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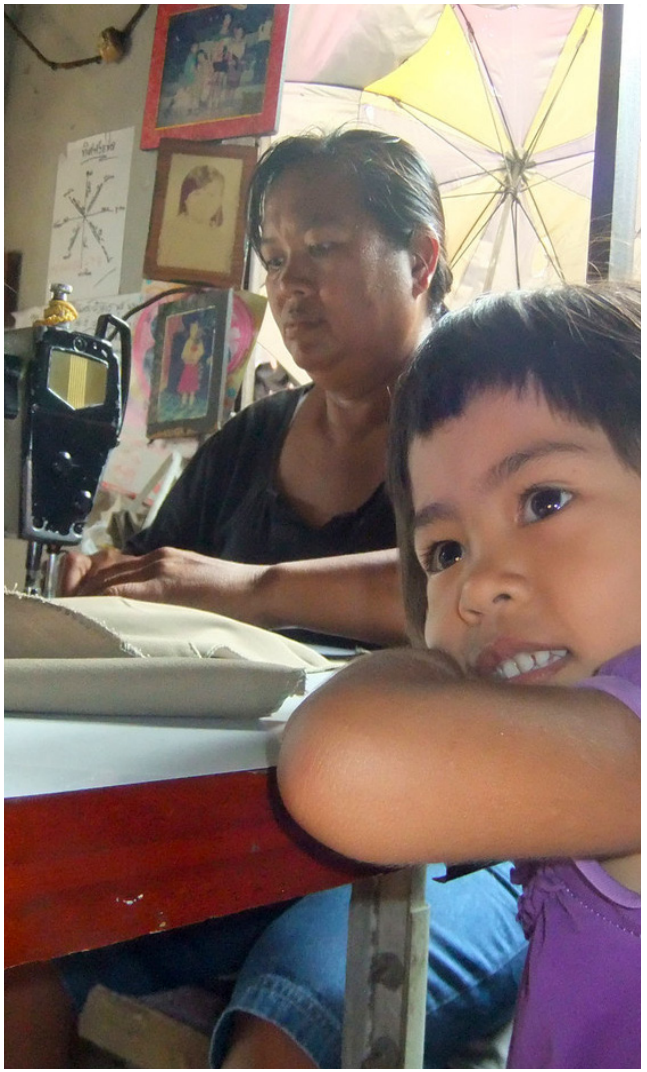
Participatory Policy Making: Lessons from Thailand's Universal Coverage Scheme

Laura Alfers and Francie Lund[1]

In 2002, the Thai government introduced the Universal Coverage (UC) scheme where, for a payment of 30 Baht per visit or procedure, all Thai citizens could access health services. In 2007, the government put an end to this 30 Baht co-payment and instituted universally free public health services funded by general taxation. Although the scheme is not entirely free of problems (Namsomboon 2011), it has had impressive results. According to the WHO's Global Health Observatory (2009-2011), 99 per cent of births in Thailand are attended by skilled attendants; maternal mortality sits at 48 per 100,000 live births (compared to a regional average of 240 per 100,000); under-5 mortality is at 12 per 1,000 live births (compared to 8 per 1,000 in the USA); and average life expectancy at birth is 66 years for males and 74 for females. Particularly striking is the high level of public support for the scheme; the results of a survey conducted by the National Statistical Office Thailand in June 2003 revealed that an overwhelming majority of 97 per cent of the sample were satisfied with the UC Scheme, and almost 91 per cent wanted to see it continued (Doane et al. 2006: 127).

Although the improved access to health services has certainly contributed to this public support, there is another important aspect that has been integral to the scheme's success: the participatory approach to policy development and implementation that was adopted by the advocates of universal healthcare in Thailand. Civil society groups, including informal worker organizations, were heavily involved in the campaign for the UC scheme and have continued to be included in its implementation and monitoring. Arguing that the Thai case provides a good example of what the political philosopher Nancy Fraser has termed "participatory parity," this brief seeks to draw out lessons from the process of health reform for both policy makers and organizations of informal workers.



The Thai government's 2007 institution of universally free public health services has had impressive results, including decreased infant mortality rates, increased life expectancy and a high level of public support for the scheme.

[1] Laura Alfers is a Researcher on WIEGO's Social Protection Programme. Francie Lund is the Director of WIEGO's Social Protection Programme.

Participatory Parity and the Development and Implementation of the UC Scheme

In engaging critically with the underlying principles governing public participation in policy processes, Nancy Fraser has developed the concept of "participatory parity." Participatory parity, according to Fraser, becomes possible when two conditions are satisfied. The first she calls the objective condition, which is satisfied by "the distribution of material resources…so as to ensure participants independence and voice." The second is the inter-subjective condition, which "requires that institutional patterns of cultural values express equal respect for all participants and ensure equal opportunity for achieving social parity" (Fraser and Honneth 2003: 36). In societies where there are deep social and economic divisions, argues Fraser, the conditions of perfect participatory parity are unlikely to be met. Not only do material resources differ vastly, but the traditional Habermasian ideal of a single public sphere in which deliberative processes can occur is likely to reinforce inequality. This is because less powerful interests are subsumed under an idea of a universalized civil society that tends to represent the interests of the more powerful members of that society (Fraser 1990).

Nevertheless, argues Fraser, conditions of parity can be "approximated" through the development of multiple public spheres, which "permit contestation among a plurality of competing publics than by a single, comprehensive public sphere" (Fraser 1990: 67). Multiple public spheres allow less powerful interest groups the space to develop their own political programmes and function as "training grounds for agitational activities directed towards wider publics" (Fraser 1990: 68). According to Fraser, it is in this tension between the drawing of boundaries in order to "regroup" and reaching outwards towards the wider public sphere that the power of multiple public spheres resides. Through the process of contestation and alliance between various interest groups, difference is more easily accommodated, which in turn strengthens wider civil society. The process of health policy reform that occurred in Thailand represents an important real life example of multiple public spheres in action.

A commitment to public health has long been a feature of Thailand's policy development. In 2003, this was officially codified in the Constitution of the Kingdom of Thailand, which declared health as a basic right of citizenship that should be provided by the state. Despite this commitment, it took a concerted effort on the part of grassroots civil society organizations and their allies in government and the public health profession to push the government to turn this constitutional commitment into a reality for the Thai people.

The UC scheme has its roots in what Nitayarumphong (2006: 74) has called "the triangle that moved a mountain" – an alliance between public health professionals, civil society movements, and political parties. The idea for the 30 Baht scheme originated with a group of public health professionals (strongly supported by the monarchy) who were committed to reforming the health system in Thailand. Early on, these reformers realized that they would stand a much greater chance of success if they had strong public support for their campaign (Nitayarumphong, 2006). The space for the inclusion of civil society in the reform process was provided by a 1997 Thai law that states that any piece of proposed legislation with 50,000 or more signatures supporting it must be debated in Parliament as a "people's sector law."

At that time, the Consumer Association, a strong Thai NGO, was led by a particularly committed woman who collaborated with the health reformers in their search for public support. The Consumer Association began to recruit other civil society groups, eventually forming a network that could push for health reform through the drafting of legislation and the collection of signatures. This alliance of nine civil society groups, which became known as the Network of People Organizations, was originally made up of groups representing a wide range of interests: informal workers, women, the urban poor, agriculturalists, the elderly, children and youth, indigenous people, the disabled, and people living with HIV/AIDS. Through the efforts of this network, 50,000 signatures were collected and a health reform bill was submitted as a people's sector law to the 2001-2002 sitting of the Thai Parliament.

Important to note is that the Network of People Organizations, while maintaining a unified overall vision of health reform, allowed for the different needs of the various groups making up the network to be heard. Informal workers, for example, were represented by the alliance of home-based worker organizations, HomeNet Thailand (HNT). At first, it was suggested by the network that HNT be included under the rubric of "the poor." HNT contested this strongly, arguing that informal workers had specific needs related to occupational health, which were not the same as the needs of all of "the poor." HNT's argument was ultimately accepted by the network, and this gave HNT the space to develop its own demands whilst continuing to contribute to the wider goal of universal access to healthcare. Other groups, such as the HIV/ AIDS sector and people with disabilities, also had clear and specific demands of the health services.

The burgeoning public support for health reform was noticed by government and opposition parties who were about to compete for election at the time the civil society drive was gaining momentum. Five other versions of

health reform legislation were submitted to the 2001-2002 sitting of Parliament – one from government and four from minority parties, including the official opposition party Thai Rak Thai (TRT). However, the Network of People Organizations' draft legislation, which had been submitted early, had a distinct influence on the other submitted drafts.

Although there was now widespread consensus on the need for the health reforms, the Network of People Organizations still faced challenges in ensuring that civil society would remain a central part of the policy reform. It had to go through the process of travelling back to areas where it had collected signatures in order to post the draft legislation and consult with the signatories. The other parties did not want to wait for this process and wanted to go ahead without civil society representation. To counter this, the network won an agreement from Parliament that it could be present at the Commission convened to consider the drafts. Although the Commission ultimately chose to adopt the TRT's draft legislation, five members of the network were drafted onto the parliamentary commission set up to consider the second reading of the bill, which later became the National Health Security Act (Pitayarangsarit 2005).

A major point of difference between the Network of People Organizations' draft legislation and that of the political parties was the issue of permanent representation of civil society on health structures. Some parties did not want this issue included in the law, so the network had to push hard for it to be included within the legislation. As a consequence, the National Health Security Office (NHSO) has developed an administrative structure that is able to respond to public needs, and "people participation" is one of the strong points of the UC scheme management. It creates openings for public participation, promotion and for the support of volunteers. Since 2002, the alliance has continued to participate in the scheme through its membership on key committees and subcommittees at local, district and other levels. Representatives from the two organizations that represent workers (informal and formal – formal workers joined the alliance at a later stage) have been on the National Health Security Board for two terms.

Long experience of exclusion from state social schemes has meant that poorer women workers are less likely to trust government services, including the Universal Coverage Scheme. This problem is exacerbated by a shortage of easily accessible information on the scheme and its benefits.

Participatory channels of communication between citizens and the scheme exist at several levels:

- NHS Boards: five elected representatives from civil society sit on each of the two boards (policy and quality control). This is no longer restricted to the Network of People Organizations – any civil society organization can put up candidates for election if they can prove that they work in an area that has public health concerns (currently this is restricted to the areas of labour, farming, women, children and youth, the elderly, ethnic groups, disability, and people living with chronic diseases). At present, approximately 100 civil society organizations are registered to put up candidates. Only those members who have registered with the NHSO are eligible to vote for candidates, so the more members who are registered within one organization, the more likely that their candidate will be elected.

- National, Regional and Provincial Sub-Committees: members of civil society organizations are elected onto these committees depending on their focus and geographical location.

- Sub-District Universal Health Security Fund: this fund has at least one representative from civil society.

- Provincial People's Coordinator Centres: each centre has at least one representative from civil society.

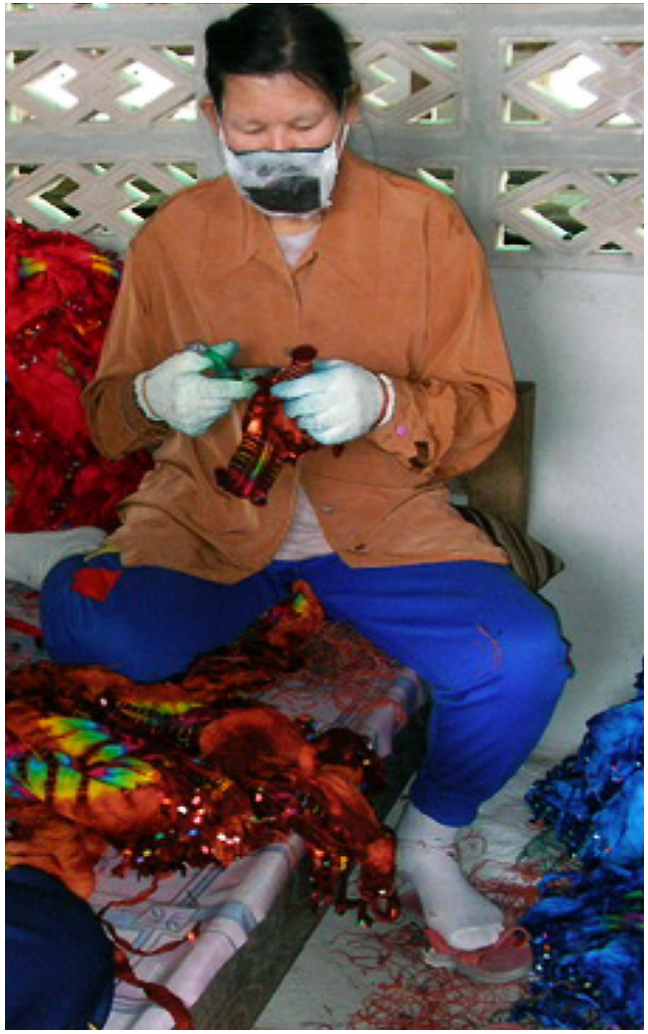
The Specific Demands of Informal Workers

Since the beginning of the health reform process, HomeNet Thailand has pushed for additional occupational health benefits for informal workers. It argues that although 50 per cent of the population who benefit from UC are informal workers, the scheme fails to see workers as having special health needs related to the nature of their work and their working environments. HomeNet Thailand has formulated a list of worker-specific demands, as below:

- annual health check-ups for occupational groups with high work-related risks
- a monitoring service and system for worker's health to improve data collection and surveillance of occupational ill-health
- development of sector-specific or occupation-specific schemes providing preventive, curative and rehabilitative services to workers

In order to further this agenda, HNT has carefully and consistently negotiated with the NHSO. It has also ensured that informal workers are represented on the National Health Security Committees by encouraging its members to register. In the last elections, HNT registered 130 affiliate groups; HNT claims this helped it to secure a representative on the Committees.

The result of HomeNet Thailand's work is that the NHSO is now running a pilot project on integrating occupational health and safety for informal workers. The pilot will run from 2012-2015 and will incorporate 335 primary care units. It is hoped that the project will form the basis of a widespread network of occupational health services for informal workers in the country. HNT will continue to play a central role by developing and improving coordination between worker's networks and healthcare providers, by developing a policy statement on occupational health and informal workers, and by conducting promotional health campaigns amongst its affiliate groups.



Silk being chemically dyed

Lessons from Thailand

The UC Scheme in Thailand is the result of a particular confluence of forces, which, it is argued, led to an approximation of Fraser's concept of participatory parity. This remarkable policy reform resulted from critical election period, a monarchy that has historically been sympathetic to the principle of equity in health service provision, a strong alliance of grassroots networks that allowed for both unity and difference amongst interest groups, and legislation that promotes public sector participation in decision making. This particular confluence of factors may not be replicable in other countries where the political landscape is very different. Nevertheless, there are some important lessons that can be distilled from the Thai experience for both policy makers and for organizations of informal workers.

1. The Power of Alliances Spanning Multiple Publics

For organizations of informal workers, the Thai case shows the importance of building up networks and engaging with other interest groups operating within the wider public sphere. It is unlikely that HomeNet Thailand would have been able to gather enough signatures on its own to submit a people's sector law or would have been strong enough to negotiate the gains made in civil society representation within the scheme's structures. Without the support of public health professionals and policy reformers, the Network of People Organizations may not have been able to develop convincing draft legislation. Likewise for the public health professionals and policy reformers, it would have been infinitely more difficult to push their intended policy reforms without the groundswell of public support that was behind the reform.

Sources from within the HNT leadership stated that their participation in the health reform process has strength-

ened their organization considerably. They have learned about the right to participate and, importantly, about what was required to participate effectively in policy making. The network has continued to be a useful engagement for HNT, which has used the network to support lobbying around a national social security scheme and around the International Labour Organization's Social Protection Floor.

2. The Importance of Maintaining a Worker Agenda within a Broader Alliance of Interest Groups

While broader alliances across civil society are clearly important in terms of securing widespread support for policy reforms, it is also important that organizations of informal workers maintain the space to formulate their own policy positions that articulate the particular needs of workers. While HNT put its energy into the broader citizen-based network that had a unified goal of establishing the UC, it has now refocused its energies on occupational health. This is an important step that has allowed the organization to differentiate its interests from the main network whilst simultaneously remaining an integral part of a wider movement. As Fraser argues, it is this dialectic that sees interest groups draw boundaries between themselves while at the same time engaging with one another in order to promote a shared interest that can be so powerful.

3. The Meaning of Participation

Whilst the academic literature stresses the importance of the early involvement of civil society in participatory processes if it is to be effective, in reality participation is too often seen as an "add on" and not as a central element of the policy making process (King et al. 1998). The Thai case shows the importance of involving target groups in policy making right from the start. Spaces were created that allowed grassroots organizations to have their voices heard from the conceptualization stage. The result is a scheme that has participation built into its core structure and which consequently has a significant amount of public support behind it. The Thai people rightly feel a sense of ownership over the scheme.

Planning meeting with National Health Security Office.

4. The Importance of Continued Involvement of Civil Society in National Schemes

A final point to emphasize is the importance of including civil society in the implementation and monitoring of schemes rather than ending public participation after the initial process of policy development. The UC scheme allows for public participation throughout its governance structures. The continued participation of the civil society network in the scheme's central decision making processes, especially in implementation and monitoring, has allowed these organizations to gain further knowledge about the challenges of running such a scheme. It has also allowed them the opportunity to challenge the UC administrators on a continuous basis to ensure that it develops in ways that benefits the people it is intended to benefit. Maintaining this system requires not only a commitment from policy makers, but also a commitment from the civil society groups involved.

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