high cost services such as treatments for heart and kidney diseases.

Pranangklao Hospital

PRANANGKLAO HOSPITAL

Initially, the Universal Coverage Scheme (UCS) in Thailand offered only basic healthcare. For example, in 2002 renal replacement therapy (RRT) was not high cost. Without the support from the government health insurance scheme, patients with end stage renal disease (ESRD) and their families would face severe financial hardship. The benefits of peritoneal dialysis (PD) over hemodialysis (HD) have been shown in terms of cost effectiveness and non-requirement for hospital stay. The “PD First Policy” was implemented in January 2008 as a model of initial treatment for ESRD patients under the UCS, with continuous ambulatory peritoneal dialysis (CAPD) as an option of choice.

One of the CAPD patients who are supported by UCS

“I’m so glad my treatment is covered by a 30 Baht UCS gold card,” said fifty-year-old Wan Moongdee. “It’s very good for low-income people like us ...If this benefit was cancelled, I would surely die.” Mrs. Moongdee used to be the family’s breadwinner by selling cooked-to-order food. Her daughter now runs the food stall. The main income for Mrs. Moongdee’s family comes from her husband who sells Thai sweetmeat (khanom-khrok) and earns about 200-300 Baht a day.

In 2012, Mrs. Moongdee had her routine check-up at Pranangklao Hospital. “Previously, I was healthy and had never had any serious medical problems,” she recalls. The doctor, however, told her she had abnormal kidney function which must to be treated with medications and followed up on a regular basis. A year later, the laboratory test showed that her glomerular filtration rate was < 15 mL/min/1.73 m^2 and she was subsequently diagnosed with chronic kidney disease (CKD). She and her family were referred for renal replacement therapy counseling. When she was first diagnosed, Mrs. Moongdee and her family were anxious about her condition, treatment and the medical expenses. After counseling, the patient and family members had a better understanding about the disease and were less worried about the medical expenses. They agreed that Mrs Moongdee should be treated with CAPD.

A PD nurse prepares patients and their family before CAPD

Patients receive advice from a nutritionist

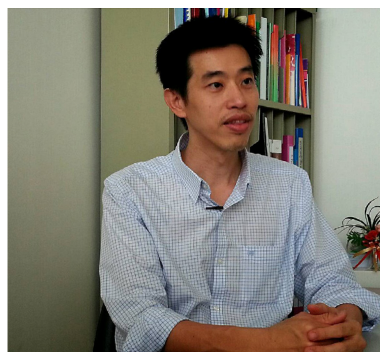
Since 2008, Pranangklao Hospital has provided CAPD to patients under the UCS's PD First Policy. The hospital applied a holistic approach to patient care. It currently has 106 CAPD cases. After diagnosis of CKD stages 4-5, there is a process that the patients and their families have to go through. The renal replacement therapy counseling is provided by the multidisciplinary health care team including a nephrologist, a PD nurse, a pharmacist and a nutritionist. The patient and their family are informed about the disease, treatment options, reimbursement schemes, self-care and life style modifications. Before the surgical procedure, physical and psychological readiness is checked and caregivers advised on hygiene. After the procedure, the caregiver is trained by the PD nurse. The training may take three days or longer.

Mrs. Moongdee's daughter volunteered to be a caregiver and she was PD trained by the health care team of Pranangklao Hospital. Three months later the patient's condition improved. Mrs. Moongdee said that "I was so lucky to have such good support from my family. I live near the hospital. The health care team of Pranangklao Hospital provides very good support for me. The staff often visits me at home. They also provided me with CAPD solution. Each month I pay less than 150 baht for the dressing wound supplies." Nowadays, not only can the patient do CAPD by herself, she can also go to work.

A PD nurse trains staff from Nonthaburi CAPD Network

The hospital CAPD team and their professional networks provide regular home visits to the patients: twice a year for those with no complications; immediately for those with complications (e.g. peritonitis, exit site infection, edema, malnutrition). In Nonthaburi, there is a Nonthaburi CAPD Network which includes staff from Pranangklao Hospital and Bamrasnaradura Infectious Diseases Institute (tertiary level); Bang Yai Hospital, Bang Bua Thong Hospital, Pak Kret Hospital, Bang Kruai Hospital and Sai Noi Hospital (secondary level); and sixty nine Tambol Health Promoting Hospitals (primary level); to ensure continuity of care.

Although Thailand has succeeded through 'PD-first policy' to ensure equitable access for patients with ESRD, there are still big challenges. New CKD cases have increased rather rapidly to some 10,000 cases per year. The Nephrology Society of Thailand (2014) estimates that eight million Thai adults have CKD and millions others are at increased risk. High risk groups include those with diabetes, hypertension and a family history of kidney failure. Some of those, 200,000 patients are at an advanced stage and in need of renal replacement therapy. Implementing the PD First Policy has a great impact on the health care system. "There are currently 17,281 CAPD cases nationwide under the UHC benefit package," said Dr. Prateep Thanakitcharoen, Deputy Secretary General of the National Health Security Office.



Dr.Wichai Sopassathit, Head of the CAPD Clinic of Pranangklao Hospital

Early detection and intervention of CKD can prevent or delay the progression of kidney disease and reduce the huge budgetary burden on public funds. But many CKD patients are not detected and managed at an early stage. "Thus, the capabilities of community hospitals and equity to quality service should be started and expanded to solve these problems. Risk behaviors and NCD control should be the focus of the primary care center," said Dr. Wichai Sopassathit, Head of the CAPD clinic of Pranangklao Hospital where there are limitations to

the provision of CAPD service. “The number of patients is rapidly increasing but we have limited availability of space and staff,” said Dr. Wichai Sopassathit. The hospital has five nephrologists and two PD nurses. And the cost of CAPD care is higher than the reimbursement provided by the National Health Security Office. “The participation of the patients, their families and networks in communities can help us to reduce direct costs and workload,” said Dr. Wichai. In addition, CAPD should be integrated into the universal health care scheme because the medical treatment is very expensive. In Nonthaburi the benefit package can protect almost 200 families from financial hardship.

In conclusion, the hospital can reduce some direct costs and workload by encouraging ESRD patients to perform their own peritoneal dialysis at home and coordinating with the professional staff in the community network. CAPD is a form of self-treatment. It needs no machine. The patients can self-administer CAPD in any clean location and any time they choose. Without the need to travel to the hospital three times a week, the patients and their families can save travel time and other indirect costs. In most cases of peritoneal dialysate, effective management is important. The key factors for success in the provision of RRT through CAPD are equitable access to treatment with suitable health care benefits, support from service providers, hospital administrators and health care teams. Participation from family is also important. This mode of operation has steadily improved the survival rate and quality of life for ESRD patients.

CENTRAL CHEST INSTITUTE OF THAILAND (CCIT): CARE WITH HEART, CURE WITH TECHNOLOGY

Central Chest Institute of Thailand

Originally established as the Central Tuberculosis Hospital in 1942, it became the Central Chest Institute of Thailand (CCIT) in 2002. CCIT is a renowned national institute with the vision "to be internationally excellent in pulmonary and cardiovascular care." As a tertiary care institute, it serves more than 130,000 out-patients with heart problems each year. Sophisticated technology and high cost services are provided including heart and valvular surgery, coronary artery bypass graft (CABG), coronary computed tomography angiography (CTA), cardiac catheterization, coronary angiogram (CAG), percutaneous coronary intervention (PCI), percutaneous trans septalmitral commissurotomy (PTMC), transcatheter closure of congenital heart defects, implantable cardiac defibrillator (ICD). These investigations, treatments, interventions and surgery can be very expensive, especially for low-income patients.

Fortunately, since 2002 the universal health coverage scheme has provided treatments for complex diseases for the underserved such as the Fast Track ST Elevated Myocardial Infarction project (Fast Track STEMI). This project aims to reduce the duration from arrival to primary PPCI: door-to-drug time to less than 30 minutes, and the duration from door to balloon to less than 90 minutes 1. Rates of severe complications and mortality after surgery must be less than five percent, a figure achieved since 2008. The project won an award of distinguished service network from NHSO.

Dr. Kriengkrai Hengrussamee : Head of the Cardiology and Intervention Department at the CCIT

Apart from the Fast Track STEMI project, CCIT, led by the former director of the institute and Dr. Kriengkrai Hengrussamee, initiated various projects such as "10,000 Heart" and "Save Thais from Heart Attack" that are supported by the Department of Public Services and the Ministry of Public Health of Thailand.

NEW LIFE, NEW PROSPECT: A GIFT FROM CCIT

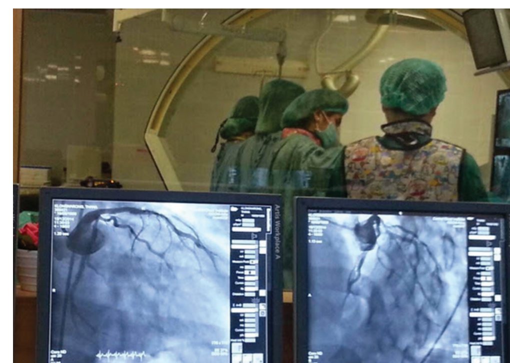
Mr.Supachai Sampaonoi came to CCIT to provide free hair cut twice a month. Who is he and why is he doing this? Mr.Supachai is currently working in a store. Every morning he does exercise by riding bicycle for one hour. After cycling, he goes home, takes a shower and follows this with meditation. He watches what he eats. Food prepared by his wife must not be salty or oily. He used to have immediate chest pain from such food. He does not want to experience the pain again.

"If it was not for the chest pain, I would still be drinking and smoking," said Supachai. He recalled 2011,

the year when the chest pain began and he could hardly walk.. The doctor told him that he had double vessels disease and severe mitral regurgitation and he needed a coronary artery bypass graft (CABG). He was so worried because some of his friends who had this heart surgery died within a few months. The surgery cost over 150,000 Baht (around $US 5,000). That, for him, would take forever to save. He was certain his life would end, and he didn't want to die. Without him, how could his family live? Who will pay for his daughter's education? Should she stop studying? There were many questions in his head.

Which is why he was so delightfully surprised when his doctor said, "Don't worry about the cost of the surgery. Your treatment here is covered by the Universal Health Coverage scheme, so you just pay 30 Baht (around 1 US dollar)." Thirty baht! For heart surgery! My goodness! He was overjoyed. The news lifted a great burden from his mind. When he thought about one of his friends who died after the operation - he did not take care of himself; continued his drinking and eating of greasy foods and ; and did very little exercise - Mr. Supachai vowed he would not repeat the pattern his friend had followed.

Catheterization lab at the CCIT


Coronary Angiography at the CCIT

However, Mr. Supachai was worried about other matters as a patient. "I'm a poor man on UHC. Will the nurses and doctors take good care of me? The CCIT experiences totally changed my attitude towards the hospitals. The staff are kind. They provide excellent care. They are very friendly and respectful. I felt so cared for. They serve everyone equally, rich or poor. I made many new friends in the ward. We support, share and learn from

each other. I received a lot of great things from people there. CCIT and UHC gave me an important gift, which is my new life. I'm so grateful. Thanks to CCIT and the Heart Lover Health Volunteer Group for giving me an opportunity to be useful to others. I use my haircutting skills to help others. It is worthwhile to see smiling faces of those patients after I've cut their hair. Although my volunteer job is nothing compared to the task of the doctors and nurses, I'm still proud of myself."

Mr.Supachai Sampaonoi, one of the heart patients, provides free hair cut in CCIT twice a month

Every Friday, Heart Lover Health Volunteers provide peer support for patients undergoing interventions

Heart Lover Health Volunteer is a group of more than 400 patients who have received either PCI or CABG. Most of them live in areas closed to the Institute. They set up their peer group to do volunteer work like lending psychological support to new patients, encouraging them to exercise, playing music, cutting hair and visiting other patients on the ward and at home. Supported by CCIT, some training sessions are conducted to enhance their knowledge and skills, such as exercise, nutrition and even cardiopulmonary resuscitation (CPR). Recently, they were able to organize a screening service for heart diseases in other communities. But doubts remain whether providing high-cost services is sustainable and can be extended to other high cost care ■

Acknowledgments

Special thanks to Dr. Vibhan Sangkahapong, the Director of CCIT, Dr. Kriengkrai Hengrussamee, Mrs. Kanokporn Jamsomboon, Miss Bubpawon Srilum and the CCIT staff; Dr. Virul Pornpatkul, Dr. Wichai Sopassathit, Dr. Kittisak Tangjittrong, Dr. Kannika Niticharoenpong, Mrs. Salakjit Pitakmongkol and the CAPD team at Pranangklao Hospital; and Mrs. Wan Moongdee and Mr. Supachai Sampaonoi for sharing their information and experiences.

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CHAPTER FIVE

HEALTH COVERAGE FOR MIGRANTS IN SAMUTSAKORN PROVINCE

BOONTUAN WATTANAKUL
ORARAT WANGPRADIT
LAIAD JAMJAN

SAMUTSAKORN: WHERE THE MIGRANTS EARN THEIR LIVING

Samutsakorn is the economic center of fishery. Fishery in Thailand is rife with three Ds–dirty, dangerous, and dark (night hours). Laborers work on the boat for months and are paid cheaply. Actually, the labor had not been scarce until 1999 when huge fishing vessels capsized in the ocean causing loss of hundreds of lives. Thereupon, Thai workers tended to avoid this job, and labor from neighboring countries was in great need.

Although the wage is quite low, the money these migrants earn is still relatively higher than what they would earn in their homeland. As a result, the influx of migrants into fishery and industrial sections in Thailand. continues to these days. The majority of them, specifically in Samutsakorn, come from Myanmar, Cambodia and Laos, through the passage sin Tak and Kanchanaburi.

Despite the increase in migrant workers in Samutsakorn, laws and regulations supporting their employment were not enforced, resulting in the under-coverage of their health care that led to the dearth of health check-up and

medical treatment and re-emerging of communicable diseases such as severe diarrhea and tuberculosis that had disappeared from Samutsakorn since the establishment of the public health system.

These resurgent diseases brought great concerns to the Provincial Governor and the Provincial Chief Medical Officer, so the registration policy for migrants was proposed to the House of Representatives. It is now an obligation that all migrants must be registered by the Department of Labor, for which health screening is required to prevent any communicable diseases from taking root.

Mr. Kitti Reungwilaiporn, public health officer at Samutsakorn Provincial Health Office, informed that there were only 30,000 registered migrants in 2003 but the number has dramatically increased to approximately 400,000 in 2014. Ms.Nahathai Chulkarat, occupational nurse at Samutsakorn Hospital, said that these migrants do not reside in one place; they frequently move and change their names to renew their registration every year for new jobs. Hence, their addresses and absolute numbers of migrants were hard to verify.

HEALTH PROBLEMS AND ADMINISTRATIVE POLICIES

Many migrants rent a townhouse and share with up to 20 of their friends. An infection from one could quickly disseminate. Certain diseases such as severe diarrhea, tuberculosis, and malaria disappeared from Thailand years ago but have recently re-emerged in Samutsakorn.

Samutsakorn has provided health insurance for migrants since 2002. Initially, migrants who purchased health coverage could access health service with the health bills covered. This health insurance did not cover occupational accidents, health promotion and disease prevention. Subsequently, the insurance was changed to “social insurance” in which employers and migrants share the medical expenses. Nevertheless, disease prevention, promotion and rehabilitation are still not included in the scheme.

Chairat Vechpanich, MD, former provincial chief medical officer of Samutsakorn

“Health promotion for migrants is important. We need to educate them on hygiene, so they can prevent themselves from the communicable diseases,” said Chairat Vechpanich, former provincial chief medical officer of Samutsakorn. Providing good hygiene for all migrants requires not only a large amount of money, but also human resources who can communicate and whom the migrants trust.

"At the beginning, we had difficulty getting to them because they were afraid we were sending them back," said Chairat, who managed to overcome the obstacle by providing primary health care formigrants, with educated migrants recruited as interpreters. With these interpreters, the migrants no longer feared being charged and were willing to cooperate with health personnel. These interpreters were the prototype of the "migrant health volunteers" who are trained by Thai nurses to perform first aid, health education and health surveillance in their communities.

Mobile health services and health education in migrant community in Samutsakorn

The most tangible benefits of this plan were manifest in 2010 when there was the outbreak of severe diarrhea among migrants in Samutsakorn. These migrant health volunteers did much to help communicate, educate, and sanitize drinking water and latrine, thus terminating the outbreak within one month. The success convinced policymakers of Samutsakorn that one migrant health volunteer should be produced to serve 50 migrants. The mobile clinic, which was first set for migrant communities in 2005, has also been developed and expanded to provide easy access for health service to all migrants.

SAMUTSAKORN HOSPITAL: THE KEY TO HEALTH EQUITY

Being one of the most visited hospitals for migrants, Samutsakorn hospital established a health service team for migrants in 2010 and set it as one of the hospital's core obligations mission.

Molee Wanichsuwan, MD, the director of Samutsakorn hospital

"The mission of the hospital is to provide health care for all, either natives or aliens. By this, we could terminate the vicious cycle of epidemic disease," said Molee Wanichsuwan, the director of Samutsakorn hospital.

"Our team is very competent. They can perform medical examination and blood tests for

approximately 3,000 cases per day," said Dr.Molee, who proudly informed that the team has recently developed a one-stop service for migrants in the hospital's out-patient department.

One-stop service for migrants in Samutsakorn Hospital

In addition, the hospital also carries out a program in health promotion and disease prevention for the migrant communities together with Samutsakorn Provincial Medical Office. The health team also has a "floating health service" whereby the hospital trained sailors on first aid. The trained boat will raise the red-cross flags while in the ocean, so other boats can notice and come for the rescue.

NGO: GOOD PARTNERS FOR PROMITING MIGRANTS' QUALITY OF LIFE

Health education, especially good sanitation, is the key to disease prevention and control. But when there is not enough governmental staff to cover all migrant communities, the collaboration between governmental and private parties could be a good alternative.

Many non-governmental organizations (NGOs) work for the migrants. Raksthai Foundation is one example whose work is associated with migrants' health.

"We go to migrant's houses to educate them on sanitation, transmission of HIV/AIDs and tuberculosis, and perform health surveillance. When we encounter health problems, we send them to Samutsakorn Hospital for medical treatment or ask the staff to come over," said Ms.Manunchaya Inklai, the lead staff of Raksthai foundation.

Samutsakorn Hospital needs human resources who can communicate with migrant communities while the Raksthai Foundation needs the expertise of health personnel and medical treatment from hospital. Both rely on each other for better improvement of migrants health. Other NGOs such as Labor Right Promotion Network Foundation (LPN) helps migrants with human rights issues including social insurance. Other NGOs, such as religious institutions established migrant schools for the migrants' offspring.

"We teach the children ethics, mathematics, English, Thai and Myanmar languages as well as living skills to prevent them from being taken advantage of," said the abbot of St. Anna Catholic Church.

Migrant children learn skills and languages in learning centers established by NGOs.

The idea of migrant school originated from the former abbot who wanted to protect the kids from abuse by their housemates when the parents were away. St. Anna Catholic Church has run the migrant school for six years now without charge.

Other NGOs in Samutsakorn establishing migrant schools include Raksthai and Life Prep foundations.

MIGRANT HEALTH VOLUNTEERS: THE EFFECTIVE NETWORK FOR MIGRANT HEALTH PROMOTION

Due to language barrier among Thai health professionals, the Director of Samutsakorn Hospital decided to train migrants to become translators and health volunteers. Samutsakorn Health Office began the training in 2005 and developed the curriculum, which has subsequently been accredited by the Ministry of Public Health. The training program continues to produce new health volunteers and provide a refresher course for the old ones. About 1000 migrants have become volunteers, but constant movement of these migrants has resulted in only 400 of them remaining in the system. These volunteers have served as a link between the health care team and the migrants in Samutsakorn ■

Acknowledgments

The authors wish to thank Samutsakorn Hospital, the Provincial Medical Office, the Raksthai Foundation, St.Anna Catholic Church, and the National Health Security Organization for their valuable information.

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CHAPTER SIX

THAI HEALTH PROMOTION FOUNDATION: INNOVATIVE FINANCING FOR HEALTH PROMOTION THROUGH INCLUSIVE GOVERNANCE

YUPAPORN TRIAPRIWONG
ACHARA SUKSAMRAN
KAMOLRAT TURNER
SAKOL SOPITARCHASAK

A FINANCING INNOVATION FROM ANTI-SMOKING CAMPAIGN TO NATIONAL HEALTH PROMOTION

Thai Health Promotion Foundation (ThaiHealth), an independent state agency, was founded by the Health Promotion Foundation Act, B.E. 2544 (A.D. 2001) to promote health and well-being among Thai population. Its revenue is derived from two percent additional levy on top of the excise taxes, from alcoholic beverages and tobacco products. It has a governing board chaired by the Prime Minister of Thailand with half of the members from independent social leaders.

Before the establishment of ThaiHealth, tobacco control movement in Thailand was driven by dedicated key persons who also contributed to ThaiHealth's establishment. Prof. Dr. Prakit Vathesatogkit and Ms. Bungon Ritthiphakdee were two of the most crucial advocates for tobacco control and the use of the sin taxes for health promotion. Dr. Supakorn Buasai, who later became the first CEO of ThaiHealth, also assisted in birth of ThaiHealth. Other persons include Prof. Dr. Prawase Wasee, Prof. Dr. Athasit Vejjajiva, Dr.Paiboon Suriyawongpaisal who also

played significant roles in the foundation of ThaiHealth. ThaiHealth is indeed the result of cooperative endeavors from a large number of people. It took years for the leading advocates to gain adequate knowledge and mechanism towards setting up the foundation through preliminary studies, site visits and workshops. One of the biggest inspirations for ThaiHealth was probably Australia's Victorian Health Promotion Foundation or VicHealth where ThaiHealth's advocates had visited several times. According to Dr. Vathesatogkit, "ThaiHealth is phenomenal. The foundation has accomplished much more than we had expected. At the beginning, we only wanted some money for our anti-smoking campaigns. But now ThaiHealth has launched all types of campaigns." He wanted ThaiHealth to work collaboratively with several sectors, especially non-health sectors. Prevention is always better than treatment.

Prof. Dr. PrakitVathesatogkit
Executive Secretary of Action on Smoking and Health Foundation,
Senior advisor to ThaiHealth

THAIHEALTH'S ROLE AS A FACILITATOR

"ThaiHealth aims to be more proactive in its health promotion strategies. Throughout its thirteen years of work, the role of ThaiHealth has been the facilitator. We believe that health issues involve several sectors, both health and non-health. That is why we need the participation from all sectors," said Dr.Krissada Raungarreerat, current CEO of ThaiHealth.

Dr. KrissadaRaungarreerat
CEO of ThaiHealth

Dr. Raungarreerat explained the vital roles of ThaiHealth are "to encourage initiatives, coordination and mobilization among individuals and organizations from all sectors, so that they have the capability to build a healthy society." ThaiHealth promotes four dimensions of well-being: physical, mental, social, and spiritual in the lives of people living in Thailand by acting as a facilitator rather than an actor.

He further explained that funding from ThaiHealth does not aim at routine activities, but is rather used to help initiate new ideas and to facilitate the translation of opportunities into concrete actions through knowledge management.

In other words, ThaiHealth plays the role of a catalyst or lubricant to support health promotion activities. ThaiHealth supports collaboration and intervention among key partners for activities that change values, lifestyles, and social environments in a positive way. ThaiHealth's partners whose projects are funded by ThaiHealth host their own projects and make their own decisions based on information provided by ThaiHealth.The budget for the projects is provided by organizations who share their social values.

For example, in ThaiHealth's "Happy Workplace" which focuses not only on health but also on quality of life, CEOs and human-resources team of companies participating in the project are engaged in the planning process of the project which aims to improve the happiness of their workers. This is based on the assumption that happy workers in crease the company's productivity and profits. ThaiHealth facilitates knowledge management to enable all partners to work together.

Most of the budget are provided by the participating companies. The engagement of participating companies shows their recognition ofthe importance of their staffs, and helps sustain and drive the project.

HOW THAIHEALTH WORKS: PROMOTING SOCIETY'S WELL–BEING

Each year, Thai Health Promotion Foundation funds over 1,000 projects and spends around US $100 million a year working witha wide range of partners. Those receiving funding from ThaiHealth include private sectors, public organizations, individuals who promote health, and academics. The aim is to promote ideas for a well–being society. This has resulted in numerous innovations that could work as models for a scale-up. ThaiHealth programs can be largely categorized into: 1) open-grant programs (10%) which are open for any organization or individual to apply; and 2) proactive programs (90%) which are initiated by ThaiHealth and its strategic partners.

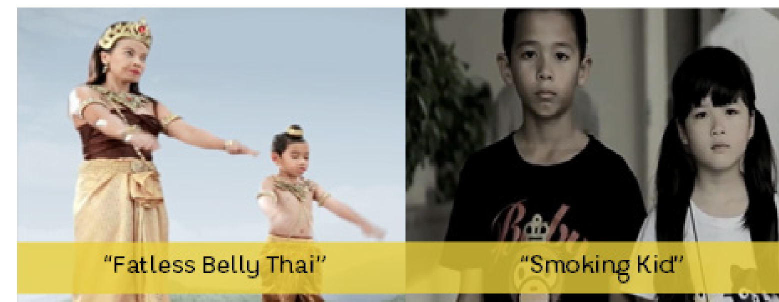
- Tobacco Consumption Control
- Alcohol Consumption & Drug Abuse Control
- Road Safety and Disaster Management
- Health Risk Factor Control
- Vulnerable Population Health
- Community Health
- Children, Youth, and Family Health
- Organizational Health Promotion
- Physical Activity Promotion
- Social Marketing and Communication
- Open Grants and Innovations
- Health Service Systems
- Health Promotion Mechanism Development
- Healthy Food
- Health Literacy

Fifteen main plans of ThaiHealth

"During the first ten years, ThaiHealth focused on health risks such as tobacco, alcohol, traffic accident, inactivity, food security and food safety. But along side these issue-based approaches, we also approach to schools, offices, vulnerable population etc., (setting-based, and population-based approach), conducing to the creation of a healthy society," said Dr. Raungarreerat.

ThaiHealth encourage health-promotion initiatives through programs with three approaches:, which are issue-based, setting (and/or population)-based, and system-based approaches. The variety of programs range from tobacco and alcohol control, to traffic accident prevention, support for physical activities, food security and safety, sexual health, community health, health promotion for vulnerable groups (e.g. the elderly, women, the disabled and the Muslims), and so on. ThaiHealth also uses media campaigns to promote health awareness and behavioral change. Some of the most renowned campaigns include 'Fatless Belly Thais', 'Give Alcohol = Curse', and 'Smoking Kid', to name only a few.

Additionally, "ThaiHealth Learning Center" has been developed under ThaiHealth to support the creation of learning networks among partners. It collects and manages bodies of knowledge from both internal sectors and external partners, and disseminates them to the public thorough various media, such as books, publications,



Media campaigns initiated by ThaiHealth

exhibitions or videos. More than 80% of the area inside the Center are public spaces and were designed to facilitate interaction, knowledge exchange, and networking, with the ultimate goal to create a pleasant society in Thailand.

ThaiHealth Learning Center

"Nowadays, health problems are more complex. You need to have innovative strategies. ThaiHealth has a proven model that can be adapted according to the context," explained Dr. Raungarreerat.

"Tri-Power Model" employed by ThaiHealth was based on Dr. Prawase Wasi's 'Triangle that Moves the Mountain" by encouraging 1) the creation of knowledge; 2) social mobilization; and 3) policy changes. An excellent example was the use of sin taxes to fund the establishment of ThaiHealth through a triad of organizations, namely the Anti-Smoking Campaign Project of the Moh-Chao-Ban Foundation (society), the Office of Thai Trade Competition Commission, OTCC (politics and policy), and Health Systems Research Institute or HSRI (knowledge). Because of their multi-faceted approach, when the OTCC was unable to generate necessary policy changes, the focus of work shifted to the HSRI to take over the lead to synthesize knowledge. The Anti-Smoking Campaign Project of the Moh-Chao-Ban Foundation served as a link between these organizations.

Tri-Power Model

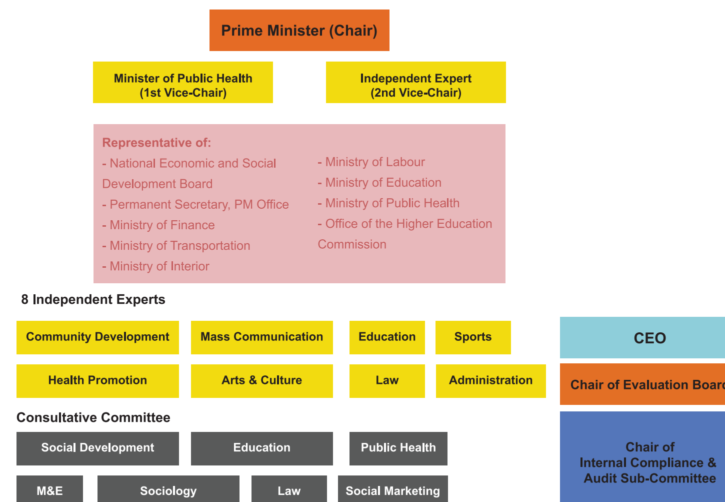
KEY SUCCESS FACTORS

In the past 14 years since the foundation of ThaiHealth, there have been improvements in health and well-being of the people living in Thailand. Smoking rate has dropped from 32% to 19.9% in the past two decades; average alcohol consumption per person has decreased by 13% between 2006 and 2012; and deaths from road accidents have decreased by 37% from 2003 to 2012. Policies and innovations to promote healthy lifestyle are being enforced across the country including measures to protect children from unhealthy food.

According to the ten-year review of ThaiHealth, conducted by experts from various organizations including the World Bank Group, Rockefeller Foundation and WHO, there are eight features of ThaiHealth's model which contributed to its success.

- Financial mechanism: ThaiHealth's funding mechanism does not compete for the health ministry's resources, thus strengthening its sustainability. Moreover, the source of the revenue, i.e excise taxes on tobacco and alcohol industry, is part of the health promotion strategies.
- Governance structure: ThaiHealth's governing structure is multi-sectoral, consisting of representatives from various backgrounds which contribute to a broad view on health promotion.

• Focus on the determinants of health: ThaiHealth's focus on social determinants of health (e.g. income level, education, work, transport) reinforces the multi-sectoral approach.
• Focus on health inequalities: Acknowledging the regressive nature of the sin taxes, ThaiHealth focuses on disadvantaged populations and communities.
• Health in all policies: ThaiHealth aims to address complex health challenges through an integrated policy response that spans various conventional silos.
• Community ownership for sustainability: Acknowledging the significance of community ownership to sustainability, ThaiHealth provides a platform to engage local government structures and communities.
• Multipronged social marketing approach: ThaiHealth's social marketing aims to induce behavioral change and develop community support on health-promoting policies.
• Stimulating innovation and measuring outcomes: To ensure efficiency and effectiveness of interventions, ThaiHealth supports evaluation and intervention research. The results of evaluation are then used to guide further investments.



ThaiHealth Executive Board

CHALLENGES AND THE WAY FORWARD

As ThaiHealth has expanded its health promotion strategies beyond the original risk factors to the current fifteen strategic plans, an enormous and continuing effort to assure success and sustainability of its work is required. And since ThaiHealth takes a role as a facilitator, the success and sustainability of programs and projects cannot be achieved without our partners, the ones who actually do the work. ThaiHealth understands the importance of strengthening its partners' capacity which has been done through various curricula and platforms.

Another challenge is the ever-changing lifestyle of people and the advancement of technology and access to information.

The situation emphasizes the significance for ThaiHealth to support the creation of public awareness and knowledge towards health, or the “health literacy.” The establishment of ThaiHealth’s learning center is one of many efforts to address the issue. ThaiHealth takes it as a challenge to create more impact. The strategies include encouraging more collaboration among partners, expanding to the international landscape, and boosting synergies through governance structures and operational platforms ■

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True success is not the learning,
but in its application to the benefit of mankind.

HRH Prince Mahidol of Songkla

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