The role of state and non-state actors in the policy process: the contribution of policy networks to the scale-up of antiretroviral therapy in Thailand

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Antiretroviral therapy (ART) is difficult in poor settings. In 2001, the Thai government adopted the policy to scale-up its treatment initiative to meet the needs of all its people. Employing qualitative approaches, including in-depth interviews, document review and direct observation, this study examines the processes by which the universal ART policy developed between 2001 and 2007, with the focus on the connections between actors who shared common interests—so-called policy networks. Research findings illustrate the crucial contributions of non-state networks in the policy process. The supportive roles of public-civic networks could be observed at every policy stage, and at different levels of the health sector. Although this particular health policy may be unique in case and setting, it does suggest clearly that while the state dominated the policy process initially, non-state actors played extremely important roles. Their contribution was not simply at agenda-setting stages—for example by lobbying government—but in the actual development and implementation of health policy. Further it illustrates that these processes were dynamic, took place over long periods and were not limited to national borders, but extended beyond, to include global actors and processes.

Keywords Policy networks, policy process, policy analysis, antiretroviral therapy, HIV, Thailand

KEY MESSAGES
- In Thailand, networks of government and non-government actors working within the country and globally have been key to scaling-up antiretroviral therapy in order to achieve universal access to treatment.
- Mapping and tracking the resources of state and non-state actors can help to understand the roles and contribution of policy networks to the development and implementation of public policies, and help to plan future strategies.

Introduction
Scaling-up antiretroviral therapy (ART) in low and middle income countries has been hindered by several factors: the high costs of antiretrovirals (ARVs) and laboratory tests, complexity of treatment administration, and lack of health system capacity including inadequate financial resources, infrastructure and an experienced workforce (Bogaards and Goudsmit 2003; Steinbrook 2004). The HIV epidemic in Thailand started in the late 1980s, and had affected almost 1 million of its 60-million population by the mid-1990s (Thai Working Group on HIV/AIDS Projections 2001). The Ministry of Public Health (MoPH) instigated a public-subsidized ART programme in 1992
to provide free access to zidovudine (AZT) monotherapy among the poor (Thanprasertsuk et al. 2004). In 1996, the service was replaced by treatment provision in clinical research projects, since an economic analysis suggested that universal ART would be unaffordable, and therapy in adults was less cost-effective than the use of ARVs to prevent mother-to-child HIV transmission. Although this initiative continually evolved in its strategies and treatment protocols during the first decade, the medication covered only a small fraction of the population in need. A dramatic shift was introduced in 2001 when the government opted to extend therapy to meet universal coverage (The Nation 2001). By the end of 2006, the number of people living with HIV/AIDS (PHA) on ART under the national programme was 80,000, a 40-fold increase from the baseline in 2000.1

Despite the fact that Thailand was well-off, compared with many countries in the developing world, difficulties in introducing complicated treatment nationwide could be anticipated, owing to the substantial demand and existing constraints in the health sector (Ainsworth et al. 2003). This paper investigates the processes by which the universal ART policy developed. It aims to understand why the government decided to scale-up ART coverage in 2001; how corresponding programme configurations were devised; and how such policy was translated into action at peripheral health care settings where significant limitations in health delivery existed. The paper illustrates the extent to which public policy-making in Thailand may be shifting towards acknowledging a differentiated polity (Rhodes 1997) where government officials are purposively acknowledging the network society, and including civil society groups, both in dialogue and exchange about key health issues and in the actual development of health policies.

**Background**

**The shifting role of the state in health policy making**

Many scholars have noted a shift in focus from government to governance in societies that are increasingly networked (Castells 1996; Rhodes 1997; Hajer and Wagenaar 2003). Although ‘governance’ is given many different meanings, its core observation is that the process of governing, of making and implementing policies, has broadened and has become more complex with the advent of the network society (Bressers and O’Toole 1998). Where once decision-making focused on the state, which controlled the policy process, attention has increasingly turned to non-state actors, who today are both more numerous and play more significant roles in health policy processes (Lee and Goodman 2002). As electronic communications have expanded, so have domestic and international networks of actors concerned with similar issues. The investigation of non-state networks involved in policy making provides useful insights into how public policy making is changing, and with it, the role of the state. While Marsh and Rhodes (1992) say ‘... focusing on policy networks will never provide an adequate account of policy change, because such networks are but one component of any such explanation’ (p. 260), focusing on the relationship between state and non-state networks raises important questions about accountability (who sets the policy agenda for example), as well as interdependence in the policy process (where does sovereignty lie). Using networks as a lens through which to explore such fundamentals contributes to an understanding of changing policy processes and policy environments.

Scholars have used the notion of ‘policy networks’ to illustrate the complex web of policy making and the inter-relationships between different state and non-state actors. In some instances, the interactions may be highly contentious, with non-state actor networks pressing the state to shift its position. An example is the action of AIDS activists forcing a policy shift in South Africa in relation to access to antiretroviral drugs (Friedman and Mottiar 2004). In other instances, state and non-state actors create collaborative relationships where the former can achieve specific policy goals with assistance from the latter, even while pursuing their own interests (Rhodes 1988). Friedman and Mottiar (2004) show how the Treatment Action Campaign fought to change government policy in relation to antiretroviral medicines, but worked with government to oppose a pharmaceutical association onslaught on national drugs policy.

Defining the characteristics of policy networks is complex (Marsh 1998), although most agree that resource mobilization and exchange is one of the most important defining elements of policy networks (Hajer and Wagenaar 2003). Rhodes (1997) emphasizes the importance of understanding the resource exchange through which network members aim to maximize their influence over outcomes. Resources may be finance, knowledge, expertise, technologies, or the capacity to mobilize any of these as well as support from members of the network and outside it. Through their networks, participants are enabled to collaborate and coordinate activities or efforts, exchange information and construct common knowledge (Stone 2001) in ways that support the achievement of policy outcomes.

Policy networks can be classified into two categories: policy communities and issue networks (Marsh and Rhodes 1992). The two types of network differ in terms of the number of members, types of interests, cohesion, resources and power. A policy community refers to a tightly integrated group with a limited number of participants, high levels of continuity and a persistent balance of power among members, though one or two interests may dominate. In highly technical areas such as those relating to some scientific or health issues, the roles of specialists in government departments and academic institutes are crucial (Smith 1993). By contrast, an issue network is less integrated as it comprises large numbers of members with broad values and background (Marsh and Rhodes 1992). Imbalance of resources and power is more likely among members of this sort of network, and conflict may be a characteristic at certain times. With a few exceptions, policy communities lead policy decisions, while issue networks have limited access to the policy process and so may have less policy influence beyond the agenda-setting stage.

In empirical research, the policy network notion can be used as a tool for describing, exploring and understanding inter-connections between actors (Lewis-Lettington and Munyi 2004). It can also be a tool for policy-makers to use in prospective planning for policy change (see Buse 2008, this issue). While widely used in disciplines other than public health, there are limited examples of where health policy...
processes have been observed through the policy network lens (Luke and Harris 2007). This paper contributes to the literature on policy analysis in developing countries, using policy networks to describe and understand the relationship between state and non-state actors in relation to ART policy development at a particular period in Thailand. It provides one example of a collaborative policy-making process between state and non-state actors, drawing on some of the characteristics of the different networks at different stages of the policy process. While its conclusions are limited and cannot be extrapolated to other policy issues, in which networks may not interact so collaboratively, it nevertheless provides insights, both retrospective and prospective, into health policy and planning processes in Thailand.

Roles of policy networks at particular policy stages
The integration of the policy network concept with the policy stages framework is useful in understanding policy development in each phase. Despite the fact that actual policy processes are repetitive and messy, the stages framework is employed as a heuristic device which helps to disaggregate these complex phenomena into a series of events. According to Baumgartner and Jones (1991), the rise of a new issue on to the government agenda and subsequent policy shifts take place only when there is substantial transformation in policy subsystems, whereby elites in existing policy communities are replaced with new clusters of actors who possess different beliefs, norms and preferences. Although policy communities are tightly restricted by technical expertise and other resources, these advantages may be disturbed in certain political situations that encourage and enable redefinitions of problems and policy alternatives. Political factors such as shifts in public opinion, movements organized by interest groups, media campaigns, and changes in the administration or responsible committees can also facilitate shifts in the policy agenda (Kingdon 1984).

At the policy formulation stage, policy options are explored, assessed, and then accepted, adapted or rejected by policy-makers or appointed task groups (Howlett and Ramesh 2003). Since the actors involved at this stage are required to search, examine and justify the appropriateness of competing policy options, they have to have a minimal level of knowledge and skills about problems and solutions in the subject domain. Given that the policy formulation process is complex, iterative and often long lasting, the participants also have to be motivated by enduring interests. As Howlett and Ramesh (2003) note, those who are appointed by the authorities, such as government experts and consultants, gain advantage over others in devising public policies. However, networks of academics—so-called ‘epistemic communities’—may also play significant roles (Stone 2001) in these processes. However, there may still be challenge and support from other interests, inside and outside government (Marsh and Rhodes 1992).

During the implementation phase, public policy intention is translated into action, generally by peripheral units of government. Due to factors such as ambiguous objectives, poor communication between responsible agencies, inadequate time and resources in implementation units, and problems in work environments, the policy may be adjusted, elaborated or even rejected by front-line government officials (Hudson and Lowe 2004). From Lipsky’s point of view, discretionary practice in service delivery seeks to counter implementation constraints and other unpleasant workplace experiences (Lipsky 1980). Eventually, such coping mechanisms become routine and established practices in the organizations. Implementation deficits may, thus, be generated by implementation actors who have not been involved in policy making, i.e. the policy networks that shape policies are not necessarily the same as those who put the policies into practice (Marsh 1998b). A useful review summarizes the involvement of policy networks at each policy stage, focusing particularly on the functions of civil society organization (CSO) networks in international development (Perkin and Court 2005). In agenda setting, networks draw the attention of policy-makers to important problems by organizing advocacy campaigns, promoting dialogue on research evidence, and fostering links between policy-makers and stakeholders who aim to influence the government agenda. Similar roles are played by civic networks in policy formulation, i.e. they provide policy-makers with the evidence necessary to assess policy alternatives. In policy implementation, however, many CSOs enhance the capacity of governments by delivering outreach services or acting as platforms for action on issues neglected by governments.

Study methods
The study’s focus was on the role of national policy networks in ART policy development, and local network involvement in policy implementation, in Thailand. Qualitative approaches, including documentary analyses, in-depth interviews and direct observation, were employed as the major data collection approaches of this study. Data on experience over the 2001–04 period were collected and analysed in 2003–04 as part of a PhD thesis (Tantivess 2006). Semi-structured interviews were conducted with a total of 80 key informants involved in agenda setting, policy formulation and implementation. A snowball technique was used in the selection of interviewees. The documents reviewed included memoranda, letters, meeting records, practice guidelines and programme manuals, research reports, conference proceedings and newspaper articles. Minutes of the meetings of MoPH advisory panels, official memoranda and government letters were particularly useful for this study as they suggested the positions, roles and resources of each network of actors at each stage of the policy. The information on policy context was drawn from a wide range of documents including those posted on the internet. Validation of information across sources, including field notes and personal communication with knowledgeable persons, was undertaken to ensure the study’s quality. The data on national policy making was mainly gathered in the MoPH’s departments, other government agencies, and NGO offices in the Bangkok Metropolitan area. Tantivess attended the meetings of a MoPH advisory panel responsible for policy formulation, as well as many conferences relating to the national ART initiative—all providing additional experience and insight to data analysis. The preliminary findings were shared with key informants to test their validity and acceptability. Data were analysed using a framework approach, which
identiﬁed themes and patterns pertaining to ART policy processes (Tantivess 2006, chapter 3).

To trace the relationship between national and provincial policy processes, fi eld work was undertaken in two provinces, both with relatively high HIV prevalence and little experience in ART provision before the programme was scaled up. In each province, three hospitals responsible for providing ART were included in the research, one at provincial level and two district-level facilities. Interviews took particular account of the roles of policy networks in universal treatment policy implementation and ART roll-out between 2001 and 2004. Provincial interviews and documentary reviews revealed that these networks included agencies involved in the translation of treatment policy into action: Provincial Health Ofﬁces, Regional Centres for Disease Control and CSOs, as well as groups of PHA located in study provinces and the areas nearby.

Finally, additional document review, participatory observation and personal communication with Thai policy-makers and government ofﬁcials involved in policy dialogue was carried out in 2006 and 2007, to identify the roles of different actor networks in treatment policy processes when Thailand issued compulsory licenses for patented ARVs. This additional work provided the opportunity to analyse how far policy networks were dynamic and adapted to changing external demands.

Results
Domestic and international context of ART expansion

Between 2001 and 2004 several reforms in Thailand’s health and bureaucratic systems affected ART scaling up. The Thai Rak Thai party came to power after it obtained a land-slide victory in the January 2001 national election. As pledged in the election campaign, the new regime instigated many large-scale, populist projects; for example, the agrarian debt relief initiative, the introduction of village revolving funds and the universal health coverage (UC) plan which benefi ted low-income groups (Phongpaichit and Baker 2004). The two new public health programmes—universal coverage and nationwide health promotion—required health workers to carry out additional tasks in health care settings and communities. New models of primary health care delivery were introduced in extended units outside hospitals. The greater access to disease prevention and treatment under both new policies resulted in rising service utilization as well as an increase in providers’ workload. However, the number of health professionals and paramedics did not increase (Jongudomsuk 2004; Kespichayawattana and Saengtienchai 2004). In addition, measures to downsize and reorganize public agencies led to early retirement and reallocation of government ofﬁcials, causing workforce shortages in some areas of the country.

In this period, mainstream access to HIV treatment in the developing world was beginning to be promoted globally. In 2001, Brazil was the sole middle-income country providing universal coverage for ARV-based medication. However, a number of HIV-medicine initiatives were organized by international agencies such as the World Health Organization (WHO) and United Nations Joint Programme on HIV/AIDS (UNAIDS) in collaboration with the pharmaceutical industry (UNAIDS 1998) to widen access to ARVs. Through these public-private partnerships, small-scale ART was implemented in some African and Latin American settings. Substantial efforts to expand treatment were introduced when the United Nations called for multisectoral advocacy to address HIV/AIDS problems in a special session assembly in June 2001 (United Nations 2001). Then in 2002, WHO, with support from UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria, established its ‘3 by 5 initiative’, aiming to get 3 million PHA on ART by 2005 (WHO 2002). Governments of industrialized countries and philanthropic organizations, including the Bill and Melinda Gates and Clinton Foundations, supported the scale-up of HIV-related services in different ways (UNAIDS 2004).

Network transformation: from outsider to insider status

After a decade of incremental changes in the national ART initiative, the Thai Health Minister declared the commitment to expand treatment to cover all PHA in need in late 2001. Many factors inﬂuenced the decision to drive the issue of treatment expansion up the government agenda (Tantivess 2006). These elements included local production of generic ARVs, drug price reductions and the NGO movement. Parallel reforms in the health sector and global efforts to expand access to HIV medicines were also important. Here we focus on the changes in ART policy networks at the time of policy innovation: in particular, CSOs, who had previously advocated treatment expansion, and were outsiders to the policy-making sphere, began to participate much more closely in policy-making processes. This was facilitated by legal changes to the Thai Constitution in 1997, whereby the rights of citizens to participate in much public policy-making were explicitly acknowledged.

The development of policy networks in HIV/AIDS could be observed from the mid-1990s and increasingly involved those living with HIV/AIDS. In 1994, 42 countries including Thailand adopted the Greater Involvement of People with HIV/AIDS principle (GIPA) at an international AIDS meeting in Paris. This principle promoted the participation of PHA and communities in policy decisions and implementation. This provided a framework to formalize PHA activities and encourage close collaboration between the government and CSOs. Coordination among HIV-afﬁliated people was strengthened at the national level when 50 groups of PHA throughout the country formed the Thai Network of People Living with HIV/AIDS in 1995, which then collaborated with the pre-existing National AIDS NGO Network (Wisartskul 2004).

By 2000 there was a large and multi-partnered network of groups involved in HIV/AIDS and ART. Alliances of HIV NGOs, PHA and human rights advocates, scientists in the Government Pharmaceutical Organization (GPO), HIV experts, schools of pharmacy lecturers, and intellectual property (IP) lawyers had promoted access to therapy in Thailand since the mid-1990s, when highly active antiretroviral therapy (HAART) was ﬁrst distributed in industrialized countries (Ford et al. 2004). This was a highly effective and active network at the national level, which was able to draw on support from international networks too. In 2003 they ﬁled a case at the Intellectual Property Court to revoke Bristol-Myers Squibb’s patent on...
didanosine (Ford 2004), and in 2004 the company cancelled its patent—before the Court ruled. Increasingly, a few NGOs began collaborating closely with officials in the MoPH's AIDS Division and clinicians in provincial and district hospitals, sharing field experience on HIV prevention and care delivery (Kumphiak et al. 2004). Treatment advocacy networks also had close relationships with the health system reformists who led the initiation of the UC scheme under the new regime. Nevertheless, prior to the adoption of the universal ART policy in 2001, only a few of these network members (for example some HIV specialists) joined government AIDS officials in making decisions on the national treatment initiative.

However, in March 2001, the civic groups’ campaign for ART extension was galvanized into close dialogue with government. This was because the government excluded ARVs from the UC benefit package owing to concerns about their unaffordable financial burden and programme sustainability. In several meetings with insurance officials and the Minister of Health, treatment advocates presented evidence on the effectiveness of HAART and the associated cost-savings from opportunistic infections averted in Western countries and Brazil, as well as the availability and prices of ARVs produced by an Indian generic company, Cipla (Tantivess 2006). Human rights, justice and equity were raised as the rationale of service extension. A leader of the treatment alliances argued:

Those who can afford it are now able to have a good quality of life for a long period of life. This raises the question whether drugs should be considered in the same terms as a commodity… or should it be considered an essential part of people’s needs and therefore a right. Should it be a right to people in the world to receive the drugs needed in order to support their life? (Ungphakorn 2001, p. 75)

In October 2001, the Thai GPO—the main supplier of generic ARVs to the national treatment initiative—succeeded in manufacturing a fixed-dose medicine combination, GPO-Vir. The subsequent price reduction of this first-line regimen, from 20,000 baht to 1200 baht per patient per month, publicized in October 2001 (Bangkok Business 2001a), was an important event. NGO networks promptly urged the government for further action. On 5 November, a letter co-signed by the presidents of the Thai Network for PHA and the Thai Non-governmental Coalition on HIV/AIDS was sent to the Health Minister and Prime Minister as well as circulated to the media, proposing the MoPH establish a commission of MoPH officials and NGO representatives, including the PHA network, to work out a plan to integrate ART into the UC scheme and oversee treatment extension (Tan-ud and Panichpak 2001). The letter stated that a thousand PHA and NGO staff would gather at Government House in Bangkok to hear the government’s decision on the eve of World AIDS Day, 30 November. The MoPH responded quickly. On 28 November, a government-NGO meeting was held, attended by the Health Minister, Deputy Health Secretaries, the Director General of the Disease Control Department, the GPO Director, HIV experts, and representatives of NGOs and the PHA Alliance (Ministry of Public Health 2001b). Subsequent to the discussion, an agreement was attained. The key resolution was that the MoPH agreed in principle to include ART in the UC package, phasing it in gradually. It could be said that from this moment, CSOs became ‘insiders’ in the policy process, involved in developing policy for implementation.

However, state actors also played crucial roles in this policy stage. It was the Health Minister’s urgent policy to strengthen the GPO’s capacity to manufacture affordable first-line ARVs that facilitated the expansion of ART (Bangkok Business 2001b). The progress in research and development and pilot-scale manufacture was monitored closely by the Minister and senior officials. Parallel to the meetings with civic networks, intensive internal discussions took place within the MoPH. It seemed that a group of health system reformists and economists who provided technical support to the Health Minister on UC introduction dominated the decision-making. Some of these technocrats encouraged the Minister to scale-up treatment since they anticipated not only the clinical and economic benefits of HAART, but also felt the policy would enhance the country’s reputation globally. However, they maintained that ARV medication should be delivered outside the UC scheme because its financial sustainability remained uncertain. This was partly due to the lack of evidence on treatment adherence profiles, drug resistance development and needs for second-line ARVs in the future.

As the Health Minister argued in interview in 2003 (Tantivess 2006), the universal treatment policy was adopted because the government had strong intentions to provide equitable access to all essential health services. An argument can, thus, be made that the ART policy innovation was not due to domestic or international political pressure but, to some extent, was motivated by true public interest expressed by government officials as well as CSO groups. Government had a commitment to improve treatment access. This was reflected in ministerial policies and actions, for example the programme to strengthen the GPO’s capacity in order to extend generic ARV production was, as already noted, implemented immediately after the Thai Rak Thai cabinet came to power. Such effort indicates that the government had clear objectives and strategies to address the treatment obstacles. Drug price reduction—a vital factor in the adoption of universal ART coverage—was partly the outcome of the administration’s advocacy. At the same time, government commitment to providing ART was accompanied by sustained lobbying and campaigning by networks of activists promoting the rights of individuals to health care.

Opposition to extending ART coverage came largely from a group of actors in the government sector, i.e. some AIDS officials and professionals in the MoPH and its sub-national units, who disagreed with the rapid expansion of therapy (Tantivess 2006). They were concerned about the inadequate preparedness of the health delivery system and the uncertainty of long-term financing. However, these concerns were difficult to maintain in the face of the powerful arguments of those who supported ART expansion.

Crafting a practicable pathway: the role of networks in policy formulation

Given that ART delivery was complex, the scale-up of the national treatment programme to achieve universal coverage
required substantial changes in both the existing HIV services and general health delivery. Scale-up affected the designations of responsible agencies; patient enrolment criteria; treatment protocols; and training of health workers in hospitals throughout the country. To devise the new configurations of the national ART service, the MoPH appointed four technical and administration panels, consisting of HIV officials, specialists in relevant areas from many institutes, health financing researchers, and representatives from NGOs and PHA groups (Ministry of Public Health 2001a). These formed the core of the policy community.

Although these advisory panels were active only in the year 2002, their contributions were beneficial to ART extension. Substantial changes in treatment delivery were introduced as recommended by experts, AIDS officials and NGOs as members of the four panels. These included, for instance, the suggestion to build up connections with new partners such as the Bangkok Metropolitan Local Government and public insurance schemes other than the UC, aimed at addressing the existing gaps of ART coverage in the capital city and private hospitals (Administration Advisory Panel 2002a). The revisions of ARV regimens, related clinical practice guidelines, and training programmes for workforce development were also attributed to this core policy formulation community. Another clear illustration of the administration panel's role was that its proposals to provide opportunities for NGO and PHA participation in training and care delivery were adopted by the MoPH (Administration Advisory Panel 2002b). Moreover, the extension of ART to treatment-experienced patients—the group which was previously not eligible for ARVs under the national initiative—resulted from these panels' advice (Administration Advisory Panel 2002b).

All of the policy recommendations made by the policy formulation panels were informed by the experience and expertise of the panel members, feedback from previous policy implementation, and the current context of the health delivery system, especially treatment challenges generated by the on-going reforms. An example is the major revisions of treatment regimens. Evaluations of the national ART programme prior to the 2001 policy innovation indicated weaknesses including inefficient procurement, poor inventory and allocation of ARVs to participating hospitals, because as many as eight complicated combinations had been adopted (Puppanich et al. 2002; Satasit et al. 2002). This led to frequent drug shortages and health providers' mistrust of the national programme managers. The panels for clinical guideline development therefore sought to simplify the protocols, lessen the problems in treatment administration and drug management, and support mass service delivery. It was observed that not only the specialists' expertise, but also the field experience of HIV treatment and care of NGO staff and PHA was useful and well considered in the panel discussion.

Apart from the MoPH's panels, the Disease Control Department played a vital role in establishing NAPHA in 2003, the National Access to Antiretroviral Programmes for People Living with HIV/AIDS (ATSI 2003). This body aimed to provide an overarching umbrella to integrate the previously disjointed ART initiatives implemented by different departments of the MoPH, with different target populations. Thereafter, ART delivery was much better organized, under the single direction of the NAPHA steering committee. This group too included CSOs in its deliberations.

Local networks: implementation on the ground

As key stakeholders involved in the policy adoption and formulation stages anticipated, ART scaling-up during 2002 to 2004 was impeded by many factors. However, networks of sub-national actors acted to counter the impediments and to facilitate the implementation of good quality treatment. The collaboration between civic groups and their government counterparts was expanded when Thailand obtained financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2003, which required NGO participation at policy-decision and operational levels of the national HIV programme. This significantly increased involvement of PHA and communities in ART scaling-up under NAPHA, especially in the HIV-endemic provinces in the north of the country (Lyttleton et al. 2007).

In two study provinces (Tantivess 2006), sub-national networks formed to address problems such as inadequately experienced ART providers and the effects of HIV-related stigma on care-seeking behaviour, seeking ways to ensure service quality. Although health workers in hospitals and officials in provincial and regional health offices were key people translating treatment expansion policy into action, the role of NGOs and patient group members was also indispensable. These civic groups carried out some tasks for which health providers had only limited capacity. These included understanding the problems and needs of HIV patients, providing necessary information in lay language, and making adequate time for talking to and working with AIDS patients and their families. They also replaced the highly visible professional health workers on home visits, to help avoid any further stigmatization of individuals and families given widespread local sensitivities about the disease. In addition, ART-experienced PHA had a role in convincing high-risk and the infected persons, who had been reluctant to receive institutional care, to seek counselling and HIV testing. In an interview in 2004, one member of a self-help group in a study province pointed out that:

"Neighbours frequently asked me how my illnesses were relieved—which kinds of medicines I took. They saw me getting healthier . . . some of them had children or relatives who had the disease so they asked me for advice. They were afraid of visiting hospitals and seeing doctors. I told them not to worry . . . drugs were available and also we had organized as a group. It was better joining the group than staying desperately at home."

The local context influenced network profiles as well as patterns of collaboration. In one of the provinces, civil society activities around HIV prevention, care and impact mitigation were relatively strong: many NGOs were established in this region when the epidemic started in the late 1980s. When the number of AIDS cases rose considerably, NGOs supported these patients to form into groups, and worked closely with health workers. For example, before Thailand had its own generic antiretrovirals, alliances of NGOs, PHA and professionals in
public hospitals helped individual patients buy generic medicines from India. The self-help groups were well accepted by hospitals and had crucial roles in promoting treatment adherence and providing information and psychological support to patients. When the national initiative was scaled up, the existing networks continued and passed on their experience to new ART providers and recipients. Patient groups in this province, especially in the provincial hospital, were also not reliant on financial assistance from health providers as they were able to generate some income from their own occupational activities. Furthermore, the networks of PHA groups at provincial and district level were well structured and managed as part of regional and national coalitions, through which technical support and funds were channelled. It seemed that the main thing these self-help groups required from their state partners was the opportunity to participate in the policy implementation process.

In contrast, only two NGOs, one on HIV and another on social development, were present in the other province. Patient groups were created and managed by health workers in the public hospitals. These groups had fewer members and were less well organized, compared with those in hospitals of the same size in the former province. However, the group leaders were helpful in treatment delivery as they visited ART recipients at home, encouraged adherence and provided information. A key feature of patient groups in this province was that they obtained very little support from the regional and national PHA alliances, and were not independent of their host hospitals. While the civic networks were relatively weak, the role of a small community of health professionals was crucial to policy implementation. The extension of treatment was hampered by a lack of experienced prescribers in this province because of the rapid turnover of general practitioners in district hospitals. To overcome this problem the small health professional group organized training courses for newly graduated doctors, pharmacists and nurses, most of whom were allocated to work in district settings. A network for consultations on clinical, laboratory and logistic issues was also established to support ART service at district level.

**Ensuring treatment sustainability: domestic networks link with global networks**

From 2002, access to ART in Thailand was expanded gradually, leading to rising budget needs. Like other antimicrobials, use of ARVs inevitably results in the development of viral resistance to drugs, subsequently increasing needs for second-line regimens. The sustainability of the universal ART initiative had been questioned from the beginning, as most ARVs on the market were patented and therefore expensive. In 2005 and 2006, the MoPH sought and failed to address these emerging problems through cooperation with research-based companies to reduce drug prices (Ministry of Public Health 2007). At the same time, the idea of introducing compulsory licensing for patented ARVs was raised in several policy discussions, including meetings of the National Health Security Board in mid-2006. The proposal was supported both by the Board members and by HIV treatment advocacy coalitions. However, it was not until November 2006 that the government announced its plan to implement compulsory licensing of efavirenz (EFZ), a high-priced, first-line ARV with lower toxicity than the regimens used in the national service (Disease Control Department 2006). The second compulsory license was issued in late January 2007, as the MoPH wanted to import generic lopinavir-ritonavir combination from India or other sources (Disease Control Department 2007).

These Thai actions ignited objections from the patent holders and their country governments (Gerhardsen 2006). Opposition also came from other drug research companies and international associations of pharmaceutical manufacturers, who feared that other developing countries might follow Thailand in issuing compulsory licenses for a wider range of patented medicines. Pressure was put on the Thai administration in several ways. The issue was discussed in special briefing sessions in the US Congress, where some participants from the drug industry urged the US government to introduce trade and investment sanctions. Administrators of transnational companies and diplomats from the USA, Switzerland and the European Union visited the Thai MoPH, National Health Security Office, Ministries of Foreign Affairs and Commerce, Department of Intellectual Property and Royal Thai Embassies to raise the issue of patent overriding. Abbott Laboratories—the patent holder of lopinavir-ritonavir combination—withdraw its drug registration dossiers including heat-stable lopinavir-ritonavir product, which had been submitted for market approval in Thailand (Head 2007).

Some opponents asserted that the Thai action was illegal, that the World Trade Organization did not intend the TRIPS flexibilities to be used to address the budgetary constraints of middle-income countries. They argued such flexibilities should be introduced only as a last resort, after trying ‘less disruptive ways’ to improve access to medicines (Pharmaceutical Research and Manufacturers Association 2007). Others suggested that by issuing the compulsory licenses, the Thai regime had put the country and its citizens at risk, since the violation to the rights of patent holders might prompt foreign businesses to withhold their investments including innovative drugs from the Thai market (Wong-Anan 2007). Overall, Thailand’s image was undermined as it was accused of piracy. An IP lobby group in the US put it, ‘The important distinction between theft of American assets on the streets of Bangkok and theft of American assets in Thailand’s public health care system is that the latter is sanctioned, endorsed and promoted by the government’ (IP Review 2007).

On the other hand, the compulsory licensing of certain HIV medicines for public use was applauded by international health agencies and NGOs, for example the WHO, UNAIDS, Oxfam, Medicins Sans Frontieres and the Clinton Foundation (Piot 2006; Chan 2007; Magaziner 2007). Among others, the WHO took a clear policy stance, saying in its letter to the Thai Health Minister, ‘WHO unequivocally supports the use by developing countries of the flexibilities within the TRIPS agreement that ensure access to affordable, high quality drugs. This includes the use of compulsory licensing, as described in paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health’ (Chan 2007). Apart from expressing their appreciation for the Thai action, HIV and human rights networks, including journalists and IP experts in US universities and private law firms, helped to address the queries as to whether the
compulsory licensing was lawful or not (Love 2006; Arunmas and Treerutkuakul 2007; Steinbrook 2007). The NGOs, academics and media also publicized several examples where ‘government-use’ policies had been introduced for medicines and other patented interventions in industrialized societies. These coalitions managed to mobilize support from some US Congressmen who sent petition letters against the threats of trade sanctions on Thailand. In addition, local and international NGOs jointly condemned Abbott’s reactions and organized a campaign worldwide to boycott all products made by this company (Bangkok Post 2007).

It is noteworthy that the Thai government action took place within a lively global discourse around IP-related barriers to essential medicines and other health products, and what constitutes a public health emergency. In December 2006, a WHO-sponsored Intergovernmental Working Group had its first meeting to develop a global strategy and plan of action to overcome drug access hurdles (WHO 2007a). Progress made by the Working Group was reported to the WHO Executive Board in late January 2007 (WHO 2007b). The Thai actions to improve access to ARVs were raised as inspiring examples showing how resource-poor settings could put the flexibilities stated in access to ARVs were raised as inspiring examples showing how resource-poor settings could put the flexibilities stated in

Discussion

Given the complexities and costs of providing ART on a large scale, it would have been very difficult to scale-up treatment and maintain the universal access initiative without the public-civic partnerships that made up the policy networks. As Bressers and O’Toole (1998, p. 215) note, the policy network concept ‘has been fuelled in part by recognition of the complex array of actors involved in policy choices as well as the inability of contemporary government to move unilaterally without incorporating the constraints, preferences, and resources of other social actors.’ This paper illustrates the actor networks’ contributions to treatment extension in Thailand, where public resources were limited.

The roles of civic organizations in each stage of the Thai ART policy were in line with that described by Perkin and Court (2005). Focusing on agenda-setting and policy adoption, the treatment advocacy coalitions encouraged the government to pay attention and commit to the benefits, feasibility and underpinning ideals of service scale-up, and lobbied hard to get attention for the issue. However, context was also important. The shift in the ART programme took place when there was a transformation of the policy community: a new cluster of state policy-makers replaced the elites who had dominated policy decisions over the past decade. Because of this change, CSOs became members of the policy community that introduced the policy innovation. As noted by Marsh and Rhodes (1992, p. 261), policy networks can be a major source of policy inertia, unless policy equilibrium is ‘punctuated’ (Baumgartner and Jones 1991) resulting in a shift in the core policy community and policy innovation. It can be argued that the Thai Rak Thai government’s commitment to universal care was the focusing event that led to a change in policy equilibrium, and opened participation in the policy process.

The analysis also provides additional insight: core or privileged communities may form collaborations with clusters at the periphery in order to achieve their goals. In Thailand’s ART policy, there were core policy communities of a limited number and range of actors, largely MoPH officials and professionals in hospitals, who dominated the policy processes. These public servants had close connections with each other as they usually worked together and were linked through shared basic values and professional background. In parallel, groups of treatment advocates such as HIV NGOs, scientists, professionals and lawyers worked jointly for similar purpose. Some of these networks were well-integrated, consensual and shared regular activities, so that they too could be regarded as policy communities according to Marsh (1998a). Some could even be described as epistemic communities, who shared ‘...a commitment to a common causal model and a common set of political values... united by a belief in the truth of their model and by a commitment to translate this truth into public policy...’ (Haas 1990, p. 41, quoted in Parsons 1995, p. 173). However, until the Thai Rak Thai government came into power, these policy communities worked relatively separately and the CSO networks were treated as relative ‘outsiders’, who put pressure on government or lobbied for change, but were not integrated into the policy process.

After 2001, however, the government policy community recognized its need to build connections with the existing networks, in order to mobilize additional resources which were not available in the MoPH and its affiliated units. The expansion of ART policy communities and resource mobilization could be observed in the policy formulation and implementation stages, where the technical expertise of HIV specialists and practical skills of, and treatment delivery support from, CSOs were required. This study found that the ultimate goal, shared by state and non-state members of the networks, was improved ART access. However, members of the network may also have been motivated by different incentives. While expressing a strong public interest in expansion of ART, the Thai Rak Thai Health Minister might also have been motivated to enhance her party’s popularity. NGOs who were in favour of extended ART for human rights reasons, may also have anticipated more financial support from donors. For HIV specialists, extension of ART and participation in the policy process gave them the opportunity to integrate their clinical research results into national HIV treatment policies. All of these motivations, however, were predicated on the recognition that it was only through the creation of a network, which used and exchanged the diverse resources of each group, that each group could achieve the overall goal.

The partnerships created by the MoPH expanded quite tight policy communities with a central core to include new members, allowing them to participate in public policy-making. As outsiders became insiders, they brought slightly different values and backgrounds and the policy community became less integrated. Compared with the core policy community members—health officials and professionals—NGOs and PHA had fewer resources and therefore less
influence, although their ability to mobilize others was a strong source of power. In contrast, the government’s authority and legitimacy to make final decisions on public policies was its most influential resource. State actors were therefore often able to dominate the policy process. The influence of health officials over civil society members could be observed at every policy stage. In agenda setting and policy adoption, for instance, it was the Health Minister and senior health officials that accepted the NGOs’ proposal to initiate formal discussion with NGOs and PHA networks on the issue of ART scaling up. However, while there was some imbalance in the relationships within the policy community, the members were nevertheless bound by common purpose and interests overall.

This paper also argues that the existence of policy networks at the international level played a crucial role in supporting Thailand’s policy to sustain its ART programme. When the country faced tough pressure from the corporate sector and industrialized country governments as a consequence of issuing compulsory licenses, the core policy communities sought collaborations with international actors well-equipped with knowledge and experience in broad areas such as HIV treatment, IP management and medicine access promotion. The support from global health agencies, and US-based academic and philanthropic organizations, helped to legitimize the Thai actions and reduce the political pressures. This again suggests that even tight policy networks will expand to include others when they need additional resources. With electronic communication, it is relatively easy to extend the network across state borders. What occurred in Thailand in late 2006 and 2007 suggests that policy networks can be extremely dynamic, and an inner core will draw on wider links in order to achieve particular aims or values.

While partnering among local and international actors contributed considerably to widening ART coverage in Thailand, the dominance of core communities could be seen in the local policy processes. It was the health officials and professionals who decided to extend the policy-making circle and draw support from selected civic groups and experts in particular ways. Within the networks at national and peripheral levels, the state actors were, to a significant extent, able to steer the process and the participation of their non-governmental counterparts. In contrast, at the international level, the policy community members could really only persuade their potential partners to back their intellectual property policy. It is noteworthy, however, that some international agencies and many international NGOs provided support with regard to this policy issue although they had never been requested to do so by Thai officials.

Other important resources of the CSO networks included the recognition and trust they had won from PHA, and in some cases, the general public. Among the international networks, complex IP-related knowledge and negotiation and lobbying capability to mobilize assistance were crucial resources that assisted Thai networks.

This paper is based on a retrospective study of ART policy process between 2001 and 2004, combined with a contemporary analysis of policy in the making in 2006 and 2007, made possible by Tantivess’s insider knowledge and participation in the policy process. The research is thus an example of the analysis of policy to further understanding. However, understanding the policy network concept can prove helpful in real-life policy making and implementation, in the analysis for policy. When the country decided to offer free-access medication and to issue compulsory licenses for the high-cost ARVs, policy-makers considered that strong policy networks to support such changes would be essential. The long-term involvement of local NGOs and PHA in HIV care prior to 2001 gave health officials confidence that civic support would be helpful and could be mobilized when needed. Moreover, given that only a few developing countries had issued compulsory licenses for medicines, and knowing that such actions had been resisted strongly by influential actors, the Thai administration expected objections from these powers. However, the health officials, who had long participated in international health policies, anticipated that in the current context Thailand would obtain support from key stakeholders worldwide, so they decided to issue compulsory licenses. If the country had been unable to mobilize support from local and international policy networks, it would not have been able to scale-up ART to meet universal coverage and make the programme sustainable.

Finally, the analysis of this one particular policy—which may be unique in case, setting and timing—offers an example of how policy processes are no longer dominated and controlled by state actors, and suggests the opportunity for more studies that test this assumption in other areas of health policy. This particular example suggests clearly that non-state actors played important roles not simply at agenda-setting stages but in the actual development and implementation of health policy, and that these processes were not limited to national borders, but extended beyond, to include global actors and processes. It would widen our knowledge and understanding of health policy analysis if more case studies could throw light on the role of non-state actors in the policy process.

Conclusion

This paper provides an illustration of different types of resources possessed by network members. The MoPH and its peripheral units commanded policy authority. It also had personnel with technical expertise, essential equipment, materials and facilities, and of course, a large budget. In contrast, non-state actors had field experience and skills in liaising with and treating HIV patients and their families. They were also able to mobilize network members to lobby the MoPH and government very visibly, by having good links to the media.

Endnote

1 When ART was limited to 2000 patients before the scale-up of the national programme in 2002, approximately 70 000 PHA required ART. However, treatment extension means that PHA live significantly longer, resulting in increased need for treatment over time. The number of PHA on ART under NAPHA will peak at 220 000 in 2015 (Revenga et al. 2006). The declining trend after that is associated with the falling number of new HIV infections and also the limited clinical effectiveness of available ARVs. The figure 220 000 does not reflect the real need for treatment, but largely the programme performance including
adherence to treatment, affordability of second-line ARVs and capacity to recruit eligible patients.

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