Health Care on the Border:
Professional Caregiving, Universal Health Security, and Tuberculosis Control
in Thailand and Its Border with Myanmar

A dissertation presented

by

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Abstract

This dissertation is an ethnography of caregiving and bureaucracy. It examines professionals’ practice of caregiving in the context of the two global health movements—the expansion of universal health coverage (UHC) and the “eradication” of tuberculosis (TB)—in Thailand, a global model of UHC, and its border with Myanmar, the other TB-laden nation in which UHC is still far from being achieved. Drawing from more than eight years of experience working as a Thai medical doctor and fourteen months of fieldwork in Thailand, I explore how professionals who work in the health bureaucracies strived to ensure health security of every person regardless of national boundaries. Focusing on the domination and governmentality of market model and management rationality embedded in the two global agendas, I found that the neoliberal “iron cage” not only instills indifference and medicalization but also inhibits the achievement of the global efforts. Using ethnographic encounter to discern the intricate assemblage of global bureaucratization, I argue that “professional caregiver”—a particular subjectivity of caregivers who have institutional and moral obligations to care for others—provides the openness for the professionals’ liberation that enables them to cross the boundaries and transform the bureaucracies from within.
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Acknowledgements

I wish to have more time to write this acknowledgment. To me, it is one of the most significant section of a piece of writing, especially a Ph.D. dissertation in which encapsulate the experience of years in the graduate school of the author. It is a long path that defines the direction of what will come in the next “chapters” of the line of the story told in it and the trajectory of life of its author. As eventually I can be an author myself, I humbly declare that this is a collective effort. So many people have contributed to the “success” of the writing of this dissertation.

The person whom I’d like to thank the most is the women who share my life and my dream, Bunga Limsawart. She is the one to whom this dissertation is dedicated. Without her care and dedication for me and our three kids, I would not only unable to finish the Ph.D. degree but also cannot survive. This dissertation is a product of our effort, as Prof. Arthur Kleinman usually asserts, “to live our moral lives” amidst many obstacles, including our illnesses, that had tried to stop us.
Note on Transliteration and Naming

Unless otherwise noted, in this dissertation I use the Romanize transliteration scheme of the Royal Society of Thailand for transliteration of Thai terms and names. The reason is that it is a simplified scheme, developed by the authoritative academics in Thai linguistics. The most recent version of the scheme is *Lakken Kanthot Akson Thai Pen Akson Roman Baeb Taisiang* (the rules for phonetic transliteration of Thai characters to Roman characters) that the Royal Society of Thailand announced on January 11, 1999. It was officially endorsed by the Office of Prime Minister of Thailand on May 11, 1999 to be the “national standard.” As Michael Herzfeld points out, however, “transliteration of Thai is notoriously difficult and inconsistent” and “no transliteration system can work perfectly” (2016:xii).

Names of the public figures are their real names, spelt in English as they prefer. For other people, I use pseudonyms to protect their privacy and confidentiality. On their first use, the pseudonyms are marked by the asterisk (*).
Introduction

Thesis question

This is a dissertation about caregiving and bureaucracy. It is a product of my intellectual journey to understand subjectivity and practice of people who are given the “role” to provide specialized care to other members of the society. They are “professionals.” The term professional I use in this dissertation, however, is an inclusive one that refers not only the members of the licensed healthcare professions such as medical doctors, dentists, pharmacists, or nurses, but also others who possess technical ability to pursue their given roles. Nevertheless, in this dissertation, the professionals I focus on are those who practice under the direction and regulation of their affiliated institutions—the health bureaucracies, national and global.

My intellectual journey began when I decided to leave the position as a medical doctor and administrator of rural hospitals in southern Thailand. After many years of medical practice, administration, and activism, I found that to be able to improve the “system” of health care for my patients and my colleagues, I need to understand something more: “medical culture,” as framed broadly by my limited sociological knowledge. Therefore, I began to embark on the journey to become a physician-anthropologist. In the training program, I have engaged with many seminal works of my professors that have shaped my intellectual trajectory and the ideas I put into this dissertation. Beginning with the distinction between illness and disease and the
intersection among *culture, illness, and care* (Eisenberg 1977; Kleinman, Eisenberg, and Good
1978), I became aware of the nuanced view of medical anthropology. Further, I learned about the
broader perspective from cross-cultural study that “biomedicine” is only a particular medical
culture that bases on biomedical sciences and biotechnologies as the prefix “bio” signifies. While
my previous critical view of biomedicine was influenced and, as a doctor myself, disturbed by
the work like *Medical Nemesis* (Illich 1976), Byron Good’s (1994) argument that it is the
“conjoining of physiological and soteriological” (86) enables me to take a more neutral stance.
Further, Mary-Jo Good’s (1995a, 1995b) analysis helps me to see that medical culture is
significantly shaped by “social context,” illustrated by the “culture of competence” of American
doctors that is in large part the product of social hostility on medical errors and medical liability
crises in the United States. By this culture, American medical professionals shift away from “soft
side” to “hard side” of medicine (Good 1995a:14). My reading of this “shift” is that it is the
moving of the focus of the doctors’ competency away from humanistic caregiving to scientific
clinical management in the name of *quality*.

My understanding of the biomedical culture is further untangled, by Arthur Kleinman’s
(1995) succinct identification of the “three-folding” feature that is specific to biomedicine—
*medicalization, professionalization, and bureaucratization*. As bureaucratization is an essence of
biomedicine, Michael Herzfeld’s (1992) analysis of the *bureaucratic indifference* helps me to
understand why “indifference” seems to be a pervasive experience of patients in their
relationship with healthcare professionals in the biomedical-based health care system.
Nevertheless, the *soteriological* aspect of medicine, the aims of salvation and redemption, makes
me aware that there is always a “moral” in the practice of the healthcare professionals. Here I
found Kleinman’s (2006) conceptualization of “moral” as “our sense of right and wrong” we
have with our “moral environment” helps to identify a point of departure for the professionals’ “moral commitment” to make the change to the “environment” in which they live and work. Influenced by my years of experience of medical activism in Thailand, I take such commitment as the “point of departure” of this dissertation in which I seek to understand bureaucracy as the “moral environment” and the professionals’ response to it in their act of caregiving.

My selection of the topic for this dissertation is influenced in a significant way by my engagement with a course in “global health” and its instructors at Harvard. It is the course entitled “Case Studies in Global Health: Biosocial Perspectives,” instructed by four physician-anthropologists, Paul Farmer, Salmaan Keshavjee, Anne Becker, and Arthur Kleinman that I was a student in 2010 and a teaching fellow in 2014 and 2015. The case studies discussed in the course provided me vivid examples of the use of social theories in public health interventions. The framework of “bio-social interaction” emphasized in the course enabled me to integrate deep biomedical studies and nuanced social inquiries and to bring my identity and experience as a medical professional into the ethnographic encounter of this dissertation. The set of selected social theories rendering as a “toolbox” helps me to incorporate multiple theoretical perspectives into my research. I was struck by a classic work of Robert Merton (1936) included in the toolbox, entitled “The Unanticipated Consequences of Purposive Social Action.” His strong argument signified by the term “unanticipated” in the title—even though unintended consequences seems to be unavoidable, there are foreseeable factors that cause unintended negative consequences. Those factors include the error caused by neglect or “pathological obsession”—what the course instructors call “rigidity of habit”—and the “imperious immediacy of interest” (901). To me, they are the two factors that embedded in the social actions of health care institutions, especially in the “immediacy” of infectious disease epidemics. These reading
and my identity as an officer of the Thai Ministry of Public Health influenced me to go further in my social analysis of health bureaucracies. As they are the social institutions that continuously “act” upon the society with promising purposes, it would be beneficial if we can prevent the foreseeable negative unintended effects of their policies or programs. Moreover, the case studies and the ongoing works of the course instructors make explicit the roles of the multi-disciplinary and the professionals’ “vitality of praxis”—the dual modes of action and reflection (Farmer, et al. 2013:3)—in enhancing the professional's ability to achieve the intended outcomes and prevent of the negative consequences.

Inspired by the works and commitment to “health equity” of the course instructors, I decided to participate with them with this dissertation in the nascent multi-disciplinary field of “global health equity.” The subject of inquiry of this dissertation are the professionals who work within the context of bureaucracies and the two post-2015 global agendas—the expansion of universal health coverage (UHC) and the “eradication” of tuberculosis (TB). The thesis question is, how do these professionals embrace and engage with the global health movements to ensure health security of every person and to eliminate suffering of people caused by tuberculosis?

A History of the Global Movements: TB and UHC

Tuberculosis (TB) is a treatable airborne communicable disease that kills millions of people throughout human history. It is still a major global public health problem even though curative treatments have been available for many decades. Recent estimation shows that from 2001 to 2020, one billion people will have TB infection, two hundred million will have active
disease, and thirty-five million will die of the illness (McMillen 2015:1). In the era of HIV/AIDS epidemic, TB has got less public attention even though it is the principal killer of AIDS patients. A reason is that most of the people inflicted by TB live in developing countries or poorest strata of the societies. Nonetheless, this infection threatens all people as it spreads through the air while the single vaccine available today can prevent solely severe disease in children. Therefore, it is plausible to state that TB is our common enemy and the only way to subdue it is to find and treat all infected people, especially those who left out of sight of the public and the states. By the “vision”—the institutionalized imagination—of "A world free of TB," WHO’s End TB Strategy (2016-2035) puts the "universal health coverage" (UHC) policy as one of its key components (WHO 2015:7) as UHC is the means to include all people into national TB program. The intertwining of the two global health agendas is the focal area of analysis in this dissertation.

**The global epidemic of TB and MDR-TB**

Based on present biomedical and epidemiological knowledge, TB is a treatable airborne communicable disease caused mainly by *Mycobacterium tuberculosis*, the germ that was first identified by Robert Koch in 1882. It is the number one killer that has killed a billion of people in the past two centuries (McMillen 2015:2). It is still a major global public health problem even though anti-TB drugs have been available since the 1940s. WHO estimated that one-third of the world population has TB infection, but the healthy body suppresses it as "latent TB." It will turn to the active disease if the body is weakened by, for example, malnutrition, cancer, or other illnesses especially HIV infection. WHO reported that, in 2016 alone, there were 10.4 million

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1 There are others species of Mycobacterium besides *M. tuberculosis* that can causes TB disease.
new cases of TB and 1.7 million deaths—more than 95 percent of the lives lost were people of low- and middle-income countries. As HIV destroys the immune system, HIV and TB become the deadliest combination; TB/HIV co-epidemic caused 0.4 million deaths in 2016 or 40 percent of the death of HIV patients caused by TB.\(^2\) While WHO reports the success of global TB movement in saving lives of million people in the past decades, it reveals the failure of the program in dealing with the emerging epidemic of multidrug-resistant tuberculosis (MDR-TB)—the epidemic that, to me, can be seen as an unintended consequence of the global efforts to control TB.

Regardless of the fact that drug-resistant strains of TB have emerged since the early introduction of TB drug in the 1940s, WHO had long emphasized using its standard regimen to treat TB in poor resources countries, known as “directly observed therapy, short course” (DOTS). This regimen requires completion of a six-month long daily medication. It is a pervasive challenge that many patients cannot complete the regimen because of biological and social factors. As a result, the infection develops new strains of MDR-TB. There is an increasing problem of “treatment failure.” One primary reason is that the patients have MDR-TB but never been detected as the drug susceptibility test (DST) is not always available. Moreover, as the treatment for MDR-TB requires more expensive drugs and longer period (about two years) it is not available for every people, especially for the poor whose living condition and malnutrition heighten their TB susceptibility and severity.

Multi-drug resistance tuberculosis (MDR-TB) is caused by *M. tuberculosis* strains that

have resistance to isoniazid and rifampicin, the two most potent anti-TB drugs. There were 480,000 new cases of MDR-TB reported in 2014. Based on WHO’s the latest Guideline for TB Treatment (WHO 2009), people with the suggestive symptom of active pulmonary TB (a productive cough more than two weeks with or without other “constitutional” symptom such as weight loss and night sweating) should access to testing for definite diagnosis. A new case of TB will be treated by a standard regimen: diagnosed by the sputum smear examination and treated by a combination of "first-line" oral anti-TB drugs for six months. For a previously treated case, either the last treatment result was “treatment failure” or “defaulted” will be tested for MDR-TB by the drug susceptibility testing (DST). The treatment for MDRTB will begin with at least six months of "intensive phase" using multiple anti-TB drugs with an injectable "second-line" drugs followed by oral chemotherapy until whole 18 months after testing for TB bacteria was negative. The cost of MDR-TB treatment is approximately 50 – 200 times higher than the standard six-month TB treatment. By this required regimen, which thus classifies MDR-TB as difficult and costly to treat

**Development of economic view of TB**

The concern of “cost” has framed how we think about TB control in the past four decades. In 1979, the meeting at Bellagio criticized the Alma-Ata Declaration as too broad and too vague and publicized the idea of Selective Primary Health Care or "Affordable Health for All," that prioritize health problems based on the calculation of "cost-effectiveness." At that time, TB epidemic was categorized as non-cost effective. Although its significance was high, TB was too complicated and costly to treat in the resource-poor setting. It thus lost its priority in global health agenda setting. By the passion for finding a low-cost method to treat TB, in the late 1980s
a team of researchers developed effective short-course chemotherapy (SCC) that shorten the time of treatment from year to only six months. Meanwhile, the World Bank had increased its interest in global health. The Bank put health an economic priority in its *World Development Report 1993: Investing in Health*. In this report, a new health metric was publicized—Disability Adjust Life Years (DALYs)—the collective number of healthy years a population lost by death or disability caused by a particular illness. It can be seen as a metric that put a concern of human economic value—years of productive lives—at the center of public health discussion. As TB affects mostly middle age people, this new calculation made explicit that TB is a significant economic burden; SCC becomes a highest cost-effective health intervention. The bank thus called for investment in TB control (Becker et al. 2013). WHO carried on this ambitious imagination. In April 1993, WHO declared TB as a "global emergency" and called for collective action against global TB epidemic using a cost-effective, standardized regimen DOTS. The principal rationale was to prevent millions of deaths and avoid the expansion of MDR-TB that costly to treat (WHO 1994). MDRTB, therefore, since 1993 has been characterized as an economic demon.

*The consequence of the economic view of TB*

The consequence of demonization of MDRTB is well illustrated by the contrast stories of two MDR-TB epidemics in New York City and Lima, Peru in 1990s (Farmer 1999; Keshavjee and Farmer 2012; Smith-Nonini 2009). While patients in New York City were treated by using DST and customized high-cost regimen, WHO insists Peruvian government use low-cost, standardized regimen, without using DST, that proved ineffective, and the MDR-TB outbreak in Peru expand. The two epidemics illustrate the uneven distribution of treatment and outcome.
between rich- and poor-resource settings, illuminating the problem of “global health inequity” (Farmer, et al. 2013). Paul Farmer (1999) explores the "political economy of MDR-TB" showing that there were prominent myths people have with MDRTB including the idea that it is less infectious than ordinary TB, and it should not be treated in resource-poor settings because it will divert resource and attention from the control of ordinary TB. The epidemic of MDR-TB kept growing. The hidden epidemic of MDR-TB revealed in almost every places that DST become available. Farmer and his colleagues took many years of efforts to make WHO accept that treatment for MDR-TB should be a part of the National TB Program in all countries. WHO revised guideline on TB control to include MDRTB in the national program. Beginning in 2006, WHO initiated the global movement to subdue TB through the Stop TB Strategy (2006-2015), attaching global TB control with the Millennium Development Goals (MDGs)—the pre-2015 global agenda.

**Global UHC movement**

The global movement of UHC began by the formulation of the financial concept of universal coverage. In 2005, the World Health Assembly (WHA) endorsed the concept UHC. In the report by the secretariat entitled “Social health insurance,” WHO identified the definition of universal coverage:

Universal coverage is defined as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access. The principle of financial-risk protection ensures that the cost of care does not put people at risk of financial catastrophe. A related objective of health-financing policy is equity in financing: households contribute to the health system on the basis of ability to pay. Universal coverage is consistent with WHO’s concepts of health for all and primary health care. (WHO 2005:1, emphasis original)

The *World Health Report 2008* on Primary Health Care revisited and articulated the idea of
Primary Health Care with UHC. As the thirtieth anniversary of Alma Ata Declaration, the report describes the “renewal of primary health care” identifying that health equity is one of the key focus and “universal coverage” is the key measure to address health equity in Primary Health Care (WHO 2008). Two years later, the World Health Report 2010, details the idea that “health financing” is the core measure to achieve universal coverage (WHO 2010).

As a middle-income country, the achievement of Thai UHC in 2002 became a source of motivation and model for global health community emphasizing the significance of healthcare financing. In 2010, Thailand was characterized as a “striking case” in The World Health Report 2010 on the theme Health Systems Financing: The Path to Universal Coverage (WHO 2010). The report begins with the story of a case of a motorcycle accident brought to Khon Kaen Regional Hospital in Thailand. Emphasizing the financial risks that the patient and the hospital bared, the case shows that Thai UHC scheme helped to eliminate the risks. The story ended with the view of the patient’s surgeon that “medical staff does not consider who is going to pay for treatment, however expensive it might be because, in Thailand, everyone’s health-care costs are covered” (WHO 2010:3).

Taking into account the context of global development agenda, UHC is put to be a solution to the more significant concern about social protection in the world after the economic crisis. UHC is the ground for WHO in working with International Labor Organization (ILO) to develop “financial risk protection” or the initiative called “Social Protection Floor” began in 2007 (WHO 2010). By this position, it is not surprising that the United Nations endorse UHC in its General Assembly in December 2012. UHC was institutionalized into the global development policy that tightly links health and economic.
Economic construction of UHC

The website of Universal Health Coverage Coalition under the domain name universalhealthcoverageday.org can be seen as a visual representation of how the concept of UHC is constructed in the present global movement. The phrase “Health for All” is the main message of the website as it appears in biggest text size at the center of the home page and in the UHC Day’s badge that appear everywhere. The web shows that UHC is “a growing movement” motivated by the recognition that “too many people are still waiting for health.” It also stresses that UHC is “the economic case” providing a link to read the Economists Declaration and also a space for “professional economist” to add one’s signature to the Declaration. The second paragraph of the Declaration emphasizes the economic ground of the present construct of UHC:

Universal health coverage means ensuring that everyone can obtain essential health services at high quality without suffering financial hardship. Resource constraints require individual countries to determine their own definition of “essential” – while recognizing, in the words of former World Health Organization Director-General Gro Harlem Brundtland, that “… if services are to be provided for all, not all services can be provided. The most cost-effective services should be provided first.”

By the recognition of resource constraints in providing UHC, the economists stress in their Declaration that selection of “essential” health services based on “cost-effectiveness” is required. The UHC, therefore, is grounded on the idea of Selective Primary Health Care as the mean to achieve the goal of “Affordable” Health for All.

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3 This description is based on the rendering of the webpage I saw in September 2017.
Global imagination, put in the management term as “vision” accompanied by a set of “goals,” was set again in 2015 when the Millennium Development Goals end. The UN General Assembly in 2015 endorses the next vision of the world and the new “Sustainability Development Goals” (SDGs) for the next 15 years. Health is one of the areas identified to achieve collaboratively by the whole global community set as Goal number 3: “Ensure healthy lives and promote well-being for all at all ages.” This goal details the imagination of the world with the achievement of UHC (Goal 3.8) and the “end” of epidemics of infectious diseases (Goal 3.3) including the millennial-old malady, tuberculosis (UN 2015).

Responding to the post-2015 global development agenda, WHO revises its global map for TB control strategies—identify as the high burden countries (HBCs). When the concept of HBC began in 1998, Thailand was one of 22 countries that collectively “burdened” by 80 percent of the total number of global TB incident. In the new HBC concept of the post-2015 era, Thailand is one of 14 countries that are in all the three lists of 30 countries that have highest number and rate of TB, TB with HIV/AIDS, and MDR-TB (Figure 1):

The 30 TB HBCs (those in all 3 lists in bold) are: Angola, Bangladesh, Brazil, Cambodia, China, Congo, Central African Republic, DPR Korea, DR Congo, Ethiopia, India, Indonesia, Kenya, Lesotho, Liberia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Russian Federation, Sierra Leone, South Africa, Thailand, the United Republic of Tanzania, Viet Nam, Zambia and Zimbabwe.  

In the regional perspective, five of Southeast Asian countries are identified as HBCs—

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Cambodia, Indonesia, Myanmar, Philippines, and Thailand. Three countries—Indonesia, Myanmar, and Thailand—are in the list of 14 countries that included in all the three lists. Therefore, TB is a major public health challenge of the region and the Association of South East Asian Nation (ASEAN).

![Diagram showing countries in the TB/HIV, MDR-TB, and TB lists.](image)

Figure 1: “The three HBC lists of 30 countries each that will be used by WHO 2016–2020”

**Contribution**

The dissertation lies at the intersection of medical anthropology, anthropology of bureaucracy, and Thai studies. It is a study in the nascent field of "global health equity" that takes *biosocial*—the interaction of biological and social factors—as its central framework for the analysis of health problems and interventions (Farmer et al. 2013). It also provides ethnography of health cares and health professionals in a resource-poor setting. Contributing to the intellectual
discussion on the studies of bureaucracy, professional, citizenship, as well as the discussions and debates on the concepts and models of UHC, such as the distinction between “universal health care” and "universal health coverage" (Global Health Watch 2014a). It will also provide a medical anthropological approach to the study of Thai neoliberal state, especially on the relationship between the state and its citizens. I also aim to contribute to the fields of healthcare researchers in Thailand by providing a ground study of Thai healthcare in the context of neoliberal world order. It will also add to the areas by introducing the framework of biosocial approach that helps to link, for example, molecular biology to the large-scale political economy and the paradigm of global health that helps to move the researchers' foci within and beyond the boundaries of nation-states. As the world is moving to the new phase of global TB movement, the "End TB Strategy" (2016-2035), this dissertation would provide insights for a nuanced integration of UHC policy and TB program in developing countries.

**Literature Review and Theoretical Constructs**

Through the review of the literature, I develop three conceptual constructs to help answer the thesis question: *how do professionals in health bureaucracies embrace and engage with the global health movements of UHC expansion and TB control to ensure health security of every person and to eliminate the suffering of people caused by tuberculosis*. The preposition “on” in the dissertation title *Health Care on the Border*, emphasizes the focus of the inquiry that is to understand how do professionals “cross the boundaries” to pursue their work’s objectives. Therefore, the “border” that this dissertation seeks to explore is not only the geographical borderland that transverses across the national border. It also the "area" between two polarities...
obscured in commonly used dichotomies: public/private, professional/non-professional, and citizen/non-citizen. I use three lines of inquiry that weave through the chapters of this dissertation to investigate them using three conceptual constructs: neoliberal bureaucratization, professional caregiving, and stateless tuberculosis.

**Neoliberal Bureaucratization**

My first line of inquiry focuses on the border between the dichotomy of public and private in the process of neoliberal bureaucratization. The conceptual construct “neoliberal bureaucratization” coined by French social critic Béatrice Hibou (2015) conjoining Weber’s concept of domination (authority) and Foucault’s concept of governmentality (e.g., 1991). In this dissertation I frame it as the domination and governmentality of market model and management rationality. As Hibou (2015) asserts it is a primary feature of neoliberal globalization that has affected every sector of the society and turned everyone to be a bureaucrat. This conceptual construct helps to put all parts of the healthcare system in one frame. Public, private, and other sectors that relate to healthcare are integrated into a complex assemblage of global healthcare system. The concept of neoliberal bureaucratization also helps to bring two poles of conflicts into one plane: the neoliberal market-based model threatened by private profit makers and the bureaucratic institution-based model threatened by "indifference" and corrupted public officials. Although there is no consensus whether Max Weber’s concept of bureaucracy is limited to state’s public administration, his “ideal type” is beneficial for analysis of social institutions beyond the scope of public administration by the national bureaucracy (e.g., Crozier 1964). While the studies of the organization of bureaucratic institutions are beneficial, anthropological studies of bureaucracy seek to understand lived experience of people through the studies of, for
example, symbolism, cultural objects such as files, or experience and representation of corruption (e.g., Gupta 1995; 2012; Herzfeld 1992; Hull 2012). Recently, anthropologists raise a focus on “new” form of “the public goods” (the preposition “the” indicates that these public goods are not consumable things, but interests) such as fiscal austerity and accountability (Bear and Mathur 2015; Ong and Collier 2005). In this vein, the concept of neoliberal bureaucratization provides a useful analytical frame to understand Thai state's reforms in neoliberal climate after the Asian Economic Crisis in 1997, especially through the dominant model of “new public management” and the discourse of "good governance." I put particular interest on the issue of fiscal austerity as it is the key strategy of “reform” in Thai UHC policy and financial management is arguably the critical challenge of TB care programs at all levels, from local to global.

**Professional Caregiving**

The second line of inquiry focuses on the border between the dichotomy of professional and non-professional in the practice of caregiving. My particular interest is in the use of this dichotomy to classify “caregivers” working together in the context of bureaucracy in dealing with “social diseases” like tuberculosis that this dissertation focuses. I use the concept of professional caregiving to problematize the usual “exclusive” connotation of the term profession. In this dissertation, therefore, the term professionals I use is an inclusive one.

To examine the practices of the professionals in the context of bureaucracies, I develop the conceptual construct professional caregiving based on Weber’s concept of Beruf that can be translated as both “profession” and “vocation” or “calling” and Wilkinson and Kleinman's (2016) conception of “caregiving.” By the concern of modern professions, Talcott Parson
identified that Weber failed to “differentiate between the organization of professional service and … ‘administrative hierarchy’ of occupational structure types” (Swedberg 2005:211). Eliot Freidson (1986) later asserted that it is “formal knowledge” that provides the professional's autonomy to regard “competence” over the hierarchical administrative control within the bureaucracies (151). Similarly, Andrew Abbott (1988) identifies that “abstract knowledge” is what makes a profession an “exclusive occupational group” (8) that has a jurisdiction to control particular occupational works. By the jurisdictional negotiation among professions, the “multi-professional environment” of bureaucracies enhances domination of some profession over the others, such as the domination of medical doctors in health care institutions. Nevertheless, their focus on knowledge and authority obscures the other dimension of the professions—that is, the “morality” that bring people to pursue the training to become professionals and to perform the professional practice. For the professions in the medical institutions, it is the soteriological aspect (the aims at salvation and redemption) that conjoins in the “symbolic formation” (Good 1994:86) of the “abstract knowledge” of biomedicine. Here I found Weber’s view of a profession as a “calling”—“a life-task [set by God], a definite field in which to work” (2001:39)—is crucial for a comprehensive understanding of professionals working within the context of bureaucratic institutions. Bureaucracy, therefore, is a “moral environment” in which professionals practice their professions. As they have autonomy to resigned from the bureaucratic positions, what holds many professionals in my analysis in the bureaucracies are not only the “secure existence” or “social esteem” (Weber 1946:199) but also their moral commitment. To understand their practice of caregiving that go beyond professional boundaries to “social care,” I thus incorporate Wilkinson and Kleinman's (2016) conception of “caregiving” as a phronesis (the experiential mode of knowing) by which, through the acts of caregiving, the professionals achieve the social
understanding that enables them to act upon the society to relief suffering of the people whom they care.

**Stateless tuberculosis**

My primary focus on the third line of inquiry is the border between the dichotomy between *citizen* and *non-citizen*. Recent studies on citizenship emphasize the “gradient” nature of this dichotomy and the need for new categories, such as “semi-citizen” (Cohen 2009; Harris 2013). I develop the concept of *stateless tuberculosis*\(^6\) to emphasize that biological and social aspects of TB are inseparable. This conceptual construct has two connotations. On the one hand, it signifies the TB germ as a stateless entity that spread across the national boundaries of geographical border and nationality of people. Here it incorporates Foucault’s concept of *biopower* (1988) and the concept of “biological citizenship” (Petryna 2013) thus investigation of how the state deal with TB in its non-citizen. On the other hand, the concept signifies the people who live with statelessness—both *de jure* statelessness, lack of registration to any nation, and *de facto* statelessness, lack of actual care from any state (Weissbrodt 2008). In this regard, the concept incorporates the theory of “structural violence” (Farmer…) and other aspects of “social suffering” (Kleinman, et al. 1997).

\(^6\) I’m grateful for my wife Bunga Limsawart who invents the term *wanarok rairat* (literally “stateless tuberculosis”).
Methodology

This dissertation is a result of eight years of experience of work as a Thai medical doctor between 2001 and 2009 and fourteen months of field research in Thailand, between June 2016 and August 2017. The field research divided into two parts: Twelve months of ethnographic fieldwork in Umphang District, Tak province and two months of archival research and interviews in Bangkok before, during, and after the fieldwork in Umphang.

My ethnographic fieldwork in Umphang aims to understand lived experience of people who give and receive cares for TB in the borderland. To get this multi-perspective, therefore, the ethnographic method of participant-observation required multiple positions in the field. As a doctor of the Thai Ministry of Public Health (MPH), I placed myself as coming to help Dr. Worawit, the director of Umphang Hospital, and his team finds ways to “control” TB in the area. This professional and bureaucratic positions, however, while facilitating my access and acceptance, complicated my acquaintance by the “distance” people in Thai society have with a doctor and middle-rank bureaucrat. To lessen this distance, I also positioned myself as a resident of the town by bringing my wife and our children to stay with me in the field and renting a house outside the hospital. Exposing my family’s everyday life and parenting provided ways for people to observe, interrogate, and participate in my daily life. Living outside the hospital allowed me to have shared-experience with other residents such as hours of power outages while people in the hospital wall got backup power from its generators.

Besides the participant observation, the method I used in the research for this dissertation can be called “engaged ethnography.” There are two levels of engagement I use in researching this dissertation: (1) planning for long-term commitment and (2) taking responsibility.
The first level of planning for long-term commitment began with my selection of TB as the topic for my “long-term engagement” in social inquiry and public health intervention working as a professional physician-anthropologist. I thus entered the field in Thailand with a long-term commitment to work on the problems of TB. My “position” was not only a Ph.D. student working on a short-term research on TB but also a professional coming to begin working for the long-term engagement with other professionals in the area of TB care and control in Thailand. I made this commitment explicit to health officers I met in the field especially the professionals working in the area of TB. As I learned from them that TB seems to be a neglected field, it is rare to have a doctor who wants to focus working on TB. Therefore, I have got good support and access to the person and the sources of information. Moreover, long-term commitment also essential for the study of the disease like TB that need the very long course of treatment. It takes a long time to follow up patients' condition and evaluate change in their health and their “network of care.”

The second level of taking responsibility began during the field work in Umphang (discussed in chapter three). After a period of observation in the trans-border TB control project that aims to control TB in non-citizen in Umphang borderland, my analysis made me aware that there are foreseeable negative unintended consequences that the project can cause. This awareness provoked my moral responsibility. In a meeting, therefore, I decided to intervene the process of the project by present my concern and offer to develop a “model” of TB program that would avoid the consequence. Even though, this intervention “distort” the object of my “scientific study,” the experience of taking responsibility provided me exposure, information, access, and insights that otherwise, I cannot achieve without such “engagement.”
Research Questions

Four research questions form the narrative and structure of this dissertation: First, I ask how professionals who work in the health bureaucracies strived to ensure health security for every person regardless of national boundaries? Second, I ask how the process of neoliberal bureaucratization—the domination and governmentality of market model and management rationality—embedded in the Thai UHC policy and the global movement for UHC expansion affects such effort of the professionals? Third, I ask how the process of neoliberal bureaucratization that infiltrates in the assemblage of the worldwide movement to end TB epidemic affects the TB inflicted people and the professionals working on TB care and control in the borderland between Thailand and Myanmar? Finally, I ask how professionals had worked and can work to prevent the unintended negative consequences of the two global agendas to ensure universal health security and remediate “suffering” of individuals and the society caused by tuberculosis and the social actions aimed at “eradication” of the germ?

Chapter Overview

In Chapter One, The Making of Thailand’s “Universal Health Coverage,” I argue that understanding of Thai UHC requires seeing it as a whole beyond the “health system financing” model. I explore the construction and implementation of Thai UHC policy, focusing on the role of people in a network of healthcare professionals calls the Rural Doctor Movement. I argue that it is the ideology of universal health security that these professionals shared that enable them to cross the boundaries of bureaucracies to make and maintain the UHC program in Thailand. I also
analyze Thai UHC in the context of the neoliberal reform of Thai public administration after the Asian Economic Crisis in 1997. In this context, I identify the new symbolism that emerges as the consequences of the Thai UHC policy—market, competence, and biomedical embrace.

In Chapter Two, *Striving for Universal Health Security at the “Border,”* I explore a consequence of Thai UHC in Umphang, a borderland between Thailand and Myanmar. As the national model of UHC limits the country’s health welfare to its citizen, the program excludes a large portion of border population who are “non-citizens.” I explore how health professionals in the borderland work to ensure health security for the excluded population by working at the periphery and engage with the national health politics at the center of the state. By the analysis of the national model in the global UHC movement, I found that what seems to be a violation of human rights of non-citizens is legitimized by international legal framework enhanced by the austerity required for the sustainability of the UHC program of each nation.

In Chapter Three, *Tuberculosis Care–Control in the “Borderland,”* I explore the consequences of the emerging concern of MDR-TB epidemic in the borderland. Through bi-social analysis, I try to make explicit how global assemblage of TB control transforms the local health care system to be a part of the global bureaucracy. By a closer observation of the local TB program, I also explore the production and consequences of the “stigma of non-compliance” a form of institutional stigmatization. Finally, I argue that the leverage point for the achievement of global TB control is caregiving.
Prologue:
Imagination of a Professional Caregiver

“I’m enough of an artist to draw freely from my imagination. Imagination is more important than knowledge. Knowledge is limited. Imagination encircles the world.”

— Albert Einstein, interviewed, Saturday Evening Post, 1929, emphasis added.

In 1973, Dr. Puey Ungpakorn (1916–99) presented his writing, “The Quality of Life of a South-East Asian” in an international expert meeting on Southeast Asian development. Born in a low-income family and paved his way to become an internationally respected economist and social reformer, Dr. Puey portrayed his ideal image of a good life from birth to death in the vigorous short writing. In the same year, he translated and elaborated it into a Thai version, Kunnaphap Haeng Chiwit Patithin Haeng Kwamwang Chak Khanmanda Thueng Choengtakon (The Quality of Life, A Calendar of Hope, From Mother’s Womb to a Person’s Tomb). After being published in a newspaper, it was rapidly circulated in the Thai public at the heightening of social concern of equity and freedom in the 1970s, especially in the circle of student-activists who were eager to make Dr. Puey’s idealistic image a reality. One of them was medical-student

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7 It was a meeting of the Southeast Asian Development Advisory Group (SEADAG) (http://puey-ungphakorn.org/index.php/wisdom-and-ideal, accessed October 25, 2017) which was an expert committee of the Asian Society. The society was founded in 1956 by a member of the third generation of Rockefeller family. It aims to promote social sciences and cultural studies in Asian countries as the mean to strengthen United States–Asia relationship.

Sanguan Nitayarumpong, a prominent leader of Mahidol University’s student organizations. After the mass massacre of radical students on October 6, 1976, many of his friends had to seek refuge in the jungle. He decided to stay, managed to avoid “communist” labeling, and continued his medical training until graduation. He then went to begin his professional works in the district hospital of a northeastern remote rural area. Dr. Sanguan had gained his understanding of rural–urban inequity through his experience of providing cares for the rural people and managing the hospital’s scared resource. In such environment, Dr. Sanguan began his life-long effort of rigorous research and practices to actualize Dr. Puey’s vivid imagination of social welfare.

A professional bureaucrat, Dr. Sanguan had been a prime mover in the movement to reform Thai health-care system for more than three decades, especially in the implementation of the Universal Health Coverage (UHC) policy began in 2001. While the Thai state claimed its “achievement” of universal coverage in 2002 as it entitled social health insurance to all Thai citizens, Dr. Sanguan deemed the entitlement as only the means. With the undivided commitment to the calling of the ideology of lakprakan sukhkaphap thuanna (universal health security), 9 he had continued, until the last day of his life, the project to ensure health security of every person in Thailand. Although his untimely death in January 2008 left the project unfinished, it has been continued by the reform mechanism he built and the reformist ideology he planted.

Dr. Sanguan’s death provoked his friends and colleagues to concern about the

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9 As the term security provides a distinct perspective on the notion “universal health coverage,” in this dissertation I want to emphasize this distinction by using the term universal health security as the English translation of the Thai term lakprakan sukhkaphap thuanna.
contingency of life of the people who commit to working for the benefits of others. His mentor and colleague Dr. Prawase Wasi called for collaborative work to support those individuals who might be in the hidden corners of the Thai society. After a year-long process of research and discussion, a capacity-building program for social leadership was launched by the guiding concept of mittraphap bon senthang udomkan (friendship on the path of the ideological goals). The program aims to bring together new generations of leaders within and beyond the health sector. It learns from Dr. Sanguan’s legacy that the network of friends is crucial for anyone embarks on an effort of social remediation. Besides personal development, therefore, the program intends to build the network of friendship within and beyond the cohorts of its participants. As a representative of Rural Doctor Society (RDS), I was appointed its project manager in 2009 to run the program for the first cohort of 19 participants. One of the six doctors in the group was Dr. Worawit Tontiwattanasap, the director of Umphang Hospital, whom I found to be the reference person in most of the discussions in the development of the program.

Even though I knew Dr. Worawit for many years as he is a senior doctor in RDS, working with him in the program provided me a better understanding of the difficulties of his work. Since the early 1990s, he has worked as a physician and the director of the Community Hospital of Umphang, the most isolated district of the country at the border of Thailand with Myanmar. As more than a half of people in Umphang lack of Thai citizenship, they were officially excluded from the Thai state’s social health welfare after the implementation of Thai UHC in 2002. Although a bureaucrat of the Ministry of Public Health (MPH), Dr. Worawit disregarded the new bureaucratic order but followed instead his professional principle to open the hospital’s door for every person who needs care regardless of citizenship or nationality. In doing so, he put his hospital at risks of bankruptcy in the new mode of health bureaucracy in
which each hospital is a business unit. Nevertheless, Dr. Worawit together with hundreds of his staff has kept “alive” the Umphang Hospital and its network of health care system in Umphang borderland. To me, these front-line healthcare workers are the people who actualize the “achievement” of UHC policy in Thailand.

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This dissertation focuses on the UHC policy in Thailand—the country that has been the “poster boy” in the World Health Organization’s effort to promote UHC a global agenda. Except for sociologist Joseph Harris’s accounts (2012; 2013; 2014; 2015; 2017), the discussions about Thai UHC policy usually concern more about its policy processes and financing model, but less about the role of people like Dr. Sanguan and Dr. Worawit. Moreover, the so-call “achievement” of Thai UHC policy is usually put out of the context of the complexity and dynamic of the policy implementation and the transition of Thai health system in particular and Thai society in general, especially in the era of ex-prime minister Thaksin Shinawatra’s administration and “post-Thaksin” Thailand.

In the following chapters, I examine the role of people whose lives contribute to actualize the ideal principle of universal health security the project put forth by Dr. Sanguan, his colleagues, and generations of people before and after them. Through analysis of Thai UHC policy and its effect on Tuberculosis care and control in Umphang borderland, I aim to identify the infiltration in it the process of neoliberal bureaucratization—the domination of market

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10 It was the word used by Dr. Renzo R. Guinto, a Philippine doctor who has worked on the development of UHC in the Philippines (personal conversation, October 2017).
model and management rationalities (Hibou 2015). I want to illustrate that this process contributes to unintended consequences of UHC policy’s implementation and Tuberculosis care and control in Thailand. As it also infiltrates the global UHC movement (Global Health Watch (Global Health Watch 2014b) and, as I will illustrate, global movement to “control” Tuberculosis, the lessons from Thailand would provide words of caution for other countries to find ways to prevent or lessen such effects. Nevertheless, the role of state officers identify in these chapters will illustrate the capability of bureaucrats in making the change from within the bureaucracy, as Michel Crozier (1964) points out:

  The imperatives of action, the will to succeed, the advantages gained from elimination pathological features from the system of organization on which one is dependent—these can lead to a choice of structures, to the imposition of types of relations that will ultimately have repercussions on values and the basic personality. It is the only through action—i.e., by acting through institutions and by modifying these institutions themselves—that a society can transform itself. (Crozier 1964:8, emphasis added)

While previous analyses view these professionals’ capability to make the change as the benefit of the social class of elite and the prestige they acquired (e.g., Cohen 1989; Harris 2017), I consider it as the result of the subjectivity they forged. Each of them is professional in Max Weber's (2001) sense of “calling” and caregiver in the sense of a social scientist who achieves social knowledge through the act of caregiving (Wilkinson and Kleinman 2016). To me, they employ a particular form of subjectivity what I call professional caregiver.
The Quality of Life of a South-East Asian\textsuperscript{11}

—— Dr. Puey Ungphakorn, October 1973

While in my mother's womb, I want her to have good nutrition and access to maternal and child welfare care.

I don't want to have as many brothers and sisters as my parents had before me, and I do not want my mother to have a child too soon after me.

I don't care whether my father and mother are formally married, but I need them to live together in reasonable harmony.

I want good nutrition for my mother and for me in my first two or three years when my capacity for future mental and physical development is determined.

I want to go to school, together with my sister, and to learn a trade, and to have the schools impart social values to me. If I happen to be suitable for higher education, that opportunity should be available.

When I leave school I want a job, a meaningful one in which I can feel the satisfaction of making a contribution.

I want to live in a law and order society, without molestation. I want my country to relate effectively and equitably to the outside world so that I can have access to the intellectual and technical knowledge of all mankind, as well as the capital from overseas.

I would like my country to get a fair price for the products that I and my fellow citizens create.

As a farmer, I would like to have my own plot of land, with a system which gives me access to credit, to new agricultural technology and to markets, and a fair price for my produce.

As a worker, I would want to have some share, some sense of participation in the factory in which I work.

As a human being, I would like inexpensive newspapers and paperback books, plus access to radio and TV (without too much advertising).

I want to enjoy good health, and I expect the Government to provide free preventive medical service and cheap and readily available good curative service.

I need some leisure time for myself, and to enjoy my family, and want access to some 
green parks, to the arts, and to traditional social or religious festivities. I want clean air 
to breathe and clean water to drink.

I would like to have the security of co-operative mechanisms in which I join to help 
others do things which they cannot do alone, and they do the same for me.

I need the opportunity to participate in the society around me, and to help shape the 
decisions of the economic and social as well as the political institutions that so affect my 
life.

I want my wife to have equal opportunity with me, and I want both of us to have access to 
the knowledge and means of family planning.

In my old age, it would be nice to have some form of social security to which I have 
contributed.

When I die, if I happen to have some money left, I would wish the Government to take 
some of it, leaving an adequate amount for my widow. With this money the Government 
should make it possible for others to enjoy life too.

These are what life is all about, and what development should seek to achieve for all.
As Siriraj Medical School granted me an M.D. in March 2001, I am qualified to be a doctor of the Thai Ministry of Public Health (MPH). I attended the orientation meeting for the MPH’s new cohort of health professionals at a big conference hall not far away from the ministry’s center in Nonthaburi at the outskirt of Bangkok. It was the first working day of April 2001—the usual date-of-appointment in Thai bureaucrats’ work record used to count ayurachakan (literally, “civil-service age”) which is a significant criterion in getting promotion in the seniority-based career patch. In the meeting, almost a thousand of doctors graduated in the year came from around the country to “select” where in the country each of us would begin our professional life. It is a part of the compulsory contract we signed before entering the medical school to receive the government’s tunkansueksa (literally, “scholarship,” usually shortened as tun) for the six-year training in public medical schools. By the contract, we agreed to work for the government for three years after graduation or otherwise pay 400,000 baht—one year of “training” as interns or phaet-phoemphun-taksa (literally, “skill-developing doctor”) that consists of eight months in General or Regional Hospitals and four months in Community Hospitals,\(^\text{12}\)

\(^{12}\) In the network of Thai public hospitals referral system, Community Hospital (rongpayaban chumchon) are the district-level hospitals classified by the number of beds available for patient admission. Most of these hospitals were built as ten- or thirty-bed ones based on the size of the “communities” for which the hospitals would provide cares. As the number of beds determines the quantity and type of infrastructure and personnel, the hospitals had been developed over time by stepping up the “path” of 10-, 30-, 60-, 90- and 120-bed community hospitals. General Hospitals (rongpayaban tuapai) are provincial-level hospitals, and Regional Hospitals (rongpayaban sun) are the provincial hospitals that are the designated referral “center” (sun) of the region. Nevertheless, in many big districts, the district-level hospitals were upgraded to be General Hospitals as they expand their capacity, such as increasing from a 120-bed to be a 200-bed hospital. Before the establishment of the Universal Coverage Scheme (UCS) by
and two years of working independently as *phaet-chai-tun* (literally, scholarship-paying-back doctor) in Community Hospitals. After ending the three-year period, we can decide to continue working in public hospitals, to enter two to five years of training to be specialists, or to resign from the government positions. In the meeting, there were new doctors graduated from the only private medical school at the time. They joined the “selection” although they paid the school by themselves the total expense of 1.2 million baht for the six-year medical training. The motivation for their participation might be the This Medical Council’s policy that set the one-year internship a prerequisite for entering any specialist training program in Thailand. As a representative of my class from Siriraj, I had worked with representatives from other thirteen medical schools in the previous month to set the procedure of the “selection” that would be fair for everyone.

After the opening ceremony, senior doctors from the MPH, the Thai Medical Council (TMC), and the Rural Doctor Society (RDS) greeted us with welcoming speeches and “survival advice” for the novice doctors. Then, after the lunch break, the selection process began. The MPH announced the list of General and Regional Hospitals that the ministry and TMC approved to be the sites for internship “training” and the number of interns allocated to the hospitals. The list was announced almost at the last minute as the MPH tried to end the “negotiation” to finalize how to distribute its new workforce. This list determines the “slots” available for us to select. If any site were over selected and unable to be resolved by negotiation, a lotto would be used to determine who got the positions. Then continued the rounds of selection to fill the remains slots, the less favorable ones, until all new doctors got somewhere to go. At the end of each round, the room filled with the cheer of the winners and tears of the losers. I selected to work in my

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the UHC policy in 2002, allocation of budget and other resources was based on this system of classification.
hometown province, Nakhon Si Thammarat, in southern Thailand. That year, its Regional Hospital was allocated 14 interns. As the hospital was a favorite site for new doctors from a southern medical school, it was also selected by a group of them who “packed” into a big group. I thus had to negotiate with them using my intention to go home. I got the position in the first round. In the room, there were also older doctors from around the country, especially from remote rural areas. They were assigned by their colleagues to join the event. They came to motivate the new doctors to choose their provinces and to welcome the new colleagues. These older doctors also helped to comfort the tearing new colleagues in their mid-twenties as they engage the reality of life as Thai state’s bureaucrats.

As usual, many new doctors left to work in private hospitals or clinics by paying the bail of 400,000 baht. It is a cheap investment for the private healthcare providers to recruit new doctors in the time that health care businesses began to revitalize after the 1997 economic crisis. Also, it is affordable for many families to liberate their sons or daughters from the obligation to work in the harsh working condition in the remote rural areas. Moreover, it was the time that the public healthcare and public health sector was overwhelmed with the rumors and anxiety about the rapid implementation of the newly elected government’s Universal Health Coverage (UHC) policy began as a pilot project in six provinces on April 1, 2001.

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This chapter discusses the development and consequences of UHC policy in Thailand. In the past decades, a network of physician-activists, the Rural Doctors Movement (RDM), has been at the core of this movement. In the view of class-based social arrangement, they are medical doctors and high-rank state’s officials who occupy elitist position in Thai hierarchical
society. In the view of the social relation of caregiving, however, they are professional caregivers who utilize their prestigious positions to act on behalf of their colleagues and people in the rural areas. Through my experience of work as a doctor in the RDM since 2002, in the following pages I will illustrate that what is known as Thai UHC is an outcome and a process in the long struggle for health security of every people in Thailand—the struggle that has continued and will continue for generations.

**Making Bureaucracy Work**

*Entering “the system.”*

Like all other medical students in Thailand, my life as a medical professional began after ending the years of preparation in the medical school. As a graduated medical student in 2002, I had to go through processes of formal and informal pathom-nithet (orientation, literally “primary informative [orientation]”)—the processes to build self-awareness (Hallowell 1955) in becoming the member of the broader society beyond the boundary of the medical school. After the first orientation by MPH as a new health officer of the state, I then went through processes of “orientation” to become a part of the network of doctors, and other health professionals, working for people in rural areas. Beginning with a week of “orientation-trip” to get familiar with the community of doctors in the seven provinces of the upper southern region. Then at the Provincial Health Office of my province, I attended the “orientation-meeting” together with other new professionals of the province, including doctors, dentists, pharmacists, nurses, and others. Rather than going directly to work in the Community Hospitals like other professionals, the new doctors had to select which Community Hospital each of us will spend the four-month period of “community medicine” besides the eight months of “training” in the Tungsong General
Hospital’s or Maharaja Regional Hospitals’ major wards: internal medicine, pediatrics, obstetrics and gynecology, surgery, orthopedics, and emergency medicine. The group agreed to let me spend my first four months working at Thampannara Hospital, the farthest ten-bed Community Hospital in the smallest district of the province. I decided to work at this hospital mainly from two motivations. One was the invitation of the hospital’s director whom I met in the MPH’s orientation at the beginning of April. The other was the “self-awareness” I had developed through the years of student activity and medical training that I want to be one of the doctors who commit to work for people in the remote rural areas.

At the beginning of May 2001, I began my work at Thampannara Hospital working with thirty staff members and its director who is a few years older than me. We separated the shifts by two to have at least one doctor available 24/7 at the hospital. He is the first doctor who is formally appointed its phu-annuaikan (director). Although the hospital was opened in 1996 to serve 17 thousand people in the newly established district, it had been overseen by the directors of the nearby hospitals for many years as there was no doctor want to stay for longer than four months. While medical doctors had some freedom to “select” the place to work, other hospital’s officers, including nurses and technicians, had to endure the difficult working condition with limited opportunity to relocate. In four months, I had gradually learned about the director’s and the staff’s difficulties and frustrations in working and living at the hospital and Thampanara people’s obstacles in getting health cares and public services from the state. I had gradually developed my self-orientation (Hallowell 1955), seeing myself as their doctor with an image of myself working for them until my retirement. After finished the internship training at the Regional Hospital, therefore, I went back to work there. I was then appointed the director of Thampanara Hospital in May 2002 as the previous director had to move to another province.
While the internship in Regional Hospital enabled me to become a member of the local community of clinicians, the experiences of work as the hospital director orientated me to be a part of the community of physician-administrators working to shape the local healthcare system.

By the appointment as a hospital director, I had the responsibility to keep the hospital “in line” as a part of the MPH’s nation-wide public healthcare system. Participation in various kinds of meeting became a part of my routine jobs besides clinical and administrative works at the hospital. At the end of each month, I had to spend a whole day to attend the monthly meetings at the provincial center, almost a-hundred-kilometers away from my hospital. One was the formal meeting in the afternoon at the Provincial Health Office in which the directors of every hospital and the Chief Public Health Officer of every district are required to present. The meeting led by the Provincial Chief Medical Officer (PCMO). Like a monthly ritual, the meeting was the formal space for the PCMO to “give the policies” (hai nayobai) from the MPH and his or her own, to “check” the progression of works assigned (tam ngan), and to discuss current public-health and administrative issues. The other one I had to attend, was an informal lunch-meeting among doctors—PCMO, the “deputy-PCMP” (formally, Expert of Preventive Medicine), and the hospital directors—at a nearby restaurant before the formal meeting. It was the space that all doctors discuss work-related issues informally in the atmosphere of phi nayobai (siblinghood, literally, “older sibling–younger sibling”) in the “community” of medical professionals. At many times, it was the site to resolve the unsettled negotiations or conflicts, especially those on the issues of resource allocation. There I witnessed that the “professional power” could go over

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13 Although in this dissertation I use the transliteration scheme of the Royal Society of Thailand, for the term phi nayobai I follow Herzfeld’s (2016) as I want to engage with his discussion of the term.
the authority of bureaucratic order (Freidson 1986). Although one of the youngest directors, I had got respect and autonomy for my administrative works. Nevertheless, it was the space for PCMO to use the “flexibility” of phi nawnɡ (siblinghood) to “command immediate compliance” (Herzfeld 2016:24) without eroding the group’s relationship as a professional community. As there is a familiar complaint that “doctors are the most difficult people to manage,” this cultural resource might be an explanation of the MPH’s organizational structure that requires qualification of medical doctor for almost all of its top administrative positions. As bureaucrats can use the flexibility of symbolic interpretation to serve ones’ interests (Herzfeld 1992), the phi nawnɡ (siblinghood) is also a symbolic resource for low-ranking officers like the directors of Community Hospitals, to “request immediate response” from the doctors on the top. I had learned that this bi-directional relationship provides the ability for medical professionals to take the initiative to modify the state health bureaucracy—what is usually referred as “the system.”

**Becoming a “Rural Doctor”**

What enables other young directors and me to “survive” in our early years in the position were supports from senior directors of other Community Hospitals besides the one-week-long training for new directors provided by the MPH. One of the most crucial supports was their help in negotiation for allocation of resources not only at the provincial or regional level but also at the national level—the work that has been done by the Rural Doctor Society (RDS). In my province, there were many core members of the RDS including Dr. Arak Wongworachat who, in 2002, had been a director of Community Hospitals for almost two decades. In the RDS annual meeting in 2002, Dr. Arak was elected the Chairman of the Society’s twenty-first committee for the two-year term from 2002 to 2004. Knowing that I was a former student-activist in high-
school and university, he invited me to join his team. By his support, I was able to attend the RDS’s monthly meeting in Bangkok. There were 15 to 20 regular participants from around the country—the core team of RDS. Each month, the RDS’s core team discussed issues related to Community Hospitals and updated the information from meetings and working groups, of the MPH or other institutions, joined by RDS’s representatives. There were also guests who came to provide up-to-date information and to answer questions on the issues essential for the RDS’s works. At that time, the main focus was the UHC policy that was expanded to be implemented in every province on April 1, 2002, after a year of experiment as a pilot project. After the morning session and lunch in the meeting room, many times there were “field activities” in the afternoon, such as going as a group to meet with, and give petitions to, high-ranking authorities. Those authorities included the MPH’s minister to discuss RDS’s opinions and requests on the management of the UHC policy.

In my early months in RDS, I was disoriented. As the youngest person in the group, I felt like I had parachuted alone into an unknown island. So I had “nothing to do but start at once on [my] ethnographic work” (Malinowski 1922:4, emphasis added) to become the “insider” to acquire knowledge of the “society” of phaetchonnabot (rural doctors). Also, I was “a beginner, without previous experience,” and “with nothing to guide” (Malinowski 1922:4). My role as the note taker and minute writer, however, helped me to decipher the complicated and dense information and provided me the “position” in my conversation and communication with people within and beyond the RDS’s monthly meetings. Moreover, I gained my “self-orientation” as one of the rural doctors when I was assigned to be RDS’s representative to attend the meeting of the Health Commission of the Senate on an issue of MPH’s workforce. This responsibility gained my self-awareness that, as a medical doctor working within the bureaucracy, I have
capability and accountability to remediate the “pathologies” of the bureaucratic state.

The issue is a consequence of the effort to remediate the nation’s economy. Since 2000, the government had implemented the policy to “freeze” the growth of state’s workforce by the recommendation of International Monetary Fund’s structural adjustment to mitigate the effect of the Asian Economic Crisis in 1997. The MPH, therefore, had to tear up the contract it signed with the new group of its health professionals graduated in the year, including doctors, dentists, pharmacists, nurses, and others. Rather than getting the appointment as karachakan (civil servants), these people got a new type of official position created by the MPH—phanak-ngan khong rat (literally, staff members of the state, hear after “staff”). The state’s civil servant system did not formally recognize this position. All new professionals, therefore, would not get benefits and prestige of being civil servants—a highest achievement of “education” in the lives of Thais for generations. After a period of intense negotiation, the government allowed the MPH to use its 3,000 vacant civil-servant positions to appoint some of the “staff.” At the beginning, the MPH planned to appoint all doctors before other professions, but the RDS opposed the plan, arguing that it would cause disparity and conflict among the professions working together. In April 2002, therefore, the MPH began to selectively appoint people in the “essential” positions, such as, those responsible for administration and procurement who need official authority. I am one of the “staff” who turned to be civil servant at that time as I was appointed a hospital’s director in May 2002. To resolves the problem, the Health Commission of the Senate convened a meeting on this issue. I attended the meeting as a representative of RDS. I joined the representatives from other rural professional organizations, including Rural Dentist Society, Rural Pharmacist Society, and Rural Nurse Society. Together, we united our opinion and recommendation. The “contingent position” eroded a significant non-financial incentive in the effort to hold health
personnel in rural areas. I learned from the meeting that, RDS’s participation in the Senate’s action on the problem of the “staff” is a part of the effort to resolve the chronic problem of scarcity of doctors in rural areas. This effort had been continued for many decades by the MPH with the active participation of a network of rural doctors formulated in the 1970s as RDS and expand to be Khabuankan Phaetchonnabot (the Rural Doctor Movement).

**Engaging the Broader Network**

Historical studies were crucial for my “ethnographic work” in the RDS to orientate myself in the broader network of Khabuankan Phaetchonnabot (the Rural Doctors Movement, RDM). I had gradually learned about the history of RDM and the genealogy of its udomkan (ideologies) through formal and informal meetings, various kind of social activities, personal conversations, books (published by RDS), and old documents. A key resource for my historical studies is the book entitled *Yisib-ha Pi Kong Khabuankan Phaetchonnabot Lae Sangkom Thai* (twenty-five years of rural doctor movement and Thai society), a comprehensive review and analysis of the RDS’s “past, present, and future” done by Dr. Suwit Wibulpolprasert, the chairman of the sixth committee of RDS (1983–4) published in 2003 by the support of WHO.

Dr. Suwit (2003) gives a description of RDM:

“A civil society network that consists of medical doctors or groups of medical doctors who had worked or who are working in rural areas. The doctors have a shared chitsamnuek (consciousness) that can be called chitsamnuek phaetchonnabot (rural doctors’ consciousness)—focusing on the development and distribution of public health services to rural areas and focusing on working for the society. [The doctors] established the konkai phaetchonnabot (rural doctors' “mechanisms”) such as the Rural Doctor Society, the Rural Doctor Foundation, the Sampran Group. And, [they also] have connections that link together the network through media and activities such as Rural Doctor Magazine, the Society’s News Letter, and the [social] movement activities in various [social] situations.” (Suwit 2003:1, emphasis added)

Learning about the “origin” of the RDM that has a close relationship with the problem of “brain
drain” helps to clarify why Dr. Suwit identifies “the development and distribution of public health services to rural areas” as the critical focus of the network.

Beginning in the 1960s, more than a half of newly graduated doctors went to work abroad, especially United States. As the United States lost its doctors to Vietnam War but need more doctors for its Medicare and Medicaid programs, it recruited doctors from other countries. A group of doctors graduated from a U. S. supported medical school in northern Thailand rented the whole aircraft to go to work in United States. To stop the out-flux of Thai state’s human resources, in 1967 the Thai government began the policy of “compulsory contract.” The government’s “demand” that every new medical student signs a contract to receive “scholarship” and work for the government for three years after graduation or otherwise paid the tuition at the rate of 10,000 baht per year. The policy affected medical students immediately. The “first-year” students of Siriraj medical school in that year had to sign the compulsory contract at the end of their final exam. For them, however, it was unfair as they were not at the beginning of their medical training. It was their “third year” in the program as they already finished the first two years of basic medical sciences study at Chulalongkorn University. Students were angry as they had never truly got the “scholarship.” Under the dictatorial government, however, they were unable to resist. A group of student-activists got together to discuss how to respond. Since opposition were not beneficial, they turned to “conformation” by prepare themselves for rural services through student activities that provide them understanding and experience of rural areas. In the following year, the students published a quarterly newsletter *Naksueksaphaet Samphan* (medical student relation) to share their ideas and concern and polled their peers the intention to establish an inter-institutional student organization. Then in 1969, The Center for Medical Student of Thailand (*Sunnisit-naksueksa-phaet hang prathet Thai*) was found. Through activities,
discussion, and direct experience of suffering in the rural areas, medical students and the new organization had been active participants in the broader social movement that led to the student uprising on October 14, 1973.

The first cohort of phaet-chaitun, graduated in 1972. They went to work in rural healthcare facilities (later became Community Hospitals) and found many difficulties. At the time they had to work under the scarcity of all resources (e.g. medical devices, supply, vehicles, and staff) while getting only a ten-thousand baht annual budget. Motivated by the spirit for rural service of “October 14,” the early cohorts of phaet-chaitun committed to provide public health services for people in rural areas regardless of the obstacles. Then, by their experience of work in the Center for Medical Student, a group of former student-activists had a motivation to get together. As one of the doctors, Dr. Suwit notes in his book that their main idea was that “only the collective effort of the people who encounter similar difficulties can find ways to mitigate the problems” (Suwit 2003: 8).

At the early of 1976, Dr. Manit Prapansin a third-cohort phaet-chaitun sent out a letter around the country called for a national meeting in August to discuss problems and find ways to develop rural health care. By his personal concern, he designed that the national meeting had to get official supported and resources from the MPH. So he also formally sent a copy of the letter to the MPH’s Permanent-Secretary (PS). As the plan directly supported the work of MPH, the PS agreed and assigned the Office of Provincial Health (Kong Satharanasuk Phumiphak) to be the organizer of the national meeting. Dr. Manit then called for an informal meeting of the rural doctors at Kaoyai National Park in northeastern Thailand to prepare for the work. In Kaoyai meeting in April 1976, the doctors shared their obstacles and discussed the ways to mitigate
them. To continue the collaborative works after the national meeting, they agreed to establish an organizing mechanism—the *Samapan Phaet-chonnabot* (the Federation of Rural Doctors) and a mean for communication—the newsletter *Phaet-chonnabot* (rural doctor). Nevertheless, they had to stop the federation’s activities after the massacre of progressive students in Thammasart University in Bangkok on October 6, 1976. It was a result of the government’s aggressive measures against Communism supported by right-wing political groups. Although the progressive doctors had been threatened by “communist” labeling, they continued their works for the indigents in rural areas. In the next year, Dr. Manit began it again. Together with Dr. Suwit, he visited 20 Community Hospitals to discuss the idea of reuniting the federation. Then in February 1978, around 50 rural doctors agreed, in a meeting in a northeastern province, to establish an organizing mechanism. As the term *samapan* (federation) at that time connoted the spirit of socialist, the new organization uses a “softer name”—*Chomrom Phaet-chonnabot* (Rural Doctor Society, RDS). They also had to explicitly declare, in the RDS’s statute, that they would refrain from participation in any political activity.

Although the federation has a short life, it establishes the RDS’s organizational cultures. One is the *culture of respecting the seniors*. This culture began by Dr. Manit by the respect he gave to the PS, a senior doctor, as he informed the PS and asked for the MPH’s support for the national meeting in 1976. Also, in the formation of the federation, Dr. Manit let an older doctor be the chair. This culture enables RDS to acquire supports from highly-respected senior doctors, especially Dr. Sem Pringpuangkeo (1911–2011), a pioneer of Thai rural health care and former ministry of MPH, and Professor Dr. Prawase Wasi, a leading academic and social activist.

Another organizational culture of RDS is the *culture of autonomy*. Since the beginning as the federation, the RDS has neither established a system of membership nor claimed itself as the
representative of “all” doctor working in rural areas. It has been a basis for people’s criticism of the RDS’s legitimacy in working on “behalf” of Community Hospitals. Responding to this critic, Dr. Arak, the chairman of RDS’s 21st committee, answered, “being a rural doctor depends on each person’s consciousness and spirit of working for society and the indigents. Thus RDS never have membership system. Membership depends on each person’s mind. Not compulsive but natural and flexible (Quoted in Suwit 2003: 14).” To me, while the culture of respecting the senior has its root in Buddhism and Thai culture, the culture of autonomy has its root in medical professionalism. These cultures provide rural doctors strength and flexibility. By the culture of respecting the seniors, in each “move” the they usually seek for seniors’ opinions and avoid the negative consequences that might affect the them. But by the culture of autonomy, the doctors may disregard the seniors’ opinions and sometimes attack the seniors directly for their misconduct. For example, between 1998 and 2002, RDS had worked with many non-government organizations to disclose MPH’s 1.4-billion-baht corrupted procurement in which hospitals were ordered to purchase overpriced pharmaceutical products and medical devices. As a result, a former-minister of MPH was imprisoned, and many senior doctors were punished.

The federation also established the rural doctors’ position within the state’s health bureaucracy. Since their first “movement”—the national meeting in August 1976—rural doctors have been the prime mover in the development of rural health care system that covers most of the people in Thailand. A significant “move” is the development and implementation of the UHC policy. The central figure in this movement was Dr. Sanguan Nitayarumpong (1952–2008), the chairman of the eight committees of RDS (1985–86). Therefore, rural doctors as state’s bureaucrats have enabled the state to expand its health welfare to rural areas throughout the country—Working from the “periphery” and at the “center,” rural doctors have helped to
maintain the operation of Thailand’s health bureaucracy.

**Collective Effort, Collective Learning**

An occasional activity of RDS, I participated, was to join the meeting of Sampran Group (*Klum Sampran*), the monthly meeting of senior doctors of RDM where I had the opportunity to meet and talk with the seniors in-person. Most of the participants were previous RDS’s chairs and core team members. By their outstanding ability and contribution, many of them rapidly became high-rank bureaucrats in the central administration units of the MPH. In this new working environment, many misunderstanding and disagreement emerged among friends. Dr. Sanguan thus consulted their mentor Dr. Prawase to create a common ground to settle the conflicts. Dr. Prawase disagreed suggesting that reconciliation may create further disputes. He suggested instead embracing diversities and having space for dialogue to develop shared knowledge and wisdom would benefit the whole society. Following that suggestion, they set up a regular monthly meeting to share and discuss ongoing works and cutting-edge issues related to Thai healthcare. Began in August 1986, they have met regularly every month on the first Monday at the Rose Garden Hotel, one-hour away by drive from the ministry center, in Sampran district of Nakhon Prathom province. The meeting thus called *Sampran Group*. Through this venue, Dr. Prawase has been the primary facilitator and teacher who bring academic reflection and social theories into the collective learning of the RDM.

Dr. Prawase has a long relationship with doctors in the RDM. He was their teacher when they were in medical school and has continued to be their mentor and colleague in social activities. Born in a low-income family in a rural village, Dr. Prawase had witnessed constraints and obstacles poor people bared. After finished medical training at Siriraj Medical School, he
went abroad to study hematology and human genetic. He returned to Siriraj in 1961 then became a leading academic especially by his discovery of the mechanism of Thalassemia alpha, a hereditary anemic disease of Thais and Southeast Asians. Through his research and clinical practice as a hematologist, Dr. Prawase realized that anemia epidemics were also caused by poverty and injustice that, in his words, “eat people blood and bone marrow.” Using the clinical approach to view Thai society, Dr. Prawase understands social problems through diseases and as pathologies in themselves. In his famous book *Banthuek Wet-chakam Thai* (notes on Thai medicine) first published in 1981, he uses stories of patients to critique Thai society and Thai public institutions. He has been a highly respected academic and influential teacher who advocates his students to go “where people need.” His social analysis, as described by a rural doctor, “fits with Thai cultural and social context, rather than Communist ideas that create confrontation and the use of violence” (Dr. Nirun Pitakwachara, quoted in Suwit 2003:4). It enables rural doctors to see the “whole picture” of social problems. In the first and only issue of the newsletter of the federation, Dr. Prawase wrote to them an article about the ways to rapidly distribute health services in Thailand. The editor described him as “a medical teacher who has a long interest in the country’s public health problems” (reprinted in Prawase 2000b:45).

Although I did not regularly participate in Sampran Group meeting, I learned that the session usually ends with “homework” (*kanban*)—the assignments that Dr. Prawase, regarded as the group’s “teacher,” assigns to specific people or institutions to turn the ideas formulated in the discussion into practices. Many of these assignments become the initiators of larger social movements in the country. For example, in 1987, Dr. Choochai Supawongse got an assignment to organize an anti-tobacco campaign. Seven days in the October of 1987, around 250 of health professional took the turns to run from four corners of the country to Bangkok. The event was
organized by RDS with the support of the Folk Doctor Foundation, the “supportive mechanism” of RDM established in 1982, and many other institutions. Through three thousand kilometers of running, they collected signatures of people along the route to support the petition requesting the government to protect the rights of non-smokers. As they collected six million signatures, the event became the largest citizen poll in Thai history at the time. As a result, the government promulgated two Anti-Tobacco laws in 1989. To continue the movement, the Folk Doctor Foundation established its Anti-Smoking Project that later became the Anti-Tobacco Foundation. Moreover, as the laws established tax measure, the “sin tax,” to discourage the growth of the tobacco industries, availability of this money led to the establishment of the Thai Health Promotion Foundation (ThaiHealth) in 2001. The ThaiHealth has been the largest source of money that stimulates the growth of health promotion activities in Thailand.

The anti-tobacco movement in the 1980s also raised the awareness of rights and political participation in Thai public. Then, the political uprising in the early 1990s led to the movement for political reform. The government appointed Dr. Prawase a leader of the reform committee. By the lessons learned from the anti-tobacco movement, the committee organized venues all over the country for people to participate in the processes to draft Thailand’s new constitution. The processes end with the landslide support in the national poll and make the 1997 Constitution of Thailand, the “people’s constitution.” Grounded on the successes of anti-tobacco movement in the 1980s and the “political reform” in the 1990s, Dr. Prawase formulates the “theory” that he calls Triangle that Move the Mountain: “The Mountain means a big and very difficult problem, usually unmovable. The Triangle… consists of: (1) Creation of relevant knowledge through research, (2) Social movement or social learning and (3) Political involvement” (Prawase 2000a: 3). This “theory” has been used in other “reform” movements in Thailand, including the health
care reform that led to the implementation of UHC policy in 2001.

Building a Reform Mechanism

Besides the collective learning in RDS and Sampran Group, gaining experience in the training program abroad helps to extend rural doctors’ capacities to make sense with and make change to health care system in Thailand. Dr. Sanguan, for example, attended the one-year training program on public health development in Belgium. There he got the ideas and models to reform Thai health-care system. After finishing the program, Dr. Sanguan and his classmate in the program established an experiment, known as the Ayuthaya Project. Began in 1989, the project, under the support of European countries, aimed to develop a primary health care model the has three characteristics: continuity, comprehensive, and holistic. The project focused on the three areas of health care reform: (1) health financing reform with the model of 70 bath co-payment per visit, (2) healthcare delivery reform with the model of family physicians, and (3) community engagement reform with the model of community ownership (Sanguan 2003:41-46). As the Ayuthaya Project provided the “knowledge” part of the “Triangle” of Thai health care reform, its primary health care model and the three focal areas of reform form the basis of the Thai UHC policy.

The economic crisis in 1997 heightened Thai public’s concern about individual’s risk of financial catastrophe caused by medical bill and the nation’s risk of “bankruptcy” caused by skyrocket of healthcare spending. In this context, Dr. Sanguan, a deputy permanent secretary of MPH and the director of the MPH’s Health Care Reform Project, and his colleagues had tried to put UHC a political agenda. They successfully put it a policy of the Police Lieutenant Colonel Thaksin Shinawatra’s newly established party Thai Rak Thai (TRT) by the support of their old
student-activist friends, Dr. Surapong Subwonglee and Dr. Prommin Lertsuridej who became the party’s politicians. It became one of the party’s “populist policies” under the name “30-Baht for Every Disease” (samsibbaht raksa thukrok) that promises all people access to essential health services at a fee of 30 baht per visit. After TRT’s landslide victory in the election, Thaksin government announced “30-Baht” one of its major policies. To ascertain UHC policy would be actualized as they wish, Dr. Sanguan and his colleague in the MPH began to implement UHC as the MPH’s pilot project. Started in six provinces on April 1, 2001, then 21 provinces on June 1, 2001, then expanded to cover all 77 provinces on April 1, 2002. In the meantime, Dr. Sanguan helped the government to draft the UHC law using his experience in passing the bill of Social Security Scheme and writing the law for the Health System Research Institute. Finally, the National Health Security Act B.E. 2545 was promulgated in late 2002. This Act established a new institution to implement the UHC policy—the National Health Security Office (NHSO).

An experience bureaucrat, Dr. Sanguan wisely worked with language to institutionalize his reformist ideology of lakprakan sukkhaphap thuanna (universal health security) in the UHC policy. Although the Thai term lakprakan sukkhaphap thuanna in the Thai names of UHC law and NHSO is usually translated to English as “universal health coverage,” English translation of the word lakprakan has been an issue of discussion since the early formulation of the policy. In the early 1990s, the newly established Health System Research Institute (HSRI) organized a meeting on this topic by the translation of “universal health security.” Using of the term security was satirized by a senior economist invited to the meeting who suggest changing to the word coverage. To avoid the misinterpretation of the ideology of universal health security, Dr. Somsak Chunharas, the first director of HSRI, personal conversation, September 2017.
Sanguan put the words *health security* in the organization’s English name—National *Health Security* Office.

By appointment as the first secretary-general of the NHSO in 2003, Dr. Sanguan left the high-ranks bureaucratic position of the MPH to continue his work. For him, the “achievement” of Thai UHC policy that *entitles* “all” people in Thailand to public health insurance was just the beginning. Implementation of the policy to ensure people’s *access* to the cares they deserve was still the challenge. He thus had to stay at the “top” of NHSO, the new bureaucratic “machine.” He had led NHSO to work with wide range of social entities and people to eliminate confusion, mitigate conflicts, and facilitate the implementation of the program. Although in the meantime he had to fight in his struggle with cancer, he had kept putting the effort in his public responsibilities. He also used his illness experience to create NHSO’s project to develop “community of care” for cancer patients—*mitraphap-bambat* (literally, friendship therapy). At the beginning of his second term as NHSO’s secretary-general, he lost his life to cancer in January 2008 at the age of 56. Although his untimely death left his life-project of healthcare reform unfinished, the “reform mechanism” he built within the state’s health bureaucracy has continued it until today.

**Working with the New Mode of Rational Government**

**Engaging the New Symbolism**

The implementation of the UHC policy and the establishment of NHSO expand the
boundary of health bureaucracy of Thailand beyond the MPH. From the view that bureaucracy is the "symbolism of rational government" (Herzfeld 1992: 17), NHSO was established in symbolism of the new bureaucratic state’s rationalities—the new mode of rational government. The major reform of the public administration of Siam (the name of Thailand before 1932) in the reign of King Rama V (1863–1910) "modernized" the country to a "bureaucratic state" (Riggs 1966). After that time, the “reform” in the era of ex-prime minister Thaksin Shinawatra (2001–6) is arguably the most significant period of transformation of Thai state’s administration (Tossaporn 2006). Even though all previous governments had continued the effort to develop the public sector (rabob rachakan), their lack of political stability diminished the effect of the effort. Under the ambition of Thai society to see “changes” brought in by the “People’s Constitution,” Thaksin, the first prime minister elected by the 1997 constitution, became the country’s new hope. By his landslide victory in the 2001 general election, Thaksin could take control of both the government and the parliament. A highly successful businessman, he had managed Thailand as a business corporation. His approach was explicit in his efforts to reform the Thai public sector:

Modifying the structure and entities of the public sector by Agenda Based; adjusting the administrative method to the mode of strategic management; creating the evaluation system by using civil service’s work-contracts; modifying the Provincial Administration to the system that each province is an integrative operational unit [led by a Chief Executive Officer]; passing the Decree on Criteria and Method of Good Governance B.E. 2546 (2003) to be the guideline for the civil services to serve citizens’ benefits; bringing in modern technologies into the public management, [including], turning the public sector’s system to e-Government [and] using GFMIS [(Government Financial Management Information System)] to develop the state’s financial system; and improving the quality of public services by reducing the steps in the public sector’s work processes or setting up the integrative units of one-stop-service. (Tossaporn 2006:164-165)

To effectively executed the reform effort, in 2003, the government established a new “mechanism” within the Thai bureaucracy —the Office of the Public Sector Development
Commission (OPDC) under the direct control of the Office of the Prime Minister (OPM). In its first five-year Strategic Plan (2003–2007), the Commission stated in the plan’s “Vision statement” (wisaithut) that it would “develop Thai public sector to be excel, capable for the development of the country in the age of globalization by the principles of good governance and for the benefits of the citizens. (Thossaporn 2006:208, emphasis added). To me, it is explicit in this “imagination” that OPDC, an apparatus of Thaksin-administration, aims to make Thai state capable to be in the new global order. Moreover, the OPDC published a book writing by its general secretary Tossaporn Sirisampan (2006) entitle Khwamru-bueangton Kiawkab Kanborihan Rachakan Naewmai (introduction to modern public management). This book, as stated in its name, emphasizes that Thailand need “new way” (naewmai) to operate its rabob-rachakan. It aimed to educate Thai public new knowledge and rationalities for public management—the new “logic of governing” of neoliberalism (Ong 2007). Therefore, the bureaucratic “reform” in the time of ex-prime minister Thaksin had transformed Thailand to be a “neoliberal state” and become a part of the global assemblage of neoliberal world order.

The influx of neoliberalism into the Thai public sector, however, began much earlier especially after the 1997 Asian Economic Crisis that began in Thailand. As the prime minister whose financial policy initiated the crisis resigned, the parliament appointed a new government to maintain the country through the crisis. Under the “guidance” of the International Monetary Fund (IMF), the new government had implemented the principles of “good governance” in the country’s public sector, such as limiting the growth of public sector’s workforce by the principle of austerity and using the principle of transparency to reduce corruption. A major change was the shift of the public sector’s concept of government to governance that enable it to incorporate market model and management rationalities from public sector into the state administration.
In this new context, Thai state created a new form of public sector administrative entities called *ongkan mahachon* (public organization) by the Public Organization Act B.E. 2542 (1999). It became the third “blueprint” for the formation of Thai government’s operational apparatus besides *suan-rachakan* (governmental offices) and *ratthawisahakit* (government-owned companies). The OPDC’s book (Thossaporn 2003) describes that a Thai Public Organization is a *juristic person* under the direction of the minister of related ministry. Its staff members are not civil servants. The officers in administrative positions come from competitive selection, rather than appointment, and can stay in the job only in the four-year term for not more than two terms. Under the cabinet’s order, a civil servant of the state can become a temporary staff of the organization. The organization, can acquire monetary support directly from the Bureau of the Budget (under the OPM) rather than proposing its budget through the ministry. It can also make the profit from its assets and maintain the income from its activities. The government, however, controls the organization and its staff through the systems of audit and evaluation, including the annual financial review by external auditors, and job evaluation using output and outcome indicators (pp. 179-181). As this form of public office provides the “autonomy” require for specific public works, the RDM had used it to create news entities in the Thai *health system governance*. For example, after the Anti-Tobacco movement in the late 1980s, the government established the Thai Health Promotion Foundation (ThaiHealth) by the Health Promotion Foundation Act B.E. 2544 (2001). It is a Public Organization under the direction of the Prime Minister. In the development of the UHC policy, Dr. Sanguan also used this availability to draft in the UHC law to make the NHSO a Public Organization under the direction of the ministry of MPH but maintain the autonomy from the politician’s interventions. Therefore, the Thai UHC policy under the administration of NHSO emerged in the new *symbolism* of Thai government’s
Solving the Old Problem of Rural-Urban Distribution

At the time that “neoliberal revolution” occurred in the US and Britain (Harvey 2007:39), Thai RDM began to engage with neoliberalism through the new approach of World Health Organization on human resource management. In 1980, WHO published a guideline and organized a workshop in Sri Lanka on Human Manpower Planning using the market modeling of demand and supply. One of the workshop’s participants, Dr. Prawase Wasi brought WHO’s approach to Thailand. To support the Thai government’s plan to distribute public health service throughout the country, Dr. Prawase and the other senior doctor suggested the government to set up an inter-ministerial collaborative center on human resource management in healthcare. He was appointed the second director of the center in 1985. As the RDM began Sampran Group in 1986, Dr. Prawase “merged” the two initiatives by making Sampran Group “technical working group” working for the center (Suwit 2003:95). Since that time, the RDM has deeply engaged with the use of WHO’s approach. Thai rural doctors have been WHO’s active participants in the area of the health workforce. In 1996, for example, WHO’s experts suggested, in an international conference in Thailand, to establish an international journal in the area. By WHO’s support, the quarterly journal *Human Resource for Health Development Journal (HRDJ)* began in 1997. Thai rural doctors, Dr. Suwit, and Dr. Ampon Chindawatana, the chairman of RDS seventh committee (1984–5), had been the HRDJ’s chief editors for the first five years before transferred its editorial to WHO’s Head Quarter in Geneva (Suwit 2003:101). By the view that neoliberalism is a “mobile technology” that its outcome depends on how it has been “used” (Ferguson 2010; Ong 2007), RDM had engaged with the use of this “technology” for decades particularly in its effort
to distribute healthcare resources to rural areas.

Since the beginning of RDM, the problem of rural-urban disparity of doctors’ distribution has been the core concern of the network. Dr. Suwit (2003) describes that in the first decade after the policy to build a hospital in every district, doctors had been continuously distributed to rural areas. Nevertheless, the economic crisis in 1985 interrupted the new constructions thus decreased the demand for doctors. Later, in the period of rapid economic development especially after 1991, the mushrooming of private hospitals led to the increasing loss of doctors from rural areas to urban cities. In 1992, therefore, Dr. Sanguan, the director of the MPH’s Bureau of Plan at the time, suggested recalculation the country’s demand for new medical doctors. This new calculation led to the plan to increase supply by training additional 300 medical students for ten years, from 1993 to 2002 (Suwit 2003:45).

Another factor that worsened the scarcity of doctors in the rural area was the TMC’s policy on internship training began in 1995. Dr. Suwit identifies that “1995 was the most critical year” (2003:45) as TMC began to require the newly graduated doctors to spend one more year for internship training in the General- or Regional Hospitals that meet TMC’s standard. In that year, therefore, Community Hospitals did not get new doctors to add to the usual lost from the relocation or resignation of their old doctors—especially their phaet-chaitun who usually left for specialist training after finishing the three-year contract. Since most of the hospitals that meet TMC standard were in the central regions of the country, in the next year the new doctors thus accumulated in the central region because they selected to work in the Community Hospitals in the nearby provinces. In 1996, therefore, this accumulation worsened scarcity of doctors in the northeastern and southern regions. Also, there were many new doctors who resigned from the
government position. As a result, 130 Community Hospitals had only one doctor in 1996. The “peak of crisis” was in April 1997 when 21 Community Hospitals did not have any doctor remained. To mitigate the crisis, RDS worked with the TMC to add four-month training in Community Hospital in the internship program (Suwit 2003:45–47). Moreover, as specialist training is a major factor that influenced doctors to leave rural hospitals, every year RDS has to negotiate with TMC to limited the quota for specialist training of the medical schools and negotiate with the MPH to limited the quota for specialist positions of the MPH’s hospitals. This RDS’s intervention initiated everlasting conflicts between RDS and the doctors in MPH’s General- and Regional Hospitals (Suwit 2003:48). To resolve the old problem of rural-urban distribution, the RDM embedded, in the design of the UHC policy, a “financial mechanism” that would influence the fair allocation of resources, especially health workforce, to rural areas.

Building the Managerial Tools for Coverage and Distribution

The main feature of Thai UHC policy that enables Thailand to achieve the goal of “universal coverage” is its model of healthcare financing reform. The “achievement" of UHC policy in Thailand in 2002 was made possible by the creation of the Universal Coverage Scheme (UCS). The scheme provided “insurance coverage” for the people who left out from the two existing schemes, the Civil Servant Medical Benefits Scheme (CSMBS) and the Social Security Scheme (SSS). Before the implementation of UHC policy, MPH had managed most of the government’s healthcare budget as it owns most of the public healthcare facilities. The critical step to achieve UHC goal is to reform the nation’s healthcare financing including to create “internal market” with the provider-purchaser split principle. Almost all healthcare-related money was shifted from the administration of the ministry to the management of NHSO. In this
“market,” NHSO is the *purchaser* buying health services and care from public and private healthcare facilities for Thai people, while MPH is the biggest *provider* of the country.

The NHSO’s financial mechanism, the UCS, however, is intended for broader outcomes of “healthcare reform” besides the “insurance” coverage. In 2002, for example, there were approximately 46.6 million people registered in the UCS. NHSO used this “head count” to acquire budget from the government by proposing the budget using “capitation” calculation. In the first two fiscal years, the number was 1,202.40 bath per head per year—approximately 56 billion baht in total. While this budget includes 934 bath per head for medical treatment services of 46.6 million people under UCS, the other two portions of the budget are intended for the “whole” population of the country: 175 baht per head for preventive and promotive services and 93.40 baht per head for the improvement of healthcare facilities (at 10 percent of the 934 baht per head of the budget for medical treatment). The financial model of UCS, therefore, enable the UHC policy to provide “universal coverage” of essential services not only for the UCS’s population but *all* people in Thailand.

Another intended outcome of the UCS is the redistribution of the health workforce. The UCS’s *allocation scheme* is an instrument to influence the redistribution as the calculated budget already included *labor cost*—financial compensation for health personnel, such as salary and overtime shifts. As the purchaser, NHSO signed annual contracts with its providers in the form of contracting units. For example, a Community Hospital with its network of Health Centers signed the contract with NHSO as a Contracting Unit of Primary (CUP). NHSO thus “pay” the CUP directly, through the hospital, based on the number of people in the CUP’s “catchment area.” In this scheme, therefore, a Community Hospital and a General Hospital that serve the
same size of the population would get the same amount of budget regardless of the number of their personnel. By this condition, the UCS aimed to influence the big hospital to reduce the number of its workforce and to enabled the small hospital to acquire more human resource. This “inclusive model” became a focal point of criticism and resistance NHSO got from the Society of Regional- and General Hospital (SRGH). The owner of those public hospitals, MPH thus seized the authority to set its “internal” allocation scheme. By the support of SRGH, MPH had tried to remove NHSO’s inclusive model. To maintain the effort to redistribute human resource, therefore, RDS has engaged actively, and at many time aggressively, in the annual formulation of the MPH’s internal allocation scheme of UCS budget and other resources. The issue of UCS budget, therefore, had been the main topic in every in RDS monthly meetings since then. Moreover, Dr. Kriengsak Vacharanukulkiete, the current chair of RDS’s committee, has worked in the MPH working group to develop a comprehensive model for allocation of healthcare facilities, resources, and budget to every area of the country using a modern information technology—the Geographic Information System (GIS). By this information-based management technology, all previously hidden “accumulations” become transparent on the “negotiation table.” After the MPH formally endorsed the GIS, resource distribution including the allocation of new health professionals has been negotiated annually using “real-time” information. To me, this modern management tool, the GIS, is arguably the most powerful tool that helps lessen the unfair resource distribution among public healthcare facilities of the MPH.
Struggling with the New Symbolism of the State and Medicine

Healthcare Market

While, for RDM, the UHC policy is the means to achieve universal health security, for ex-prime minister Thaksin it is the means for other goals. Primarily, it was his “political tool”—a populist policy that brought him the landslide victory in the 2001 general election. As “his” administration kept the promise by actualizing the policy, it reaffirmed the Thai electorate that they made the right decision. By its tangible benefit experienced by millions of people, “30-Baht” policy becomes the most memorable “gift” that makes Thaksin a most-beloved national leader. For many people, he becomes their “father” who “truly” cares with their suffering. As this kinship sensibility is extremely sensitive in Thailand where people have long regarded the king the country’s father. This sensibility became a critical influence for the uprising of Thaksin's opponents that led to the Coup in 2006 that ended his administration. Nevertheless, in the ongoing political conflicts in the "post-Thaksin" Thailand, "30-Baht" has continued to be the "political tool" for Thaksin's proponents to call for his return.

The UHC policy was also Thaksin’s tools for his management of Thailand as a business corporation. It was his “administrative tool” for a neoliberal reform of Thai health-care system. By remodeling of the healthcare financing and reorganizing of the health system governance, UHC policy had enabled his government to efficiently manage healthcare budget and effectively control the growth of government healthcare spending. Moreover, it was also his “investment tool” for the prosperity of the country. On the one hand, it was akin to the World Bank's perspective publicized in its 1993 World Development Report that "investing in health is critical to economic development." On the other hand, it was an investment to support private healthcare
businesses in Thailand those suffered by the 1997 economic crisis. By the UHC policy, people don’t have to spend a lot of money for essential health services, so they have surplus purchasing power to seek for services in private healthcare facilities. This intention later became more explicit by the “Medical Hub” policy, began in 2003, that aimed to strengthen private sector to “export” their services "on-site" by targeting high-income patients from around the world. Seeing the two policies together in a broader "business model" of Thaksin’s “Thailand Corporation:” the Medical Hub policy generates income to support the expense required by the “30-Baht” policy.

The claim that Medical Hub policy generates revenue to support the UHC policy, however, is skeptical. Historically, the policy emerged in the context of medical tourism began in many developing countries those aspired to gain income from medical tourists from rich nations. For Thailand, however, the main motivation was the effort of the private sector to survive after the economic crisis in 1997. In the “economic bubble” period (1991–1997), private hospitals had rapidly expanded their investment in infrastructure to serve the increasing demand. As domestic market slowed down after the crisis, they turned to target new customers from abroad to fill the empty rooms. Then, in 2003, Thaksin’s government took this “business opportunity” by implementing the policy to make Thailand the “Medical Hub” of Asia, putting Singapore, a leading “hub” of high-tech medical services at the time as its model as well as chief competitor. By the government support, Thailand rapidly became a major destination of medical tourism. In the beginning, the two policies linked closely. Thaksin’s government assigned the MPH to be

15 I got this information from a conversation, in August 2016, with one of Dr. Sanguan’s colleagues whose role was the coordinator between Dr. Sanguan’s team and ex-prime minister Thaksin in the early 2000s.

16 The Numbers of foreign patients in Thailand increased from 550,000 in 2001 to 1.1 million in 2004, and 1.3 million, three times of those in Singapore, in 2006 (Anchana 2011).
the “focal point” of both policies. Later, however, the Ministry of Commerce became the Medical Hub’s “focal point,” and the primary goal of the policy shifted to economic strengthening rather than health system development. Moreover, the claim was investigated by Dr. Tinnakorn Noree, a rural doctor who has long worked in the area of health workforce. In his Ph.D. research in the field of health economics, Dr. Tinnakorn investigates the “belief” that medical tourism creates “substantial economic gain” to the country. He found that while foreign patients generate a large portion of these hospitals’ income (30 to 60 percent), but they paid the government only 5 percent of their income as corporate tax because they were all listed in Thai stock market (Tinnakorn 2015:231). Medical Hub policy, therefore, neither created revenue to support the UHC policy nor generate “substantial revenue” to Thailand as claimed. But, as Dr. Tinnakorn (2015) argues, its consequences were substantial.

One of the most concerned consequences of Medical Hub policy is “internal brain drain” especially the “drain” of doctors from rural public hospitals to private healthcare providers in the urban cities. While the growth of private sector had attracted patients from overseas, it had also stimulated domestic customers in the period of Thailand’s economic recovery after 2001. The expansion of private healthcare market increased the demand for doctors in private healthcare businesses, while the implementation of UHC policy also heightened the demand for doctors in public healthcare sector. The two policies, as commonly called “dual track” policies thus competed in the limited resource of the country. The income gap between the two sectors had markedly expanded, as did the severity of doctor scarcity in rural areas (Cha-aim and Suwit 2006).

As this situation once happened in the 1990s, RDM and MPH had long worked to counter
the “sucking power” of the private sector by improving public sector’s financial incentives. To decrease the income gap, for example, many new types of financial compensation have been added to the fix civil servant salary. For an instant, at the beginning newly graduated doctors in 2002 would be appointed naiphaet (Medical Physician)17 with the beginning salary 8,120 baht. While the salary increases slowly at the rate of 5 percent per year, the doctors also got income from working in the overtime shifts for about 10,000 to 12,000 baht (800 baht for an eight-hour shift). Topping up to this work-based compensation, they got additional 10,000 baht per month if they refrain from “private practice”—after-hour services in private clinics or hospitals.

Moreover, doctors in Community Hospitals also got the bia kandan (hardship compensation) paid on a grading scale of the level of the districts’“hardship.” The MPH classified districts by using multiple factors such as distance for the provincial center, road condition, population’s income level, availability of public transportation, and the signs of development, such as, bank branch or ATM, a 7-eleven store (the biggest franchise convenient store in Thailand). In 2002 there were three levels of the hardship compensation: 2,200 baht per month in 600 districts, 10,000 bath per month in 127 districts, and 20,000 baht per month in 69 districts (Suwit 2003:106). Therefore, in 2002, working in the districts classified as highest level of hardship, a first-year phaet-chaitun got at least 40,000 baht per month—five times of the civil-servant salary. Nevertheless, this amount was un-comparable with their peers in private hospitals who got more than 100,000 baht a month.

The significant factors that hold health professionals in public sector are non-financial

17 This is the standardized English name of the position. It is one of those of 128 positions of MPH’s employees. It was formally announced by the MPH in the official letter (serial number, thi so.tho. 0201.0310/wo 913) signed by the permanent secretary on November 10, 2014.
incentives. The major ones are the social prestige and benefits of the position of kha-rachakan (civil servant)— the “servant” (kha) of the king (racha). The healthcare benefit is arguably a most significant one that makes many doctors reluctant to resign from the government positions.

The Civil Servant Medical Benefit Scheme (CSMBS) entitles not only the civil servants, but also their immediate family members—spouse, children, and parents—to get health benefits that generally regarded as “higher” than UCS. For example, CSMBS allows getting care and medical services in private providers and pays a higher rate for patients' room and service. If the doctors resigned, their family members would lose their eligibility for CSMIS and get automatic registration into the UCS. As UCS has developed its benefits over time and CSMBS has increased its austerity to reduce government expenditures, the position of kha-rachakan has declined its attractiveness, particularly for doctors whose profession provides social prestige in Thai society. Moreover, the effort to increase incentive to hold doctors in the rural areas had worsened the disparity between the medical doctor and other health professionals, especially nurses who are the doctors’ primary colleagues in patient care. As a negative consequence, the collaborative relationship between medical professionals and other professionals and between the RDS and other professional organizations, has been eroded.

**Competence**

After the implementation of UHC policy in the early 2000s, a driving force that brought doctors out of Community Hospitals, and public healthcare sector in general, has accelerated—that is, the threat of medical malpractice lawsuit. UHC policy is usually blamed as the primary accelerator. A common argument people make is that the acceleration is the result of the heightened rate of medical error and adverse outcome created by the overloaded professionals
working amidst the scarcity of resources. Moreover, for them, it is also caused by the rapid transformation of doctor-patient relationship from *paternalism* to *patronage* brought into public sector by the UHC policy. In this new relationship, patients ask the doctor for the services they deserve rather than seeking for cares given by the doctors’ compassion. Here, patients are customers and doctors are the service providers worked under the contract made with the NHSO. Doctor–patient confrontation was exacerbated by the controversial court judgments in two cases known as *Dokrak case* and *Ronphibun case*. As an urgent response, a national working group was set up in 2008 to seek for comprehensive solutions to the heightened confrontation between health professionals and patients and between the medical profession and the public. Dr. Tinnakorn Noree, the director of MPH’s Health Manpower Research and Development Office (HMRDO) at the time, was appointed the working group’s secretary. As a representative from RDS, I was invited to help him. By this responsibility, I had gained my understanding of the problem and my acquaintance with the people from both sides of the confrontation and those involved to seek for the reconciliation.

To understand the threat of medical malpractice lawsuit that had frustrated doctors in public hospitals in Thailand, it is essential to understanding the two controversial cases. The first one is the *Dokrak case*. In 1999, Dokrak, a 45-year-old woman, developed itchy rashes and teary irritated eyes after taking a medication she got from a private clinic. So she went to a public hospital where a doctor did not recognize that she had a drug allergy. Her symptom progressed rapidly and brought her back to that hospital. In three days, Dokrak developed a severe form of drug allergy. Rashes and crusts covered all over her body including her both eyes that made her completely blind. Dokrak sued the hospital by the assistance of the Thai Medical Error Network (TMEN) a consumer protection network initiated and operated by Preeyanan Lorsermwattana a
victim of medical error in the early 1990s. Dokrak asked for a 17-million-baht compensation. This case initiated the public debate on the issue of doctors’ legal responsibility for the adverse outcome like severe drug allergy that, for the professionals at the time, was hetsutwisai (literally, an event beyond personal control) or force majeure. In 2005, a Provincial Court\textsuperscript{18} sentenced MPH to indemnify 800,000 baht to Dokrak. The judgment initiated hostility of the professionals and worsened the ongoing conflict between the TMC and TMEN. At the end of 2006, TMC publicized an official announcement entitled Kho-thet-ching Thangkanphaet (the fact of medicine [in Thailand]) claiming that it aimed to increase public understanding of the “reality” of medical practice in the country. It is the council’s response to the outcry of doctors around the country for the professionals’ rights and patients’ duties to “counterbalance” the 1998 Declaration on Patient’s Rights in Thailand. This announcement had encountered with criticism that it is the TMC’s effort to protect medical professionals rather than to maintain its foundational principle of protecting the patients.

The second case, Ronpibun case, worsened the situation. In December 2007, a Provincial Court sentenced a doctor to a three-year imprisonment without probation for the death of a patient in 2002. At the time of the incident, the doctor was a second-year phaet-chaitun of Ronpibun Hospital, a 30-bed Community Hospital in my hometown province Nakhon Si Thammarat. The patient died from a complication of “spinal block,” an anesthetic procedure, done by the doctor for appendicitis surgery performed by her colleague. As the means to seek for

\textsuperscript{18} In Thailand, the court system divides into three tiers: The Courts of First Instance, The Courts of Appeal and The Supreme Court. In each province, excepted Bangkok, there is at least one Provincial Court which is a Court of First Instance. The Provincial Court “exercises unlimited original jurisdiction in all civil and criminal matters including bankruptcy within its own district” (Prasobsook n.d.:10). There is no jury system like in the US, but there is a judge, or judges, who are responsible for each disputed case.
compensation, the patient’s daughter asked for TMEN’s help. She filed a complaint with TMC’s ethical board and medical lawsuits. TMC decided in 2004 that the doctor is not guilty since her procedure conforms to standard practice guideline and the complication is an expected consequence of that procedure. Next year, however, a Provincial Court sentenced, under the civil servants’ tort law, that the hospital is guilty of negligence thus the MPH must indemnify the patient’s family for 600,000 baht. The MPH claimed that, by the law, it was unable to make the compensation using government budget unless it was sentenced by the Supreme Court. Thus it “had to” appeal the case. Then, in July 2007 a Court of Appeal ended the case by ruling that it exceeded the five-year civil suit’s time limit. So the patient’s family did not get any substantive compensation after their five years of loss. As this ending is a common tragedy faced by many victims of medical error, filing a criminal suit became a tactic to use its longer time limit of ten years. Since the civil servants’ tort law does not cover the criminal suit, the law suit is thus a personal responsibility of the doctor. On December 6, 2007, a provincial court sentenced the doctor to a three-year imprisonment for her negligence without a probation due to “her” lack of compensation for the suffering of the patient’s family. The patient’s daughter admitted that her family did not expect this result. They needed only some compensation that they had never got even a word of lament. Even though this kind of lawsuit is not new, Ronpibun case is the first one in Thailand that a doctor is imprisoned because of an adverse event that, for the profession, is difficult to distinguish between medical “accident” and negligence. This case, thus, markedly deepen Thai doctors’ anxiety and fear of the threat of malpractice lawsuit.

\[19\] In Dokrak case, MPH was forced by the public and authorities not to appeal the case. The MPH thus used another source of money for compensation.
To me, the ongoing disputatious relationship between the medical profession and the public in Thailand is similar to the “medical liability crises” in United States in the 1970s and the 1980s. In those periods, the skyrocket of malpractice lawsuit at the time put “malpractice” the core concern of American medical profession. In 1990, the Harvard Medical Practice Study found that American physicians were reluctant to “equate medical mistakes with an intent to practice poor medicine” (Good 1995:16). For the physicians, the causal question in a case of medical injury is controversial. But in the malpractice lawsuit, establishing of causal link and blame is necessary as compensation requires the evidence of the doctor’s violation of the professional standard. The U.S. tort system, thus, tends to link “medical accident” to negligence. This linkage is even more problematic for the physicians, as Mary-Jo Good (1995) points out, by the profession’s misconception of the legal concept of negligence. While negligence in the legal perspective focuses on the doctor’s momentarily lack of competence "at the time of treatment," the profession perceives it as a judgment of the doctor’s lack of "essential competence" (1995:17). As competence is at the core of the profession, this judgment led to their “resistance.” Moreover, as “mistake” is an intrinsic feature of medicine that everyone made (Freidson 1975) and medical uncertainty is the key factor that leads to the adverse outcome (Groopman 2007), the profession in United States thus shifts the focus of competence away from "soft side of medicine" such as the art of doctor–patient relationship to "hard side of medicine"—the scientific and technical aspect of clinical practice (Good 1995). In Thailand, the TMC’s Khortetjing Thangkanphaet (the fact of medicine [in Thailand]) can be regarded as a collective resistance by officially express Thai doctors’ “therapeutic frustration” (Wendland 2010) caused by working in a clinical setting of resource scarcity and difficult working conditions which greatly diminishes
their clinical *competence*. A government’s institution established by law, TMC used the “official announcement” as a symbolic means to blame the *secular theodicy* (Herzfeld 1992) of “the system” (the national bureaucracy that includes MPH, NHSO) as the cause of medical errors and adverse outcomes. Moreover, doctors’ resignation from the government positions can be seen as a form of “resistance” as they know that the scarcity of doctors makes reappointment a possible option in the future. Therefore, the threat of malpractice lawsuit is arguably a dominant force that drives doctors out of public hospitals especially those in remote rural areas.

**Biotechnical Embrace**

While people usually blame financial incentive as the primary cause of the "internal brain drain," studies on the resignation of doctor form Thai public hospitals give a clue to the other significant factor. A well-known study done in 2003 identified that economic reasons did not significantly influence the doctors’ resignation. Rather, the most important reason the doctors gave was their lack of “satisfaction with the work” (Kamthon, et al. 2003). As the problem has continued in the changing context of Thai healthcare system in the past decade, a public administration student conducted another study in 2016. The study found that, the main reason that influenced doctors to resign is the “overloaded responsibilities” (Ingkharat 2016). This study also analyzes the "motivational factors" that cause brain drain. The finding is straightforward: the most significant motivation is that the doctors lack the confidence that “the working environment and context will enable them to achieve the goal of the medical establishment” (Ingkharat 2016:165). Although the two studies were done a decade apart, they found a consistent result—

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20 This frustration was vividly described by Claire Wendland’s (2010) study of medical students and doctors in Malawi. But the term “therapeutic frustration” was suggested by Arthur Kleinman in a seminar discuss Wendland’s book, in which I had participated in spring 2011 at Harvard University.
that is, what drive doctors out of public hospitals is their concern about the outcome of their work as medical professionals. As the resigned doctors were mostly young doctors, they just immersed for a few years in the "clinical reality" of Thai public hospitals after graduated from the medical schools. For them, the new "clinical reality" was much different from those in which they had got acquainted by the six-year medical training. Therefore, it is understandable that their dissatisfaction with the work and work condition became the critical motivation for their resignation. Also, it might be the influence for the young doctors to go back to medical schools for the training to be specialists then move to work in the hospitals that have higher capability, rather than continue to be generalists working in the small hospitals in the remote rural areas.

In the “backdrop” of these studies, the growth of private providers and the influence of Medical Hub policy created other public and private disparities besides the income gap. In her analysis of medical tourism in Thailand, Ara Wilson (Wilson 2010) points out that Thaksin administration’s “dual-track creates a tiered medical system… It is portrayed in contrast between high-tech medical care for foreigners and socialized medicine providing basic health care for Thai citizens” (2010:135, emphasis added). As the private hospitals have invested more in high-technologies to compete in the international healthcare market, medical school hospitals have developed to be modernized and to meet global standard. For example, Siriraj Hospital renovated its facilities and establish excellence centers. One of them is the center for the cardiac disease under an English name “The Heart by Siriraj” established in 2006 as an autonomous unit under the Faculty of Medicine, like a private hospital inside the public medical school. The former administrator of Siriraj who began the projects told that they aimed “to keep the medical school’s status of the [nation’s] center of excellence in medical sciences [and technologies] and to prevent the school from losing its personnel to the private sector” (Anchana 2011:69). In this context,
medical schools have also aspired to be at the forefront of global development of cutting-edge technologies and therapeutic research. The schools, therefore, have been the primary sites that the medical students engage and appreciate the high-tech biomedical technologies that lead to what Mary-Jo Good (2007) call “biotechnical embrace.” As they began their professional lives in the Community Hospitals, they had encountered the new “clinical reality” in which most of what essential for clinical practice they learned in the medical school were unavailable. The doctors thus engage with therapeutic frustration as they could not help many of their patients just because of the unavailability of the required technologies on-site. As they “embrace” the “medical imaginary” (Good 2007) in the medical school, the new doctors’ frustration is intense. Working in such context, they frustrated with their lack of competence which for them is much different from that of the senior doctors. Working since the early stage of the Community Hospitals, the senior doctors were familiar with “sub-standard” practices amidst deficiency of resources. The biotechnical embrace makes the young clinicians’ competence depends significantly on the “quality” of the facilities in which they work. Therefore, it is not surprising to see almost all of the new generation of Thai doctors relocate or resign to work in the healthcare facilities those have much higher quality than the small rural hospitals. Therefore, the biotechnical embrace becomes another critical challenge for the actualization of healthcare universalism.

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I first met Dr. Sanguan at Thampanara Hospital when he visited the hospital in 2003 in the program called phi yiam nong (literally, older sibling visits younger sibling). The program was operated by the Rural Doctor Foundation. In the program, senior doctors who have high
experience and *barami* (charisma) brought the “visiting teams” to visit young doctors and their hospitals’ staff in the remote rural areas. The program aimed to provide the doctors and the hospitals’ staff *raengchungchai thang sangkhom* (social incentive). In the atmosphere of *phi nawng* (siblinghood), the senior doctors gave encouragement, advice, and help and received complaints and feedback back to the MPH. It was a part of RDM’s effort to maintain doctors and other health professionals in rural areas.

The visit began with my presentation. At the time, I was trying to grapple with the problems in hospital administration under the UHC policy especially financial and human resource management. As my hospital has less than 30 thousand people in its “catchment area,” the allocated budget under the UCS allocation scheme was not enough to keep the hospital operate. By using a simple calculation table, I showed Dr. Sanguan that the hospital needed additional one million baht to continue the operation. Also, I told him that I need some extra money to improve the hospital’s infrastructure, especially its power system to prevent lengthened outage. After the meeting, Dr. Sangaun called a senior Rural Doctors in my province to help. One of them promised immediately to give me 200,000 baht to improve the hospital’s infrastructure.

Even though, at that time Dr. Sanguan was busy pushing forward the UHC policy at the “center.” He volunteered to lead a team to visit young doctors working at the “periphery.” As a Rural Doctors, he knows that the so-called “achievement” of Thai UHC in 2002 that entitles all Thai people to the rights to state’s health welfare was just the beginning. For Dr. Sanguan, as well as other people in the RDM, the challenges of Thai UHC lie in the struggle to ensure *health security of every* person—especially those who live at the “border” of the state.
Although that morning was not my first trip to Umphang, it was the first time I drove by myself from Maesot to the town. It was also the beginning of my extended stay there while my previous trips lasted never longer than four days. It was a sunny morning in the rainy season of 2016, my wife and I brought our three kids to the hotel’s café. It was a small hotel at the outskirt of Maesot that Dr. Worawit and his team usually stayed to help save the hospital’s budget. After a while, Dr. Worawit walked to our table and greeted us with his usual smile. He apologized for being unable to welcome us when we arrived after a long drive from Bangkok last evening. He was tired and caught a cold as he drove through the rain from the other Community Hospital where he was assigned to be its interim administrator because its director had been sick for months by drug-resistant tuberculosis in the spine.

The morning that we were preparing to go to Umphang, the vehicle I used is my younger sister’s hatchback Toyota Yaris, a subcompact car designed for urban use. The trip required readiness of the driver as well as the vehicle. With his expertise in the automobile and extended experience of local driving conditions, Dr. Worawit reassured me that our Yaris was capable of bringing us to Umphang. Before we start, however, he gave me a brief “lecture” on how the car’s automatic gear, break and stabilizing systems work and how to use low gears as “engine-break” and to press foot-brake pedal correctly when going down the hills. My older sister who worked with my dad at his mechanic garage reaffirmed that she just changed the car’s four tires and
checked its breaks and engine just before lending it to me. The windshield wipers’ blades, however, needed to be changed because we had to get ready for the unexpected heavy rain or thick fog on the mountain tops. Dr. Worawit brought me to buy ones at Mega Home, the superstore where we can buy almost everything required for home use and construction at a lower price than smaller stores in Maesot. This store had opened just two years ago. Like other newly opened giant stores, it attracts consumers from Myanmar and changes Maesot from a remote border gateway to an urban commercial city—a “success” of the Thai government’s development of a Special Economic Zones at the Thai-Myanmar border.

After filling up the fuel tank at the last PTT gas station, we were ready for the five-hour trip on Route 1090 from Maesot to Umphang, known as the “1,219 curves, 164 kilometers, sky-high road”—the “only” roadway to go to Umphang. As it was my first drive, Dr. Worawit led us on his 4x4 Chevy pickup truck. My nine-year-old son took the position of his passenger, the position that my wife and I took in our first trip to Umphang fourteen years ago when I was a novice director of a community hospital coming to seek advice. I kept a certain distance driving so I followed them to bring the two daughters in their car seats and their mother to our new home to spend a year in Umphang for my ethnographic fieldwork.

Being the driver myself, I had to deal with the challenge of each hill and each curve. Driving our small automatic gear hatchback after him, my body gradually learned how to shift gear and press the brake pedal to go up and down steep hills and how to steer the wheels to keep the car on the two-lane paved road passing through sharp curves. The car’s horn was needed at many curves I had to remember, to give a signal to the vehicle coming from the opposite direction, a small motorcycle or a big truck, to stay in its lane. At the middle of the journey, we
stopped at Umpiam, the last village before entering the district of Umphang. It was the only resting area on this route where we could get beverage and food, use a restroom, take a walk, and change the kids’ diapers. After taking a break for everybody’s refreshment, we then continued on the second half passed the Umpiam Refugee Camp in the valley on our left. Then we crossed the district’s borderline into the territory of Umphang Wildlife Sanctuary. In the last thirty kilometers, the road brought us onto a plateau, went through small villages, corn fields, and hills. After passing the Northern style wooden gate and crossing the last concrete bridge, we went on a short four-lane highway that suddenly turned into a narrow concrete road of the small town of Umphang.

Regardless of the danger and motion sickness, the roadside scenic mountains and valleys make it an enjoyable road trip for thousands of people a year. It actualizes the rustic image of the most remote district of the country. For tourists, this road makes Umphang, with its world-famous Tee Lor Su Waterfall, a once-in-a-lifetime natural destination. For activists, this road makes Umphang, with its “underdeveloped” hill tribes, a romantic site for humanitarian aid workers. But for health professionals, this road makes Umphang, with its remote villages, ever-changing roads’ condition, and mountainous terrain, a challenging work site to provide the people essential health services and to control epidemics of infectious diseases—the foundation of health security of the people and the nation.

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This chapter discusses the effects of the Thai Universal Health Coverage (UHC) policy on health professionals and people in the borderland of Umphang. As Sandra Hyde (2007) points out, state’s health workers in borderland employ “multiple subjectivities.” By the position of
state’s officers, they “embody” the “boundaries” that, by Thongchai’s (1994) concept of “geo-body,” construct the “border” of a modern nation by geography and categorization. At the same time, they also employ other subjectivities in their professional and humanitarian positions. These subject positions are, at times, conflicting, especially in the context of a large political and social projects such as the Chinese state’s effort to control HIV/AIDS epidemic in a borderland that Hyde (2007) investigates. In Thailand, the implementation of Thai UHC policy began in the early 2000s is a political and social project that instigates new symbolism into Thai state administration and Thai society at large. It thus affects subjectivities of state’s health workers and people in the borderland and their intersubjective relationship of caregiving. In this new context, Dr. Worawit, the director of Umphang Hospital, as a rural doctor in the network of Rural Doctor Movement utilizes the multiple subjectivities of people in the network to work collectively to remediate a “pathology” of Thai health bureaucracy from within—in the effort to ensure health security for every people in the borderland.
Figure 2: Tee Lor Su Waterfall at the end of rainy season (October 2016)
Universal Health Security: A View from the Periphery

An “Enclosing Element” of the State

From the view of Thai government’s provincial administration, Umphang is one of the five border districts of Tak Province that form the most of the western border between Thailand and the Karen State of Myanmar. By its 4,500 square kilometer area—three times of the area of Bangkok metropolitan—Umphang is the largest one among the 878 districts of the country. It is also the farthest one, by the comparison of the distance between the town's center and the province's urban center. Traveling to Umphang, an officer at the provincial center has to go westward across the Thanon Thongchai Mountain Ranges for 80 kilometers to Maesot District, then go southward on Route 1090 passing Phobphra District for the other 160 kilometers to Umphang. Before the completion of Route 1090 in 1983, people commuted between Maesot and Umphang through a path that cut into a part of Myanmar, by walking, riding cow- or buffalo-hitched carts, elephants, or tractors. From Phobphra they crossed the beginning part of the Moei River—the river that flows northward and becomes the line divides the two countries—into Myanmar soil. Then they went southward through the plateau that expands across the two nations’ territory and, finally, crossed the border to enter Umphang. Without clear natural boundaries like a waterway or a mountain ridge, this part of Umphang border is an imaginary line that matters to the state only. People in this area, most of them were Karen, had lived here for centuries before the line was drawn to separate Thailand and Myanmar.

21 Regarding the Department of Provincial Administration, on December 31, 2016, the provincial administration of Thailand consists of 76 Provinces (Changwat), 878 Districts (Amphoe), 7,255 Sub-district (Tambon), and 75,032 Villages (Muban) (Department of Provincial Administration 2017).
Before the public administration reform in the reign of the King Rama V (1853–1910), Siam (the former name of Thailand) was a “galactic polity” (Tambiah 1976). At the center was the king’s palace surrounded, from the pericenter\textsuperscript{22} to the periphery, by numerous political entities called moeang\textsuperscript{23}. The polity was organized by the traditional blueprint of the mandala—consist of the core (manda) and the “enclosing element” (-la) (Tambiah 1976:102). The area that is Umphang district today was the site of Maeklong Outpost (Dan Maeklong) of Moeang Uthai Thani responsible for observing the movement of Burmese army passing through Maelamao Pass\textsuperscript{24}—the less known western military pass in the popular histories of Thai-Burma wars that popularize the Three Pagoda Pass. Although a small political entity, the outpost was an “enclosing element” that maintain the territory of the kingdom. The implementation of local government (thesaphiban) reforms (1893–1915) transformed the traditional polity into “radial polity” (Tambiah 1976) by establishing the hierarchical system of Monthon. Maeklong Outpost was officially declared as a part of Uthai Thani that became a Province (Changwat) under the aegis of Monthon Nakhon Sawan. By this reform, the “outpost” transformed from a post that helped stabilize the center’s power from the periphery to a piece of land that claimed the territory

\textsuperscript{22} I follow Tambiah’s lead in using the astronomical analogy to describe the dynamic configuration of Thai polity. The term pericenter is described in the online version of Meriam-Webster Dictionary as “the point in the orbit of a revolving body nearest the center of gravity about which the body moves,” https://www.merriam-webster.com/dictionary/pericenter, accessed September 21, 2017. To me, this term illuminates the positioning of a political entity or actor that, by constantly maintaining a distance that is close but not too close to the center, can influence the center of power while having the freedom to move by oneself. It is the position of many health professionals whose works significantly contributed to the reforms of Thai healthcare system whom I discuss in this dissertation.

\textsuperscript{23} The term moeang is usually, but not correctly, translated as “city” (Herzfeld 2016:44). Although in this dissertation I use Romanize transliteration scheme of the Royal Society of Thailand, for the term moeang I follow Herzfeld’s (2016) because his transliteration helps the non-Thai readers to read this word easier (Herzfeld 2016:xiii).

\textsuperscript{24} Maelamao Pass is now the name of a sub-district of Maesot District on Highway 12 that crosses the Thanon Thongchhai Mountain Ranges between Maesot district and Tak’s provincial center.
of a bureaucratic state. Although the Monthon system was abolished after the revolution in the 1930s, the system has continued to influence the configuration of the geographical hierarchy of the state’s public administration until the present.

The state passed the piece of land declared as Umphang District today among the “administrative hands” of three provinces—from Uthai Thani to Kamphaeng Phet in the 1920s, then to Tak in the 1950s. Zooming in and out to see the geographical relationship between Umphang and the urban centers of the three provinces in Google Maps, I found that Umphang is almost entirely isolated from the three provincial centers by the southern part of the Thanon Thongchai Mountain Ranges. It is thus not surprising why the Communist Party of Thailand (CPT) set its bases here in the early 1970s.

In the time of Communist insurgency in Thailand between the mid-1960s to the mid-1980s, Umphang was a familiar name for the general public as a “red zone.” The officers of the Border Patrol Police and other state forces had engaged in psychological and physical warfare. Resided by ethnic groups, mainly Karen and Hmong, who cannot speak Thai, it was difficult for the officers’ psychological operation (patibatkan chittawittaya) to put the idea of national loyalty against the “brainwash” (lang samong) by the radical Communist ideology. Umphang’s geography and isolation were beneficial for the CPT’s insurgent forces making them difficult to be defeated by the state’s defense. Thai government thus began the project to build Route 1090 in the early 1970s to stabilize the state's route for mobilization of forces and supplies. The project had been interrupted and resisted by the armed rebels until the war ended in 1982 by the government’s order of amnesty for the CPT’s members to “return to participate in the development of Thai nation” (klab khaoruam phattana chatthai). The road was formally opened
after ten years of construction. It became a primary infrastructure that ascertains the connection of Umphang in the “geo-body” (Thongchai 1994) of the “Thai nation” created by cartography a century ago. Through this road, it was possible for the state to build a modern healthcare facility—–Umphang Hospital—a “tangible” promise of the welfare state given to its marginal population. It is an “outpost” that helps to ensure health security of Umphang people. Also, it is an “outpost” that is responsible for surveillance and control the spreading of epidemic diseases at the Thai-Myanmar border to ensure health security of the inner part of the nation.

**Developing an “Outpost” to Protect People at the Border**

I first met Dr. Worawit in late 2002. It was the first year of my appointment as the director of Thampanara Hospital in my hometown province in southern Thailand. As I had been a student-activist since high school, my medical-school classmates who graduated from the same high school know that I preferred to be a general practitioner in a rural area rather than a specialist in an urban city. At that time, one of them was working as a phaet-chaitun at Umphang Hospital. He recommended that I should visit Dr. Worawit to get advice on working as a rural hospital’s director. I agreed. Because the hospital in which I worked had only two physicians, it took me a while to seek doctors from nearby hospitals to help my colleague as he had to work 24 hours a day during my absence. To shorten the trip, my wife and I decided to spend our scarce saving for the roundtrip airfares. After three connecting flights, we arrived in Maesot in the late afternoon. My friend and a driver picked us up at the airport by a pick-up truck labeled “Umphang Hospital” on its sides. We then went to the bus terminal to pick up our younger friends who want to join our “study visit.” After having dinner in the town, the experienced driver brought us through the rain in darkness on the bumpy mountainous road. In the middle of
the trip, the driver revealed his identity that he concealed to test us how differently we would treat him. At the time, he emphasized, he was a driver. But, he was also the director of Umphang Hospital. As we passed his test of “respecting that all people are equal,” he began his “lecture” to teach about hospital management from his self-studied knowledge and a decade of first-hand experience.

Dr. Worawit, born in central Thailand, came to the town in 1991 as a *phaet-chaitun* (doctor under three-year compulsory contract). He graduated from Srinakharinwirot Medical School in Bangkok as its first graduated class. He came to Umphang by chance, as he gave the position he got in the “selection” day to the other doctor who, with his group, told that they want to go to the other province together. He got Umphang Hospital’s position as it was a remaining unselected one that met his criterion of a far-from-home place. He began his first year working at Umphang Hospital with an older phaet-chaitun. In the following year, Dr. Worawit was appointed the hospital's director as his senior colleague left for the training to be a specialist. At the time, Umphang was known as a very remote town in the harsh forest powered by diesel generators that have to take a rest in the night. The Ministry of Public Health (MPH) officially opened the hospital as a ten-bed Community Hospital in 1984, a few years after the completion of Route 1090. Its first director was the person who invited journalists to help promote Tee Lor Su Waterfall and turned Umphang to be a tourist destination. Under the shortage of doctors in rural areas, many times in his early years Dr. Worawit was the only doctor of the hospital responsible for administrative and clinical works. Sleeping in the director’s office helped shorten his commute to see emergency patients. Many of them arrived in the middle of the night after hours or days of the journey in the forest to the hospital seeking cares for life-threatening conditions, such as ruptured appendicitis, abortion, or severe trauma. Sadly, many of them could
not survive the long trip especially on the muddy routes in the rainy season. Those patients included the victims of the wars between the Karen National Union (KNU) and the Burmese military government as well as the victims of the 1988 student-uprising in Myanmar that forced hundred-thousands of people to seek refuges in Thailand. At the time of my first visit in 2002, Umphang Hospital had three physicians—Dr. Worawit and two phaet-chaitun.

The morning after we arrived in 2002, we walked up the hill from our friend’s dorm to the hospital’s cafeteria for breakfast with Dr. Worawit to begin our “study visit” in Umphang Hospital. For breakfast, we had porridge that every morning the hospital provided for free for patients and the hospital’s staff as well as anyone coming to the hospital, the patients’ relatives or visitors. It is a “benefit” (sawatdikan) that aimed to reduce people burden to seek for food in the small town of Umphang. After we washed the dishes in the provided dishing area, we then followed him to walk through the hospital buildings. To keep the floor clean and to respect the patients who sit on the floor or sleep on the floor-beds, everyone had to take off the “outside” shoes. At the time, Umphang Hospital was a thirty-bed Community Hospital after the official opening of its new four-story building in 1996. The new building was customized to fit with limited space and slant landscape of the hospital. In contrast, the old one was built by the standard blueprint in the “package” that the MPH had used to construct hundreds of hospital all over the country under the policy to distribute a hospital to every district, including the one in which I worked. As we walked, he explained to us how he had worked to modify and develop the buildings and facilities to improve the hospital capability to fit with the needs of Umphang people.

We took a short walk to the front of the hospital’s old “ten-bed” building. The design of
the one-story building and the size of one-fourth of a soccer field was familiar to me. The front ramp brought us to the emergency room (ER) at the center of the building. The room for two simple examination beds was rearranged and equipped to be a resuscitation unit ready for the entering of a stretcher with a patient who needs immediate life-saving treatment. Behind the ER, the operating room (OR) on the left now used for minor procedures such as wound sutures as major procedures such as cesarean section had better rooms in the new building. The delivery room on the right was equipped with portable ultrasonography machine and incubators ready for premature births. The room connects with the old In-Patient Department (IPD) at the northern end of the building that now reserved its ten beds for pregnant women before and after delivery. After visiting the Labor and Delivery Department, we then walked through the front hallway passed the ER to the other end. Surrounded by rooms and counters, the waiting area of Out-Patient Department (OPD) was crowded by patients waiting for their names to be called. Unlike my hospital that had two examination rooms, Umphang Hospital had two more using the space of former dental clinic and laboratory unit. While the new dental clinic relocated to the new building, the Laboratory moved to the other side of the waiting area. It occupied a larger space that joins two rooms that formerly were the X-ray unit and the health promotion clinic. Its bigger space provided room for a blood bank and new equipment for advanced tests. Availability of on-site tests provides timely information that enabled doctors to manage complicated cases at the hospital.

We then walked on the corridor to the new building. When we passed the Supply Unit of the ORs on the first floor, he explained to us how medical devices were cleaned and re-sterilized. Like all other public hospital in Thailand, Umphang Hospital reprocessed and reused single-use
medical devices\textsuperscript{25} including surgical gloves and silicone tubes to reduce the hospital’s cost. While the reprocessing and reusing was done by “improvisation”\textsuperscript{26} in most of the other places, Umphang Hospital had done it with Dr. Worawit’s keen interest in quality management and engineering. He told us by-heart the details of the standards the hospital kept so he was confident that all the devices are safe for the patients. He also showed us the devices-cleaning machines that he and his staff invented. As the brand-name ones are much more expensive, these inventions make the “standard” achievable for a rural hospital. We then walk up the stairs to the second floor as the elevator was reserved for patients’ stretchers and wheelchairs. The new In-Patient Department (IPD) occupied the whole second floor. Although the hospital was officially

\textsuperscript{25}The label of “single-use medical devices” and the stigmatization attached to the practice of “off-label” use of them are socially constructed. In the past decades, medical devices have increasingly been produced and “labelled” as single-use medical devices (SUDs), primarily by increasing concerns of cross-infection of Hepatitis B virus and HIV (Hussain et al. 2012). The practice of reuse and reprocessing of SUDs is common around the world to reduce material cost of healthcare. For example, in United States, the General Accounting Office estimated in 1999 that while there were around 100,000 models of medical devices used in United States that cost approximately 56 billion U.S. dollars, 20 to 30 percent of American hospitals reported reuse and reprocessing SUDs. The office pointed out the “off-label” use’s potential benefit and called for a regulatory system (United States Government Accountability Office 2000). Later, the U.S. Food and Drug Administration developed its regulation that requires reprocessed devices to meet a standardized requirement (U.S. Fed. Regist. 2006). Other developed countries take various positions on the practice; for example, it has been prohibited in France, banned in the UK, and controlled in Australia, and Sweden, while developing countries are lack of the established policies and regulations for this practice (Collier 2011; Hussain et al. 2012). While the practice in developed countries mainly includes expensive or technical devices, the practice in developing countries also includes cheap ones. An international survey of the “off-label” use of SUDs points out that unsafe injection is the main problem of reuse SUDs in developing and transitional countries (Popp et al. 2010). Based on WHO’s estimation, in 2000 there were 16 billion injections in which 40 to 70 percent done by reused syringes and needles without sterilization in developing and transitional countries (Jha et al. 2010:44). The authors of WHO’s report suggest that healthcare provider in developing countries “must” stop reusing “cheap” SUDs such as syringes, needles, and surgical gloves (Popp et al. 2010). To me, however, in the perspective of local healthcare workers, the practice of “off-label” use might be the only means to make modern healthcare available for the people. Rather than stigmatize the “off-label” use of SUDs by the stereotype of the ubiquitous unsafe injection, we should work closely with the local healthcare workers to find the best way to appropriately reprocess and reuse the devices to ensure both patient safety and people’s access to essential care.

\textsuperscript{26}As Wendland (2010) observes in her study of doctors in Malawi, “improvisation” is a means that the doctors make medical care available in the context of resource scarcity.
entitled to have thirty beds in its IPD ward, it had to add more legged- and floor beds to accommodate many more patients, especially in a “season” of dengue fever or in an outbreak of diarrhea. In the ward, a zone was designated the Intensive Care Unit (ICU) equipped with four ventilators, monitors, and other electronic devices that usually unavailable in rural hospitals. For Umphang, however, availability of these medical technologies is “essential” as many patients could not survive the three-to-four-hours ambulance trips on the mountainous road to Maesot General Hospital. As we walked, Dr. Worawit talked to the patients and their relatives while explaining to us about their suffering from illness and living condition. We end our first morning visit in the hospital by attending then the weekly meeting of the hospital’s “executive committee” (kammakan borihan)27 on the top floor of the new building. A message that he repetitively emphasized is that everything Umphang Hospital does or invests is based on the needs and benefits of the patients and people in Umphang borderland—to save their lives and wellbeing.

*Constructing a “Network” for Border Protection*

At the time of my first visit, there was an emergence of an epidemic of meningococcal infections in Umphang. A patient was referred from the Health Center in Poeng-kleong village, the western gateway at the border of Umphang and the Karen State of Myanmar. At the hospital,

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27 The hospital’s *kammakan borihan* is a formal structure of every hospital of MPH. Members are appointed by the director’s *kamsang* (official order). Most of the committee’s members are heads of the departments and units as well as others whom the director deems essential to include. The committee usually convenes on a monthly basis. By its official’s role, the committee serves as the “executive committee” by which important decisions are made, and executive problems are solved. In many hospitals, however, the committee’s meeting is just a “ritual” to legitimate the directors’ decisions. A sign of this tendency is the irregular meeting schedule or, in some hospitals, the lack of such meeting for many months or years.
the doctor found that the patient had a bacterial infection caused by *Neisseria meningitidis*. It is the germ that causes fatal meningitis that kills a half of untreated patients. It also causes septicemia characterized by hemorrhagic rash and “shock” that kills one-eighth of the patients within 24 to 48 hours of the symptom’s onset. The germ is transmitted only among human by the droplets of secretion from the carries’ nose or throat through, for example, coughing, sneezing, or sharing cigarette or utensils. The risk of transmission is heightened in people who have close and prolong contact with the carriers such as those who live in a high concentration residence or participate in a mass gathering. By WHO’s recommendation, this infection “should always be viewed as a medical emergency.”

Therefore, in the weekly meeting of Umphang Hospital’s “executive committee” that I attended, Dr. Worawit told his staff about the situation and alerted everyone to be vigilance for the cases that may present at the hospital. He informed the committee that, after the meeting, he and a team from the hospital and the District Health Office (DHO) were going to go into the “epidemic zone” to investigate and “control” the epidemic. He invited my “study-visit team” to join.

Right after the meeting, we met the team at the meeting point beside the hospital’s cafeteria. There were almost ten people in the group, including Dr. Worawit, my friend Dr. Ping who was assigned the lead physician of the team, Wanlee, head of the hospital’s Technical Department (*fai wichakan*), and public health technical officers of the hospital and the DHO. Our final destination was Poeng-kloeng Health Center, two hours away by drive. The vehicles we used were Umphang Hospital’s 4x4 pick-up trucks driven by the hospital’s drivers. As it was the rainy season, we need reliable vehicles and the drivers who familiar with uncertain road

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condition and who can immediately turn to be mechanics if the trucks encounter mechanical problems in the midst of the thick forest. Dr. Worawit was the official leader of the team as epidemic control is one of the Community Hospital’s director’s designated responsibility. It is, however, a co-responsibility the director has with the chief officer of the DHO who, by the MPH’s line of command, is the commander of all Health Centers in the district. To facilitate the cooperation among the medical and public health units of the MPH, in every district there is an official collaborative committee—kanakammakan prasan-ngan satharanasuk amphoe (the committee for district public health coordination)—in which the hospital director and the DHO’s chief officer take the turn to lead. As the DHO’s chief officer could not join the trip to the epidemic zone on that day, Dr. Worawit led the team.

At the midway on the mountainous road between Umphang and Poeng-kloeng, we stopped at Nupo Health Center to have lunch and to use the restroom. Then we went to Nupo Refugee Camp located in the village. The camp, set up in 1997, is one of the nine remaining refugee camps along the western border of Thailand with Myanmar. Most of Nupo camp dwellers are Karen who fled the dreadful control of Burmese Army on their homeland. Resided by more than ten thousand people in its 400 rai (about 0.64 square kilometers) area, the camp is a high-risk site for the massive epidemic of meningococcal infection. Our destination was the camp’s hospital, operated by a European-funded international medical aids organization. Although the hospital was built with bamboo similar to all other construction in the camp, it was a comprehensive modern medical facility. It was divided into OPD and IPD with isolation rooms and equipped by “on-site” laboratory. We met the head physician of the hospital and discussed the plan to respond and control it together. As the hospital provided care not only for the camp dwellers but also healthcare seekers crossing from Myanmar territory, it can rapidly detect and
respond to the “spreading” of the infection.

Then we continued on the trip to our final destination, Poeng-kloeng Health Center. At the end of our route, the road runs down the mountain into a small plain. The driver told us that we were entering Poeng-kloeng village. As signified by its Mon-language name that means “the bottom of the ship’s bilge,” the village locates at the lowest part of the gap of the mountain range that runs north to south. The range aligns parallel to the Thanon Thongchai range with its southern part forms the border between Thailand and Myanmar. This village, therefore, has been a “pass” that people use for centuries to travel across the land that now is separated into two countries by a small brook called *hui dan* (literally, “territorial brook”). At the Health Center, Dr. Worawit led a meeting to discuss the epidemic. As the patient referred to Umphang Hospital and many others became ill after attending a gathering in a village in Myanmar’s territory, the meeting joined by local authorities and healthcare workers from both sides of the national border. The participants included the local military leaders of Thai Army, Karen National Union (KNU), Democratic Karen Buddhist Army (DKBA), and Burmese Army. Besides their “fear” of the deadly infection, their “trust” in Umphang’s health professionals who had worked for years to care for health and wellbeing of everyone regardless of nationality and affiliation motivated all parties in the zone of hostile conflict to agree to put hands together.

In the effort to control epidemic at the border, however, state’s health professionals employ “multiple subjectivities” (Hyde 2007). For Dr. Worawit and his team in this epidemic control, they employ at least two subject positions, one is official, and the other is professional. As the Thai state’s health officers, they “embody” the state’s “boundaries” that classifying whose life is entitled to the state’s protection. From the perspective of this subject position, Dr. Worawit
and his team have the duty to protect health security only of Thai people and the whole nation. Therefore, the aim of the trip and the meeting is to construct a local “network” of “border protection” to prevent the epidemic from spreading into the inner part of the country. Nevertheless, by their experiential knowledge of the borderland and their sympathy to the suffering of the marginalized population of the Burmese state, they go beyond the official limit by the perspective of the other subjectivity—professional caregiver that strive for universal health security of every person. The two perspectives seem to be complementary as the epidemic control in this area is possible only if every threatened community and individual are protected regardless of the national territory and political boundaries. Nevertheless, they become contradictory when the limitation of Thai state’s resources essential for epidemic control, such as medicines, vaccines, and medical devices, is concerned. This “concern” is at the core of Thai healthcare system, since the implementation of Thai UHC policy in 2002.

I left Umphang after my first visit with new ideas and inspiration on how to manage my hospital and its healthcare network. I heard about the epidemic from my friend Dr. Ping. Experts from MPH and other institutions went in to help. Limited numbers of vaccine were brought in with some conflicts about who should get them. Some people died. By the collaborative work of health officers at the periphery and the center, the epidemic at the border of the state was quickly controlled. On the days that I left, I also had to be counted as a “subject” of the state control. As a visitor in the epidemic zone, I was contaminated and had the risk of meningococcal infection. To get rid of this “contamination,” I need chemoprophylaxis by taking rifampicin (rifampin, in U.S. market) twice a day for two days. It was the first time I took it and terrified by its side effect by myself. I had prescribed the drug for my patients for years as it is also the “most potent” chemotherapy for Tuberculosis—the epidemic that brings me back to Umphang in 2016.
When my wife and I returned to Umphang in 2016, the town was much different from our first visit a decade and a half ago. Concrete commercial building substituted many wooden shop houses. Two banks opened their branches in the town. There were many mobile phone shops and even a goldsmith shop. These material changes tell us about the growth of local economics stimulated by not only tourist industry, but also mono-agriculture especially corn that used for produced animal foods. A significant one is a 7-Eleven store, the franchised 24-hours convenient store that is a sign of “urbanization” in Thailand. The store was opened for a few years as the town power has been stabilized by the outside supply, besides the district’s diesel generators power plant opened in 1959. After decades of negotiation, the Provincial Electrical Authority, a government-owned company, was allowed to build an electrical line along Route 1090 passing through the wildlife sanctuary from Maesot to Umphang. This electrical line connects the small town of Umphang with the large generators hundreds of kilometers away from the biggest dam in the country—the Bhumibol Dam—named after the King Rama IX. While the electrical line “connect” Umphang with the power supply of the nation, the mobile phones shops signified the connectivity of Umphang people to the “outside” world. Also, the convenient store—7-Eleven—connects Umphang people to the outside consumer market of Thailand. The store is a sign of urbanization where similar merchandise and services are available for local consumers and the visitors who can feel “at home” as they can get into “familiar” consumer experience by going into any of thousands of 7-Eleven stores around the country. The store, in the view of “imagined community” (Anderson 2002), makes people in
Umphang—residences or visitors—a part of the Thai national “community.” For people in Thailand, “pai sewen” (“go to Seven-[Eleven]”) becomes a part of everyday life. It is a successful goal of the business strategy of a large corporation in the country that is becoming an international one. To me, it is a similar goal of the Thai UHC policy that wants to ensure that all people in Thailand can go into any hospital around the country to get the similar experience of “caregiving.” The primary purpose of my return to Umphang in 2016 is to investigate this goal in the borderland and how the effort to achieve the goal affects tuberculosis control in the area.

My family and I arrived Umphang in early September. By the assistance of Maew* whom Dr. Worawit assigned to accommodate us, we were able to rent a beautiful house that was just five minutes away by walk to Umphang Hospital. We were “lucky” to come to reside in Umphang town at the time because many good “for-rent” houses just became “vacant” as their long-term tenets left. Most of them are the employees of international humanitarian aid organizations those began to close their Umphang units in responding to the plan to close the refugee camps along the Thai-Myanmar border including the ones in Nupo and Umphiam as the political condition in Myanmar was improving after decades-long conflicts.

The house we rented is in the group of seven residential units owned by a local Thai landlady. They align along a small concrete driveway on a land, enclosed by the concrete and steel fence, on the shoulder of a hill. The houses located on half of the area while the other half is a slant grass field. On the top of the field a Karen couple resided in a Karen bamboo thatch-house. The landlady hired them to take care of her property and accommodate her tenets. The two houses beside our house were rented by the staff of humanitarian organizations. One is a Christian organization works on providing aid, including educational funding, for the children in
remote villages. The other organization works on offering food to the refugees in the nine camps along Thai-Myanmar border that its Umphang office oversight the ones in Nupo and Umpiam. The young teachers of local schools resided in the other houses. They just began their professional career in this remote rural area. The other houses’ residences were temporary visitors who came to the town by various missions—tourism, business, humanitarian—or just visiting friends or relatives. To me, this group of houses is like a microcosm of Umphang.

Organizations and people come into this borderland with different missions. Many of the people are “professionals” whose goal is to mitigate “suffering” of the “marginalized” populations in the area. As a health professional, I can contribute only in some areas of what the local people need. So, I humbly continued the mission of my “visit” working with the local network of health professionals.

Umphang Hospital at the time had seven doctors including the director, Dr. Worawit. The six doctors were two second-year phaet-chaitun, three third-year phaet-chaitun, and a pediatrician whose appointment is a specialist of the hospital. By the MPH GIS-based healthcare network management, Umphang Hospital is identified as a hospital that needs to have specialists in significant areas. The pediatrician was a third-year phaet-chaitun whom Dr. Worawit gave the position to support her specialist training. After finishing the program, she thus went back to work at the hospital. There were also many others health professionals who are local people, including the Karen and the Hmong, working in Umphang Hospital. Many of them were the children in remote villages who got educational aids from humanitarian organizations. They also got support from the dedicated director of the only high school of Umphang until graduation. Then they got scholarships to pursue their professional training. The primary sources of the awards are the fund and foundation of the royal family members who have and had worked in
the area of healthcare for the people in remote rural areas. By the coordination of the MPH’s health workforce management, the funders, the training institutions, and the MPH have worked together to mitigate the scarcity of health workforce in rural areas. New generations of local people had got the scholarships to attend the additional seats of the training institutions with await positions in the remote hospitals. After graduations, they went back to provide professional cares for the people in their community. By the expansion fo Umphang Hospital’s capacity and Dr. Worawit’s responsibilities, the six doctors agreed to help liberate him from clinical works. Dr. Worawit told me, “now I’m a ‘full-time’ nak chadkan (literally, management specialist).” His primary role is now to deal with all managerial issues to keep the hospital operated and to make happen its new initiatives. By having this “specialist,” the hospital and its network have been capable of actualizing the promise of the Thai state to ensure health security of Umphang people, especially after the implementation of UHC policy in 2002.

**Umphang Hospital under the UHC Policy**

In Umphang Hospital, Dr. Worawit provided me a working space in Maew’s office on the third floor of the four-story building. Her office is a part of the Department of Health Insurance (fai prakan sukkhaphap). The department is responsible for patient registration, medical record collection, and hospital services transaction recording and processing. As the Thai UHC policy instigates a new symbolism of “market”—the healthcare and health insurance market in which each hospital is a “business unit” responsible for its financial survival. The department is also responsible for collecting and processing the documents for insurance claim and reimbursement. Therefore, it is the hospital’s “business apparatus” by which patients are classified by their health insurance. As citizenship is the prerequisite for the eligibility for public
health insurance under UHC policy, the policy thus excluded almost a haft of the 60 thousand people in Umphang who lack the status of Thai citizen are excluded and thus classified as “uninsured.” By profession as a social worker, Maew is responsible for determining which uninsured patients are qualified for free service and then ask Dr. Worawit to sign “anukro” (charity, literally, “help”) on the records to exempt the patients from the out-of-pocket payment. For Umphang Hospital, however, most of the uninsured are marginalized low-income people. In the early period of the UHC policy implementation, the hospital’s staff had a new duty to ask patients for payment. This duty had frustrated the staff as well as the patients. Dr. Worawit thus imposed a policy to liberate his personnel from such responsibility. He allowed Maew as well as other officers to sign “anukro” to provide free care for any patient they deemed appropriate. Umphang Hospital, therefore, open its door to everyone regardless of health insurance, nationality, or ability to pay. Anytime people ask or criticize him about this policy, he responds simply, “I choose to shoulder the costs (kachaichai), rather than to see patients die beside the hospital wall.”

The hospital’s compassionate approach to the problem of uninsured, however, has been a chronic burden in the view of financial management. Annually Umphang Hospital spent around 70 million baht while it was allocated only 30 million baht a year. Therefore, it has been one of many hospitals in the country that are classified by the MPH’s and NHSO’s financial monitoring system as being in the highest level of “financial crisis.” While other public hospitals in Thailand also got substantial “income” from reimbursement of services provided for people under CSMBS and SSS, or the out-of-pocket payment from special services such as private rooms, these source of income is trivial for Umphang Hospital. Moreover, its operational costs are higher than other places as the long distance transportation increase the prices of most of the supplies. Although
MPH and NHSO had provided financial support, their supports are only temporary remediation. By the burden caused by “uninsured” population, each year the hospital has to shoulder the “debt” of around 30 million baht. To reduce the hospital’s costs, Dr. Worawit and his staff have implemented many austerity practices and cost-saving initiatives. Besides the utilization disciplines such as turning off unused electrical equipment, they reduced their comfort. For example, to reduce the cost of meeting participation, they choose to spend only 400 baht a night in a cheap lodging rather than 1,200 baht a night in a four-star hotel allowed by the MPH’s regulations. The hospital set up a biodiesel producing plant to produce bio-fuel from donated used cooking oil to reduce the fuel cost. The biodiesel production also provided the by-product that can turn to cleaning agents. Moreover, as the hospital spent 10 to 12 million baht a year on pharmaceutical products, the head of the pharmacy department initiated a project to receive the donation of “ya kaya” (unused prescribed drug, literally, “junk medicine”) from around the country. The project is originally an effort of the Thai Pharmacist Council to solve the problem of inappropriate disposing of unused prescription drugs especially antibiotics. While in the following years the council ended the project and moved on to other issues, Umphang pharmacists have continued the project. When I was doing my fieldwork in Umphang, the project had continued for almost a decade. I saw thousands of postal boxes from around the country sending the “junk medicine” to Umphang. Some days the boxes almost occupy the whole hallway of the third floor where Maew’s office locates. Staff from many departments volunteered to open the boxes to separate the medicine and other donated items. The team of pharmacists then classified the donated medicine using their expertise to restore the usable ones and appropriately discard the real “junk.” In 2015, this project helped save almost 400 thousand baht for the pharmaceutical cost. It also helped to make many expensive medicines available for
Umphang people.

Nevertheless, a hospital is an organization that consists of lives of people. It is difficult for many hospitals in rural areas, or even those in urban cities, to keep similar level of staff’s morale and “group harmony” as Umphang Hospital, while engaging endless constrain and austerity measures. From her study of caregiving in Thailand, Felicity Aulino (2012; 2014) points out a collective subjectivity that enhances “group harmony”—the “social body.” From the recognition of this “body,” an organized social entity—an organization or a polity—is “an actual living organism of which everyone is a part” (Aulino 2014:417). As in Thai society khwan (“life force” or “spirit”) is an essential component of individual bodies, it is a significant element that holds people together in harmony in collective bodies, a hospital or a nation, in which khwan is nurtured by its “leader.” From this view, a key element that has kept Umphang Hospital alive is its director, Dr. Worawit. As he is compassionate to the patients, he also “gives” his compassion and care to the people in his organization. Moreover, As mentioned in chapter one, the primary reason of doctors’ resignation from public hospital is not financial issue, but the working environment. Dr. Worawit’s administration provide his staff the working condition for them to achieve their professional idealistic goals. I found that he always says “yes” to any initiative that would be beneficial for people, and give autonomy and support for his staff to get it done. Therefore, it is not surprising that although Umphang is a hardship workplace, the hospital has a low turnover rate of its personnel.

Like many other rural doctors, Dr. Worawit has been a “leader” in the development of the local healthcare system not only by his official or professional prestige but also management
competency and *barami* (charisma)*\(^{29}\)* accumulated over the years of continuous work in the rural area. His understanding of multiple aspects of the jobs—medical, engineering and managerial—had enabled him to efficiently procure and construct what the hospital needs without engaging in the custom of commission or bribe. His enduring altruistic work for marginal population had attracted private donors and supporters. Moreover, his connections within and beyond state bureaucracy—accumulated not by the mutual personal profits but by the commitment to benefits of people—allowed him to transcend bureaucratic barriers to strengthen the healthcare system of Umphang. I got this insight after my first visit in Umphang in 2002 as I worked on the initiatives to “improve” my hospital infrastructure.

In my “study visit” in Umphang Hospital in 2002, in a night walk around the hospital buildings, I got an understanding that a hospital couldn’t function without stabilization of its infrastructure especially the power supply. Umphang Hospital couldn’t rely on the district’s diesel generators that frequently put the town into hours of outage. With his keen interest and self-studied knowledge in engineering, Dr. Worawit had developed the hospital’s electrical system to meet high standards of stability and safety. In an outage, hundreds of electronic medical and office devices were stabilized by the big battery of the central Uninterruptible Power Supply (UPS) while the rest of the electrical system got back up power from the hospital’s automatic-run generators within minutes. By this insight, I was frustrated by a realization that what seemed to be normal in my hospital was unacceptable—services and procedures had to stop

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*\(^{29}\)* The term *barami* is commonly translated as “charisma” based on Max Weber’s concept of charismatic authority in Thai quotidian use of the word. However, *barami* is also a central concept of power in Thai society. It’s rooted in the Theravada Buddhist ideology of Perfection in which a bodhisattva accumulates barami to become a Buddha in the future. Since the beginning of Bangkok era, the king has been regarded as a Bodhisatta-king ruling the kingdom under his barami (Jory 2002).
at least ten minutes in an outage waiting for a person to check the engine and hand start the
generator. Many times, I was the person who had to do this job. Therefore, when I got back to
work after the study visit, I began with an initiative to improve the electrical infrastructure of
Thampanara Hospital. To make this kind of improvement project happened, however, I learned
that it required not only knowledge and management skills, but also barami as it needs
coordination and money. As I was a novice director of a small MPH’s hospital, the initiative that
requires 200 thousand baht seemed to be impossible without entering the complicated and
delayed bureaucratic budgeting processes. Luckily, I had the opportunity to present the plan to
Dr. Sanguan in his visit to Thampanara Hospital in the Rural Doctor Foundation’s pi yiam nong
program in the next year. By Dr. Sanugan’s barami, I got the money and official support to make
the hospital “a step” better to serve people in the rural area.

Politics of “National” Health Security

The Embedded Symbolism of National Bureaucracy

While many rural doctors moved on to work for the “rural” people from the “center,” Dr.
Worawit and many others have continued their works at the “periphery” of the health
bureaucracy. By the new responsibilities in the central administration, many of them “embrace”
the new symbolism as the means to achieve their idealistic goals. I got this insight from a story
Dr. Worawit told when we discuss the adverse effects of UHC policy in Umphang. He insisted
that he is a supporter of the policy as it is beneficial to the large part of the Thai population. But
the problem for him is that its small “defect” creates adversary effects to large part of the people
in the borderland. Dr. Sanugan was responsive to the problem, he told from his vivid memory: “I remember that it was December 21, 2002. I was driving for Pi Sanguan [on Route 1090] in his visit to Umphang. He said to me, ‘Give me three years. I will make the [UCS’s] financial distribution (klia-ngob) better!’” Then he went on to narrate the changes in NHSO after Dr. Sanguan’s death in 2008. It seems to him that no one truly cares about Umphang’s obstacle as he had been left alone to find ways to pay the “debt.” When he invited to join the leadership program I managed in 2009, he complaint to one of my team members that, because of Umphang’s burden, he wanted to resign from the program. She quickly informed Dr. Wichai Chokwiwat, the chairman of the fourth and fifth committees of RDS (1981–83), the head of senior advisors of the project. Dr. Wichai thus talked to NHSO’s authorities who are younger than him. He asked NHSO to provide 20 million baht to support Umphang Hospital. As she witnessed the conversation, later she told Dr. Worawit. One said to Dr. Wichai, “I think, we cannot bare helping Worawit. Any amount we give; it is never enough for him.” The other added, “It is like Worawit is running a rongtan (literally, “alms canteen”).” Dr. Wichai then asked, “Do you know why?” The two paused. “Because Worawit is still a doctor (mo), but you already forgot [who you are]!” A few days later, Dr. Worawit got a phone call from one of the two doctors that NHSO will send him a 20-million-baht subsidy. After that time, he emphasized, he has never got such help again. As both of the NHSO’s authorities are also rural doctors, the story surprised me. So I asked Dr. Worawit for his idea about the reason why they see him this way. He once answered with a voice of disappointment, “I don’t know. Maybe, they have the [patriotic] feeling of bang rachan!” In Thai popular history, the village of Bang Rachan where villagers fought against Burmese Army on its way to destroy the Siamese capital of Ayutthaya is a symbol of patriotism of the Thais and the cruelty of the Burmese, the historically constructed
enemy. Dr. Worawit’s used of the symbol signifies the sense of “otherness” Thai officers have with the Umphang’s “non-Thai” population whom I found usually be called by the ethnic stereotype “phama” (“Burmese”). It signifies the “indifference” that is socially constructed by the symbolism of the national bureaucracy, as Herzfeld (1992) points out, that is nationalism.

When the UHC policy began as “30-Baht” program in the early 2000s, it had another name—“krongkan bat thong” (literally, “the gold-card project”)—named after the color of the new insurance cards distributed to millions of people around the country. It was a symbolic tool signifying that the cardholders are entitled to “privilege health services for the citizens” rather than “free care for the indigents.” Distribution of the gold cards to all citizens was the primary means that help the country to rapidly “achieved” its goal of providing “universal coverage” in most of the areas of the country. It was, however, not the case for borderland like Umphang. Moreover, at the beginning of the program, every “gold card” holder was required to show one’s proof of citizenship—the citizen identification card or a copy of household registration (tabian ban)—every time one comes to the hospital for a “visit.” This requirement symbolically and essentially created a new barrier that excludes non-citizen from the state’s health welfare. Many patients were reluctant to come to Umphang Hospital because of the lack of the gold card and the fear to be captured by the lack of the proof of legally present in Thailand. To ascertain the people that they can continue receiving health care from the hospital and its healthcare facilities, Dr. Worawit provided them the alternative identification card using the color of peace—white. Thus began Umphang’s system of “white card” (bat kao). For Dr. Worawit, implementing this system has two aims. One is to reaffirm the “cardholders” that they are welcome to get healthcare in Umphang. The other is to register the non-citizens of Umphang to understand the scope and characteristics of the “uninsured” population in the hospital’s “catchment” area.
As the “white card” system helps Dr. Worawit to understand the problem of “uninsured” population in the borderland, he can find ways to deal with their “barriers” directly. One means is the establishment of Maew’s office—Umphang Legal Clinic—established in 2013 by the support of a group of legal experts. The “clinic” is the office that Maew, a social worker, and the two young lawyers worked to provide legal assistance to Umphang people on the issues related to nationality status problems. The clinic’s services include working to get sutibat (birth registration) from the district’s Civil Registration Section for every child born in the hospital. The other service is to investigate the “cases” to find legal evidence that could help them to get Thai nationality or accurate *lekprachamtao prachachon* (officially, “Personal Individual Digit [PID],” literally, “citizen identification number”) in the Thai state’s registration system. This system, as Harris (2013) asserts, is a “rigid state system of classification” that clearly distinguish between citizens and non-citizens by which the state assigns a 13-digit identification number to every documented resident (113). Thai PID contains 13 digits written in the form of X-XXXX-XXXXX-XX-X. The most important one is the first digit as it identifies the classification of the person registered—only 1, 3, and 5 signify "Thai citizen," the others, "non-citizen." The remain digits are the four-digit code of the registration office, the seven-digit serial number, and one accuracy-proving digit at the end. Before 2002, low-income people could get subsidized health insurances from the MPH regardless of their citizenship. As the status of Thai citizen is, “by the UHC law,” the prerequisite for getting the state’s health insurance under the UHC policy, their PIDs became the matter for the people and the hospitals in the borderland. The health insurance

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30. By the effort to resolve the problem of the registration status of people in Thailand, in 2005 the Thai government began a new category assigning number “0” for people who previously did not have registration status. Later, the registration system also involves migrant workers by providing them the number “00” as the first digit in their PIDs (Chuthimatra 2008).
market created by UHC policy strengthens the “rigid” system of 13-digit registration. In this “market,” the PID system is the tool that the Thai state uses for categorization and quantification of the complex combination of people’s lives in Thailand. By the identification as insured or uninsured, people are subjects for the state to exercise its “sovereign power” to save the lives or let die (Foucault 1979). To deal with this issue, therefore, Dr. Worawit needs the other means—that is, to accumulate the “momentum” of the periphery to tackle at the center the “rigidity” of the organizing principle of the Thai polity.

**Remediating the Polity**

The Thai Universal Health Coverage (UHC) policy is developed in the legal framework of *human rights* in Thai Constitutions—the sets of legal rational principles that has organized and re-organized Thailand as a polity. Although Thailand is one of the first 48 states that adopted the Universal Declaration of Human Rights in 1948, rights to health care was just first enshrined in the 1974 Constitution in Section 92: “the State should provide healthcare to the indigent, free of charge” (Wichai 2002:69).\(^{31}\) Two decades later, the country’s legal framework added the principle of healthcare universalism in the 1997 Constitution, the “People’s Constitution,” in Section 52: “A person [(bukkhon)] shall enjoy an equal right to receive standard public health service, and the indigent shall have the right to receive free medical treatment from public health centres of the State, as provided by law.”\(^{32}\) This new “organizing principle” of the Thai polity

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\(^{31}\) As I cannot find a reliable source of the English translation, this text is my translation from what quoted in Wichai 2002 on page 69.

provides the legal-rational framework for Dr. Sanguan and his colleagues to institutionalize the principle of universal health security into the national health bureaucracy. The Section 5 of National Health Security Act B.E. 2545 (A.D. 2002) writes “The Thai population [(bukkhon tuk khon)] shall be entitled to a Health service with such standards and efficiency as prescribed in this Act.” The UHC Act, therefore, obligates the Thai state to provide health welfare not only for the indigent but for, in the Thai version of the Act, bukkhon tuk khon (literally, every person) that is translated as “Thai population” in NHSO’s official English translation of the Act. Nevertheless, the term bukkhon tuk khon in Section 5 became a fundamental ambiguity of the Act as it determines the people whom the state health welfare covered. This “legal term” thus became a new entity in the “symbolism of rational government” opens for bureaucratic interpretation and intervention.

When MPH implemented UHC policy as a pilot project began in April 2001, the ministry used information from Civil Registrations to distribute the “gold cards” to “every person” registered. Nevertheless, after the promulgation of UHC Act in November 2002, emerged the concern of eligibility of the person registered as khontangdao (“non-Thai,” literally, aliens) for the UHC. Hospitals asked NHSO whether they should give the “gold card” to this registered population. NHSO responded:

The person (bukkhon) who has the rights to receive health services as described in Section 5 of the National Health Security Act B.E. 2545 is the person who has Thai nationality. This because the Act is established (banyat) based on Section 52 of the

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33 This text comes from the official English translation of the Act provided on NHSO’s website, http://law.nhso.go.th/files/forms/MTE/=c6f10d10-18db-415a-9d31-a2dfbd8f403a-129610478550118729.pdf, accessed March 29, 2018. I add the Thai term bukkhon tuk khon (literally, every person) that uses in the original Thai version in the place of the term “Thai population” to emphasize the difference.
By NHSO’s interpretation, non-Thai were explicitly excluded from the new health welfare policy. Hospitals stopped distributing the “gold cards” to these people and asked those who got the cards to return. They began to be seen as the hospitals’ burden. In 2005, the MPH rename the policy from “samsib-baht raksa tuk rok” (“30-baht to treat every disease”) to “samsib-baht chuai khonthai hangklai rok” (“30-baht to keep Thai people away from diseases”) (Chuthimas 2008:5-6). Even though the MPH’s main purpose of renaming is to shift the focus from diseases’ treatment to prevention, the use of the term khonthai in the new name emphasizes the exclusion of people who lack Thai nationality. This exclusion alerted a group of legal professionals who have long worked on the problems of citizenship and statelessness in Thailand. In 2008, they conducted a series of researches on the problem under the title Health for Stateless. Then, at the end of 2009, they began to publicize the finding and initiate a social movement to request the government to provide health security for stateless and nationality-less people. It was the same time that Dr. Worawit began his participation in the leadership program I managed. As the program aims to enhance collaboration and networking, it provided a venue for him to connect with the legal experts and other social activists. This connection brought Dr. Worawit to the center of the social movement.

Dr. Worawit’s complaint about Umphang’s burden alerted people in the leadership

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34 The project was funded by Health Insurance System Research Office under the Health System Research Institute (HSRI). HSRI is a Public Organization under the direction of the Ministry of MPH. This project, therefore, facilitated the collaboration between this group of legal expert with the network of rural doctors.
program to step in, especially other participants in his cohort who were eager to help. Supported by the program, they organized a special forum joined by directors of border hospitals, legal experts, and social activists. In the forum, information from various aspects was aggregated, the leverage points were identified, the social movement strategies were clarified, and a new organizing body—the Border Hospitals Network (*krueakai rongpayaban chaidan*)—was established. Dr. Worawit was elected the leader of the network. Other participants of the leadership program jointed the movement from their professional position and expertise. An epidemiologist helped to clarify the information of a leverage point—the threat of *roktidor chaidan* (literally, “communicable diseases at the border”). Journalists enhanced social support through popular media. A television correspondent put the issue “on air.” As the ministry of MPH, motivated by the heightening of public concern on the issue, planed a visit to border hospitals in northern Thailand in February 2010, she invited him to her “live” program that planned to “on air” from the area. In that program, Dr. Worawit handed to the minister the network’s requests, including to “return” the health rights to “non-Thai” people who could get state health welfare before the implementation of UHC policy. In that “live” program, the minister promised to do so. He brought the issue into the cabinet meeting on March 23, 2010. By the meeting’s consensus, the government ordered MPH and NHSO to “return” the right to *healthcare* to 450 thousand people and set up a hundred-million-baht fund to support border hospitals. The cabinet’s consensus, however, helped to mitigate only a part of the burden of the border hospitals. For Umphang, for example, only five thousand people among the 30 thousand uninsured population got the entitlement. People in the leadership program, the participants and the senior advisors, thus went to visit Umphang to figure out what more can be done. Then, a mechanism to acquire external support, *mulaniti rongpayaban umphnag pue manusayatam*
Umphang Hospital Foundation for Humanitarianism, was established by the effort of people in the leadership program. Then, by the support of the group of legal experts, Umphang Legal Clinic was established to continue the effort to help the others "non-Thai" people.

The primary leverage points of the social movement in 2010 are the “return” of the health right of the registered “non-Thai” population and “the threat of roktittor chaidan.” The first one was identified as it fit with the political condition. The government at the time was led by the opponents of Thaksin after the 2009 coup that ends his “formal” administration. Identifying a defect of Thaksin’s popular “30-Baht” policy, thus, a catchy political tool. The discourse of “return” became an effective instrument to gain political support from the government. The other leverage point is “the threat of roktittor chaidan.” It was identified as an antidote of the concern of national security that has long heightened the “fence” of Thai/non-Thai classification of the Thai state. The past efforts to grant “non-Thai” people full coverage by UHC policy were failed by security concerns related to “security issues that could arise from immigration spurred by granting healthcare rights to non-citizens” (Harris 2013:118). The discourse of “the threat of roktidtor chaidan” utilizes the symbolic power of “national border.” It emphasized the other concern of national security besides ethnic harmony and national loyalty—that is, *biosecurity*. The minister of MPH said in an interview, “the government has to support the border hospitals in providing healthcare to non-citizen. Otherwise, the health of all Thai people will be affected” (quoted in Rural Doctor Society 2010:19, emphasis added). By the concern of roktidtor chaidan, the new policy, officially called as “cabinet consensus (*mati kanaratthamontri*) on March 23, 2010,” makes “non-Thai” population at the border the subjects of state surveillance and control. Border hospitals are thus designated by the “center” of the Thai polity to be its “outposts” to observe and respond to the “movement” of these people, as they
contain the “threat” to national health security.

**Inclusive Society, A Global Concern?**

In December 2016, Dr. Worawit asked me to help to edit and translate into English an article he was invited to submit and present in a side meeting of the 2017 Prince Mahidol Award Conference (PMAC) on the theme, “Addressing the Health of Vulnerable Populations for an Inclusive Society.” The topic of the side meeting was “The Last Mile of UHC in Thailand, ‘Do We Reach the Vulnerable?’” In the meeting, non-citizens in borderlands are classified as a group of vulnerable population among others, including, patients with end-stage renal diseases (ESRD), elders who need long-term care, the youth with substance abuse, and children with learning and behavioral disorder. As the concept of vulnerable population used in the PMAC is an “inclusive” term, the populations identified in the side meeting illustrate the view that non-citizens should be a concern, in the discussion of UHC. The other groups of people who, even though they are citizens, also need more “inclusion” into the national UHC program.

Nevertheless, the term non-citizen is usually used to signify the “cross-border” population, including the migrant workers who “often fall outside universal health coverage discussion” (PMAC 2017:56). Exclusion of non-citizen into the UHC not only violate their human rights (Guinto, et al. 2015) but also “put the general public at risk,” for example, by preventing the noncitizen with tuberculosis to get treatment (Hacker, et al. 2015:176). Therefore, “solutions are

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PMAC is an international conference organized in January in Bangkok to honor the awardees of the Prince Mahidol Award. The award was established in 1992 to commemorate the 100th birthday of His Royal Highness Prince Mahidol of Songkla—“The Father of Modern Medicine and Public Health of Thailand.” The award has got international acceptance as four of its awardees in the later years became noble laureates. Since 2007, the PMAC has gained its status as an international venue for the discussions of policy-related critical global health issues.
needed that provide noncitizen healthcare” (Hacker, et al. 2015:175). Nevertheless, the inclusion of noncitizens into a nation’s UHC put a significant challenge to the management of the country’s healthcare financing—the core modus operandi of the model of UHC popularized by WHO in the past decade.

By the inspiration created by many developing countries, including Thailand, embarking on UHC, WHO (2008) put in its annual World Health Report in 2008 that the three-decade-old Health For All goal can be achieved in any country regardless of economic status. By the new concept of “affordable Health For All,” WHO publicized health system financing as the solution. In its 2010 World Health Report entitled Health Systems Financing: The Path to Universal Coverage, WHO (2010) devices a geometrical conceptual model of UHC—“The UHC Cube”—identifying the three dimensions of coverage: population, services, and direct costs (paid by the covered people) (figure 2). By the UHC Cube, a country can “measure” the three dimensions of the “cube” to determine its progress toward the UHC achievement. Universal health coverage had quickly gained its “momentum” in the global community, by human rights and economic perspectives. In January 2012, the PMAC convened under the theme “Moving toward Universal Health Coverage: Health Financing Matter” and in the conference the participants declared the “Bangkok Statement” to support UHC. In the same year, the United Nation General Assembly, on December 12, unanimously endorsed UHC a global agenda. Three years later, economists around the world signed a declaration to support UHC in 2015 emphasizing that UHC is the “investment” that is essential for the economic sustainability of the world. Thus, UHC is a crucial element to achieve the Post-2015 global agenda of Sustainability Development Goals.
Nevertheless, the *Global Health Watch 4: The Alternative Global Health Report* published in 2014 provides a critical view of the UHC model popularized by WHO, by putting it in the context of neoliberal globalization. The report identifies that since UHC was first mentioned in the World Health Assembly in 2005, its main focus is *financing* as it uses the term “coverage” rather than “care.” The logic of *provider-purchaser split* create internal market in which government has the role to ensure that all healthcare providers, public and private, operate efficiently and cost-effectively and, by neoliberal ideology, are treated fairly (Global Health Watch 2014a). As the report identifies that we are now moving from “neoliberalism 1.0, structural adjustment and free market” and “neoliberalism 2.0, financialization” to “Neoliberalism 3.0, austerity” (Global Health Watch 2014b), every country has to enhance its
austerity measures in healthcare financing to keep UHC viable. The geometric conception of UHC Cube helps to visualize that to provide coverage of essential services and direct (out-of-pocket) costs by a finite amount of resources, the number of people under the UHC program have to be limited. As the “global” UHC movement is driven by the “international” institutions, WHO and UN, its focus is “national” healthcare system. Therefore, target “people” of UHC are the citizens of each nation. Thus non-citizens are excluded. Even though this exclusion seems to be a violation of human rights, it is legitimized by the international legal framework:

The architecture of international human rights law is built on the premise that all persons, by virtue of their essential humanity, should enjoy all human rights unless exceptional distinctions—for example, between citizens and non-citizens—serve a legitimate State objective and are proportional to the achievement of that objective. (Weissbrodt 2008:45, emphasis added)

As the UHC become a global agenda, states are increasingly put UHC for the citizens its objective. To achieve this objective, austerity is thus required in the management of the state’s limited resources. Therefore, exclusion of non-citizens from a country’s health welfare is not unlawful discrimination but a legitimate measure for the viability of the national UHC program.

In Thailand, although the achievement of UHC policy was declared in 2002, the UHC program has continued to improve as more people, services, and direct costs are waiting to be covered. For example, people with ESRD cannot survive without the high-cost renal dialysis and, in the end, renal transplant. Therefore, their lives are vulnerable thus need coverage in the national UHC program. As there are still demands to include high-cost services and “vulnerable” citizens, it is thus not surprising that NHSO’s authorities were reluctant to provide support for noncitizen in Umphang in 2009. Their response to Dr. Wichai’s request using the word rongtan (alms canteen) signifies their concern of the national UHC program’s sustainability that would be threatened by unlimited resources required for Umphang Hospital’s humanitarian efforts. As
the rationality of *sustainability* dominates the world from global to local, managers at all levels are given the responsibility to efficiently and cost-effectively manage their finite resources. The *domination* of market model and management rationalities, in the view of a French social critic Hibou, is “one of the main figures of neoliberalism” (2015:xv). By combining Weber’s concept of *domination* (authority) and Foucault’s concept of *governmentality*, Hibou points out that people become the “bureaucrats” of the *neoliberal bureaucratization*. Building on Herzfeld’s (1992) analysis of bureaucracy, Hibou identifies that “the selective deployment of discrimination between ‘them’ and ‘us’ is firmly anchored in the *imaginaires* of society” (2015:94). To me, the UHC Cube is a powerful abstract image of a sustainable “healthcare system” in which the symbolism of market reduces the meaning of lives of people identified as “them” thus deserve exclusion. Therefore, it is not surprising to see the conflicts emerge between Maesot General Hospital and the Community Hospitals as they refer to Maesot the seriously-ill non-citizens.

By the analysis of Umphang Legal Clinic, there are other groups of noncitizen beside the “cross-border” people, such as migrants and refugees. Even though many of them are “Thais,” they are classified as noncitizen by their lack of the proof of Thai nationality. Therefore, the rubric of “noncitizen” is a problematic one for Thai state’s health professionals at the border. Providing care for everyone regardless of nationality is not totally a humanitarian effort that uses public resources of the country for the benefits of “others.” Moreover, by the threat of the trans-border epidemics, they are responsible for preventing the spread of the infectious diseases to the inner part of the country. For them, therefore, to ensure *health security* of the nation, it is crucial to ensure *health security* of every person in the “borderland.”
Chapter Three:
Tuberculosis Care and Control in the “Borderland”

It was a sunny afternoon in the cold December of 2016. I ride a motorcycle followed Ew, a "TB worker" of Umphang Hospital, to visit a man who had lived in the hospital’s Herbal Garden for more than a year. Besides the herbs that the hospital’s Thai Traditional Medicine Department grew, the garden at that time filled with banana trees for which he got the “job” to care. The dirt road led us through the garden to his residence. It was a small one-story house built specially for him a year ago with a cost-effective design which the hospital’s staff can finish making it in just a few weeks. It was not difficult to find as the similar model and material were used to build other buildings of Umphang Hospital inside and outside the hospital wall. Ew parked her motorcycle on the gravel ground beside the house which helps lessen the slippery mud, especially in the rainy season. My research assistant and I followed her.

Ew called out in Karen language telling the man that it was the time for his daily medication. In a few minutes, a man in his sarong walked out from the lines of banana trees, greeted us with a smile. He asked Ew for a few minutes to change his clothing in the house. He then came out with a plastic water bottle in his hand and walked to Ew for his daily routine. Ew spreaded out some pills on his palm. He put them all at once into his mouth, followed with a sip of water from the bottle, then opened his mouth for Ew to check that all pills were gone. All these processes were under Ew’s gaze as “doing DOT” (Directly Observed Therapy) was her designated daily job in the man’s treatment “regimen.” The processes were his “prescribed”
responsibility as a TB patient of Umphang Hospital. He was the first patient under the hospital's new standard of “isolation” for TB patient. His residence is the first house in Dr. Worawit’s plan to build a “TB village” preparing for a lot more patients like him that would come to get TB care from Umphang Hospital in the future. After they finished their routine, Ew explained to the man the purpose of my visit. As he gave his permission, we arranged a discussion circle on the floor. I took off my shoes and put it on a cement brick to make a seat. The man, Ew, and my research assistant looked for their comfortable ones. Then I began an interview.

The man in his mid-thirties recalled his memory to explain us the course of his life. His name is Mo-e-se* which is his Burmese given name that he did not know its meaning. He was a Pow Karen born in the Karen State of Myanmar. His mother did rice farming, and his father worked as a Karen Soldier. When he was around 13 years old, a fever killed his mother, then a few months later, his father was killed by the Burmese army. As they were afraid of the Burmese soldiers, he and his siblings moved to work in Thailand. Mo-e-se had lived in Umphang for almost ten years, earned his living by daily labor jobs. Through the connection to other Karen migrants on the mobile phone, he met his future wife. At that time, she was working in Bangkok. As they decided to get married, her uncle motivated them to go to Songkhla in southern Thailand for a better-paid job in shrimp farming. After four years of working intensely, sometime all day and night, he began to have chronic coughing. For almost a year, he had been fatigued and later had some blood stain in the sputum as he coughed. By his wife’s insistent, he went to seek care from the district hospital by paying the costs of hospital visits and transportation by himself. A doctor at the hospital told him that he had an infection called “TB.” After six months of oral medication and regular visits to the hospital, he stop coughing and felt healthy. Then Mo-e-se and his wife moved to Bangkok to work in a garment factory. After a while, they moved again to
work in a sea-salt-producing plant in Samutsakhon—a province with a high concentration of factories and migrant workers. Nevertheless, a month later he began to have bloody cough. As his health condition was getting worse, his relatives in Umphang suggested him to leave the city and come to rest with them. So he went “back” to Umphang after the thousand-kilometer journey across the country. He went to seek healthcare at Umphang Hospital and finally got the diagnosis that he had “TB” again. Our conversation had to stop at this point as it was late in the afternoon. Although I was unable to go into the details of his illness narrative after he became a TB patient of Umphang Hospital, this part of his story gives me an “image” of the mobility of migrant workers who were identified as a challenge of TB control in Thailand.

I learned the other parts of Mo-e-se’s story from his medical records and the report written by Umphang District’s Surveillance and Rapid Response Team (SRRT)—an official entity designated to investigate and intervene the threat of the epidemic in the area. The team led by Wanlee, the head of Technical Department of Umphang Hospital whom I met in 2003 in the trip to “epidemic zone” of meningococcal infection in my first trip to Umphang. In the report, Mo-e-se is the “index case” in the effort to construct an “outbreak narrative” (Wald 2008) in which he is the carrier of a contagious germ. In the report, the role of SRRT is to identify the scope and severity of the geography and people affected by the “potential” epidemic and find ways to control it. Although TB is not in the scope of SRRT’s “rapid response,” Mo-e-se case is a special one that alerted the team as the germ he carried is not a “normal” TB. It is the multi-drug resistant tuberculosis (MDR-TB).

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This chapter discusses the “emerging concern” of the epidemic of MDR-TB in Umphang
borderland. As Thai–Myanmar borderland is a significant locus of the global TB epidemic, Umphang local health care system is a part of the assemblage of the global effort to “eradicate” worldwide epidemic of TB.

**MDR-TB in the Borderland**

*The “Clinic” and its “Network” of TB Care and Control*

The area of works on TB care and control is one of many responsibilities of a bureaucratic unit of the national health bureaucracy like a Community Hospital. Its development, therefore, depends on the hospital director’s prioritization and organizing strategies to modify the local “bureaucratic machine,” as well as the capability of the people assigned to do the works. The integration of care and control aspects of TB is a challenge to the Thai health bureaucracy from national to local levels. The organizational structure of a Community Hospital replicates that of the MPH in which disease treatment and disease control are separated into different Departments (*krom*) of the ministry—Department of Medical Services (*krom-kanphaet*) and Department of Disease Control (*krom-khuabkhumrok*). Therefore, In Umphang Hospital the two aspects had been separated before 2005. TB care was a part of Out-Patient Unit of the Nursing Department (*fai-kanpayaban*) and TB control was a part of the other department that is responsible for disease control. By the standard “blue print,” disease control is a part of the Sanitary Department (*fai-sukhaphiban*). For Umphang, however, it is a part of the Technical Department (*fai-wichakan*) that was set by Dr. Worawit’s policy to unite technical works and human resource development. The integration of the two aspects began in 2005 by Dr.
Worawit’s re-organizing policy to consolidate the TB works. TB care was separated from the Nursing Department to be overseen by Wanlee, the head of the Technical Department who is also a nurse. She came to the hospital in 1991 on the same day as Dr. Worawit, as a two-year trained technical nurse (payaban teknik). Working for many years in the Sanitary Department, she left for two years of further study to be a public-health officer. Then she went back to work in the newly established Technical Department. By her dream to be a nurse, she did an intensive part-time training and finally, in 2003, got the qualification to become a registered nurse (payaban wichaship, literally, “professional nurse”). By her experience and professional positions, therefore, Wanlee is capable to oversight both care and control aspects of TB. In addition, by the support of Dr. Worawit, Wanlee appointed a new public-health technical officer of the department to be the “focal point” of the area of TB works. He had helped to connect Umphang Hospital into the broader “network” of Tuberculosis care and control from local to national and global levels. By having the facilitating “organizing structure” and responsible people, Umphang TB works have been improving since that time.

The integration of care and control aspects of TB is beneficial as for the epidemic of TB care and control are inseparable. Since the 1990s, WHO has insisted that "Cure is the Best Prevention" (WHO 1994:8) thus, in the global imagination, the only way to stop the worldwide epidemic of TB is the find and treat every case of “active” TB infection who can spread the germ to many other if not being treated. By this care–control mentality, therefore, at the core of TB control is the TB care activities in which the case is put under the “gaze” of health professionals throughout the “regimen” that aims to convert the contagious body to a healthy one. At the center of TB care and control efforts is, therefore, the TB Clinic. The clinic, in Foucault’s sense of the term, “demands as much of the [medical] gaze as natural history” (1973:89, emphasis
added). By the knowledge of the natural history of TB, a doctor uses his or her medical gaze to selectively identify the patient’s symptoms from “illness narrative” in “history taking” and to search for signs by physical examination. These symptoms and signs become the doctor’s scientific evidence for differentiation and classification—the process known in the medical circle as differential diagnoses. By his or her clinical decision, the doctor gives a diagnosis that turns a patient into a case and constructs a treatment “regimen” based on the natural history of that particular disease. Also, the clinic, as Foucault points out, is “the first attempt to order a science on the exercises and decisions of the [medical] gaze” (1973:89). As care and control are inseparable for TB, the doctor working in the TB Clinic is thus required to bring in sciences of medicine and public health described and standardized in textbooks as well as the practice guidelines produced by national and global institutions. The primary symbolism of the sciences and bureaucratic rationalities in TB care and control is thus the standardized treatment regimens recommended by WHO.

The TB Clinic of Umphang Hospital was scheduled to “open” every Wednesday afternoon except the last week of the month. It was a specialized “clinic” of the hospital among many others in which each clinic requires a doctor to spend the whole afternoon providing care for a group of patients who have specific conditions, such as HIV/AIDS, or diabetes mellitus and hypertension. As all doctors were busy with “regular” morning activities especially in out-patient and emergency services, the afternoon was the possible time to have a doctor available to do the special jobs. Because of the increasing number of TB patients, TB Clinic had to be “opened” once a week for three week. It was “closed” in the last week of the month as the staff went out for TB patients’ home visit, and the “space” was scheduled for the HIV/AIDS Clinic that opened once a month. The clinic occupied the first floor of the four-storied building. This space provides
a certain level of privacy and isolation as it hid in the back part of the hospital’s service area and has a special door for the TB patients to enter into the TB clinic directly from the parking spot beside the building. Nevertheless, as the idea to build a better space for the TB Clinic was still a plan, people in the clinic suffer from insufficient air ventilation of that part of the building. Therefore, everyone was required to wear a mask. For the patients, wearing a mask in public spaces is their new habit required by the TB treatment “regimen.” Wearing a normal medical mask or even a handkerchief is the most effective means to prevent the speeding of the droplet of sputum from the patient’s lung. For the clinic staff, however, to prevent inhalation of the micro-droplet that can cause infection even it contains only one MTB particle, the specialized mask—“N-95”—is required. At the time I began my fieldwork in Umphang, Dr. Ching*, a third-year phaet-chaitun (doctor after graduation) was the responsible doctor of the TB Clinic. The main reasons for him to “volunteer” to do this job and that other doctors did not like wearing the think and tight N-95 masked for hours and that he was interested in becoming a specialist in internal medicine. As it is the field most needed for TB care, he is the appropriate person to be in-charge of the clinical part of the hospital’s TB care and control.

Umphang Hospital’s TB Clinic began to “take place” when Pan, the hospital TB coordinator puts all required documents—registration forms and patients’ files—on the table in the “place” designated to become the clinic. To accommodate the patients and to prevent them from spreading TB in the hospital, their medical record files were prepared for them without the need for patients to take a trip to the registrar office. On the desktop computer, Pan enters her password to open into the hospital’s electronic medical record system. Scanning on the list prepared by the registration officers, she arranged the physical files in order and began entering information for each patient a new out-patient visit. Pan entered the information of the “visit” by
hand into the TB-03, the standard registration form of the National TB Program that requires her to enter the information again in the web-based national TB information system overseen by the MPH’s Bureau of Tuberculosis. Meanwhile, patients had taken their seats in the waiting area. Most of them came to the hospital early in the morning taking the special route to get their sputum tested and get the chest X-ray done. At the time of the clinic, all results were ready for the doctor to see and to interpret. A large group of patients from the refugee camps in Nupo and Umpiam came in accompanied by an employee of an international NGO who was their patient aid. They stayed in Umphang town for a night in the NGO’s “Patient House” to get all the tests done early in the morning.

When it was time, Pan began to call the patients to her “counter,” where other officers of the Technical Department came to help to do the vital signs and weight check and “history” taking. As Pan and Ew, the TB worker, are Karens and the NGO’s patient aid can speak Burmese and other ethnic languages, the TB Clinic needs help from one of the hospital’s medical interpreters only for the doctor. The core process of the clinic is doctor consultation. In the consultation room, Dr. Ching reviewed patient’s “history” of illness and treatment, interpreted results of test and imaging, and re-evaluated the treatment regimen. The regimen provides the meta-narrative for the doctor’s “emplotment” (Mattingly 1998) of the “clinical narrative” (Good 2007) that determines, for the patient, the kind and timeline of “cares,” including types of medication, testing, social support, and the next consultation. Carrying the files back to the counter, the patient got Pan’s help to clarify the plan and make the appointment for the next visit. Then they went to wait at the pharmacist counter at the other side of the clinic. By the model of one-stop-service, their medications were ready at the counter. The pharmacist and his interpreter explained to them the details of the prescription the patients should follow and the potential side
effects they should aware. The visit ended there. The TB Clinic operated until every patient went through all the processes. Finally, Pan closed all the physical and electronic files. The “place” was returned to its original condition. It thus ended another session of the ritual that reaffirm everyone’s subjectivity in the TB care–control functioning of the national health bureaucracy.

The clinic then operates through the district’s health care “network” consists of healthcare facilities and people. Each TB patient was “referred” to be under “care” of the officers and healthcare workers, including the village health volunteers (asasamak satharanasuk pracham muban) in one of the nine sub-district health offices, overseen by the District Health Office (DHO), that is responsible for his or her village or the staff of TB Unit of the camp’s hospital if the patient was referred from there. This network of healthcare facilities and people, except the refugee camp, is the foundational structure of the local public healthcare system of almost all districts in Thailand. A map of the system is a primary visual aid to orientate the local officers or visitors to the functional and geographical topography of the district health care system (figure 4). To make healthcare accessible for people in remote villages of Umphang, especially in the rainy season, the facilities called suksala (literally, “happy post”) were built in 15 villages. A villager was selected and trained to be the healthcare provider of each suksala, overseen by the Technical Department of Umphang Hospital. By blurring the boundary between the hospital’s and DHO’s geographical responsibility and between the villager and the officers, suksala thus helps to weave together the offices, facilities, and people in the district’s healthcare network. The connectivity that transcend bureaucratic pedantry to enhance the ability of Umphang district healthcare system in the efforts to control any emerging epidemic.
Figure 4: The “Network” of Public Health Care Facilities in Umphang District.

This map identifies the official division of the district into six sub-districts (tambon) and 36 villages (muban). It identifies the location of public healthcare facilities and offices: Umphang Hospital, the District Health Office, nine sub-district health centers (rongpayaban songserm sukaphap tambon), four community health service centers (sun borikan sukkaphap chumchon), and 15 suksala. It includes one suksala in Myanmar territory, supported by Umphang Hospital. (Source: Department of Health Promotion, Umphang Hospital, October 2016)
A “Case” of MDR-TB

In May 2015, Mo-e-se came to Umphang Hospital with a complaint that he had a dry cough for three days. He received a diagnosis and treatment for bronchitis. Almost a week later, he had bloody coughing that brought him back to the hospital. This time he had to do sputum test and chest X-ray (CXR). Using a century-old “acid-fast” staining technique, the lab technician found in his septum the acid-fast bacilli (AFB) under the highest magnification power of a light microscope. Seeing through his chest in the shadow image made by an X-ray technician, a doctor identified that the germ was destroying his lung showing as infiltration in the CXR film. By the evidence, the doctor diagnosed him as a case of active “sputum positive” Pulmonary TB, shorten as “PTB M+.” The doctor thus prescribed him the standard short-course regimen encapsulated in the symbol:

2HRZE/4HR

This chemotherapy is a cocktail of four first-line TB drugs: six months of the two most potent TB drugs, Isoniazid (H) and rifampicin (R), and the two months of intensive phase that added the other two drugs, pyrazinamide (Z) and ethambutol (E). This “cocktail” is aimed to “eradicate” all the active population of the germ in the patient's body. As a standard practice, his sputum was sent three hundred kilometers away to a regional center of the MPH’s Department of Disease Control for further investigation. There it was put in the culture media in which the germ grew slowly. While other bacteria take days to grow, TB germs take several weeks. Almost two months later, the center sent a report to Umphang confirm that Mo-e-se’s sputum contains Mycobacterium tuberculosis (MTB). Thus, the cultured population of “his” germ was then put into the Drug Sensitivity Test (DST) to measure its responsiveness to TB drugs. In the
meantime, Mo-e-se’s sickness was improving, he stopped coughing and gained his weight. His sputum’s AFB exam at the end of intensive phase was negative. So the doctor continued the treatment regimen. Nevertheless, at the end of the third month of the “short course” regimen, the result of the DST came.

At the middle of August 2015, a lab technician found that three “first-line” TB drugs cannot stop the growth of the cultured population of MTB from Mo-e-se’s sputum. She thus wrote in the DST Report that his MTB resisted to them: isoniazid, rifampicin, and streptomycin. By the standard guideline of MTB classification, she recognized immediately that the patient had the active population of MDR-TB as the germ resist to both isoniazid and rifampicin—the “backbone” of the “short course” regimen. As the staff of TB division of the DDC’s regional center knew the DST result, they responded immediately by reporting the result to Umphang SRRT. As it was an “urgent” communication, they use “social media”—the Line application on the mobile phone network that at the time becomes a part of the official mode of communication in Thailand. Alerted by the “Line message,” Umphang SRRT contacted the Health Center that is responsible for the village where Mo-e-se’s relative resided. The healthcare worker of the center went to the house to seek him and told him to go to the hospital for a doctor visit. On the next day, a doctor reviewed his medical record and re-evaluated his health condition. Although his health had been improving and his CXR showed the decreasing of the active TB infection in the lung, the evidence indicated that he had an active MDR-TB population in his sputum the “system” got three months ago disapproved the short-course regimen. As the new evidence “enacts” (Mol 2002) the new ontological existence of Mo-e-se as a hybrid human–MDR-TB being, he received a new “label” as a “case” of MDR-TB. By this label, his name was removed from the registration number “TB-03” of MPH’s TB care and control system, noted as a “case”
of “treatment failure.” By the standard guideline, the doctor at Umphang Hospital had to refer him to Maesot General Hospital to meet an Infectious Disease (ID) specialist for re-evaluation of his disease and “construction” of a new treatment “regimen” as well as prescribed him the expensive MDR-TB drugs stocked only at the regional hospital.

A week later, Mo-e-se had an appointment at the TB Clinic of Maesot Hospital. On that day, he arrived Umphang Hospital early in the dark morning to wait for other patients who had appointments at Maesot Hospital on the same day. When everyone was ready, a Patient Aid of Umphang Hospital called out in Karen and Burmese languages telling patients, and if needed, their relatives to get on to the hospital’s van. Then the driver brought the Patient Aid, Mo-e-se, and other passengers to embark on the three-hour trip through the mountainous road to Maesot, rushing to meet everyone’s appointment time. For the driver and the Patient Aid, the trip was the other round of their daily job to provide free commute for Umphang Hospital’s patients. For Mo-e-se and other passengers, however, it is the trip that will determine the next period in the course of their lives.

On that day, Mo-e-se met Dr. Beer, the only ID specialist of Maesot General Hospital. She is an “alumnus” of Umphang Hospital as she spent her two years as second- and third-year phaet-chaitun in Umphang. She then got the specialist position at Maesot Hospital to enter the training program to be an Internal Medicine specialist at Chiangmai Medical School near her hometown province in northern Thailand. Then she continued to study a sub-specialty in the field of Infectious Disease at Siriraj Medical School, motivated to some extent by her experience working in Umphang Hospital. So she understands the living condition of people and working condition of health professionals in Umphang. As Maesot Hospital TB Clinic has been crowd by
migrants living in Maesot and those referred from the four border districts of Tak province, Dr. Beer is familiar with a patient like Mo-e-se. By her profession as an ID specialist, she is authorized to construct an expensive regimen to treat an MDR-TB patient. She reviewed his information from the referral letter written by Umphang doctor and reevaluated his condition by history taking, physical examination, laboratory tests, and chest X-ray. For Mo-e-se, she prescribed him the standardized regimen called “Empirical MDR-TB”—the regimen that endorsed by WHO and adopted by Thailand’s National Tuberculosis Program. She decided for him to begin with the 18-month regimen, the shortest course required to cure the infection. Mo-e-se’s new chemotherapy cocktail thus written in his medical record by the symbol:

6Km5LfxEtoCs+PAS/12LfxEtoCs+PAS

The cocktail contains the 18-month course of the oral forms of four second-line TB drugs: Levofloxacin (Lfx), Ethionamide (Eto), Cycloserine (Cs), and para-Aminosalicylic Acid (PAS). In the first six months of the intensive phase, the regimen adds an injectable form of a second-line TB drug, Kanamycin (Km), five times a week. All these drugs are antibiotics that have been used in many other infectious diseases, but for active MDR-TB, they are “recruited” to help “bombard” the resistant germ. Moreover, Mo-e-se’s new regimen included intensive compliance that needs the enhancement by a healthcare worker imposing the DOT strategy. Even though he had a “good record” of compliance in the three months of the previous short-course treatment, by the new regimen, he needs a healthcare worker to ensure the completion of every single dose of the chemotherapy. Therefore, after that day, Mo-e-se had to stay at a place that the healthcare workers could find him easily to give him the daily medication once or twice a day. On the trip back to Umphang in that evening, Mo-e-se’s carried to Umphang doctor the document written
and signed by Dr. Beer, a “graphic artifact” (Hull 2012) of Thai health bureaucracy that officially turned him to be a new “subject” of the National Tuberculosis Program of Thailand and the Global TB movement as it entitled him to get the expensive medicines for free by the funding provided to Thailand by The Global Fund.

By the emergence of the “new” case of MDR-TB in the district, Umphang SRRT had to rapidly respond by going to the residential area of the “index case” to investigate the potential epidemic. The team found that Mo-e-se lives in a Karen bamboo thatch house in which ten other people, including six children, resided. By the standard guideline, the team identified them as his “household contact” whose risk of contracting the contagious germ from him is highest. All of them were required to pass the CXR testing; luckily all their films did not show the sign of active TB. Also, all children under 15-year-old were required to pass the Tuberculin Skin Test (TST) for the “non-active” germs contained in their bodies, identified as Latent TB Infection (LTBI). 36 Although the TST is a standard test for LTBI in many developed countries, for a high-prevalence country like Thailand, it was just “suggestive” testing as its result was affected by the BCG vaccine given as a standard vaccination for all children in Thailand on the day they were born. Nevertheless, it has been used because it was the only affordable one, as the more specific test, the Interferon-Gamma Release Assays (IGRAs) blood test, is much expensive. Therefore, the “normal” result of CXR and TST of all ten people living in the same house as Mo-e-se “suggested” that each of them was neither an active TB case nor a case of LTBI. But, to prevent

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36 In the latest WHO’s guideline, Latent tuberculosis infection (LTBI) is defined as “A state of persistent immune response to stimulation by Mycobacterium tuberculosis antigens with no evidence of clinically manifest active TB. There is no gold standard test for direct identification of Mycobacterium tuberculosis infection in humans. The vast majority of infected people have no signs or symptoms of TB but are at risk for active TB disease” (WHO 2018, emphasis added). As there is “no gold standard test,” LTBI is thus still an ambiguous issue in the effort to “eradicate” TB.
them from contracting the MDR-TB germ from the droplets of Mo-e-se sputum he spread when he coughed or sneezed, he had to be placed in isolation. By this requirement, Dr. Worawit decided to build him a new house on Umphang Hospital’s property that is not far away from the village where Mo-e-se’s relative lived. As a story of "TB village" in a foreign country inspired him, Dr. Worawit planned to build one in Umphang. By having such facility, he hoped that the Umphang healthcare network would be capable of controlling the MDR-TB epidemic by ensuring that the patients could complete the required course of treatment. This capability is crucial in the time of heightening of the concern of the “superbug”—the germs that resist to all available anti-microbial drugs—in Thailand and worldwide.

The Symbolism of TB Care—Control

The Global Assemblage of TB Control

As Thailand is a high burden country and a member state of WHO, Thai MPH has to set its goal in accordance to the target of WHO’s End TB Strategy (2016–2035) that aims to decrease global TB incident rate to less than 10 per 100,000 by the year 2035. Therefore, the first National TB Strategic Plan (2017–2021) was endorsed by the government making TB a national agenda. The national plan set the goal to decrease annual TB incident of Thailand from 171 per 100,000 in 2014 to 88 per 100,000 by 2021. The primary means to achieve this goal are (1) improving treatment outcome to meet 85 percent success rate and (2) active case finding to find 80 percent of new TB cases in the population. These indicators frustrated health professionals in Umphang, as the outcome of the district, were lower than the national target. The outcome of
Umphang Hospital’s TB clinic shows the low success rate (77 percent) with a high number of defaulted (14 percent) (Table 1), while “active case finding” for TB is difficult amidst the “whirlwind” of many other routines and responsibilities.

Table 1: Treatment Outcome of Umphang Hospital’s TB Clinic in Fiscal Year 2012–2015

<table>
<thead>
<tr>
<th>Treatment Outcome</th>
<th>Total</th>
<th>Average</th>
<th>%</th>
<th>Evaluation (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed</td>
<td>119</td>
<td>29.8</td>
<td>37.0</td>
<td>77 Success</td>
</tr>
<tr>
<td>Cured</td>
<td>128</td>
<td>32.0</td>
<td>39.8</td>
<td></td>
</tr>
<tr>
<td><strong>Defaulted</strong></td>
<td><strong>45</strong></td>
<td><strong>11.3</strong></td>
<td><strong>14.0</strong></td>
<td><strong>22 Failure</strong></td>
</tr>
<tr>
<td>Died</td>
<td>22</td>
<td>5.5</td>
<td>6.8</td>
<td></td>
</tr>
<tr>
<td>Failure</td>
<td>2</td>
<td>0.5</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>MDR-TB</td>
<td>2</td>
<td>0.5</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Transfer out</td>
<td>1</td>
<td>0.3</td>
<td>0.3</td>
<td>1 Other</td>
</tr>
<tr>
<td>Change diagnosis</td>
<td>3</td>
<td>0.8</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td>Number of patients</td>
<td>322</td>
<td>80.5</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Source: Technical Department, Umphang Hospital, October 2016.

Since WHO’s introduction of Directly Observed Therapy, Short-course (DOTS) in the 1990s, the DOT intervention has been emphasized as the primary means for the success of TB treatment. For Umphang, Wanlee and Pan understand the significant of DOT intervention. Nevertheless, it is challenging for their team to do it in every TB cases because of resource constraint and difficult geographical condition. Therefore, to counter the lack of DOT, Umphang healthcare network implemented initiatives to increase patients’ compliance, such as subsidizing.
and accommodation for the patients’ commute to the TB Clinic and home visits by the staff of the hospital and the public health officers and community health workers. For them, the outcome of the clinic was “good enough.” In the group of “Thai” patients, they got a high rate of “success”—identify as “cure” or “complete.” Nevertheless, the overall outcome of the TB Clinic affected by the high rate of “defaulters”—the patients who stop coming to the appointments thus stop taking medications. In the view of bureaucratic auditing system, therefore, Umphang’s result of TB works was still unacceptable especially in the heightening concern of MDR-TB epidemic in the borderland.

In 2015, a team of health professionals of Tak Provincial Health Office published in the *Thai Journal of Tuberculosis Disease and Critical Care* a study of MDR-TB epidemic in Tak Province (Yongyuth, et al. 2014). A key finding of their research is that most of the MDR-TB cases of the province were “non-Thai” people who resided in the five border districts. Using statistical analysis, they identify the higher problems of MDR-TB in “non-Thai” patients comparing to “Thai” patients (Table 2). The numbers of “non-Thai” MDR-TB patients were three times of those who are Thai. A half of them “failed” the previous treatment signifying the challenge to get their compliance in the lengthily regimen of MDR-TB, especially when their DOT observers are community health workers or their relatives. Therefore, MDR-TB in “non-Thai” population is the primary challenge of the prevention and control of MDR-TB epidemic in Tak. Interestingly, the Thai/non-Thai distinction using in the article based on *chueachat* (ethnic nationality) rather than *sanchat* (legal nationality). This distinction might be the evidence that support a member of the team, Dr. Wittaya, a senior physician-epidemiologist, to conclude that “We have failed to control TB in “our home” (*banrao*) because “Burmese” people (*khon phama*) fill the new germs in.” By this image, Dr. Witaya and another member of the team, Dr. Kitipat, a
Ph.D. graduated public health officer, organized a project to control TB in “non-Thai” population across the Thai-Myanmar border. Although Dr. Witaya was in his last year of official work before retirement at sixty, he set an ambitious goal to control TB in the area within five to ten years motivated by the success of the trans-border malaria control. Umphang district was selected the site of this project mainly by the responsiveness to new initiative of Dr. Worawit and health professionals in Umphang borderland.

Table 2: Clinical Characteristic of MDR-TB patients in Tak Province, in Fiscal Year 2011 to April 2014 Classified by chueachat (“ethnic nationality”)

<table>
<thead>
<tr>
<th>Clinical Characteristic</th>
<th>Total Number (%)</th>
<th>Thai Number (%)</th>
<th>Non-Thai Number (%)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>34 (100.0)</td>
<td>8 (100.0)</td>
<td>26 (100.0)</td>
<td></td>
</tr>
<tr>
<td><strong>Type of Drug Resistant TB</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.128*</td>
</tr>
<tr>
<td>New case</td>
<td>10 (29.4)</td>
<td>3 (37.5)</td>
<td>7 (26.9)</td>
<td></td>
</tr>
<tr>
<td>Failure in previous treatment</td>
<td>17 (50.0)</td>
<td>2 (25.0)</td>
<td>15 (57.7)</td>
<td></td>
</tr>
<tr>
<td>Defaulted in previous treatment</td>
<td>1 (2.9)</td>
<td>1 (12.5)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Relapse</td>
<td>4 (11.8)</td>
<td>2 (25.0)</td>
<td>2 (7.7)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2 (5.9)</td>
<td>0</td>
<td>2 (7.7)</td>
<td></td>
</tr>
<tr>
<td><strong>DOT observers</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.047*</td>
</tr>
<tr>
<td>Public Health officers</td>
<td>13 (38.2)</td>
<td>5 (62.5)</td>
<td>8 (30.8)</td>
<td></td>
</tr>
<tr>
<td>Community Health Workers</td>
<td>12 (35.3)</td>
<td>0</td>
<td>12 (42.6)</td>
<td></td>
</tr>
<tr>
<td>Relatives</td>
<td>9 (26.5)</td>
<td>3 (37.5)</td>
<td>7 (23.1)</td>
<td></td>
</tr>
</tbody>
</table>

* Fisher’s exact test
Source: reproduced from a part of Table 3 in Yongyuth et al. 2015, p12.
Meanwhile, the Tak Provincial Health Office (PHO) initiated a project to search for new active TB cases in the population as a response to the national TB policy. The project set its “target” using WHO’s post-2015 estimation of new TB cases in Thailand using 2014 incident rate and the number of registered population at mid-2015 in the national database of the Ministry of Interior. By the incident of 171 per 100,000 population, and the number of 618,382 registered people, it is expected to have 1,058 new cases of active TB in Tak Province in the Fiscal Year 2017 (October 1, 2016, to September 30, 2017). The provincial target is the aggregation of the target set for every district. For example, the number of mid-2015 registered population of Umphang district, included citizens and non-citizens, is 40,622, the district’s target is thus 69.\(^\text{37}\)

This project was under the responsibility of Dr. Kitipat, the head of TB unit of PHO. In the previous year, Dr. Kitipat did an active case finding project in high risk groups in the two districts of Tak province. At that time, he implemented a “model” that use mobile digital Chest X-ray (CXR) unit and the new technology that can rapidly detect MTB and MDR-TB in the sputum exam technology known as the “Gene X-pert” endorsed by WHO. In this case finding model, the target of TB screening is everyone whose name is on the list. As the stigmatization influences the patient to hide his or her TB symptom, the CXR “cuts” through the patient’s body and makes it “transparent” to show the concealing pathology to the eyes of the state health officers (Figure 5). Therefore, CXR has been the most powerful tool to seek for the hidden cases in the population around the world. The nascent digital technology put a new power into this old method. It enables rapid circulation of a person’s CXR image to get multiple interpretations in the rite of passage in the “becoming” of the person to be a case or, later, a cured body. For the

\(^{37}\) Source: Tak Provincial Health Office’s Official Note (bantuk khokwam) Number to ko 0032.003.4/wo 69, dated October 28, 2016.
sputum exam, “Gene X-pert” is the genomic technology supplementing the standard microscopic AFB exam of which reliability depends largely on the lab technician. It has higher sensitivity than the sputum AFB test as it can identify MTB in many of the cases whose AFB result is negative. Moreover, it can rapidly single out the sputum that contains the MDR-TB germ. Therefore, it is an ideal technology, besides its cost, for the TB screening in the high MDR-TB prevalence like the Thai-Myanmar borderland. By his experience in the previous project, Dr. Kitipat applied the “model” to the new PHO’s TB screening program. He also used the model in trans-border TB control project in Umphang that was scheduled to begin at the same time. As he began his career as a public health officer in Tak’s border districts including Umphang, Dr. Kitipat understands the local working condition. Therefore, in the meeting in December 2016, he and the local team worked together to integrated into two projects. This kind of “integration” is a common “survival tactic” for officials of Thai health bureaucracy to get results for multiple demands and orders by truly “doing” the jobs rather than “making up” the numbers.
4a: In the mobile digital x-ray unit, a radiology technician set the posture of a person in half-naked to make all area of his chest visible on the CXR image. (Umphang District, January 2017)

4b: The other radiology technician adjusted the two parameters of the x-ray “dose” to produce, in the CXR image, the optimal visibility of the organs and tissues in the chest. (Umphang District, January 2017)

Figure 5: “Cutting through the body to inspect the hidden disease.”

In the preparation meetings in 2016, Dr. Wittaya, Dr. Kitipat, and Umphang health professionals identified the ten public places in Umphang district where they could mobilize the highest number of people to enter the TB screening processes. Their target was 10,000 individuals from the six sub-districts of Umphang and the adjacent Myanmar territory. Umphang officers’ local knowledge of geography and road condition helped to determine where the mobile x-ray unit can go. A “table” was constructed as the organizing tool in which time,
people, and other resources were allocated to enable the operation of the “mobile TB screening unit” at each site. Dr. Worawit alerted the team to concern about the instability of electrical power in many places and offered Umphang Hospital’s mobile generator to accompany the x-ray machine. Through the one-month long operation, they got around 7,000 individuals into the TB screening. By the interpretation of Mae Sot Hospital’s radiologist, 419 people have abnormal CXR. Two third of them are “non-Thai” half of this group reside in Umphang, and the other half resided in Myanmar territory. The next step was to get the sputum of “all” these people to examine to identifies the active TB cases. Then began the treatment regimen to bring the patients to cure, or to the completion of chemotherapy.

Through the implementation of the trans-border TB control project, Umphang “network” of TB care and control was articulated into the assemblage of the global TB control—in which the “forms and values of individual and collective existence are … at stake” (Collier and Ong 2015:4). Non-Thai people in Umphang borderland, especially those whose CXR is abnormal are “subject to technological, political, and ethical reflection and intervention” (Collier and Ong 2015:4) to ensure the health security of individuals and the national and global. Although the project makes the biometric registration—taking photo and collecting digital fingerprint—of every un-registered “non-Thai” individual entered into the TB screening, it is challenging to search for the specific individuals in the borderland to get sputum from all of them. Nevertheless, it is even more challenging to ensure that the people who got the diagnosis as active TB cases could complete the treatment regimen. Otherwise, the project would unintentionally worsen the problem of drug-resistant TB in the borderland.
The Stigma of Patient Non-compliance

A discussion about TB cannot complete without addressing the issue of stigma. TB patients usually suffer not only from the disease itself but also from being discredited and discriminated based on their identity attribute to the sickness. Much of the discussions on stigma focus on this aspect of TB’s stigma and stigma reduction. Nevertheless, there is the other aspect, that is the stigma that attributes to the patients’ behavior. In the efforts to control harmful health behavior, stigma has been a handy “device” for health workers and institutions. In this view, stigmatization of smoking in the anti-tobacco campaign is a paradigmatic example. In the mid-twentieth century, a global movement aimed to control TB epidemic by stopping the patients’ behavior to “spit” contagious sputum on the floor of public places. The illustrations produced for the campaign (two examples in Figure 6) visualize the stigmatization by blaming and imposing shame to the patients. There is another pervasive stigmatized behavior of patients in TB control effort that I want to focus here. It is framed by what Paul Farmer and colleagues call “analytical flimsy concept” (McMillen 2015:292 n.50)—that is patient non-compliance.
In a review article on *compliance* published in the early 1990s, a group of physicians asserts that “the most serious problem hampering tuberculosis treatment and control is *patient non-compliance* with therapy” (Farmer 1999:225-6, emphasis added). This conception is

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persistent and has been a “trap” that make individuals and institutions working to control TB attribute the failure of TB control to patient’s behavior (McMillen 2015). In the heightening concern of drug-resistant disease, non-compliant patients are blamed as the breeders of the resistant germ thus deserve “confinement”:

Obviously, failure to continue medications precludes successful therapy and promotes the emergence of drug-resistant organisms as it did in New York City… Because of heightened public health concerns regarding transmission of *M. tuberculosis* by noncompliant patients and, in particular, concern about MDR organisms, public health statutes that could require DOT or, in some instances, *confinement* until treatment is completed were strengthened in the early 1990s. A review of the use and usefulness of these laws in New York City has shown that they were not abused and added significantly to the ability of health authorities to improve treatment outcome and minimize spread of tuberculous infection. (Hopewell, et al. 2016:628 e18, emphasis added)

As patients are discredited by “their” noncompliance, WHO insists that “a health worker must always be present to directly observe the patient taking the medicine” (WHO 1994) to ensure that every patient complies with the treatment regimen. The DOT intervention is thus at the core of WHO’s TB control strategies beginning with the DOTS strategy in the 1990s. the accountability to the completion of the treatment regimen is thus transferred to the healthcare providers. Therefore, the other element of the DOTS strategy besides the DOT intervention and the short-course regimen is the “rigorous evaluation system.” WHO (1994) emphasizes that this system “must be in place in every nation TB control program to track the patient’s progress” by which “health workers or treatment centers which are not achieving good results can be easily targeted for further supervision and training” (8). The results of Umphang TB Clinic (shown in Table 1), therefore, makes Umphang health workers the target of “supervision” of the Thai health bureaucracy. For them, a disturbing factor that prevents them from “achieving good results” is the high number of “defaulters” (14 percent).
As my “position” during my fieldwork in Umphang is an officer coming to help them, I began with Umphang problem of defaulters. Beginning with statistical analysis, I found that almost all the “defaulters” are “non-Thai” patients. Classifying them by “residence” (Table 3), I found that the majority were refugees in the two camps, one-fourth of them came from Myanmar, while only one-fifth were “non-Thai” living in Umphang whose “non-Thai” identity is complicated by the nationality issue I discussed in the previous chapter.

Table 3: Residence of the “defaulters” of Umphang Hospital’s TB Clinic in Fiscal Year 2012-16

<table>
<thead>
<tr>
<th>Defaulters' Residence</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nupo Refugee Camp</td>
<td>7</td>
<td>4</td>
<td>9</td>
<td>4</td>
<td>2</td>
<td>26</td>
<td>48</td>
</tr>
<tr>
<td>Umpiam Refugee Camp</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Myanmar</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>13</td>
<td>24</td>
</tr>
<tr>
<td>Umphang (All are non-Thai)</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>54</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>12</td>
<td>12</td>
<td>10</td>
<td>9</td>
<td>54</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Technical Department, Umphang Hospital

Analyzing these numbers with the national data reveals that high rate of defaulters in non-Thai TB patients is a pervasive problem. The national rate of “defaulted” in Thai TB program in the Fiscal Years 2009 to 2015 is 10 to 14 percent in “non-Thai” population while in the group of “Thai” patients, the number is three to four percent (Department of Disease Control 2016). While the stigmatization of patient noncompliance makes health workers to regard “defaulted” as the problem of the behavior of the individual patient, Farmer (1999) asserts that it is rather the problem of “program failure.” Moreover, while defaulters are blamed as the breeders of drug-resistant TB (primary resistance), the widespread problem of patient got the resistant germs from other (acquired resistant) has been well recognized since the 1960s (McMillen 2015:151–152). As patients worried about the effect of their past noncompliance, they hide the
“history” of the previous treatment. They thus began to be treated as “new case” with the short-course regimen. As the demanding and lengthy regimen was unable to improve their sickness, they thus “escaped” from the TB program and became a defaulter. Putting this data together with the review of MDR-TB care in Tak discussed earlier (Table 2), I found disturbing evidence. There is the missing of “non-Thai” patients who have or admitted the “history” of default in the previous treatment. To me, these evidence signifies an effect of the stigma of patient noncompliance, that is it put patients away from re-entering the TB treatment program. It may also prevent them from re-entering the healthcare facility asking for care for other sicknesses those might include life-threatening conditions. Suffered by this de facto statelessness, their health security is at risk and the health security of the public is threatened.

Caregiving, A Leverage Point for TB Care and Control

Developing the “Network of Care"

While the failure of the treatment mainly blames patient non-compliance, Farmer (1999) argues that what should be accused is rather “program failure.” He calls for a close analysis of local context by ethnographic research to identify complex factors that influence patients’ access and adherence to care. Engagement with this complexity helps to develop an effective program to treat TB and MDR-TB as illustrated by the works of Farmer and his colleagues in many places, such as Haiti, Peru, Rwanda, and Russia. For example, Keshavjee and his team (2008) successfully develop a program to care for MDR-TB patients in Tomsk, Russia that can bring mortality rate down, even to zero. Essence for the success of their program is the use of
“programmatic approach” that developed and adapted specific interventions based on what found in local analysis such as providing food to all patients whose suffering include poverty and malnutrition and using caregivers who can give the care about medication as well as “accompaniment.”

By the recognition of the potential unintended consequences of Umphang trans-border TB control project, I decided to turn from passive observation to active engagement with it by offering to develop a model of “trans-border TB care and control network”—a “programmatic approach” that would ensure treatment completion and avoid stigmatization. To me, it is not an effort to add new things into healthcare system of Umphang but an effort to articulate and strengthen the existing elements I found in my ethnographic encounter in the borderland.

A significant one is the trans-border network of health services that Dr. Worawit and his team have arduously developed and maintained for many years. As people from the adjacent area in Myanmar territory have continued to come to Umphang Hospital to seek help, Dr. Worawit and his team have gained the understanding of the people’s suffering caused by the fragile health care system at the margin of the neighboring state. Dr. Worawit thus decided to help developing healthcare facilities for them. Beginning with the construction of a suksala khamdan (“cross-border” suksala) in 2013 in the biggest village on the other side of the border of the Karen State with Mogro sub-district and provided support to existing health posts of the KNU using donation money he got from donors in Thailand and abroad (Figure 7). At the time I was doing my fieldwork in Umphang, the other suksala khamdan was under construction. He once tried to do it officially by asking for money from the MPH and contact the Burmese government through the Thai Ministry of Foreign Affairs. Nevertheless, after everything was ready for the construction,
the Burmese government stopped the project blaming the conflict it had with the KNU. Therefore, Dr. Worawit has continued to develop Umphang trans-border health network unofficially claiming humanitarian and health security reasons to legitimate his “intrusion” into the boundary of the other nation. Regardless of criticism, his effort is unofficially endorsed by the MPH as visiting the suksala khamdan is usually on the schedule of the MPH’s minister and other high-ranking officials in their visits to Umphang. By their cross-border effort to provide care for all people, Dr. Worawit and his team have gain trust and cooperation from military forces and people. This trust enables them to control trans-border epidemics such as the epidemic of cholera in the area in 2015 that kills many patients and affected people in Umphang district and more than 50 thousand people in the Karen State. Therefore, the “stateless tuberculosis”—the infection that not respect people nationality and national boundary—would be the other one that health professionals in Umphang borderland are capable of controlling.
Figure 7: Umphang’s Trans-Border Network of Health Services

This map identifies the locations of some villages and healthcare facilities in the adjacent Myanmar’s territory. Some of the facilities are supported by Umphang Hospital. Although this map is constructed with limited geographical knowledge of Myanmar, it illustrated the effort of Umphang Hospital to locate the residences of the patients who came to the hospital. (Source: Department of Health Promotion, Umphang Hospital, October 2016)

I found the other elements by chance when the project set it mobile TB screening Unit in the parking lots of Mogro Subdistrict Administrative Organization (SAO). There I met Panya,
the Chief Executive of the SAO and learned about his development of the SAO’s Emergency Medical Service (EMS) unit. The SAO is a product of the political reform in Thailand that aims to distribute “political power” to local people. Its Chief Executive is a local politician elected by people in the Subdistrict to be in the position for a four-year term. Panya is a Karen born in Mogro whose father was a well-known head of the village in which the SAO located. Nevertheless, he has accumulated his popularity not by inheriting it from his father but from many years of services as a local politician beginning at a very young age. He told me that being a politician is his “profession.” As he has traveled in this area since before the Route 1090 became the main connection of Umphang and Maesot, he knows the geographical and political condition of the area very well. For him, all the Karen villages in this area are in the same community regardless of the national border. Through many terms in the position, Panya has expanded the Mogro SAO’s services from the general infrastructure improvement to education and healthcare. One of them is the EMS that many other SAOs deems outside their scope of responsibility. By his keen knowledge of the SAO regulations and national policies, Panya told me that every SAO has got the authorization and support by the national effort to expand EMS system all over the country, especially after the establishment of the National Institute for Emergency Medicine (NIEM) in 2008. He thus set up Mogro EMS unit by using SAO’s budget and the support of NIEM and linked it in the healthcare network of Umphang Hospital. Besides the work as “first responder” to transfer accident victims to the hospital, Mogro EMS unit has been the site that people from both sides of the national border come to seek for help in the cases of urgent conditions such as obstructed labor, trauma, or high fever caused by cerebral malaria. For severely ill patients from villages in Karen State, they have to be transferred to the border where the EMS unit’s staff would wait for them. To help his team to locate the resident village of
each patient, Panya made a map of the area using the military map he is authorized to access and his “local knowledge” to identify the exact geographical position of villages in the borderland (Figure 8). Therefore, the EMS unit has been a significant element of the network of Umphang healthcare that helps to ensure health security of people across the border. To me, a factor that enables them to work effectively is their possession and use of the geographical information—the implicit knowledge of Panya himself and the explicit one showing on the map.

Figure 8: The Area Map of service at the Emergency Medical Service Unit of Mogro Subdistrict Administrative Organization. (Umphang district, January 2017)
A network of TB care and control requires the geographical knowledge of the location in which the patients live. This knowledge enables the health workers to keep track of each patient and to reach out rapidly to provide health cares, social supports, or encouragement to help the patient to complete the treatment. It also requires patients’ trust in the treatment program to keep them in the demanding and lengthy treatment regimen of TB especially for “non-Thai” people who are “mobile” population as they move to stay close to their work sites. This kind of trust is a universal essence required for every clinical encounter in which the human relationship is ruined by the disease-oriented medical gaze. What I learned from Umphang Hospital and Mogro SAO is the possibility that the trust can be nurtured by the attention to health security of the patients and their communities beyond the boundary of a particular disease or health threat. To me, therefore, a TB control program requires a “network of care” that truly provides “care” for the patients’ wellbeing in addition to the “cure” of the infectious disease.

*Re-humanization of TB care and control*

As DOT is critical to the success of TB control, the DOT observers are arguably the significant people in the network of TB care. They are the caregivers who meet the patients every day throughout the months or years of treatment. The DOT observers thus can understand and respond to the needs of the patients beyond the medication. Experience of the successful TB programs those make the DOT observers to provide other care and accompaniment, reaffirms this potential. Nevertheless, since the 1990s, WHO has framed the role of DOT observers mainly as the “auditors” to see and to document the patients’ taking drugs. This role is reiterated in local TB programs such as those programs in Thailand where a large number of DOT observers are
the village health volunteers and community leaders. The DOT is simplified for them as an “easy” three-step job:

1. **yib ya hai** ("hand the one the drugs")
2. **du khao kluenkin** ("watch the one swallow")
3. **set laew banthuek** ("then, take the note")

Besides the DOT, their main duties in the visit to the patients’ houses, as described in their handbook, are to ask the patients about the drugs’ side effects and to encourage the patients to keep up with the treatment. This clear and concise prescription of the role enables the TB program to increase the participation of the village health volunteers and community leaders and the effectiveness of DOT practice. Nevertheless, it also has an “anticipatable” unintended consequences. By the prescribed role, the DOT observers are like “bureaucrats” thus the patients are likely to be seen as the “objects” of bureaucratic surveillance and control. As DOT is only a job in their busy day, it is not surprising that they would neglect the complicated social dimension of the patients' illness.

Nevertheless, the **TB care–control mentality** obscures the biomedical knowledge explicitly declared in the **natural history** of the disease described in a medical textbook that “Tubercle bacilli are a necessary, but not a sufficient, cause of TB.” (Maher 2009:129). The whole picture of the “epidemic” of TB infection and active disease is succinctly illustrate in the commonly seen diagram that incorporate its **natural history** and epidemiology (Figure 8).
Figure 9: “Consequences of exposure to an infectious source case of tuberculosis depending on the status of immunity.”

Exposure to a patient with infectious tuberculosis causes tuberculous infection in approximately 30% of those exposed. Of those who are infected, 3% to 10% develop tuberculosis within 1 year of their becoming infected. Beyond 1 year, an additional 3% to 5% develop tuberculosis during the remainder of their lifetimes (figure 35-3 in Hopewell, Kato-Maeda, and Ernst 2016:598).

Many other factors affect the body’s immunity thus activate the "latent" infection to become the active "disease." While the global community is moving toward an imagination of the world without TB, the germ itself is still escaping from our ability to fully understand its “body” and its relationship with the human body.

We are still far from understanding why the natural immune system (which prevents 90% of persons infected from developing active tuberculosis) fails in 10% of those infected and why the adaptive immune response in tuberculosis does not protect us from repeated infections…

Although important scientific advances have been made recently, major gaps in understanding the basic biology of the organism and the human response to infection with *M. tuberculosis* remain. (Hopewell, Kato-Maeda, and Ernst 2016: 627)

The limitation of biomedical knowledge reminds us to be aware of the complicated biological
and social determinant of the disease, while the global assemblage of TB control de-socializes TB by focusing on the treatment aiming at eradication of the “germ” from each patient’s body. In the global effort that aim to “eradicate” the infection, therefore, the medicalization of the “social disease” by the germ theory is prevail.

There is a hope, however, that the “professionals” working in such bureaucratized health care system could re-socialized the TB care. Byron Good (1994) points out that the "object" of biomedicine is constructed not only by the materialistic physiological aspect of the disease but also the moralistic soteriological aspect of suffering. Therefore, health professionals have a potential to re-socialize the disease by the act of caregiving. In the “clinical encounter” of health workers in providing care for TB patients including the DOT observers, what Arthur Kleinman (2010) calls “presence” might be a means for them to liberate themselves from the constraint of working context thus re-humanize the patients:

Presence—being there for those in need, being with them in the experience of illness, being free to express the most human sentiments in the context of moral commitment and solidarity—may be the fulcrum that swings the professional out of the bureaucratic mode of engagement and into the humanity of the healer. (Kleinman 2010:25, emphasis added)

Reading this passage, one might notice that indeed Kleinman strongly believes that presence is an antidote to “bureaucratization” he identified two decades ago as the disturbing characteristic of biomedicine (Kleinman 1995a). His humble words “maybe” here emphasize the fact that it is challenging to be true “presence” as it is difficult to liberate oneself from the bureaucratic domination infiltrates in the global assemblage of TB control.
Conclusion

The “Process” of Neoliberal Bureaucratization

In this dissertation, I examine the tragic dimensions of the two global health movements—the expansion of universal health coverage (UHC) and the “eradication” of tuberculosis (TB). These tragic dimensions are the results of the implicit process of “neoliberal bureaucratization” (Hibou 2015)—the domination and governmentality of market model and management rationality. It is the domination of what Weber identifies as the legal-rational authority in the process of bureaucratization he described by the ideal type of bureaucracy a century ago. To bring Weber to the present, the rationality that prevails is that of neoliberalism—market and management. It is the governing in the mode of governmentality that Foucault points out—not the influence from above, but the mentality from within that makes a person, the “professional” in this dissertation, become a part of the bureaucracy.

Thailand is a useful case study for many other nations embarking on the path to UHC achievement. It is a global model of a developing country that the government obligated itself on the “expensive policy” (Harris 2012) since the early 2000s, a decade before the United Nations endorsed UHC a global agenda in 2012. This dissertation aims to provide a comprehensive view of the Thai UHC from its formulation roots in the student movement in the 1970s to the implementation and consequences after the official declaration of UHC achievement in 2002. As I have tried to illustrate, Thai UHC needs to be understood in a broader perspective besides its health system financing. Focusing on the process of neoliberal bureaucratization, I want to make
explicit the somewhat obscured “healthcare market” of the “dual track” policies—Thai UHC and Medical Hub. While UHC provides people health welfare, it enables them to utilize private providers thus enhanced the growth of private healthcare market. The Medical Hub policy, rather than help creating income to support UHC as it claimed at the beginning, a close analysis reveals its detrimental effects besides the growth of the country’s economics. Therefore, more rigorous interventions are required to make the “dual track” policies beneficial for everyone in the country.

Moreover, the growing “market” enhance the growth of private sector and healthcare related industries. Together, the two policies enable the adoption of new products and services of biotechnologies—the “essential” ones into the UHC scheme and the “potential” ones into the realm of Medical Hub. It may seem to be an old critique of UHC that it will increase healthcare spending, but it is a potential that we have to concern as medical communities are transformed by the new symbolism such as “medical competence” and the “biomedical embrace.” Here I want to suggests that Thailand is not a unique case as the same model of UHC is now being implemented in countries around the globe. We have to face the ethical questions of “how best to serve all patients” (Good 2007:377).

One of the tragic dimensions of UHC I focus is the exclusion of non-citizen from the national health welfare program. As illustrated by Thailand case, it is the act of the state to discriminate against non-citizen legitimized by the international legal framework of human rights. The symbolism of neoliberal bureaucratization of UHC is encapsulated in the “UHC Cube.” It is an influential abstraction of the “volume” of money that each country need to maintain the sustainability of the country’s UHC program. By the limit amount of resources, non-citizen need
to be excluded. The exclusion of non-citizen is, therefore, a rational and moral decision to ensure health security of people in the jurisdiction of the state.

Nevertheless, the trans-border epidemic of infectious diseases such as TB challenges the exclusive mentality as it spread disregard of national boundaries. The state thus has to provide care for the non-citizen to ensure health security of its citizen. But it is still done by the rationale of exclusion—they are “other” who became the “subject of care” of the national health care system because they are the threat to the citizens’ health security. By this subject formation, as they are the outsider, they deserve control, rather than care. In this dissertation, I want to illustrate that this “control mentality” make the national TB program and the global assemblage of TB control fail. Patients are human who can leave or escape from the “confinement” of the program. Therefore, I argue that the effort of control itself prevents the global TB movement form achieving its goal.

**The Moral Ground of Professional Caregiving**

Throughout, I illustrate the role and potential of the people working within the national and global health bureaucracies—those are transformed by the “process” of neoliberal bureaucratization. As emphasized by the word “process,” I argue that bureaucracy is always in the making. Through everyday practices of people, the “system” is reified in the old way or is redefined into a new way. The bureaucratic indifference (Herzfeld 1992), therefore, can be that of nationalism to exclude “others” or that humanism that everyone is included.
The professionals I describe in this discussion are those people who have potential and use such potential to re-humanize all the people they care. Nevertheless, they are not on the “moral high ground” as they are all human beings who have suffered by misconception and self-interests at many points. What I want to illustrate here is that they work together in a “network” in which each of them has liberty and autonomy to do either good or bad things. But, together they collectively maintain a particular set of ideology. In the case of the Rural Doctor Movement in Thailand I described here, it is not the left-wing socialist ideology but what can be called as a radical Buddhist-socialism bringing into their deliberative practice and rigorous reflection by their mentor, Dr. Prawase Wasi. As one of the RDM members remark, Dr. Prawase’s social analysis “fits with Thai cultural and social context, rather than Communist ideas that create confrontation and the use of violence” (Dr. Nirun Pitakwachara, quoted in Suwit 2003:4). Also, sociologist Paul Cohen identified decades ago that, to understanding Thai public health development it is essential to understand Dr. Prawase’s Buddhist roots of his social and public health ideology (Cohen 1995).

Focusing on this Buddhist ground is crucial as it reveals a universal dimension of all religious-based moral practice. It is like a “calling” that is the “moral justification of worldly activity” (Weber 1930:41). It based on the teaching of a radical Buddhist monk Buddhadasa Bhikkhu (1906–1993) who insist on bringing Buddhism into everyday practice and social problem. His teaching, for example, kantam-ngan kue kan patibat tham (“doing work in everyday life is the religious practice”) emphasizes the role of worldly activity in religious meaning. At the core of his teaching, he insists on correcting people understanding of the Buddhist concept of karma: It is not that we should let karma determines our faith, but that karma is what we should learn about the result of the past and thus do the right thing in the
present. The present action, the new karma, is what will determine the trajectory of each person. The role of caring professionals like the medical doctors, therefore, is to bring in the new action, new karma, to shape the future of individual patients. Caring professionals could also flip the “observation gaze” inward to observe oneself (Stonington 2011) thus learn about a core teaching of Buddhism—the shared suffering that every human being has endured. By “observation” to suffering of other through the practice of caregiving, the professionals could also accumulate their understanding of the suffering of the society. This understanding provokes them to provide “social care” to improve the well-being of their patients and the well-being of the society.

This moral ground is arguably the primary influence of the RDM’s ideology. Besides health care reform, RDM members have engaged in every level of political movements, including the grass-root community development groups, the civil society movement against detrimental development projects, or the process of national health reform and political reform. One result that is like a capstone of the health system reform in Thailand is the institutionalizing of the new concept of health by the promulgation of the National Health Act in 2007.

Section 3: “health” (sukhapap) [is defined as] a state of human being which is perfect in physical, mental, spiritual and social aspects, all of which are holistic in balance; “spiritual” [referred to] the comprehensive knowledge and conscience leading to kindness and sympathy. This comprehensive meaning of health has provided the ground for the professionals to engage in various aspect of practices, policies, and politics claiming health as the legitimate ground.

Here one might recount the view of “social medicine” by a century-old remark of Rudolf Virchow (1821-1902) that “medicine is politics and politic is medicine writ large” (2010). Nevertheless, it is not only the “social medicine” or “medical charity” that can be the ground for social care, but also medicine in its soteriological dimension that aims for salvation and redemption of each patient and all people in the society. It is, arguably, a universal potential that “moral obligation” is the ground for every professional. The moral in the practice of care is at the heart of the reification of being caring professionals. It is in the act of care—the interaction with the sufferer—that humanistic sensibility of the caregiver and the system of care can be vitalized. Through the everyday practice of care and the dual mode of action and reflection—the “vitality of praxis”—that will enable the profession to not being caught up by the provision of care but the reflection to see how to improve the “caring environment” of the bureaucracies. Here I found anthropology to be a profession that could help for such reflection.

Anthropology as a Caring Profession

This dissertation is a product of my intellectual journey in the graduate study program to be a professional anthropologist at Harvard. A piece of writing that shapes my intellectual trajectory is the "Introduction" to a classic anthropological writing first published in 1934, Pattern of Culture (Benedict 2005). It was written by Franz Boas, the mentor, and colleague of the book’s author. In it I found that Boas quotes four lines of German poem written by the world-renown German poet Johann Wolfgang von Goethe (1749–1832):
Wer will was Lebendig’s erkennen und beschreiben,
Sucht erst den Geist heraus zu treiben,
Dann hat er die Teile in seiner Hand,
Fehlt leider nur das geistige Band. (Benedict 2005:xxii).

[Who would know and describe a living thing,
Seeks first to expel the spirit within,
Then he stands there, the parts held in his grasp,
Lost just the spiritual bond, alas!] 41

He quotes these German lines to show how Goethe satirized anthropologists to criticize those who selectively collected and classified cultural artifacts as losing a grasp on the living whole. In Boas’s view, “the whole” is what that is important for anthropological inquiry.

What I have tried to do in this dissertation is to understand “the whole” of the global bureaucratization—the “moral environment” in which people lived their lives and work as professionals. Through the three lines of inquiry—neoliberal bureaucratization, professional caregiving, and stateless tuberculosis—that help to demystify the boundaries created by commonly use dichotomies, I wish to clarify the features that embedded in the two global movements. They are the “rigidity of habit” and the “imperious immediacy of interest”—that Merton (1936) precisely points out as the causes of unintended negative consequences. I have also tried to make clear the detrimental "symbolism" that social movements unintentionally created to call for attention to prevent expansion of their detrimental effects. In doing so, I hope that at least my effort would provide words of caution and hope.

Moreover, Boas’s use of Goethe’s work inspires me to learn more about this German

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41 I did a research to find the source of the German poem that Boas quotes. By the help of a Tozzer librarian, I found that Boas picked it from Faust (Goethe 1986) line 1936–1939. This English translation is from Faust: A Tragedy: Interpretive Notes, Contexts, Modern Criticism (Goethe 2001).
poet. I found that Goethe was not only a poet but also many others professionals including a
scientist. His method of phenomenology values the observer’s direct experience over all other
scientific equipment. In his *Theory of Colors* (Goethe 1970), for example, he defines colors as
human experience. It was explicit to me that Goethean epistemology of *wholeness* strongly
against the Newtonian reductionist method that uses a prism to show that colors are only the
different wavelength of the white light. To me, Goethean method of *observation* is similar to the
one that anthropologists today arduously insist on using.

My intellectual journey brought me to the works of a Goethean scientist, Rudolf Steiner
(1861–1925) whose wide range of studies also cover the studies of human and the society.
Through his *observation* of the society, Steiner (2009) identifies the “three-folding” character
that maintains the society as an organic whole: *culture, politics, and economics*. I was impressed
by his precise identification that each domain requires a specific “essence” to maintain the
“health” of the whole social organism: *liberty, equality, and fraternity*—the outcry of humanity
explicit in the French Revolution. Here I became aware of the implicit explanation of
Kleinman’s (1995) remarkable observation of biomedicine. Its character is also a three-
founding—*medicalization, professionalization, and bureaucratization*—that each fold seems to
relate to a particular domain of the society. In *every* domain, biomedicine forces the society to go
against what it requires and thus causes negative consequences (Table 4). Therefore, it is not
surprising why it can become what Ivan Illich (1976) calls *Medical Nemesis*. 
Table 4: Biomedicine’s negative consequences in the view of social three-folding

<table>
<thead>
<tr>
<th>Social three-folding</th>
<th>Culture</th>
<th>Politics</th>
<th>Economics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required essence</td>
<td>liberty</td>
<td>equality</td>
<td>fraternity</td>
</tr>
<tr>
<td>Biomedical three-folding</td>
<td>medicalization</td>
<td>professionalization</td>
<td>bureaucratization</td>
</tr>
<tr>
<td>Biomedicine’s negative consequences that against the “required essence” of the social organism</td>
<td>Devaluation of other medical cultures and other domains of life thus limit the freedom of choice of care</td>
<td>Hierarchical political relationship in decision making among caregivers and between “doctor” and “patient”</td>
<td>Indifference and discrimination in the distribution of resources for health care</td>
</tr>
</tbody>
</table>

Here I see the role of anthropology in employing the method of *observation* to engage in the social movement toward the “sustainability development” which to me aims to ensure *health security* of every person. In this movement, anthropology is an essential profession in the collaborative effort to remediate the ubiquitous malady like tuberculosis—in its physiological and metaphorical senses.

Taking into account the present pathological conditions of cultural, political, and economic domains in the countries or regions around the world, including my country, Thailand, I think that we need collaboration among all of us as “professionals” by crossing the professions’ boundaries. Whatever it is that is happening, I think it is temporary and deserve our enduring engagement to shape its trajectory. It is a point in the “plot” of our society’s long “narrative.” Metaphorically, we are clinicians whose role is to *emplot* the *clinical narrative* in remediating the society. As Dr. Somsak Chunharas rightly put it in his visit to Harvard in October 2017 talking about the reform movement in Thailand, “We have no choice but to be hopeful.”

To be hopeful is essential for enduring any personal or social malady. It is, however, not
enough for the professionals who have institutional and moral obligation to care for others, thus, obligated to encounter such pathology. Here I found Steiner’s observation provide a guiding imagination:

World revolution demands that as professions become more specialized and mechanized, people feel the need for the opposite pole to become proportionately more intensely active in them. This means that *each human being should fill his soul with what brings him close to every other human being, no matter what their specialized work may be.* (Steiner’s lecture in 1916, quoted in Link 2012:47, emphasis added)

To me, what Steiner suggests here is similar to Kleinman’s insistence on the role of the act of caregiving. For the professionals, *presence* and the *phronesis* of caregiving (Kleinman 2010; Wilkinson and Kleinman 2016) are what could bring them “close to every other human being.” In the act of *professional caregiving*, therefore, the professional could employ a particular subjectivity that provides the openness for the professionals’ liberation that enables them to cross the boundaries to shape the courses of the social malady by transforming the bureaucracies from within.
I begin the first chapter of this dissertation with this sentence: “As Siriraj Medical School granted me an MD degree in March 2001, I was qualified to be a doctor of the Thai Ministry of Public Health (MPH).” I begin it with this message to pay my respect to Professor Dr. Chana Sathonkij who was the chair of the Department of Surgery when I was in my last three months of my medical training. He granted me an approval to pass the surgical ward training, even though the brain tumor I had and the brain surgery in January 2001 prevented me from completing the last three months of my training. Otherwise, I cannot become a medical doctor to begin the journey that brought me to write this dissertation.

One of the primary driving force that brought me to pursue my graduate study and to write a dissertation about TB is the teaching of His Royal Highness Prince Mahidol of Songkla. He turned from being a navy to study medicine and public health at Harvard. He was and is still the inspiration of the TB work in Thailand. I want to end my dissertation with one of his teaching:

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