HEALTH JUSTICE
and Thailand's COVID-19 response

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Foreword

I believe people who read this report are interested in knowing what health justice actually is as we are more familiar with working toward the term health equity. When Prof. Lincoln Chen from The China Medical Board Foundation gathered a handful of scholars to discuss health justice, one of the essential assumptions is that working to reduce the gap of inequity in health or socio-economic status is not sufficient.

Looking at some existing movements on health justice raises the question of whether they are a mere choice of words or a radically different approach to health, given the fact that there is widespread acceptance on lack of equity and fairness in health. In addition, during our discussions three terms, equity, fairness, and justice, used interchangeably: The concept of health justice arises from concerns about societal well-being as a whole, which a social good, which should be available to everyone, which is based on one of the oldest definitions of justice since Roman times.

The initiative on health justice is academically initiated by Prof. Lincoln Chen and Prof. Sudhir Anand, and aims to introduce a fundamental change in society which will reduce not only the gaps in healthcare but also ensure that related social institutions are designed and operated to make everyone achieve good health, by following the most holistic concept of 'a complete physical, mental, social, and spiritual health'. It is definitely a challenge to find practical actions and solutions that will demonstrate what needs to be done besides what various countries have attempted for many years, which include improving access to healthcare and financial risk protection. The framework on Health Justice reveals beyond addressing socio-economic differences or rectifying gaps in social determinants of health. It fundamentally asks questions of what needs to be done to design various social institutions and set rules and regulations that ensure that the ecosystems and relationships among groups of citizens in a diverse society will lead to holistic well-being as much as possible, without having to solve health or socio-economic gaps of individuals.

While there are various philosophical thoughts to define or guide the achievement of health justice, it is crucial to understand the meaning of health justice from other perspectives beyond philosophy. As lay people, we confront injustice daily. Our perceptions and interpretations can help guide us on what needs to be done, what should be done, and what could be done. Our experiences and observations can help balance out the argument of what health justice means from a theoretical or a philosophical framework into practical realities of daily life.

The COVID-19 pandemic reveals the hidden injustice in society in different aspects. We realise citizens with low socio-economic status can barely practice self-protection or social distancing. Although the overall public health measures for containing the spread of virus are required, the implementation of some of the measures like home quarantine led to the inability to work and earn for a living for some people in society. This is definitely devastating for those who live from hand to mouth. Although many countries have introduced mitigation measures to assist the people adversely impacted from such public health interventions, it is very apparent that these existing social institutions or mechanisms have limited reach to those most affected. Thailand's economy is driven by informal workers, many of whom are migrant workers, employed in various sectors from domestic work to manufacturing. The presence of injustice among this group has been obvious in this. This report attempts to understand health justice in the context of Thailand's fight to control the pandemic. This does not mean to criticize various efforts by many sectors, including key policy decision-making bodies, in containing the spread of COVID-19. It is more of an effort to apply a justice framework to the existing measures and consequences in order to identify gaps in social institutions and their operations without undermining their efforts. From the preliminary findings and discussions, it is apparent that applying the justice framework has helped us in identifying some of the fundamental social institutional rules and regulations better. It enables us to look beyond the health sector and ensures that all sectors of society are involved in achieving and maintaining better health for all. The goal of this Health Justice framework is not towards having everyone possess the same level of security and safety in a pandemic situation, but to work towards minimizing what Prof. Amartya Sen calls "remediable injustice"

This report is part of a wider regional initiative led by Prof. Lincoln Chen of the China Medical Board Foundation. The initiative started before the pandemic and was halted when the pandemic emerged. However, the pandemic reveals and makes sense of how the justice framework could be applied to health, defined as a state of complete well-being and not mere safety from disease infection. We hope it is helpful for other countries and partners interested in pursuing health justice

based on Thailand's shared experiences in combating the pandemic. We hope to move forward and establish networks for health justice. Moreover, we expect that the global network on health justice will take shape and collaborate to address the challenges in health equity or a lack of fairness in the health system by applying a justice lens.

Finally, on behalf of the National Health Foundation, I would like to sincerely thank the China Medical Board Foundation for entrusting us to start working on health justice in Thailand. I also would like to thank Dr.Borwornsom Leerapan from Faculty of Medicine Ramathibodi Hospital at Mahidol University for convening a team of skillful researchers comprising of an economist, a sociologist, and an anthropologist to deliver a preliminary framework, which I believe, is useful for further action. I also hope that the readers find it aspiring to work towards a world with more Health Justice, which the concept of health as defined holistically, a complete physical, mental, social, and spiritual well-being for all.

Dr. Somsak Chunharas

President, National Health Foundation

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Summary

This Health Justice initiative was conceptualised in facilitated discussions of two academic and technical meetings in 2019 - the Prince Mahidol Award Conference (PMAC) academic partners with support the China Medical Board Foundation (CMB), and the Commission of Health Justice Asia Beas River Retreat. Thailand's COVID-19 experiences provides an opportunity to document the strengths and challenges related with health justice, within the context of the response to the pandemic, from a systems approach, with consideration on health governance.

This report was produced during the COVID-19 pandemic in May 2022, with data collected between January 2020 – September 2021. The draft report was reviewed in several rounds of discussions, including the PMAC side meeting in January 2022 and 3 facilitated discussions in March 2022.

The first chapter of the report introduces this health justice initiative and provides an outline of the report. The second chapter draws on the literature of justice to propose a conceptual framework for health justice within the context of the COVID-19 pandemic for considering the documented case studies in Thailand. The conceptual framework is largely derived from Rawls's theory of justice which has been further elaborated by other scholars. The third chapter outlines seven case studies selected to reflect Thailand's governance structure and considerations made towards health justice in the COVID-19 response. The fourth chapter discusses the case studies vis-à-vis the health justice framework with a focus on three major concepts, procedural justice, distributive justice and corrective justice. The fifth chapter draws a conclusion and recommendations from the discussions.

The pandemic reveals multiple levels of challenges, from the policy decisions to communication with the public during the crisis. The impact of COVID-19 is far and wide, but the response was largely executed with a national security mindset, focusing on disease control, with little consideration of the social, economic and political impact on individuals, communities, society and the nation at large. The case studies demonstrated a diverse and evolving understanding on health justice in the Thai context. At the same time, there is a clear demand for more accountability, transparency and fairness from the government, the state and the private sector. Calls have been made for the public sector to diverge from a benevolent to a more rights-based approach.

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1 Introduction

Thailand was the first country outside China to detect COVID-19 infection in a traveller less than a week after the World Health Organization (WHO) informed the world of the emerging new disease in January 2020. Later in the year, WHO commended Thailand's rapid responses, praising the government's strong leadership and the well-established public health infrastructure of the country. It recognised the contribution of village health volunteers (VHV) in containing community transmission[1]. Thailand was also ranked among the top 10 most prepared countries by the 2019 Global Health Security Index (GHSI 2019)[2]

Between January 2020 and September 2021, Thailand was faced with 3 major epidemic waves of COVID-19, in March 2020[3], December 2021[3] and March 2021[4]. From the outset, disease control measures included movement restrictions, immigration and border control, proactive communication, provision of welfare and compensation, development and procurement of medical devices such as diagnostics, therapeutics and vaccines and provision of essential medical services were implemented. Laws and regulations were revised and issued to enforce and support the implementation of these measures. The outbreak which emerged in Bangkok in March 2021 witnessed large clusters of transmission and explosive numbers of infections. The emergence of the Delta variant of the SARS-CoV-2 virus, along with decisions made by the government at the time, not only overwhelmed the public health system but also exposed the country of the disparities in access to health care exacerbated by the inequalities in the country.

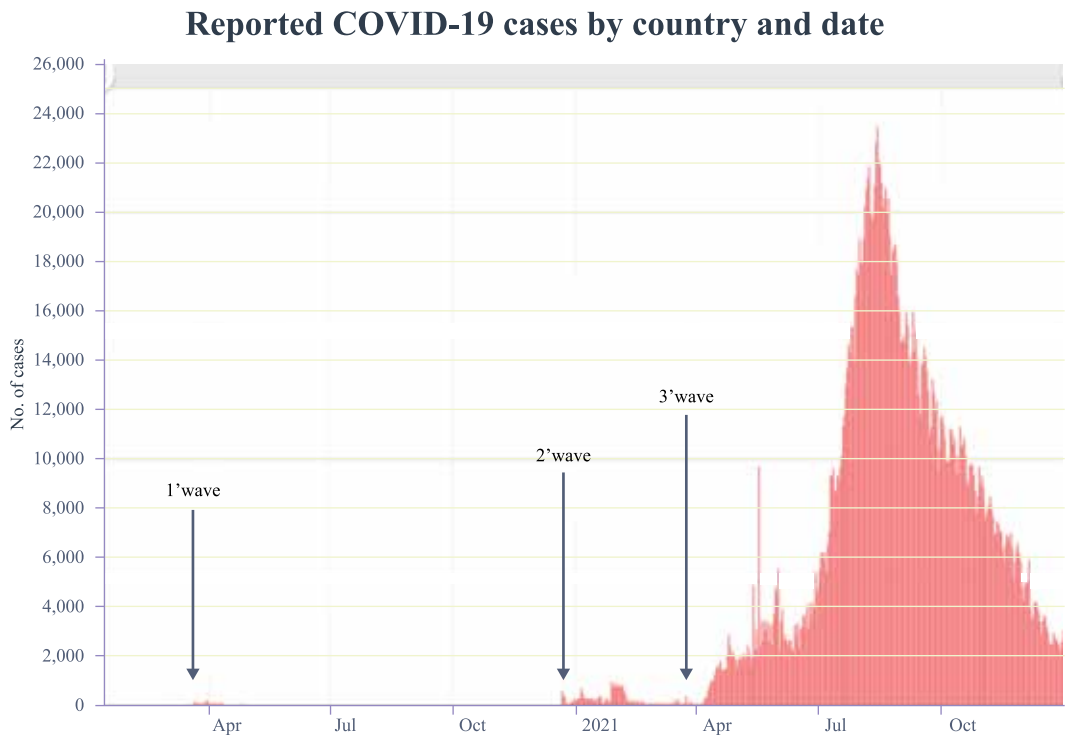

Figure 1: WHO SEARO COVID-19 Situation in the WHO South-East Asia Region
Soure: https://experience.arcgis.com/experience/56d2642cb379485ebf78371e744b8c6a
Accessed on 27 December 2021

COVID-19 has impacted different social, economic, and geographical groups differently. The government's responses, be it laws and regulations issued to control the spread, or support provided in forms of recovery and rehabilitation packages demonstrate that little consideration was given to truly address the health and wellbeing of the people with justice. The public health measures deployed to contain COVID-19 were tightly interconnected with the social, political, and economic status of individuals, families and communities, and this interconnectedness exacerbated the unequal access to health prevention, protection and care[5]. For instance, disease control measures like lockdown and movement restrictions impacted migrant workers, the homeless and lower income families most. To address these health discrepancies, it is prudent for the state to execute policies and their implementation which systematically and consciously consider justice in health[6].

1.1 Background on this Health Justice initiative

This Health Justice initiative was conceptualised before the emergence of COVID-19 in facilitated discussions of two academic and technical meetings - the Prince Mahidol Award Conference (PMAC) academic partners with support from the China Medical Board (CMB), and the Commission of Health Justice Asia Beas River Retreat in 2019. Meeting participants analyzed the contexts of Universal Health Coverage (UHC) and factors that led to the occurrence of diseases and issues related to equitable access to health care in Asia. The group agreed on the need to create a new momentum to call for justice in health, with a people-centered focus to reduce health inequalities.

They also agreed to develop a "joint design thinking" whereby academics, and operational partners working in close collaboration with population groups understand the issues from the ground up. To do so, they emphasized on the need for academics working on health justice to collaborate with counterparts from disciplines of social sciences to systematically study the experiences of the people such as the vulnerable populations at the regional level in Asia and at the national level, to capture the rapidly changing socio-economic landscape and to develop policy proposals as well as expand networks of scholars for future health equity agenda in Asia.

1.2 Structure of the report

Thailand's COVID-19 experiences provides an opportunity to document the strengths and challenges related with health justice, within the context of the response to the pandemic, from a systems approach, with consideration on health governance. With seed funding from CMB, the National Health Foundation (NHF) convened a working group to conceptualise a framework for Thailand's health justice and document case studies. Data for this report was compiled from December 2020 to September 2021 from various sources including reviews of academic papers and grey literature such as media and social media discussions. Focus group discussions and interviews with selected public health professionals, NGO representatives, and civil society leaders were also conducted. This was

followed by discussions with wider social groups which generated and expanded public discussions on health justice. The objective was to create a momentum to demand for a systematic consideration of health justice in health governance.

Chapter 1 introduces this health justice initiative and provides an outline of the report.

Chapter 2 draws on the literature of justice to propose a conceptual framework for health justice within the context of the COVID-19 pandemic for considering the documented case studies in Thailand. The conceptual framework is largely derived from Rawls's theory of justice which has been further elaborated by other scholars. Considerations are made to relations between health inequalities, health inequities and health injustice[7] at different levels from the state to individual levels, through analysis within the context of procedural justice, distributive justice and corrective justice. Through deliberations of what justice means, it looks at injustice, to explain that health injustice is multifaceted, and that injustice in health comprises of health inequities and health inequalities, but not all health inequalities are health injustice. This report mainly considers health justice from procedural justice, distributive justice and corrective justice.

Chapter 3 outlines the 7 documented case studies selected to reflect Thailand's governance structure and considerations made towards health justice in the COVID-19 response. The 7 case studies include:

1. National COVID-19 prevention and control
2. Public health resource management: COVID-19 vaccine procurement and distribution
3. Workforce, economy and access to health care
4. COVID-19 and the new normal education with digital divide
5. Urbanism and post-pandemic deconstruction: A sociomaterial analysis
6. Role of the private sector and volunteers in providing humanitarian aid and collective civil society support during the COVID-19 pandemic
7. Role and influence of the media and social media in shaping and addressing health justice in Thailand

Chapter 4 discusses the case studies vis-à-vis the health justice framework with a focus on three major concepts, procedural justice, distributive justice and corrective justice.

Chapter 5 draws a conclusion and recommendations from the discussions.

1.3 Limitations

This report focuses on the synthesis of a practical framework to address health justice through the consideration of the abovementioned 7 case studies. It does not cover all aspects of health or justice theories. The report is based on secondary data obtained through reviews of grey and conventional literature and through discussions with selected groups of experienced persons. The case studies compiled were reviewed in discussions organised during a PMAC side meeting in January 2022 and round table discussions organised by NHF in March 2022. It is largely based on data publicly available during the pandemic. It does not reflect a comprehensive picture of the impact of Thailand's COVID-19 response and does not cover multiple individual experiences faced by different social groups, including women, children, persons with disability, the elderly, and so on. The working group acknowledges the limitations in documenting the different experiences faced in different parts of the country as a result of the pandemic. Data collection for this report was carried out between January 2020 to September 2021, and was drafted and reviewed in May 2022, when Thailand and the world is still in the COVID-19 pandemic.

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2 The Conceptual Framework

Author: Pakpoom Saengkanokkul

Introduction

In health economics, personal health is considered a special good, a product which directly serves to create personal wellbeing, allowing individuals to perform various activities to pursue the purpose of life[1]. Poor health undermines and blocks individual's opportunities. It is therefore important for people to have the choice of living, to achieve their goals[2]. Public policies, public health measures, and social factors influence the distribution of health at a collective level, and the inequalities in their distribution impact social justice[3].

The current spread of the COVID-19 pandemic across the world has impacted people's health, causing unexpected illnesses and deaths. Moreover, measures implemented to contain the spread of the epidemic, including lockdown, have negatively impacted sectors beyond health, like manufacturing, trading, consumption, employment and financial sectors[4], both psychologically and socially. The new normal and social distancing measures have changed the way people interact with one another, exacerbating concerns and uncertainty beyond the spread of the disease. Although the epidemic has impacted all sectors and social groups in society, the level of impact varies between population groups. For instance, the children, the youth and the health care professionals are at higher risk for anxiety[5].

COVID-19 is referred to as a virus of inequality in an Oxfam report. It states that the epidemic has revealed a shortage of state funding the health system, and the private health care services have failed to provide care beyond what is based on the purchasing power of consumers. Marginalised population groups are left with more severe health impact and higher mortality due

to COVID-19. The impact of the pandemic on the education sector has taken back the development of human capital by more than 20 years. Children in lower income countries have not been able to access schools for a continuous period of over four months. Additionally, unemployment levels have risen, leaving millions of people out of jobs, and more than half of the unemployed ineligible for compensation[6].

COVID-19 is an emerging epidemic, with uncertainty. The main challenge in managing this disease is the incomplete understanding of virus and the spread of the disease. This comes despite advancements in medical research and technology, and the international collaboration. The disease has impacted different population groups differently, with varying levels of severity, which raises pertinent questions related to justice. Different concepts of justice may have been applied intentionally or unintentionally in different countries. What is needed is a comprehensive conceptual framework of justice that is fair and equitable to reflect on health justice within the context of the COVID-19 pandemic[7].

1 Literature Review

1.1 Disease prevention and determinants

Risk is defined with a situation where the probability of an outcome can be calculated (both positive and negative), and therefore can be insured[8]. Disease and illness are consequences of health risk. Each disease has several risk factors that work together. Each person has different probabilities of ill health. Health risk is not merely personal risk but are also social risk and can have multiple impact on society, where collective societal management of the risk is needed. To understand risk, it is important to understand disease prevention to reduce avoidable health loss[9].

Important health risk management tools include: 1) financial savings for emergency use or precautionary savings where individuals choose to sacrifice some of their personal finance as savings for future use, in the event of an illness; 2) health insurance, where members of society join together to distribute the health risk by sacrificing and paying for insurance premium, to receive medical insurance in the event of an illness; 3) health prevention, which is divided into 3 levels, which include primary prevention, secondary prevention and tertiary prevention. Primary prevention refers to using various interventions to reduce the likelihood

of a disease, an illness, or an injury. Secondary prevention refers to various interventions taken to detect a disease early, to minimize loss. Tertiary prevention refers to measures taken to reduce further risks of complications, opportunistic infections, or loss or injuries that may arise due to disease infection[10].

The sudden onset of COVID-19 has however taken countries by surprise and the health emergency has gone on for a prolonged period. Since the beginning of the first wave in Thailand in March 2020, it has left individuals unable to plan for sufficient savings to deal with the emergency. The scale of its spread has been wide, resulting in simultaneous disruptions and damages, impacting large population groups. Under such circumstances of risk, obtaining private health insurance is not suitable. The most appropriate primary risk management tool is disease prevention. Prevention of COVID-19 can be divided into 2 categories, through the implementation of 1) pharmaceutical measures, and 2) non-pharmaceutical measures, to reduce spread. Pharmaceutical measures include diagnostics, treatment and vaccination, while non-pharmaceutical measures include masks, temperature screening, maintaining physical distancing and lockdown.

In economics, health prevention is an investment for which the objective is to maximize utility. Individuals invest in health prevention when the marginal utility of prevention is greater than or equal to the marginal cost of health prevention. Optimal health prevention investment model[11] explains that factors such as attitudes towards the risk, prudence, and effectiveness of prevention, can influence an individual's decision on health prevention. This model is based on factors such as education, medical knowledge, understanding, and illness experience. Attitude towards the risk alone can complicate decision-making on disease prevention. Prudence is more sensitive towards risk and can increase the marginal cost of disease prevention. Hence, when more people are involved in disease prevention, the level of fear increases and when the level of fear is high, the level of caution reduces.

The above model is based on rational choice theory. However, disease prevention can be complex because it involves human psychology and the thought process. For instance, low vaccine coverage continues to be observed in multiple places from rural India[12] and in middle-and-high-income countries despite being offered for free by the state. This is due to several factors related to both supply and demand. Supply factors include shortage and lack of widespread vaccine distribution, while demand factors include refusal or reluctance to receive vaccines which is also referred to as vaccine hesitancy, despite available services[13]. The 3C Model: convenience, complacency, and confidence explain that vaccine adherence is a result of complex decision-making which

impacts behaviour, and is derived from complex decision-making processes. The cause of reluctance or hesitancy for vaccine uptake depends on the level of convenience, complacency and confidence. Factors that have strong influence on convenience, complacency and confidence include: 1) factors at the social, cultural and economic levels, the health context, and the political systems. These include media discourses on vaccines and disease spread, religious beliefs, and geographical barriers; 2) factors at individual and family levels, such as vaccination experiences of family members, beliefs and awareness on disease prevention, awareness of risks and benefits of vaccines, and knowledge and awareness on disease spread and vaccination; and 3) factors related with vaccines such as price, supply, efficacy and risks of vaccination, management of the vaccination process, including logistics related with transportation and distribution of vaccines, and provision of information by health care providers. Communication is an important component of the decision-making process. Poor communication can lead to reluctance or hesitancy despite the availability of supplies and the readiness in vaccine distribution[14][15].

Disease prevention impacts large population groups despite being based on decision-making processes of individuals. Public health measures are required to control the spread of disease outbreaks, particularly in the context of the pandemic, where the state has a role in managing the crisis at the national level. Preparedness of the public health sector is important to reduce the spread of an epidemic. Atun et al. proposes a multifaceted assessment and evaluation of the preparedness of health systems which include political, legal, social, economic, population, financial, health management, source management, and resource distribution dimensions[16]. A pre-existing well-managed health system will facilitate the development of new structures and immediately link with the newly established disease prevention systems during outbreaks. Additionally, disease prevention programmes should be regularly assessed for their readiness in different aspects, including the finance, the resources, the allocation and distribution of health services, information management, communication systems, and other issues relevant to disease prevention.

1.2 Health determinants and health services

Health is a durable good and we obtain benefits from good health daily. Investment in health is required to slow down its deterioration. Health is also considered a capital, which can be reproduced. Health is, however, an indivisible and a non-transferable good. Instead of redistributing health directly, many interventions are aimed at redistributing health determinants[17]. Healthcare is an important determinant of health. It can directly promote, maintain, and restore health. Health services can be distributed and exchanged under market mechanisms. Access to health services, therefore, depends on price and affordability. The state has a role to play in the distribution of healthcare services, because the difference in usage among different population groups can lead to health inequality. The state can provide healthcare in the form of universal health insurance to avoid dependence primarily on private service providers and the market force. Services related to health are complex and relate with multiple factors, including health systems, population demographics, epidemiology, socio-economic, and other factors, all of which influence the utilization of health-care services[18]

The expansion of universal health insurance and development of medical technology does not lead to equitable distribution of health[17] because health determinants are complex and related with factors beyond healthcare. Several studies have been conducted to consider frameworks for health determinants, including social health determinants of Dahlgren and Whitehead which divides health determinants into 4 levels: 1) individual and lifestyle factors, such as genes, sex, ethnicity, health behaviour; 2) social and community networks, such as social security and community networks; 3) working environment and living conditions, such as type of occupation, income, occupational safety; and 4) macro level factors, such as the economic system, cultural system, and public policy, which determine different levels of health among different population groups[19]. For instance, smoking is considered as an individual factor which increases the

risk of lung cancer of individuals, but such behaviour is supported by community level factors which can influence smoking, like residing in communities where smoking is considered a community lifestyle, or a norm in the working environment, or a habit picked up as a result of dealing with high risk or stressful situations. Such behaviours continue to be observed despite government policies and campaigns against smoking.

Wagstaff's conceptual framework of health determinants is like that of Dahlgren and Whitehead which divides factors into 3 levels: 1) proximal factors that directly impact health. These include households and communities, comprising of household assets, both physical and financial, use of health services, diet, sanitation, cultural norms, community institutions, social capital; 2) intermediate factors, which include health systems and other relevant systems like basic infrastructure, health financing, production and distribution of health services, and procurement of supplies like pharmaceuticals, clean water, and food. These intermediate factors influence proximal factors like the distribution of medical personnel based on population groups. This impacts the differences in use of health services among different population groups; and 3) distant factors, which include government policies and actions like economic policies, health policies, and investment in national infrastructures, whereby policies impact the functioning of the basic health infrastructures such as the policy changes in remuneration for health workers which impacts the distribution of new health personnel in different locations[20].

The framework on social determinants of health has been expanded by the Commission on Social Determinants of Health (CSDH), established in March 2005 by WHO, to include: 1) mental-social analysis; 2) economic -social-political health context analysis, and social impact related to illness; and 3) socio-economic framework and the multiple levels of analysis to designate and classify groups of health determinants. These provide explanation for unequal distribution of health. This framework divides health indicators into 2 groups which include structural factors of health inequality, and the intermediaries of health determinants. Structural factors are difficult to change and include socio-economic-political contexts, like the pastoral system, macroeconomic policy, social policy, and other public policies and values or social culture. The structural factors clearly divide society into different levels with negotiating power and resources for security such as educational inequalities which resulting from economic and social discrepancies. Structural factors of health inequalities determine the directions and work through the second group of factors, which include the intermediaries of health determinants that lead to unequal health outcomes. Intermediate factors that determine health outcomes include: 1) material environment, such as living

and working conditions, and access to food; 2) health behaviours and biological factors, such as genetics; and 3) psychosocial environment, such as stress, relationships with and support from surrounding people, etc. The social structure of class, such as education, income, and ethnicity, puts each class at unequal health risks. Generally, the disadvantaged are at higher risk of serious illnesses and their recovery is much slower than other social classes. They also face with higher adverse economic impact. Measures to reduce the health gap should therefore be taken at several levels, including system-wide policies aimed at reducing social stratification; macro level policies aimed at reducing chances of getting sick and exposure to diseases for disadvantaged populations, community level policies aimed at reducing severe impact of illnesses for the disadvantaged groups, and at individual levels aimed at reducing disparities that accompany the illnesses such as loss of income due to absence from employment[21].

The abovementioned model considers a wholistic approach at the macro level from structural to individual factors which is different from the Community Organization model where emphasis is placed on basic community structures, the community and members of the community who are key actors who determine health. Community members are assisted to define common health problems, to devise processes for change, to mobilize resources and to develop action plans to achieve common health goals. A community can be both a geographical community and non-geographical community, where members are linked in terms of identity, such as race, language, etc. To encourage community engagement, the community should have the capacity to convince members to participate and to empower members to learn and solve problems. An open forum should be established where everyone can express their opinion and accept different views. The decision-making power of the community should be shared[22].

1.3 Health justice

According to Rawls, health is an essential primary social good needed by all free and equal human beings, for participation in societal activities[23]. Daniels proposes that healthcare should also be a primary social good because healthcare directly affects health and equitable allocation of healthcare should be respected[24]. Health is complex and is determined by multiple factors, including socioeconomic determinants. Inequality in healthcare can adversely impact the health status of individuals and their equitable opportunities. According to Wagstaff and van Doorslaer, equity in health system can be analysed from 1) health equity; 2) healthcare equity; and 3) health financing equity[25].

Although equal distribution of health is important, it is not necessarily considered fair. For example, females have an overall higher life expectancy rate than males due to various factors, and it would be unreasonable and unfair to lower the life expectancy rate of females by restricting access to healthcare. In certain situations, health inequalities can be justified. Whitehead proposes a distinction between equality and equity by defining health equality as not necessarily leading to equal health, while health inequity is the unnecessary and avoidable differences in health, which is judged as being morally unjust[26].

Anand argues that justice should go beyond equality or equity because such framework considers only comparative justice and distributive justice, which compares levels of health between different populations[7]. Health justice is multifaceted. Other than mere comparison of levels of health, it includes procedural justice, substantive justice, corrective justice, and so on. This document will specifically analyze procedural justice, distributive justice, and corrective justice.

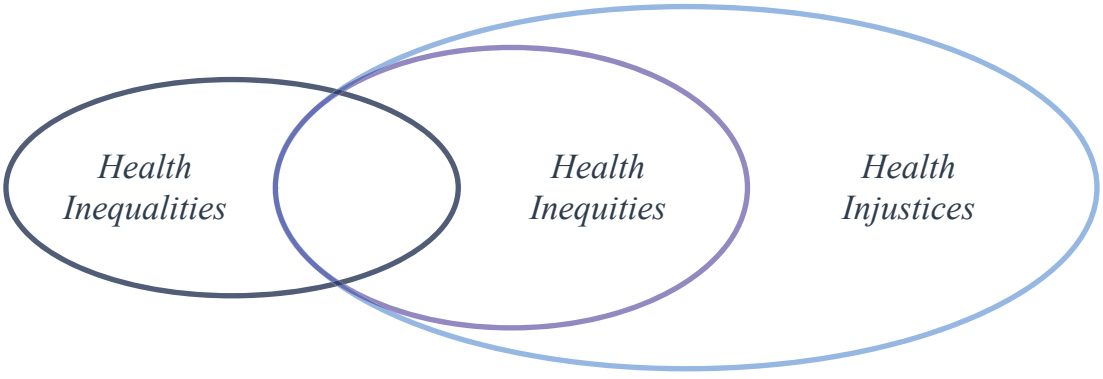

Figure 1: The relationship between health inequalities, health inequities and health injustices. Source: Anand, S. The Many Faces of Health Justice.

Procedural justice refers to the justice involving the process which leads to benefits, resources, and responsibilities. It is concerned with how these benefits and resources are distributed to individuals. In other words, procedural is justice in the process of the distribution of resources, benefits, and responsibilities. Procedural justice therefore prioritises the pe-distribution process rather than the outcome of the distribution where results of the distribution may not at all correlate with procedural fairness. Procedural justice can be classified as 1) perfect procedural justice, which is justice of outcome that relates with procedural justice; and 2) imperfect procedural justice, which is justice of outcome that does not relate with procedural justice[23].

Procedural justice consists of 6 characteristics: 1) accuracy, where all decisions require accurate and up-to-date information; 2) consistency, where rules and regulations set by policymakers must be consistent; 3) impartiality, where decisions must be free from conflict of interest; 4) reversibility, where in certain conditions, decisions can be challenged and questioned; 5) transparency, where the policy-making processes must be transparent; and 6) voice, where opportunities are given to stakeholders to express opinions and to participate[27]. Daniels emphasises why procedural justice is important in health policy processes. He argues that fair distribution of health and healthcare should not be based solely on utilitarianism which prioritizes maximisation of social utility. Public policy processes should be fair. There should be 'transparency and participation', public access to information or what is referred to as 'publicity condition'. Decision-making should be based on reasoning, empirical data, and generally accepted principles or 'relevance conditions'. There should be mechanisms for complaints and review of decision-making or 'revision and appeal conditions'. These principles described should be implemented under 'regulative conditions'[24].

Procedural justice is even more important under circumstances where health resources are limited and cannot be distributed evenly. Prioritisation must therefore be made, particularly in the context of the COVID-19 pandemic where there is high uncertainty in terms of the virus itself or the availability of resources like vaccines. Such uncertainties create expectations, and therefore requires transparency in policy decision processes, including the process to review prioritisation of vaccines when the outbreak situation changes. Transparency in communicating with the public on both the benefits and risks of vaccination provides an avenue for explaining reasons for the policy decision, including prioritisation. Communication can also facilitate public acceptance and reduce dissatisfaction of the vaccine distribution process[28].

Distributive justice means equitable, equal, and appropriate distribution of resource, where decisions are made with fair value judgement. Distributive justice is therefore concerned with the outcome of the distribution of resources. Resource allocation includes materials resources such as income, healthcare; and intangible resources such as political rights, social rights, and duties. Distributive justice concerns with the allocation of benefits, resources, and processes within which these resources are distributed by those who have the authority or power to distribute. Distributive justice therefore concerns with those who are responsible for the distribution, the recipients, and the processes involved. The concepts used in distributive justice is further explained under sections 2.3 and 2.4, which also explains the reason for different outcomes between health and health services.

A conceptual framework is needed to help determine equity in the decision-making processes. The concept of distributive justice has been variously proposed. Beauchamp and Childress divides the theory of distributive justice into four groups[29]:

1. Utilitarian theories, where just distribution is based on the principle of utility. Distribution does not have to be based on the market and voluntary exchanges. Coercive power or government interventions are allowed to intervene. The purpose of distribution, for instance of health or health resources are to maximize social utility. However, this concept of justice may raise questions on protection of privacy and private property. In addition, in certain situations, the distribution process aimed at obtaining maximum social utility may lead to the emergence of some groups being losers, while others as winners.
2. Libertarian theories, where just distribution is based on voluntary exchanges and the market. The role of the state is to protect private property and freedom. Individuals know their needs best and make their own decisions on whether to participate or not. Distributive injustice in society can be resolved through individual voluntary contributions. In addition, in some cases, liberal principles do not necessarily conflict with utility principles or other principles of justice if such principles align with liberty.
3. Communitarian theories, where society is of pluralistic nature, the concept of justice is diverse in each community. Health is an issue of individual and community responsibility. Local traditions should be included in health and healthcare allocation. Community members should be involved in community health justice decisions.
4. Egalitarian theories, where the distribution of resources must be equal for all groups (equality of outcome). However, unequal distribution is also permitted under certain conditions, and is considered fair. For example, Rawls proposes the difference principle whereby unequal distribution to favour the most vulnerable populations in society is considered to be fair and equitable[23]. Another example is Sen's capacity approach where justice is achieved when the distribution process provides choices to individuals, and these choices lead to changes in outcome that leads to being well[30]

There are several principles on allocation of resources for health: 1) principle of efficiency by distributing resources, which considers little production factors with maximum results; 2) principle of necessity or the needs approach of distribution, where resources needed for health, such as patients requiring organ transplant should be given medical treatment for organ replacement; 3) principles of

the right to health, where distribution of resources are based on rights and duties indicated by law; 4) principles of affordability, where distribution of resources depend on the affordability, and those who can afford have greater health payment burden; and 5) principles of equal opportunity[31].

For Wagstaff and van Doorslaer, equity in health financing is based on vertical equity. Those who can afford more are responsible for more health expenses. By contrast, equity in healthcare is based on horizontal equity. Those who have similar health needs must receive similar healthcare, for example, people with the same diseases deserve the same treatment. For equity in health, only health disparities resulting from socio-economic factors, such as income, education, etc. should be considered as unjust[25].

For Anand, equitable allocation of health, healthcare and well-being can be based on several principles: 1) equality. For example, health levels should be equal; 2) priority. Certain individuals, or groups have priority over others; and 3) sufficiency. The distribution is not necessarily equal but can be different by providing enough for every person. For instance the distribution of health services according to the level of health needs of each individual[7]

Sections 1.1 and 1.2 indicates that macro-level, policy level, family and community level factors, and personal factors can impact disease prevention, health distribution, health services and the varying principles of distributive justice theory. The study of justice, health and welfare therefore does not only consider equal outcome of health, but also the inequalities. This is because in certain cases, they are acceptable and justified. To clarify what inequality is considered fair and acceptable, health determinants are divided into 2 categories: 1) effort related variables or variables with personal influence such as personal taste; and 2) circumstantial variables or variables outside of personal influence such as public policy. The disparities caused by effort variables would be acceptable and fair, while the disparities caused by circumstances are unjustified[32][33][34].

When injustice is derived from different variables, rewards and compensations are considered[33]. The principles of rewards are based on injustice. This include variables of effort, which does not need to be intervened with. It is considered fair for an individual to have better outcome than others, because the rewards are a result of their own effort. For instance, an individual with good health outcome because of daily physical activity is considered fair and there is no need to intervene to reduce their health outcome to the same level as others. Compensation is based on considerations where compensation is needed when injustice is caused by circumstantial variables. For instance, the poor have less opportunity to access healthcare than

the rich, which is unfair, and they should be compensated to the level where they can have access to healthcare like others.

These variables can, however, be switched based on the type of theories considered for distributive justice. For instance, in libertarianism, individual behaviour is an effort variable, where individuals who make decisions are responsible for the consequences, and the outcome is therefore considered fair. An example is heavy smokers should be responsible for their own health expenditure. However, when considering the circumstantial variable, smoking could be influenced by the social structure, where smoking rates are highest among labour groups, reflecting that smoking is influenced by surrounding circumstances, and therefore, part of their healthcare should be a social responsibility.

Corrective justice concerns with bilateral relationships between two parties, the violator and the party whose rights were violated. The party involved with violation of the other party's rights intentionally or unintentionally can lead to loss and the loss can occur through interactions that take place regardless of whether the violator benefits from the violation or not[35]. Corrective justice can lead to protection of entitlements defined under distributive justice[36]. However, there are some differences in the concepts. Distributive justice concerns with interventions between multiple parties and includes decision-makers for the distribution of resources, and multiple actors involved in receiving the resources. Distributive justice is therefore applied to social institutions to achieve equitable resource allocation[35].

By contrast, corrective justice is based on equality between the wrongdoer and the victim, similar to a mirror reflecting one another[37]. When the wrongdoer benefits from the act which impacts the victim, corrective justice is considered, making the wrongdoer return the benefits to the victim or to reverse to the original position before the act of violation[38]. Corrective justice compensation is applied when injustice is caused between private entities and appears in civil law, and tort law. Corrective justice does not necessarily lead to distributive justice. A clear example is when a poor person robs assets of a rich person, which is an act of wrongdoing and leads to loss. To return to the situation prior to the wrongdoing, the poor person must return the assets to the rich person. The situation of injustice related to unequal distribution of resources or assets between the rich person and the poor person remains.

In certain situations where the wrongdoer is not a private entity, but a state party who commits fault or causes harm to a private entity, the state can exercise immunity in state liability as a public authority, by issuing policies and not take responsibility for the fault. Under such situations, the victim does not have any right to demand for compensation. The immunity in state liability is beneficial in economic terms, as it protects the loss of

the state budget which may be used for compensation due to the act of wrongdoing on the part of the state. It also avoids inactions on the part of the state, for if the state for fear of doing wrong[39].

Immunity in state liability has however, been criticized and recommendations have been made for its removal. It can for instance provide the state with an incentive to be more careful of the wrongdoing and reduce the incentive for the state to do wrong[39]. In some cases, the state accepts liability, such as 1) infringement liability, so that there is a clear distinction between the violation caused by officials or by the state. It provides the state with guidance on protection of rights and liability of the people which is the responsibility of the state. These include principles for control over the administrators, principles for protection of the rights and freedom of the people; 2) liability without guilt. This is to supplement the remedy for serious damage that has not been committed by any party, be it the state or private individuals. For social reconciliation, all members of the society must be responsible for the damage, such as loss caused by public policy[40][41][42]. Corrective justice can be applied for medical liability. For instance, in the case where a patient is victimised by reckless medical care on the part of a doctor, or a doctor being medically liable without wrongdoing.

2 Conceptual framework for health justice within the context of the COVID-19 pandemic

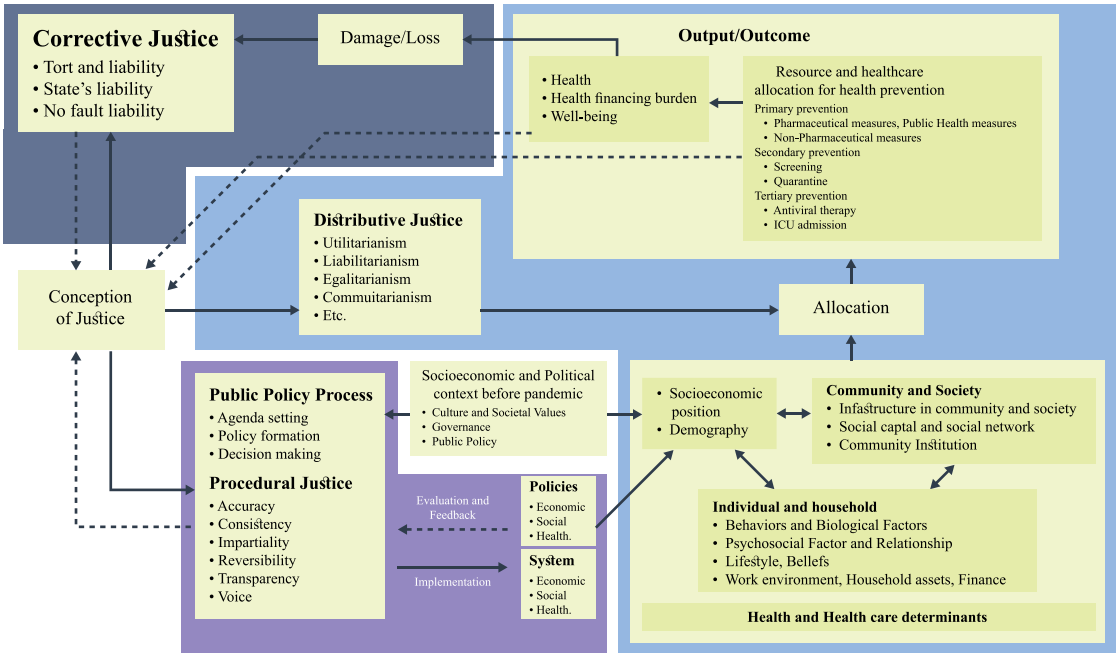

Figure 2: Health justice conceptual framework within the context of the COVID-19 pandemic
Source: synthesized by the author

Figure 2 shows the conceptual framework or health justice in the context of the COVID-19 pandemic developed by considering the concepts of disease prevention and factors related to decisions on disease prevention, determinants of health and health services, and health justice. It describes factors at different levels including the state, the society, the community, the family and individual levels, which interact and combine, resulting in diverse distributive outcomes in different population groups. This report describes different forms of justice through the analysis of the concepts of procedural justice, distributive justice and corrective justice.

2.1 Concept of justice

Pluralistic societies comprise of members with diverse ethnicity. Justice is intuitive for human beings, whereby feelings and reflections are exercised upon encountering events where justice is questioned, and where processes are employed to rethink the event when the situation changes. The concept of justice is diverse for different individuals who may have similar or different characteristics. To elevate the level of justice from individual to societal levels, it is necessary to identify similarities and differences within different concepts of justice of the collective, to obtain an equilibrium between the differences. Every individual has equal rights and freedom to participate in the process which ultimately leads to a conclusion. A consensus is eventually reached, and the conclusion of the conflict leads to concrete actions[23].

Daniels explains the difference between narrow reflective equilibrium and wide reflective equilibrium, with the first being controversial when an individual's moral judgement is challenged by the changing circumstance, or by other moral principles which leads to a reconsideration, or an adjustment of the moral decisions made. A narrow reconsideration provides specific answers to specific cases related with justice rather than general consideration which are widely acceptable. This is different from a broad equilibrium review which considers moral decisions from an individual's personal perspective and from the perspective of others. This leads to coordination and challenges, involving diverse ideas derived from different moral decisions and stands of different individuals, influenced by different experiences and limitations. The broad equilibrium is a characteristic of a social contract where a consultation process is required to bring about consensus among various competing ideas of justice within a free and fair social structure[43] [44].

In the COVID-19 situation, different parties have different opinion, with each having different perspectives sometimes with conflicting proposals on justice. Measures to deal with COVID-19 should therefore not be emphasized on the concept of utility which only considers disease control, but should also consider justice from other perspectives, such as equality or freedom. Concepts of procedural justice and corrective justice need to also be considered.

2.2 Policy process

The outbreak of COVID-19 is considered a national problem. The government's public policy therefore plays an important role in managing the crisis and requires the involvement of multiple agencies. Its impact has been acute, and several governments have exercised their power under the emergency situation in managing the crisis[45]. Accuracy, consistency, impartiality, transparency, reversibility, and voicing are principles of procedural justice which can support the development of policies that are reliable to the public (see procedural justice, section 1.3). Such principles can be applied under various steps in the process of designing policies which include agenda setting, policy formulation, decision-making, implementation, policy assessment, and policy review and provision of recommendations[46].

In addition, the production of public policies to cope with COVID-19 needs to be considered along with the economic, the social, and other relevant public policies because the spread of the pandemic and the measures for its control are not exclusive to health, It is also concerned with social security and the economy, as can be seen in the measures required like allocation of medical resources, communication and information provision, which requires the state and private sector involvement. The extension of lockdowns has severely impacted the economy and requires balancing the benefits and losses of the disease control measures enforced. These measures are also linked with the political, the economic, the social and the welfare systems. For instance, lockdown measures should be implemented with a good welfare system to encourage the people to comply with the measures.

In the Figure 2, the dashed arrows extending from procedural justice represents the process for reviewing procedural justice to again develop concepts of procedural justice.

2.3 Health and healthcare determinants

Each country has different social, economic and political contexts, namely culture, social values, political systems, government and public administration, with varying public policies. These determinants of structural health establish and maintain hierarchies (see CSDH Conceptual Framework in Section 1.2). Under disease outbreak situations, the population is divided into different groups according to their economic, social, political positions, such as educational levels, race, income, occupation, etc. Such social stratification also reflects the power to participate and

negotiate in the distribution of resources, resulting in different policies for different population groups.

Other factors that impact disease prevention and health determinants include family, social and individual factors (see Sections 1.1 and 1.2). Structural-level factors coordinate with health (services) determinants at community and social levels, such as community values, strength of social networks, social capital, community infrastructure, management of public and private spaces in the community, etc., and coordinate with individual and family level factors such as behavioural health factors and individual biological factors, psychological factors and family relationships, lifestyle and health behaviours, access to health services, influence of family members on disease prevention and illness experience, etc., all of which impact decisions on disease prevention and the distribution of health.

The 3 determinists of health are interconnected and assigned different distributive outcomes in different population groups. For instance, disease control policies that mandate the closure of public areas such as flea markets greatly impacted urban poor communities because markets are commercial areas for accessing food, for meeting people and is a way of life for local communities. The closing of flea markets also affected income and food security of households in the community. With lack of state support in terms of income, food or transportation, the probability for the people to comply to such state measures are low, thus further expanding the outbreaks.

2.4 Resource and healthcare allocation for health prevention

The primary level objective for disease prevention is to reduce the risk of contracting the disease through the deployment of various pharmaceutical and non-pharmaceutical measures such as vaccination, use of personal protective equipment (PPE) including masks, hand sanitizers and provision of public information and knowledge on disease prevention, etc. Different determinants of health lead to different levels and types of distribution of health services and health resources to different population groups. However, such differences do not always lead to injustice. The concept of distributive justice is therefore required to determine whether their values can be justified or not. The concept of distributive justice is diverse and includes utilitarianism, liberalism, communitarianism, and other schools of thought, where different actors may employ different concepts of distributive

justice. For instance, the government that focuses primarily on utility and disease prevention will employ measures to limit high-risk activities such as limiting eating in restaurants or limiting the opening of entertainment venues. From the state's perspective, such discriminatory measures are justified, while the entrepreneurs who are impacted by such measures may perceive it as unfair and discriminative.

Distributive injustice can also be based on rewards. Rewards can be made in favour of certain population groups who sacrifice for public good, for instance rewards in the form of provision of more masks and other PPE materials to frontline workers who sacrifice and risk disease infection. Such forms of distributive justice is in line with utilitarianism because it involves the distribution of equipment for disease prevention for large groups of people at risk.

The secondary level objective of disease prevention is aimed at early detection of illness to reduce loss that may occur due to the spread of the disease. Important measures include distribution of COVID-19 screening tests, isolation of infected persons from the non-infected and quarantine of persons at high-risk. Disparities can be observed in the secondary level disease prevention, where the concept of distributive justice should be employed to consider whether the value given can be justified. For instance, in the case where the government sets out criteria for providing free-of-cost testing for COVID-19 which is accessible only to those with predefined symptoms, considered to be of high risk due to exposure with a COVID-19 patient, and where the free testing is not extended to all population groups[47]. This is based on the principle to maximize the use of limited resources. Those who do not fit the criteria are considered ineligible for free COVID-19 tests and must pay out of personal pocket to obtain a test from the private sector. This leads to a financial burden, particularly for the poorer populations, thus putting them at higher risk of contracting the disease.

Patients with mild COVID-19 symptoms were advised by the government to maintain social distancing, including at home. They were asked to stay in separate rooms from other members of their family to practice universal precaution. However, for poor families, these measures put the whole family at high risk of infection because of the limited household spaces. This example of narrow reflective equilibrium allows for a review of individual case-specific, value-based decision-making. However, the distribution of health resources and services changed according to the situation and circumstances, thus resulting in large numbers of people benefiting and losing from such distribution of resources. It is important to find an equilibrium from a wide perspective, for the outcome of such distributions (indicated with dashed arrows in Figure 2), to reduce levels of differences

in opinions. This includes reviewing of health resources, distribution policy, and implementing a new policy with new distribution processes for fairer distribution.

Tertiary level objective for disease prevention is the post disease infection prevention measures which is aimed at reducing illnesses caused due to COVID-19 and subsequent deaths. Since Favipiravir was the main antiviral for treating patients, all patients whose conditions deteriorated should have access to the medication, the specialists and intensive care as needed. However, the cost for such medical services was high with limited availability. This resulted in large outbreaks with large numbers of patients with severe conditions, and a health system unable to cope, to provide equitable care, thus leading to prioritization, or the employment of sufficiency principles (see Distributive Justice in Section 1.3).

For instance, Favipiravir, an antiviral, was fairly distributed to all patients without discrimination, based on their disease symptoms. Such distribution, considered under equality principles, would immediately be questioned under conditions of shortage of the drug. Equal distribution may not be useful for treatment if the amount each patient receives is insufficient for their treatment. Therefore, other principles of justice should be considered for the distribution of new drugs, for example, distribution based on classification of symptoms or patients' conditions. Patients with higher levels of disease severity, with higher risks should be prioritised for the drug, while supportive care may be considered for patients with lower risks like the younger population who may develop mild symptoms.

Decisions on the management of limited health resources under outbreak situations often lead to stress and mental exhaustion because the decision-makers bear moral responsibility. Decisions to treat one patient may lead to the certification of another patient's death. For this reason, having clear evidence and scientifically sound guidelines are important for medical personnel, to help facilitate their decision-making. Such guidelines should be regularly reviewed as needed (shown as dotted arrows in Figure 2)[49].

2.5 Health, health financing and wellbeing allocation

Different levels of access to COVID-19 prevention measures lead to different health outcomes. They lead to different health expenditures and welfare, including income and freedom. It is therefore necessary to consider whether such outcomes can be

justified. We can employ justice principles of vertical equity of health financing, where persons with more distributive power should have more responsibility on health finances. This means the state, which has the responsibility for distribution, should consider progressive taxation in their budget for managing COVID-19. Alternatively, the horizontal equity of health can be considered, where health disparities arise due to socio-economic factors. For instance, the poor have more difficulty in purchasing PPE, which puts them at higher risk of contracting the disease, developing the illness, and suffering from health deterioration. States could also employ principles related with determinants of health, with effort variables and circumstance variables where inequality from efforts is considered fair, and equality from circumstance is considered unfair. For example, the decision not to wear masks is a personal choice and in case of infection and worsened health conditions, individuals making those decisions should be responsible for their own health. However, if the act of not wearing masks is partially due to shortage of masks, which is a circumstantial factor, the deterioration of the person's health due to infection is partially unfair.

When considering distributive justice, the outcome leads to a review and improvement of the theory of justice (shown in Figure 2 as dotted line from the health outcomes/ health expenditure/other benefits). For instance, if distributive injustice is caused by the government's policy it should be reviewed to improve the government's policy towards more justice.

In addition, when considering health outcomes under distributive justice, the burden of health expenditure and other benefits should be separated from outcomes caused due to violation, which is considered based on corrective justice. The objective for considering corrective justice is to help compensate those who are impacted. Compensation can take the form of civil violation, involving private entities as perpetrators and victims. For example, when two parties entre into a contractual agreement on the purchase and delivery of substandard masks which can lead to COVID-19 infection.

In the event where the damage is caused without a wrongdoer, and there is no compensation process, the loss is caused could be due to unpredictable uncertainties, and the damage caused is too large for one person to take on the responsibility. In such situations, society joins in to help with reconciliation. For instance, loss due to adverse effects of COVID-19 vaccination, where the government should have a policy for guilt-free compensation provided by the state (see Corrective Justice in Section 1.3).

The management of COVID-19 requires public policy management under the responsibility of the state, with no liability for infringement. Some measures such as the lockdown can however affect freedom of movement and the right to work, which are fundamental human rights. People should therefore be able to file lawsuits against the state. For instance, in France, several lawsuits have been filed against the state for unintentionally causing deaths and illnesses due to the COVID-19 measures, and the lawsuits were referred to the judicial process for further investigation[50]. Lessons learnt must be reviewed (shown in Figure 2 as dotted lines out of Corrective justice box) and further development of corrective justice framework should be considered along with the concerned policies.

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3 Case Studies

Introduction

COVID-19 has impacted all aspects of society. It has revealed both the strengths and weaknesses of the social order which has been disrupted as a result of the spread of the pandemic. The social order has been exacerbated by the implementation of measures to prevent and control the spread of the disease. It has introduced new norms for which all sectors of society have had to adjust. It has taken policy makers by surprise and has given them the power to make immediate decisions to deal with uncertainties.

This chapter documents Thailand's COVID-19 response through the illustration of 7 selected case studies, with the lenses of health justice. It deploys the health justice framework conceptualized through review of the relevant literature on justice, health and determinants of health, as discussed in the previous chapter. The documentation presented through these case studies consider the 'ecology of governance' within which Thailand's COVID-19 experiences have evolved from the time of the first reported infection in the country in January 2020, up to the end of the data collection period in September 2021. These cases do not represent all aspects of the pandemic, the response and their consequences, as the data collection process was done during the pandemic, and the intensity of its spread continues during the production of the report.

The first case study documents the national COVID-19 prevention and control. The second case study documents the public health resource management through illustration of the COVID-19 vaccine procurement and distribution. The third case study documents the workforce, the economy and access to health

care. The fourth case study documents COVID-19 and the new normal education with digital divide. The fifth case study documents urbanism and post-pandemic deconstruction through a social material analysis. The sixth case study documents the role of the private sector and volunteers in providing humanitarian aid and collective civil society support during the COVID-19 pandemic. The seventh case study documents the role and influence of the media and social media in shaping and addressing health justice in Thailand.

These case studies have been discussed in various forums, where analyses and reflections were made through the Health Justice Framework to conceptualise and propose recommendations for systematically considering health justice in Thailand's public policy development and implementation.

Case Study 1

The national COVID-19 prevention and control

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Introduction

At the outset of the spread of COVID-19 in early 2020, Thailand's Ministry of Public Health (MOPH) was proactive in establishing mechanisms to monitor the epidemiological situation, and implement control measures like screened passengers entering the country. They disseminated information on the situation and health protection measures through the social and mainstream media. The Emergency Operations Center (EOC) was activated on 3rd January, 2020. The Department of Diseases Control (DDC) coordinated with airport authorities and set-up thermal scanners to screen in-coming passengers from China. This led to the detection of the first patient on 8th January 2020 who was confirmed with COVID-19 on 13th January 2020 through genomics sequencing carried out by Chulalongkorn Hospital and the Department of Medical Sciences, in collaboration with China's Wuhan University[1][2].

The number of people detected through screening at international airports in the country rose in March 2020. By then the MOPH expanded their COVID-19 surveillance from international points of entry to hospitals and local communities. COVID-19 was declared a 'dangerous communicable disease' under the Communicable Diseases Act 2015 on 26th February 2020 which obliged hospitals, public and private, to report cases to MOPH[1]. The network of village health volunteers (VHV) was activated in all provinces, with the responsibility to ensure community level screening, whereby those entering or returning to villages had to undergo mandatory home quarantine for at least two weeks[3]. On 12th March 2020, Prime Minister Prayut Chan-o-cha established the Centre for COVID-19 Situation Administration (CCSA) to coordinate the national COVID-19 response under his leadership and on 25th March 2020, declared a State of Emergency in response to the COVID-19 situation[4].

This case study considers the national response to COVID-19 with the CCSA as the main actor, in its capacity as the key governing body that provided leadership, coordination and communication in managing the COVID-19 pandemic in Thailand. It reviews laws and regulations issued to control the spread of COVID-19 and asks whether these were necessary, justified and led to the prevention, control and mitigation of the impact of the pandemic. It considers the coordination mechanisms established under the CCSA and the basis within which the coordination or its lack of was revealed in the responses carried out by different ministries and organizations. It discusses the role of the CCSA in communicating pandemic related risks and its responses to the public's concerns. This case study asks whether any, and if so, what measures were taken by the government to consider justice in health in the COVID-19 response.

Deliberations

The CCSA has full legal and operational authority in managing the COVID-19 response in Thailand. All ministries are represented at the senior most levels in this committee. The CCSA comprises of 34 ministers and senior civil servants from the Office of the Prime Minister and ministries including Public Health, Defense, Foreign Affairs, Tourism and Sports, Social Development and Human Security, Science and Technology, Education, Agriculture, Transport, Digital Economy and Society, Natural Resources and Environment, Interior, Justice, Industry, and Royal Thai Police. Additionally, the prime minister also set-up a committee of experts to provide technical advice, most of whom are retired civil servants[4][5][6].

Legitimization of authority

The regulations and announcements issued by the prime minister and CCSA since March 2020 are based on the 2005 Emergency Decree aimed at imposing public control and restrictions more than facilitating collaboration and seeking cooperation under emergency situations. The CCSA was established the CCSA on 12th March 2020 to oversee the EOC of the MOPH which was active since mid-January 2020. Gen Prayut issued the first declaration on a nationwide State of Emergency on 25th March 2020, authorizing himself with power to override his cabinet ministers in enforcing regulations related to COVID-19. This announcement was initially declared until 30th April 2020 and extended 13 times until 30th September 2021. From 25th March 2020 to 25th August 2021, the Prime Minister issued 1 Declaration, 43 Announcements, 31 Regulations and 36 Prime Minister Orders[5][6], the necessity of some of which are questioned publicly.

CCSA's Administration Structure

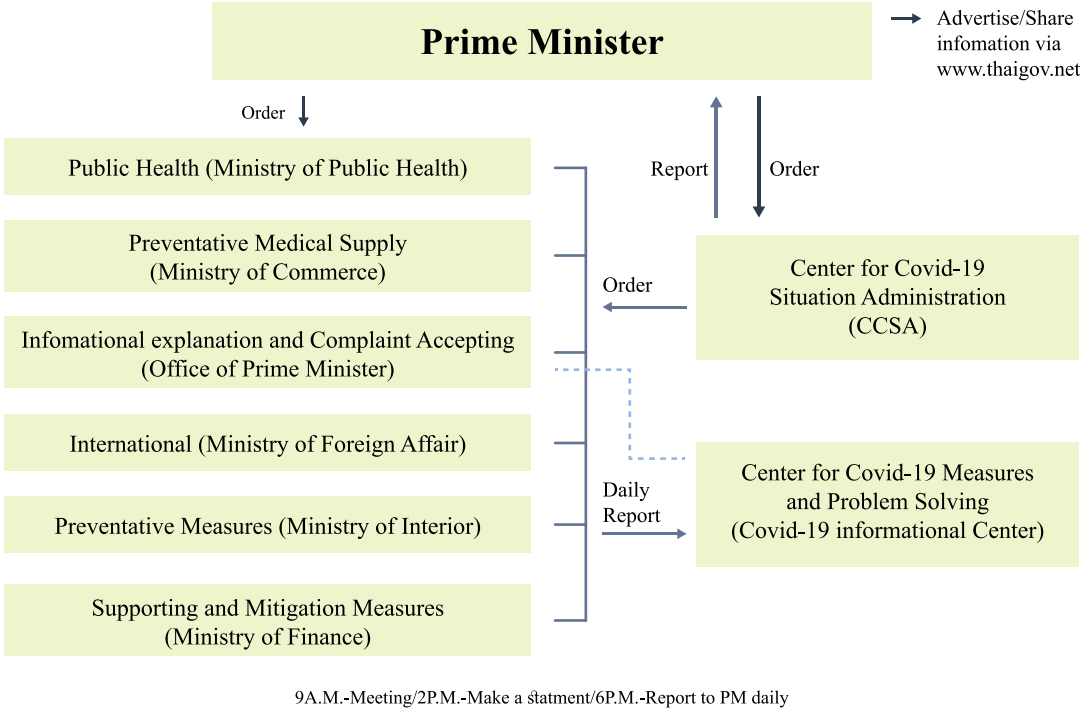

Figure 1: A translation of the structure of the CCSA administration provided on the Royal Thai Government website.
Source: https://www.thaigov.go.th/news/contents/details/27471

Between 26th March 2020 to 25th August 2021, the State of Emergency announcement was renewed 13 times, all of which was followed by declaration of curfews, restricting movements during night to early morning hours. The first regulation, issued on 26th March 2020, announced closure of international points of entry and public recreational and entertainment venues. These included boxing stadiums, sports arenas, playgrounds, pubs, restaurants, theatres, and other sites in Bangkok and vicinity provinces including Nonthaburi, Pathum Thani, Nakhon Pathom, Samut Prakan and Samut Sakhon. Hoarding goods such as medical supplies, medicines, food, drinking water and daily consumer items was prohibited. Public gatherings and control over dissemination of fake news or misinformation deemed to cause fear or misunderstanding was prohibited. The public were asked to stay at home and avoid unnecessary inter-province travels[6].

The Prime Minister issued 3 orders on 25th March 2020, 26th May 2020 and 27th April 2020 to temporarily transfer legal authorities of various ministers to himself,

overruling their authorities in managing their civil servants. The government decisions made on the COVID-19 response were largely prescriptive and based on centralised decision-making. Provinces under varying outbreak situations were categorised under various colours which were revised from red (highest controlled areas), orange (controlled areas), yellow (highy monitored areas) and green (monitored areas) in December 2020 to dark red (highest controlled and restricted areas), red, orange and yellow[7] in July 2021, as provinces moved from no reported cases to reporting a few cases).

Border control requirements and exemptions for diplomats

The Civil Aviation Authority of Thailand raised restrictions on incoming travels from 19th March 2020 through the enforcement of guidelines requiring Thai nationals to obtain 'fit to fly' certification within 72 hours before departure, along with an endorsement from the Thai Embassy or Consulate. Foreigners had to present a negative COVID-19 certification obtained within 72 hours prior to travel along with a health insurance coverage of 100,000 US dollars. On 26th March 2020 closure of air, water and land borders for entry into Thailand except for diplomats, foreigners with residence or work permits, Thai citizens, carriers of goods deemed necessary, and crew members of permitted transport operations was announced[8].

Travel requirements for ordinary citizens were however, different from that of diplomats. Ordinary citizens had to go through a mandatory state quarantine for 14 days upon entering the country, while diplomats were exempted. In July 2020, following COVID-19 infections related to two incidents which led to public outcry, the government revised their regulations for mandatory quarantine for all incoming travellers into the country. The first incident involved a foreign diplomat's family and the second a foreign military crew. At the time, it was considered illegal in Thailand at that time for anybody with COVID-19 not to be hospitalised, but a member of the diplomat's family stayed in their condominium in Bangkok after testing positive for COVID-19[9]. The foreign military delegation made a stop-over in U-Tapao, Rayong, following travel from United Arab Emirates and Pakistan on 8th July 2020, flew in and out of Thailand to China on 9th July 2002, and tested positive for COVID-19 the following day without quarantine. Regular travellers had to quarantine for at least 2 weeks following any travel. The military crew led to closure of several places in Rayong, including two malls, schools, and partial closure of the hotel where the crew members stayed while in Thailand[10]. Following public outcry, CCSA Spokesman Taweesilp Visanuyothin announced a temporary postponement of travel permits for foreign visitors categorized as 'VIPs, government guests, diplomats and representatives of international organisations or business investors'[11].

On 1st July 2021, Thailand launched the 'Phuket Sandbox' initiative to test grounds for reopening the country for fully vaccinated international travellers. The event's launch was marked ceremonially with the presence of Gen Prayut and all his cabinet ministers who were criticized for not observing physical distancing during their visit[12] . A month later, in early August 20201, parts of the province went into lockdown, sealing it from unnecessary travels following upsurge in COVID-19 infections[13].

With increase in COVID-19 infections in Thailand caused by the third wave of the epidemic, the European Union in July 2021[14] and the United States in August 2021[15] elevated their warnings against travel to Thailand. The United Kingdom moved Thailand from Amber to Red country list in late August 2021, whereby permitting entry only to UK residents with a mandatory out of pocket hotel quarantine of 14 days[16].

Coordination under the CCSA

During the first wave of the pandemic in March 2020, the prime minister issued an order to establish 2 offices and 8 operations centres, comprising of the Office of the Secretariat and Office of the Central Coordination. The 8 operations centres include for medical emergencies and public health, for prevention and support to the people, for distribution of masks and public allocation of essential supplies, on control of goods, on travel to and from the country and care for Thai citizens abroad, on media and online communications, on security measures and on solving problems caused by COVID-19[17].

On 25th December 2020, Gen Prayut ordered (Order 39) the restructuring of CCSA with 7 operations and administrative centres under its jurisdiction. The new structure and appointments include deputy secretary-general for politics of the Prime Minister's Office as the head of the secretariat, the National Security chief as head of coordination, the permanent secretary of Public Health as the head of the COVID-19 for Medicine and Public Health, the Interior Ministry permanent secretary as head of the Management Centre for COVID-19 Situation, the permanent secretary of Foreign Affairs as the head for the Operations Centre for entry into and exit from the country, and provision of support to Thai citizens abroad. The chief of the Supreme Command as head of the Operations Centre for Security and the director of the National Research Council as head of the Operations Centre for Medical Innovation and Research and Development[17][18].

In May 2021, when the COVID-19 situation reached a critical peak in Bangkok, Gen Prayut took direct control over the management of the CCSA and appointed the chief of the National Security Council Secretary-General as chairman of the committee on the national response for public health and medical matters, while reducing the role of the health

minister and deputy health minister to advisors . Between March 2020 and September 2021, the prime minister restructured the CCSA several times and issued several orders to appoint advisors in various fields (economic, social, public health, medical, legal), and set-up several sub-committees within the CCSA, shifting authority to and away from the MOPH and some cabinet ministers. Despite establishing several sub-committees and advisory committees to coordinate CCSA's work, what was publicly perceived through media briefings and interviews of several ministers, advisors and the prime minister himself reflected lack of coordination and internal communication[19].

Despite having the legal authority to take immediate strategic action in managing the operations of COVID-19 prevention and control, the regulations, orders and announcements issued by the prime minister and the CCSA largely focused on national security with a military mindset. It is noted that there was very little intersectoral coordination between different operational and managerial centres, thus reflecting on confusion and poor implementation. Clear evidence has been observed through several announcements made by Bangkok Metropolitan Administration (BMA), which were overruled by follow up announcements made at the CCSA level. Some of these CCSA announcements were issued on the same day, while others were issued a day later[20]. Additionally, engagement with the private sector and the media was limited to a few meetings where they were informed of the government's decisions and asked to collaborate. Participation of NGOs and civil society representatives was absent in the CCSA coordination.

Communicating epidemiological data, risks, and response measures

A key public feature of the CCSA was their daily situational update aired via mainstream and social media channels. During these sessions, epidemiological updates were provided in Thai and English, on key relevant decisions, followed by question and answer session from the media. However, following the upsurge in cases in the country from March 2020, the physical presence of the media in the Government House was limited. This enabled the facilitator of the press briefing to have full control over the selection of questions from journalists.

Additionally, the MOPH also held daily press briefings and the prime minister regularly held media interviews and press conferences. Senior medical advisors, including Chulalongkorn University's head of clinical virology Dr.Yong Poovorawan and Siriraj Hospital Dean Dr.Prasit Watanapa have also been vocal and active on their personal social media accounts and often gave media interviews. A review of some of these different press briefings, interviews and social media posts showed that personal opinions were provided. Some opinions

reflected differences in views or contradicting information and some comments and remarks exacerbated public confusion. These include comments on the severity of the COVID-19 outbreaks, on movement restrictions, and on the effectiveness and availability of vaccines. Additionally, overnight changes as a result of government's decisions like travel restrictions, lacked clarity. Information on the availability of COVID-19 tests and availability of vaccines caused confusion and impacted the government's credibility.

Multiple telephone hotlines and mobile phone applications were set-up under various COVID-19 related schemes to facilitate the government's data collection and dissemination of relevant information. The DDC's hotline number 1442 provided basic information on COVID-19 in Thai, English, Myanmar, Khmer and Laotian languages. The National Health Security Office's hotline number 1330 expanded their responsibilities from compensating vaccine-related adverse effects to allocating beds and arranging COVID-19 tests at community level. The MOPH announced several hotline numbers, including 1669 of the EOC for medical emergencies, 1668 of the Medical Services Department for advising COVID-19 patients, and 1323 of the Mental Health Department, for providing mental health counselling. The Office of the Prime Minister's hotline number 1111 received complaints on COVID-19 measures, while the BMA EOC hotline 1646 provided information to city residents, in addition to two other lines operated during regular working hours 094-386-0051 and 082-001-63739. Additionally, other ministries and state bodies have other numbers for the public to telephone for different COVID-19 related schemes[21].

Several complaints were voiced in social media and mainstream media on the lack of response from these COVID-19 related hotline numbers. The prime minister himself once complained publicly in April 2021, stating that he had asked his team member to call the hotline which was unanswered. He instructed officials to resolve the issue, following which the NHSO was instructed to support the coordination of 3 main medically related hotline numbers to allocate beds for COVID-19 patients[22].

On mobile phone applications, Mor Chana[23] and Mor Phrom[24] were launched at the national level for public health purposes. The Mor Chana application for contact tracing supported the government to collect data through tracking people's movements to predict the spread of COVID-19. It has been widely used and the public have been asked to cooperate in checking into the application when entering public and private buildings, including shops, restaurants and malls. These check-ins have, however, been random. The Mor Phrom application managed by the MOPH was often inaccessible or showed errors when users tried to access it, particularly in the early months of its

launch[25]. This prompted the CCSA to decentralise the registration for vaccines at the provincial level, some of which were done manually through VHV and health promoting hospitals, while others launched provincial level mobile phone applications for the registration. Additionally, further confusion was observed following the launch of the national vaccination campaign in early July 2021, when the vaccines did not arrive as expected and the vaccination appointments to the public had to be postponed. The postponement caused confusion and impacted the credibility of the government. The credibility of experts involved in advising the government, in procurement and in allocation of the vaccines was also impacted[26] [27] [28].

Challenges

The government of Thailand, like many governments across the world, was able to execute their legal authority to impose special measures including movement restrictions, quarantines, and allocation of medical supplies. The measures implemented by the Thai government in 2020 and 2021 emphasised on containment of the spread of COVID-19 through control of the people with a militarized security mindset, with some short-term economic compensation initiatives. The prolong extension of the pandemic over at least 2 years has led to questions of whether the government can continue to implement the same measures focused on disease containment or shift towards a new normal in living with COVID-19, while emphasizing protection for the most vulnerable populations.

Communication, information sharing and engagement are critical components of an emergency response, particularly for wide scale prominent events such as the pandemic. These components can facilitate and strengthen coordination among different sectors and stakeholders and can enhance efficiency of the response to COVID-19 through recognition of each sector and stakeholder's strengths and capacities. The government has been proactive in disseminating information to the public, but the needed health information to help make informed decisions to limit the risks was missing in many of the press briefings and interviews. The government needs to consider addressing the public's concerns and to avoid over-reassurance, which is a key to risk communication11. A 'whole of society' approach towards management of the COVID-19 pandemic through strong engagement with partners and stakeholders can lead to a collective response involving different sectors at different levels , where disease prevention and control is localised and support is provided from the central level.

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Case Study 2

Public health resource management: COVID-19 vaccine procurement and distribution

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Introduction

On 13th November 2020, World Health Organization (WHO) Director-General Tedros Adhanom Ghebreyesus praised Thailand on Twitter, calling the country extraordinary with a united government and society which offered a comprehensive approach to contain the spread of COVID-19 despite the absence of a vaccine[1]. However, the situation turned out to be very different seven months later. The COVID-19 pandemic turned out to be more severe and widespread than expected, and between April to July 2021, over 1,900 deaths were reported. The increase in severity came with the third wave of the pandemic, overwhelming capacities of hospitals in Bangkok and suburban areas. Many patients could not access hospitals; some died at home or on street corners. Several parts of the country witnessed new clusters of infections daily[2].

Meanwhile, vaccine supplies were limited, and there was skepticism on the efficiency of the available vaccines towards emerging new variants of the SARS-CoV-2 virus that was circulating, especially the Delta variant. The government planned to procure only 100 million vaccines by the end of 2021, and reserved 63 million doses officially, while 37 million doses were being negotiated for. Of the 63 million doses, 61 million was of AstraZeneca and 2.5 million Sinovac. The planned vaccine procurement was however inadequate to cover all the people living in Thailand. However, the actual total amount of vaccines obtained at the time was much less. By August 2021, 32 million doses was obtained, which included 16.6 million doses of AstraZeneca, 13. million doses of Sinovac, and 1.5 million doses of Pfizer which was obtained through donation[3].

This case study explores and analyses the government's policies and the management of COVID-19 vaccines within the context of health justice. It discusses Thailand's

COVID-19 vaccine procurement and distribution plans, reflecting on the rationales for policy changes during the peak of the pandemic. It considers the rationale for formulating these policies and for the allocation of vaccines.

Deliberations

Right from the outset, people seemed to be confused by the announcement of the national COVID-19 vaccine strategy. At first, the government expressed confidence that they would obtain sufficient vaccine doses to vaccinate at least 70 percent of the population and attain herd immunity. The rollout would begin by first vaccinating frontline health workers, elderly people, and persons with underlying health conditions nationwide, followed by the public. However, the vaccination plans changed with the evolving outbreak situation. The plans were shifted and diverted to different geographical locations, some of which were questionable as they did not represent epidemic centers or what was referred to as 'red zones'.

Procurement and distribution of COVID-19 vaccine

The distribution of COVID-19 vaccines in Thailand revealed the underestimated risks of spread of the pandemic among concerned authorities. The government's initial plan was to secure 100 million vaccine doses for half the nation's population, or 30 million persons considered to be at high risk. They played down the importance of vaccination and emphasised other public health measures, including urging the people to wear masks, frequently wash hands, regularly conduct temperature screening, and avoid leaving home unnecessarily[4].

Dr.Nakorn Premsri, Director of the National Vaccine Institute (NVI), announced at the outset that vaccination could not prevent COVID-19 infection. He stated that the vaccination scheme aimed to reduce disease severity and avoid preventable deaths[4]. Additionally, Dr.Yong Poovorawan, Head of the Center of Excellence in Clinical Virology at the Faculty of Medicine, Chulalongkorn University announced that there was no evidence to indicate that vaccinating most of the general population would reduce infection and spread of COVID-19. With predictions on limited global supply of vaccines, the Ministry of Public Health (MOPH) decided to prioritise vaccination for frontline medical staff with high risk of exposure to patients, and for populations with vulnerable health such as the elderly population of 65 years and older, and persons with underlying health conditions[4]. The prioritisation was justified back then.

By the time the second pandemic wave began in December 2020, there was news on more availability of vaccines at the global level. With this new information, the Thai government decided to shift its vaccine distribution policy towards stimulating the country's economy by expanding the target population for vaccination to include workers and the general public. They had hoped to vaccinate 50 percent of the population[3]. However, the situation was differently perceived by the private sector who were skeptical of the state's capacities in delivering vaccination with the planned procurement of only two vaccines – AstraZeneca and Sinovac. They offered to support with the import and dinstribution of alternative vaccines[5].

During the second and third waves of the pandemic in December 2020 and March 2021, Thailand faced with vaccine shortage. The government was forced to adjust vaccination plans, to cope with new and emerging outbreak epicenters. Additionally, they were pressured to reopen the country for tourism and resume schools and businesses. But to do so, Thailand needed to secure more significant amounts of vaccines. Additionally, the earlier planned procurement of vaccines was not met. The hope for obtaining 16.6 million doses of locally produced AstraZeneca reduced to 5-6 million doses, mainly because the company was not fully equipped to manufacture 10 million doses a month as planned[6]. This led to a communication chaos that impacted the public's trust in the government's vaccine policy. Many hospitals that made appointments with the elderly population and persons with underlying health conditions during the nationwide launch of the vaccination campaign in June 2021 had to be indefinitely postponed at the last minute. Additionally, the government replaced AstraZeneca with Sinovac, which was not earlier planned. Sinovac was given to frontline health workers, the elderly, and persons with underlying health conditions5. The shortage and indefinite availability of the AstraZeneca vaccine prompted officials to procure more Sinovac vaccines, thus leading to adjustments and changes in the vaccine procurement plan.

Shifts in prioritized populations and geographic locations

Between 28th February 2021 to 19th July Between 28th February 2021 to 19th July 2021, 14.5 million people were vaccinated in the country. Five provinces with the highest vaccination rates include Bangkok (377,1946 with first doses, and 944,831 with second doses), Phuket (401,808 with first doses, and 320,206 with second doses, Samutprakarn (519,749 with first doses, and 95,437 with second doses), Nonthaburi (437,912 with first doses, and 156,721 with second doses) and Chonburi (321,245 with first doses, and 112,624 with second doses)4. Despite not being listed as the epicenter of the COVID-19 outbreak, Nonthaburi, adjacent to Bangkok, was among the top five areas

with high vaccine coverage rates[7][8]. Additionally, the media reported that booster doses of AstraZenecca[8] was given in Buriram, another province not listed as the outbreak epicenter.

The tourism sector normally generates 52.4 percent of the country's gross domestic product (GDP). Hence the hospitality industry wanted the national vaccine plan to focus more on vaccinating people in Phuket. They launched the 'Phuket Sandbox scheme'[9], allowing travellers who tested negative for COVID-19 to move freely in the province for at least 7 nights without quarantine before they could travel to other provinces. The Ministry of Labor wanted to vaccinate 12-13 million workers registered under the social security scheme to prepare the workforce for the reopening of the country.

The pressure from the business and the labor sectors led to adjustments in the nation's vaccine plan with a focus on the opening of the country. These adjustments were made with little consideration to maximise the use of limited resources available in the country. They provoke the question of whether the high availability of vaccines for Nonthaburi, Buriram, and Phuket was fair or justified.

Changing vaccination plans during the peaks of the pandemic and its impact on the elderly

Following the third wave of the epidemic, Thailand hoped to vaccinate at least 70 percent of the country's population by October 2021. This plan was emphasized with aspirations to open the country for domestic and international travel, trade, and tourism4. However, the frequent changes in the vaccination policy raised questions on whether the adjustments were made to protect the people with the highest risk or whether it was to boost the country's economic image[3].

Thailand's mass vaccination campaign was launched in June 2021, when vaccine supply was scarce in the country. During that time, the government had announced that they would postpone vaccination for the general public and prioritize the high-risk groups. However, only 146,930 older adults were fully vaccinated, compared to 1,709,095 general population. During the same period, high COVID-19 related mortality was observed among the high-risk groups[9].

COVID-19 related deaths attributed to vaccination or the absence of

In July and August 2021, several incidences of COVID-19 related deaths in private homes were reported in the media. On 1st July 2021, a mother and son were found dead in their home two days apart. The son could not access a hospital or test for COVID-19[10]. Another media report stated that on 2nd August 2021, an elderly couple who tested for COVID-19, died in their home while waiting to be hospitalized in Bangkok. On 14th August 2021, the

MOPH announced that 18 out of 217 persons died at home or on their way to hospitals[11]. These statistics raised questions on whether the government's revisions of the vaccine plan contributed to the deaths of the unvaccinated high-risk groups, in addition to problems with access to healthcare.

The National Health Security Office (NHSO), a national funder on healthcare to state hospitals, stepped in to support the government's vaccination campaign. Their role was however limited to providing compensation for persons with adverse effects following vaccination until the third quarter of 2021. To qualify for compensation, each vaccinated person must meet one of the criteria, the first involving COVID-19 related signs and symptoms diagnosed by physicians, the second involving loss of organs, and the third involving disability or loss of life. As of 2nd September 2021, 2,641 persons received compensation for the first criteria and were paid up to 100,000 Baht, 12 persons received up to 240,000 Baht for the second criteria, and 222 persons received up to 400,000 Baht for the third criteria.

Mixed doses of vaccination and its justification

On 12th July 2021, the national infectious disease committee decided to provide mixed vaccine doses under the national scheme, with the first dose being Sinovac and the second Astra Zeneca. This mix was proclaimed the best option to cope with the then circulating Delta variant in Thailand[12]. The MOPH announced the mixed dose vaccination as a national policy. The justification of this policy was questioned for its impact on people's lives amidst uncertainties over its safety, immunogenicity, and long-term effects.

Advocates of the mixed vaccination scheme assured that the mixing was not a new measure and that had been implemented in Europe, although the combination of vaccines involved was different. For instance, Spain experimented on the mixing of AstraZeneca and Pfizer in February 2021 on 600 volunteers who showed positive results. The United Kingdom had in May 2021 administered AstraZeneca and Pfizer to the elderly population(15). Thailand's decision was made based on a study involving 125 vaccinated volunteers at the MOPH and Siriraj Hospital in Bangkok, which suggests an increase in immunity following the administration of Sinovac as the first dose, and AstraZeneca as the second. The results were compared with volunteers who received 2 doses of AstraZeneca[13].

The Thai government's rationale was publicly disagreed with by several senior medics in the country. For instance, Dr.Manoon Leechawengwongs, a pulmonary specialist at Vichiyut Hospital insisted that no clinical study confirmed the safety

of using 2 doses of different vaccines, particularly Sinovac and AstraZeneca. Available research suggested that the first dose of Sinovac did not prevent severe illness or death among high-risk groups, especially the elderly and persons with underlying health conditions[14]. Furthermore, WHO chief scientist Soumya Swaminathan warned that mixing different vaccine doses could be dangerous and was not recommended[15].

Challenges

Planning and management of public health resources to respond to the COVID-19 pandemic has not been easy. Challenge and pressure have been observed even among the most economically stable and prepared countries in terms of global health security. This is despite rapid advancements made in the sharing of scientific knowledge and medical technologies, like the production of diagnostics, therapeutics, and vaccines for COVID-19. The government of Thailand was foresighted where COVID-19 vaccine procurement was concerned from the beginning of the epidemic in the country. However, their predictions of the capacities to control the outbreak and their underestimations on the urgent and diverse needs of the medical resources, particularly vaccines, impacted their credibility. It has led to mistrust in some vaccines available in the country. The multiple adjustments in the vaccine plan and the confusion over the registration and postponement of vaccination impacted the credibility not only of vaccine providers, but also the effectiveness of the vaccines.

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Case Study 3

Workforce, economy, and access to health care

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Introduction

As of 13th July 2021, the World Health Organization (WHO) reported over 209 million[1] infections globally, with over a million[2] cases in Thailand. It is undeniable that the COVID-19 pandemic has disrupted the health and the socio-economic wellbeing of the people globally, causing significant impact on wage earners in the formal and informal sectors, and among national and migrant workers. In Thailand, an estimated 39 million workers registered are of Thai nationality. Of these 38 million are employed[3]. In addition, there are 2.3 million foreign workers with work permits. Of these 1.6 million are Burmese, Laotian, Cambodian, and Vietnamese[4]. These figures do not include informal workers, 600,000 of whom are estimated to contribute to the country's workforce[5].

This case study discusses COVID-19 and the workforce in Thailand, highlighting the difficulties they faced in accessing health services and the impact some pandemic control measures have had on their lives, within the context of health justice. It considers both blue-and-white-collar workforce, both Thai nationals and foreigners who were impacted by the public health measures implemented through the course of the pandemic from early 2020.

Deliberations

Unequal access to health care among Thai nationals and migrant workers which existed before the pandemic was exacerbated during its course. This was particularly observed when major economic hubs such as Samut Sakhon, Bangkok and other cities became epicentres of outbreaks. Additionally, the public health measures such as lockdown, which led to closure of factories, markets and other businesses, significantly affected the workforce and their families. Although the government initiated several COVID-19 related welfare schemes, access was limited, particularly among certain population groups.

Unequal access to health services highlighted by COVID-19

Before the emergence of COVID-19, both Thai and foreign workers were entitled to 3 welfare schemes which allowed access to health services, but their entitlement did not guarantee equal access to healthcare. The 3 schemes Thai workers are entitled to include: 1) Civil Servant Medical Benefit Scheme (CSMBS); 2) Social Security Scheme (SSS); and 3) Universal Health Coverage Scheme (UHC). The 3 schemes foreign workers are entitled to include 1) SSS; 2) Health Insurance Card Scheme (HICS); and 3) UHC[6]. Both Thai and foreign workers have access to SSS and can obtain treatment for ailments related with disability, chronic diseases, psychiatric care, false denture and dental implant, and can obtain benefits from compensation[7]. However, foreign workers cannot access benefits related with disease promotion and prevention[3]. In addition, although the HICS offers similar benefits to UHC, services provided for sophisticated medical care is limited for foreign workers in hospitals that offer services under the HICS[7][8]. Both the HICS and UHC provide limited access to mental health care and access to certain medicines[6].

During all 3 major waves of the COVID-19 outbreak in Thailand between 2020-2021, concerned officials continued to manage the provision of health care by the book, disregard of the different health service needs of different groups of workers. To illustrate, during the second and the third waves of the COVID-19 epidemic, 'bubble and seal" measures were applied, confining movement of workers within restricted areas of factories construction sites[9][10], which was later supplemented by curfew prohibiting them from leaving these sites[9][11]. These decisions were made with oversight of the poor living conditions of many workers. The response to the outbreak in Samut Sakhon's shrimp market where the COVID-19 outbreak emerged was criticised for its slowness and confusion, particularly in the beginning of the outbreak. Despite being designated as quarantine areas, no measure was taken to separate COVID-19 infected persons from the non-infected in Sri Muang accommodation[12]. Policies on provision of COVID-19 tests were unclear, resulting in employers having to pay for their employees to be tested for RT-PCR in private health care facilities[13]. Additionally, a field hospital with bed capacity for 100 patients was established in Samut Sakhon, which at that time, had over 3,000 workers[12].

In June 2021, when the construction sites in Bangkok and 4 neighbouring provinces were made to shut down, workers were said to be living in poor conditions7, and despite quarantine requirements for two weeks, many were quarantined for over 20 days due to lack of guidelines and coordination between the responsible district officials and construction company management[10]. Additionally, Bangkok and key provinces

faced with problems of inadequate hospital beds and shortage of vaccines. Despite announcements on compensation for COVID-19 care, many patients admitted to private hospitals had to pay for their own healthcare[14]. Shortage of vaccines pushed the government to prioritize vaccination for Thai nationals, particularly during the launch of the mass vaccination campaign[15]. To register for vaccination, several web-based platforms and mobile phone applications such as Mor Phrom and Thai Ruamjai were launched. The registration excluded foreign nationals[15][16] prompting countries concerned about their citizens such as France to offer vaccination to their citizens through the French embassy[17].

The socio-economic impact of COVID-19 on workers in Thailand

Data from the Ministry of Labour revealed that in 2020, COVID-19 affected the Thai economy and workforce, contracting the country's gross domestic product (GDP) by 6.1 percent, while reducing the value of export by 6.6 percent. Tourism and the food service industry shrank by 36.6 percent. These figures reflect the scale of economic impact COVID-19 had on the economy and the people. The overall unemployment rate increased by 1.69 percent, and workers laid-off from their jobs lost access to the SSS by 19.73 percent when compared with data from 2019[18]. The rate of employment among foreign workers decreased from 6.67 percent to 2.02 percent. The employment rate among nationals of Myanmar, Lao PDR and Cambodia declined from 7.78 in 2019 to 5.48 in 2020[18].

Public health measures such as lockdown and social distancing implemented during the 3 major waves of the epidemic impacted the low-income and migrant workers more than other groups of workers, and has increased the gap between people from different social class[19]. It is evident that measures such as closure of fresh markets and continued opening of supermarkets have had lower impact on the middle-class workers when compared with low-income workers. The campaign 'Yud Chua Phua Chart' or 'stop the spread of the virus for the nation' increased social pressure for people to stay and home[19].

Since most workers in Bangkok and other major cities and provinces are migrants from other parts of the country, many returned home to find new employment alternatives, and adapted to different measures differently. For instance, data from National Bank of Thailand showed that over 280,000 workers employed in the service industry and 180,000 basic skilled workers including informal workers relocated back to their hometown[20]. Closure of construction sites in Bangkok and neighbouring provinces in June 2020 observed mass exits of migrant workers

(national and international) to the provinces and their countries[21]. In the first wave of the outbreak in 2020, workers who remained in Bangkok changed jobs to suit the market demand, for instance, from driving taxis to delivering food, from dress-making to mask-making[22].

Mitigation measures and their execution

Several mitigation measures to support workers were announced through the course of the COVID-19 pandemic, but the question is how have these measures been conceptualized and were they beneficial for those who needed them most. A clear example was observed during the first wave of the outbreak, where informal workers, temporary workers, daily wage earners and freelance workers were denied access to 3 months compensation worth 5,000 Baht offered to workers under the 'Rao Mai Thing Kan' or 'we will not leave each other' campaign administered by the Ministry of Finance. This scheme offered subsidy to workers with social security[23] . The compensation was planned for 3 million registered workers, while data of the Association of Informal Workers showed that Thailand has approximately 20.4 million informal workers[24].This reflects the lack of coordination between the National Statistics Office and other sectors[23]. Asst.Prof.Boonlert Visetpreecha of Thammasat University's Faculty of Sociology and Anthropology said these measures were likely developed based on the idea of providing aid to selected population groups rather than everyone impacted by COVID-19. As a result, officials compensated only 3 million workers.

Although several schemes registered by foreign workers offered compensation, they did not enjoy the same benefits as Thai citizens. Some benefits were exclusively reserved for Thai nationals. These included the abovementioned scheme administered by the Ministry of Finance[25] and the scheme of the Social Security Office (SSO) which provided 500 Baht per day and 3 meals to workers who remained at campsites, during the time construction sites in Bangkok and 4 other provinces went into lockdown in June 2021[10]. According to Thai Contractors Association leader Lisa Ngamtrakul, more than half of the construction workers who lived outside the construction camps were foreigners. According to one foreign worker from a sub-contractor company, not all of them have social security, as it was provided by only a few construction companies and the workers had to purchase their own health insurance[10].

Challenges

Although SSS includes mandatory and voluntary health insurance, was extended to both Thai and foreign workers, they had different benefits. The difference in benefits was made more obvious during COVID-19. In addition, response measures such as the lockdown took little consideration of the ground realities, raising questions on the intensions and purposes of such measures. For instance, although migrant workers and informal workers largely contribute to the national economy, support provided to them was executed as an afterthought, following complaints from employers and NGOs. A key question is how can mitigation measures be designed to consider support for those with most needs, particularly among the undocumented, unregistered workforce?

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Case Study 4

COVID-19 and the new normal education with digital divide

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Introduction

The COVID-19 pandemic forced lifestyle changes across the world, particularly for students. The impact on the education system was heavy and across the board, with the need for a rapid shift from on campus or onsite to online education. Despite being in the pandemic for over 2 years, approximately half of the world's students and teachers continue to be impacted by the partial or full closure of schools, universities and other education institutions. The World Bank estimates that more than 100 million students will fall below minimum literacy rates due to this health crisis[1]. During the peak of the pandemic, 45 countries in Europe and Central Asia closed schools which affected 185 million students, prompting school administrators to immediately offer remote learning. Emerging evidence from some of the highest income European countries show that the pandemic caused more learning loss and increased inequalities. Its impact is expected to be more among middle-and lower-income countries like Ukraine, where access to technology is lower and a large proportion of the population live below the poverty line[1].

Although Thailand is considered a middle-income country, the economic consequences of the pandemic will have a long-term effect on the students. Data from Equitable Education Fund (EEF) shows that the pandemic further complicated the poverty situation in the country. It is estimated that 65,000 students dropped out of schools by the end of academic year 2021, with a 4 percent dropout from compulsory education, 19-20 percent from secondary schools, 48 percent from high schools, and approximately 8-9 percent discontinued higher education[6],[8]. This case study discusses COVID-19 and education inequalities. It raises issues related with the socio-economic impact caused by the public health measures and the mitigation measures extended to during the COVI-19 pandemic in Thailand.

Deliberations

Thailand's education reform has been debated long before the emergence of the COVID-19 pandemic. The 3 major challenges faced in the country include high levels of inequality, low levels of quality of education, and low standards of resource management in the education system. COVID-19 has brought another challenge to the country's education system, specifically related with the digital divide, increasing the opportunity gap among students. Replacement of onsite education with online has impacted the health, the nutrition status, and the mental health of students. Although mitigation measures were introduced, they have been slow.

COVID-19 has expanded the inequality in education

Prior to COVID-19, Thailand's education was criticised for being of low quality and propagating inequalities both geographically and socially. The need for more human resources and efficiency was recognized. Data from Thailand Development Research Institute (TDRI) showed that literacy levels in rural areas was inferior to that of urban areas by 3 academic years. The curriculum offered in Thai language focused on memorized academic style of learning rather than balancing with the development of practical skills for life and work. This led to large dropouts, particularly from higher education[2]. TDRI's assessment also showed that out of 15,809 schools, 12,000 small schools with less than 120 students, face with shortage of teachers and learning equipment, particularly at kindergarten and primary education levels. In these schools, each teacher was assigned to teach more than one subject, and at multiple levels[3]. Data from the Bureau of Policy and Planning of the Ministry of Education showed that approximately 3.55 million students from Kindergarten to Mathayomsuksa 6 (level 12) studied without having their own textbooks, 3.45 million students went to school without the required uniforms, and 3.21 million students did not have access to the school lunch programme[2], which was introduced to reduce malnutrition through provision of balanced diet for students who struggled to maintain good health due to unaffordability to pay for their meals[4].

The new challenge in the digital divide was brought by COVID-19. Online learning through Massive Online Courseware (MOOC), virtual classroom, or television broadcast put students, their families and their teachers at a new level of dependence on information technology (IT), and the internet. Lack of equipment or poor internet connectivity impacted the education of students, mainly those from the lower income families. Data from the National Broadcasting and Telecommunications Commission (NBTC) revealed that only

21 percent of Thai households owned computers. This statistic is lower than the world average of 49 percent. Additionally, the statistics showed that 68 percent of Thai households have access to the internet, which is higher than the world average of 55 percent[5]. Data from the National Statistic Office (NSO) also showed that 3 percent of households with an annual income lower than 200,000 Baht have access to computers connected with the internet, while 19 percent of households with an income higher than 200,000 Baht have access to computers connected with the internet. Majority of the households with internet access are in Bangkok and other big cities in the country[5]. Another challenge with online education, particularly for primary education level, is the constant requirement constant of the presence of the parents. This poses a major challenge for working parents and carers who must divide their time between their jobs and support to the children[3].

The impact of COVID-19 related measures on students and their health

Delay in vaccination led to postponement of opening of schools, which increased levels of anxiety among students who were already stressed by the online education and the lockdown. The reopening of schools was postponed several times and some schools had to shut down a few days after reopening due to COVID-19 infections in their locality. The first postponement was made from March to July 2020 and extended at least until September 2021. This long period of shift from onsite to online learning increased concerns over malnutrition among poorer students, who were unable to access the school lunch programme[6].

The online education led some schools to place additional study hours on students to compensate for the 19 days lost during the transition period from onsite to online education, while some schools gave their students a break during this period. The pressure from additional hours of online education caused stress among some students[7]. High school students also faced stress related to advanced payment of fees to reserve university accommodation[8]. A survey showed that 3 drivers of stress among 181 Srinakarinwirot university students included their course content (4.4 percent), their assignments (4.12), and learning capacity (4.10) [9]. A poll conducted in April 2021 by a network of Rajabhat universities showed that during the second wave of the pandemic, 41.15 percent of students struggled to cope with their studies due to the internet connectivity, while 29.10 percent were challenged with the understanding of practical subject taught online. The poll also showed that 31.81 percent of students had problems related with the overuse of their eyes due to studying from computers or from mobile phones[10]. Data from Thailand Physical Activity Knowledge Development Centre (TPAK) showed that during the

third wave of the pandemic in June 2021, levels of stress and anxiety increased among students from Prathomsuksa 6 (level 6) to Mayomsuksa 6 (level 12), where 74.90 percent of students expressed worries on their workload and the enrollment process for higher education. The data also showed that the workload of 71.60 percent of the students disrupted their sleep and time for recreation[11].

Confusion over vaccination for students

Poor vaccine communication led to

backPoor vaccine communication led to backlash against vaccines offered to students prior to opening of schools in October 2021. On 4th October 2021, the government announced that they would offer vaccination to 5 million students aged 12-18 years old in Bangkok and in 15 provinces before the opening of schools. They had planned to administer Pfizer-BioNTech, but due to poor advocacy there was a backlash among some students and parents against the mRNA vaccine for children[12]. Anti-vaccine messages went viral on Tiktok social media platform. Students posted videos expressing fear of the vaccine, concerns over being given fake vaccines, and worries related with the possible vaccine related side effects. The hashtag #pfeizer went viral during the planned vaccination dates for students. Parents also raised concerns over the safety of the mRNA vaccine despite assurance from the Department of Disease Control (DDC) that chances of developing myocarditis were small and that they were treatable. Studies conducted internationally showed that out of a million vaccine doses administered, 10-30 children developed myocarditis following 2 full vaccine doses[12]. During the vaccination period, only 3.6 million out of 5 million students were vaccinated, following which Education Ministry officials began sharing information on Tiktok and other social media platforms commonly accessed by students[12].

Mitigation measures with little preparedness

Through the course of the pandemic, the government came out with several measures to support students, their families, teachers, and education institutions to cope with the changes. The implementation of these measures reflected the lack of preparedness, the response was slow, and the communication was sometimes confusing. For instance, during the first wave of the pandemic in April 2020, parents of students from an international school voiced complaints through the media that the school continued to charge high fees, despite offering classes online[13]. The Education Ministry issue guidelines related with fees in July 2021, only after there was a delay in the opening of schools and complaints from parents[14]. The ministry also provided a remuneration of 2,000 Baht for each student along

with a modest support of 2 GB internet access and 79 Baht landline telephone payment for 2 months[15]. Additionally, the government reduced the frequency of teachers' internal and external assessments to reduce their workload and asked them to reduce the demand for homework from students to a practical level based on online learning[15].

Challenges

COVID-19 forced adjustments onto students, parents, teachers, school administrators and policymakers. These adjustments required quick fixes in terms of access equipment, infrastructure, resources, and time. Despite some support offered by the Education Ministry, they were slow and insufficient, considering the scale of the problem. The challenges in moving from onsite to online education extends beyond the development of theoretical skills. It also demonstrates the importance of equitable digital access. To tackle the shortcomings revealed by the pandemic, the government needs to consider strengthening investment in human resources of both teachers and pupils, and provide equipment and spaces materially and spiritually, to support learning and skills development.

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Case Study 5

Urbanism and post-pandemic deconstruction: A sociomaterial analysis

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Introduction

The COVID-19 pandemic is indeed an issue of urban planning. Like other cities across the world, Bangkok became the epicentre of COVID-19 epidemic with health workers on the frontline of defense. Urban life without COVID-19 is already precarious, but the pandemic brought new challenges for city dwellers. Home quarantine and community quarantine posed a major challenge for the tens of millions of people living in small spaces. Many frontline health workers in medical and non-medical work, including doctors, nurses, ambulance drivers, and cleaners in both public and private health facilities are migrants to the city, obliged to work to support their families in the provinces. During the pandemic, these frontline care workers have had to work for long hours with little or no personal support, often with limited personal protective equipment (PPE)[(1)]. Additionally, other frontline workers in the city such as garbage collectors, domestic care worker[(2)], taxi drivers, delivery motorcycle drivers, etc., continued to provide services to Bangkok's residents during the lockdown. They have had to navigate their safety through the increased workload and the expectations, while negotiating with the risks of COVID-19 infections under complex and diverse city structures and spaces.

This case study presents a unique opportunity for reflecting on the COVID-19 pandemic through mixed methods by considering the spread and control of COVID-19 in an urban setting on the basis of 'epidemic nowcasting', which broadly refers to assessing the current state of understanding disease infection, the epidemiology of its spread, and the related socio-behavioural characteristics which consider the architecture, the planning and the infrastructure of the city vis-à-vis the urban lifestyle, and its benefits and limitations, within the context of capitalism and the pandemic situation.

Deliberations

Bangkok is a diverse city, a home to an astonishing multiplicity of ethnicity and culture. Until 2016, the city's population was 10 million, including 6 million registered and 4 million unregistered residents[3]. A large proportion of the dwellers in the city lack access to public services, including education, transportation, and healthcare. Mobility can be challenging with multiple small lanes, and personal security a major concern. Housing in and around Bangkok is largely compact with overcrowding and shared spaces.

Bangkok, a home for domestic and international migrant workers

A young nurse working for a field hospital hoped the clapping of hands expressed in appreciation to health workers could be exchanged for other forms of recognition for their efforts. In an interview with the author on 14th July 2020, she stated that she hoped the appreciation was shown through provision of PPE so that they could better protect themselves while working in hospitals. She expressed anxiety on being reassigned to work in intensive care units (ICU) for which she felt she did not have sufficient skills. Her way of finding temporary relief through this crisis was to share her grievances with her peers, other nurses in a group chat, through a mobile phone application, which she considers as safe space. She also had other personal worries. She had to move out of a shared flat due to the limited space and confinement during the lockdown. The new rent was higher than what she paid in the shared flat, which meant that her regular contribution to her family in the rural area had to be reduced.

In a more affluent side of Bangkok, a domestic worker living in an area surrounded by several COVID-19 outbreaks recounted her almost daily trips outside her residence. In an interview with the author on 24th December 2020, she said she had to deliver food to her coworker, an undocumented migrant worker almost daily because of the person's immobility. Her coworker was with stage 4 cancer and lived alone in the city. The two domestic workers bonded and took care of each other like family, until the cancer-afflicted care worker died in July 2021. During the pandemic, the lady interviewed stated that she continued to work to send money to her family in the province despite her poor health and increased vulnerability due to the spread of COVID-19. She neglected self-care and focused on the housework for her boss who brought her to Bangkok during their relocation from Northeast Thailand.

These two personal accounts are among hundreds if not thousands of examples of lives of workers in Bangkok, many of whom are invisible. Like other cities of the world, Bangkok can be hostile to certain population groups. The COVID-19 pandemic has increased challenges for the urban community, particularly among those who are already in precarious conditions.

Bangkok diversity and duality

On 22nd March 2020, reports on sudden unexpected outflow of tens of thousands of migrant workers from Cambodia, Lao PDR and Myanmar was reported. Their return home was motivated by a combination of factors, including the partial lockdown of Bangkok and closure of 18 border points of entry from 23rd March 2020. Data showed that about 10 percent of over 2.7 million registered migrant workers[3] and an unknown number of undocumented migrant workers returned home during the period. This incident happened just before the government announced that the country had been free from local transmission of COVID-19 for over a month on 24th June 2020 and that the reported cases at the time were all linked to international travellers[4].

Large numbers of migrant workers in Bangkok are employed in high-rise buildings, apartment complexes and on construction sites. Although most migrant workers were left jobless during the first 2 waves of the pandemic in 2020, workers in the construction sector were spared. However, the third wave of the pandemic led to the closure of construction camps following reports of over a hundred clusters of infections[5]. This heavily impacted the workers, particularly migrants who had no option but to remain in lockdown under poor living conditions with little support. The imbalance of the city and its duality as home to slum dwellers and the wealthiest global elites[6] marks a drastic contrast, highlighting gaps in the social strata. While the elites and the rich live in luxury, marginalized communities are forced to live in limited spaces with little access to open public spaces and are prone to limited mobility due to the high transportation expenses. The expansion of city slums as seen in Samyan area near Chulalongkorn University and Klongtoey, the largest congested community in the country, within proximity from the busiest business centres and entertainments reveal that the city cannot function without the working class.

Bangkok reported the highest rate of infection in the country[7] and the city appeared to have higher-than-average vulnerability in terms of job security and health security of families compared to the rest of the country. Some domestic spaces turned into spaces of violence(8) and shared public spaces became inaccessible. Pandemic related deaths occurred in hospitals, care homes, private homes and on the streets. More than 13,000 deaths were reported, with few people vaccinated and the economy severely impacted, the city witnessed

regular demonstrations against the government on an almost regular basis[9].

Designing cities to promote health and wellbeing

Prevention and control of COVID-19 in Bangkok was largely challenged by limited access to health services, confusion over information released by the government, and the need to implement the required public health measures with little state support. Despite these challenges, the positive impact of the lockdown is that it propagated community connectedness, with peer-to-peer support. It also led to an improvement in the quality of air in the city. A study by Wetchyont et al showed that COVID-19 significantly improved the level of surface air pollution. The study showed that the levels of concentration of PM 2.5 pollutants decreased during and after the lockdown when compared with that of the previous year[10]. This led to the reconceptualisation of developing more green spaces, building social connectedness to identifying inherent human needs, and usage of these spaces. Closure of public paths and communities around health facilities and residential areas need reconsideration in future applications of new technologies to build healthy cities. Experts from multiple sectors, including architecture, public health and social sciences should be mobilized to develop the city's health and wellbeing for disease prevention and control. A whole-of-government approach is needed to address disease prevention and control measures systematically and comprehensively in the city.

Active and passive measures for reopening workplaces and businesses

Many businesses require employees to physically report for work. Considering the need for maintaining basic public health measures post-pandemic, small offices may need to adjust their spaces and adopt technologies such as High Efficiency Particulate Air (HEPA) and Ultraviolet (UV) filters in air conditioning. They may need contactless technologies for electricity switches and water taps. Smart systems to monitor indoor air quality, infrared camera for temperature scanning and automated disinfection booths may be considered. It will be costly to introduce or retrofit such technologies in different facilities, although it may be affordable for some businesses.

More e-commerce

Rise in networks of delivery services during the lockdown reflects the need for shops and supermarkets in and around residential areas. Social distancing and quarantine requirements have pushed e-commerce[11] to more users who can afford the additional cost. Its popularity has also developed even among users not familiar with digital technology and has led shopping malls and supermarkets to evolve and offer more online services. The need to prepare for the logistics and

the delivery has been on a rise since the beginning of the pandemic along with concerns over fair payments and benefits for workers, particularly for those in the logistics and the delivery services. Most workers in delivery services are informal workers and are not protected under the labour law.

A shift towards the 'work from home' (WFH) policy forced by the pandemic has proven possible and convenient for some senior and managerial roles, while continuing to challenge workers in other positions. The challenges of working from home include lack of space, separation of work and non-work hours, lack of roof insulation, and the high cost for comfort cooling under high temperature, and the patchy connection and speed of the internet. Employers, on the other hand, have increased risks of confidentiality and data security issues. During the pandemic, personal health information of patients was hijacked several times from the database of hospitals[12].

Retrofitting the slums

Residents of Klongtoey community are characterized by civic movements with a long history of contemporary planning relevant to Bangkok. Klongtoey houses 100,956 residents, Thai nationals and migrants, in 43 sub-communities located in an area of 12.99 square kilometres. It is the largest congested community in the heart of the city. The residents have diverse occupations, status and lifestyle. They work in different sectors from fresh markets to elite nightclubs in different parts of the city.

The community is largely supported by NGOs with little attention from the government. Several volunteer groups and NGOs established themselves in the community with organized relationships and networks. Their collective actions and collaboration were clearly observed during the response to the COVID-19 outbreak in the community, which was sparked by the third wave of the pandemic. Approximately 10 percent of the residents were reportedly infected. The community became the epicentre of the pandemic in March 2021. Community leaders trusted the NGOS and they worked with public health officials to organize COVID-19 tests and home quarantine. They established temporary isolation centres in the community temple Wat Kamphaeng to provide care for patients needing support. COVID-19 vaccination was also administered in the area. The outbreak in the community enabled residents who were healthy but jobless to support the response in the community[13].

A project was initiated during COVID-19 to consider how positive cycles of change or improvement could be brought into Klongtoey amidst the pandemic response. These included: 1) considerations such as the development of a community clinic with support from the city administration to function as the healthcare centre for informal settlers. Approximately 500 informal workers

reside in the community's new dwelling area; and 2) mobilization of architects, planners, health workers to discuss measures to sustain urban planning and designing, with the engagement of the marginalized community dwellers. The key question, however, is whether these initiatives will be supported by capitalist entrepreneurs and whether the rich city residents are willing to share and redesign the city spaces for the collective.

Challenges

When Bangkok became the epicentre of COVID-19, there was little access to safe spaces in the city for majority of the people who enabled the city to function. COVID-19 turned the city's safe spaces into fearful areas. The pandemic exacerbated inequalities and increased the vulnerability of the already precarious population groups, some of whom were forced into homelessness or to the streets, while others had to return home to the provinces, due to joblessness. The city depends on domestic and international migrant workers, but little is done to systematically support the working class, be it in terms of public spaces, transportation, or social welfare. The COVID-19 pandemic is a stark reminder of the complex links between the environment and our health in the city. There is an urgent need to break down silos across sectors and advocate for a new integrated approach to drive systematic changes. The shift in development of disease prevention and control measures from focusing on the pathology alone, to understanding its epidemiology and socio-behavioural characteristics requires new ideas, datasets and questions from multiple disciplines including but not limited to medicine, engineering, architecture, and social sciences.

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Case Study 6

Role of the private sector and volunteers in providing humanitarian aid and collective civil society support during COVID-19 pandemic

Author: Sumonmarn Singha

Introduction

Following the declaration of COVID-19 as a global pandemic[1], countries across the world mobilized resources nationally and internationally to respond to the health emergency. Through the course of the pandemic, the global health emergency led to different phases of shortage of medical supplies, human resources, and access to daily consumables goods. This pandemic has brought about lifestyle changes to the public and the way in which healthcare services are provided.

Volunteers played an important role in reflecting the needs of the people impacted by the pandemic. They have enabled the state to adjust and adapt their responses to correspond with the needs and the realities on the ground. They have provided support on the resource needs of the health service sector and on distribution of required equipment, which helped reduce congestions in health care facilities where possible. Volunteers have acted to reduce injustice related with access to care in several communities in Thailand.

This case study documents the role of non-state actors in fulfilling Thailand's aspirations of protecting the nation's health security. Apart from the need to develop and increase the potential, the capacity and the resources of the public health sector, it reflects the important of the role of civil society and the private sector in health emergency responses. Collective experiences demonstrated during COVID-19 can inform the development of strategies with proactive engagement of non-state actors in responding health emergencies.

Deliberations

Thailand's community participate and community care is deeply embedded with a culture of 'charity'. In crises situations such as the Tsunami in 2004, or the major floods in 2011, volunteerism and community solidarity were mobilized through 'Thamboon' or to make merits. During the COVID-19 pandemic, volunteers came together to create 'spaces of care' by extending support to vulnerable communities, lay population and health workers.

Mobilizing people, mapping resources

Since the beginning of the detection of COVID-19 in the country, the government's response was prioritized on medical measures, including hospital-based quarantine for all positive COVID-19 cases. Testing for the disease was only done for those with a clear history of exposure to an infected person. Attempts were made to prioritize procurement of vaccines which were unfortunately delayed, resulting in shortage, while infections were rising. During the third wave of the pandemic in March 2021, a key outbreak control measure needed at epicentres included thorough and efficient screening of COVID-19 infections so that infected persons could be isolated and cared for. This measure was also important to protect their families and their communities from infection. COVID-19 screening was also needed to support the functioning of certain businesses and social activities, along with area-based lockdowns for a limited period. These measures were however, lacking due to limited supplies of COVID-19 tests, and control over its availability and use outside healthcare facilities.

The unplanned largescale lockdowns hugely impacted many people. Volunteers, many of whom were also impacted by the COVID-19 control measures, emerged from the first wave of the outbreak to continue with active support to other community members in the epidemic waves that followed[2]. Several groups of volunteers were formed in hospital-based facilities and in community areas to provide peer-to-peer support. Some groups are shown in the 'stakeholder map' adapted from DoDone[3] in the Figure below.

Stakeholder map

CORE OPERATION

- *หน่วยงานภาครัฐ*
- *ภาคเอกชน / อาสาสมัคร / ภาคประชาสังคม*

Screening/Test

FAQ/Screening

- 1330 สปสช.
- 1422 กรมควบคุมโรค
- 1668 กรมการแพทย์
- อาสาเฉพาะกิจ
- CoCARE
- Line สบายดีบอก
- อาสาเฉพาะกิจ
- เป็ดไทยสู้ภัยโควิด
- zen-dai
- Rural Doctor Club
- Klongtoey D-Jung
- Self-care volunteer group (migrant camp in BKK)

ตรวจ/คัดกรอง

- 1330 สปสช.
- สถานพยาบาล
- Primary care
- หน่วยคัดกรองเชิงรุก กทม.
- สถานพยาบาลเอกชน
- CoCARE
- เทคนิคการแพทย์อาสา (ช่วยอ่านผลโควิด ตรวจเชิงรุกแคมป์คนงาน)

จัดสรรการรักษา

- สปสช.
- กทม.
- สสจ.
- Co-link (DEPA, ศนช. กรมการแพทย์)
- Co-ward
- คณะกรรมการโรงพยาบาลเอกชน

Home isolation

- 1330 กด 14 สปสช.
- อปท.
- CocarePlus
- Com COVID-19 (Pre-register ก่อน สปสช.)

Community isolation

- 23 ชุมชนโมเดล มูลนิธิพัฒนาที่อยู่อาศัยร่วม รพ.ปิยเวช
- คลองเตยโมเดล
- มูลนิธิอิสรชน (All service)
- Klongtoey D-Jung
- Self-care volunteer group (migrant camp in BKK)

Hospital

- Uhosnet
- โรงพยาบาลเครือ กทม.
- คณะกรรมการโรงพยาบาลเอกชน

Field hospital

- โรงพยาบาลสนามภาครัฐ
  - รพ.บุษราคัม
  - รพ.สนามธรรมศาสตร์
- โรงพยาบาลสนามภาคเอกชน
  - รพ.สนาม (มงกุฎวัฒนะ)

Hospitel

จัดการผู้เสียชีวิต

- มหาเถรสมาคม
- Jitasa.care

Field hospital

- กรมสุขภาพจิต
- อาสาสุขภาพจิต
- Telemed-Chewii
- Waste management

Accessibility

- กทม. คกก. ดูแลผู้พิการ
- มูลนิธิอิสรชน ดูแลคนไร้บ้าน (All service)
- กล้าอาสา (ดูแลกลุ่มแรงงานข้ามชาติ)

RESOURCE

จัดหาอาสาสมัคร

- CoCARE
- Jitasa care
- สมาคมเพื่อผู้บริโภค
- zen-dai
- Rural Doctor Club
- Klongtoey D-Jung
- Self-care volunteer group (migrant camp in BKK)

Medical Vendar

- BOI
- โอสถศาลา
- TFC
- วิศวกรอาสา
- Bangkok Industrial Gas

Food & supply Vendar

- สมาคมภัตตาคาร

Patient logistics

- 1669 สพอ.
- รถพยาบาลจิตอาสา

Supplies logistics

- ไปรษณีย์ไทย
- Local rider
- เป็ดไทย

IT/Tech/Communication solution

- True
- ธ.กรุงไทย
- Telemed-Startup ภาคเอกชน
- Test appointment
- GISDA
- Jitasa care (Resouece map)
- เป็ดไทยสู้ภัยโควิด

PR

กลุ่มอาสาสมัคร

- Coccare
- กล้าอาสา
- Thaicare
- Test appointment

สื่อ/เพจต่าง ๆ

- อาสาเฉพาะกิจ
- TPBS

หมอแล็บแพนด้า

Drama addict

CAPACITY PLANNING AND POLICY

- Demond supply management - Local warroom
- Demand forecasting - SD-Covid madelers
- Process design, Scheduling สำหรับ Near future demand
- BOM - Dodone
- Capacity expansion

KM

- กระทรวงสาธารณสุข
- Uhasnet
- DoDone

Figure 1: Stakeholder mapping which the author had been adjusted from DoDone FB page
Source: https://www.facebook.com/DoDoneNotDoDie/

The 'stakeholder map' shows that many organisations, including that of the state, the private sector, NGOs and civil society were involved in supporting each other during COVID-19. For instance, the Thai Red Cross Society, Friends of Service Workers Foundation, SWING Health House and others supported sex workers in Pattaya City and in Bangkok. The volunteers provided relief to infected persons and their families during quarantine through the distribution of food, relief bags, and other supplies, while some helped arrange transportation to health facilities. The support was done in an area-based system approach so that risk mitigation measures could be deployed rapidly to correspond with the needs.

Medical device support for hospitalized patients

Prime Minister, Prayut Chan-o-cha, met with the private sector twice in April and in July 2021. The two meetings included representatives from Federation of Thai Industries, Thai Chamber of Commerce, Thai Bankers' Association, and businesses associated with tourism and other service sectors. In both meetings, the private sector expressed interest in supporting the government with the procurement and the distribution of COVID-19 vaccines, particularly for the workforce in the industrial sector who are recognised as important drivers of the economy.

Some private firms have been more proactive than others. For instance, Saijo Denki mobilized medical personnel and experts from various universities with knowledge in engineering, medicine and public health to jointly discuss the use of innovative technologies for developing negative pressure rooms for COVID-19 patients according to WHO and UC Centers of Disease Control and Prevention (CDC) standards. The first mobile negative pressure room which was able to control the air pressure inside the room to a negative level while purifying the old air before releasing it to the outside was developed in collaboration with Siam Cement Group (SCG) and its use was piloted in Rajavithi Hospital. This innovative technology was used as first line treatment rooms for COVID-19 patients. Following the pilot, SCG continued to develop mobile isolation units which were easy to install and operate, meeting the requirements of hospitals in remote areas[4].

CP All Public Company Limited, the management of franchised convenient store Seven Eleven launched a project titled 'Thais do not leave each other' during the third wave of the pandemic to support COVID-19 prevention and control by providing assistance to state organisations and concerned officials[5]. In addition, Siam Yamto Steel Company Limited (SYS) and Electricity Generating Authority of Thailand (EGAT) supported the development and provision of cardboard beds for field hospitals and waiting centres for COVID-19 patients.

Active connections between the community and home isolation

Bangkok and surrounding provinces had high numbers of COVID-19 patients who were considered as green patients or with mild or no symptoms, the yellow patients, or patients requiring some medical support, and red patients or patients critically ill. Volunteers stepped in and took on an important role of screening and separating patients from the non-infected community members, and helped with home isolation and community isolation.

Thai CoCare, an ad hoc multi-disciplinary volunteer group developed mobile phone applications to support large numbers of people under quarantine. They developed a three-tier volunteer groups, the first comprising of pharmacists and public health professionals, the second nurses, and the third doctors, who were assigned to support patients by providing advice via video calls and chats. They also reached out to engineers to seek support for the development of negative pressure rooms under limited time and budget. In 2020 and 2021, Thai CoCare group came together twice in April 2020 and in May 2021[6].

Rural Doctors Society, AIDS Access Foundation and the National Health Security Office[10] joined forces with volunteers to proactively screen slum dwellers in Bangkok during the third wave of the outbreak. They were able to separate persons infected with COVID-19 from the rest of the community through 3 rounds of screening and were able to prevent persons infected with COVID-19 from travelling back to their hometown in various provinces. Proactive screening was carried out in Klongtoey slum community in the heart of Bangkok, in addition to providing information on disease prevention.

NGOs like Raks Thai Foundation, Human Settlement Foundation and Labour Rights Promotion Network Foundation of Samut Sakhon supported migrant workers with COVID-19 screening and consolidated complaints from vulnerable communities which were fed back to the government and the Ministry of Public Health (MOPH), so that community concerns were addressed.

Sendai (Thread) volunteer group worked in collaboration with the state sector in Bangkok's Region 6 under the leadership of former city governor candidate from Future Forward Party to tackle issues related with connecting patients to health care facilities. This initiative began with 3-4 volunteers on 26th April 2021, expanding to over 80 volunteers within a few months. They provided support in Bangkok and surrounding provinces. Sendai's connection centre supported over 2,200 patients with COVID-19 while waiting to be hospitalised. They provided over 5,000 transportation trips, and counseling to patients based on information compiled from over 13,000 patients from call centres.

The centre, based in Prathum Thani province, operated in collaboration with the provincial Office of Social Development and Human Security. Doctors, nurses, pharmacist, emergency medical practitioners, radiologists, nutritionists, dietitians, psychologists and medical technicians volunteered for the group[7].

Community relief and home isolation

When the Centre for COVID-19 Situation Administration (CCSA) announced closure of construction camps in dark red zones with high rates of COVID-19 infections on 28th June 2021[13], self-care volunteer groups emerged. During the first month, they networked by connecting professionals in various fields with different sites across Bangkok who needed support. They compiled data through surveys, developed maps of localities of various sites, developed web-based applications, and organised information management systems to support the communication. Within a month following the establishment of the group, they were able to mobilise over 10,000 volunteers to support 650 camps, reaching over 50,000 workers[8].

Klongtoey D-Jung, in collaboration with the Society and Health Institute of the Bureau of Policy and Strategy of the MOPH employed community residents to collect data on newly established communities in Klongtoey. Data on household level health needs were consolidated from the registered 1,469 persons and 454 households[9] to provide timely and specific support according to individual needs which included care for children, the elderly, and bed-ridden patients. They also helped with early screening, isolation, and care for COVID-19 patients. Preliminary assessments of the data compiled facilitated the referral of patients to health facilities as needed. The planning on provision of resources to patients also helped with timely patient care. This led to the development of a model based on the response in Klongtoey, in other communities in the city area.

Challenges

Although migrant and urban workers were most vulnerable to COVID-19 infections, they did not have the negotiate power to access COVID-19 related resources or care. This group was often either socially excluded or discriminated against. While living with high risks and having chances of being severely impacted by the pandemic, this group had limited capacity to deal with the consequences of the measures imposed to control the spread of the pandemic such as quarantine. Additionally, existing social structures did not allow them to attain and sustain resilience.

The private sector and the volunteers had an informal and a proactive role in alleviating the inevitable sufferings of communities during COVID-19. They provided support on issues from access to hospital beds, therapeutics, vaccines, diagnosis, to day-to-day assistances, including meals and counseling for families and community members requiring quarantine. They mobilised resources and expertise to support the COVID-19 response with the objective of saving lives and alleviating sufferings of the people most at risk. They worked with little support or recognition from the government or the state.

Mismanagement of COVID-19 can worsen social inequalities and expose power relations, leading the people to challenge those in power. This could lead to a political awakening, involving the formation of political solidarity, political activism, and possibly new power relations. Engagement in the recovery and relief processes may also create opportunities for new groups to emerge within the economic and political processes, creating new political identities with negotiable benefits for the disadvantaged. This emerging political activism also challenges the status quo and disrupts the existing power relations, as witnessed in the protests by medical personnel and citizens in Thailand on issues related with vaccine availability for health workers, and the political changes in at least 9 governments worldwide, including the resignation of health ministers for mismanagement of the pandemic response observed in Argentina[10], Ecuador[11], United Kingdom, India and Mongolia. There is also more pressure for political accountability.

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Case Study 7

Role and influence of the media and the social media in shaping and addressing health justice in Thailand

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Introduction

The media in Thailand went through significant changes over the last decade with the transformation of businesses, the introduction of new platforms and technologies, and the evolving consumer behaviour. Advertisements, which are the main sources of revenue for mainstream media has significantly declined, falling from 12,782 million Baht in 2016 to 3,834 million Baht in 2020 for print media, according to a Nielsen survey conducted in 2020[1]. Many businesses have been forced to adapt to new internet-based platforms, the popularity of which has been explosive during the pandemic. Social media outlets such as Facebook, Line, Twitter, Instagram, Youtube, TikTok, Club House and others are popular in Thailand.

The COVID-19 pandemic has further pushed the mainstream media to explore different digital platforms and change the way they present their content to distinguish themselves from others, to suit their consumers. This shift has significantly led to the shut-down or downsizing of certain media outlets[2], while facilitating the emergence of the new digital media. The scale and frequency of the social media has significantly expanded from exchange of information to facilitating e-commerce[3], online education[4], and entertainment[5].

This case study discusses the role and influence of the media and the social media in shaping and addressing issues related with health justice in Thailand. It considers the role of journalism which shares the public space with citizen journalism on internet-based platforms. It also considers the role of key actors including leaders, institutions, public figures, and civil society in health justice. It discusses how

the media and social media have been used to mediate or negotiate power and actions observed during COVID-19. It highlights concerns over the labeling and the management of fake news amidst the use of new technologies to suppress distorted or false information.

Deliberations

Social media outlets like Facebook and Line became the main channels for official information dissemination, be it the daily updates provided by the Center for COVID-19 Situation Administration (CCSA), the Ministry of Public Health (MOPH), or official statements of Prime Minister Prayut Chan-o-cha. Likewise, these social media outlets have actively been used by scientists, scholars, medical professionals, influencers, politicians, and the lay public to voice their opinions on the situation, the government's decisions, and the impact the pandemic response has had on individuals, families, communities, societies and the nation.

Press freedom

Right from the outset, the Thai media collaborated with the government in supporting their information dissemination on the evolving COVID-19 situation and the public health measures recommended to the people. They reported daily updates from the CCSA, the MOPH, and the prime minister. They regularly interviewed prominent medical professionals and other influential social figures. The national lockdown in March 2020 prevented face-to-face CCSA media briefings, which facilitated the government to provide one-sided communication by largely ignoring media questions deemed critical of the government's actions. The activation of the Emergency Decree in March 2020 raised concerns over restriction of the freedom of the press[6]. The relationship between the government and the media reflected through the behaviour and the remarks of the prime minister, and regulations he issued between 2020-2021 demonstrat his frustration on criticisms against the government. In an incident where Gen Prayut jokingly sprayed alcohol sanitiser on reporters in March 2021 to avoid tough questions, the premier was heavily criticised by the people and the international media for his inappropriate behaviour[7]. The prime minister also often scolded journalists while being questioned during media briefings. In 2020 and 2021, he called for a meeting with the senior management of the nation's key media outlets at least thrice and asked them to collaborate with the government in disseminating information announced by the government.

Public freedom of expression

Gen Prayut extended control over expression of opinions to include social media influencers and celebrities with the issuance of Regulation No 27 under the Emergency Decree on 10th July 2021.

The regulation prohibits the distribution or dissemination of texts deemed to 'instigate fear or distort information, misleading the purpose of the emergency situation to the extent at which it affects the state security, public order or the morale of the people'. The prime minister promulgated another regulation number 29 on 29th July 2021, permitting the National Broadcasting and Telecommunications Commission (NBTC) to cut internet access of social media users by revoking their Internet Protocol (IP) addresses if they expressed opinions or shared information considered to instigate fear or considered to be fake news. The state interpretation of these announcements included opinions critical of the government's pandemic control measures. The announcements were heavily criticized by the media, nationally and internationally. They were also criticised by human rights advocates and the people. Gen Prayut was also taken to court by some media outlets active on social media platforms and human rights lawyers, accusing him of violating the constitution. Six associations of Thai journalists issued a joint statement to Gen Prayut, urging him to cancel the restriction on grounds of its attack on freedom of expression[8]. An alliance of 17 international human rights organizations denounced the Thai government, calling this an attack on the rights to freedom of expression and rights to information[9]. On 6th August 2021, the Civil Court ruled in favour of the media representatives and human rights lawyer, stating that Section 9 of the Emergency Decree on Public Administration in Emergency Situations BE 2548 (2005) does not provide the prime minister with the authority to suspend internet services[10].

Trusted yet confusing expert opinion

A Suan Dusit poll conducted between 19th-22nd July 2021 on 1691 people showed that they were most interested in information related with vaccines and its side effects. They trusted information from medical personnel and experts the most, and considered the social media to be the most reliable source of information. The people surveyed also stated that they felt confused with the information released by the government on vaccines.

Several experts and medical professionals have been active on the social media, releasing information under their personal accounts as well as through their institutional accounts. Although the overall level of trust on medical experts was high, it declined during different intervals, as observed in the public opinions expressed against them in the social media during different periods[11]. Additionally, experts providing advice to the prime minister lost public credibility and were criticised by frontline medical personnel, particularly young medical professionals, for not taking COVID-19 seriously. This negative reaction on senior experts followed a press briefing held by Gen Prayut following his meeting with senior medical experts on

25th June 2021. Gen Prayut spoke light-heartedly and laughed while announcing the lockdown of construction camps in and around Bangkok to stop the spread of COVID-19[12][13]. This led to calls on social media for senior medical experts to remain scientific and not align themselves with politics.

Media as convener

When the COVID-19 outbreak emerged from Krystal Club in Bangkok's Thong Lor district, much of the media focus was on politicians,elites visitors and dancers. Within days, new clusters of infections were identified in many parts of the country, one of them being in Klongtoey community, Thailand's largest overcrowded low-income community. The first 5 COVID-19 infections reported from Klongtoey on 21st April 2021 isolated themselves at the back of their pick-up trucks to avoid infecting other family members, before they managed to access a hospital on 23rd April 2021. At that time, it was illegal for COVID-19 patients not to be hospitalised while the number of cases was rising in the city. Discussions on whether it would be feasible to lock down Klongtoey community emerged in the public sphere. Amidst uncertainty, Thai PBS, a state funded independent media outlet organized a public forum, bringing together representatives from the community, NGOs working in the area, MOPH, National Health Commission Office and Bangkok Metropolitan Administration, to discuss measures that could be implemented in Klongtoey[14]. They organised several discussions, and through this process, community members proposed the establishment of a tripartite working group comprising of community representatives, BMA and MOPH to jointly make decisions on the COVID-19 response in the community. This collaboration transpired into the establishment of daily screening for COVID-19 infections, and the preparation of a local temple Wat Saphan as an isolation facility for confirmed patients, while waiting to be hospitalised. They also organised vaccination for community[15]. This proactive initiative demonstrated the strength of the media in facilitating discussions for local level responses, bringing together different stakeholders.

Fake news and bitter realities?

In one day, on 21st July 2021, 3 bodies were found lying on different streets of Bangkok amidst the rise in COVID-19 infections[16]. Their images were widely shared in the social media. These bodies were kept on the streets for long hours, while waiting for relief workers with personal protective equipment (PPE) to attend to them. The relief teams also had to carry out COVID-19 tests on ever corpse they collected, before removing the body from the scene. Following these simultaneous incidents, the prime minister instructed the CCSA not to allow such situations to occur again. Within days, similar images of people lying on the streets reemerged. On 29th

July 2021, multiple images of one man lying on 2 different streets were widely shared on social media. This was taken up by the national police, claiming it to be fake news. They warned the public that violation of the computer and emergency laws led to 5 years imprisonment and/or a fine of not more than 100,000 baht. The image turned out to be of that of a homeless man, reflecting bitter realities of life in the capital city. His image was widely shared on social media because of concerns that he could have been infected with COVID-19 and needed support. Through the course of the pandemic, the Digital Economy and Society minister held press conferences threatening legal actions against media outlets and social media influencers, accusing them of instigating and propagating what the government refers to as fake news which includes criticisms against the government. The media and the public were discouraged from posting or sharing information that criticised the government or the COVID-19 response on grounds that it could propagate fear and cause public confusion[17][18].

Stigma and discrimination

In the early days of the COVID-19 pandemic, the language used by some media outlets in Thailand was discriminative to foreigners as 'carriers' or 'spreaders' of the pandemic. Such language was observed even after Thailand began to report local infectious in the country. Health Minister Anutin Chanvirakul called 'farangs' or Caucasians 'dirty', blaming them for spreading COVID-19 in the country[19]. This was when Europe became the epicentre of the global pandemic in March 2020. Through the course of the pandemic in 2020 and 2021, hate speech used by the media, the politicians, the social media influencers and some population groups against foreigners and migrant workers was observed. The prime minister and other senior government officials blamed illegal immigrants and foreigners for the outbreak in Thailand during their media briefings. Sentiments against people from Myanmar was reported in the mainstream media and on the social media to the level where the Labour Protection Network called on the Thai people to stop labelling the people of Myanmar for spreading COVID-19[20]. Hundreds of comments classified as hate speech on YouTube, Facebook and Twitter was reported by the Independent Social Media Monitoring for Peace Group, some of which used racist language to promote nationalism[21][22].

In mid 2021, when the government shut down construction camp sites in Bangkok and neighbouring provinces to contain the spread of COVID-19, chaos was observed in the management of the lockdown. Construction workers were blamed for the spread of the pandemic in the country. The government's decision to push the construction workers to return home to the provinces led to the spread of

COVID-19 in many provinces. The blame was placed on construction workers, rather than the governments poor judgement and decision[23].

The term 'Rang Roke' or infection nest is widely used epidemiologically to refer to disease reservoirs. When spoken in the everyday language in layman terms, people associated with areas, social groups or professions referred to as nesting the disease are stigmatised. For instance, residents of Klongtoey community in Bangkok, migrant workers from Myanmar working in Samut Sakhon and construction workers have been negatively reflected in the media and social media for nesting COVID-19 infections[24].

Challenges

The mainstream media has a special role in health emergencies like the COVID-19 pandemic, which extends beyond regular journalistic functions. Their key role is to provide fast, transparent, and accurate information to the people so that the needed health information reaches the people, to enable them to make informed decisions to protect themselves from infection. Their actions can save lives and reduce pressure on the public health and the social systems. At the same time, they have an important role in scrutinising the decisions and performances of the government and the state. However, it is undeniable that as a business entity, the mainstream media business has also been impacted by the pandemic. Moving forward, they will have to adapt their business to meet the significant growth of the social media and the citizen journalism, while maintaining ethics in journalism.

The Digital Economy and Society Ministry joined forces with the police in scrutinizing and announcing threats or actions against fake news, including threats to the media and social media users to avoid criticisms of the government's COVID-19 response. Public confusion was notably caused by these announcements. The confusion resulting from the information released by the government and the controls imposed on voicing opinions in the social media has propagated the circulation of rumours, misinformation and fake news.

In addition, some key government figures and social media influencers have used language that is xenophobic, racist and discriminative of certain population groups. These statements are made without any acknowledgement for apology or correction.

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4 Discussion

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Health is fundamental to every human being. It is a necessity and directly impacts the ability for an individual to perform. Poor health thereby, limits opportunities in life. Health is determined by several facets related with the distribution of public policies, public health measures and are influenced by social factors such as society, culture, education, employment, economic stability, the environment, and so on. Health determinants are complex and require public policies, the state and the government (to facilitate, provide for, and regulate market mechanisms), civil society and the people, in order to have fair and effective distribution of health and health services. Health equality is important, but equal distribution of health does not lead to fairness, and in certain situations, health inequality can be justified (as discussed in Chapter 2, 1.3) Health equity on the other hand, considers the differences in health that are unnecessary and avoidable as being morally unjust. Health justice goes beyond equality or equity and is multifaceted. This report mainly considers health justice from a Rawlsian approach from a practical viewpoint and does not reflect all concepts of justice. Thailand's experiences during the COVID-19 pandemic documented in the 7 case studies from January 2020 – September 2021 (Chapter 3) have been reviewed from procedural justice, distributive justice and corrective justice concepts (Chapter 2).

Although equity and justice are fundamentally linked, the primary distinction this report makes between the two theoretical concepts is that health equity takes a long-term approach towards the full potential for health and well-being[1] of each member of the society, while health justice can be addressed rapidly, through policies and practices of the government, the state and the people. Health equity requires improvement in political, legal, economic and social determinants of health, while health justice focuses

on the inherent measures or actions to consider fairness in the governance or public policy processes. Societies can achieve health justice through policy formulation with more justified distribution of public resources (distributive justice), correction of policies that discriminate or negatively impact certain populations (corrective justice) and application of good governance in all steps of public policy processes (procedural justice).

Governments and the state in multiple countries took on crucial roles in imposing restrictions and controls to reduce the spread of the pandemic. The question is to what extent should their jurisdiction be. Should the state have the authority to intervene and control, or to preserve the rights, freedom, and privacy of the people? How should conflict which involves the state, or the government be resolved, and what role can civil society take on in such situations?

Thailand's overall experience with the pandemic was similar to that faced in many countries where preparedness and acquisition of necessary medical devices like personal protective equipment and masks were concerned. However, the pre-existing social inequalities exacerbated the impact of COVID-19 in many ways. Public policies, the state and the government have a crucial role when it comes to provisions and support for vulnerable population groups. However, during COVID-19, the security measures imposed in the form of movement restrictions, quarantine and home isolation put vulnerable communities at higher health risks. These measures did not consider the limited personal spaces they live in and the delayed arrangements of public spaces in response to major outbreaks were insufficient and inaccessible to large numbers of people. This impacted the urban poor communities the most.

Thailand is recognised as a successful middle-income country with a strong health system which provides universal health coverage to most people in the country. However, COVID-19 revealed the limits of access to health care, particularly among the urban poor and foreign workers. Additionally, the state's finances under the national health security scheme was insufficient to deal with the rapidly evolving health needs of the people, particularly during the peaks of the pandemic waves. The impact of the pandemic was felt among all population groups, including the middle-income group, who under normal circumstances have less dependence on state funded health care. Access to basic medical supplies like masks and hand sanitizers, and to prevention tools like vaccines were limited and required private sector interventions.

The pandemic revealed multiple levels of challenges, from the policy decisions to communication with the public during the crisis. The body central to the government's COVID-19 response, the CCSA, operated with a national security

mindset with militarised disease control measures. Little consideration was made on the response measures like movement restriction and curfew had on the overall impact on the health of individuals (physical, mental, social), on livelihoods of the people, on the social relations and on the economy of the country. The measures implemented were universal, with limited consideration on the local contexts and realities of the challenges and risks faced in different provinces, among different sectors and population groups. The government underestimated the severity and impact of the pandemic. The response lacked forecasting and projections on the evolving situation. This was evident with the slow and confused response implementation, and lack of foresight on the impact beyond the health sector.

Control over access to COVID-19 diagnostics, which was not widely accessible in Thailand until the third quarter of 2021 led to loss of lives and increased risks of COVID-19 infection. Changes in vaccination policy and shift in prioritisation from groups with vulnerable health to area-based geographies, without scientific evidence led to confusion and distrust in the government's vaccination measures. The decisions made on outbreak containment measures and allocation of medical resources lacked transparency. Support provided to the people was mainly in the form of populist approach, aimed at stimulating the economy through immediate day-to-day purchases, which was inaccessible to some population groups because of the requirements-multiple schemes were accessible through different mobile applications and platforms, all of which required the Thai national identity card number. Lack of transparency resulted in 'trust issues' with the public and negatively impacted the effectiveness of communication, and disease control measures. The lack of trust and confused communication propagated fake news, including on vaccine hesitancy[2]. These challenges, pertaining to distributive justice, further put people with limited reach of the health information through the state, the mass media and the social media at higher risk of infection.

With regards to education, the students who were negatively affected by the disease control measures like the lock-down were not appropriately compensated. The policies implemented, including the shift from on-site to online education ignored the realities of living condition. The tuition fees were maintained at the same level during the first wave of the pandemic, despite job cuts and financial implications on individual families. This led some students to drop out of schools and universities. The re-opening of schools was postponed several times, while many families had difficulties in engaging with online learning for various reasons. It was also evident that the measures implemented on the education sector focused on control of the spread of COVID-19 with little consideration on the quality of education. The assistance towards

the education sector (students, teachers, private education operators and state organisations concerned with education) was minimal and centered around providing limited tangible support like hours of internet access for a limited time, subsidy for purchase of devices such as mobile phones or tablets, or for meals. Several groups have demanded for a systematic change in the Thai education sector from a charitable or aid provision approach to that of investment in human resources[3].

The impact of COVID-19 was far and wide. When the pandemic hit its peak in Bangkok, the middle-class population had challenges with accessing health care. Access to health care was worse for the urban poor communities and migrant workers, particularly undocumented migrant workers and their families. Disease control measures which had a national security focus affected migrant workers the most. Thailand has for a long time provided support and health care for migrant workers on short term basis despite their significant contribution to national economy. During the pandemic, a clear disparity was observed in access to health services and COVID-19 related information between workers registered with companies and independent workers, and between Thai nationals and foreign nationals. The pandemic has also shown that more information is needed to better understand the informal workforce in the country[4].

COVID-19 has indicated that a 'whole of society' approach is needed, where all sectors of society contribute to limit the spread and impact of the pandemic. The Thai state is proud of its public health welfare system and strong public health infrastructure. However, during the pandemic, despite realisation of the limits of the state sector and the capacity of the government, particularly in terms of sourcing alternative vaccines or providing health care in city areas, the government was reluctant and slow to engage with the private sector and non-government entities, including civil society groups. The lack of engagement with the private sector paved way for private healthcare practices to decline patients, particularly in city areas, where multiple private health care businesses thrive. Despite experiences of collegial working relationships with NGOs working on health or with migrants or marginalised communities, little was done to incorporate them into the pandemic response. NGOs like Sendai, Klongtoey D-Jung, Rural Doctors Society, AIDS Access Foundation, Raks Thai Foundation and Thai CoCare were able to take on their roles in localised community responses with the support of local civilians.

The case studies demonstrate that inequitable health outcomes are intertwined with socio-economic and political issues in the health policy processes. They reflect opportunities to advance with

systematic consideration of justice in health in all policies, particularly in procedural justice, with an inclusive approach on policy formation, information sharing and communication, and in distributive justice, with the distribution of roles and responsibilities, resources and resource management. Furthermore, aspects of corrective justice, which mainly concerns with compensation for health care and for health impact of COVID-19 response measures such as the lockdown, or adverse health effects due to COVID-19 vaccination, can be made strategic with stronger and fairer impact.

There are different concepts of fair distribution in utilitarianism, equalitarianism, liberalism and communalism, all of which have their strengths and limitations. Although the disease prevention and control measures are the main priority in the context of the pandemic, other socio, economic and political factors that impact the economy and people's rights need to also be considered so that disease prevention can preserve the important values while at the same time draw unity and participation. The question is whether Rawls's theory, which reconciles concepts of liberty and equality can be applied to the Thai social structure, or what changes are needed in the social structure to address health as a primary social good. This is because the three principles of distributive justice – equality, proportionality and fairness, should not have been caused by lack of resources for people in powerful positions.

The case studies also show that there is diverse and evolving understanding of what health justice is in the Thai context, and that policymakers and the Thai public at large have not yet subscribed into Rawls's or other egalitarian justice theories. At the same time, calls have been increasingly made for the public sector to diverge from a benevolent to a more rights-based approach. There is a clear demand for more accountability, transparency and fairness from the government, the state and the private sector.

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3. *วงเสวนา Health Justice ครั้งที่ 2 ในหัวข้อ 'เปิดห้องเรียนที่เป็นธรรม: ปิดความเหลื่อมล้ำทางการศึกษา ในสถานการณ์โควิด' เมื่อวันที่ 16 มีนาคม 2565 [Internet]. [cited 2022 May 1] Available from: https://waymagazine.org/health-justice-education/*
4. *วงเสวนา Health Justice ครั้งที่ 1 ในหัวข้อ 'แรงงานเคลื่อนเมือง: โอกาสและความเหลื่อมล้ำในสถานการณ์โควิด' เมื่อวันที่ 2 มีนาคม 2565 [Internet]. [cited 2022 May 1] Available from https://waymagazine.org/health-justice-city-and-labor/*

5 Conclusion and Recommendations

Authors: Aphaluck Bhatiasevi, Pakpoom Saengkanokkul, Bawornsom Leerapan, Natchaya Ritthisirikul, Sumonmarn Singha

Authors: Aphaluck Bhatiasevi, Pakpoom Saengkanokkul, This report is produced during the COVID-19 pandemic, in May 2022, with data collected between January 2021 – September 2021, and reviews conducted through discussions held in January and March 2022. At the time of writing this report, key issues on COVID-19 at the global and national level in Thailand continues to be around the allocation, distribution and access to vaccines, diagnostics, therapeutics and health care. The report focuses on the synthesis of a practical framework to address health justice in the context of Thailand's COVID-19 experiences and does not cover all aspects of health or justice theories. The main concepts for analysis was obtained from Rawls's theory of justice, with focus on procedural justice, distributive justice and corrective justice. Despite closely linked, the distinction this report makes between health equity and health justice is the immediacy in action that can be taken towards health justice, while health equity requires a longer-term structural change which involves political, legal, economic and social determinants of health.

The role of public policy, the state and the government are particularly important when it comes to vulnerable populations with high health risks or with limited capacities to manage health risks. For instance, their chances to recover from a sickness puts them at risk of bankruptcy due to the high medical expenditure, while living with low income. Under normal circumstances, health policies in many countries generally prioritise support for vulnerable populations, but with COVID-19, the situation was different because it impacted all populations groups. This report, however, does not capture the case studies specific

to vulnerable population groups. The case studies reviewed show that despite the unpredictable scale of spread and the severity of the pandemic, policies, laws and measures taken in Thailand did very little to consider the demographic differences of the population.

The spread of the pandemic was rapid and unpredictable. It gave little time for the health system to prepare, leaving the country with limited resources and supplies. This meant that the distribution of the available resources had to be prioritised. However, the prioritisation processes and decisions lacked transparency, thus impacting the levels of trust on the public policies, the state authorities, the government and some experts responsible for advising the government. The distribution and allocation of the limited resources were questioned and criticised for being unfair. Some example questions publicly raised include: who is responsible for the distribution of the health resources; how are different population groups prioritised for receiving the medical resources like vaccines; and what criteria was used in making such decisions? Although the SARS-CoV-2 virus directly affects individual's health and impacts the public health system, the measures deployed in response need to go beyond the health sector, balancing disease control measures with the overall health of individuals, communities and societies, and livelihoods.

In conclusion, to achieve health justice, the government, the state and the people must consider socio-economic dimensions of health and wellbeing in policies, laws and practices. The case studies presented in this report demonstrate the necessity for a systematic and consistent consideration of justice in health in all policies. The case studies suggest that is 1) no substantial evidence that justice was considered in the health policy processes, both in policy formulation and policy implementation phases of the responses to COVID-19 in Thailand. Hence, health justice is not yet achieved in Thailand; 2) negative consequences of the existing policies which reflect a considerable demand for more accountability of the central government, the local governments, and even the private sector to participate in more justified public policy processes. If not, we are less likely to achieve an equitable health outcome during public health emergencies; 3) both the content and the formulation processs of policies matter. Shifting the governance paradigm from a paternalistic view of the state to a more responsive, respectable, and collegiate style of governance networks is crucially needed for Thailand to become a just society.

6 Annexes

Annex 1:

Based on deliberations of the case studies, the following questions were framed to stimulate discussions in January and March 2022. These include:

On the national COVID-19 prevention and control

1. Has the CCSA been designed or structured to consider health justice in the COVID-19 response? If so, how much of it can response to the injustices observed?
2. From the perspective of the concept of procedural justice, what recommendations can be made to improve policy platforms and processes that systematically conform with procedural justice?
3. 3. With right to health considered a fundamental human right, what immediate adjustments can be made towards governance to systematically consider justice in health in all policies?

On public health resource management: COVID-19 vaccine procurement and distribution

1. What value judgement facilitated or challenged the government's considerations on the scale of the COVID-19 epidemic and the public health needs, particularly vaccines?
2. What rationale did the government use to shift priorities for vaccination during the epidemic peaks and how were they perceived by different stakeholders and the public?
3. Could health justice be considered beyond the concept of distributive justice where vaccine availability is concerned? For example, should beliefs, values, the ability to pay, freedom of choice, etc. have been considered, and if so, to what extent?

On Workforce, economy and access to health care

1. Taking on the perspective of health justice, how can the Thailand (public and private sectors) better support migrant workers and the informal workforce?
2. What value systems exist in relation to health justice, how deeply are they integrated in Thai society, and what can be done to address the challenges and gaps?
3. Mitigation schemes of the government such as Rao Mai Thing Kan (No one left behind : subsidized freelance workers 5,000 THB for 3 month) have been conditional and provide short term subsidy. What should be done for the government to consider long term mitigation measures for workers?

On COVID-19 and the new normal education with digital divide

1. What value systems exist in relation to Thailand's education and how do they reflect the social changes recently observed in Thai society? How do they reflect on some of the key ideas of justice related with concepts of empowerment?
2. What kinds of injustice has been exposed by the COVID-19 pandemic and how have they been perceived and dealt with by the government?
3. What reform priorities are needed to support students, teachers, parents and those concerned with Thailand's education system?

On urbanism and post-pandemic deconstruction: a sociomaterial analysis

1. What can be done to address the systems/structural limitations related with health justice in big cities like Bangkok, for instance in relation to health care for the disadvantaged population groups?
2. What value systems are in place, and what changes are needed to reconceptualize the city's structures and infrastructure as shared spaces; for instance construction of bike lanes or walking paths?
3. Considering procedural and distributive justice, what role and responsibility should the state take in facilitating values thinking for health justice in the city's administration?

On role of the private sector and volunteers in providing humanitarian aid and collective civil society support during COVID-19 pandemic

1. From the health justice perspective, what value systems exist in recognizing and drawing on community strengths and actions to respond to health emergencies and beyond?

2. What role can the state take on in systematically addressing health justice through the engagement with civil society and private sector networks? For instance, what can the government do to enable volunteers, civil society or groups that organically emerge to support the vulnerable population or those needing assistance during crisis situations?
3. What kind of coordination mechanism should exist at the national, regional and local levels to strengthen the engagement of civil society, NGOs and the private sector in crises situations?

On role and influence of the media and the social media in shaping and addressing health justice in Thailand

1. What role can and should the media and social media take on as important institutions for paradigm shift, in addressing health justice and injustice in Thailand. For instance how can they address issues related to the mishandling of the pandemic to the extent where injustice is created in society?
2. What value systems exist when it comes to identifying, branding and addressing 'fake news' and how should they be dealt with to avoid being insensitive (through the use of discriminative language or hate speech), thus causing further injustice?
3. What value systems exist and how can they be built or integrated to reflect health justice in terms of empowerment and expression of public opinion?

Annex 2:


PMAC PRINCE MAHIDOL AWARD CONFERENCE 2022
SIDE MEETING
HEALTH JUSTICE IN THAILAND IN THE CONTEXTS OF THE COVID-19 PANDEMIC : A WORKING PROGRESS
Speaker
Assoc Prof Boriwoonsom Leerapan
Faculty of Medicine Ramathibodi Hospital, Mahidol University
Speaker
Dr Pakpoom Sangkunkul
Faculty of Economics, Chiang Mai University
Speaker
Ms Aphaluck Bhatiasevi
Medical Anthropology Scholar
Agenda
Introduction: Background and Overview
Discussion: Framework and Case Studies
Q&A and Feedback
Next Steps
Commentator
Dr Somsak Chunharas
President,National Health Foundation)
Commentator
Prof Lincoln Chen
The China Medical Board
Commentator
Assoc Prof Nipon Poapongsakorn
Thailand Development Research Institute
Commentator
Dr Nuttagarn Chuanchuen
Mae Sot Hospital
Commentator
Ms Sanitsuda Ekachai
Columnist/ Ex-Editor, Bangkok Post
Commentator
Ms Akkarasorn Ophan
Columnist,Disrupt Website
DATE : JANUARY 24TH, 2022
TIME: 2-5.00 PM (GMT+7)
VENUE : ZOOM WEBINAR
REGISTRATION: HTTPS://PMACONFERENCE-MAHIDOL-AC-TH.ZOOM.US/WEBINAR/REGISTER/WN_RDW-7OJSS2CLJCWPOC-CDQ
Mahidol University
Faculty of Medicine Ramathibodi Hospital
CHINA MEDICAL BOARD

PMAC 2022

Health Justice in Thailand in The Contexts of The Covid-19 Pandemic: A Work in Progress

Side Meeting Agenda

Date : January 24th,2022 Time: 2-5 pm (GMT+7)
Venue: Zoom Webinar
Registration link: https://pmaconference-mahidol-ac-th.zoom.us/webinar/register/WN_Rdw-7Oj5S2CLjCwPoc-CdQ

#1 Introduction
(1 hour)
- 2-3 pm

- Welcome guest and Introduce Team Members and Key Commentators by Dr.Somsak Chunharas
- Project Background and Overview, Context of Covid-19 and Policy by Dr.Borwornsom Leerapan
- Key Cases Study Presentations by K.Aphaluck Bhatiasevi
  -Procedural Justice & Centre of Covid-19 Administration (CCSA)
  -Distributive Justice & Vaccine Allocation,
  -Corrective Justice & Workers

Break(15 minutes)

#2 Discussion
(1.20 hours)
- 3.15-4.35 pm

- Health Justice Framework by Dr.Pakpoom Saengkanokkul
- Discussion on framework and all case studies by Dr.Nipon Poapongsakorn,K.Sanitsuda Ekkachai, Dr.Nuttagarn Chuenchom, and K.Akkarasorn Opilan and others

#3 Questions and Feedback
(10 minutes)
- 4.35-4.45 pm

- Open floor to all meeting attendees

#4 Next Steps
(15 minutes)
- 4.45-5 pm

- International Health Justice and movement by Dr.Lincoln Chen
- Summarize the expected outcomes and reflect on key issues from the discussion and feedbacks
- Set up next steps

Mahidol University
Faculty of Medicine Ramathibodi Hospital

Annex 3:


HEALTH JUSTICE #1
2 มีนาคม
2565
14.00-16.00 น.
แรงงาน
เคลื่อน
เมือง
โอกาสและความเหลื่อมล้ำ
ในสถานการณ์โควิด
14.00 น.
แนะนำโครงการวิจัย Health Justice โดย ดร.ภาคภูมิ แสงกนกกุล
อาจารย์ประจำคณะเศรษฐศาสตร์ มหาวิทยาลัยเชียงใหม่
14.15 น.
ร่วมเสวนาโดย
อดิศร เกิดมงคล
ผู้ประสานงานเครือข่ายองค์กรด้านประชากรข้ามชาติ
อนุกูล ราชภูณา
แอดมินเพจ สหภาพไรเดอร์ - Freedom Rider Union
ผศ.ดร.บุญเลิศ วิเศษปรีชา
อาจารย์ประจำคณะสังคมวิทยาและมานุษยวิทยา
มหาวิทยาลัยธรรมศาสตร์
ธนพร วิจันทร์
ตัวแทนเครือข่ายแรงงานอุตสาหกรรม
สุเทพ อู่อ้น
ประธานกรรมาธิการการแรงงาน
ศุภกร เผ่าดี
อุปนายกฝ่ายสมาชิกสัมพันธ์
สมาคมการจัดการงานบุคคลแห่งประเทศไทย (PMAT)
ประธานชมรมผู้บริหารบุคคลรุ่นใหม่อุตสาหกรรม (MAC+)
ดำเนินรายการโดย
กรรณิการ์ กิจติเวชกุล
CHINA MEDICAL BOARD
4th decade forward
Building Knowledge Toward Health Justice
way
LIVE
มูลนิธิสาธารณสุขแห่งชาติ-มสช
และ way magazine

Annex 4:


HEALTH JUSTICE #2
เปิดห้องเรียนที่เป็นธรรม
ปิดความเหลื่อมล้ำทางการศึกษาในสถานการณ์โควิด
16 มีนาคม 2565
14.00-16.00 น.
14.00 น.
แนะนำโครงการวิจัย Health Justice
โดย อาภาลักษณ์ ปาคียเสวี
นักวิชาการของโครงการความยุติธรรมทางสุขภาพ
LIVE
มูลนิธิสาธารณสุขแห่งชาติ-มสช
และ way magazine
14.15 น.
ร่วมเสวนาโดย
ณัฐชยา แย้มไธสง
ผู้อำนวยการกลุ่มวิจัยและพัฒนานวัตกรรมการจัดการเรียนการสอน
สำนักพัฒนานวัตกรรมการจัดการศึกษา สพฐ.
ธนายุทธ ณ อยุธยา
Elevenfinger ทีมบินดีบ้องดี
นายแพทย์ไพฑูรย์ อ่อนเกตุ
รองผู้อำนวยการฝ่ายปฐมภูมิ
โรงพยาบาลทำแพงเพชร
พริษฐ์ วัชรสินธุ
CEO StartDee (บริษัทพัฒนาเทคโนโลยีด้านการศึกษา)
ศิริพร พรมวงศ์
ผู้จัดการโครงการคลองเตยดีจัง
ดำเนินรายการโดย
กรรณิการ์ กิจติเวชกุล
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Annex 5:


HEALTH JUSTICE #3
ระบบสาธารณสุขที่เป็นธรรม
30 มีนาคม 2565
14.00-16.00 น.
เงื่อนงำข้อมูลข่าวสาร
และอำนาจรวมศูนย์
ในสถานการณ์โควิด
14.00 น.
แนะนำโครงการวิจัย Health Justice
โดย สุมนมาลย์ สิงหะ
นักวิจัยนโยบายสาธารณะ มูลนิธิสาธารณสุขแห่งชาติ
LIVE
มูลนิธิสาธารณสุข
แห่งชาติ-มสช
และ way magazine
14.15 น.
ร่วมเสวนาโดย
พญ.สุมนี วัชรสินธุ์
ผู้อำนวยการสำนักสื่อสารความเสี่ยง
และพัฒนาพฤติกรรมสุขภาพ กรมควบคุมโรค
นพ.สุภัทร ฮาสุวรรณกิจ
ประธานชมรมแพทย์ชนบท
ศ.นพ.เกียรติ รักษ์รุ่งธรรม
ผู้อำนวยการศูนย์วัคซีน จุฬาลงกรณ์มหาวิทยาลัย
ชูวัส ฤกษ์ศิริสุข
บรรณาธิการบริหารประชาไท/Commentator Voice TV
คริส โปตระนันทน์
ประธานกรรมการมูลนิธิเส้นด้าย
ดำเนินรายการโดย
กรรณิการ์ กิจติเวชกุล
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BUILDING KNOWLEDGE TOWARDS
HEALTH JUSTICE

"สร้างความรู้สู่สังคมที่เป็นธรรมทางสุขภาพ"