Appendix

Capacity development for health policy and systems research: experience and lessons from Thailand

Key message

Creation of relevant knowledge through research is very crucial, but not adequate by itself; it must interact with social movement or social learning. Without relevant knowledge, social movement cannot go very strong or may deviate to something else.… Politicians have authority over utilization of state resources and in law promulgation, which are very often needed in development. Thus without political involvement the working structure is not complete. Politics without knowledge and social movement will not solve the problems (Wasi 2000).

Key message

Introduction

Thailand was in a state of political turmoil at the end of 2006. Upheaval notwithstanding, the Thai Parliament passed the National Health Act in January 2007. This act was the result of vigorous efforts on the part of health policy networks in Thailand dating back to 1999. The act forms the 'health constitution' of Thai society, stipulating the directions, philosophy and principles of the health system (National Health System Reform Committee 2002). It was developed using the 'triangle that moves the mountain' approach. Prawase Wasi explained that "the mountain means a big and very difficult problem, usually unmovable. The Triangle consists of: (1) Creation of relevant knowledge through research, (2) Social movement or social learning and (3) Political involvement" (Wasi 2000).

Since the transformation from the absolute monarchy to the constitutional monarchy in 1932, the structures of political power in Thailand have fluctuated between military dictatorships and civilian governments. Although an initial transition to democratic rule was made in 1973 there have been many subsequent military coups. The political environment has had a significant impact on the health sector; in particular, the events of the 1970s helped instil a shared set of values and a desire for health-care reform in order to ensure a more equitable health system, among many medical students of that era. As these medical students graduated and took up posts in the health sector, they carried their experience with them. Now holding senior positions in the Thai health system, they have not only driven health reform in Thailand but have also forged active alliances with civil society groups within the country and internationally.

The Thai National Health Act is an obvious example of a health policy shift which involved wide participation and reflected cumulative capacity in generating evidence through research, as well as communicating it to stakeholders. Other policy reforms also demonstrate the role and capacity of Thai organizations in each of the four functions identified in this Review: priority setting, knowledge generation, filtering and amplification of the knowledge created, and application of that knowledge to policy-making.

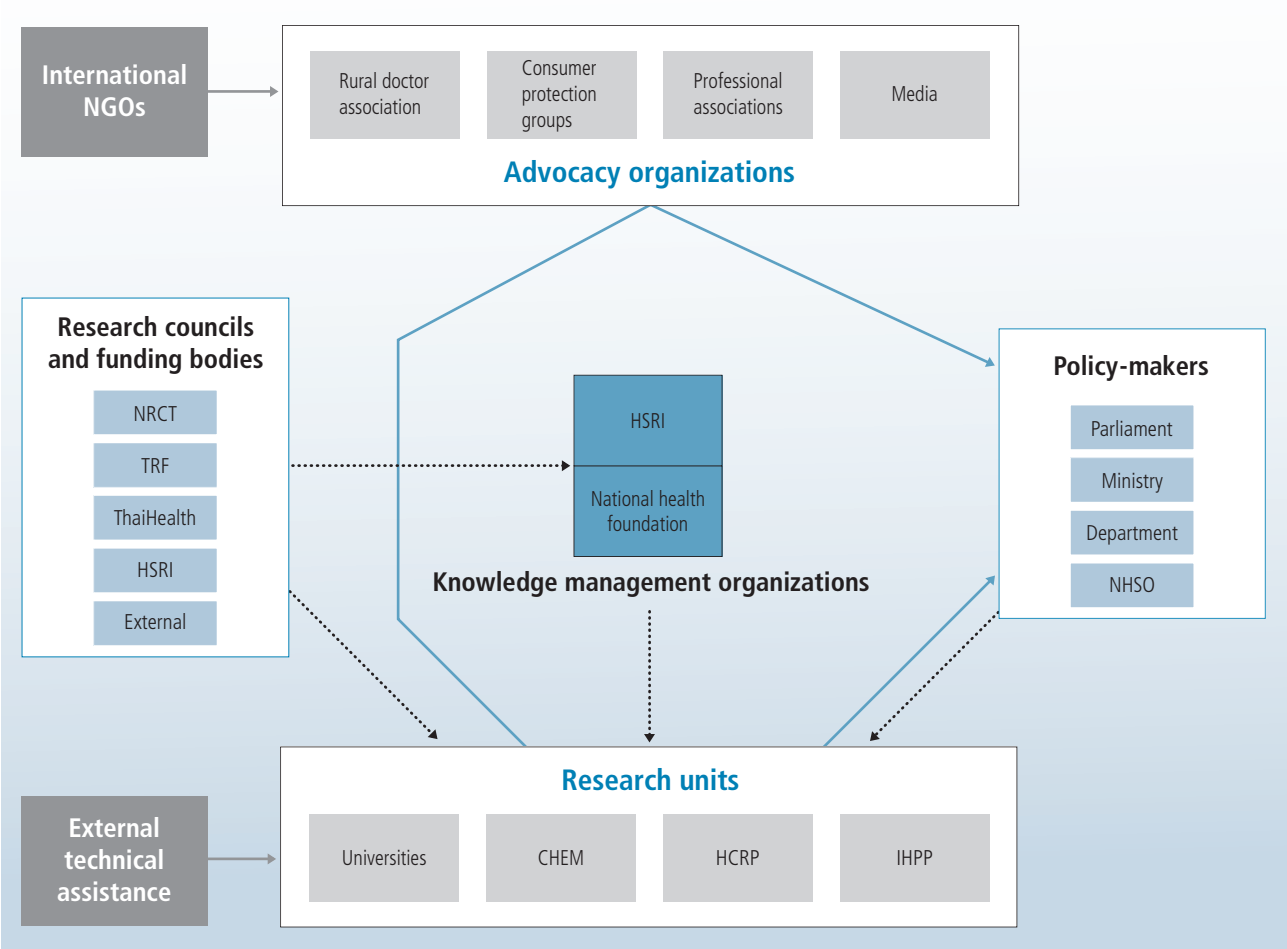
This case-study uses the framework developed by the Alliance to document the key organizations involved in health policy and systems research (HPSR) in Thailand and the functions they perform, and considers how these roles have contributed to health system reform. The final sections evaluate the effects of initiatives in Thailand to strengthen capacity in HPSR, and draw conclusions about the factors that have contributed to the success of those initiatives.

Key organizations involved in HPSR in Thailand

Myriad organizations work in the HPSR field in Thailand – governmental, nongovernmental and civil society. Many are financed through tax revenues, while others receive international funding. The current dominant organizations in HPSR are:

- government organizations, including the Ministry of Public Health, the Health Committee of the House of Representatives and Senate, and the National Health Security Office (NHSO);
- funding agencies, including the Health Systems Research Institute (HSRI – an autonomous government agency funded from general tax revenues), the National Research Council of Thailand (NRCT – a government body funded by general tax), the Thailand Research Fund (TRF – an autonomous public body funded by a general tax) and the ThaiHealth Foundation (an autonomous body funded by a 2% earmark tax from tobacco and alcohol);
- research institutes such as the International Health Policy Program (IHPP), Centre for Health Equity Monitoring (CHEM), Health Care Reform Project

Figure A.1 Organizations involved in HPSR in Thailand



(HCRP), universities and other think tanks (all research institutes are funded by grants from government or international agencies);

- knowledge-management organizations which package and synthesize evidence, for example, the National Health Foundation (NHF – a nongovernmental organization (NGO) funded by project and programme grants); and
- advocacy and civil society organizations such as the Rural Doctor Society and the Consumer Protection Foundation.

Figure A.1 shows the relationships among the various organizations.

Recently, there has been a growing focus in Thailand on the importance of knowledge management in linking together the four functions of HPSR; for example, HSRI and NHF play increasingly important roles in coordinating priority setting, research management and research dissemination, as well as facilitating the use of evidence in policy debates. Box A.1 describes in more detail the objectives and strategies of such organizations active in Thailand.

The sections below discuss the roles of the various organizations in Thailand with respect to the four main functions identified in the Review.

Priority setting

The NRCT has been responsible for the formulation of national research policy since 1964. Participation in the research priority-setting process has gradually increased over time, however, from a limited group of experts in each discipline to all stakeholders in research

BOX A.1 OBJECTIVES AND STRATEGIES OF THE MAIN HPSR ORGANIZATIONS OPERATING IN THAILAND

Health Systems Research Institute, Thailand – established in 1992 as an autonomous government agency.

Mission (2007): creating mechanisms in knowledge management for societal growth and linkages to politicians to promote health-system reform and balanced health systems.

Main functions: Promoting and supporting research and academic activities aimed at obtaining essential knowledge and information for policy-making and restructuring of the health system.

Strategies for achieving the vision:

1. Research management: improving the process of research management to be efficient and consistent with health system reform
2. Partnership development: developing networks of research institutes and health partners to enhance the process for public health policy
3. Area-based capacity development: supporting participatory action research in specific areas – both geographic areas and specific components of the health system
4. Getting knowledge into practice: developing policy advocacy and social mobilization to influence health system reform.

National Health Foundation (NHF) – established in 1991 as an NGO

Objectives: In the beginning the foundation aimed to open the public space for knowledge exchange and seek consensus for national health policy. After 2002, the focus changed to create a knowledge-based society for health.

Main functions: research management, knowledge management and health communication.

Strategies for achieving the objective:

1. Conducting public fora for direct communication and knowledge exchange among related stakeholders in specific policy issues
2. Network development on specific policy issues.

(including both users and researchers). For example, the 2008–2010 National Strategic Plan for Research was elaborated through a bottom-up process based on four regional research plans.

While the NRCT sets high-level priorities, these priorities actually drive less than half of the total (health and non-health) research budgets, with public organizations and state enterprises being given considerable latitude in determining their own research priorities. For example,

BOX A.1 (CONTINUED) OBJECTIVES AND STRATEGIES OF THE MAIN HPSR ORGANIZATIONS OPERATING IN THAILAND

Health Care Reform Project

– established in 1997 as a cooperation between the Thai Government and the European Commission

Objectives: The first phase (1997–2001) focused on research and field-model development to recommend and demonstrate appropriate models of health-care service. The second phase focuses on capacity building of key functions and structures of the health-care system.

Main functions in the first phase:

1 Policy research and development (especially in primary health care and health insurance)
2 Field-model development (especially in primary health care and health care financing)
3 Capacity building/training
4 Advocacy through the promotion of civil society involvement.

Center for Health Equity Monitoring (CHEM) – established in 1998 as a unit within Naresuan University

Objectives: To conduct research for developing a health equity index; to promote the use of the index through partners; and to monitor equity aspects of the Thai health system.

Main functions and strategies:

1 Conducting research (regarding the equity of the health system)
2 Collaborating with partners for equity index development and knowledge sharing
3 Developing indexes and databases, such as diagnostic related groups (Thai DRG Grouper) that guide government funding decisions.
4 Training post-graduates in HPSR.

the research budget for the whole country in 2003 (Office of Policy and Planning 2007) was 10.2 million baht,[1] 11.5% of which was for proposals reviewed by NRCT, 3.5% was for the programmes granted by the NRCT, 9.8% was for programmes granted by the TRF, 8.1% was for the programmes granted by the National Science and Technology Development Agency (NSTDA) and 1.1% was for programmes granted by HSRI. The remaining 66% (6.8 million baht) was scattered though the regular budgets of public organizations and state enterprises. The NRCT recognizes that each department, faculty and research organization has its own research priorities (National Research Council of Thailand 1997); the review process is meant to reduce duplication in government-funded research.

Priorities identified by the NRCT do not always match allocations made by public organizations, however.

[1] At the time of writing 1US$ =32.7 baht

BOX A.1 (CONTINUED) OBJECTIVES AND STRATEGIES OF THE MAIN HPSR ORGANIZATIONS OPERATING IN THAILAND

International Health Policy Program Thailand (IHPP) – established in 1998 as a programme under HSRI, transformed into an independent organization jointly supported by the Ministry of Public Health and HSRI in 2001

Mission: To develop and strengthen human capacity in two major areas, namely, HPSR and international health.

Objectives: research, capacity building, and strengthening the country's capacity in research and communication in international health arenas.

Strategies for achieving the objectives:

1 Conduct policy-relevant HPSR
2 Encourage policy interface wherever possible to get research into policy and practice
3 Foster partnerships and networks with key stakeholders in the long term
4 Foster regional credibility by exposing researchers to international fora and partners
5 Publish research articles in peer-reviewed journals, both domestically and internationally
6 Research capacity-building through apprenticeships and financially supporting people to attain post-graduate degrees.

Sources: Phoolcharoen (2004); http://www.thainhf.org/ThaiNHF/a.asp; Wongkhongkhathep, Jongudomsuk & Srivanichakom (2000); http://www.hcrp.or.th/; http://www.med.nu.ac.th/chem/ (last accessed 28 August 2007); Pitayarangsarit (2005); http://www.ihpp.thaigov.net/ (last accessed 23 August 2007).

For example, differences between the research plans approved for the regular budget and the actual research topics arise as organizations have the authority to adjust their work plans according to emerging problems and needs.

Previous national plans were criticized because they proposed what research should be conducted but did not prioritize across topics. In 2005, the NRCT Committee on Bio-medical Science initiated a priority-setting project for health research guided by a list of diseases with a considerable burden on health, and appointed a working group to conduct the project. The working group was composed of experts in health and research methods from five universities across Thailand, and the secretariat for this process was formed by the National Health Foundation. The working group used a conventional survey with 365 respondents, followed by a consultative meeting with researcher representatives. The respondents were asked to rank 10 of 20 diseases (from the 20 diseases in Thailand with the highest burden on health) to be suggested for research investment and then rated each according to three barriers to solving the problem: lack of knowledge; lack of technology; and lack of system capacity. The report was produced in September 2006, but the results were not included in the 2008–2010 draft plan, which had been issued prior to this.

There were limitations to this study. The burden of disease was the only input information for respondents, and the study was able to rank only the 'priority diseases' but not for research agendas within a disease or for health systems research priorities that were not linked to a specific disease.

Knowledge generation and management

Two critical public agencies were established in 1992. Each has a high degree of autonomy and is not bound by the usual bureaucratic rules and regulations.

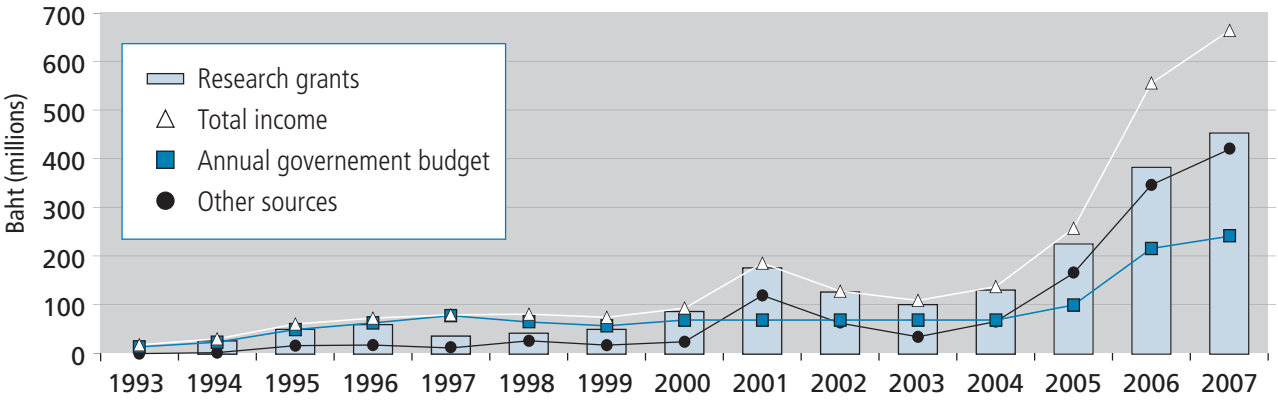
The TRF is a role model for research management in Thailand. The fund aims to strengthen Thai research infrastructure across all sectors, including research policy, budgeting, research institutions and researchers. The TRF offers a range of awards, including grants for basic research, research career development, post-doctoral research, new researchers, senior researchers and graduate student fellowships. The health sector in Thailand has benefited from many of them. For example, the Faculty of Medicine, Naresuan University, managed the graduate student fellowships in health system and policy; the College of Public Health at Chulalongkorn University managed the graduate student fellowships in health system development; and HSRI benefited from the grants to senior researchers, which helped to build a cadre of young researchers as well as promoting institutional development. The work done under these last grants led to the development of the current International Health Policy Program in Thailand (Box A.1). The TRF identifies four levels of research agendas: national; sectoral; area; and platforms. At the platform level, TRF supports learning and information exchange among technical experts and researchers, and those who use evidence in policy development. The TRF has also advocated for the establishment of two distinct research careers, namely, the professional researcher and the research administrator.

HSRI has its own board chaired by the Minister of Health; it supports health research and also undertakes research synthesis for policy purposes (see Box A.1). Although HSRI started out by conducting much research in-house, during its second phase (1997–2004) it evolved more along the lines of a research management model, contracting out most of its research. HSRI works with about 30 affiliate research agencies and has supported the establishment of research agencies and research networks, including the Health System Reform Office, the Health Information System Development Office, the Health Insurance System Reform Office, the Social and Health Research Institute, the International Health Policy Program, the Center for Health Equity and Monitoring, and the Clinical Research Collaboration Network. HSRI created alliances of organizations for each research programme and let these groups identify their research agendas and formulate their research plans. Stakeholders, including political appointees, senior health administrators, service providers, community leaders and consumer representatives, were identified and invited to become involved at the beginning. As a consequence it was possible to secure resources for the resulting programme of work from several sources, such as the Ministry of Public Health, the Thai Health Promotion Fund and the National Health Security Office (NHSO).

In 2007, 63% of HSRI funds were from sources other than the government budget. It spent approximately 659 million baht, of which 5% was for administrative support, 3% for research management, 6% for network development and 69% for research grants (see Figure A.2). The remaining 17% was the budget for the Office of Hospital Accreditation and the National Health System Reform Office.

Increasing funds for health research have come from the Thai Health Promotion Fund (ThaiHealth). Since 2002, ThaiHealth has supported various projects that serve the objectives of health promotion and relate to

Figure A.2 Annual government budget and research grants provided by HSRI, 1993–2006



the 13 programmes approved by the ThaiHealth Board, including supporting the cycle of knowledge generation to policy change and implementation. Each of the 13 programmes aims to develop an issue network, which would generate knowledge, develop alternative policies for the issue and include advocacy efforts to support it. Some sub-programmes were outsourced to other experienced organizations. For example, the NHF has managed the project Civil Society Network for Health Promotion, funded by ThaiHealth.

Overlapping membership of the governance bodies of these organizations helps promote mutual knowledge transfer and coordination; for example, Dr Suwit Wibulpolprasert is a board member of HSRI, ThaiHealth, NHF and a member of the Research Evaluation and Monitoring Committee of the TRF.

Most of the organizations described above were institutionalized in the years following 1992. They have seen an increase in national financial support only during the past five years. Before that time, the organizations' pioneering leaders struggled to keep them afloat, seeking funds from multiple external sources, which during the late 1980s and early 1990s played a much bigger role in supporting knowledge generation. For example, the core group of the Health Care Reform Project (see Box A.1) was involved in the Health Card Project (1988–2002) supported by the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), the Ayuthaya Project on the development of model primary health care in an urban setting by the Institute for Tropical Medicine, Antwerp, Belgium (1990–1995), the Community Health Project in Khon Kaen Province (1991–1996) by the Japan International Cooperation Agency and the Health Care Reform Project by the European Union (EU, 1997–2001 and 2004–2009). Other international sources (including the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID)) provided for other recipients in Thailand.

Filtering and amplification of knowledge

> In the Thai context, many prominent doctors are able to present themselves as government officials, academics and/or NGO activists, depending on the situation. This flexibility of approach, a reflection of the pluralism and relative openness of Thai society, is often crucial for the project of alliance-building, since leading doctors are able to command respect and support from a wide range of organization and social groups. (Chantornvong & McCargo 2001, p.52)

It is true that several senior health officials in Thailand have activist roots, and occasionally play this role

depending on the situation they find themselves in. Many of the current health sector leaders were student activists who entered the civil service compulsorily on graduation and worked initially in rural districts. Others are also founding members of advocacy organizations: Dr Suwit Wibulpolprasert (the Ministry of Public Health Senior Adviser on Health Economics) was a founding member of the Rural Doctor Society (1978), the Rural Doctor Foundation (1982), the Sampran Group (1986) and the IHPP (2002); Dr Sanguan Nittayarumpong (General Secretary of the NHSO) was a founding member of the Sampran Group (1986), the NHF (1990), the Foundation for Consumers (1994) and Chairman of the Local Development Institute (LDI, during 1998); Dr Somsak Chunharas (a senior public health adviser) is the Secretary General of the NHF, Dr Chuchai Supawong is a consultant to Thailand's National Human Rights Commission, a committee member of the NHF and was the first Secretary General of Thailand's National Human Rights Commission (1999). Box 6.3 in the main Review exemplifies how these close personal networks, and willingness to work across the domains of research, civil society advocacy and policy have contributed to policy change in the field of tobacco control.

The rural doctor networks in particular have played a prominent role in public health advocacy. The initial gathering dated back to the establishment of the Rural Doctor Federation in 1976, and the network has since evolved into three organizations: the Rural Doctor Society, the Rural Doctor Foundation and the Sampran Group – a working group coordinating the support of health service policies and organized by the Bureau of Health Policy and Strategy. Many major policy movements were initiated by the Sampran Group, including, for example, blocking the amendments to patent law on pharmaceutical products in 1992, promoting generic names on labelling and advertising of pharmaceuticals, establishing ThaiHealth and spearheading health system reform through the drafting process of the National Health Act.

Consumer movements were previously coordinated through the Coordinating Committee for Primary Health Care of Thai NGOs (CCPN), an NGO that was founded in 1983. More recently, the Foundation for Consumers (FFC) – also an NGO – was founded. This organization works directly with consumers in policy advocacy for consumer protection. The FFC has many instruments for advocacy, such as *Smart Buyer* magazine and the television programme 'Assembly of Consumers'. The FFC also strengthened the consumer network by supporting many sub-networks. Successful policy initiatives arising from the consumer movement include the anti-corruption campaign on a drug scandal worth 1400 million baht (initial information for this campaign was derived from the Rural Doctor Society and the Rural Pharmacist Association), the campaign for universal coverage of health care and support for the use of compulsory licensing to increase access to affordable medicines. The campaign to achieve universal coverage of health care for the whole country benefited from multiple alliances (see Box A.2).

Again, strong linkages between many NGOs appear to be an important factor in their success. In particular, the LDI has played a key coordinating role. The LDI, itself an NGO, functions as a coordinator for learning communities and policy advocacy. The LDI emphasizes community empowerment and self-reliance through supporting local initiatives and influencing macro-policy formulation).[2] The LDI has alliances with both NGOs and public organizations. It also has a mandate to strengthen civil society organizations, including at the provincial level, a goal it shares with the health system reform movement.

Media have played a crucial role in issue amplification, especially on 'hot' issues. Many newspapers have direct

[2] http://www.ldinet.org (last accessed 23 August 2007).

BOX A.2 UNIVERSAL HEALTH CARE COVERAGE IN THAILAND

Policy context: Thailand's democratization created new actors in the health policy-making process, which had long been under the control of bureaucrats and professionals. When proposals for universal coverage coming from the Ministry of Public Health had not met with success, key policy champions tried to engineer the development of a broader coalition in favour of the policy. The Thai Rak Thai Party adopted the policy as part of its 2001 political campaign. The campaign was also supported by senior officers in the Ministry of Public Health, 11 NGO networks forming the Campaign Project for Universal Coverage and more than 50 000 general citizens. However, there was also significant opposition to the reform coming mainly (initially) from health care providers within the MOPH system, the Social Security Office, together with labour unions and the Civil Servant Commission.

Getting evidence into policy: Much policy-relevant research was conducted, including the following.

- The Health Care Reform Office (with EU support) carried out research and development on models of health-care financing and implementing a primary care system.
- HSRI appointed a task force to develop a proposal of the design of the universal coverage of health care, which was useful in the policy formulation process.
- The Center for Health Equity Monitoring created the health equity index for Thailand and monitored the changes regarding equity in health. Their study of the budget required for the universal coverage scheme was used to communicate with the politicians – as evidence on the feasibility of the policy.
- IHPP contributed to the cost studies and budget required for the scheme during the implementation phase and produced a manual for analysing the financial status and performance of hospitals.

Dr Nitayarumpong, a member of the health research community, played a pivotal role as a policy entrepreneur, helping to disseminate the evidence to politicians and NGOs for use in policy debates.

Impacts: In 2001, the newly elected government established a tax-financed health-care scheme which entitled all citizens to health care. In 2002, Parliament passed the National Health Security Act, which established the NHSO. This office was tasked with acting as a purchaser of health services separate from the Ministry of Public Health. Health insurance coverage among Thais rose from 69% in 2000 to 91.9% in 2002.

Source: Pitayarangsarit (2004).

contact with researchers and NGOs such as the Rural Doctor Society and the Rural Pharmacist Association. Many research-funding organizations such as HSRI, TRF and NHF also produce press releases for journalists. Freedom in disseminating information has increased but also fluctuated over time, depending on the government in power.

Application of knowledge to policy-making

The Ministry of Public Health is the primary organization responsible for service provision and the overall governance and regulation of the health system. Historically, policy-making was mostly the preserve of bureaucrats,

BOX A.3 INVESTING IN PROTON RADIATION THERAPY: DESIGNING POLICY BASED ON EVIDENCE

Policy context: In 2000, the National Cancer Institute (NCI) of Thailand proposed an investment of 4500 million baht (about US$ 120 million) through a loan for a proton radiation therapy centre. The Ministry of Public Health appointed a committee to review the appropriateness of investing in this expensive service.

Getting evidence into policy: Three substudies were conducted by IHPP (without a grant): a literature review on clinical effectiveness; the health needs and service impact; and the opinions of the radiotherapists on the potential utility of the therapy for cancer treatment in Thailand. The findings presented to the ad hoc committee suggested that the proposal be rejected.

Impacts: Based on the analysis of the committee the Ministry of Public Health rejected the proton investment project. There was also a recommendation to legally establish a Technology Assessment Committee to deal with similar cases in the future.

Source: Prakongsai, Tantivess & Tangcharoensathien (2001); Prakongsai, Tangcharoensathien & Chunharas (2006).

but of late political parties and political appointees are increasingly engaged in policy design. Furthermore, decision-making powers have to some extent been transferred to actors outside the Ministry of Public Health. These developments reflect the increasingly pluralistic political system. Key organizations that now require evidence for policy-making include the policy and planning divisions of all Ministry of Public Health departments, the NHSO, which performs a purchasing role, political appointees and also the Health Commission of the Parliament.

Personal contacts between researchers and policy-makers can help get evidence into policy. This was particularly the case for the Universal Coverage for Health Care Policy (see Box 7.2 in the main review).

The role of HPSR in policy development and implementation

This section provides a series of examples of how HPSR evidence has been used in policy development in Thailand. Clearly, research evidence has played different roles in different contexts. Where the policy issue is not politically charged, research evidence may be used directly. For example, with respect to a proposal for a major investment in proton radiation therapy, research played a direct role in influencing the decision not to proceed (Box A.3). A more deliberative formulation is reflected in the policy on renal replacement therapy in Thailand (Box A.4). Researchers spent several years conducting research on different aspects of the issue and regularly presented findings and recommendations to the Health Minister, the NHSO Board and the Health Committee of Parliament. While the NHSO Board was reluctant to fully adopt the findings of the research, a small pilot project based on the research was nevertheless initiated, which led to a Ministry of Public Health

BOX A.4 RENAL REPLACEMENT THERAPY IN THAILAND

Policy context: The universal coverage scheme has never included renal replacement therapy for end-stage renal disease patients in the benefit package. This is despite the fact that a policy decision to include renal replacement therapy was decided in March 2005 by the former Minister of Health, who chaired the board of the NHSO. Members of the board did not approve of the policy to extend the therapy due to its significant long-term financial implications. While universal access to ART was successfully advocated by an active civil society movement, the extension of coverage to renal replacement has received much less vocal support.

Getting evidence into policy: IHPP, with partners, conducted a package of research in 2005, including an incidence survey, a 20-year demand forecast, estimates of fiscal requirements given different cost scenarios, a supply-side assessment and identification of bottlenecks for scale-up, a cost-effectiveness analysis and consideration of rationing criteria. Economic evaluation of renal replacement therapy strongly suggested that it was not appropriate to allocate resources for it in the first stage of the universal health care-coverage programme. However, due to the implications of catastrophic illnesses on households (and inequities across the other two public insurance schemes), the researchers and partners recommended that the NHSO extend the service to its beneficiaries selectively, on a case-by-case basis. A comprehensive policy package was proposed in September 2005. Research progress and recommendations were regularly presented to the Health Minister and the NHSO Board, and also to the Health Committee of Parliament.

Impacts: Limited uptake of the research appears to have occurred, although the researchers were appointed as members of a Ministry of Public Health task force to develop the national strategic plan for treatment of chronic renal failure patients. The NHSO later approved a small project to support 200 cases of renal transplantation.

Source: Pitayarangsarit, Tangcharoensathien & Daengpayont (2006).

task force on the development of a national strategic plan for treatment of patients with chronic renal failure.

This case was in contrast to the policy on antiretroviral therapy (ART) provision (Box A.5), which was more politically charged. A coalition of AIDS activists advocated strenuously for a new policy on ART provision. Lessons regarding treatment benefits, advocacy on treatment by global activists, changes of drug regimen and a substantial decrease in drug prices were all used by the coalition to advocate for ART provision for all people with HIV/AIDS. Even though a cost-effectiveness analysis of ART was not yet completed, ART provision for all was made policy in 2001. This shows that when a policy issue is very politically sensitive, other factors besides research evidence are likely to substantially influence decision-making.

The process of tobacco control in Thailand has been very political – involving multiple stakeholders, including the Ministry of Public Health, the international tobacco industry and civil society (as described in Box 6.3 in the main review). Research played a major role in demonstrating trends in tobacco consumption, the cost of tobacco-related illnesses, and providing evidence on the sensitivity of consumption patterns to changes in

BOX A.5 ANTIRETROVIRAL THERAPY PROVISION IN THAILAND

Policy context: From 1996 until 2001, ART therapy was available through the public health-care system to only a limited degree, largely through a research network conducting clinical assessments of antiretroviral medication in public hospitals. The policy to extend the service to all people with HIV/AIDS was opposed by many health economics researchers and professionals because they were concerned about the long-term budget requirements and programme sustainability. Over time the context changed; drug prices fell and the focus increased on human rights and ethics issues associated with access to treatment. The local production of many new generic antiretroviral medications was also crucial, because this lowered costs of the therapy. The policy to extend the service was supported by a very active civil society movement, including ART-advocacy coalitions; the National AIDS Network; the Drug Study Group; the Thai AIDS Society; the Thai Lawyers Association; individual scientists from the Government Pharmaceutical Organization; experts on intellectual property laws; and HIV clinicians from medical institutes.

Getting evidence into policy: The first decision that limited ART service to a research network was clearly influenced by cost-effectiveness data and the budget impact; a domestic study illustrated the unaffordable fiscal burden and inefficient use of resources in public provision of ART. But in 2001 the previous cost-effectiveness data were overruled, and the decision was made to include ART in the universal health care coverage package. The substantial decrease in drug prices owing to local generic production was critical. Networks of NGOs and people living with HIV/AIDS made use of such information to encourage the Ministry of Public Health to extend treatment to all people in need.

Impacts: The ART policy changed in 2001 when the new government pledged to extend the service to more people, as part of its commitment to universal health coverage. Targets of people receiving ART escalated from 6500 in 2002 to 23 000 and 50 000 in 2003 and 2004, respectively.

Source: Tantivess & Walt (2006).

price and income. The evidence served as a platform for effective health promotion strategies and was used by civil society organizations to advocate for a dedicated tobacco tax linked to health promotion activities. Success factors behind the 1999 reform that established the dedicated tobacco tax included the active role played by civil society, founded on research evidence, political support from the Ministry of Finance and engagement of international actors.

When policy issues are politically contentious, civil servants at the Ministry of Public Health will sometimes disseminate research results to civil society organizations to exert external pressure for policy change. The universal coverage policy case illustrates this point (Box A.2). Several attempts were made to propose a universal coverage bill via bureaucratic channels, but success was achieved only by linking political parties with NGOs, including the People Living with HIV/AIDS Network, and the wider dissemination of the idea via a booklet on the topic (Nittayaramphong, personal communication, 2002).

Capacity development in HPSR

Past initiatives

Several previous initiatives have attempted to strengthen HPSR capacity in Thailand. In 1986, the Pew Charitable Trusts supported HPSR in countries in Asia and Africa through the International Health Policy Programme (not to be confused with the current IHPP-Thailand). IHPP competitively identified a team of economists in Thammasat University. Unfortunately, this group had a limited understanding of the policy needs of the Ministry of Public Health. Although the director of the ministry's planning division played a bridging role between the researchers and the Ministry, this did not function very well. The group's work on costing and health-financing analysis did not leave a lasting legacy in terms of HPSR institutional capacity either in the Ministry of Public Health or in Thammasat University. When IHPP support ended, so did the programme.

In 1988, USAID supported a Health Economics Programme, physically located in the Health Planning Division of the Ministry of Public Health. Following the military coup in 1992, USAID withdrew totally, and several plans to enhance capacity and support research in health economics and financing failed to fully materialize.

In 1994, Chulalongkorn Faculty of Economics established a Centre for Health Economics (also a WHO Collaborating Centre), which provided courses at the master's level in health economics and related fields. The goal was to strengthen research capacity and the application of health economics to policy formulation and planning in Thailand and South-East Asia. Due to the nature of the curriculum and limited research (judged by research profiles and publication records (Faculty of Economics, Chulalongkorn University 2007)), as well as the distance from the policy environment, the Centre for Health Economics contributed little to policy formulation, monitoring or evaluation in the vibrant health-care reform of the past decade.

The Field Epidemiology Training Program (FETP) initiated in 1979 but still operational, represents a good model of a successful capacity development programme (even though field epidemiology clearly entails skills different from those key to HPSR). The FETP was initiated by far-sighted leaders within the Ministry of Public Health's Communicable Disease Control Department. It was initially supported financially by the US Centers for Disease Control and Prevention, but fully managed by the Epidemiology Department of the Ministry of Public Health. FETP is a formal on-the-job field-training programme (affiliated with the epidemiology division), involving two years spent conducting field epidemiology and disease outbreak investigations, and a third year either in Thailand or abroad with full scholarship. Candidates were doctors mainly from rural districts. The opportunity to study for a master's degree provided a strong, non-financial incentive. FETP alumni made significant contributions to the epidemiology services and development of weekly epidemiological surveillance systems. They are now posted at several high levels in the Ministry of Public Health. Epidemiological capacity in Thailand has flourished, and the country has fulfilled all core competencies as required by WHO`s International Health Regulations.

National efforts to enhance capacity

In the past two decades, the Ministry of Public Health focused on rural health service extension and production of health workers (Wibulpholprasert 2006), and failed to produce an explicit policy direction or vision for capacity development for HPSR. Historically, policy-makers in the ministry have been recruited from experienced provincial chief medical officers. Policy decisions were not that sophisticated and were made based largely upon experience and intuition rather than evidence.

Table A.1 The joint WHO-Thailand IHPP fellowship programme, 1998–2007

Biennium	Certificates/master's degrees	PhD	Total
1998–99	Seven degrees (across public health, human resources for health; health economics; health service management; international health; health policy, planning and financing)	—	7
2000–01	One degree (public health – epidemiology)	Seven degrees (across the fields of health economics, policy analysis, service management and public health)	8
2002–03	One degree (health promotion)	Five degrees (medical anthropology; health economics, policy and public health)	6
2004–05	Four degrees (across the fields of epidemiology and public health)	Two degrees (health service research and public health nutrition)	6
2006–07	Five certificates and four degrees (across the fields of genetic epidemiology and public health)	—	9
Over the past decade	Five certificates and 17 degrees	Fourteen degrees	36

Source: WHO Thailand Office (2007).

When the HSRI bill was enacted in 1992, it mandated HSRI to provide funding to support health systems research, as a vital element of health system development. A few key staff were seconded from the Ministry of Public Health to work full-time for HSRI. HSRI experience during the period of 1992–1995 indicated that calls for proposals often elicited low-quality proposals. While HSRI fully exploited a few good researchers, there were only a limited number of committed, professional researchers in HPSR. In the context of ample resources for health systems research, this became the main constraint. The development of IHPP-Thailand responded to this need, using the experiences from FETP and the Senior Research Scholar Programme (supported by the TRF).

An informal discussion during the World Health Assembly in May 2000 among Thai delegates reflected an urgent need to enhance capacity in HPSR. With the leadership of the Deputy Permanent Secretary of the Ministry of Public Health responsible for International Health,[3] IHPP was set up under a memorandum of understanding between the Ministry of Public Health and HSRI. The first task was to recruit fellows for a research apprenticeship for a few years prior to PhD training in a needed area (IHPP-Thailand 2002). The WHO Thailand Office and IHPP-Thailand have jointly managed the fellowship programme since 2000. IHPP-Thailand also focused on post-doctoral research assignments to ensure that returning graduates employed their new skills. Table A.1 shows the numbers of students enrolled in the programme over the past decade.

Nearly all the 36 fellows who received a certificate or degree through the programme are now actively

[3] That is why IHPP-Thailand, has two major foci, one on capacity in HPSR and the other on international health.

Table A.2 Numbers of IHPP researchers, grants and their sources, 2004–2006

Number of researchers				Research grants (Thai baht)				
Year	Total No. of researchers	Cumulative on study leave	PhD graduated	Domestic source	%	International source	%	Total grants
1999	7	2	1	2390 820	88	338 400	12	2 729 220
2000	9	3	1	3 477 003	100	—	—	3 477 003
2001	15	5	1	9 977 614	51	9 775 997	49	19 753 611
2002	16	9	1	569 490	29	1 400 560	71	1 970 050
2003	16	9	2	4 860 754	30	11 179 682	70	16 040 436
2004	16	7	3	1 274 750	32	2 676 553	68	3 951 303
2005	16	7	4	12 481 804	38	20 686 754	62	33 168 558
2006	17	4	8	14 736 746	53	13 072 739	47	27 809 486

engaged in HPSR (mainly in the Ministry of Public Health and a few universities), and there has been no loss to overseas institutions. The high return rate contributes to sustainable capacity development.

Most IHPP fellows were recruited from talented young medical and public health staff who had some years of experience in public health and related fields. They were, on average, in their mid-thirties when they completed their studies, meaning that they would theoretically be able to work approximately 25 years before retiring. In addition to the WHO long-term fellowships, IHPP also seeks support from other sources. By 2007, 10 PhDs in IHPP constituted a significant capacity to supervise and conduct more diversified HPSR.

With the increasing number of PhD researchers and a strong reputation, IHPP finds it increasingly easy to get funding. Initially, international funding accounted for more than half of total revenues, and there was substantial fluctuation in income; but this has changed since 2006. In 2005, IHPP established the Foundation of the International Health Policy Programme, which provided an independent organization for financial and human resource management. Since that time, research grants have paid out competitive 'top-up' fees to retain proficient researchers. Table A.2 shows the research capacity in Thailand over the period 2004–2006.

Thailand is seeing an exponential growth of capacity in HPSR in 2007. Inspired by the British model set forth by the National Institute of Clinical Excellence (NICE), a special three-year programme (Health Intervention and Technology Assessment) was initiated with funding secured from multiple local resources in the amount of 55 million baht (US$ 1.7 million). The Health Intervention and Technology Assessment Programme attracted some 15 additional professionals (7–8 post-doctoral) and should contribute significantly to producing evidence regarding the adoption of health technologies. The scale-up of IHPP is also reflected in the number of publications (IHPP-Thailand 2006), see Table A.3.

Table A.3 Publication records, IHPP-Thailand 2001–2006

	International journal	Thai journal	Research report	Book chapter English	Book chapter Thai	Proceedings (Thai/ international)
2001	2	11	4	0	2	1
2002	4	15	2	3	7	2
2003	5	11	6	1	1	2
2004	7	14	12	12	4	1
2005	12	9	17	3	0	5
2006	13	16	13	2	2	10
Total	43	76	54	21	16	21

International collaboration

International collaboration can help strengthen research capacity, sustain funding and provide academic assistance. Many Thai students have studied abroad, but only in relatively few cases has that led to long-term institutional collaboration. Among the more successful collaborations are those with the Institute for Tropical Medicine, Antwerp, Belgium, and the London School of Hygiene and Tropical Medicine. The collaboration with the Institute for Tropical Medicine was strengthened by Dr Nitayarumphong after he received a scholarship from the Belgian government to study for a master's degree at the institute in 1984. Based upon his recommendation, a further 31 persons graduated from this university during the period 1986–2002.

The Health Planning Division of the Ministry of Public Health has a long-established research collaboration with the Health Economics and Financing Programme of the London School of Hygiene and Tropical Medicine; and after Dr Tangcharoensathien graduated from the latter, the relationship emerged more formally between the two institutions, and later IHPP-Thailand. This partnership is characterized by collaborative research and building of research capacity through PhD training.

Most of the capacity-development activities are targeted to individuals rather than strengthening the institutional capacity of IHPP-Thailand. To date, there is continued support and partnership through the Health Economics and Financing Programme for PhD training in various fields.

In addition to these collaborative measures, other partners such as WHO, UNAIDS, the World Bank, the Harvard School of Public Health, the International Labour Organisation and the Rockefeller Foundation also bring technical support, helping local researchers keep abreast of recent research developments, and occasionally provide grants for specific projects. Thai teams also have links to regional networks, including the Asia Pacific National Health Account Network and Equitap (Equity in Asia-Pacific Health Systems) funded by the EU. These networks provide opportunities to exchange knowledge and share lessons learned among developing and transitional countries.

Explaining the successes

Shared values and informal networking

Common experience of the difficult political transition in the 1970s helped define the values of many current public health officials; it influenced their vision of health system reforms and social development. Informal and formal health policy networks, such as the Sampran Group, forged by the events of the 1970s, have contributed significantly to the growth of HPSR evidence and to policy changes. The membership of the network is small, and the members have a close relationship dating back to 1986. At that time, they worked independently but met and exchanged ideas regularly. These individuals bring their cumulative experiences and interests into the research institutions, funding and advocacy organizations they work in and collaborate with. During recent years their capacity to influence national policy has increased significantly as they have attained senior positions.

An active role for civil society

The political shift in 1997 provided the opportunity to strengthen civil society organizations that have since played a major role in health policy development, often drawing on research evidence. Several organizations have been involved in strengthening civil society networks. This success was partly developed through established relationship between health officials (who were also sometimes researchers) and partnerships between NGOs and civil society organizations. As Thai politics have become more pluralistic, the role of civil society in influencing policy debates has become increasingly important.

Establishing dedicated institutions for HPSR

The institutionalization of HSRI was a great contribution to the growth and success of health policy and system research in Thailand. Without the constraints of regular bureaucratic rules, HSRI was able to work independently and efficiently, providing competitive salaries for its staff. HSRI also supported many Ministry of Public Health staff and promising researchers to train abroad, and developed research units through financial and logistical assistance. TRF's approach to strengthening both research teams and individuals was also effective. The selective process and the incentives (scholarship for domestic study or study aboard) were crucial in helping to identify potentially capable researchers. Parallel emphasis on research management and improving the work environment helped not only to retain research staff but allowed them to continue to be productive. While researchers within the Ministry of Public Health have an advantage in terms of links to policy-making, the Thai MOPH cannot ensure an appropriate career ladder for researchers, and lacks the necessary systems to support appropriate human resource and funding management.

Moving from international to domestic funding

While international funding sources were significant for starting many projects and strengthening the early capacity of research organizations in Thailand, the increase in domestic research funding through HSRI and the earmarked tax of the ThaiHealth Fund has led to quantum improvements in HPSR capacity by facilitating many policy-research packages and promoting links from research to policy via knowledge management processes.

Formalizing processes for promoting evidence-informed policy

In the Thai context, close relationships between researchers and research users has been a critical factor both in developing a culture of evidence-informed policy and actually employing evidence in policy-making. Thus far, however, much of this culture has relied upon connections between particular individuals and their motivation to make this link. Further attention now needs to be paid to designing a system to promote, or even enforce, the use of evidence in policy-making institutionally.

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Notes