Neo-liberalism, the Rise of the Unelected and Policymaking in Thailand: The Case of the Medical Tourism Industry

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Abstract

This paper discusses how neo-liberal ideas about development take root when they encounter the very different political and economic context of a developing economy. It analyses Thailand's medical tourism industry, earmarked by the Thai government as one of several priority industries to reflate the economy in the aftermath of the 1997 Asian Financial Crisis, which ravaged Thailand and ushered in a group of unelected actors intent on disbursing supposedly de-politicised neo-liberal governance reform. Amidst the apparent ascendancy of these "reign-seekers" and their economic ideology, this paper makes three interrelated arguments. Firstly, these unconventional actors function as a fluid intermediary interlinking various public agencies, private sector players and civil society actors, fostering dialogue and reconciling diverging interests. Secondly, the influence of neo-liberalism on the working of the Thai state has been relatively modest as the "reign-seekers" in this study have primarily promoted welfare-oriented policies over pro-business ones. Thirdly, the "reign-seeking" elites' welfare-oriented stance underlines the fracture and heterogeneity within a supposedly unified group of neo-liberal proponents.

Keywords: Medical Tourism; Health Policy; Reign-Seeking; Policymaking; Globalisation; Thai Politics

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Introduction

Thailand has been one of the fastest growing developing economies since the conclusion of the Second World War. It has benefited from a relatively liberal outlook towards international trade and capital. Consequently, the country became one of the second-tier newly industrialising economies (NIEs), following close on the heels of the first-tier NIEs, namely Korea, Taiwan, Singapore and Hong Kong (Suehiro 2008; Phongpaichit and Baker 2015; Rigg 2016). Nevertheless, Thailand's growth was interrupted by the 1997 Asian Financial Crisis (AFC), culminating in a severe recession which reversed the growth of the previous years (Rigg 2002; Sheng 2009). The hardship induced by the AFC forced Thailand to seek support from the International Monetary Fund (IMF). The IMF in turn demanded austerity programmes and liberalising structural reforms in exchange for its bailout of the Thai economy (Phongpaichit and Baker 2008).

The crisis also shaped Thai politics as widespread public anger with the government led to the passing of the "People's Constitution", the country's 16th constitution. This was a watershed event as more than two-thirds of the Constitutional Drafting Assembly (CDA) were not drawn from the traditional Bangkok elite (McCargo 2002). In addition, public consultation over the articles of the constitution was carried out. However, the elites maintained a stranglehold of the drafting process as they contrived to dilute most of the more progressive and popular proposals (Connors 2003; Hewison 2007). For Kanchoochat (2016), these events have deeper repercussions as they soon ushered in a cohort of unelected "reign-seeking" agencies. Managed by professional and official elites, these supposedly impartial agencies are tasked to stem rent-seeking behaviour among elected politicians and senior government officials, often through neo-liberal governance reforms modelled after the Washington Consensus (and/or iterative versions of it) (see, for example, Flinders and Wood 2014; Heins

2015).[1] In this school of thought, the economy is to be liberalised and deregulated to allow market mechanisms to function. As such, the state is advocated only a minimal role in governance affairs displayed most clearly by the consensus' emphasis on reducing public expenditure and encouraging privatisation (see Beeson and Islam 2005). Politics is also to be eschewed because it opens the door for interest groups to "distort" the "rationality" of the market system. The neo-liberal solution to this problem is to "de-politicise" the economy by strengthening the rules on technocratic conduct and/or establishing "politically independent" policy agencies (Chang 2001). In spite of the marginalisation of political contestation and the remoulding of societal conduct by the elites, it is not a given that they will opt for market-friendly policy prescriptions (see, for example, Jayasuriya and Hewison 2004). As this paper shall subsequently demonstrate, supposedly market-friendly elites have instead favoured welfare-oriented policies, underlining the heterogeneity within a group of actors that owe their pre-eminence to the promulgation of the Washington Consensus.

Notwithstanding the above development, contemporary scholarship offers relatively little insights on how the rise of neo-liberalism and its supposed proponents – the "reign-seekers" – relates to the growth of an industry, particularly one (in this paper, it is the medical tourism industry) which is highly globalised. For the sake of brevity, medical tourism is defined as the movement of patients across borders for medical care that is more expensive or less accessible at home (Connell 2011).[2] Analysing worldwide trends, some scholars (see, for example, Peck and Tickell 2002; Aalbers 2013; Stiglitz 2016) postulate that despite different political configuration, states typically have little choice but to adopt market-complying neo-

[1] Espoused principally by the Washington-based IMF and World Bank, the consensus was originally designed to resuscitate the crisis-stricken developing economies of South America and Africa during the 1980s. Despite its generally ineffectual impact, the consensus remains popular amongst mainstream economists and policymakers (Stiglitz 2002; Chang 2003).

[2] Although all definitions are contested, medical tourism is usually combined with some elements of vacationing. Activities covered under this broad umbrella include but are not limited to plastic surgery, traditional medical therapy and corrective dental work (see, for example, Oxford Business Group 2016; KPMG 2018).

liberal economic logic. Nevertheless, studies focusing on the Thai context suggest that such a process is fraught with contestation, exhibiting uneven outcomes across industries and territories (see, for example, Glassman 2007; Suehiro 2008; Doner and Wad 2014). There is also a need to unpack the role of unconventional (yet instrumental) players – such as the professional elites – and their actions in the shaping of Thai politics, extending analysis that has placed much emphasis on the traditional elites centred around the royal house (see, for example, McCargo 2005; Winichakul 2008). Although recent works by Harris (2015) and Kuhonta (2017) detailing the agency of a group of progressive bureaucrats outside the conventional line ministries have deepened our insights on the policymaking prowess of these unconventional players, their emphasis is on the wider healthcare sector rather than a specific domain within it. Focusing on the medical tourism industry, this paper not only builds on such scholarship, but also affords us a better understanding of the political dynamics shaping the industry's governance structure. It does so by examining the major players (e.g. public agencies, private firms and civil society organisations) involved in crafting Thailand's medical tourism policy. The spotlight will be trained especially on the National Health Commission (NHC; the Commission), a highly influential body managed by unelected professional elites and its interactions with other key players. The paper argues that the NHC has played an important intermediary role in fostering dialogue and reconciling the interests of the other stakeholders within the industry. As a result, a set of coherent policies has been reshaped and implemented to raise the standards of the Thai medical tourism industry.[3] It also shows that the Thai state, courtesy of the agency of the reign-seekers, has managed to retain ample policy autonomy. This was evidenced in the provision of relatively equitable access to medical treatment for the general public. Although the reign-seekers' rise to power has been underwritten by the neo-

[3] This is the intention of the policy measures. While their longer-term impacts are important, they are not the main focus of this paper. This research's primary agendas are to illustrate the role of reign-seeking actors in fostering dialogue amongst divergent interest groups and to link their agency in managing the impacts of neo-liberalism.

liberal agenda, their pro-welfare stance suggests that they are *not* a unified bloc of neo-liberal proponents.

The paper is based on research conducted from May to June 2016 in Bangkok, Thailand. It draws principally on interviews with academicians, think tank analysts and public officials responsible for shaping and implementing policies related to the medical tourism industry. Questions – in both English and Thai languages – were asked about the dissimilar priorities of different actors (namely, public agencies, private sector and civil society) and how they were reconciled, resulting in concrete policy outcomes. In addition, the interviewees were probed on the evolution of the medical tourism industry since the late 1980s and the business environment in general. To improve the reliability of the primary data provided by these parties, the data were cross-validated with relevant archival and secondary materials e.g. annual reports of major private sector players, governmental websites, newspaper essays and technical manuscripts in the English and Thai languages. The use of these sources of information allowed for data verification and triangulation, resulting in a clearer reading of the situation from multiple perspectives. Given the sensitive nature of the issues discussed (such as business-state interactions), all interviewees were promised confidentiality.

This paper begins with a critique of the literature on neo-liberal governance reforms, drawing from worldwide to more Thai-specific cases. Analysing the role of the state and the multi-faceted ways it deals with international capital, the purpose is to extract the implications of such cases and highlight their relevance to Thailand, the focus of this paper. It also discusses the rise to power of a group of neo-liberal, unelected professional and official elites following the drafting of the People's Constitution. The subsequent section provides background information on Thailand's medical tourism industry by outlining its evolution since the late 1980s. It then sheds light on the major stakeholders involved in shaping medical tourism policy, focusing on their (divergent) priorities. Particular attention is paid to the role the reign-seeking

NHC in undertaking participatory policymaking. Three key events – the toning down of an originally pro-business incentive scheme, the pursuit of a pro-welfare overall healthcare system by top politicians and the partial marketisation of the Siriraj Hospital – will be analysed to shed light on the NHC's influence. Its persuasive powers and ability in mediating the differences between public agencies, private firms and civil society shall be discussed in the following section. The paper concludes with a summary of the main argument and suggests ways for future research.

Neo-liberalism and Reign-Seeking in Thailand

In Van Apeldoorn's (1998) study on European economic integration, he argues that despite the seeming inevitability of neo-liberalism, the promulgation of such ideas is often convoluted with unpredictable end results. This is because neo-liberalism does not take place in a vacuum but is instead shaped by state-society relations exhibiting dissimilar power dynamics across time and space. The political bargaining and compromise at different locales thus lead to several competing, or at least different, forms of neo-liberalism. According to Brenner and Theodore (2007, 154-5), there exists a "profound disjuncture between orthodox neoliberal ideology and the complex, contested and uneven geographies of regulatory change that have emerged in and through projects of neoliberalization". Put another way, it is a process which continues to evolve and reinvent itself, interacting with place- and context-specific variables to forge the rules and the role of the state vis-à-vis the market.

While devoid of the organisational capacity of the more developed economies, Thailand has retained an under-rated autonomy in crafting public policies in spite of its apparent conformance to the neo-liberalism agenda. While Bangkok has generally promoted market liberalisation and integration into the regional and global economy, these policies were adopted with varying degrees of openness and contestation. In his analysis of the Thai banking industry, Hewison (1989) shows that the Sino-Thai firms adeptly collaborated with the military and

bureaucrats in the immediate years after the Second World War. Taking advantage of the political protection and business privileges from the then military administration and the collapse of the European-dominated financial network in Asia, four families soon captured the lion's share of the market and rose to prominence: Sophonpanich (Bangkok Bank), Lamsam (Thai Farmers Bank), Techaphaibun (Bangkok Metropolitan Bank) and Rattanarak (Bank of Ayudhya).[4] However, the economic slowdown in the mid-1950s pushed the other domestic business groups and foreign capital to pressure the state to further open up the economy, which it eventually did (but not always on terms wholly acceptable to foreign capital). Greater foreign participation generated new opportunities for other domestic business groups, with the state apparatus facilitating capital accumulation of both international and domestic firms, but with mixed outcomes.

In agribusiness, for example, the CP Group saw its fortunes rise after Thailand welcomed foreign capital to propel industrialisation especially in agro-industry. The firm got its first major breakthrough in the late 1960s when it established a feed manufacturing company (Suehiro 2008). Tapping into the government's investment promotion programmes and forming joint ventures with foreign firms to access technology-intensive production technologies, the company by 1981 captured 50 percent of the nation's total animal feed production. Operating three core divisions (agribusiness and food, retail and distribution and telecommunications), the CP Group emerged as one of Thailand's largest business groups by the 1990s. Its owners – the Chearavanont brothers – rank among Thailand's wealthiest people, with an estimated wealth of USD 30 billion in 2018 (Karmali 2018). The Thai automobile industry also emerged following the more liberalised environment. While some capital-intensive Thai firms benefited from generous incentive schemes and equity collaboration with

[4] The Sophonpanich and Lamsam families retain respective control of their banks while the latter two families have failed to do so.

foreign firms (especially Japanese ones), they have been relegated to junior partners in the ensuing decades. Facing financial distress during the AFC and with the state curtailing financial support (as part of the IMF programme), they were forced to auction equity off to the foreign firms. Despite the industry's export success, the domestic engineering ecosystem has not substantially deepened its technological know-how. As a result, the country is stuck in a low-wage, low value-added production model.[5] These concise yet contrasting accounts on two of Thailand's more prominent industries show that rather than conceptualising the state as either retreating or strengthening vis-à-vis cross-border capital, it is more helpful to view it as an entity that constantly reconfigures itself to forge new and innovative forms of state-business cooperation (often in concert with domestic firms) to propel growth (Held et al. 2000; Lim 2018). Suehiro (2008, 164) sees such a dynamic trilaterally, with Bangkok regulating the interaction between the domestic firms and their foreign counterparts. At the same time, these firms combine with each other in various ventures, inducing competition and cooperation over markets and profit.

Enriching the above perspective is Kanchoochat's (2016) analysis on the rise of a cohort of reign-seeking actors following the drafting of the 1997 constitution. One of the underlying logics behind the drafting of this constitution is that certain "independent institutions" should be divorced from politics to provide checks on elected politicians (Kanchoochat 2016). They include but are not limited to the Audit Commission, Human Rights Commission and National Counter-Corruption Commission. According to Hewison (2007), participation in such bodies was limited to the elites and carefully selected representatives of civil society from the middle class. Consequently, Thailand has witnessed the increasing power of unelected professional and official elites who craft technocratic and judicial bodies designed to discipline supposedly

[5] See Doner and Wad (2014) for a detailed account of its development.

dishonest and partisan elected politicians (see, for example, Vibert 2007; Flinders and Wood 2014; Heins 2015). Using exclusive material from the minutes of the constitution drafting assemblies, Mérieau (2016) demonstrates that the hegemony of these unelected actors has been preserved since the passing of the People's Constitution. If anything, their clout has been entrenched by the coups of 2006 and 2014. Echoing her work, Dressel (2018) argues that the 2016 Thai constitutional referendum has essentially replaced popular representative institutions with appointees and extra-constitutional institutions. This curtailed any meaningful expansion of civil and political rights under the pretext of political stability and economic progress (see, for example, Tonsakulrungruang 2016). Jayasuriya and Hewison (2004) interprets their emergence and subsequent strengthening as a distinctly political project that uses the liberal language of participation and empowerment as a strategy of "antipolitics" that marginalizes political contestation, aiming to shape and discipline social conduct within society in the elite's favour. Put another way, the discourse and practice of economic development is carefully managed and propagated by a small group of elites with alternative visions of development given short shrift. Nonetheless, this does not negate the fact that the act of moulding societal conduct is just as valid a concern for both right- and left-leaning elites. As Bamber (1997) shows, some of Thailand's healthcare reforms and institutions that emerged during the 1980s and 1990s have been pushed by progressive-minded technocrats, despite resistance from more conservative elements within the state machinery.[6] This underlines the heterogeneity within the reign-seeking elites with ideological contestation serving as points of fissure.

Existing studies have not commonly examined the impacts of these unconventional actors on the economy, despite growing consensus on their clout in Thai politics. More

[6] Bamber's (1997) research has since been enriched and updated by the likes of the afore-mentioned Harris (2015) and Kuhonta (2017).

specifically, research on how such reign-seekers have managed economic affairs through policymaking is lacking. Although recent scholarship on Thailand's broader healthcare sector has shed light on the role of networked bureaucrats in leveraging unique resources to promote the broadly progressive Thai Baht (THB) 30 universal healthcare programme during the tenure of Prime Minister Thaksin Shinawatra (in office from 2001 to 2006) (Harris 2015; Kuhonta 2017; Selway 2011), there is still relatively little insights on how the exchanges between these bureaucrats and the more established public agencies and market players pertain to the growth of a major industry (such as the medical tourism industry) within the sector. The medical tourism industry is important because it enjoys extensive linkages with the regional and global production and financial networks. This is partly due to the increasingly less restrictive regulatory regime on the provision and trade in medical goods and services as well as technological advancement in cross-border transportation. The medical tourism sector is also important because increasing numbers of developing economies (including Thailand) are devoting considerable resources to tap into its earning potential. Understanding such development is therefore critical for it assists these economies in crafting effective policies to more effectively facilitate value capture for its stakeholders, stimulating broader economic catching-up.

The Emergence of Thailand's Medical Tourism Industry

The Thai medical tourism industry emerged during the late 1980s as the economy enjoyed an extended period of growth. As the Kingdom's gross domestic product (GDP) rose from USD 43 billion in 1986 to USD 183 billion in 1996, its rising middle class sought quality medical services which triggered the burgeoning of private medical facilities (Rigg 2002). However, the severity of AFC drastically shrunk domestic demand, forcing the private healthcare providers to seek overseas clients. Taking advantage of the depreciation of the THB, these private players enjoyed almost immediate success in attracting foreign patients (Teh

2007). As such, several new facilities catering to foreign demand mushroomed in major tourist destinations such as Phuket, Pattaya, Chiang Mai and Koh Samui (Lempert 2010). Table 1 highlights the main hospital groups involved in Thailand's medical tourism industry. It is dominated by well-capitalised Thai firms (collaborating with foreign investors).[7]

Insert <Table 1: Major Hospital Groups of Thailand's Medical Tourism Industry> here

Although the private sector was active in reaching out to foreigners, medical tourism did not appear on the national agenda until Thaksin became the Prime Minister. He rose to power promising to lift the Kingdom out of the still-recovering turmoil induced by the AFC. Securing a strong mandate from the voters, the Thaksin administration rolled out several ambitious economic stimulus programmes ranging from upgrading the automobile industry to eradicating rural poverty (Lauridsen 2009). The administration also noticed the private medical service providers' potential to generate additional income through the export of services and was willing to support it. The 9th National Economic and Social Development Plan (2002-2006) underscored Thaksin's vision as it aimed to turn the Kingdom into the region's medical hub (NESDB 2001).[8] To achieve this goal, the First Strategic Plan, "Thailand: the Excellent Medical Hub of Asia" (2003-2008), was launched by the Ministry of Public Health (MOPH). It aimed to transform the country into the Excellent Medical Hub of Asia, the Wellness Capital of Asia and the Origin of Precious Herbs for Superior Health (Alberti et al. 2014; Pitakdumrongkit 2017).[9]

[7] While these firms have sold some of their shares to foreign investors on the stock exchange, Thailand's 49-percent cap on foreign ownership in private healthcare services means that they have preserved some degree of autonomy against foreign capital while tapping into the latter's expertise.

[8] The National Economic and Social Development Plan is formulated every five years since 1961 by the Prime Minister's Office to guide Thailand's overall economic strategy.

[9] On balance, the administration devoted more resources towards the aforementioned THB 30 universal healthcare programme than the medical tourism industry. It was because the former appealed immediately to the voters, especially the rural electorates that made up Thaksin's strongest supporters (Selway 2011).

However, Thailand's medical tourism policy was discontinued as the follow-up plan was only launched in 2014 or six years after the first one ended. This hiatus can partly be explained by a series of political crises including the fall of Thaksin in 2006. Notwithstanding the absence of national plans, the medical tourism industry blossomed. For instance, it contributed to around 0.4 percent of the country's GDP in 2011 (NaRanong and NaRanong 2011). By 2015, the industry's revenue rose to about USD 3 billion, accounting for 1.6 percent of the nation's GDP (Oxford Business Group 2016). KPMG (2018) reports that Thailand was ranked as the 18th most popular medical tourism destination in the world. The study also expects the Kingdom's medical tourism industry to expand at 14 percent annually from 2017 to 2020, corresponding with the yearly 12 percent growth of international tourist arrivals in Thailand. Medical tourist spending is also lucrative, estimated at close to twice that of Thai patients (Oxford Business Group 2012). This revenue stream is adeptly captured by Bumrungrad Hospital, Thailand's fourth-largest hospital group (see Table 1). In 2017, as much as 65 percent of its total revenue (USD 560 million) was derived from international patients, the highest ratio amongst all hospital groups in the country (Bumrungrad Hospital 2017).

Largely because of its importance, medical tourism re-appeared on the national agenda in 2012. The sector was incorporated into the 11th National Economic and Social Development Plan (2012-2016) (NESDB 2011). Two years later, the Second Strategic Plan "Thailand as a World Class Health Care Provider" (2014-2018) was concocted. Building on the First Strategic Plan, it envisaged the advancement of the Kingdom's expertise in four areas: medical services, traditional and alternative medicine, herb products and health promotion (International Health Policy Programme 2014). Nevertheless, the industry's growing linkages to other sectors of the domestic and global economy renders a need for Bangkok to incorporate the divergent stances and preferences of various stakeholders such as the welfare-oriented MOPH, the pro-business Board of Investment (BOI), private firms and civil society actors. As the subsequent sections

show, one of the more prominent actors is the Private Hospital Association (representing the interests of private hospitals). Cooperating with its allies, it has lobbied for more pro-business legislation.

Streamlining Policy in an Age of Neo-liberalism

Inter-Agency Gridlock

As previously illustrated, the formulation of Thailand's medical tourism policy involved several government entities harbouring different priorities. For an analytical purpose, this paper focuses on the four most influential public stakeholders and their objectives because they wielded the greatest influence over the final policy. The first actor is the MOPH. The MOPH was tasked by the government to act as the leader in shaping the Second Strategic Plan (Interview, a research director of a Bangkok-based research institute, May 26th, 2016). Its main goals are to ensure equitable access to medicine for the public and the sustainable development of the country's healthcare system. Therefore, the medical tourism policy is to be devised in a way that will not undermine the accessibility and sustainability of the entire healthcare system. Unlike its other three counterparts, the MOPH accords commercial interests only a secondary priority.[10]

Another entity involved in the policymaking process is the Ministry of Commerce (MOC) whose main responsibility is promoting a business environment that facilitates fair trade, minimises transaction cost and enhances value capture for entrepreneurs. It represents the interests of the business community, conducting regular consultations with firms. Moreover, the MOC is to deal with various international regulations such as services liberalisation in trade agreements between Thailand and other nations. It also facilitates the operations of foreign firms in Thailand through the granting of business licenses, work visas and permits. The entity

[10] It should be noted that the MOPH in turn mandated its Department of Health Service Support (DHSS) to design the Plan. Thus, the MOPH's stances reflected those of DHSS. DHSS is also involved in the crafting of the Third Strategic Plan (2017-2016) (Department of Health Service Support 2017a, 2017b).

wants to leverage on the growth of medical tourism to attract additional export revenue and spur economic development.

The Tourism Authority of Thailand (TAT), a state enterprise under the Ministry of Tourism and Sports, also participated in the shaping of the medical tourism policy. The TAT's main task is customer recruitment, which includes promoting the nation's goods and services to the world markets via its online platforms and in-country road shows (Interview, an officer of TAT, May 5th, 2016). It conceptualises medical tourism as tourism with a distinct medical undertone, using this notion to enhance its marketing schemes. The entity plays up "Thai-ness" as a brand-building tactic to harness the nation's strength in specialised services such as cosmetic procedures, sexual reassignment surgeries, dentistry and LASIK (Interview, an officer of TAT, May 8th, 2016). Beyond cost-competitiveness and service quality, medical care is promoted as highly tailored to the needs of individual patients. This is based on the assumption that such customisation establishes bonding and rapport between clients and medical staff, which in turn raises the former's satisfaction and influences their re-visit decisions (Veerasoontorn et al. 2011).

Another involved actor is the BOI which operates under the auspices of the Prime Minister's Office. Its primary task is to attract foreign direct investment (FDI) by providing information, services and incentives to prospective investors. As the "international face" of the Thai economy, the BOI has its own agenda in shaping policies related to the medical tourism industry. It views the policymaking process as an avenue to design incentive packages to more proactively attract FDI. Some of its considerations include offering tax exemptions to prospective investors in the broader medical ecosystem, lifting foreign equity restrictions in specific areas of the industry and waiving tariffs charged on imported medical equipment (Interview, officers of BOI, June 4th, 2016).

To recap, the MOPH's goal is to achieve equity in the citizenry's access to good quality medicine and promote the sustainability of Thailand's overall healthcare system. In contrast, MOC and BOI aspire to leverage medical tourism to ramp up export revenue and attract foreign investment respectively. TAT instead utilises medical tourism as a component to enhance its marketing campaigns (Interview, an officer of TAT, June 8th, 2016). In other words, such diverging interests indicate that the MOPH is focused on the "medical" aspect while the other three agencies emphasise the "tourism" part of the policy (see Figure 1). Although the MOPH took the lead in shaping the Second Strategic Plan, it still has to balance the requests of its three counterparts who favour a more pro-business approach. In particular, it has to resist the bureaucratic behemoth that is the BOI, which not only has direct access to the Prime Minister, but also possesses vested interest in promoting a more neo-liberal vision of economic development.

Insert <Figure 1: Main Public Agencies and their Shaping of Thailand's Medical Tourism Policy> here

Despite these conflicting goals and the seeming power disparity between the MOPH and the three other more pro-business agencies, the Second Strategic Plan eventually managed to incorporate all of such interests, evidenced by its four broad, inclusive strategies (see Table 2). The four strategies each represent the outlook of the four agencies, balancing the MOPH's "medical" orientation as well as the "tourism" wishes of the MOC, BOI and TAT. Overall, it is clear that Strategies 1 and 3 reflect the interests of the MOC, BOI and TAT while Strategies 2 and 4 dovetail well with the MOPH's agenda. While it is indeed well-designed and fulfils the demands of all four agencies, there is not much information on how *exactly* were the different preferences articulated and eventually reconciled. In other words, how did these entities agree on the final terms of the Second Strategic Plan?

Insert <Table 2: Four Strategies of the Second Strategic Plan: Thailand as a World Class Health Care Provider (2014-2018)> here

Fieldwork data reveals that the MOPH played an important role in reconciling different stances among the government entities, although it was challenged by the other three agencies (Interview, an officer of TAT, June 8th, 2016; Interview, officers of BOI, June 4th, 2016). Illustratively, Strategy 1.2 of the Plan is aimed at boosting healthcare trade and investment, which aligned well with the preferences of MOC and BOI. Furthermore, TAT's interest in undertaking marketing activities to promote medical tourism are addressed in Strategy 3. Nevertheless, the initial demands from the MOC, BOI and TAT were considerably more ambitious. These three bodies also supported each other at the negotiation table as their interests were much aligned. Specifically, the MOC and BOI argued that medical tourism must be promoted as it would generate revenue and attract investment into the country. Seeing medical tourism as a fruitful way to expand its marketing campaign, TAT sided with the MOC and BOI. However, the MOPH adopted a relatively reserved stance, stressing that medical tourism must not be encouraged if doing so led to the undermining of the public healthcare system (Interview, an officer of TAT, June 8th, 2016). Initially, these four entities could not reach a common ground, resulting in a deadlock. This impasse was only broken following the lobbying efforts of the NHC. One of the key events diffusing the bureaucratic contestation was the NHC's introduction of an innovative policy, the "Siriraj Piyamaharajkarun" model, which eventually fostered a compromise between the four state agencies. Such issues are further delineated in the subsequent section.

Mediation through Reign-Seeking

Amidst the interagency squabbling pitting the MOPH against three of its more pro-business rivals, the role played by the relatively obscure NHC and its mechanism, the "National Health Assembly" (NHA), deserve special attention. The origin of the NHC can be traced back

to the National Health Act (2007) which not only created the entity but also gave it power to shape the national health agenda, including issues related to medical tourism.[11] In other words, the NHC's role is to ensure that healthcare policies are designed in a balanced manner, taking into account perspectives from multiple stakeholders. According to the Act's Articles 13.1 and 13.2, the Prime Minister and Minister of Public Health serve as its Chair and Vice-Chair respectively. The grouping could have up to 39 members, drawn from government, academia, health professionals and civil society organisations (Kumanan et al. 2012; NHC 2017b).[12] Figure 2 displays the composition and organisation chart of the NHC. The Prime Minister is allowed to appoint up to five ministers he deems fit into the NHC. In addition, four local administrators (Article 13.6), six qualified non-public healthcare professional practitioners (Article 13.9) and 13 representatives from the non-profit, private sector (Article 13.10) are to be appointed by the NHC's Selection Committee.[13] As several NHC members are selected directly by the Prime Minister (the Chair of NHC) or indirectly through the NHC's Selection Committee (for which the Prime Minister is also Chair), they tend to enjoy good ties with the Prime Minister or his Cabinet or both, granting the NHC considerable clout in shaping the Kingdom's health policies.

Insert <Figure 2: National Health Commission Organisation Chart> here

Moreover, Article 25.3 grants the Commission power to organise NHAs as part of its effort to undertake participatory policymaking, complementing the viewpoints of public agencies with that of other key stakeholders. NHA conferences serve as venues where public officers, private enterprises and civil society players (such as non-profit organisations and scholars) collectively discuss and examine various health and health-related issues facing

[11] This Act had been initiated during the 1990s but was only passed in 2007 (Harris 2015).
[12] The Act's Article 25.1 and 25.2 outline the NHC's responsibilities, which include creating the National Health System Statute and advising the Cabinet on national health strategies and policies.
[13] The Chair of the Selection Committee is the Prime Minister of Thailand.

Thailand (e.g. universal access to medicine, water sanitation, infectious diseases and teenage pregnancy), in addition to concocting policy recommendations (NHC 2017c). The gatherings are usually summoned at the end of every year, with the latest one taking place from December 20th to 22nd 2017. Put differently, the NHA is a tool that the NHC uses to engage stakeholders in formulating health policies, especially those related to the development of the medical tourism industry.[14] Government bodies such as the MOPH are regular participants in the NHA discussions. The Commission can select specific health issues to be tabled and discussed at NHA conferences. Its decision is guided by a set of pre-determined criteria such as the public health importance of the issue in Thailand, public interest in the issue and potential for policy development and implementation (Kumanan et al. 2012). Each meeting concocts resolutions which are in nature non-binding as the NHA aims to achieve influence and compliance by setting norms that derive legitimacy from the process and range of actors involved in their formulation. However, recommendations that require "stronger political support can be submitted by the Prime Minister as Chair of the National Health Commission for Cabinet action" (Kumanan et al. 2012, 90). The NHA's influence on Thailand's medical tourism policy is evident in Resolution 8, one out of nine resolutions formulated at the 3rd NHA which took place from December 15th to 17th 2010 (see Table 3). Within the context of this paper, this gathering was significant because it was the first NHA conference which discussed issues related to medical hub (including medical tourism) development. These elements appeared in this convention's agenda due to the NHC's actions.

Insert <Table 3: Resolutions Coined at the 3rd National Health Assembly> here

Thailand's medical tourism policy came under public pressure after the authorities conducted several high-profile international roadshows to promote it in the months leading up

[14] The NHC's initiative in fostering participatory policymaking does not translate into an equal effort in tracking the outcome of the resolutions made at the NHA conferences. The Commission's unsatisfactory outcome tracking ranks as one of its major shortcomings, diluting somewhat its policy impact.

to the 3rd NHA. The main grouse centred on the brain drain of healthcare personnel from the public to private sectors (Treerutkuarkul 2010).[15] This pressure was brought to bear, for example, in Point 1.5 of Resolution 8, which urges the MOPH "to implement the medical hub policies or strategies that are not affecting the health service system provided to the Thai people and must develop a mechanism for collaboration between the people, private sector and related agencies to develop such medical hub policies, both the national plan and action plan, in order to lessen negative impacts on the development of the health service system to the Thai people" (NHC 2010). Furthermore, the Cabinet of Prime Minister Abhisit Vejjajiva (in office from 2008 to 2011) approved the above components in April 2011, a mere four months after the Resolution was reached. It also tasked the MOPH to include them in the Second Strategic Plan. The result was the Plan's Strategy 4, which attempts to ensure that the implementation of a medical tourism policy does not beget negative spillover effects onto the national healthcare regime (MOPH 2014) (see Table 2). Some key policy actions include enhancing the public's equitable access to healthcare, raising the quality of public medical services and curbing brain drain from the public to private sector.[16] More prosaically, the Second Strategic Plan mentions that this Resolution was among the inputs used to compose such details (MOPH 2014), further underlining the NHC's clout over the policymaking dynamic.

[15] According to Wibulpolprasert and Pachanee (2008, 12), Thailand does not face a serious case of external brain drain (i.e. the migration of Thai healthcare professionals to other countries), at least compared to other regional economies such as the Philippines. Some of the factors undergirding this phenomenon include "[f]avourable income, good working environment, opportunity for career development and limited capacity in foreign language" of the Thai healthcare professionals.

[16] Some of the landmark policies to stem brain drain are the special medical tourism tax on foreign patients seeking treatment in Thailand. The revenue from this tax is then used to finance the public healthcare sector, such as by raising staff salaries and offering more attractive fringe benefits to retain staff in the public sector (Noree et al. 2016). More long-term policies include the government-funded special rural recruitment schemes: the Collaborative Project to Increase Production of Rural Doctors (CPIRD) and One District One Doctor (ODOD). Both schemes recruit medical students from the rural area and provide incentives for them to pursue a career in the Thai countryside after their graduation. CPIRD participants do not get scholarships during their six-year medical training and are required to work in the public healthcare facilities in rural constituencies for three years with a non-adherence fine of USD 11,300. ODOD students are given full scholarships for their six-year medical training, in addition to monthly stipends. Upon graduating, these individuals must complete a mandatory service in public healthcare facilities in the Thai countryside for 12 years. The penalty for non-compliance is USD 56,000 (Arora et al. 2017).

Another aspect of Thailand's medical tourism policy shaped by the NHC is the BOI's incentive schemes. These matters were discussed at the 3rd NHA. As the BOI had previously offered tax reductions and other privileges favouring private healthcare investors, the NHA participants feared that such an approach could in the long run undermine the national healthcare system. Illustratively, private enterprises could use BOI's incentives to raise their staff's salaries, ultimately exacerbating a brain drain and jeopardising the Thai populace's access to medical care (Treerutkuarkul 2010). Such concerns were reflected by Point 1.2 of this NHA's Resolution 8 which calls for BOI "to comply with the provision of Section 51 of the 2007 National Health Act by not rendering support or special tax or investment privileges to public health services which are business interest oriented" (NHC 2010). Section 51 mandates all involved implementation bodies of this Act to comply with all regulations, rules and notifications issued by NHC. Much like Point 1.5 of Resolution 8, this recommendation was later endorsed by the Abhisit administration in April 2011 (Pachanee 2012), effectively forcing BOI to eliminate its tax subsidy schemes given to private hospitals (Interview, an officer of MOPH, June 2nd, 2016).

Nevertheless, such a move was initially opposed by stakeholders aligned with the BOI, especially those private hospitals that benefit more from privileges under the previous schemes. For example, in January 2011, a task force consisting of representatives from the NHC and BOI was established to amend the BOI's Promotional Privilege Framework for the Health Industry as a follow-up action to the 3rd NHA. However, the powerful Private Hospital Association and its allies – Thai Chamber of Commerce and the Union of Thai Traditional Medicine Society – attempted to intervene. On March 30th 2011, the Private Hospital Association and its partners lobbied the then Minister of Public Health, Jurin Laksanawisit, to include some of their representatives as additional members of the task force. Their rationale was that a broadening of the task force's perspective will help it undertake a more objective

analysis. However, this attempt was unsuccessful as the task force decided against expanding its membership a day later (on March 31st 2011), underlining the NHC's pro-welfare stance and technocratic power (NHA 2011). Indeed, according to the final Promotional Privilege Framework for the Health Industry, the purpose of BOI's assistance was shifted "from supporting medical hub policy to strengthening Thai health systems" (Kongvichienchep 2017). The NHC justified its decision on the basis that it is in the best interest of the Thai public (Kongvichienchep 2017).

The prowess of the Commission in making policy recommendations and in getting the support of the Cabinet can also be explained through its unique organisational design. To delineate this point, the Commission's set-up deserves a second look (see Figure 2). Despite its seemingly inclusive nature and an active participatory process, the most powerful position resides with the Thai Prime Minister courtesy of his position as the Chair. The second most powerful position is occupied by the Vice-Chair, the Minister of Public Health. During his tenure, Abhisit chaired most of the NHC meetings. For instance, he attended three out of five meetings and four out of six meetings in 2009 and 2010 respectively (NHC 2019). In his absence, the Minister of Public Health (or the Deputy Minister of Public Health, if the Minister of Public Health was also absent) was tasked to chair the meetings. This gave the MOPH some influence in shaping the agenda, in addition to its expertise in issues of health and medicine in its "home" portfolio. As such, differences amongst the other participants can be reconciled, or at the very least, minimised by the MOPH through the NHC internal meetings, which must be held every two months (Rajan et al. 2017). The position also allows the MOPH to extract the other entities' priorities and interests, giving it an advantage when the NHA is held later on in the year.

In addition, Abhisit's rise to Prime Ministership in December 2008 on the back of a raft of populist policies seems to have provided fertile ground for a more people-friendly version

of the medical tourism industry. Campaigning under the slogan of "Putting People First", one of Abhisit's promises was to improve the THB 30 universal healthcare programme initiated by the Thaksin administration, turning it into an even more affordable healthcare service (The Nation 2012). At a glance, it looked like campaign rhetoric that could be quickly abandoned after the election. However, the Abhisit administration was determined to turn the slogan into reality. This is evidenced by the announcement of Abhisit's Minister of Public Health, Jurin, on January 20th 2010, a mere five days after he took over the helm of the MOPH. According to Thai Rath (2010), Jurin announced 10 key areas which he wanted to advance under his ministership: i) Protect and support the Thai people's health; ii) Better quality medical services; iii) Enhance the effectiveness of containment of contagious diseases; iv) Better consumer protection in the health sector; v) Increase the use of Thai herbs and medicines in the healthcare system; vi) Pay more attention to enhancing medical services personnel that match the country's healthcare needs; vii) Increase the roles of healthcare volunteers in the healthcare system; viii) Improve the ministry's communication system; ix) Transform Thailand into a medical tourism hub; and x) Create new regulations supporting the healthcare system. The ranking of these key areas suggests Jurin's priorities, with medical tourism ranked only at the ninth spot. In other words, Jurin, favoured the "medical" angle of the industry more than the "tourism" component. Jurin further underlined the "Putting People First" agenda of his administration, declaring that his "immediate priority is to listen to the concerns and proposals of people" when he was asked about plans to persuade foreigners that it is safe to visit the country following a series of political clashes from March to May 2010 (International Medical Travel Journal 2010). Jurin's stance cannot be dismissed as mere rhetoric as electoral reforms since the late 1990s have forced the major Thai political parties, both conservative and liberal, to take on a more welfare-

oriented position on healthcare (Selway 2011). This structural political shift in turn provided impetus for Jurin and his colleagues to promote a more welfare-centric medical ecosystem.[17]

Notwithstanding the welfare directives of Jurin and the MOPH that he led, the medical tourism industry also exhibited a reasonable degree of pro-business orientation. This is evidenced in the proposal and eventual adoption of the "Siriraj Piyamaharajkarun" model. The model proposes a two-track development of the healthcare system - with one catering to private, fee-paying patients while the other geared towards subsidised patients. Indeed, in a significant public statement endorsing this policy, Siriraj Hospital, one of the country's oldest public hospitals, opened the USD 287 million Siriraj Piyamaharajkarun Hospital in April 2012 as a private subsidiary to engage in medical tourism by offering services targeting higher fee payers (Pratruangkrai 2012). This move was also politically significant as the hospital had been caring for Thailand's revered late King Bhumibol Adulyadej since 2009 (and continued to do so until his passing in 2016). With treatment costing 20 to 25 percent less than private hospitals, Siriraj Piyamaharajkarun Hospital has secured a portion of the lucrative international medical tourist market. According to Associate Professor Dr Pradit Panchavinnin, Director of Siriraj Piyamaharajkarun Hospital, this new business model leverages the infrastructure, reputation and experience of the parent hospital without significantly hampering the latter's mandate of providing subsidised healthcare to the Thai citizenry (Pratruangkrai 2012). He added that the establishment of Siriraj Piyamaharajkarun Hospital will supplement the revenue of Siriraj Hospital as the latter incurs an operating loss amounting to about 10 percent of annual income, with the Thai state keeping it afloat through subsidies (Pratruangkrai 2012). While Siriraj

[17] The Democrat Party, of which Abhisit led from 2005 to March 2019, traditionally favours a more *laissez-faire* approach to the economy (including the healthcare industry). It has taken on a more welfare-oriented stance only after the introduction of the late 1990s electoral reforms. The reforms forced political parties to be more responsive, at least relative to the pre-reform era, to the demands of a much larger proportion of the Thai populace. This critical juncture of Thai politics also saw the emergence of Thaksin and his brand of populist policies (see, for example, Selway 2011).

Hospital's private sector entrance is the most prominent, similar moves are being considered nationwide, particularly in border areas where private hospitals have yet to make major inroads and public district and provincial hospitals dominate (Oxford Business Group 2012).[18]

According to an academician involved in the 3rd NHA, key NHC members accepted the above proposal because Siriraj Hospital had already experimented with a smaller scale two-track healthcare system in 2006 (Interview, an academician, May 26th, 2016). The hospital got lauded for "The Heart by Siriraj" project in which it offered part of its cardiology services to patients willing to pay higher-than-normal rates for expedited treatment (Chanasongkram 2007).[19] "The Heart by Siriraj" initiative not only brought additional revenue but also reduced the exodus of medical professionals wanting to leave the hospital for private practice. Its success convinced the senior management of Siriraj Hospital to "extend the services into a full general hospital" which eventually led to the creation of the "Siriraj Piyamaharajkarun" model (Pajee 2012). Several NHC participants believed that this approach could be applied in other hospitals as part of Thailand's medical tourism policy. More importantly, this two-track healthcare system is ingenious because it manages to placate the "tourism" demands of the MOC, BOI and TAT, while not overly compromising the MOPH's "medical" orientation.

Discussion

Extending Kanchoochat's (2016) analysis on the rising clout of Thailand's reign-seekers since the late 1990s, this paper underlines the influence of the NHC in shaping industrial policy. The focus on this group of professional elites also enriches the literature detailing Thailand's political economy as it moves the spotlight away from the traditional elites centred around the palace. More importantly, it highlights the Commission's ability in

[18] The Thai government's recent move to extend the stay for medical tourists from Cambodia, Laos, Myanmar and Vietnam from the previous 30 to 90 days is likely to swell the coffers of well-prepared hospitals, especially those along its borders (KPMG 2018).

[19] Manpower shortage at the hospital means that regular fee paying patients have to wait a considerably longer period for the same type of medical treatment.

mediating conflicts and in coordinating dialogue between several public agencies and other stakeholders.[20] This demonstrates that reign-seekers play an important (albeit understated) technocratic role in stimulating the medical tourism industry, a relatively understudied issue. In-line with Jayasuriya and Hewison (2004), the NHC's clout underscores the manner in which seemingly inclusive concepts like participatory policymaking have been deployed to open up space for policy discussion, with representatives from different segments of Thai society roped into it (see Figure 2). Nevertheless, it must be stressed that substantive power still rests with the Prime Minister (Chair) and the Minister of Public Health (Vice-Chair), which implies that some form of selection preference is likely to have been exercised in the appointment of the professional elites into the NHC.[21] At least within the medical tourism industry, this suggests that the philosophy and practice of economic development remain controlled by a small group of elites, reinforcing the works of Jayasuriya and Hewison (2004) and Hewison (2007).

In addition, this paper uncovers the welfare-oriented outlook of the NHC. The Commission's alignment with the MOPH rather than the more pro-business MOC, BOI and TAT contrasts somewhat with Kanchoochat's (2016) observation of a correlation between the propagation of neo-liberalism and reign-seeking professionals. While Chang (2001) and Flinders and Wood (2014) stress that one of the major factors undergirding neo-liberal governance reforms is that they "de-politicise" the economy, preventing interest groups from distorting the "rationality" of the free market, the paper shows that the supposedly market-friendly NHC has defied such a narrative. Indeed, political contestation is detected amongst key agencies and stakeholders, with the Commission not only functioning as a coordinator-cum-mediator, but also tilting towards the MOPH. The wider implication of this observation is

[20] As previously stated, the Commission's prowess would have likely been enhanced if it put more effort into tracking the outcome of the resolutions made at the NHA conferences.

[21] Conversely, the will of the Chair and Vice-Chair is unlikely to be materialised without the support of reign-seeking institutions such as the NHC. If anything, the relationship between both groups can be seen as a form of symbiosis.

that reign-seekers are not to be viewed as a monolithic, undifferentiated bloc. Although they are not averse to tweaking supposedly broad-based participation to their favour, this does not automatically mean that they will support more market-friendly agendas. Indeed, the paper shows the exact opposite – the NHC's reign-seeking professionals opting for welfare-oriented policies. This finding also supports Van Apeldoorn's (1998) thesis, underlining the need to examine the social forces that collectively underpin state power rather than to focus on the state in a narrow and traditional sense. Notwithstanding the apparent appeal of the neo-liberal offensive, this finding shows once again that neo-liberalism does not occur in a vacuum. Its eventual fruition is in turn contingent upon state-society relations (and their profound asymmetries and contestations). This disaggregated mode of analysis is useful in teasing out the power relations embedded within particular societies and settings, suggesting that the battle is often not so much state versus market as left-leaning entities versus right-leaning ones within the state itself.

Furthermore, the NHC's avoidance of a lopsided tilt to neo-liberal prescriptions (such as proposing the two-track "Siriraj Piyamaharajkarun" model) shows that the Commission not only shared concerns with public sentiments but also devised an innovative way of solving potentially thorny public sector challenges. These observations can be partially explained by the political ideology of the Abhisit administration, especially its desire to engineer an affordable public healthcare service and the personal policy entrepreneurship of Jurin, the then Minister of Public Health. In addition, the NHC's organisational design deserves special attention for it grants the MOPH some advantages through the authority of the Vice-Chair. By extracting the priorities and interests of the other stakeholders through the bimonthly internal meetings, Jurin – the Vice-Chair – succeeded in reconciling the differences of the participants. This in turn allowed the MOPH to shape the agenda somewhat before the 3rd NHA was held during the latter part of the year. These observations have a twofold implication. Firstly, the

NHC through its governance mechanism represents the Thai state's efforts to refashion the nature of engagement with external parties to its advantage. This resonates with Held et al. (2000) who argue that it is more fruitful to analyse the manner in which the state has reconfigured itself to harness international private capital than to examine the strengthening or weakening of the state vis-à-vis the latter. Although the industry remains private sector-dominated (with Siriraj Piyamaharajkarun Hospital as the only notable player from the state sector), it does not necessarily mean that the state has relinquished responsibility to coordinate and implement policies.[22] If anything, the NHC can be conceptualised as an attempt by the Thai state to not only enable bargaining between key stakeholders, but also deliberate the most appropriate form of intervention for the medical industry.

Secondly, the crafting of Thailand's medical tourism policy demonstrates that neo-liberal ideas of development have been watered down, preserving the autonomy of the state. What is even more remarkable is how the MOPH managed to stand its ground – with support from the NHC – versus its more free market-leaning counterparts. Disputing scholarship such as Aalbers (2013) and Stiglitz (2016), this paper shows that where there is a strong alliance of unconventional actors (in this case, the welfare-oriented NHC) with the state (specifically the MOPH), the impact of a diminution of state power is likely to be less. It further suggests that there is considerably more degree of freedom for such an alliance to navigate and advance its agenda than the usual accounts of globalisation imply there should be. More specifically, the paper notes a tripartite partnership between the state (represented by politicians and reign-seeking bureaucrats), certain factions of domestic capital (i.e. the large hospital groups) and foreign capitalists who act as minority shareholders of the Thai hospital groups. While messy

[22] Although less illustrious and smaller scale than Siriraj Piyamaharajkarun Hospital, some public hospitals along Thailand's northern borders also offer relatively sophisticated services to medical tourists from the adjacent countries. For example, the better-equipped public (and small private) hospitals at Udon Thani city are popular amongst increasingly wealthy Laos patients.

and confrontational on the outside, the policymaking process has been conducted in ways that apparently furthered the interest of all the major stakeholders, reinforcing the trilateral state-business dynamic detailed in Suehiro's (2008) research. Nevertheless, this dynamic has recently been complicated by the attempts of foreign capital eager to expand their market share. The aforementioned Thai Chamber of Commerce, acting in concert with the influential Joint Foreign Chambers of Commerce in Thailand, has repeated the call for the state to allow foreign ownership of Thai businesses (including private healthcare providers) to exceed 49 percent. Stanley Kang – the Chairman of the Joint Foreign Chambers of Commerce in Thailand – reasons that: "If the government does nothing, we expect that ongoing efforts to attract foreign investment will be quite tough" (Arunmas 2018). That this lobbying was spearheaded by commercial players who work closely with the well-capitalised domestic hospital groups (e.g. in their unsuccessful attempt to alter the Promotional Privilege Framework for the Health Industry following the conclusion of the 3rd NHA) speaks to the constantly-shifting, but not necessarily adversarial, relationship between domestic capital, its foreign counterpart and the state.

It is still too early to demonstrate the Second Strategic Plan's longer-term impact in stimulating technological upgrading within the Thai medical tourism industry in the manner of what has been illustrated in, for example, the automobile industry (Doner and Wad 2014). Nevertheless, the evidence detailed so far provide reasons for optimism. In particular, the four strategies of the Second Strategic Plan have seemingly struck a good balance between the polarising demands of the industry's "medical" and "tourism" aspects. The partial privatisation of the prestigious Siriraj Hospital – to capture the market demand for medical tourists while not forgoing the welfare of ordinary Thai citizens – is another noteworthy example of state autonomy. To recap, too strong a swing towards either aspect will most certainly disrupt the long term growth of the industry. More specifically, an overemphasis on the public's welfare

will deter the entry of foreign firms and medical tourists while too neo-liberal an approach will undermine the Thais' equitable access to proper healthcare. The observation thus far offers a good case study of the way in which a developing economy can still forge an alternative economic policy pathway and navigate through an age of supposedly supercharged globalisation. This has important and wider implications for other developing economies aspiring to craft a modernisation pathway compatible with their specific set of socio-historical circumstances.

Conclusion

The above analyses have demonstrated how the Second Strategic Plan which set the directions of Thailand's medical tourism policy was formulated through inter-institutional bargaining and an unconventional policymaking process orchestrated by reign-seeking elites. It was revealed that the Plan's final details were outcomes of negotiations among the involved public entities, private stakeholders and civil society. Firstly, despite coming up against other more pro-business public agencies, the MOPH was finally able to reconcile its preferences as well as that of the latter. The entity successfully did so in large part because of the unique deliberation process as well as the NHC's organisational design which allowed the former to gain the initiative through the position of Vice-Chair. Although the resolutions raised by the NHC are technically non-binding, they were approved by the Thai Cabinet merely four months after the 3rd NHA was concluded with key welfare policy measures incorporated into the Second Strategic Plan. Notwithstanding the political leanings of the Abhisit administration to promote a more welfare-oriented healthcare system, the NHC has also formulated the innovative two-track "Siriraj Piyamaharajkarun" model to pacify the more pro-business public agencies. Overall, this highlights the Commission's clout over the policymaking process of the Thai medical tourism industry, serving as an intermediary to foster dialogue and reconcile diverging interests.

Secondly, the paper has illustrated that there is little to suggest that the state is losing ground. Contrarily, the evidence points to a relatively autonomous state. Therefore, mainstream arguments about the impact of rising cross-border trade and investment flows on the state may need to be qualified when the spotlight is trained on a developing economy. More specifically, the paper has unpacked the nature and interplay of power in Thailand, debunking the tendency to overstate the influence of private, foreign capital on the state. Even within the category of "capital", it appears that despite similar objectives, domestic capital (represented in this paper by the large hospital groups) is more dominant than its foreign counterpart (who can only own up to 49 percent equity of private healthcare services).

Lastly, the "state" must not be seen in a homogenous and narrow manner as it is made up of several public entities such as the parastatal NHC that harbour diverse objectives. This further underlines the need to examine more closely the power relations inter-connecting key economic actors such as the reign-seekers, how they mesh with neo-liberal economic logic and to what extent they shape development outcomes. In addition to the disaggregation of key players within the state, it is crucial to *not* assume the allegiance of reign-seeking elites to neo-liberalism ideals, although their rise to prominence coincided with the propagation of governance reforms inspired by the Washington Consensus.

Notwithstanding the findings, this paper can still benefit from future research. As the focus of this paper is the political interplay between key Thai stakeholders in crafting policies outlined in the Second Strategic Plan, prospective researchers would do well to examine in-depth the relationship between the Plan and actual, *on-the-ground* development outcomes. Further analysis on the role of hospitals located in the border provinces, for example, would shed light on the "Siriraj Piyamaharajkarun" model's replicability outside of Bangkok. Another fruitful research direction is to conduct more fine-grained analysis on the reign-seekers themselves. As earlier detailed, the NHC professionals' support for welfare-oriented policies

rather than market-friendly ones implies that there is some fracture within a supposedly homogenous bloc of neo-liberal proponents. One can most certainly unearth the contestation and conflict in greater detail by examining their motivations, educational background and actual policy moves. Finally, there is a need to compare the impact of the reign-seekers in other industries such as automobile and mining with that in the medical tourism industry. Admittedly, carrying out this form of analysis could be challenging as different industries evolve under different political contexts and respond to dissimilar incentives. Yet, such assessment is worth undertaking because it would enrich our understanding on the increasingly noticeable influence wielded by the unelected reign-seeking elites in the Thai political arena.

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Table 1: Major Hospital Groups of Thailand's Medical Tourism Industry

Name	Ownership Structure*	Capacity
Bangkok Chain Hospital	Harnphanich Family (Thailand, 50%); Free Float (38%); Others (12%)	2,178 beds
Bangkok Dusit Medical	Prasarttong-Osoth Family (Thailand, 22%); Free Float (47%); Others (31%)	8,015 beds
Bumrungrad Hospital	Bangkok Bank Public Company Limited (Thailand, 32%); Free Float (40%); Others (28%)	580 beds
Chularat Hospital	Plussind Family (Thailand, 26%); Free Float (38%); Others (36%)	830 beds
Siriraj Piyamaharajkarun Hospital	State-Owned (Thailand, 100%)	344 beds

*: Free float represents the portion of a firm's equity that can be publicly traded on a stock exchange.

Source: Arunothai (2015), Bangkok Chain Hospital (2018), Bangkok Dusit Medical (2017), Bumrungrad Hospital (2017), Udomvej (2018).

Table 2: Four Strategies of the Second Strategic Plan: Thailand as a World Class Health Care Provider (2014-2018)

Strategy 1: Increase the Country's Healthcare Services Capacity • 1.1: Improve the healthcare management system to better serve the clients • 1.2: Increase trade in healthcare services and attract investment in the healthcare sector from domestic and overseas sources • 1.3: Improve healthcare services and develop national product champions • 1.4: Enhance the public-private partnership (PPP) in the healthcare sector • 1.5: Improve the medical mediation system • 1.6: Encourage and develop internationally-accredited healthcare services centres, providers, and products
Strategy 2: Increase the Capacity of Healthcare Institutions and Personnel • 2.1: Increase the capacity of education institutions in the healthcare and related sectors • 2.2: Increase the capacity of research institutions in the healthcare and related sectors • 2.3: Increase the capacity of healthcare personnel • 2.4: Increase the capacity of healthcare professions • 2.5: Increase the capacity of skilled labour in healthcare-related sectors
Strategy 3: Undertake Marketing and Public Relations Activities • 3.1: Carry out in-bound marketing activities • 3.2: Carry out out-bound marketing activities
Strategy 4: Implement the Medical Tourism/Hub Policy which does not Negatively Affect the National Healthcare System

- 4.1: Adopt a well-rounded, effective healthcare management model
- 4.2: Develop measures to prevent the potential adverse effects of the implementation of this Strategic Plan on the national healthcare system. If the implementation causes adverse effects, employ remedial measures to alleviate them

Source: MOPH (2013).

Table 3: Resolutions Coined at the 3rd National Health Assembly

- Resolution 1: Overcoming Crisis of Injustice for the Wellbeing of Thai Society Together
- Resolution 2: Control of Food Marketing Strategy for Infants and Young Children
- Resolution 3: Fairness in Access to Health Services by the Disabled
- Resolution 4: Solving the Problem of Unplanned Pregnancy in Thai Teenagers
- Resolution 5: Measures to make Thai Society free from Asbestos
- Resolution 6: Measures on Health Risk Factors particular on Tobacco Control
- Resolution 7: Policies to Support Self-Management Areas for Social Wellbeing
- Resolution 8: Medical Hub
- Resolution 9: Protection of Well-Being and Society from the Impacts of Free Trade

Source: NHC (2017a).

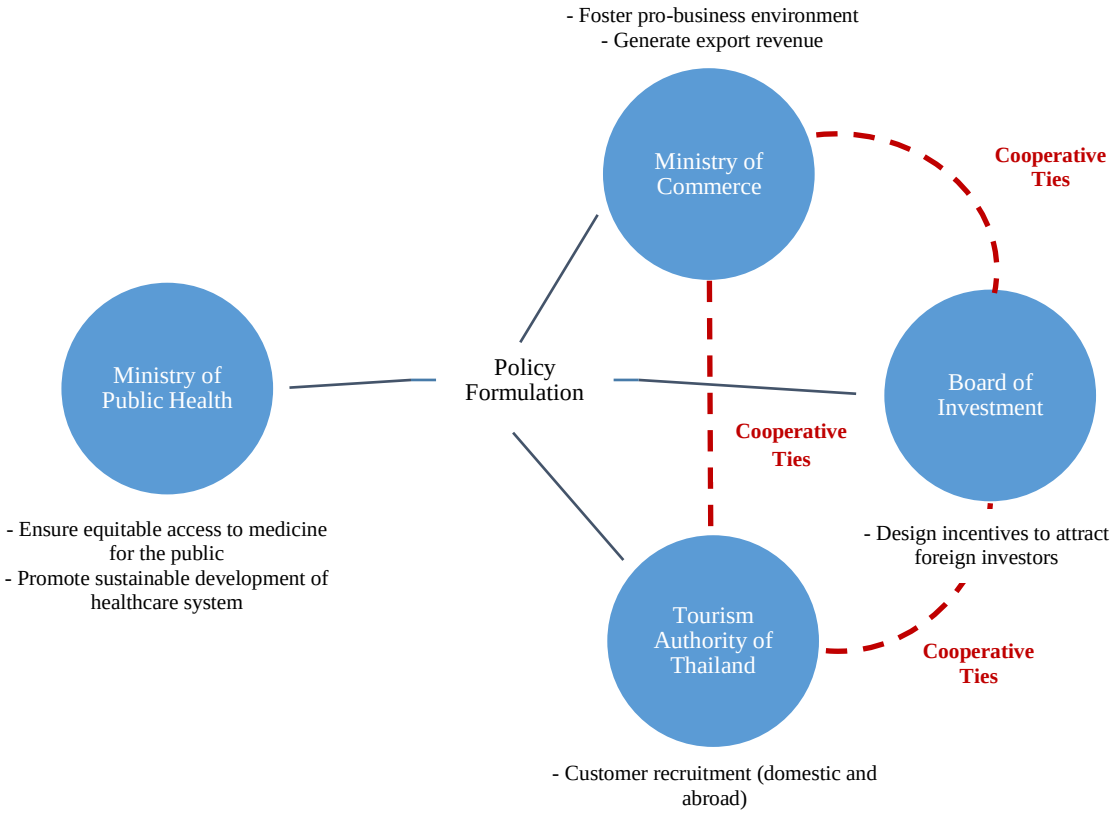

Figure 1: Main Public Agencies and their Shaping of Thailand's Medical Tourism Policy

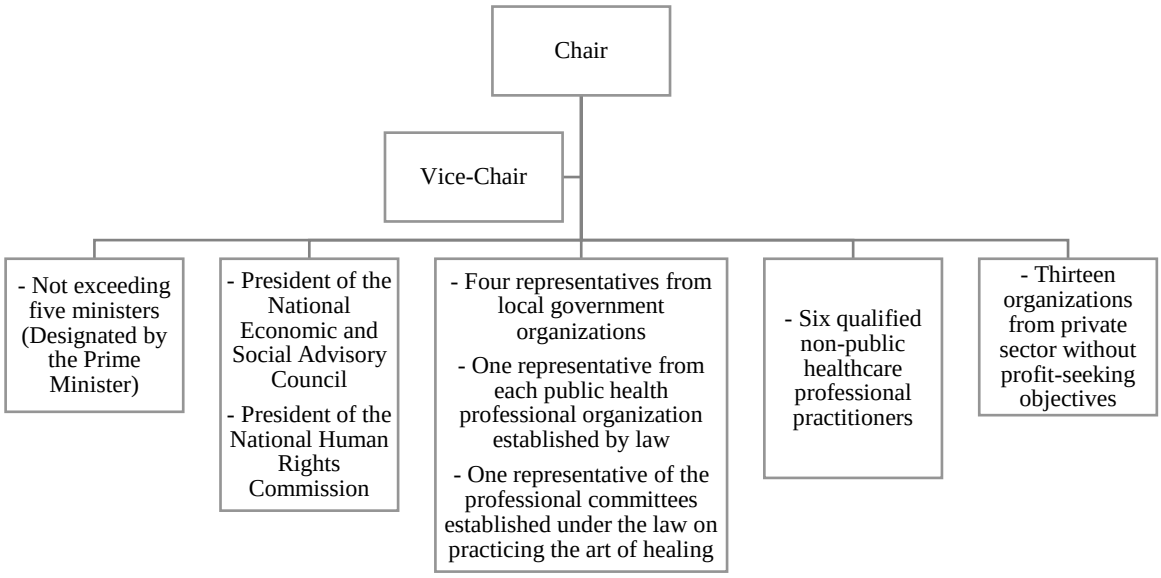

Figure 2: National Health Commission Organization Chart

Source: NHC (2017b).