Thai Version

Author : Parichart Siwaraksa

Editor : Paiboon Suriyawongpaisal

English Version

Translated by Vijavat Isarabhakdi

Thai Health Promotion Foundation (ThaiHealth)

PREFACE (to the Second Edition)

Ever since the birth of ThaiHealth, one question I have frequently been asked concerns the “historical background” of the foundation. What was the evolution of the foundation leading up to the enactment of the Health Promotion Act, B.E. 2544 (2001), which established ThaiHealth in November of that year. There are those who claim that ThaiHealth is the product of one government or another, or the brainchild of one individual or another. However, as a person who has participated in the establishment of ThaiHealth from the very beginning, I wish to affirm that ThaiHealth was not conceived by any one individual in particular, but is the result of the repeated cooperative endeavours and support of a large number of people. It took almost ten years for us to have come this far.

It is very fortunate that such a highly accomplished person within academic and communications circles such as *Arjarn* Parichart Siwaraksa, an independent researcher who formerly worked at the office of the United Nations, has taken an interest in studying, compiling and transcribing the evolution of ThaiHealth in the form of a paper entitled **“A Case Study of the Birth of the ThaiHealth Fund”**. This paper formed part of the document series entitled **“Learning Lessons from Knowledge and Research Management”** published by the National Public Health Foundation on the occasion of a Workshop organised by the Foundation in late 2002.

This booklet offers facts and critique in a very readable manner although I would like to contest some of the data contained in it and provide explanations for some of the criticism. Overall, however, this publication can be considered the best piece of work on this subject at present, compiling the events leading up to the establishment of ThaiHealth in a most systematic manner.

In the hope that the story behind the establishment of ThaiHealth will be of use to some of our friends who are trying to “move mountains”, and with a view to clarifying the origins of this extraordinary organisation, the Thai Health Promotion Foundation has decided to support the second printing of this booklet.

In addition to a special word of thanks to *Arjarn* Parichart, I would also like to express my appreciation to Associate Professor Dr. Paiboon Suriyawongpaisal, one of ThaiHealth’s beloved friends who took on the task of editing the booklet. I also wish to thank the National Public Health Foundation, the Office of the Thai Research Fund, and the World Health Organisation, who collaborated to support the undertaking of this study and the publication of the first edition.

The substance of this booklet reveals the efforts to push for the establishment of ThaiHealth, which can only be described as highly “proactive”. We did not sit around idly, waiting for miracles to happen. The whole process took 8 years altogether, from 1993 to 2001, not including the deliberations that took place before that. We must admit that some of the conditions which helped to transform our dreams into reality came about purely by coincidence.

Most of the success achieved can be attributed to the untiring and indomitable efforts of all those concerned, whether in terms of planning or implementation. A non-partisan coalition was forged, comprising politicians, civil servants, developmentalists, academics, lawyers, members of the mass media, public health experts, and so forth. Implementation of the idea was based on the existing body of knowledge and supporting information at every level.

In our efforts, we were spurred on by our great aspiration to see Thailand as one of the world leaders with an advanced mechanism for national health promotion.

In short, this success is the result of the determination, knowledge and support of a large number of people, coupled with the efficient management of the small window of opportunity that became available.

Dr. Supakorn Buasai
Manager of ThaiHealth

INTRODUCTION
5

KEY ADVOCATES AND CATALYSTS FOR CHANGE
10

ORGANISATIONS
13

KNOWLEDGE BUILDING, OPPORTUNITY, AND POLICY CONTEXT :
POLICY PROMOTION DURING **THE FIRST PERIOD**(1993-1997)
17

BUILDING A KNOWLEDGE PACKAGE AND
THE SECOND ROUND OF POLICY PROMOTION (1998-2001)
52

SUMMARISING EXPERIENCES
69

SUMMARISING THE LESSONS LEARNED:
THE TRIANGLE MOVES A MOUNTAIN
87

REFERENCES
91

1. INTRODUCTION

Cigarettes and alcohol are related to the lives of the Thai people and Thailand's economic system, whether in terms of production, sales, consumption, or employment. They represent both a household expenditure as well as a government revenue. At the same time, they also constitute an unnecessary expense on the part of the household, and are the source of many serious illnesses, resulting in increasing costs for the government. Since 2001, however, taxes from cigarettes and alcohol have enabled the establishment of a Fund that is playing a significant role in the promotion of health for all Thai citizens. It is therefore a very interesting innovation which has transformed society.

The Thai Health Promotion Foundation (ThaiHealth) was established by virtue of the Thai Health Promotion Foundation Act, B.E. 2544 (2001). It is a state agency which is not part of the bureaucratic system but is under the supervision of the Prime Minister. It commenced operations in April 2001 (in the form of a public organisation until November 2001)[1]. The responsibilities of ThaiHealth are to advocate, stimulate, support and provide funding to various organisations in society for health promotion activities, with a view to reducing infirmity and premature death rates. ThaiHealth aims to trigger a change in behavioural patterns and beliefs as well as in our living environment in such a way that is conducive to a better quality of life. Its main source of funding comes from a two percent levy imposed on alcohol and cigarette taxes.

ThaiHealth is a new policy phenomenon that is quite extraordinary in the following dimensions :

- the birth of ThaiHealth as an independent organisation with annual revenues of over one thousand million baht per year.

---

[1] The Thai Health Promotion Office was established by Royal Decree on 1 July 2000. It transferred its activities to the Thai Health Promotion Foundation after the enactment of the Thai Health Promotion Foundation Act, B.E. 2544 (2001).

- the delegation to ThaiHealth of responsibilities which may duplicate and overlap with those of other state agencies.
- alcohol and tobacco are two very influential businesses with a great deal of vested interests. They have the potential and clout to oppose any changes that may impact upon their business interests.

When all of these different dimensions are taken into consideration, the chances are extremely high that opposition to an organisation such as ThaiHealth would be so formidable that it had no hope of coming into existence. In this respect, ThaiHealth is a policy by-product that does not occur very often in Thai society. This research work will demonstrate that although an element of luck was involved, ThaiHealth was by no means an accident, but is rather an interesting example of the process in which knowledge is transformed into policy.

1.1 Sin Taxes-the Path towards a Health Promotion Foundation

When one considers the idea of coupling sin taxes (alcohol and cigarette taxes) with health promotion foundations, such as presently epitomised by the establishment of ThaiHealth, the question that comes to mind is whether it is necessary for sin taxes and health promotion foundations to be one and the same. What is it that makes them the two sides of the same coin?

Sin taxes or sumptuary taxes are a kind of tax levied against certain goods or services that are considered hazardous or detrimental to the public's health or morals. They may also be levied against goods or services that impact upon society as a whole.[2] Some of the goods on which most countries impose sin taxes are alcohol, tobacco, and playing cards since excessive consumption of such products is not only detrimental to one's self, but also incurs additional budgetary expenses for the government in solving the ensuing problems. In effect, they create an additional cost for

[2] Supavadee Thirapanish and Sasithorn Kitsawangrat, "Sin Taxes and the Health Promotion Fund" Kan Ngern Kan Klang Magazine, Vol. 15 Edition 48, April 2001, p. 11.

society. Therefore, taxes are imposed against these goods in order to regulate their consumption and create additional revenues for the State.

In Thailand, sin taxes are collected in the cases of alcohol, tobacco, playing cards, and opium (sales of which have been prohibited since 1959). Sin taxes are not levied against the Government Lottery Office although a portion of its revenues must be set aside for the Treasury and another portion is donated directly for charitable purposes and the benefit of society as a whole.

In Thailand, the sin taxes levied against cigarettes are mainly aimed at raising revenues for the State. The campaign to increase cigarette taxes in this country has evolved from the campaign to control and lower the smoking rate among the Thai public. Such campaign has arisen in close conjunction with calls to protect the rights of non-smokers. It is a health issue that has attracted the interest of policy makers and the general public for a long period of time. Interest in this matter has recently picked up, however, due to the efforts of one of the superpowers to force Thailand to liberalise and open up her cigarette market (Section 301 of the U.S. Trade Act). This led to a social tide against cigarettes which took the form of a wide range of measures.

Health promotion foundations do not necessarily always have to be linked with sin taxes. Actually, in the greater context, health promotion foundations arose from the need to have some kind of organisation to assume direct responsibility for health promotion in accordance with the philosophy and approaches of health promotion, namely, by emphasising "building rather than repairing". Such an approach was widely publicised with the declaration of the Ottawa Charter for Health Promotion in 1986.

Ever since Thailand embraced the concept of health promotion, some debate has arisen from time to time about the structure, role, duties, etc. of such an organisation. However, any consideration or debate about this matter remained narrow in scope and at a preliminary stage. This may be due to the fact that there were no external circumstances pressing in this direction. There was no serious process for transforming the concept into concrete actions. This all changed, however, when the anti-smoking,

pro-sin tax campaign reached the point in which there was a change of strategy to realign such campaign with health promotion as a whole.

The path of sin taxes proceeded to a juncture in which serious steps were taken to establish a health promotion foundation around 1995-1996. Before we proceed further, however, let us reach an understanding about the greater context of both issues by examining the development of the campaign to control tobacco consumption in Thailand.

1.2 The Campaign to Control Tobacco Consumption in Thailand

The campaign to control tobacco consumption in Thailand over the past four decades can be divided into four periods:[3]

The Evolution of Efforts to Control Tobacco Consumption in Thailand

Period	
1st Period -	Prior to 1957 until 1986: "the Beginning". Each side went its own way, without any coordination or continuity of action.
2nd Period -	1986 to 1989: "Setting the Direction for Society". There started to be some coordination and establishment of organisations as well as networking and promotion of social activities.
3rd Period -	1989 to 1991: "An Empowered Society". The Thai cigarette market is forced to open up to the foreign tobacco industry.
4th Period -	1991 to 1996: "Towards a Policy". The start of an offensive through the use of legal and tax measures.

[3] Choochai Supawongse, Supakorn Buasai and Jitsiri Thanapatra, Wiwattanakan khong kan khuab khum kan boripok yasoob nai prathet thai, (The Evolution of Tobacco Consumption Control in Thailand), Research Paper submitted to the Institute for Research on Public Health Systems, 1998.

The third period and part of the fourth were a time in which the movement had to first be on the defensive in order to push public policies and change in an expeditious manner. Activities concerning a sin tax and a health promotion foundation took place during the fourth period, but they were a result of the rigorous drive from the third period.

1.3 A Ready Made Formula for Transforming Knowledge to Policy : Advocates, Organisations, Knowledge, Opportunity and Policy Context

- Advocates may consist of individuals or groups of individuals with a common goal to push for change in the same or corresponding direction.
- Organisations, in the most narrow sense of the word, refer to units that manage resources and networking on a continual basis.
- Knowledge may be used as an indicator for leading the direction of change, or may be used to support the direction of change which has already been determined (by the leading advocates). This knowledge includes the substance of the changes and the tactics to be used for achieving such change.
- Opportunity and Policy Context play an important part in determining what kind of role the leading advocates, organisations and knowledge will play, as well as the degree of success they will have in pushing the policy forward.

This paper will first provide an account of the leading advocates and organisations that pushed for change. It will then describe the process of knowledge building, the opportunities and policy context for change to occur, as well as the efforts to push the policy proposals in two periods: 1993-1997 and 1998-2001.

2. KEY ADVOCATES AND CATALYSTS FOR CHANGE

ThaiHealth is a case in point in which certain key advocates, or catalysts, played a very prominent role in initiating and pushing for change. They played a part in building knowledge through their own research as well as through their support for other academics to pursue research on related issues. At the same time, they also directly pushed the policy proposals from the beginning of the process until its completion.

The key advocates thus played a role in building knowledge, managing the knowledge process, and utilising the knowledge all at the same time. This led to a phenomenon of **"Building Knowledge for Use and Using the Knowledge that has been Built", which, in turn, led to the highly efficient process of transforming knowledge into policy.**

All of the leading advocates occupied high posts within the bureaucracy. As a result, they were well acquainted with the policy process, were well aware of the policy opportunities, and were in positions in which they could pursue their activities effectively within the policy process. **They coordinated their efforts at the international level,** which enabled them to seek cooperation in every form, whether knowledge, funds or a constant base of international support. They were also interested in seeking, receiving and adapting knowledge acquired from overseas in order to continually support their push for change.

Another strength lay in the fact that **the leading advocates collaborated together as a small group. All of them worked in the same circles** so they were always able to coordinate with one another and reach agreement in an expeditious manner. However, in their activities to push forward their policies, they were also able to rely on the network of the anti-tobacco movement, which had a very broad social base that had been continually expanding for a long time.

Professor Dr. Prakit Vathesatogkit, M.D., and Dr. Supakorn Buasai, M.D., were two key advocates, or catalysts, with the most prominent role in the movement. It could perhaps be said that, without the two men, there was a great possibility that ThaiHealth could not have come into existence, or its birth could have been significantly delayed.

Professor Dr. Prakit Vathesatogkit was a renowned physician specialising in pulmonary diseases at the Faculty of Medicine, Ramathibodi Hospital. He began campaigning against smoking around 1982, and in 1986 he established the Thai Anti-Smoking Campaign Project (TASCP) of the *Moh-Chao-Ban* (Folk Doctor) Foundation. He collaborated with **Ms. Bung-On Ritthipakdee** in the drive for a sin tax against cigarettes and a health promotion organisation. He also played a leading role in campaigning against the liberalisation and opening up of the Thai cigarette market under Section 301. This enabled him to expand his networking with other anti-tobacco groups at the global level. As a result, he was able to learn more about campaign tactics, innovative ideas, and examples of success from other countries, all of which served as a very important knowledge base for his subsequent activities. In this case, Dr. Prakit played a very outstanding role in the policy process, opening the window of opportunity and constantly turning the situation around in the direction of success.

Meanwhile, **Dr. Supakorn Buasai** was studying for his doctoral degree in Public Health Planning at the University of Hawaii. He started to take an interest in, and to campaign against, Section 301 as well as the liberalisation of the Thai cigarette market in 1989. His activities brought him into contact and collaboration with Dr. Prakit. Even though their activities at that time were not successful, such activities nevertheless provided an opportunity for the two key advocates to meet and work together, which they have been doing ever since. Upon returning home from the United States, Dr. Supakorn took up a position at the Policy and Planning Division of the Office of the Permanent Secretary for Public Health, while also assisting in the work of the Tobacco Control Institute up until his appointment as Deputy Director of the Health Systems Research Institute at the end of 1992. All the time that he was working in various offices, Dr. Supakorn maintained his interest in sin taxes and the idea of a

health promotion foundation. When ThaiHealth was finally established, he became the foundation's first Manager.

Another person who played a very significant role as an "adviser" or "guru" was **Professor Dr. Prawase Wasi, M.D.,** who sparked off the anti-tobacco movement after he came back from attending an international conference organised by the World Health Organisation in 1975-76. The conference highlighted the fact that cigarette smoking was the main cause of death for the world's population, and that the death rate would peak at the turn of the century. At that time, there was no awareness in Thailand of this problem and no attempt to deal with it. Therefore, Professor Prawase joined hands with **Professor Dr. Athasit Vejjajiva, M.D.,** to initiate a collaborative undertaking between the Faculty of Medicine of Ramathibodi Hospital and the *Moh-Chao-Ban* Foundation. They established a special project under the responsibility of **Dr. Paiboon Suriyawongpaisal, M.D.** This marked the first step towards the establishment of an anti-smoking campaign. Ever since, the two doctors have continued to provide constant advice and support to the movement.

Professor Dr. Vitoon Ungpraphan, M.D., of the Project for the Promotion of Legal Research, Mahidol University, had a hand in drafting the relevant legislation.

Other key members of the coalition who played significant roles in supporting the process were **Dr. Sanguan Nittayarumphong, M.D., Dr. Choochai Supawongse, M.D., and Dr. Hatai Chitanondh, M.D.** The three men had pushed for tobacco control for such a long time that they were dubbed "the Cigarette Godfathers". These individuals were all high-ranking officials of the Ministry of Public Health at that time.

3. ORGANISATIONS

The outstanding feature of this case lies in the fact that the leading advocates of the anti-smoking movement in Thailand were able to **gain benefit from, or make use of, existing institutions and organisations.** This enabled them to carry out their activities more easily and sustainably, and to a broader and greater extent. With an organisation, there also come a mandate and duties, funding and a team of workers as well as a forum and opportunities to push ideas forward and take action to realise policy proposals.

The most important thing is that such institutions and organisations help to elevate the level of personal or group interests and ideas, turning them into public issues. As a result, the campaign becomes clearer and more tangible. Accordingly, support can be mobilised from other groups which might otherwise not have been interested in or supported the activities in the absence of such organisations.

The period 1986-1992 was a time in which many important institutional developments took place, namely the establishment of the Anti-Smoking Campaign Project of the Moh-Chao-Ban Foundation, the Office of Tobacco Consumption Control (OTCC), and the Health Systems Research Institute (HSRI).

3.1 The Thai Anti-Smoking Campaign Project of the Moh-Chao-Ban Foundation

The "Thai Anti-Smoking Campaign Project of the *Moh-Chao-Ban* Foundation" (later to become the Action on Smoking and Health Foundation of Thailand) was established in 1986 with **Dr. Prawase** as Chairman, **Dr. Athasit** as Vice Chairman, **Dr. Prakit** as Executive Secretary, and **Ms. Bung-On** as a key member. The Project coordinated the networking among

the various organisations and groups that were interested in the issue, which resulted in a wide range of diverse activities.

One activity that is said to have constituted a major turning point for Thai society occurred in October 1987 when the Anti-Smoking Campaign Project joined with the Rural Doctors Society of Thailand in coordinating efforts for 250 community doctors and nurses from all over the country to participate in a 7-day run originating from all 4 regions of the country. The destination and finish-line was at the Bangkok Metropolitan Administration City Hall, a distance of over 3,000 kilometres. The objective of this campaign was to demand the rights of non-smokers. Along the route of the run, over 6 million people signed a petition supporting this cause. This marked the first and largest nation-wide health campaign.

3.2 The National Tobacco Consumption Control Board (NTCCB) and the Office for Tobacco Consumption Control (OTCC)

As a result of the campaign opposing the liberalisation of the Thai cigarette market, the Government of General Chatichai Choonhavan agreed to enact a law controlling tobacco consumption. This was aimed at alleviating societal opposition and improving the Government's image following the decision to open up the cigarette market in the face of foreign pressure (Section 301 of the U.S. Trade Act). This law was the Tobacco Products Control Act, B.E. 2535 (1992), whose main thrust was a ban on advertising and sales promotion of all tobacco products.

In 1989, when the Government had already agreed in principle to such a legislation and efforts were underway to draft the law, the National Tobacco Consumption Control Board (NTCCB) was established. Its duties included laying down policies and operational guidelines, coordinating, overseeing and evaluating. The first Chairman of the Board was Mr. Chuan Leekpai, the then Minister of Public Health. **Dr. Hatai Chitanondh,** Deputy Director-General of the Department of Medical Services, who had written the memo proposing the establishment of such a Board, was appointed a Member and Executive Secretary. Subsequently, in 1990, approval was granted for the establishment of the Office of Tobacco Consumption

Control (OTCC) as part of the Health Planning Division of the Office of the Permanent Secretary for Public Health. The OTCC served as the Secretariat of the NTCCB and was the focal point for all kinds of information, rules and regulations regarding tobacco consumption. It also was involved in analysing, planning and disseminating both knowledge and understanding aimed at reducing the smoking rate.

The establishment of the OTCC created an agency with a mandate involving resource and personnel policy that could pursue work on this issue on a continual basis. Although the OTCC had its limitations since it was established as a government agency, this was nevertheless the first time that an organisation with such responsibilities had been created. During the first year of its operations in 1990-1991, the OTCC was allocated a budget of 32 million baht. When the Non-Smoker's Health Protection Act was enacted in 1992, the OTCC was charged with carrying out the work in accordance with the aims of the Act.

In 1993-94, the OTCC was transferred from the Office of the Permanent Secretary for Public Health, which is a policy-making organ, to the Department of Medical Services. This move, and the change of supervisors, transformed the OTCC's work from one that was policy-oriented towards one that was more inclined towards public relations. This reduced the OTCC's role in driving change at a later stage.

3.3 Health Systems Research Institute (HSRI)

Since 1992, one organisation that has played a significant role in driving forward the anti-smoking campaign is the Health Systems Research Institute.

HSRI was established in accordance with the Health Systems Research Institute Act, B.E. 2535 (1992). It has the status of a juristic person and responsibilities for studying and researching the body of knowledge with a view to developing and transforming national health in a systematic manner in line with the country's socio-economic conditions. During the first four years of its operations (1993-1996) under the management of **Dr. Somsak Chunharas, M.D.,** HSRI utilised a budget of

162.3 million baht to create and promote research work that would be beneficial to policy-making. Later on, under the leadership of **Dr. Wiput Phoolcharoen, M.D.,** HSRI was allocated a budget of approximately 70 million baht a year. It continued to expand its role in reforming the country's health system and promoting national health as well as in supporting the establishment of ThaiHealth.

Issues such as cigarettes, sin taxes and a health promotion organisation were not the main subjects of HSRI's work plan and achievements during the first four years. This is apparent from the fact that research work on these issues accounted for only a small proportion of HSRI's total work. Nevertheless, after only 1-2 years of its establishment, HSRI became the most important source of knowledge building and primary centre for the campaign in favour of sin taxes and a health promotion foundation.

One main cause contributing to this success was the appointment of **Dr. Supakorn** as the Deputy Director of HSRI. In addition, such success can also be explained in two other ways. First, HSRI was highly efficient in managing knowledge, especially in terms of transforming knowledge into policy. Second, Thai society at that time suffered from a great gap of knowledge in this matter. Therefore, even a newly established organisation such as HSRI was able to become the centre of knowledge on this issue after only a few pieces of research work.

4. KNOWLEDGE BUILDING, OPPORTUNITY, AND POLICY CONTEXT : POLICY PROMOTION DURING **THE FIRST PERIOD** (1993-1997)

For over three decades, the personnel in public health circles in Thailand had amassed a body of knowledge and launched a public relations campaign concerning the dangers of smoking. Such campaign was aimed at raising the awareness of the general public and urging the government sector to come up with measures to control and supervise the sale and consumption of cigarettes. This constituted an **"old package of knowledge"** which had gradually accumulated over the years.

The drive for the establishment of ThaiHealth did not rely solely on this old knowledge package. A **"new package of knowledge"** also played a significant role in this endeavour. Knowledge about sin taxes, fiscal laws and regulations, and the establishment of health promotion foundations elsewhere was borrowed, created, amassed, and utilised to successfully propel change.

Cigarettes-a Hazard to the Lives of the Thai People

Data from the HSRI* indicates that two-thirds of all Thai deaths come before the age of 70. Of this amount, most deaths occur from preventable causes, namely:

Smoking-related Diseases (Heart Disease, Lung Cancer Emphysema, Stroke, and other Vascular Diseases, etc.)	42,000 deaths/year
Accidents	34,000 deaths/year
Childbirth Complications and Infant Mortality	20-30,000 deaths/year
Cancer (excluding Lung Cancer)	16,000 deaths/year

Assault and Suicide	8,000 deaths/year
Tuberculosis	3,500 deaths/year
HIV/AIDS	31,000 deaths/year

* Compiled from the estimation of Professor Dr. Prakit Vathesatogkit, Health Systems Research Institute of Thailand; Mahidol University Population Institute; and 1993 public health statistics from the Division of Epidemiology, Ministry of Public Health.

4.1 Referring to and Utilising the Knowledge of the World Bank

The annual report of the World Bank, entitled the **World Development Report (WDR) 1993,** highlighted the topic of "Investing in Health". This report was translated and edited by Dr. Hatai Chitanondh, and published in the Journal of the Health Systems Research Institute Vol. 2, No. 3 (July-September 1994). It provided an opportunity for the leading anti-smoking advocates and organisations working on this issue to capitalise on the debate sparked by this influential international organisation.

The WDR 1993 demonstrated the necessity of **applying the economic approach of cost-effectiveness to health issues,** particularly cigarettes, which is clearly a public policy area to which the government sector must pay attention. Accordingly, the World Bank changed its lending policy in 1992 by refraining from providing credits to countries that sought to use the loans for any kind of investment in tobacco, whether planting, exporting or other activities concerned.

World Bank Study (1993)
The Economic Burden of the Global Trade in Tobacco

- 1,000 tons of tobacco causes 650 deaths, yielding a profit of 65 million baht for the producer and an economic loss of 745 million baht. This represents a net loss of 680 million baht.
- At the time of the study, world tobacco production totalled 7.3 million tons per year, which amounts to an economic loss of 5 million million baht per year. The World Bank concludes that investing in measures to prevent tobacco addiction is the most cost-effective way to cure the people's smoking-related illnesses.
- In developing countries with an average annual per capita income of less than 50,000 baht per person, an annual expenditure of only 500-1,000 baht per person towards an anti-smoking campaign will be beneficial in deterring the public from smoking or persuading them to quit smoking before they fall ill.
- However, after they have already become ill, doctors are able to extend the lives of only 10 percent of the patients, requiring annual expenditures of 450,000 baht per person.

The WDR 1993 received widespread interest among the global community. In Thailand, it was frequently cited in documents and academic conferences. Therefore, the Report must surely have played a role, to some extent, in underscoring and supporting the concept of health promotion among policy-makers and bureaucrats, both within and outside public health circles.

In addition to using the WDR 1993 as a reference source, Thai public health technocrats also utilised economic principles in studying about tobacco issues in order to compare the pros and cons of the tobacco industry. These efforts served to create a new knowledge package directly concerning the campaign for sin taxes.

4.2 Knowledge and Support from the World Health Organisation

During the period between the proclamation of the Ottawa Charter for Health Promotion in 1986 until the year 1997, the World Health Organisation (WHO) attempted to ignite the health promotion movement. Towards this end, the WHO organised a total of four international conferences on health promotion. These conferences were attended by the leading advocates in Thailand, which enabled them to acquire much knowledge and experience for use within the Thai context.

As part of the anti-smoking coalition, and as a global organisation advocating health promotion, the WHO rendered support to, and cooperated closely with, the key players in Thailand. Such cooperation took many different forms, including providing support for building a knowledge package, offering ideas and data, providing opportunities for study tours, organising international conferences, and meeting with Thai policy-makers to present and advocate the demands of the key players in Thailand. Such cooperation took place throughout the campaign as evidenced by the following cases.

4.3 Knowledge about Sin Taxes and the 1993 Campaign for a Tax Increase for Health

This heading refers to knowledge concerning sin taxes (tobacco excise tax stamps), fiscal policy regarding cigarette taxes, and estimation of the fiscal impact of fixing the cigarette tax at various levels. Actually, the public health technocrats have always been keen to see the State utilise pricing policies through the increase of excise taxes in order to control and lower the number of smokers. This is based on the assumption that increasing the price of cigarettes would decrease the rate of smoking. Such an assumption, however, has not been verified through systematic research in Thailand. Therefore, no comprehensive answers could be given to the following questions :

If excise taxes were increased at the rate of A, B, or C,

- what impact would this have on cigarette consumption?
- how would it change the pattern of cigarette consumption among various groups?
- would it cause an increase or decrease in the State's expenditures for medication and treatment, and to what extent?
- how much taxes would the State be able to collect?
- what impact would this have on the cigarette and tobacco industry?

In early 1993, Dr. Supakorn received advice from Neil Collishaw of the World Health Organisation regarding how to calculate government revenues from an increase in cigarette taxes.[4] He then undertook a study on the "Demand Analysis of Aggregate Cigarette Consumption in Thailand, 1976-1981", which would be used to push for an increase in the cigarette tax.

Study on "Demand Analysis of Aggregate Cigarette Consumption in Thailand, 1976-1981" by Dr. Supakorn Buasai, M.D. (1993)

Dr. Supakorn employed a loglinear model to calculate that the elasticity of demand to price and income among the Thai population was -0.666 and -0.359, respectively. That is to say, if cigarette prices were increased by 10 percent, the volume of consumption would then decline by approximately 7 percent.

Dr. Supakorn concluded that increasing cigarette taxes is an essential measure to curb the increase of smoking. Lessons learned from other countries showed that no country had managed to slow down the rate of smoking without utilising tax measures. Moreover, it was found that as long as cigarette prices remained low, any other measures would be ineffective.

Dr. Supakorn proposed that the Government should increase the cigarette tax from 55 percent of the retail price to between 61-63 percent. This would result in the following:[5]

- cigarettes prices would rise by 2-3 baht per pack.
- sales of cigarettes would not decline below the 1992 level of 1,983 million packs.

---

[4] Neil Collishaw, "Potential Health Benefits of a 10% Increase in the Real Price of Tobacco through Taxation in Thailand", 1993 press release, cited in Prakit Vathesatogkit, "Seeking Success: Thai Tobacco Control", October 2002 (draft).

[5] Data from "Supporting Document for the Consideration of an Increase in the Cigarette Tax: an Essential Measure for Protecting Additional Children and Youth from Becoming Addicted to Cigarettes". Supporting Document for Consideration by the Cabinet regarding an Increase in the Excise Tax of Cigarettes, November 1993, printed in the Journal on Public Health Research, Vol. 2, No. 1, January-March 1994.

- the number of youth smokers (aged 10-24, accounting for the largest group of new smokers) would decline by 160,000 from the level of 2,450,000.
- the Government's revenues would increase by 4,000-5,000 million baht per annum.
- since there would be no decline in cigarette sales, the Thailand Tobacco Monopoly and Thai tobacco growers would face no loss of income, especially since the Thailand Tobacco Monopoly, at that time, was unable to keep up with the market's demand for cigarettes anyway.

Furthermore, the study also demonstrated that:

- the level of excise taxes for cigarettes in Thailand was fairly low (55 percent) when compared with other civilised countries (approximately 60-85 percent).
- since 1976, the real price of cigarettes (adjusted by the consumer price index) had not increased, but rather had declined by 23 percent, while the real income of the Thai people had risen by 151 percent.
- since the price of cigarettes had not been adjusted in line with the increased per capital income, this was a major reason why the prevalence of smoking had rapidly increased.

Dr. Supakorn also argued that the experiences of other countries confirmed that the most effective means of using tax increases to curb the number of new smokers is to raise taxes by small increments but to also do so frequently and continually. The most prominent foreign example is the case of Canada, which had continually increased its cigarette tax until the level was very high. This had a clear impact in controlling and decreasing the rate of smoking in Canada.

Dr. Supakorn presented the findings of his study to **Dr. Arthit Ouirairat**, Minister of Public Health, to push for an increase in the cigarette tax. At the same time, Dr. Prakit invited **Dr. Judith Mackay**, an adviser to the World Health Organisation, to join him in paying a call on Dr. Arthit in order to present the results of the calculations. These were based on the epidemiology statistics of the WHO, and estimated that, in the absence of an efficient and strong campaign, by the year 2025 the number of smokers in Thailand would increase from the 10.4 million people at that time to 13 million, with a smaller number of male smokers and a larger number of female smokers.

With supporting data from both Thai and foreign sources concerning the positive effects on both public health and the Government's fiscal and budgetary position, coupled with social pressure from the continued public campaign against cigarettes arising from the Section 301 case in 1989, the Chuan Leekpai Government, with the support of Dr. Arthit, decided to increase the cigarette tax from 55 percent to 60 percent on 7 December 1993. The Government also instructed the Ministry of Finance to increase the excise tax on cigarettes periodically in accordance with the inflation rate. The drive for an increased cigarette tax was therefore successful within a period of less than one year since Dr. Supakorn initiated his pioneering study on this matter.

It must be noted that before the matter was submitted for Cabinet consideration, the Anti-Smoking Campaign Project of the *Moh-Chao-Ban* Foundation requested Dr. Paiboon to conduct a telephone survey of 1,000 Bangkok residents, with 70 percent of respondents approving of the tax increase. The results of the survey were released to the media in order to generate further public support.

That rise in the cigarette excise tax marked the first time that cigarette taxes had been increased for health purposes. (Other cigarette tax increases in the past were prompted by the Government's desire to create greater revenue.) The tax increase was genuinely brought about through the efforts of the key players in the anti-smoking movement since the Government at the time had no fiscal necessity to raise taxes.

In 1994, state revenues from cigarette taxes rose from 15,000 million baht to 20,000 million baht, an increase of 5,000 million baht. In

comparison, the increase in revenues from cigarette taxes had never exceeded 500 million baht in previous years. Since then, the excise tax on cigarettes has now been increased another 6 times until it now stands at 75 percent of the retail price of cigarettes. In sum, the Government was able to collect over 1,000 million U.S. dollars in additional revenues from the cigarette tax increase, while the smoking rate declined from 26.3 percent in 1992 to 20.5 percent in 1999.[6]

...This marked the first victorious round in the campaign for a sin tax policy. The next step was finding a way to use the revenues from the increased cigarette tax in order to promote better health. At that time, the leading advocates still did not have any clear ideas or directions on this matter.

4.4 Additional Knowledge about Sin Taxes

After the cigarette tax increase in 1993, HSRI continued to promote the dissemination of additional knowledge about sin taxes, especially regarding the impact of smoking on one's health.

A research work by **Dr. Isra Sarntisart** of the Centre on Public Health Economics, Faculty of Economics, Chulalongkorn University, entitled "The Impact of a Change in the Excise Tax for Cigarettes", was completed in July 1995 and found that an increase in cigarette taxes had many effects.

Research Work on "the Impact of a Change in the Excise Tax for Cigarettes" by Dr. Isra Sarntisart (1995)

Dr. Isra employed a consumer theory to analyse the price elasticity of product demand in four categories, namely food and non-alcoholic beverages, alcoholic beverages, tobacco products, and other goods. A Linear Expenditure System (LES) model was used since it had been demonstrated that such a model was best suited for explaining the behaviour of Thai consumers.

[6] Prakit, "Seeking Success: Thai Tobacco Control", October 2002 (draft).

This research work arose from the concern that the prices of narcotic substances tended to rise more slowly in comparison with the prices of consumer products in general. During the past two decades, the proportion of household expenditures for tobacco products declined from 3.4 percent to only 2 percent. This may have caused the population to consume more narcotic substances.

The study found that the price elasticity of demand for narcotic substances over the long term was -0.0926, which is very low. This finding corresponds with the conclusion of Dr. Supakorn's study, which found that the use of price mechanisms by means of adjusting the excise tax rate, or the rate of other taxes, would cause the level of smoking to decline in the short term only. In the long term, however, consumers will return to smoking at their usual level due to their addiction. Moreover, if price policy is not utilised on a continual basis, this may simply result in a reduction in the real income of consumers.

Dr. Isra also pointed out that an increase in the excise tax for cigarettes will result in greater excise revenue collection for the State even though it may cause some consumers to purchase contraband cigarettes instead. However, this would occur at only a small level. For this reason, the continued impact on employment as well as on the tobacco growing and tobacco product sectors would not be severe.

Nevertheless, Dr. Isra concluded that the use of pricing policy alone should not be sufficient in preventing and controlling the number of new smokers (children and youth) as commonly believed. The most effective means should be to wage a campaign and educate the public on the dangers of smoking. At the same time, steps must be taken to ensure that the Tobacco Products Control Act, B.E. 2535 (1992) (stipulating that smokers must be no younger than 18 years of age) must be strictly enforced.

In sum, the findings of Dr. Isra's study supported the study conducted by Dr. Supakorn in the following matters:

- an increase in the cigarette tax would result in increased revenues for the Government.

- an increase in the cigarette tax would not have any impact on the tobacco industry and cigarette business.
- only the use of pricing policies (through taxes) on a continual manner would have any chance of success in controlling smoking.

However, the conclusions of this piece of work differed from those of Dr. Supakorn in two key areas:

- Narcotic substances, including cigarettes, were found to have a very low price elasticity of demand over the long term, equal to -0.0926. This can be compared to Dr. Supakorn's study, which found that the price elasticity of demand over the short term was -0.666.
- Increasing the price of cigarettes (through higher taxes) was not expected to deter new smokers (children and youth) as commonly believed.[7] A more effective means would be to launch a campaign to make the public aware of the dangers of smoking. At the same time, there must be strict enforcement of the Tobacco Products Control Act, B.E. 2535 (1992), stipulating that smokers must be no younger than 18 years of age.

If this were simply a case of building knowledge for knowledge's sake, then the differing conclusions of the two studies would probably be the subject of much debate, presentation and further study. However, the fact that there was no additional study to seek clarification on these conflicting points demonstrates the inclination of all parties concerned, who were merely interested in utilising and publicising only those research findings that would benefit their campaign. This could therefore be considered a case of "discarding knowledge for the sake of righteousness".

Another piece of research work, employing economic principles and undertaken with the support of HSRI, is entitled "The Economics of

[7] Australian Council on Smoking and Health et al. Tobacco Taxes: A Case for Action, a Submission to the Australian Federal Government, May 1992, cited by Dr. Isra.

Cigarettes and Cigarette Tax Rates" by Dr. Suchada Tungthangthum of the Economics Department at Sukhothai Thammathirat University. This work reinforced the legitimacy of increasing cigarette taxes and maintaining pressure for a continual increase in cigarette taxes.

Findings from the Study on "The Economic Losses Caused by Cigarettes" by Dr. Suchada Tungthangthum (1998)

The Government earns revenues from the tobacco industry to the tune of over 20,000 million baht per year, or around 3-4 percent of its total revenues. However, the Government has to use up a budget of no less than 7,000 million baht each year on medical expenses to treat over 40,000 patients with smoking-related illnesses. It also has to spend over 2,300 million baht of foreign exchange to import foreign tobacco and other products related to cigarettes.

Moreover, there is also an incalculable amount of damage caused by smoking-related fires as well as harm inflicted upon the environment and eco-system owing to the use of forest land to grow tobacco and to cure tobacco leaves (50,000 square metres per year). Therefore, in order to achieve a policy balance, Dr. Suchada recommends that the State increase the excise tax on cigarettes.

4.5 Knowledge about an Earmarked Tax and the Establishment of a Health Promotion Foundation

The linkage between an **earmarked tax**, or **dedicated tax**, and the establishment of a health promotion foundation is a novel approach in Thai society. In this case, the most significant "package of knowledge" on this matter involves the **Victorian Health Promotion Foundation, or VicHealth**, from Australia.

Dr. Prakit had learned about VicHealth ever since it was first established in 1987 through his discussions with **Nigel Grey**, an Australian anti-tobacco advocate, at an international conference on cigarettes. However, he did not have much of an opportunity to learn any experiences

on this matter. Subsequently, the World Health Organisation (WHO) commended VicHealth as a pioneering organisation and a model for other member countries to study and adapt for use. During the campaign against Section 301 of the U.S. Trade Act, the "Thai Anti-Smoking Campaign Project of the Moh-Chao-Ban Foundation" also used the example of VicHealth to recommend that the Government earmark one percent of the revenues from the tobacco tax for use in the anti-smoking campaign. The Ministry of Finance, however, did not agree with the idea and saw the proposed cigarette tax increase and the anti-smoking campaign as two separate issues. The Ministry believed that such a campaign should rely on government funds, yet it did not allocate a budget for this purpose.

The first serious step in building knowledge in this matter took place when **Dr. Supakorn met with Rhonda Galbally**, the Director of VicHealth, at an international conference in 1994. Only a short while thereafter, namely from mid-1995 to mid-1996, efforts were undertaken to study and learn about the structure of both VicHealth and the Health Sponsorship Council (HSC) of New Zealand. This was aimed at paving the way to push for the establishment of a health promotion foundation.

- In July 1995, **Dr. Supakorn Buasai**, Deputy Director of HSRI, and **Ms. Bung-On Ritthipakdee**, representative of the "Thai Anti-Smoking Campaign Project of the *Moh-Chao-Ban* Foundation", were invited to visit VicHealth.
- In August 1996, the WHO provided a grant to Dr. Kaemthong Indaratna from the Health Economics Centre, Faculty of Economics, Chulalongkorn University, along with representatives of the Thai mass media, to undertake a study tour about health promotion foundations at VicHealth.

This study tour further reinforced the conviction among Thailand's key anti-smoking advocates that VicHealth was the appropriate model to follow, especially when compared to HSC, which did not directly link the earmarked tax with the establishment of a health promotion foundation. The two issues were only indirectly connected by the Government's allocation of a budget for this purpose. Moreover, HSC's work covered only certain areas of health promotion.

The Health Sponsorship Council (HSC) of New Zealand

HSC does not have the responsibility to provide funding to other organisations as in the case of VicHealth but rather to be a national service provider. Its main duty is to provide sponsorship for sporting and cultural events that formerly were sponsored by the cigarette industry. HSC also produces commercials and advertisements aimed at disseminating knowledge and creating values regarding health promotion. In addition to HSC, there were also other organisations that had similar responsibilities in various areas.

HSC had 3 main "social-marketing" programs in the form of "health brands", which focus on major health problems at the national level. First, a "SmokeFree" campaign against smoking. Second, a "StreetSkills" campaign to lower traffic accidents. Third, a "SunSmart" campaign against skin cancer caused by the sun. In 1996, HSC was awarded a "service agreement" and budget from the state totalling 8 million dollars.

This practice of buying and selling social services, arose from the bureaucratic reforms of the 1980s, which transformed the relationship between government agencies as well as between the public and private sectors to one of buying and selling services. In this regard, a government agency was assigned to oversee policy formulation and evaluation.

VicHealth*

The Victorian Health Promotion Foundation was established under the 1987 Tobacco Act by the State of Victoria, Australia. It is an independently-administered, quasi-governmental organisation with the following responsibilities: 1) provide funding for activities connected to the promotion of health, safety and illness prevention, 2) create community awareness concerning the importance of good health, 3) promote healthy lifestyles through community involvement, 4) provide research and development grants that support all of the above activities.

The Board of Governance of VicHealth consists of 14 prominent citizens who are specialists in their respective fields, namely 3 health

experts, 4 sports specialists, 2 telecommunications or legal experts, 1 art expert, 1 public relations specialist, and 3 members of the State Parliament. The State Minister appoints one person as Chairman and may appoint other specialists to serve on the advisory board on an ad hoc basis. VicHealth has an Executive Director with a staff of 37. In 1996, VicHealth provided support to a total of 305 projects. Each year, a budget of approximately 20 million dollars is used to support such projects, with administrative costs accounting for around 10-15 percent of the budget.

In addition to specifying the source of VicHealth's funding, the Tobacco Act also stipulated the manner in which such funding should be allocated, namely that no less than 30 percent of the health promotion tax should be spent on sports promotion, with at least another 30 percent to be expended on health promotion.

VicHealth's activities were a major factor in reducing the rate of many risky behaviours. It was expeditiously successful in decreasing accidents (by 35 percent since 1988). At present, every state in Australia (with the exception of New South Wales) has established a similar kind of organisation.

Dr. Kaemthong Indaratna conducted a case study of VicHealth and proposed an approach for prioritising the population groups that would receive funding support. Priority was given to indigenous people, rural communities, the impoverished, and the disabled. In this respect, VicHealth developed its own means of access to such groups through cultural activities as well as through promotion of greater participation by the community and campaign organisations who had specific goals.

---

* Kaemthong Indaratna. Victorian Health Promotion Foundation: A Model of Health Promotion. Centre for Health Economics, Faculty of Economics, Chulalongkorn University (undated).

VicHealth: Revenues

Since 1987, VicHealth has received annual funding from a health promotion tax as determined by the State Minister for Finance. However,

the total amount was not to exceed one-sixth of the cigarette license tax. The different states in Australia are unable to collect excise taxes since such taxes are already collected by the federal government. Therefore, they had to levy a cigarette license tax instead at the rate of 100 percent of the wholesale price. At this rate, the health promotion tax amounted to 5 percent of the wholesale price.

During the period 1988/1989 to 1995/1996, the health promotion tax amounted to between 22 to 29.7 million Australian dollars. This tax gradually declined in proportion when compared to the cigarette license tax, i.e. there was a decrease from 16.6 percent in the first year to only 3.8 percent in the last year. The main reason for this decrease is the fact that in 1992 a new government amended the law to decrease the health promotion tax to a level not to exceed one-fifteenth of the cigarette license tax (adjusted for inflation at the rate of 3% per year.

In addition to the case of VicHealth, Victoria also applied a dedicated tax in at least 3 other instances, namely a petroleum tax allocated to the Injury Prevention Fund, a forestry duty allocated to the Forest Conservation Fund, and a gambling tax allocated to the Community Development Fund.

Revenues are certainly a key issue, and the experience of VicHealth demonstrates the necessity of linking a dedicated tax with health promotion foundations as well as the need to "protect" such organisation's source of funding from the influence of politicians.

In the case of VicHealth, even though a dedicated tax was earmarked as the organisation's source of revenue, there was a "ceiling" imposed. It was stipulated that VicHealth's revenues from the dedicated tax would not exceed one-sixth of the cigarette license tax. It was then left to the discretion of the Public Health Minister to determine the amount of revenue within such boundaries. However, a mere 5 years later, there was another change of government. This new government then amended the law to reduce the proportion of the dedicated tax to a level not to exceed one-fifteenth of the cigarette license tax. The result of this amendment, and

the meddling of politicians, caused the "health promotion tax" gradually to decline in proportion even though the amount of money remained basically the same. This served as a lesson to the key anti-smoking advocates in Thailand about the risks of politician's interference in the affairs of the health promotion foundation.

In the legislative drafting process in Thailand many years later, there was a debate about whether the sin taxes to be used for health promotion should be a fixed percentage, or whether there should be a ceiling or minimum. This was an issue that was continually amended at different stages of the process. What was most interesting is that the person who played a key role in determining that there should be a fixed rate to prevent against meddling by the politicians was none other than a politician who held the post of Deputy Finance Minister at the time.

Research Paper on "A Review of Foreign Legislation on Health Promotion Funds" by Mr. Sira Boonphinon (1997)

This research paper covers the legislation dealing with health promotion funds in the states of Victoria and Western Australia in Australia, the state of California in the United States, as well as in New Zealand, Canada and Finland. It found that:

- There were two approaches to the establishment of health promotion foundations. In the first category, comprising the two Australian states, New Zealand and Finland, the establishment of such organisations was enacted as part of the tobacco control legislation. In the second category, consisting of California, this was stipulated in the tax legislation.
- Revenues for the funds may come from a cigarette tax, as in the case of Victoria, California and Canada, or from a budget allocated by the government, as in the case of New Zealand.

In addition, this research work also touched on 5 issues worthy of consideration:

- competent agency-this may be an existing agency with expanded duties, or a newly-established agency within the bureaucratic system, or a newly-established agency that is unaffiliated with the bureaucracy, which would create greater flexibility.
- legitimacy of using a cigarette tax for health promotion-why should cigarettes have to bear responsibility for other illnesses and the health of non-smokers?
- nature of enabling legislation-a tobacco products control law could not be used, as many countries had done, since the objectives were different.
- source of funding-no opinion was offered as to whether this should come from cigarette excise taxes or the government's budget.
- stipulating the fund's revenues as a fixed percentage - this was deemed inappropriate since it ran contrary to the principle of budget allocation. The amount of revenues entering the fund may be inappropriate, and may not be in line with economic conditions and spending each year.

In order to prepare for drafting a bill for the establishment of a health promotion foundation, the HSRI in collaboration with the Thailand Criminal Law Institute, Office of the Attorney-General, and with funding from the World Health Organisation, commissioned a research project in August 1996 to review foreign legislation concerning the establishment of health promotion foundations. The researcher was **Mr. Sira Boonphinon**, an attorney at the Thailand Criminal Law Institute, Office of the Attorney-General.

It should be noted that this research paper disagrees with the thinking of the key advocates in some crucial aspects of the health promotion foundation, namely the legitimacy of using a cigarette tax for health promotion in general and the issue of earmarking a fixed percentage of revenues for the fund.

The researcher's views on these issues were not widely debated or disseminated, nor did they have any impact on advancing the process. However, this research work provided a comparison of the organisational format and founding of health promotion foundations in various countries. It also offered some interesting observations regarding the establishment of a health promotion foundation in Thailand. Nevertheless, it was merely a research paper and not a draft legislation in itself.

In sum, the years 1995-1996 were a period in which the leading advocates were able to acquire and accumulate adequate knowledge concerning health promotion foundations along the lines of VicHealth, thus enabling them to formulate policy proposals and launch a serious campaign.

4.6 Opportunity and Policy Context : Pushing Forward the Proposal for the Establishment of a Health Promotion Foundation

1996 was a golden year for the movement to push for anti-smoking policy proposals at the upper level. The main reason for this was the favourable political context at the time. The government of Mr. Banharn Silpa-Archa had come to power on 13 July 1995 and had begun carrying out its campaign pledge to carry out "political reform".

On 19 October 1995, the Government appointed a **Policy Committee on Distributing Prosperity to the Provinces and Localities.** This was a highly active national committee, chaired by the Prime Minister. The Committee had continually carried out its activities since the government of General Prem Tinsulanonda although the Committee's name and scope of work have changed from time to time.

Dr. Surakiart Sathirathai, the Minister of Finance at that time, chaired the Subcommittee on Decentralisation of Power, which was one of the four subcommittees under the Policy Committee on Distributing Prosperity to the Provinces and Localities. He believed in the concept of **"financing for social development"**, namely employing fiscal and financial measures to support and promote the ties between business organisations and community organisations. Under this concept, community organisations would be strengthened in line with the policy to evenly distribute basic social services and create health insurance.

In the process of drafting the **"Fiscal and Financial Master Plan for Social Development"**, a number of consultative meetings were extensively held among the parties concerned from November 1995 to February 1996. This created an opening for the idea of a health promotion foundation to be advocated as one of the key measures of the Master Plan. In this connection, the Fiscal and Financial Master Plan for Social Development was approved by the Policy Committee on Distributing Prosperity to the Provinces and Localities. A **Committee for the Implementation of the Fiscal and Financial Master Plan for Social Development** was appointed under the chairmanship of M.R. Chatu Mongol Sonakul, Permanent Secretary for Finance, on 24 May 1996.

A close look at the essence of the Fiscal and Financial Master Plan for Social Development reveals that the thinking on this matter is far from clear-cut. The Master Plan contains elements of both a health promotion foundation and health insurance interspersed.

In any case, one can see that the political atmosphere during that period was highly conducive to the drive for a sin tax and health promotion foundation. The leading advocates therefore took advantage of the timing and seized this golden opportunity to grasp the issue by the horns and propel it forward in the intended direction.

The leading advocates pushed the issue at the highest level of the political spectrum. At the same time, they also opened a public debate on the issue, raising it with the various agencies and network organisations in order to forge understanding and mobilise support.

Fiscal and Financial Master Plan (1997-2001)*

The Master Plan contained 12 fiscal measures and 11 financial measures, which can be divided up in terms of goals as follows:

Goal 1: Empower Community Organisations

Fiscal Measures
- establish a Community Organisation Development Bank
- establish a National Cooperatives Bank
- disperse financial resources

Financial Measures
- provide tax incentives for the community to establish community organisations that will carry out the community's business activities
- provide tax incentives for private businesses and the general public to develop community organisations
- provide support to non-governmental organisations that help in empowering community organisations

Goal 2: Develop the Community Economy

Fiscal Measures
- provide credits for the development of vocations and community income
- disperse credits to the provinces and rural areas
- promote and support public and private fiscal institutions to participate in community development

Financial Measures
- provide tax incentives to business enterprises, with a view to encouraging them to join with community organisations in engaging in community business and industrial activities

Goal 3: Develop and Disperse Basic Social Services

Fiscal Measures
- fiscal measures for education
- fiscal measures for the development of skilled labour
- fiscal measures for housing
- fiscal measures for public utilities

Financial Measures
- a fund for educational loans
- establishment of a private health institution
- establishment of a health promotion and insurance fund
- decentralisation of local financial authority

Goal 4: Conserve and Revive Natural Resources and the Environment

Fiscal Measures
- fiscal measures to preserve natural resources and the environment
- establishment of a fund to alleviate the hardships of victims of natural disasters and other calamities

Financial Measures
- tax levied against polluters
- support for those who conserve the environment

Goal 5: Conserve and Maintain the Heritage of Local Culture and Virtues

Financial Measures
- establish a fund to promote local culture and virtues

* Fiscal and Financial Master Plan (undated), pp. 9-11.

Measures to Support the Establishment of a Private Health Institution*

Rationale : While the provision of health services has been dispersed to cover all rural and urban areas, there has also been an increase in health services offered by the private sector. Nevertheless, such services remain inadequate owing to budgetary limitations and a shortage of health personnel. For this reason, it is deemed appropriate to promote and support private institutions to share a greater responsibility in providing adequate health services to people in the communities. This would enable the problem to be swiftly alleviated. The role of the Government would be to provide support in the establishment of such private institutions. These institutions would be non-governmental agencies so the State would not have to involved in their management other than to provide sufficient financial support.

Principle: The State should support the establishment of private health institutions by acquiring or providing financial support for the operations of such institutions, enabling them to provide widespread health services in the communities. The people in the communities and community

organisations should oversee the work of such private health institutions. This would be a means of empowering community organisations without requiring the power of the state.

* Fiscal and Financial Master Plan (undated), page 25.

Measures for the Establishment of a Health Promotion and Insurance Fund*

Rationale : The provision of medical care during times of illness is considered one of the most important basic social services. This is particularly essential in the case of low-income earners and the disadvantaged in the communities since medical services and welfare provided by the State are not yet adequately distributed. With better health promotion and insurance, the people would be able to enjoy sufficient services.

Principle : A fund should be established to promote health among the general public as well as to provide medical welfare during times of illness. The fund's initial source of capital should come from the Government's budget. In the future, consideration may be given to the possibility of supporting the fund by levying a special tax on products that are detrimental to the public's health.

Support should also be given to the establishment of a health insurance scheme, which would be operated and supervised by the public and community. Such scheme may be divided into two categories: 1) a health insurance scheme for members of the public and communities who are capable of paying insurance premiums, and 2) a health insurance scheme for those who are incapable of paying insurance premiums. The community and the State should join together in providing support for the latter.

* Fiscal and Financial Master Plan (undated), pp. 25-26.

In February 1996, HSRI was scheduled to organise the first workshop on "Health Reform: a New Strategy for Developing the Health System". Although it was labelled a "workshop", the objective of this conference organised by HSRI was not to present research studies as was the practice of academic workshops in general. Rather, the aim was to use such a forum to advocate new policies and launch a campaign front geared towards both the politicians and the society.

Rhonda Galbally, the Director of VicHealth, participated in this workshop to give a presentation on the experiences of VicHealth. Not only did **M.R. Chatu Mongol Sonakul**, the Permanent Secretary for Finance, deliver the keynote speech at the workshop, but **Dr. Kaemthong** also arranged for **Dr. Prakit and Dr. Supakorn** to accompany Ms. Galbally for a call on both Finance Minister **Surakiart Sathirathai** and M.R. Chatu Mongol at the Ministry of Finance for discussions. Subsequently, Deputy Public Health Minister Thawatwong Na Chiangmai assigned HSRI to study the matter and develop a policy proposal.

In so doing, HSRI organised a conference on "The Establishment of an Organisation to Support and Develop Health Promotion" on 10 April 1996 at the Siam City Hotel, Bangkok in order to consider the "Thai Health Promotion Foundation Bill". The main issues considered at the conference were the nature, structure, responsibilities, role, and source of funding for such an organisation. This conference played an important part in pushing forward the thinking on this matter and mobilising support from academics and technocrats from various circles.

The conference resulted in the establishment of a working group to draft the "Health Promotion Fund Act, B.E......." It was compared with other legislation existing at the time such as the "Science and Technology Development Act, B.E. 2534 (1991)" (which was a basis for the establishment of the National Science and Technology Development Agency-NSTDA); the "Thailand Research Fund Act, B.E. 2535 (1992)" (which was a basis for the establishment of the Thailand Research Fund-TRF); the Health Systems Research Institute Act, B.E. 2535 (1992)" (which was a basis for the establishment of the Health Systems Research Institute-HSRI); and the Educational Loan Fund Bill, B.E.....

The approach used in the consideration of this bill reflects the thinking at the time that the proposed health promotion foundation that would be established would take the form of an independent agency like the other independent agencies existing at the time.

It should be noted that although the concept was circulating about using cigarette excise taxes as operating capital for a health promotion fund, there were no new proposals about how to make the fund a reality. The idea was still to attain the initial allocation for the fund from the government budget. Annual funding support would also come out of the government budget through the normal budgetary process, with the stipulation that the amount should not be less than 3 percent of the total cigarette excise tax. In this sense, such an arrangement does not constitute a "short cut" in which a direct linkage is created between tax collection and the allocation of revenue for the health promotion foundation, thereby bypassing the Comptroller-General's Department and the normal budgetary process.

Selected Participants at the 10 April 1996 Conference[*]

Participant	Affiliation
Prof. Dr. Prakit Vathesatogkit	• Faculty of Medicine, Ramathibodi Hospital
Prof. Dr. Hatai Chitanondh	• Thai Health Promotion Institute
Prof. Dr. Vitoon Ungpraphan	• Project for the Promotion of Legal Research, Mahidol University
Prof. Dr. Vicharn Panich	• Office of the Thailand Research Fund
Assoc. Prof. Dr. Porapan Punyaratabandhu Assoc. Prof. Surachart Na Nongkai *Ajarn* Lakkhana Termsirikulchai	• Faculty of Public Health, Mahidol University
Assoc. Prof. Phijaisakdi Horyangkura	• Faculty of Law, Chulalongkorn University
Asst. Prof. Dr. Kaemthong Indaratna Asst. Prof. Dr. Isra Sarntisart	• Faculty of Economics, Chulalongkorn University
Dr. Silaporn Nakorntup	• Education Council
Dr. Chaisri Supornsilchai	• Coordinating Centre on the Development of Non-Communicable Diseases
Khun Saree Ongsomwang	• District Health Officers Coordinating Committee

[*] Information from "Chap Krasae", the newsletter of the Health Systems Research Institute, Vol. 1, Nos. 8-9, March-April 1996.

Main Gist of the Health Promotion Fund Bill of 1996[*]

The Health Promotion Foundation would have the status of a juristic person under the supervision of the Ministry of Public Health. Its initial founding capital would come from the government budget and it would also receive annual funding support, which would be allocated by the Government from the national budget. In total, this would amount to no less than 3 percent of the cigarette excise tax.[**] The Foundation would be under the supervision and control of two committees, namely the Policy Committee on Health Promotion and the Evaluation Committee on Efforts to Support Health Promotion.

[*] Sira Boonphinon, "A Review of Foreign Legislation on Health Promotion Funds", a research paper submitted to the Health Systems Research Institute, 1997, pp. 86-87.

[**] Dr. Prakit and Dr. Supakorn were advised by the World Health Organisation that the Fund should have annual revenues of approximately 1 percent of the public health budget. This comes to around 700 million baht or approximately 2.5 percent of the cigarette excise tax at the time.

Another noteworthy point was the stipulation that the foundation should be under the supervision of two committees, namely a policy committee and an evaluation committee. This differed from the case of VicHealth, which had only one committee. These two committees stemmed from the format of the Office of the Thailand Research Fund. This signified that the leading advocates attached importance to creating a system of checks and balances as well as to monitor the use of power. Such an arrangement corresponds with the current age of political reform. It also represents an effort to use an old "knowledge package" that had proven to be successful and to adapt it for use in a new case.

On 15 May 1996, HSRI joined with the Department of Public Health, Mahidol University in organising a meeting entitled **"Visions on Health Promotion"** at the Royal City Hotel. This represented another endeavour to communicate with members of academia and the general public with a view to fostering wider support.

At this meeting, **Dr. Prawase Wasi** presented the idea of establishing a "Thai Health Promotion Foundation" as an independent public agency using sin taxes.[8] He proposed that such organisation be fairly large and have a degree of independence under the supervision of a committee. The duty of such organisation would be to stimulate the serious generation of activities dealing with health promotion on a continual basis. Dr. Prawase also proposed the option of modifying the Department of Health, which oversees the Health Promotion Centre, Region 10, and transforming the Department into that independent public agency. However, such proposal was not endorsed or picked up by anyone.

The debate over the need for a health promotion foundation was not limited to Thailand. On 17-19 November 1997, HSRI joined with the WHO (Dr. Desmond O'Byrne) in organising a meeting entitled **"Regional Workshop on Organisational and Funding Infrastructure for Health Promotion"** at the Asia Hotel, Bangkok, with a view to finding ways and means to establish a mechanism or infrastructure for health promotion. It was the first meeting of its kind in the world, and was attended by representatives of health and financial organisations, academics, and health promotion experts from Australia, Fiji (the 13th country in the world to establish a special mechanism for health promotion 15 months earlier), Thailand, Vietnam, Malaysia (in the process of establishing such a mechanism), Myanmar, Singapore, Laos, Cambodia and Germany.

All 10 countries declared a common agreement to join together in developing an infrastructure, consisting of a coordinating mechanism and source of funding, in order to reduce the losses brought about by the treatment of diseases and other symptoms caused by risky behaviour or by living in an at-risk environment. These include illnesses caused by traffic accidents, HIV/AIDS, and diseases stemming from the use of narcotic substances. The agencies concerned would be responsible for submitting the declaration to their respective governments. This international meeting prompted the idea of establishing a health promotion foundation to become

[8] Prawase Wasi, "Vision and Strategy for Health Promotion in Thai Society", paper presented at the seminar on "Vision and Reform of Health Promotion in Thai Society", 15 May 1996, Royal City Hotel, Bangkok (photocopy).

more widely accepted at the international level, and gave it greater weight in the eyes of domestic policy makers.

A sign of success in pushing the policy at the top level was the decision of the Committee for the Implementation of the Fiscal and Financial Master Plan for Social Development to appoint a Working Group for the Preparation of Proposals on Measures for the Establishment of a Private Public Health Institution and a Health Promotion and Insurance Fund on 9 August 1996. Dr. Sanguan Nittayarumphong (Assistant Permanent Secretary for Public Health) was the Chairman of this working group, with Professor Dr. Prakit Vathesatogkit as Vice Chairman.

At this point, the policy proposal on this matter was about to be concretely transformed into a policy product of the bureaucratic system.

As for the establishment of a private public health institution and a health promotion fund, HSRI was the main locomotive in presenting the preliminary guidelines for realising this objective, in line with the studies it had conducted. Two principles were emphasised, namely 1) putting in place a good system and good organisational management, with work administration and oversight shared among many groups for greater transparency, and 2) having a continual source of funding support.

The Working Group produced a proposal that endorsed the establishment of a health promotion institution along the same lines as VicHealth. This proposal was submitted to the Committee for the Implementation of the Fiscal and Financial Master Plan for Social Development for consideration in November 1996. The proposal was approved in principle by the Committee, which then assigned the Fiscal

Working Group for the Preparation of Proposals on Measures for the Establishment of a Private Public Health Institution and a Health Promotion and Insurance Fund

Dr. Sanguan Nittayarumphong (Assistant Permanent Secretary for Public Health)	Chairman

Dr. Prakit Vathesatogkit (Faculty of Medicine, Mahidol University)	Vice Chairman
Dr. Supasit Pannarunothai (Buddhachinaraj Hospital, Phitsanulok Province)	Member
Dr. Viroj Tangcharoensathien	Member
Dr. Samrit Srithamrongsawat (Public Health Office, Phuket Province)	Member
Dr. Pongpisut Jongudomsuk (Deputy Director, Health Insurance Office, Office of the Permanent Secretary for Public Health)	Member
Dr. Supakorn Buasai (HSRI)	Member
Representative of the Budget Bureau	Member
Representative of the Office of the National Economic and Social Development Board	Member
Representative of the Comptroller-General's Department	Member
Representative of the Revenue Department	Member
Representative of the Excise Department	Member
Mr. Kitipong Urapeepattanapong (Baker & McKenzie Ltd.)	Member
Mrs. Suwanna Langnamsank (Bangchak Petroleum Public Company Limited)	Member
Mrs. Supavadee Thirapanish (Tax Policy Division, Fiscal Policy Office)	Member/ WG Secretary
Representative of the Office of the National Economic and Social Development Board	Member/ WG Assistant Secretary
Representative of the Excise Department	Member/ WG Assistant Secretary

Policy Office, the Comptroller-General's Department and the Bureau of the Budget to jointly propose some options regarding the fund's source of revenue. The Committee also assigned the Ministry of Finance to **send a delegation for a study tour on health promotion at the Health Sponsorship Council, New Zealand and VicHealth, Australia**. The purpose was to study the organisational structure, operations, problems,

limitations and source of revenue of the above organisations, particularly their use of sin taxes for health promotion.

In December 1996, the Ministry of Finance joined with the agencies concerned in sending a delegation for a 5-day study tour. This may have been the most concise and effective study tour in Thai bureaucratic history.

The fact that the Ministry of Finance dispatched as many as 4 officials to participate in this study tour demonstrates the great potential and significance of this matter. At that time, it was extremely difficult and rare for the Permanent Secretary for Finance to send any of his officials on study tours. The issue in which Permanent Secretary Chatu Mongol was particularly interested was cost effectiveness, i.e. what evidence was there to prove that the establishment of a health promotion foundation would be a worthwhile investment? This was a new question and equation which the leading advocates had not previously paid attention to and for which they had not prepared any supporting foundation of knowledge.

The delegation undertook a study tour of both VicHealth and HSC, although the emphasis was clearly on VicHealth. In addition to visiting the VicHealth Office, the delegation also met with some organisations that received support from VicHealth. These included some local governments that were granted funding to create a model project for accident prevention in the community and some model elementary schools which focus on supporting the development of children from troubled homes.

The delegation also met with a number of important persons, such as the Public Health Minister of Victoria, the Adviser to the Finance Minister of Victoria, senior officials of the Victorian Department of Treasury and Finance, representatives of the Committee for Melbourne--a public benefit organisation comprising leading Victorian businessmen--representatives of private health organisations, as well as various technocrats and academics.

Delegation Participating in the Study Tour of Australia and New Zealand, 9-13 December 1996*

Mr. Suparat Kawatkul
- Financial Adviser, Office of the Permanent Secretary for Finance, Ministry of Finance

Mrs. Satri Pradipasen
- Director, Department of Budget Policy and Information, Bureau of the Budget

Prof. Dr. Prakit Vathesatogkit
- Faculty of Medicine, Ramathibodi Hospital

Dr. Sanguan Nittayarumphong
- Assistant Permanent Secretary for Public Health (Policy and Planning), Office of the Permanent Secretary for Public Health

Dr. Supakorn Buasai
- Deputy Director, Health Systems Research Institute

Dr. Choochai Supawongse
- Policy and Planning Specialist, Department of Health, Ministry of Public Health

Mr. Manas Jamveha
- Legal Officer 7, Acting Director, Laws and Regulations Section, Finance and Fiscal Bureau, the Comptroller General's Department

Mrs. Suwatana Sriphiromya
- State Enterprise and Other Revenues Section Chief, Tax Policy Division, Fiscal Policy Office, Ministry of Finance

Mrs. Supavadee Thirapanish
- Chief, Goods and Services Tax Policy Section, Tax Policy Division, Fiscal Policy Office, Ministry of Finance

* Information from Report on Study Tour concerning Health Promotion Organisations in New Zealand and Australia, 9-13 December 1996, submitted to the Permanent Secretary for Finance.

The conclusions of the delegation were not different from those of the working group, namely:

1. **The organisational set-up and operations of VicHealth is an appropriate model**, i.e. it had a comprehensive array of health promotion activities but played more of a coordinating role instead of carrying out its own activities as in the case of HSC, which was not very successful. Moreover, VicHealth also had a more flexible and adaptable organisational structure with legislative backing. Therefore, conditions were favourable for VicHealth to be a more effective management organisation than HSC.

2. **The health promotion fund should have a guaranteed source of regular income rather than having to fight for its budget each year, which would open the way for political interference. Cigarette taxes should be collected at the rate of 1-5 percent of the tobacco excise taxes (amounting to approximately 200-1,300 million baht). Linking the cigarette tax to the issue of health promotion was deemed appropriate** since it would create a greater public awareness of the dangers of cigarette smoking as a cause of bad health. It would also point out to the public that the problem of cigarettes is not specifically the problem of any single person, but is a burden that the entire society must bear. For this reason, linking the issue of sin taxes with the establishment of a health promotion foundation was therefore acceptable. It created a clear image for the organisation, which was easily comprehensible among the general public.

On this matter, the delegation was influenced by the thinking of the Victorian Finance Minister and senior officials of the Victorian Department of Treasury and Finance that **the dedicated tax in this case accounted for only a small proportion of the government's expenditures when compared with total government expenditures. Such a tax would only be allotted in cases which are clearly in the public's best interests and which would be acceptable to the society. The experience of previous years did not indicate that such actions would lead to a "copycat syndrome" or a wave of proposals for the establishment of other similar funds.** Such knowledge and experience carried great weight in the eyes of the Thai Finance Ministry representatives, who attached great significance to the principle of fiscal discipline.

3. **The establishment of a health promotion foundation is a worthwhile investment** based on data from the experiences of VicHealth and HSC. This was therefore a new knowledge package acquired by the delegation to answer the question posed by the Permanent Secretary for Finance.

Benefit-Cost Analysis of a Health Promotion Foundation and Fund*

Professor Neville Norman, an economist at Melbourne University, did an evaluation of the economic benefits of VicHealth during 1987-1992 as follows:

- The state of Victoria invested a total of 121 million dollars in health promotion through VicHealth.
- The smoking rate of the population of Victoria and two other states with similar health promotion foundations was lower than that in other states.
- The status of Victorian citizens clearly improved in relation to the health promotion activities of VicHealth.
- Victorian citizens engaged in more exercise and sporting activities than before.
- The number of Victorians protecting themselves from the harmful rays of the sun (to prevent skin cancer) increased by over 50 percent.
- The quit-smoking campaign alone, which used a budget of 15 million dollars, yielded benefits of no less than 200 million dollars, or a B/C ratio of approximately 13:1.

Research work undertaken by Garry Egger demonstrated that the 188 health projects conducted in Australia during the early 1990s managed to lower medical expenses by 7,000-8,000 million dollars.

Dr. Murray Laugesen, an economist at Health New Zealand, assessed that

- Health promotion activities during 1985-1995 were able to reduce the number of cigarette-related deaths by 10,000. This group of people extended their lives by 14 years each, making a total of 140,000 years. Such success was achieved at a cost of 42 million dollars. When this cost is calculated against the number of years of extended life, we find that the cost of extending the lives of New Zealanders amounted to 700 dollars per person each year.
- During 1985-1995, health promotion activities managed to reduce cigarette-related deaths by 40 percent and to lower medical expenses by 80 million dollars per year - a B/C ratio of 20:1.

---

* Data from Report on Study Tour concerning Health Promotion Foundations in New Zealand and Australia, 9-13 December 1996, submitted to the Permanent Secretary for Finance

Assessing the Benefit-Cost of Establishing a Thai Health Promotion Foundation*

- Accidents claim the lives of 34,000 Thais each year, with traffic accidents accounting for 15,000 lives. Damages are estimated at 70,000-90,000 million baht. If these accidents could be reduced by 10 percent, this would save 1,500 lives per year and reduce damages by 7,000-9,000 lives.
- Cigarettes are the cause of 42,000 deaths a year. Lung cancer alone kills 10,000 Thais on a yearly basis. If the human cost is estimated at 0.7-1.9 million baht per person, the cost of human lives lost due to cigarettes would be 17,000-45,000 million baht. This can be reduced over the long term if the smoking rate is reduced.

- Thais spend 250,000 million baht each year on health, or 5-6 percent of the national income. If this amount is reduced to the level of Singapore, Malaysia, Sri Lanka or Hong Kong, namely 3-4 percent, health costs would be lowered by 100,000 million baht per year.

If health promotion efforts succeed in reducing damages in these three areas by 10 percent, the country would save 20,000 million baht in expenditures (according to Dr. Supakorn Buasai's assessment).

---

* Data from Report on Study Tour concerning Health Promotion Organisations in New Zealand and Australia, 9-13 December 1996, submitted to the Permanent Secretary for Finance.

Note - Subsequently, at the phase in which organisational strategy is developed, the substance and details will be further expanded (see Supavadee Thirapanish, "Report on the Results of Recording the Process of Establishing a Health Promotion Fund", research work submitted to the Health Systems Research Institute, 2001, pp. 61-63.

The delegation also tried to calculate the cost-effectiveness of investing in a health promotion organisation, although this was merely a preliminary assessment. In any case, other than the Permanent Secretary for Finance, the issue of cost-effectiveness and the knowledge package to be used as a reference were not really a matter of debate for anyone, and there was no attempt to build additional knowledge on this matter.

In March 1997, the Working Group presented its proposals to the Committee for the Implementation of the Fiscal and Financial Master Plan for Social Development, which gave its endorsement regarding the cost-effectiveness of the investment. However, the Committee, particularly M.R. Chatu Mongol Sonakul, the Permanent Secretary for Finance who served as chairman, did not agree with the idea of an earmarked tax since it ran contrary to fiscal discipline. He believed that the decision should be made at the political level. The Chairman tasked the Committee to prepare additional details concerning the organisation's work plan and budget for consideration by the Policy Committee on Distributing Prosperity to the Provinces and Localities. Towards this end, the Working Group collaborated with HSRI and

technocrats from the Department of Health in drawing up an initial work plan and budgetary plan, which was completed in May 1997.

This move to "pass the buck" or "elevate" the decision on this matter to the level of the Cabinet caused developments, which had been proceeding swiftly during the past year, to come to a halt. This was especially the case in November 1996 when there was a change of government, causing the politicians who had previously supported the idea to fall from power.

Subsequently in 1997, two major incidents occurred that had a significant impact on the campaign to press for a sin tax and health promotion foundation.

- The first incident was the onset of the "Economic Crisis", beginning in the middle of 1997, which prompted the Cabinet to order a freeze on the establishment of all new agencies. This was an adverse impact.
- The second incident was the enactment of the new Constitution, which contained a clear intent, philosophy, approach, and provisions concerning the right to health, health guarantees, public participation, and increasing the role of the third category of agencies--private organisations. This was a positive impact.

5. BUILDING A KNOWLEDGE PACKAGE AND **THE SECOND ROUND OF POLICY** PROMOTION (1998-2001)

5.1 Additional Knowledge concerning Cigarettes, Sin Taxes and Health Promotion

During this period, no new knowledge was created concerning sin taxes. However, the issue of cigarettes and their health impact was once again the focus of interest when the concept of health promotion gained greater acceptance in Thai society.

As a result of the first academic workshop, health promotion became an issue with the most clear-cut approach for pushing forward. For this reason, HSRI chose health promotion as the main theme of its second workshop in 1998. HSRI also supported research work aimed at creating greater understanding concerning the background of the problem and actions taken on 3 issues that constitute priority health problems for Thai society, namely:

"The Evolution of Tobacco Consumption Control in Thailand" by Dr. Choochai Supawongse et. al.

"The Evolution of HIV/AIDS Control in Thailand" by Dr. Wiput Phoolcharoen et. al.

"The Evolution of Traffic Accident Prevention" by Asst. Prof. Dr. Banchorn Kaewsong et. al.

This series of research papers was used to open the debate **at the Second HSRI Workshop on "Health Promotion: a New Role in a New Era for Everyone"** during 6-8 May 1998. The main objective of the Workshop was to communicate to the society that health promotion was a new approach to public health, emphasising a broader framework of

thinking and action than simply providing public health services by public health personnel. In order to succeed, it was necessary to employ a civil society-led strategy.

The 20 research papers presented at the Workshop were aimed at communicating three main points:

1. At present, the main threat to the lives and health of Thai citizens comes from a group of illnesses that are not caused by germs (non-infectious diseases). The top three causes of death are accidents, cardio-vascular diseases and cancer. The society has to increasingly expend a vast amount of resources for the treatment of such illnesses each year.

2. Such problems can be controlled and reduced through pro-active work, namely through health promotion. However, the 8th Public Health Development Plan (1997-2001) continued to treat health promotion activities separately as a sub-set of other areas. The emphasis was also limited to just personal health, which was not in line with the nature of the problem.

3. The lessons from 3 different cases - HIV/AIDS, cigarettes and accidents -- demonstrated that health promotion:[9]

- was more likely to enjoy a broader alliance and a greater chance of success if undertaken outside public health circles by utilising the civil society process.
- required a managing and coordinating unit in order to support the work of the entire network.
- needed an adequate and constant supply of resources.

The main points raised during the Workshop all pointed towards the establishment of a health promotion organisation. Presentations were made at the Workshop regarding health promotion organisations, using VicHealth as a sample case. However, there was not any serious attempt yet to push

---

[9] Interview with Dr. Supakorn Buasai on 25 September 2002.

for the establishment of a health promotion organisation in Thailand at the policy level since the leading proponents of the idea were of the opinion that the Economic Crisis remained a major obstacle.

5.2 Opportunity, Policy Context, and Propelling the Proposal for the Establishment of a Health Promotion Organisation

The fact that the idea of a health promotion organisation was appended as one of the measures of the Fiscal and Financial Master Plan for Social Development provided the movement with some continuity from one government to the next even though the idea did not enjoy the same level of support as before.

The leading proponents did not pursue the matter closely since they believed that the social setting following the Economic Crisis was not conducive to the idea. Nevertheless, the proposal regarding a health promotion organisation had already been placed on the “policy conveyor belt” under the framework of the Fiscal and Financial Master Plan for Social Development. The proposal was therefore tabled for consideration at the meeting of the **Committee for the Implementation of the Fiscal and Financial Master Plan for Social Development in April 1998.**

When the opportunity arose in this second round, the Working Group followed the advice of Mr. Abhisit Vejjajiva, Deputy Chairman of the Bureaucratic Reform Commission, who recommended that such an organisation should be established through the enactment of a Royal Decree in accordance with the Public Organisations Bill, B.E......, which was currently being deliberated by the Thai Parliament.

The Commission gave its approval to this approach and appointed another working group to tend specifically to this matter. (The existing working group was already preoccupied with the issue of health insurance.) This new working group was called the **Working Group to Propose Measures for the Establishment of the Health Promotion Foundation,** with **Dr. Prakit** as Chairman along with 6 other working group members, namely **Dr. Vitoon Ungpraphan, M.D., Professor Dr. Apichai Puntasen, Mr. Yongyut Tiyapairat, Dr. Choochai Supawongse, M.D., and Dr. Suwat Kittikilokkul, M.D.**

However, the proposal to establish such an entity in accordance with the Public Organisations Bill prevented the organisation from linking its funding to a cigarette tax as intended because the Bill clearly stipulated the source of revenue for all public organisations, which did not include taxation. Nevertheless, while this limitation was not yet made clear and there was still no certainty about the source of funding for such a health promotion organisation, an incident occurred which had a significant impact on the establishment of the organisation.

While consultations on the matter were still taking place, the Bureau of the Budget came out with its opinion on the establishment of a health promotion organisation as follows:

We have reached a crossroads between success and failure. The obstacles concerning the format and procedure for the establishment of the organisation poses a new equation that must be considered. Even though some efforts have been made to create a knowledge package on this matter, some gaps remain in regard to knowledge about the policy and legislative processes, which are in a transitional phase and subject to rapid changes.

This new problem and equation are not merely from the legal standpoint but are also due to the fact that a parallel project had arisen in the form of the “Campaign Fund for Cessation of Alcohol and Tobacco Consumption”. This has emerged as a result of the policy to liberalise the alcohol business but has expanded to include cigarettes as well. This marks the first time that both alcohol and tobacco have been incorporated together.

Main Gist of the Health Promotion Organisation Royal Decree of 1998*

- the name of the organisation in Thai was changed to convey a

nuance emphasising a broader meaning and the creation of new activities

- the source of funding is in accordance with the organic law, namely the Public Organisations Act, B.E. 2542 (1999) as follows:
  - an initial start-up fund allocated by the Government
  - funding support allocated by the Government on an annual basis, as deemed appropriate
  - financial contributions from the private sector or other organisations, including foreign or international organisations as well as funds or assets donated by others.
  - fees, membership dues, remuneration, service charges or revenue from the organisation's operations
  - interest earned from the savings or revenues of the public organisation's assets

- the organisation shall be under the supervision of the Ministry of Public Health

* Information from Supavadee Thirapanish, "Report on the Results of Recording the Process of Establishing a Health Promotion Fund", research paper submitted to the Health Systems Research Institute, 2001.

Summary of the Views of the Budget Bureau on the Royal Decree for the Establishment of the Health Promotion Foundation in 1998*

1. The establishment of a fund/revolving fund, which is granted exemption to use its revenues without having to transmit such revenues to the Treasury, would have to be done in accordance with the Annual Expenditure Budget Act or an Act that is specifically enacted for this purpose.

2. If a fund office is established in accordance with the Public Organisations Act, there would be no need to actually set up a fund since a public organisation is considered a state agency but is not a part of the bureaucratic system nor is it a state enterprise. It would therefore have funding which would enable its operations to be independent and flexible.

3. A health promotion agency offers public services as an option for the people. Therefore, it should not have to be a state agency and would actually have an overlapping role with other existing state agencies. For this reason, it should not be established as a new state agency. On the other hand, if it is established as a public organisation, other existing agencies should be incorporated as part of this new organisation. Another option would be to establish it in the form of a foundation, which would be in line with the recommendation of the World Health Organisation.

* Information from Supavadee Thirapanish, "Report on the Results of Recording the Process of Establishing a Health Promotion Fund", research paper submitted to the Health Systems Research Institute, 2001.

In this regard, the **Office of the Bureaucratic Reform Commission,** which oversees the establishment and development of public organisations, was of the view that the establishment of a health promotion fund should take into consideration other existing funds or sources of funding with similar objectives. The health promotion fund should set an example for others.

The main reason for this problem is that the leading advocates had discontinued their efforts for the time being to push for a health promotion fund. This caused their project to lose visibility and, as a result, new duplicative projects were created within the walls of the Ministry of Finance.

The Origins of the "Campaign Fund for Cessation of Alcohol and Tobacco Consumption"

The Thai Cabinet made a decision on 15 September 1998 to liberalise the production and sales of alcohol. In so doing, it tasked the Ministry of Finance to come up with ways and means to alleviate the social impact arising from competition in the market to entice the public to consume

greater quantities of alcohol. In other words, support should be given for a campaign to persuade the public to lower its consumption of alcohol. Financial support for this campaign may be sought from the alcohol manufacturers themselves.*

Accordingly, the Ministry of Finance established a working group under the oversight of the Excise Department. The Director-General of the Excise Department at the time was Dr. Somchai Richupan, who had the idea of collecting revenue for the fund from the sale of alcoholic beverages. Tobacco, which was another substance detrimental to the health of the public, should also be included under this umbrella. He was of the opinion that examples of the collection of a sin tax in this manner could be found in many countries. The working group therefore drafted a “Bill on the Campaign Fund for Cessation of Alcohol and Tobacco Consumption, B.E......”, which was submitted to the Ministry of Finance for consideration in June 1999.

* In an interview on 7 October 2002, Dr. Prakit was of the opinion that this proposal most likely originated from the Government's experience of a social backlash from the liberalisation of the cigarette industry as well as the personal character of Prime Minister Chuan Leekpai, who was opposed to alcohol consumption.

In any case, the establishment of a new organisation would have to undergo the scrutiny of the Thai bureaucratic system which, although laborious, was also rather effective in obstructing the creation of new organisations that were unnecessary or had responsibilities that duplicated those of existing or soon-to-be-established organisations. For this reason, the project faced a number of problems and hurdles upon reaching the point in the process that required consultations with other agencies. Seeing the duplication of responsibilities, the Office of the Bureaucratic Reform Commission recommended that the project be shelved for the time being. The Ministry of Public Health was of the opinion that the Fund's Office should fall under the Ministry's supervision since it was responsible for work related to the Tobacco Products Control Act, B.E. 2535 (1992) and the Non-Smoker's Health Protection Act, B.E. 2535 (1992).

Issue	Health Promotion Fund	Campaign Fund for Cessation of Alcohol and Tobacco Consumption
Organisational Format	◆ a public organisation with the status of a juristic person	◆ has status of juristic person without being a state enterprise and is independent from the bureaucratic system
Objectives	◆ create health promotion values and comprehensive health promotion activities ◆ promote a reduction in the rate of deaths caused by preventable causes ◆ emphasise the civil society process; promote the activities of the people sector and existing agencies	◆ publicise and disseminate information about the harm caused by alcohol and tobacco ◆ conduct study and research as well as organise training courses and meetings to campaign against alcohol and tobacco consumption ◆ provide funding to other agencies to organise campaign activities
Governance	◆ has a governing board chaired by an eminent person,with 5 *ex officio* members, 4 members chosen from eminent persons and 1 director; also has an evaluation board chaired by an eminentperson, with 1 director acting as member and secretary of the board ◆ the director is responsible for overall administration and management	◆ has a governing board chaired by the Director-General of the Excise Department, with 9 *ex officio* members, 3 eminent persons as members, and the Deputy Director-General of the Excise Department as Secretary. ◆ the director of the Fund is responsible for overall administration and management
Source of Revenue	◆ original plan was to draw funding from the excise tax in the form of an earmarked tax. However, the Public Organisations Act, B.E. 2542 (1999) did not authorise the collection of additional taxes. It was proposed that the Fund use a budget of 700 million baht, which was equivalent	◆ the bill authorised the Minister of Finance to collect revenue for the Fund from the producers and importers of alcoholic beverages and tobacco at a rate not exceeding 2 percent of the alcohol and tobacco taxes. In the first stage, a rate of 1 percent was to be applied, while the alcohol and tobacco

	to 1 percent of the Government's public health budget, or 1 percent of the alcohol and tobacco taxes.	tax was to be reduced by the same rate so as not to have any effect on prices in a way that would impact on consumers.
Supervision	◆ an agency under the supervision of the Ministry of Public Health	◆ an agency under the supervision of the Ministry of Finance
Means of Establishment	◆ enactment of a royal decree by virtue of Section 5 of the Public Organisations Act, B.E. 2542 (1999)	◆ enactment of an Act of Parliament

* Source - Summarised from Supavadee Thirapanish, "Report on the Results of Recording the Process of Establishing a Health Promotion Fund", research paper submitted to the Health Systems Research Institute, 2001, pp. 80-83.

For this reason, the matter had to be referred back to the Ministry of Finance to resolve. This provided an opportunity for Dr. Prakit and Dr. Supakorn to call on Dr. Pisit Leeahtam, the Deputy Minister of Finance. Dr. Prakit had previously presented the idea of a health promotion fund to Deputy Finance Minister Pisit when the latter was hospitalised at Ramathibodi Hospital in April 1999. On this occasion, Dr. Prakit and Dr. Supakorn proposed that the two projects should be combined as one. Dr. Pisit then assigned the Fiscal Policy Office, the Excise Department and the Working Group to prepare a comparative study of the two projects.

The outcome of this comparative study was that the agencies concerned were in agreement that the organisational format of the first project was more appropriate since it dealt with the problem in a holistic, non-bureaucratic manner. However, in terms of funding and from a legal standpoint, the second project was more suitable and would be more sustainable, but would require more time to establish since it entailed an Act of Parliament.

At this point, the leading advocates once again mobilised their forces to push forward their objectives. They employed new channels such as the **National Social Policy Commission,** established in 1998 with the main

objective to coordinate and provide impetus to any work involving the social impacts of the economic crisis. This was the only national-level commission with more members from outside the bureaucratic system than from government agencies. It came about through the efforts of Dr. Prawase through Khunying Supatra Masdit, the Minister to the Prime Minister's Office. The National Social Policy Commission therefore became a channel for civil society leaders to directly push their civil society agenda, both short-term and long-term, into the high-level policy process.

At the meeting of the National Social Policy Commission in September 1999, chaired by Prime Minister Chuan Leekpai, with **Dr. Prawase Wasi** and **Dr. Sanguan Nittayarumphong** as members, the policy was set to establish an office for the support of health promotion. An ***ad hoc working group*** was appointed to study the possibility of merging the two funds, under the responsibility of Mr. Abhisit Vejjajiva, Minister to the Prime Minister's Office, and Dr. Pisit Leeahtam, Deputy Finance Minister. A very important role was played by the legal experts of the Excise Department **- Mr. Parkiet Samanbutr, Mr. Viboon Boonyasiroj, Mr. Chumphol Rimsakorn, and Mr. Chaiyuth Sutthithanakorn -** who drafted two pieces of legislation using the Bill on the Campaign Fund for Cessation of Alcohol and Tobacco Consumption as a model. The two pieces of draft legislation were:

1. A "Royal Decree on the Establishment of an Office for the Campaign for Cessation of Alcohol and Tobacco Consumption and to Support Health Promotion, B.E......." This Office would have the status of a juristic person by virtue of Section 5 of the Independent Public Organisations Act, B.E. 2542 (1999). The Government would provide sufficient funding to support the Office's operations, which would be allocated from the central government budget. Management of the Office would be in accordance with the Independent Public Organisations Act.

2. A "Bill on the Campaign Fund for Cessation of Alcohol and Tobacco Consumption, B.E.....," establishing such a Fund and receiving transferral of the responsibilities of the Office.

One month later, on **19 October 1999, the Thai Cabinet approved in principle the two pieces of draft legislation submitted by the Finance**

Ministry. The Cabinet also assigned Deputy Prime Minister Korn Dabbaransi, Finance Minister Tarrin Nimmanahaeminda, and Minister to the Prime Minister's Office Khunying Supatra Masdit to jointly consider the draft legislation in detail and to proceed accordingly. Nevertheless, the member of the political leadership who played the most significant role continued to be the Deputy Finance Minister, Dr. Pisit Leeahtam.

The operations centre used for considering the draft legislation in detail was the Fiscal Policy Office, Ministry of Finance. The agencies concerned were invited to jointly deliberate the main points of the legislation. In particular, there was a change in the wording of the legislation's name to indicate "reduction of consumption" instead of "cessation of consumption".

There was also a change in the composition of the different committees. This reflected a compromise between the Ministry of Public Health, which wanted the Office and Fund to fall under the Ministry's supervision, and the leading advocates, who preferred that the two come under the supervision of the Office of the Prime Minister. The reason for this is that the leading advocates wanted to expand the reach of the Office and Fund beyond the Ministry of Public Health and medical experts. In their view, the Office should fall under the supervision of the Prime Minister's Office, with the Prime Minister as Chairman of the Fund's Committee and the Public Health Minister as First Deputy Chairman.

	Governing Board	Evaluation Board
Draft Royal Decree Establishing Office	Chairman - Eminent Person	Chairman - Eminent Person
Fund Bill	Chairman - Prime Minister 1st Vice Chairman - Public Health Minister	Chairman - Finance Minister

At the phase in which the legislation was required to be considered by the **Council of State**, the draft Royal Decree was taken up for deliberation by the 6th Committee chaired by **Mr. Amorn Chantara-Somboon**.

The Bill, meanwhile, was taken up for consideration by the 1st Committee chaired by **Mr. Plang Meejul.** The agencies concerned were invited to offer clarification and consider the draft legislation in detail. The process took 6 months and resulted in the following changes:

1. The name of the legislation was changed to the present one.

2. The Office was charged with drawing up an annual work plan, indicating the proportion of funds to be used for the various activities and capping the operating costs at no more than 10 percent of the annual budget.

3. An additional provision was added concerning interests. It was stipulated that the Chairman and Board Members of the Office shall have no stake or interests in the activities associated with the Office, nor in activities conflicting with the objectives of the Office, with the exception of those who are involved in non-profit work which is in the public interest. This is to prevent alcohol or tobacco proprietors from serving as Chairman or Board Members.

4. The Fund's Evaluation Board was modified by eliminating the *ex officio* posts comprising government officials. The Chairman of the Board continued to be the Minister of Finance, with other Board Members selected from eminent persons.

During this stage, in which the draft legislation was deliberated by the Council of State, it is interesting to note that the leading anti-tobacco advocates engaged in some internal lobbying to have the consideration of the Bill moved from one committee to another since the Chairman of one of the committees did not support the Bill.[10] This demonstrated that there was the opportunity for a swing of the pendulum between success and failure at every step of the policy process. It also indicated that there was still ample ground within the policy process for capable advocacy groups to alter the conditions in order to increase their chances of success.

[10] Prakit Vathesatogkit, "Seeking Success: Thai Tobacco Control", October 2002 (draft).

The Secretariat of the Cabinet presented the draft Royal Decree on the Establishment of the Thai Health Promotion Foundation, B.E..... to His Majesty the King to be signed into law. It was then published in the Royal Gazette, Decree Issue, Volume 117, Section 63 Khor, dated 30 June 2000, and came into effect the following day. In total, this second round of campaigning and lobbying specifically with the administrative branch took approximately 2 years and 2 months.

After the law came into effect, the leading advocates continued to press the selection committee, which was chaired by Khunying Supatra Masdit, Minister to the Prime Minister's Office, to propose that the Cabinet appoint Professor Dr. Athasit Vejjajiva as Chairman of the Board. Dr. Athasit was the father of Mr. Abhisit Vejjajiva, the Minister to the Prime Minister's Office at the time, and was a person of great social and political stature. He had been one of the initiators and supporters of this cause from the beginning. Consequently, Dr. Athasit resigned from his post as Chairman of the Action on Smoking and Health Foundation of Thailand (1996-2000) to take up this new position. His appointment served as an insurance and confidence booster in the drafting of the necessary rules and regulations as well as in pushing forward the Bill, which was of crucial importance to the future of the Thai Health Promotion Foundation. The significance of the Bill lay in the fact that it was the mechanism for linking the Foundation's revenues with a sin tax. Otherwise, the Foundation would have to operate in the form of a public organisation, relying on an annual budget allocated by the Government.

Five eminent persons were chosen to serve on the Foundation's Board of Governance in July 2000. Subsequently, in December 2000, **Dr. Supakorn** was appointed Manager of the Foundation. In its first year of operations, the Foundation was allocated a supporting budget of 152 million baht.

...Although the establishment of a health promotion foundation in Thailand took its first steps at this point, another round of battles lay ahead to push for enactment of a Bill setting up a fund for an earmarked cigarette tax. Such a Bill would guarantee a regular and adequate source of revenue for the Foundation without having to rely on the Government's budgetary allocation. The battleground in this case thus moved to the legislative branch.....

The Bill was approved in principle at a session of the House of Representatives on 4 October 2000. The House then appointed an extraordinary committee to consider the Bill under the chairmanship of **Dr. Pisit,** who fully supported the Bill, with **Dr. Prakit** as Vice Chairman.

During the meeting of the extraordinary committee, Dr. Prakit and Dr. Supakorn argued that the taxes collected into the Fund should be adjusted from "no more than 2 percent" to become "shall be levied at the rate of 2 percent". The authority of the Finance Minister to exercise his discretion in lowering the Fund's revenue was to be withdrawn. This would enable the Fund to have a fairly fixed income of approximately 1,400 million baht a year. This proposal was received positively by **Dr. Pisit.** In addition, the composition of the Fund's Board of Governance was amended to provide for greater flexibility of administration. The composition of the Evaluation Board was also adjusted to increase the role and weight of the members selected from eminent persons, thus ensuring greater independence.

Since Parliament was about to be dissolved, the politicians had to return to their constituencies to canvass for votes. Therefore, they did not pay too much attention to this Bill. The Committee submitted the amended Bill to the House of Representatives for consideration in the second and third readings on 12 October 2000, and the Bill was then sent to the Senate. The Extraordinary Committee on Senate Affairs deliberated the Bill on 17 October 2000 and placed it on the agenda for consideration by the Senate on 20 October 2000, which was the last day that the Senate would sit in session before Parliament would be dissolved by the Chuan Leekpai Government. However, by then there was no time left to consider the Bill. This was the same fate that befell many other pieces of urgent legislation.

The new administration, led by Police Lieutenant Colonel Dr. Thaksin Shinawatra, came to power on 9 February 2001 as a result of the first general elections held under the new Constitution. One of the main policies

of the new government was the "Thirty Baht Health Care Scheme", with **Dr. Surapong Suebwonglee** as Deputy Public Health Minister. Therefore, it was not a difficult task for the leading advocates to seek support from the Government by pointing out that the establishment of a health promotion foundation was entirely in line with and promoted the Government's policies.

On 23 May 2001, at a joint committee meeting of the Thai Parliament, the Bill was approved. It was then submitted to the Senate, which gave its approval in principle on 25 May 2001. An extraordinary committee was appointed under the chairmanship of **Mr. Prasit Phitoonkijja.** The committee made a few amendments to the details of the Bill and made an observation expressing concern regarding fiscal discipline, with a view to deterring others from proposing similar legislation that would involve an earmarked tax.

Record of Observation by the Extraordinary Committee of the Senate for Consideration of the Bill: Observation by Senator Chirmsak Pinthong (economist)

"Reference is made to the Bill on the Establishment of the Health Promotion Fund, B.E...., proposed by the Ministry of Finance. Such Bill authorises the Fund to collect a levy amounting to 2 percent of the taxes imposed by law on alcoholic beverages and tobacco. Such taxes would be used as earmarked revenue for the Fund, thus creating a kind of "earmarked fund" without having to turn such revenue over to the Treasury. Even though such taxes are levied in the form of a "sin tax" against alcoholic and tobacco products, which are detrimental to public health, and such revenue will be used in conducting a campaign to encourage public behaviour that promotes better health; and even though this constitutes a good and beneficial public health investment in line with the practice of many countries; however, such an arrangement would run contrary to the country's fiscal practices, namely that the collection of taxes and duties shall be submitted as the country's revenue and shall be expended through the allocation process in accordance with budgetary procedures. Therefore,

the Government is requested to take this observation into consideration. Should any other draft legislation be submitted in the future in a similar fashion, it is hoped that the Government would pay greater attention to fiscal and financial discipline in deliberating the matter."

The Bill was approved by the Senate at a meeting on 10 August 2001. Since there were a few amendments, the Bill had to be returned to the House for reconsideration.

Throughout the parliamentary process, the leading proponents had to work very hard to engage with the parliamentarians in order to lobby for support. Dr. Prawase, in particular, played a significant role in persuading certain groups of parliamentarians who initially were opposed to the idea. There were not too many problems or obstacles when the Bill was deliberated by the House of Representatives since it had the support of the Government and government parties. The Senate, however, was a different matter. This was the first Senate to be elected under the new Constitution and all the Senators enjoyed independence of thought. The leading proponents had to push the Bill by actively and aggressively meeting with the Senators for discussions outside the meeting room. What was most noteworthy is the fact that the main group most opposed to the idea was the group of former high-level government officials from many ministries.[11]

Finally, the Bill on the Establishment of the Health Promotion Foundation, B.E.... was approved by the House of Representatives on 26 September 2001. It was published in the Royal Gazette, Decree Issue, Vol. 118, Section 102 Khor, dated 7 November 2001, and came into effect the following day.

In order to implement the Bill, the Minister of Finance had issued the "Finance Ministry Regulation on the Collection, Remittance, Exemption and Reimbursement of Revenue to the Health Promotion Fund for Alcohol and Tobacco, B.E. 2544 (2001), with effect from 8

[11] Prakit, "Seeking Success: Thai Tobacco Control" 2002 (draft)

November 2001 (sections 12, 13, 14). The operations of the former Office established by the Royal Decree of 2000 were terminated, and the Office's business operations were transferred to the Foundation.

....The curtains were thus drawn on 8 years of campaigning for sin taxes and a health promotion foundation....

6. SUMMARISING EXPERIENCES

If we were to consider the success factors which made it possible to transform knowledge into policy in the case of ThaiHealth, the following observations can be made regarding 4 main issues: key advocates, knowledge, organisation, opportunity and policy context.

6.1 Key Advocates

Clearly Identifiable Key Advocates

All movements involving every issue require some key advocates who are clearly identifiable. In this case, it was Dr. Prakit and Dr. Supakorn, who formed a highly complementary team.

If there were only Dr. Prakit and no Dr. Supakorn, or only Dr. Supakorn but no Dr. Prakit, it would have been difficult for ThaiHealth to come into existence. In addition to his resolve and determination in pursuing this matter, Dr. Prakit was also a key advocate who was virtually unparalleled in terms of policy presentation skills. He always had a quick sense for pouncing on and making use of any policy opportunity that may open up. Dr. Supakorn, meanwhile, played a significant role in building knowledge for driving issues forward. He was capable of analysing public health issues from the viewpoint of an economist. This was a package of knowledge with which the Ministry of Finance could relate. Collaboration between the two was therefore a highly significant success factor.

Support from Other Advocates and Policy Allies

If there were only Dr. Prakit and Dr. Supakorn, ... then ThaiHealth would still not have come into existence.... Support from other advocates and policy allies also played an important part. The case of ThaiHealth demonstrated that time is of the essence in pushing for change. It requires a long, continuous effort as well as approval and support from a large

number of people and agencies. **For this reason, it would be difficult for only 1-2 key advocates to bear the burden of pushing the cause beyond all the different obstacles and barriers. Therefore, other advocates and policy allies are needed to help alleviate the burden and play a role at the different stages of the process.**

In this case, the advocates and policy allies all shared an interest in pushing for change in public health circles, especially with regard to cigarettes, which were a specific issue. They also wished to push for a new approach to public health, which was a broader issue. Both issues were highly related to one another. This group of persons mostly comprised government officials. Their role was to facilitate constant contact as well as rapid communications, consultations and cooperation without creating any undue burden on time or expenses. In many cases, such actions could be considered a part of their daily government work. From this viewpoint, it could be said that change was driven from “within the system” rather than from “outside the system”. In other words, **the change was propelled from “inside-out” rather than “outside-in”.**

Governmental and Social Status of the Key Advocates

The key advocates were all high-ranking officials in the Ministry of Public Health and the Ministry of University Affairs (Faculty of Medicine), and played an important role in pushing for rethinking and a change of attitude at the Public Health Ministry. This enabled them to lessen and manage the conflict between the Ministry’s policy and the proposals of the key advocates to some extent. **Had such proposals come from other groups outside the system, they would most likely have met with greater opposition from the Ministry of Public Health, whose mandate and responsibility it was to oversee public health.**

In addition, **the key advocates also enjoyed prominent positions within the society and had access to key policy makers,** for example:

- Dr. Prakit had the opportunity to make a presentation to Deputy Finance Minister Pisit while the latter was recuperating at Ramathibodi Hospital, where Dr. Prakit served as Dean of the Faculty of Medicine.

- Dr. Sanguan was able to use the National Social Policy Commission, in which he served as a member, as another means to push the draft legislation.

Besides having the chance to utilise their government positions and social status to open up the window of opportunity for their cause, the key advocates also benefited from the fact that their positions enabled them to learn of various significant developments. For example, they found out about the Bill on the Campaign Fund for Cessation of Alcohol and Tobacco Consumption, B.E..... from the Ministry of Public Health. Had the leading advocates been from outside government circles, it may have been too late to take any action by the time they found out about the Bill.

Personality of the Key Advocates

The role played by the key advocates was of great significance. Not only were they a highly determined group, but these individuals were also **widely respected within society for their integrity. Therefore, they were trusted** that their actions would be neither for personal gain, nor for the benefit of their associates, and that they would see to it that the Fund’s financial resources would not be used in an improper manner.[12] This helped to allay the concerns of the Ministry of Finance and others in this matter.

Dr. Prakit believed that his status and position as Dean of the Faculty of Medicine of Ramathibodi Hospital, which was directly concerned with health matters, also played an important part in earning acceptance for his role and thinking, both within policy circles and the society at large.[13]

6.2 Knowledge

Building a Knowledge Package

In the process of establishing ThaiHealth, the emphasis was not on building a large quantity of knowledge but, rather, on building knowledge

[12] Interview with Ms. Supavadee Thirapanish on 17 September 2002.
[13] Interview with Dr. Prakit Vathesatogkit on 7 October 2002.

in an efficient manner. Virtually all the created knowledge could be used to drive the policy forward for the following reasons:

- In the process of building knowledge, there was a **clear objective** from the very beginning as to how such knowledge was to be used. Those utilising the knowledge had a clarity of purpose regarding the knowledge that they wished to build. In particular, they knew how such knowledge would be used and for what purpose.

- The knowledge was created with Dr. Supakorn as the **Manager** of the knowledge-building process. Therefore, he was able to delegate the responsibilities for building the knowledge package to various researchers. He was also able to compile and synthesise the knowledge from various research work in an integrated manner, thereby creating a body of knowledge that covered all the main issues and which could be used in pushing the policy forward.

In any case, to say that the knowledge was created in an efficient manner does not mean that such knowledge was produced as a result of careful planning and analysis, with step-by-step implementation. The process was actually somewhat more ad hoc to the extent that it was not really a knowledge "package". It was more a case of simply creating knowledge "as needed". When compared with other research series by HSRI, the knowledge created in this instance was done without any teamwork, nor was there any attempt to assemble a team for this purpose. The reason for this may be because the key advocates already possessed adequate knowledge that could be readily utilised and did not consider the issue to be a major success factor. Some of the key proponents themselves admitted this fact and were of the opinion that the policy process in Thai society was not adequately challenged to the point that a large amount of knowledge had to be created and used, as was the case in western societies.[14]

[14] For further details, see Prakit, "Seeking Success: Thai Tobacco Control" 2002.

Compiling and Synthesising Knowledge

The compiling and synthesising of knowledge took place in two ways. The first was carried out by Dr. Supakorn, the "Manager of Knowledge". It was a continuous, natural process, resulting in a blend of knowledge that became embedded in the Manager himself. Such knowledge could be summoned for use whenever the opportunity or situation required during the process of policy advocacy.

The second was through arrangements for the compilation and synthesis of knowledge, particularly meetings organised by HSRI, which was a major source of research funding. Dr. Supakorn attached great importance to this process of compiling and synthesising knowledge since it helped to develop the body of knowledge jointly among researchers, academics and the leading advocates. This resulted in exchanges of information and mutual learning, with the research work as a medium.[15]

This process also helped to disseminate knowledge to the other advocates, policy allies, and key members of the network, thus paving the way for the consolidation of ideas and coordination of efforts.

In this regard, it should be noted that Dr. Supakorn was not only a policy advocate but, in his capacity as Deputy Director of HSRI, he also played a part in determining the research topics, the recipients of the research grants, and the persons who would compile and synthesise the research work. In some cases, he would even conduct the research himself. His role was therefore a very comprehensive one. The centralisation of knowledge management in this manner proved to be highly efficient in creating knowledge and transforming it into policy. This was the strong point. It should be cautioned, however, that the paradigm and attitudes of such an omnipotent knowledge manager may lead to the imposition of ideas and serve as a barrier to other viewpoints that may not be in line with those of the knowledge manager. From this perspective, the participation of the key advocates and other parties concerned in the determination of the research series as well as the compilation and synthesis of knowledge takes on even greater importance.

[15] Interview with Dr. Supakorn Buasai on 25 September 2002.

Another noteworthy point is that Dr. Prakit, another leading proponent, did not have much of a part in the creation and synthesis of knowledge under the auspices of HSRI, which was done within the context of Thai society. Rather, Dr. Prakit attached greater importance to knowledge derived from the experiences of other countries.

Making Use of Knowledge from Other Countries

The key advocates attached importance to the search for and utilisation of knowledge from other countries with the widespread support of international and foreign organisations. This knowledge from overseas played a significant role in creating a sense of awareness, enabling the leading proponents to realise what the possibilities were and to be cognizant of examples of success from other countries. It also provided a shortcut for knowledge building by directly studying the success stories of others. This was especially the case with regard to the establishment of the health promotion foundation, which benefited from the transfer of knowledge from VicHealth.

It must be noted that the cooperation from international organisations, particularly the World Health Organisation (WHO), helped to **support the policy proposals of the leading advocates by showing that they were along international lines, not simply some personal ideas or those of any specific groups.** This enabled the proposals to be more easily accepted, especially within academic circles and among high-level policymakers.

Knowledge and the Knowledgeable

The case of ThaiHealth demonstrates that knowledge requires a knowledge presenter. The knowledge embedded in the knowledge presenter, whether great or small, plays a more important role in pushing policy than knowledge from research work, studies, and so forth. Even though the drive for change regarding a cigarette tax and a health promotion foundation took a long time to be realised, the players involved in the policy process knew very little about the research work on this issue. However, they were well informed about all the different proposals as well as the principles and rationale of such proposals. Most importantly, they knew where to find the relevant information.

It should also be noted that most of the major decisions were made during discussions and meetings, which required a higher degree of oral presentations and persuasion than written documents. In the cases in which written papers played a significant role, such as the documents prepared for Cabinet consideration of the proposal for an increase in the cigarette excise tax in November 1993, such documents were not very lengthy and did not require considerable reference sources or supporting research.

Since the Thai policy process attached greater significance to “the knowledgeable” rather than to the “knowledge” itself, this resulted in the fact that the policy makers did not receive complete information. The knowledgeable were able to pick and choose knowledge for presentation that would specifically be beneficial in pushing their proposals forward.

Another point to consider is that those who are interested in pushing policy have to project themselves so that they are accepted by society as being “knowledgeable”. This means that it is necessary for them to have presented knowledge and views on specific issues to the society on a continual basis. Such knowledge may be self-created, imported, or compiled and synthesised from other sources. Whenever a policy opportunity opened up, these “knowledgeable” persons have a great opportunity to play a major role in driving change. In this case, both Dr. Prakit and Dr. Supakorn were widely accepted as being “knowledgeable” on the issue of cigarettes, while Dr. Prawase and the other leading advocates were accepted and respected as being “knowledgeable” on the subject of health and social change in general.

Tactics for Presentation of Knowledge

The leading advocates had learned to adapt their tactics from their former approach of concurrently pushing for an increase in the cigarette tax and having part of such tax earmarked for health promotion. This approach had not been accepted by the Ministry of Finance. Therefore, they decided to separate the two issues and push for both objectives one at a time, starting with the campaign for a cigarette tax increase.

The key advocates learned this tactic from David Sweanor, a campaigner for the Nonsmokers Rights Association of Canada, who had exchanged experiences with the Thai Anti-Smoking Campaign Project in 1993. He recounted that he had been unsuccessful in proposing that cigarette taxes be increased in order to use the revenue for an anti-smoking campaign. Therefore, he decided to employ a different approach by calculating how much extra revenue the Government would earn from an increase in the cigarette tax. At the same time, he also calculated how many children would be prevented from becoming addicted to smoking, how many young smokers would be cured of smoking, and how many children's lives would be saved. This would undoubtedly be a win-win situation. Presentation of this information enabled the campaign for a cigarette tax to eventually meet with success.

It should be noted that the decision to separate the issue of a cigarette tax increase and the matter of using such tax for health promotion actually resulted in greater support for the tax increase since it was not seen that the proponents were trying to gain benefit from the increased tax revenue.

To sum up, the key advocates learned the art of coupling vs decoupling the different issues, namely:

- coupling the fiscal and health benefits resulting from a cigarette tax increase
- decoupling the cigarette tax increase and the use of cigarette taxes for establishing a health promotion foundation

The leading advocates also learned what kind of information carried greatest weight among policy makers and decision makers. In this case, the key decision makers were politicians and government officials in the field of finance who required very specific information to clearly assess the advantages and disadvantages. The accuracy of these assessments is hardly as important as having such information to back up one's arguments.

Furthermore, a highly effective means of presenting information in this case was the study tour to VicHealth and HSC, which corresponds

with the saying that "seeing is believing" and "a picture is worth a thousand words". In this case, the members of the study tour delegation not only saw the picture with their own eyes, but they also had the opportunity personally to ask questions and seek answers from the "horse's mouth" concerning any reservations they may have had. In particular, they were able to meet with representatives of the Finance Ministry. This brief five-day study tour was therefore highly worthwhile.

The Opponentless Struggle

In this case, it is apparent that **the Ministry of Finance, which was the competent agency in this matter, remained entirely on the defensive. It did not make any attempt to develop any package of knowledge to counter the knowledge presented by the leading proponents. The most that they did was to examine such knowledge and to set an equation requiring additional knowledge and information.** One such equation was the one concerning the cost-effectiveness of investment posed by M.R. Chatu Mongol, the Permanent Secretary for Finance.

Actually, in this case, there were only three sets of knowledge packages that were of significance:

Knowledge concerning the fiscal impact of a tax increase. The knowledge possessed by the Ministry of Finance was not different from that of the public health officials, namely that alcoholic beverages and tobacco are products with low price elasticity of demand. An increase or decrease in excise taxes would not lead to a great change in consumption. Therefore, there is no concern that there might be a loss of revenue from a tax increase. The issue that the Ministry of Finance attached great attention to is the impact on personal income of a tax increase, namely which group is most affected. And since alcoholic beverages and tobacco products are goods which are only consumed by certain groups of people, not goods that must be consumed by everybody, the Finance Ministry was able to accept the notion of a tax increase for alcoholic beverages and tobacco products.[16]

Knowledge concerning the health impact of a tax increase - the Ministry of Finance did not have any data on this matter and had to rely on

the knowledge package provided by the public health officials. Whatever the correctness of such knowledge, it did not seem to do any harm. Therefore, the Ministry of Finance did not seriously attempt to verify the facts in this knowledge package. Moreover, the research work produced by the public health officials on this matter was not well known among the Finance Ministry officials.

Knowledge concerning the establishment of a health promotion foundation using sin taxes - the Ministry of Finance did not have any knowledge concerning this issue and did not try to seek other sources of information. They relied solely on the data supplied by the key advocates from the public health sector. However, they did make an attempt to verify the knowledge package provided by the public health sector to a certain extent. For example, they sent representatives on a study tour overseas and posed additional questions concerning the cost-effectiveness of such investment. Nevertheless, the Ministry of Finance was not very serious about these questions, as can be seen from the fact that the answers provided were mostly mere estimations.

Therefore, this was clearly a case of two sides who had no conflict concerning data, but had some differences over the means for establishing a health promotion foundation. The differences revolved around the main principle of the Ministry of Finance concerning "fiscal discipline" since there was only one other case of a fund being established in this manner, that is, the Petroleum Fund, which is under the supervision of a state agency. The Ministry of Finance feared that this would create a precedent for other similar funds to be established. Moreover, the Ministry of Finance was also concerned about the **"legitimacy"**

[16] Supavadee Thirapanish (in an interview on 17 September 2002) made the comparison that the Ministry of Finance agreed to an increase in the cigarette tax (for health) since cigarettes are consumed by specific groups of people; however the Ministry did not agree with an increase in the packaging tax (for the environment) since this would impact on most consumers. Meanwhile, Puangthong Palawatvichai, Chief of the Tax and Services Policy Section, (in an interview on 8 October 2002) was of the opinion that alcoholic beverages and tobacco products are goods that are subjected to excise taxes. The mechanism for managing, collecting and increasing such taxes is convenient and practically worthwhile. It is also in line with the philosophy behind levying taxes on luxury goods that are detrimental to public health.

of using tax revenues collected from alcohol and tobacco consumers for use in dealing with problems that have nothing to do with alcohol and tobacco.

The Ministry of Finance's conservative approach during the past decades not only caused the Ministry to be firmly wedded to the principle of fiscal discipline. It also resulted in the fact that the body of knowledge possessed by the Ministry dealt only with the Ministry's direct line of work. Consequently, the Ministry lacked initiative to use fiscal and financial measures and tools for driving social change. This was the case until the politicians pushed for the "Fiscal and Financial Master Plan for Social Development".

This approach to work resulted in the fact that at the Ministry of Finance there was no creation or accumulation of knowledge and knowledge sources, which could be used to counter or verify these policy proposals. On the other hand, the Ministry of Finance is one organisation that does attach importance to "knowledge"; therefore, when knowledge is presented by others, the Ministry is willing to accept it.

It is interesting to note that the tobacco industry and cigarette business had tried to mount an opposition to a proposed tax increase in 1993 but did not offer any resistance to the idea of linking an earmarked tax with the establishment of ThaiHealth. This can be explained as follows: linking the tax with the establishment of ThaiHealth did indeed translate into an additional 2 percent surcharge tax levied by the Government; however, since the increased tax burden was minimal and since it was a social measure, it was not worthwhile for the tobacco industry to engage in any activities that would make it the target of scrutiny by the society. Two other points to ponder:

- the tactic of decoupling the proposal for a cigarette tax increase from the establishment of a health promotion foundation helped to dissolve opposition from both the Ministry of Finance and the cigarette business.

- the cigarette industry did not have a true understanding about the establishment, goals and work of ThaiHealth; therefore, the

industry did not see the fact that, although there was no impact on their interests in the short term, it was most likely that the cigarette business would be adversely impacted over the long term.

Common Vision, Clear-cut Principles

Actually, it may be incorrect to conclude that the Ministry of Finance was put on the defensive concerning the proposals for a sin tax and establishment of a health promotion foundation. This is because certain groups and quarters within the Ministry, especially those whose work dealt with this issue, strongly supported the proposals, even though they may not have fully believed the "knowledge" that was submitted to back up such proposals.

The reason why these proposals were embraced by the Ministry of Finance may be due to a **"common vision" that the proposals were proper and reasonable. Both sides saw the necessity of caring for health and viewed cigarettes as a major obstacle to health promotion, which would lower the country's financial burden over the long term.**[17] The differences that arose at certain steps of the process were, therefore, simply a matter of different "means" towards the same end.

It should be noted that the issues of a sin tax and a health promotion foundation were linked together in a very clear-cut and straightforward manner, particularly in terms of the **principle** behind the sin tax (things that are detrimental to health) and the **organisation** (health promotion work). Therefore, the idea was acceptable to most of the Finance Ministry officials concerned to the extent that they were willing to turn their backs on many key principles that were part of the Ministry's "Bible", such as:

- decreasing as much as possible the number of funds, which are a kind of extra-budgetary capital.

[17] Interview on 8 October 2002 with Chaiyuth Sutthithanakorn, specialist on fiscal and tax matters, Fiscal Policy Office, who played an important role in pushing the proposals. He expressed the view that caring for one's health is of great significance to Thailand, whose population is enjoying continually higher average life expectancy. If a large number of people are ill, this would create a great burden on the public health budget in the future.

- allocating resources according to the prevailing socio-economic conditions of the country (which makes it necessary to place all of the country's revenues in a single pile, thus maximising flex ibility of resource allocation).
- maintaining a check-and-balance through the budgetary process, which must be checked by both the administrative and legislative sectors.

6.3 Organisation

In this case, it was found that, as an organisation, HSRI played an outstanding role on the issue of a sin tax and establishment of a health promotion foundation in 5 dimensions:

- It was the most important **source of knowledge creation** even though HSRI did not have any clear research work on this issue until approximately 1997 when the Institute prepared a series of 20 research papers on the subject of health promotion for the 2nd Workshop that was held in 1998. This demonstrates the organisation's flexibility in adapting its research agenda to correspond to the policy opportunities.

- It was the **focal point for coordinating between the key advocates and policy allies**, many of whom were members of HSRI's Board or had worked with HSRI on public health policy issues. This made it possible for frequent discussions to take place on this and other issues, thus maintaining close cooperation.

- It was a **base of support for resources, management and coordination with other agencies.** It also organised various activities that presented perspectives and knowledge to academics, government officials and people organisations outside the public health sector, in addition to disseminating and publicising such knowledge to the general public.

- It was a source for accumulating knowledge and experiences concerning the policy process and tactics for driving change. Besides ThaiHealth, HSRI also pushed for the establishment of other organisations that were important locomotives in transforming the face of the health system in Thailand. One case in point is the National Health System Reform Office (HSRO), which was established under a Regulation of the Prime Minister's Office, B.E. 2543 (2000).

- It was an example of the operations of an organisation that lies outside the bureaucratic system. This enabled the key advocates and other parties concerned to see the proposal for the establishment of ThaiHealth in more concrete terms.[18] HSRI can be considered the strongest organisation among all the allied organisations pushing this issue. It was not faced with the same bureaucratic limitations and lack of operational continuity as the Office for Tobacco Consumption Control (OTCC). It also enjoyed a stronger personnel and resource base than the Anti-Smoking Campaign Project of the Moh-Chao-Ban Foundation.

6.5 Opportunity and Policy Context

Neither Favouritism Nor Partiality

This push for change took a total of **9 years, from 1993 to 2001, spanning 5 governments**[19], namely the administrations of Mr. Chuan Leekpai (Chuan 1), Mr. Banharn Silpa-Archa, General Chavalit Yongchaiyudh, Mr. Chuan Leekpai (Chuan 2) and Police Lieutenant Colonel Thaksin Shinawatra. Throughout this period, except during the administration of General Chavalit Yongchaiyudh when the country faced an economic crisis, the push for change incrementally met with success. It can therefore be concluded that the system of party politics was not a condition or obstacle in driving the policy forward.

[18] The opinion of Dr. Supakorn Buasai from an interview on 25 September 2002.

[19] Prakit, "Seeking Success: Thai Tobacco Control" October 2002 (draft) pointed out that from the time of the Section 301 case in 1989 up until 2001, Thailand had a total of 9 governments and 11 Public Health Ministers.

However, Dr. Prakit did attach importance to the coalition government headed by the Democrat Party, especially since Prime Minister Chuan Leekpai's personal ideals favoured the suppression of vices and narcotic substances. The Democrat-led government helped to support the drive for change, starting with the anti-smoking campaign and the campaign against the liberalisation of the cigarette market. It also gave the "green light" for the cigarette tax increase as well as the establishment of ThaiHealth.

New Generation of Politicians

It is noteworthy that **it was the politicians, whichever side they were from, who played an important role in opening the window of opportunity,** especially **Dr. Surakiart Sathirathai,** the Minister of Finance, and **Dr. Pisit Leeahtam,** the Deputy Minister of Finance. Even though they were from different parties and different governments, both men came from **a new generation of politicians with academic backgrounds.**[20] **Therefore, they paid greater attention to new knowledge and new approaches.** They were also the key to destroying the conservative paradigm of the Ministry of Finance and opening up new ways of thinking regarding fiscal and financial policy, thus making this matter more feasible. Dr. Pisit, in particular, was the politician with the most prominent role in the whole issue, insisting that the idea of linking a sin tax with a health promotion foundation "has never existed before...but can be done."[21]

Long-Term "Alliance" Base

The drive for a sin tax and ThaiHealth benefited from the anti-Section 301 movement in 1989 amidst an atmosphere of sharing a

[20] In Prakit, "Seeking Success: Thai Tobacco Control" October 2002 (draft), Dr. Prakit cited Dr. Athasit Vejjajiva, M.D., Dr. Arthit Ourairat and Dr. Pisit Leeahtam as examples of politicians with backgrounds as academics / technocrats. Therefore, their thinking and behaviour were different from those of career politicians in general, namely, they attached greater significance to the substance of each issue rather than thinking of interests and electoral base.

[21] Information from "How the Thai Health Promotion Foundation (ThaiHealth) Came About", an internal document of ThaiHealth (undated) as well as interviews with Dr. Supakorn Buasai on 25 September 2002 and with Dr. Prakit Vathesatogkit on 7 October 2002.

common "external enemy". The key advocates worked closely with officials from the Public Health Ministry, the Finance Ministry, and the Commerce Ministry. All parties had a good experience of working together. They had built up a degree of understanding and confidence with one another, both at the level of politicians and career government officials. The experience of raising the cigarette tax, which greatly increased the Government's revenues, helped to further cement this relationship and feeling of mutual trust. Accordingly, this served to increase the chances and possibility of success for the subsequent drive towards the establishment of a health promotion foundation.

The Process is of the Essence

The main obstacle impeding the push for change was the policy process, both in terms of the administrative and legislative branches. A succession of commissions, committees, working groups, etc. of all forms were established. Each commission comprised representatives of various agencies, both those who were inclined to approve and those who were inclined to disapprove; both those who were uninterested and those who were uninformed.

It was essential for the leading proponents or their allies to possess skills in "agenda setting" in the different commissions. This required considerable knowledge, experience, stature and skills regarding the policy process at the highest level. **The nearer they got to the target, the more important became the role of the leading proponents and the multi-dimensional "knowledge" that was embedded in them.** The key advocates worked together as a team in taking turns as committee members or working with the various committees. This played an important part in enabling them to maintain the lead and drive the issue forward throughout the lengthy duration of the policy process.

It should be noted that there was always the opportunity for the policy proposals to be amended at every stage of the process. The key advocates had to pursue the matter closely in order to fight to maintain the major principles. At the same time, they had to wage an offensive in order to continually improve their proposals. This was the case regardless of whether it involved major issues, such as the source of revenue and operational format of the health promotion foundation, or minor issues. In any case, one thing that was most frequently modified was the composition of the Governing Board and Evaluation Board as well as the method of evaluating how to set the rate for collecting revenue for the Fund.[22]

Closed Budgetary Process

In the case of ThaiHealth, the closed budgetary process, which was centred around the Ministry of Finance and the Cabinet, enabled the key advocates to continually push their proposals for change with hardly any intervention from others, especially from those outside the public sector. There were no meetings of specialists or stakeholders; no public hearings to learn the views of the people. There was only the Health Promotion Fund Bill that needed to go through the legislative process. The key advocates had to work very hard during this stage before they were able to successfully push the Bill through.

Had there been a more participatory process, the leading advocates would have had to exert greater efforts in networking and campaigning with the civil society. There was also a greater chance that the main issues may have been distorted. At the same time, however, there was also the chance of riding the social tide to push the proposals forward even more easily and swiftly.

The Changing Context

The efforts to push the policy proposals through took only 8 years (1993-2000), which is not very long in view of the success that was achieved and in comparison with other efforts to push for change. However, these were 8 years in which **the policy context was rapidly changing, thus creating both obstacles and opportunities.**

The rapid changes in government, Cabinet ministers and government officials concerned were a major obstacle causing the proposals to

[22] Supavadee Thirapanish, "Report on the Results of Recording the Process of Establishing a Health Promotion Fund", research paper submitted to the Health Systems Research Institute, p. 121.

stall and to be intermittently reviewed. The main turning point came in 1997, with the onset of the economic crisis and the promulgation of a new constitution. Looking back, it can be said that **although the economic crisis caused some delays to the process, the new Constitution, however, played a significant part in supporting the proposal to establish ThaiHealth.** That is to say, the Constitution supported the civil society approach, which was in line with the thinking regarding establishment of ThaiHealth. The Constitution supported the establishment of a non-governmental state organisation such as ThaiHealth. It also provided for a system of checks-and-balances, including a system in which the public could play a role in monitoring the work of the different organisations. This made others feel more confident that the Fund to be established would be adequately monitored. Therefore, they felt more at ease in supporting the idea.

Transforming Crisis into Opportunity

The lesson to be learned from this case is that if the first three factors - key advocates, organisations and knowledge - are ready and swift to react to opportunity and policy context, then this would make it possible to seize the golden moment and to transform crisis into policy opportunities. Examples of this include:

- Being forced into liberalising the cigarette market in 1989 resulted in the enactment of 2 cigarette control laws in 1992.
- Initiating the Fiscal and Financial Master Plan for Social Development provided a policy opening for the idea of a health promotion foundation to enter the policy process in an official and concrete manner.
- Having a parallel project, such as the “Fund for Cessation of Alcohol and Tobacco Consumption”, helped to revive the idea of a Health Promotion Fund. A sin tax against alcoholic beverages was also attained whereas initial expectations had been only for a sin tax for cigarettes.

7. SUMMARISING THE LESSONS LEARNED: **THE TRIANGLE** MOVES A MOUNTAIN

If we were to take Dr. Prawase Wasi’s idea of a triangle moving a mountain and apply it in the case of the sin tax and establishment of ThaiHealth, we will find that such a triangle almost came into being in 1992 in the form of a triad of organisations, namely the Anti-Smoking Campaign Project of the *Moh-Chao-Ban* Foundation (moving society), the OTCC (moving politics and policy), and HSRI (building knowledge). However, when the OTCC was unable to perform its duty of moving politics and policy, the focus for driving change shifted to HSRI, which was best prepared in terms of organisation and resources. The Anti-Smoking Campaign Project of the *Moh-Chao-Ban* Foundation served as an allied organisation with the individuals of each organisation linking them together.

Looking back to that point in time, one finds that the success that was achieved had come about mainly through the efforts to press policy concerns with the politicians. This was the most important factor. The building of knowledge to support opening the debate in order to help push policy was only a minor factor. Moreover, some social activist movements took place simply to provide indirect support.[23] This is to say that the whole movement benefited from the political context at the

[23] The movement to push for the establishment of ThaiHealth was little known among the general public. Even among media circles, the issue was not very well known. After the Bill on the Establishment of the Health Promotion Fund was approved by Parliament, a public opinion poll was conducted among the people in the Bangkok Metropolitan area and vicinities. Out of the 1,953 people sampled, it was found that 62.7 percent did not know that the Bill had been enacted. At that time, the Fund’s Office had already been operating for several months and news about the Bill’s enactment had appeared in the media. Therefore, in looking back at the period when the proposal for the establishment of the Fund was being pushed, one finds that very few people knew about it. And from asking many people who are close observers of social change, the same answer was received that they did not know about the matter until the Fund’s Office was established.

time as well as from the conditions of Thai society during a period of political and social reform. It also benefited from the fact that the new Constitution prompted the ideas concerning reform of the healthcare system and health promotion through the civil society process to gain greater acceptance by society in general.

It should also be noted that any other attempts in the future to link an earmarked tax with a fund or organisation along the same lines as ThaiHealth should be very difficult. This is for the following reasons.

- The case of ThaiHealth was a very special one in terms of clarity and international acceptance of the principle and rationale for having a sin tax for health promotion. Nevertheless, it still had to overcome the “fiscal discipline” barrier on a number of occasions. Therefore, other proposals of this kind should also have very clear-cut principles at the same or even higher level.
- The issue of “copycatism” is the greatest cause of concern for all sides with regard to the establishment of ThaiHealth. However, the experiences of foreign countries reaffirmed that such a phenomenon would not be repeated since cigarettes and tobacco are a truly special case. This reinforces the first point that other proposals of this kind must truly have clear-cut principles at an equal or higher level.
- Many sides are still wedded to the same benefit-cost equation concerning the cost-effectiveness of health investment through the establishment of ThaiHealth. They would therefore insist on having the answer to this question before considering any similar proposals.

For this reason, **the successes or obstacles encountered by ThaiHealth in its operations represent “new data” and “new knowledge”, which will benefit the drive for other kinds of change seeking to follow a similar approach and format.**

In any case, widespread changes have taken place at present with regard to the policy context and process, and a period of chaotic change

will ensue for quite some time. Under such circumstances, there may be some limitations in adapting and utilising knowledge that has been synthesised from former cases and older context. Moreover, there is also the possibility that new policy opportunities may arise, which are conducive to groups that are well prepared and which may be capitalised by such groups to turn the tables.

Governing Board of the Thai Health Promotion Foundation (8 November 2001 - Present)

Chairperson	Prime Minister
First Vice Chairperson	Minister of Public Health
Second Vice Chairperson	Prof. Dr. Prakit Vathesatogkit
Board Members	Representatives from the: Office of the National Economic and Social Development Board
	Office of the Permanent Secretary to the Prime Minister’s Office
	Ministry of Finance
	Ministry of Transport
	Ministry of Interior
	Ministry of Labour and Social Welfare
	Ministry of Education
	Ministry of Public Health
	Ministry of University Affairs
Eminent Persons	Prof. Dr. Udomsilp Srisaengnam
	Dr. Jingjai Hanchanlash
	Mr. Surin Kitnitchee
	Mr. Thongdee Photiyong
	Dr. Saisuree Chutikul
	Mr. Paiboon Wattanasiritham

	Prof. Dr. Vicharn Panich
	Assoc. Prof. Dr. Kanjana Kaewthep
Board Member and Secretary	Fund Manager
Advisers to the Board	Dr. Pirote Ningsanonda
	Prof. Dr. Prawase Wasi
	Dr. Paichit Pawabutr
	Rear Admiral Dr. Vitura Sangsingkeo
	Prof. Sumon Amornvivat

(The Evaluation Board is independent from the Governing Board and is appointed by the Cabinet at the recommendation of the Finance Minister)

Chairperson	Dr. Dumrong Boonyuen
Board Member in Charge of Evaluation	Prof. Dr. Pratya Vesearach
Board Member in Charge of Health Promotion and Assessment	Assoc. Prof. Dr. Pornpun Boonyaratpan
Board Member in Charge of Financial Affairs	Dr. Somchai Richupan
Board Member in Charge of Financial Affairs	Prof. Dr. Ammar Siamwala
Board Member in Charge of Evaluation	Prof. Dr. Chitr Sitthi-Amorn
Board Member in Charge of Evaluation Suriyawongpaisal	Assoc. Prof. Dr. Paiboon

REFERENCES

Thai-language Documents

Action on Smoking and Health Foundation of Thailand. (1997). *Khor mun lae sathiti kan sub buree khong khon thai* (Data and Statistics on Smoking by Thais). Vorasan kan vichai rabob sataranasuk (Health Systems Research Journal). Health Systems Research Institute. Vol. 5, No. 3.

Choochai Supawongse, Supakorn Buasai and Jitsiri Thanapatra. (1998). *Wiwattanakan khong kan khuab khum kan boripok yasoob nai prathet thai* (The Evolution of Tobacco Consumption Control in Thailand), Research Paper submitted to the Health Systems Research Institute.

Choochai Supawongse and Supakorn Buasai. (1997). *Wiwattanakan khong kan khuab khum kan boripok yasoob nai prathet thai* (The Evolution of Tobacco Consumption Control in Thailand). *Vorasan kan vichai rabob sataranasuk* (Health Systems Research Journal). Health Systems Research Institute. Vol. 5, No. 3.

Health Systems Research Institute. *Chap Krasae*, the newsletter of the Health Systems Research Institute. Various issues.

Health Systems Research Institute. (1993). *Phaen sathaban vichai rabob sataranasuk 2536-2539*. (The Plan for a Public Health Research Institute, 1993-1996).

Health Systems Research Institute. (1994). *Kan khuen pasee buree matrakan champhen phua pong kan dek lae yaowachon mi hai tid buree pherm khuen* (A Cigarette Tax Increase: an Essential Measure in Order to Prevent Additional Children and Youth from Becoming Addicted to Cigarettes). *Vorasan kan vichai rabob sataranasuk* (Health Systems Research Journal). Vol. 2, No. 1 (January - March).

Health Systems Research Institute. (1998). Supporting document for the 2nd Health Systems Research Institute Workshop on "Health Promotion: a New Role in a New Era for Everyone". 6-8 May.

Isra Sarntisart. (1995). *Phon krathob khong kan plien plaeng phasi sanpa samit buree.* (The Impact of a Change in the Cigarette Excise Tax). Research Paper by the Health Systems Research Institute.

Khwam phen ma khong samnak ngan kong tun sanap sanun kan sang serm sukhapab (sor sor sor) [The Origins of the Thai Health Promotion Foundation (ThaiHealth)], an internal ThaiHealth document (author unknown and undated).

Phaen mae bot kan ngern kan klang phua sangkhom (Fiscal and Financial Master Plan for Social Development) (undated).

Prawase Wasi. (1998). *Bon sen thang mai kan song serm sukhapab: apiwat cheewit law sangkhom.* (On a New Path to Health Promotion: Enriching One's Life and Society) Moh-Chao-Ban Press.

Rai-ngan kan du ngan ongkon sanap sanun kan song serm sukhapab prathet new Zealand lae prathet Australia 9-13 thanwakhom 2539 (Report on the Study Tour concerning Health Promotion Organisations in New Zealand and Australia, 9-13 December 1996), submitted to the Permanent Secretary for Finance, 1996.

Sathanakan buree (The Cigarette Situation). Health Systems Research Institute. Sathanakan (Situation). Paper disseminating data on medicine and public health. No. 1 (undated).

Sira Boonphinon. (1997). *Kan thob thuan khotmai tang prathet kiew kab kong tun song serm sukhapab* (A Review of Foreign Legislation on Health Promotion Funds), a research paper submitted to the Health Systems Research Institute.

Sira Boonphinon. (1997). *Kong tun song serm sukhapab doy chai thun chak pasee buree* (A Health Promotion Fund Using Funds from a Cigarette Tax), article for publication in the Law Journal of the Faculty of Law, Chulalongkorn University.

Suchada Tungthangthum. (1997). *Sethasat kan Muang ruang buree.* (The Political Economy concerning Cigarettes). *Vorasan kan vichai rabob sataranasuk* (Health Systems Research Journal). Health Systems Research Institute. Vol. 5, No. 3.

Suchada Tungthangthum. (1997). *Utsahakam yasoob lae khor mun tang tang thee kiew khong kab kan sub buree nai prathet thai.* (The Tobacco Industry and Related Information on Smoking in Thailand). *Vorasan kan vichai rabob sataranasuk* (Health Systems Research Journal). Health Systems Research Institute. Vol. 5, No. 3.

Supakorn Buasai. *Pruettigam kan sub buree khong yaowachon thai.* (The Smoking Behaviour of Thai Youth). Health Systems Research Institute. *Sathanakan* (Situation). Paper disseminating data on medicine and public health. No. 18 (undated).

Supavadee Thirapanish and Sasithorn Kitsawangrat. (2001). *"Sin tax kab kong tun sanap sanun kan sang serm sukhapab"* (The Sin Tax and the Health Promotion Fund). *Kan Ngern Kan Klang* Magazine, Vol. 15, Edition 48 (April).

Supavadee Thirapanish. (2001). *"Rai-ngan phon kan banthuek krabuan kan khan ton kan chad tang kong tun sanap sanun kan sang serm sukhapab"* (Report on the Results of Recording the Process of Establishing a Health Promotion Fund), research work submitted to the Health Systems Research Institute.

Surakiat Achananuparp. (1998). *Wiwattanakan songserm sukhaphab radab nanachat* (The Evolution of Health Promotion at the International Level). Project of the Health Systems Research Institute Press.

Thai Health Promotion Foundation. (2002). *2001 Annual Report.*

Thailand Development Research Institute. (2002). *Pramern phon ngan sathaban wichai rabob satharanasuk* (An Assessment of the Work of the Health Systems Research Institute). Comprehensive study submitted to the Board of the Health Systems Research Institute.

Thira Limsila. (1994). *Buree-mareng pod kan sun sia sukhapab cheewit lae kan sun sia sethakit* in Vorasan kan vichai rabob sataranasuk (Health Systems Research Journal). Health Systems Research Institute. Vol. 6, No. 1.

Vichai Exphalakorn. (1997). *Kan samruat pracha mati wa dua kan songserm sukhaphab doy chai pasa buree* (A Public Opinion Poll on the Promotion of Health through Cigarette Language). *Vorasan kan vichai rabob sataranasuk* (Health Systems Research Journal). Health Systems Research Institute. Vol. 5, No. 3.

Wiwit Wuthiwirawat and Waraporn Panpong. (1998). *Parithat kan ronarong songserm sukhaphab nai sangkhom* thai. (A General Overview of the Health Promotion Campaign in Thai Society) (drawn from the research study by Choochai Supawongse, Wiput Phoolcharoen, Banchorn Kaewsong, *et. al.*). Project of the Health Systems Research Institute Press.

English-language Documents

Collishaw, Neil. (1993). Potential Health Benefits of a 10% Increase in the Real Price of Tobacco through Taxation in Thailand. Press Release.

Vathesatogkit, Prakit. (October 2002). *Seeking Success: Thai Tobacco Control.* (draft).

Interviews

Interview with Ms. Supavadee Thirapanish, a former official of the Fiscal Policy Office, Ministry of Finance, and presently employed at the Thai Health Promotion Foundation in the internal audits section, on 17 September 2002.

Interview with Dr. Supakorn Buasai, Manager of the Thai Health Promotion Organisation, on 25 September 2002.

Interview with Dr. Prakit Vathesatogkit, Dean of the Faculty of Medicine, Ramathibodi Hospital, on 7 October 2002.

Interview with Mr. Chaiyuth Sutthithanakorn, a specialist on fiscal and tax matters, Fiscal Policy Office, Ministry of Finance, on 8 October 2002.

Interview with Ms. Puangthong Palawatvichai, Chief of the Tax and Services Policy Section, Fiscal Policy Office, Ministry of Finance, on 8 October 2002.