Chapter 9
National Health System Reform and Health Decentralization

1. National Health System Reform

The process of national health system reform began officially in 2000 when the government issued the regulations of the Prime Minister's Office on National Health System Reform of 2000, establishing the National Health System Reform Commission (HSRC) chaired by the Prime Minister and charged with the support for the drafting of the National Health Bill and the recommendations for national health system reform, having the National Health System Reform Office (HSRO) established as an ad hoc agency under the Health Systems Research Institute (HSRI) to serve as the secretariat.

The drafting of the National Health Bill to be used as a principal law on health used a participatory approach involving all sectors in society so that Thai people across the nation could participate in thinking, recommending, and drafting the Bill; the drafting process was also used as a tool for joint learning in Thai society.

1.1 Background of the National Health System Reform

Over the past 30 years, there have been efforts of a group of health leaders within and outside the MoPH to develop a proposal for national health planning using the community-based approach. There were recommendations for medical education reform, using the community as the centre rather than the large hospital which was nearly impossible. There was also an effort to set up a National Health Council to serve as a mechanism for formulating national health policies with the participation of all sectors concerned as health is regarded something that involves a number of people in the government and civic sectors.

Later there was a policy on distribution of health services to rural areas at the district and subdistrict levels nationwide. District hospitals and subdistrict health centres were established all over the country and the **"primary health care"** strategy was adopted to promote people's participation in health services. That was clearly considered as health service reform focusing on rural areas.

In 1992, the Health Systems Research Institute (HSRI) Act was enacted during the premiership of Mr. Anand Punyarachun to serve as a state agency, but not a regular civil service agency, under the supervision of the MoPH. HSRI's duties include the creation of body of knowledge related to the public health system (during that period, "public health system" was more commonly used than "health system") in response to changes that will occur in the future. The knowledge created by HSRI was important for health system reform at a later date.

At the 1996 technical conference, organized by HSRI on 1-2 February 1996, on **"health reform: a new strategy for system development,"** there was a preparation for reforms of several health systems. And Dr. Prawase Wasi wrote a book entitled **"System Reforms for Health"**. In the preface, Dr. Prawase stated that:

"Health means perfect happiness in physical, mental and social aspects, which is the ultimate goal of life and development, and the linkage of all factors affecting health is called " ***health system*** *".*

The health system includes other factors outside the health sector such as social, economic, environmental and political factors; the health care system is part of the health system.

A health system of a country or a region or on any issue is specific for that particular country, region or issue as it is dependent on its specific cultural, governmental, social, economic and political factors. So it is impractical to use the knowledge of health system from other places, but its own health system research has to be undertaken to gain an insight on the working conditions and the direction in which the system is moving. Then the health system will be properly improved.

While things are rapidly changing, the health system reform is essential. If there is no reform, the old system will be at a disadvantage, affected by the new situations and problems, *which* ***will severely affect the health, economic and social systems.*** *Thus, health system reforms are becoming a great trend globally.*

In reforming a health system, it is necessary to have systematic thinking.

The ***major thinking process*** *has to cover the entire system as fragmented thinking, or thinking in one's own area of interest, would not result in a health system reform. This point is to be especially emphasized as we have been familiar with fragmented or minor thinking. There are people who are in a position to do a major thinking, but do a minor thinking. So we need to form a group of knowledgeable and capable people to do a major thinking, covering the entire system so as to have a health system reform for all the people."*

Dr. Prawase also mentioned about the need for health system reform, based on the use of knowledge and the management for social movement, and suggested eight paths for health system reform as follows:

1. Creation of a system for all concerned to participate in the reform process.

2. Research on major trends that will affect health.
3. Research aimed at creating the value of health and health indicators of society.
4. Research aimed at promoting and supporting the culture of health.
5. Evaluative research on health service systems.
6. Reform of the health service system.
7. Promotion of civil society for health.
8. Research for drafting a national health law or a health system reform bill.

The term **"health system"** began to have a clearer meaning as a system that is broader than medical and public health matters, broader than the health service system. And the direction for health system reform movement has become more clearly envisioned.

The efforts for health service system reform, which is a subsystem the health system, had a lot of problems related to service distribution, personnel distribution, service quality, inequities, financing and ethics, even though all governments have tried to resolve such problems and improve the health service system. The MoPH set up the Health Care Reform Project in 1996, in collaboration with the European Union (EU), with Dr. Sanguan Nittayarumphong being a key person in creating the knowledge, personnel development, pilot studies on models of health service systems, and pushing for policy reforms. The most important achievement of this project was the pushing for adoption of the universal coverage of health care (30-baht health care) scheme by the Thaksin Shinawatra government in 2001. Following the adoption was the promulgation of the National Health Security Act of B.E. 2545 (2002). The project worked very closely with the people's network for universal health care, which could collect 50,000 signatures of people for proposing the National Health Security Bill in 2001.

In 1997, Thailand had a new constitution and was faced with a severe economic crisis. The new constitution opened a new era of "participatory democracy" in parallel with "representative democracy". In 1997, the seventh Senate Commission on Public Health (the last senate prior to the promulgation of the 2006 Interim Constitution) set up a working group to prepare **"a report on national health system"**, chaired by Prof. Dr. Prasop Rattanakorn with Prof. Dr. Kasern Wattanachai as vice chairman and Dr. Supakorn Buasai as secretary. The report contained recommendations for health system reform in accordance with the 1997 Constitution of Thailand.

This technical paper comprehensively mentioned about eight essential elements for a desirable national health system, i.e.: (1) purpose, intent and principles, (2) rights, duties, equality and security in health of the people, (3) health promotion and disease prevention, (4) service system, (5) resources and investment in health system, (6) mechanism for quality examination and health protection, (7) management of health information and knowledge, and (8) role of the government and devolution to local administrative organizations. In each element, there were descriptions about the

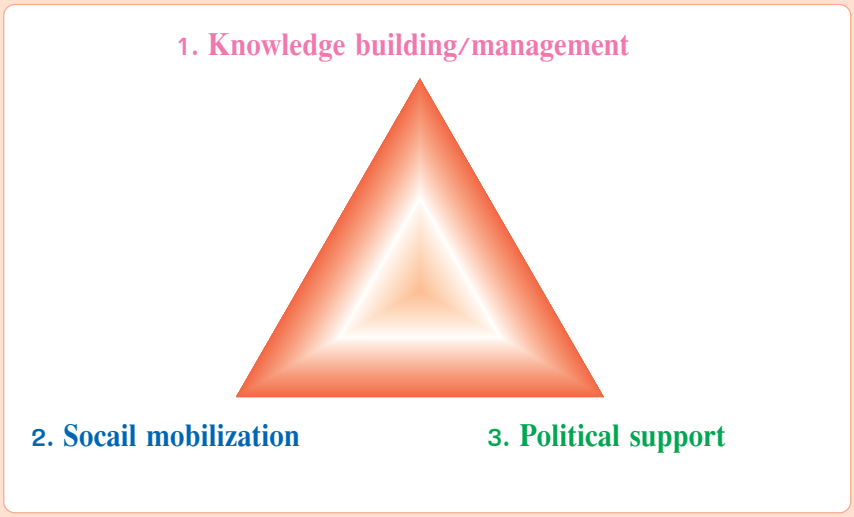
principles, purpose, desirable characteristics and meaning of changes in the existing health system. Also presented were concrete examples and recommendations for legislation in the future. Some essential parts of the report led to the drafting of the National Health Bill and a part became the slogan **"building before repairing health"**, which was widely used in a later stage in the promotion of the strategy for creating good health before repairing ill health.

In July 2000, the Regulation of the Prime Minister's Office on National Health System Reform was issued. Its rationale was that "whereas the current national health system cannot help the people to be healthy and have a good quality of life, there is a rising prevalence of diseases and health threats, and the health management system is inefficient, of low coverage and not in accordance with the intent of the Constitution of the Kingdom of Thailand."

1.2 Strategy and Progress of National Health System Reform

The process for national health system reform used a "triangle that moves a mountain" strategy, emphasizing the linkages between knowledge building/management, social mobilization, and political support as shown in the figure below.

Figure 9.1 The "triangle that moves a mountain" strategy



Source: Prawase Wasi, 2002.

1) Knowledge Building/Management or Technical Work

This effort creates the wisdom, which is a basis for health system reform, in coordinating the understanding of political groups and civil society so that they can jointly build up a clear intention for health system reform. It is like a guiding tool for society to get away from misconception that may influence the interest groups in the health system. It will also help gather relevant experiences and knowledge from within and outside the country for presentation to the

participants in the health system reform process to use in making decisions in a scientific and unbiased manner. The collective efforts of academics from various disciplines were made in analyzing and digesting technical data and presenting it to the public to understand and learn as well as to synthesize the knowledge for health system reform together with political groups and civil society. Then the movement for reform would be clearer (Wiput Phoolcharoen, 2001).

2) Social Mobilization

Social mobilization is the creator of social power so that civil society will become stronger and get involved in pushing for political changes at the local and national levels; the political reform resulting in the 1997 Constitution was a result of civil society's power formed in a systematic manner. The constitution was an important tool for increasing and expanding the potential of civil society to become stronger. Members of civil society included interest groups and professional organizations as well as those assembled to protect the public benefits. They all developed their experiences and expanded their networking in working on issues of common interest. The power of civil society could thus more clearly reflect the problems and health needs (Wiput Phoolcharoen, 2001).

3) Political Support

Political support or power is the power in the democratic system which has representatives of all Thai people to carry out the legislative functions. Political power also carries out the administrative functions through state officials implementing the policies set by politicians. Political power is thus important in changing the policy structure, budget, and relevant laws in response to the intent of health system reform. Regarding the decentralization of political power, at present, the mechanism of local politics has evolved into political power responsible for the missions linking to health system in each locality. It is the power group that has drawn attention of all sectors even though local politicians are "new hands" taking charge of administering the health system at the community level. If we all can help create their potential and seek clarity of the model and role in maintaining the health system of each locality, local politics will become a principal power in health system reform (Wiput Phoolcharoen, 2001).

The new government formed in 2006 stated in its social policy that "the government is committed to creating a strong society for the people in the nation to live happily together on the basis of reconciliation and righteousness." In its health policy, item 3.4 states that "Develop people's well-being in the physical, mental, social and intellectual dimensions by reforming the health system to reduce risk factors related to behaviours and the environment emphasizing public participation, and develop the health service systems for normal and emergency situations in a well-balanced manner covering health promotion, disease prevention, medical treatment and rehabilitation, which are of good quality with a wide coverage and equity, and will propose the legislation of a national health law."

The three coordinated forces according to the "triangle that moves a mountain" strategy are the principal guidance for bringing about a paradigm shift that will lead to partnerships for designing an organization and creating linkages among organizations and networks under the health system. This is to respond to people's needs in a globalized social and economic system and to the rapid evolution of health-related science and technology (Wiput Phoolcharoen, 2001).

1.3 Progress and Chronology of the National Health System Reform Process 2000

- Jan 2000 — The Health Systems Research Institution (HSRI) established the National Health System Reform Office (HSRO) as a temporary office.
- Jan-July 2000 — The body of knowledge was synthesized about subsystems under the health system, based on the knowledge that had been continuously created for nearly 10 years, with HSRI as the lead agency.
- Mar 2000 — The Senate Commission on Public Health proposed a report entitled **"Report on National Health Reform: Recommendations according to the 1997 Constitution of the Kingdom of Thailand"**, based on the knowledge accumulated by HSRI.
- July 2000 — **Issuance of the Regulation of the Prime Minister's Office on National Health System Reform; establishment of the National Health System Reform Commission (HSRC)** and HSRO to get the reform functions completed within three years.
- Aug 2000 — HSRI organized a conference on **"Civil Society's Wisdom for Thai People's Health"** with 12 networks and 1,500 participants making recommendations and perspectives for health system reform in various aspects.
- Nov-Dec 2000 — Development of a conceptual framework on national health system reform for use in publicizing with all sectors in society.

2001

- Jan-Aug 2001 — Holding more than 100 public forums nationwide by people's networks to seek opinions on the conceptual framework of the national health system.
- 1-5 Sept 2001 — Holding a **"Health Market"** forum for exchanging experiences in health promotion with about 150,000 participants. A national health assembly was also held for 1,599 partnerships with 5,000 people to discuss and seek comments on the conceptual framework of national health system.
- Oct-Dec 2001 — Synthesis of recommendations and drafting of essential points for inclusion in the National Health Bill.

2002

* Feb-Apr 2002 — Holding approximately 500 public forums by people's networks at the district and

provincial levels with approx. 40,000 participants to solicit comments on the draft essential points.

- Apr-May 2002 Synthesis and review of the essential points and **preparation of the National Health Bill.**
- June-July 2002 Presentation of the National Health Bill at provincial health assemblies in all provinces and in specific-issue health assemblies for review and comments; more than 100,000 people participated in the assemblies.
- 8-9 Aug 2002 Seeking comments on the National Health Bill at a national health assembly with approx. 4,000 participants from more than 3,000 partnerships or alliances of all sectors in society. **The Prime Minister also participated, gave a special address and agreed to take the lead in legislating the law.**
- Sept-Oct 2002 Revision of the National Health Bill; its final draft was accepted by the HSRC and then submitted to the Cabinet for further action.
- 1-7 Nov 2002 A campaign on **"Joining Hands for Promoting Health Following the Royal Footsteps"** was organized by all sectors of civil society, including five lines of running and cycling rallies during the same period of time across the country. **There was a collection of 4,717,119 names of Thai citizens who supported the legislation of the National Health Act. The names were handed over to the President of Parliament to show the intention of the people.**
- Dec 2002 The National Health Bill was accepted for consideration by the Cabinet Meetings Screening Committee.

2003

- Jan 2003 The Cabinet Meetings Screening Committee, chaired by Mr. Chaturon Chaisaeng, endorsed the National Health Bill and forwarded it to another screening committee chaired by Mr. Visanu Kruangarm for reconsideration according to the cabinet's resolution of 21 January 2003.
- Feb-July 2003 Area health assemblies/forums were held in four regions of the country to seek ways to test and develop mechanisms prescribed in the National Health Bill.
- June 2003 The Cabinet approved an extension of the timeframe of the HSRC and HSRO for not exceeding two years (not beyond 8 August 2005) to oversee the legislation of the national health law.
- Aug 2003 The national health assembly 2003 was held to review six issues of public policies and organize activities/forums for exchanging learning experiences in various dimensions of health promotion. There were approx. 3,000 participants at the assembly.

2004

- Jan-Feb 2004 — The civil society networks that helped draft the National Health Bill joined hands in establishing a **"Network for Promotion of People's Law Proposition Process (PLP)."** The network's purpose was to study ways for the civic sector to propose a law according to the 1997 Constitution as they had deemed that the National Health Bill had been with the Cabinet **for quite a long time and there was no sign as to when it would be endorsed by the Cabinet.**
- Feb-Mar 2004 — The PLP gathered names of people who supported the National Health Bill (target, 150,000 names) coordinated by the Community Organizations Development Institute.
- 27 May 2004 — The PLP handed over a list of 120,000 names of people who supported the National Health Bill to the President of Parliament.
- Feb-Aug 2004 — Area health assemblies and specific-issue health assemblies/forums were held (173 forums for a total of approx. 32,600 participants) to review six public policy issues.
- July 2004 — The Cabinet Meetings Screening Committee, chaired by Mr. Visanu Kruangarm, endorsed the National Health Bill that had been **on hold at the cabinet level for about one and a half years.**
- Aug 2004 — The Cabinet approved the National Health Bill in principle and forwarded it to the Council of State for urgent review/revision by its special committee and further submission to Parliament.
- Sept 2004 — A national health assembly 2004 was held on agriculture and food for health for approx. 3,500 participants from all sectors to review 10 sub-issues.

2005

- Mar-June 2005 — Sixty-four forums or sessions of area health assemblies and specific-issue health assemblies with approx. 8,000 participants were held to review eight groups of public policies.
- Apr 2005 — The National Health Bill proposed by the people (95,410 names of people passing the qualification examination process) was included in the agenda of the meeting of the House of Representatives.
- 7-8 July 2005 — A national health assembly 2005 was held for approx. 3,800 participants to review the major issue of well-being and another 12 sub-issues.
- July 2005 — The National Health Bill that was endorsed by the Cabinet was revised/endorsed by the special committee of the Council of State; later it was endorsed by the HSRC and MoPH.
- 23 Aug 2005 — The Cabinet approved the National Health Bill that had been revised by the Council

of State and sent it to the House Coordination Commission for review and submission to the House of Representatives.

- 30 Nov. 2005 The Prime Minister signed a letter transmitting the National Health Bill to the Speaker of the House of Representatives for urgent deliberation.
- 14 Dec. 2005 The House of Representatives deliberated the National Health Bill in its first reading and unanimously accepted it (277 votes accepting and 3 abstaining) and resolved to use Cabinet-endorsed version for further deliberation/revision by a 47-member special commission.

2006

- Feb 2006 The dissolution of Parliament resulted in five versions of the National Health Bill (submitted by the Cabinet, civic sector, and political parties) having to await the deliberation of the following House of Representatives.
- 19 Sept 2006 There was a coup d'etat (democratic reform) and an abrogation of the 1997 Constitution of Thailand, resulting in the dropping of the National Health Bill.
- 3 Nov 2006 The new government of Prime Minister Gerneral Surayud Chulanond presented in its policy statement to the National Legislative Assembly, item 3.4, that there would be a national health system reform.
- 7 Nov 2006 The Cabinet approved the National Health Bill again and forwarded it to the National Legislative Assembly for deliberation.
- 22 Nov 2006 The National Legislative Assembly accepted the Bill in principle in its first reading (118 votes for, 5 against and 1 abstaining) and set up a 33-member special commission to review/revise the Bill.

2007

- 4 Jan 2007 The National Health Bill was deliberated by the National Legislative Assembly in its second and passed into law in its third reading by a voting of 154 in favour, 9 against and 2 abstentions.
- 19 Mar 2007 The National Health Act was published in the Government Gazette, Vol. 124, Part 16 Gor, and effective on 20 March 2007.

1.4 National Health Act: A Tool for Health System Reform

The National Health Act is expected to be the principal law for health and while it was being drafted, it was expected to be a tool for all sectors of Thai people to take part in the process for exchanging experiences and learning from each other to transform disease-oriented thinking into well-being-oriented thinking.

The Act was designed and prepared by the extensive participatory process; its essentials or highlights are as follows:

(1) The meaning of "health" is expanded to go beyond medical and health issue to mean a human condition that is perfect in physical, mental, social and intellectual aspects, linked to each other in a well-balanced manner, leading to the opening of opportunity for all sectors in society to jointly work for building health and resolving health problems as well as health risk factors in an efficient manner in all localities.

(2) Description of important rights and duties on health that have never been prescribed in any other laws, such as the right to live in a healthy environment, right to receive health information sufficient for making a decision to accept or refuse any health service, and the right to refuse medical intervention intended merely for delaying death of the terminally ill patient.

(3) Establishment of the National Health Commission (NHC) comprising the Prime Minister as chairperson and representatives from the public sector, academics, health professionals and the civic sector, and charged with making policy recommendations to the Cabinet on health policies and strategies. The NHC is a national mechanism that will promote the participation of all sectors in society to move forward the national health system through the participatory process of healthy public policy formulation and to push for the implementation of such policies in a concrete manner.

(4) Organization of national health assemblies (forums) and support for holding of area health assemblies and specific-issue health assemblies on a continual basis as a process for all sectors in society to participate in the healthy public policy formulation and the exchange of experiences in health interventions that will lead to the implementation of various health approaches, rather than just waiting for health services or assistance from the state or health professions.

(5) A requirement for the NHC to prepare a **statute or constitution on national health system,** which will be submitted to the Cabinet for approval and to the House of Representatives and the Senate for acknowledgement. Then the statute will be published in the Government Gazette for use as a framework and guidance in formulating policies, strategies and operational guidelines of health programmes of all sectors in society. The statute preparation process will involve all sectors in society as widely as possible and its review is to be done at least once every five years in accordance with the changing context of society.

In accordance with the aforementioned essential matters, the benefits that the people and society will receive once the National Health Act comes into force are as follows:

(1) There will be a national mechanism with participation from the political and government sector, the academic and professional sector, and the civic sector that will jointly oversee the direction of healthy public policies, supporting health programme operations of the government, MoPH and other health agencies in all sectors.

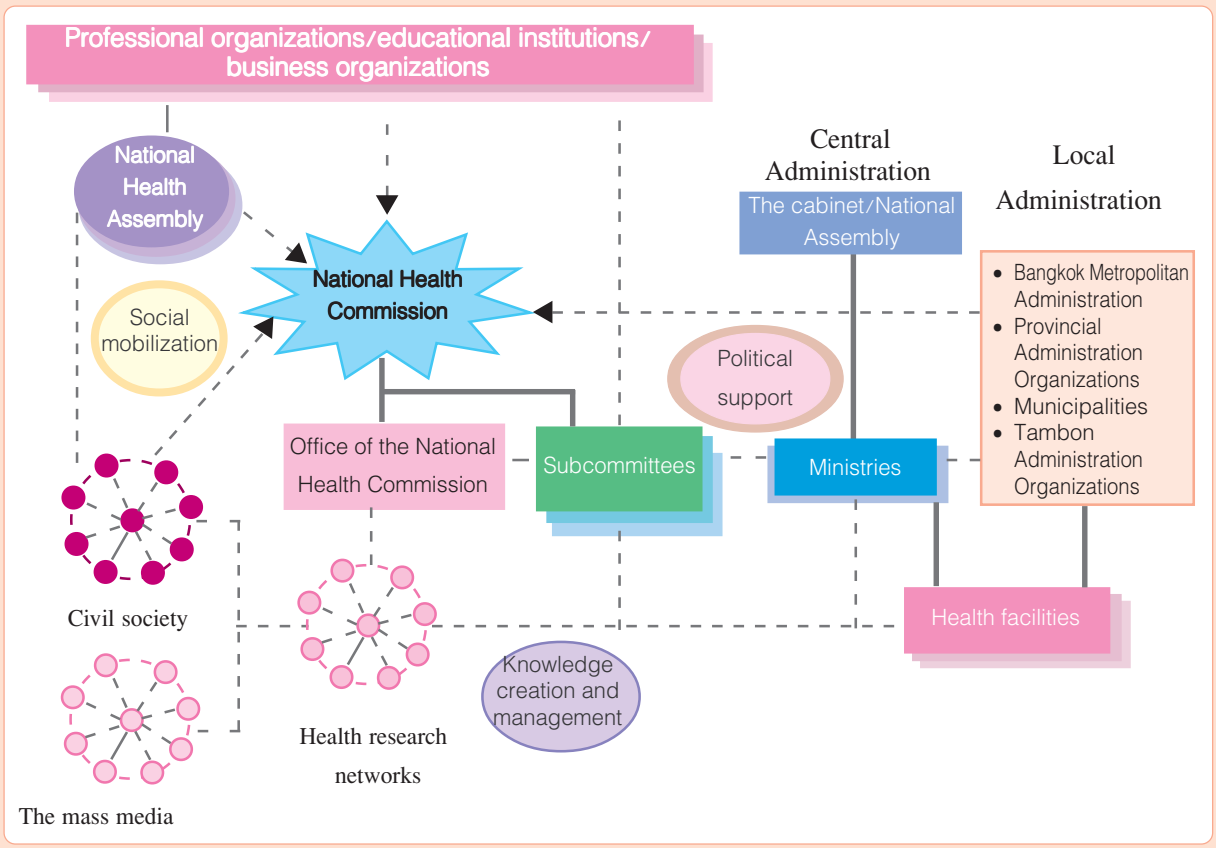
(2) There will be a mechanism and process of health assemblies or forums as one of the public participation mechanisms according to Sector 76 of the 1997 Constitution for all sectors in society to take part in the formulation and implementation of healthy public policies.

(3) There will be a statute of national health system for use as a framework and guide for formulating health policies, strategies and operational guidelines of the country that all state agencies, local administration organizations, and other relevant agencies will jointly use in their health programmes.

(4) The improvements and revision of various sub-systems in the national health system will be undertaken appropriately and in accordance with the desirable national health system under the oversight mechanism of the National Health Commission.

(5) In the long run, there will be a reduction in morbidity, disability and mortality of Thai people, as well as a reduction or slight increase in health expenditure, which will lessen the state's burden related to health spending according to the universal health care policy and also reduce people's overall health spending.

Figure 9.2 Relationship of various mechanisms under the new health system



Source: Suwit Wibulpolprasert, 2005.

Furthermore, there have been misunderstandings about the National Health Act, the National Health Security Act, and the Public Health Act, the table below provides brief comparative descriptions of the three Acts as follows:

National Health Act	National Health Security Act	Public Health Act
1. The drafting process: by 3 parties (political and state officials; academics and professional groups; and civic sector); began in 2000 emphasizing public participation; enacted as law in 2007.	- By the government according to its policy: began in 2001; enacted as law in 2002; people also participated by submitting 50,000 names in proposing people's version of the law.	- By the public sector; became a law in 1992 (some parts being amended).
2. Coverage: total health systems, beyond medical and public health systems.	- Health service system.	- Public health activities.
3. Purpose: For use as a tool for all sectors in society to jointly work on health matters: - the process is supported by public sector; - the output will be used to support the operations of all sectors; - de-emphasizing the use of state power; - developing the health system with a dynamic process (through the statute of national health system and participatory process in formulating healthy public policies.	- A tool for state affairs administration. - Setting up rules and mechanisms for public sector financing of universal coverage of health care.	- A tool for state affairs administration. - Setting up rules and mechanisms for management in public sector.
4. Process of policy development: participatory healthy public policy process, a tool for participation in health of all sectors in society.	- Use of health financing reform system as a tool for health service system reform to ensure universal coverage of essential health services.	- Use of state power to deal with public health activities such as cleanliness, markets, animal raising, and any operations with potential health hazards.
5. The Commission: Prime Minister as chairperson and representatives of public, civic, and professional groups as members.	- Public Health Minister as chairperson and representatives of other relevant agencies as members.	- Permanent Secretary for Public Health as chairperson, director-generals as members, and DG of Health Department as secretary ; no representatives from other partners.

2 Decentralization in the Health Sector

2.1 Achievements of Decentralization in Health

According to the Plans and Process for Decentralization to Local Government Organizations Act of B.E. 2542 (1999) enacted in accordance with the 1997 Constitution of the Kingdom of Thailand, all ministries including the MoPH are required to develop a detailed plan of action to decentralize their missions, resources and personnel to local government organizations (LGO) which include Tambon or subdistrict administrative organizations (TAO or SAO), municipalities, and/or provincial administrative organizations (PAO) within 10 years (by 2010).

The Decentralization Act also sets a target on increasing the proportion of central budget to be allocated to LGOs from 9% of total state revenue in 1999 to 20% in 2001 and 35% in 2006. With the additional revenue, LGOs will have to play an important role in making preparation for social services in several forms in line with local administration laws. Their major responsibilities include:

1) Building of essential infrastructure
2) Improvement of people's quality of life, i.e. **health** and education services
3) Management of communities and society
4) Planning and investment at local level and promotion of tourism
5) Management of natural resources and the environment
6) Management of Thai culture and wisdom

The Act has led to the development of the **2000 planning on decentralization to LGOs and the Plan of Action for Decentralization** to LGOs of B.E. 2545 (2002), published in the Government Gazette on 13 March 2002.

Regarding the devolution of health activities, the MoPH has undertaken the following:

1) Setting up an Area Health Board (AHB) to take responsibility for the transfer of health facilities to LGOs, aimed at transferring a group or network of health facilities and the universal coverage of health care services to AHB by the end of 2003.

In 2002, an AHB was set up in each of 52 provinces (focussing on 10 provinces) by the MoPH to act as an advisory board; but the operation was put on hold as more efforts had to be made in implementing urgent policies on health system reform according to the universal health care policy and the public sector reform according to the Reorganization of Ministries, Sub-Ministries and Departments Act of B.E. 2545 (2002).

2) Transferring health missions to LGOs. The plan was to transfer 41 health missions to LGOs, of which 16 have been undertaken as shown in Table 9.1, including:

(1) Programmes on infrastructure: 7 missions related to water resources and rural water supply systems.

(2) Programmes on quality of life promotion: 5 missions on health promotion, 1 on environmental health, 1 on subsidy for health behaviour development, 1 on mental health promotion and mental problem prevention in specific target groups, and 1 on laboratory analysis services.

Table 9.1 Transfer of health missions to local government organizations by programme

Major mission	Mission	Agency	No. of missions			
			Total	Transferred	Remaining	Remarks
Infrastructure	**Public utilities**					
	- Water resources/rural water supply system	DOH	7	7	-	To Ministry of National Resources and TAOs
Promotion of quality of life	- Health promotion	DOH	12	5	7	
	- Environmental health	DOH	4	1	3	
	- Water supply	DOH	1	-	1	
	- Food sanitation	DOH	1	-	1	
	- Occupational health	DOH	1	-	1	
	- Health facilities: building/repair	OPS	1	-	1	
	- Universal health care	OPS	1	-	-	Not to LGOs, but to NHSO
	- Subsidies for health promotion development	OPS	1	1	-	To DLA/ TAOs
	- Mental health promotion and problem prevention in specific target groups	DMH	1	-	-	
	- Development of personnel and communities for communicable disease surveillance, prevention and control	DDC	1	-	1	In the eligibility package

Major mission	Mission	Agency	No. of missions			
			Total	Transferred	Remaining	Remarks
	- Communicable disease surveillance, prevention and control	DDC	1	-	1	In the eligibility package
	- Primary medical diagnosis and treatment	DDC	1	-	1	Ongoing
	- Food subsidies for leprosy patients	DDC	1	-	1	Ongoing
	- Welfare subsidies for leprosy patients		1	-	1	Ongoing
	- Production of public information materials on food and drugs	FDA	1	-	1	Ongoing
	- Capacity building for consumers and legal rights claims	FDA	1	-	1	Ongoing
	- Creation and expansion of networks for local health consumer protection	FDA	1	-	1	Ongoing
	- Inspection and follow-up for consumer protection purposes of health products at points of sale	FDA	1	-	1	Ongoing
	- Health services in Bangkok, its vicinity and urban areas	DMS	1	-	1	Upgrading as tertiary care underway
	- Laboratory analysis services	DMSc	1	1	-	
			41	7	27	

Source: Decentralization Support and Development Group, Bureau of Policy and Strategy, MoPH.

Note: DDC = Dpt of Disease Control; DLA = Dpt of Local Administration; DMH = Dpt of Mental Health; DMS = Dpt of Medical Services; DMSc = Dpt of Medical Sciences; DOH = Dpt of Health; FDA = Food and Drug Administration; OPS = Office of the Permanent Secretary, MoPH.

In summary, the decentralization of health missions has progressed to a certain extent but not as intended in the 2002 action plan. Thus, the MoPH has to revise its direction and operational plan in the near future.

2.2 Future Plan on Decentralization in Health

1) Principles of Decentralization in Health

The principles of decentralization as prescribed in the 1997 Constitution, the 1999 Decentralization Act, and the 2000 Plan of Action for Decentralization to Local Government Organizations are as follows:

1.1) **Emphasis on people's maximum benefits.** LGOs are expected to have capacity in **making decisions on long-term actions**, resolving health problems, and implementing decentralized programmes so that the local health service system will be established and maintained in an **equitable and efficient manner with good quality**.

1.2) **Emphasis on flexibility and dynamism.** Actions related to decentralization are to be flexible according to capacity feasibility and changing circumstances, as well as lessons learned, leading to a **continuous** decentralization process and **sustainable** health development.

1.3) **Emphasis on participatory action system.** It is essential to create a strong participatory mechanism/process involving central/provincial/local officials and local residents in making a joint decision, through the process of consultation, or **based on good intention, love, goodwill, and forbearance, avoiding egotism** and self-assertiveness. This is to make the transfer of actions move forward smoothly and in line with the **specific features of the health care system**.

It is noteworthy that to make LGOs have a 35% share of state revenue is not the major goal of the decentralization for health.

2) Scopes of Missions to Be Transferred

The missions to be transferred to LGOs may be divided into two categories:

2.1) **Characteristics of mission, i.e.** missions on medical treatment, health promotion, disease prevention and rehabilitation.

2.2) **Breadth and coverage of missions;** some services might be specific to certain individuals or families or can be implemental in the community; certain LGOs can rapidly take over all missions relating to disease prevention (with environmental condition improvement) and health promotion.

3) Features of Decentralization in Health

There could be four features of decentralization (which are integrable) as follows:

3.1) **LGOs as service purchaser:** LGOs are the owners of the budget (from their own revenues or state budget transferred under the universal health care scheme) and the health care

purchasers from public and private health facilities within and outside their jurisdiction.

In this regard, LGOs' capacity will have to be enhanced so that they will be able to effectively handle the financing and health care quality systems.

3.2) LGOs' operations in collaboration with central/provincial administration agencies. In this case, a LGO may collaborate with the universal health care scheme in investing in health promotion activities or with several health centres or hospitals in developing a health service system structure.

3.3) LGOs' partial operations. Some LGOs may take responsibility for programmes on community environmental condition development and health promotion.

3.4) LGOs' full operations. Some LGOs may own health facilities and operate all health programmes in their jurisdiction.

Which feature, programme or when any LGO will undertake the decentralized health system is to be in accordance with the principles mentioned in 1).

4) Models for Mission Transfer to LGOs

There could be several models of transfer which may be adjusted according to the readiness of parties concerned, locality's suitability and circumstances as follows:

4.1) Segregative transfer. Certain health facilities may be transferred to different levels of LGOs, such as a health centre to a TAO, a hospital to a municipality or PAO.

4.2) Service network transfer. An entire network of health centres and hospitals in a certain locality may be transferred to a LGO or area health board (AHB) with operational involvement of the LGO.

4.3) Transfer to an autonomous public organization (APO). An APO may be specifically established to manage health services in collaboration with a LGO in each locality; any health facility or network of health services may be set up as an APO; or an AHB may be set up as an APO.

4.4) Transfer to a service delivery unit (SDU). Each hospital may be set up as a SDU under the supervision of a Health Facility Authority (or Hospital Authority), which is a public organization under the supervision of the MoPH, with LGO's involvement in the system management.

The operations of Model No. 4.3) and 4.4) may not be considered as direct mission transfer as the LGO that is involved in the management does not own the system.

5) Mechanism and Process for Supporting Decentralization

In order that the decentralization is undertaken in accordance with the principles, scopes, features and models mentioned above, the mechanism and process for supporting decentralization in health are set up as follows:

5.1) Mechanism and process for decision-making. A mechanism and process must be set up and developed with the involvement of **all sectors** at different levels to review and make decisions on the direction, model, process and steps of the transfer in **each locality** and at each level. Then there will be various models, directions and steps for mission transfer, **which will not be similar in all localities**, namely:

At the national level: there will be an ad hoc subcommittee on health decentralization under the committee on health decentralization.

At the provincial level: the AHB, chaired by the provincial governor and/or the chief executive of the PAO with all LGOs representatives as members, can be in charge of this function.

At the district level: the district health board (DHB), chaired by the district chief officer and/or municipal mayor, can take this role.

At the Tambon (subdistrict) level: the Tambon health board (THB), chaired by Tambon chief (Kamnan) and/or the chief executive of the subdistrict administrative organization, can take this role.

5.2) Mechanism and process for supporting the transfer operations. The mechanism and process mentioned in section 5.1 have to be developed and supported, especially with regard to the capacity building for all LGOs as follows:

5.2.1) General support: The support required for all features and models of transfer includes: the process for development of LGO's capacity in implementing the health system, the development of health information system, the development of a system for networking of all health facilities, the development of budgeting system coordination (particularly under the universal health care system), and research studies as well as model development.

5.2.2) Specific feature/model support: For the transfer of specific feature/model of health system, the support may include: the enactment of a royal decree establishing a public organization, a legislation setting up an AHB as a juristic person, and the development of criteria, standards and guidelines for the transfer of health facilities at various levels to LGOs.

5.3) Mechanism Structure

5.3.1) At the central level, the Health Decentralization Support and Development Group of the Bureau of Policy and Strategy, MoPH, is the coordinating unit working under the guidance from the Committee on Decentralization to Local Government Organizations. The Group also coordinates with several ad hoc subcommittees and other technical departments. **In the future the Group will be upgraded as a Bureau, independent of the Bureau of Policy and Strategy**.

5.3.2) At the provincial level, the decentralization process is supported and coordinated by the provincial public health office, the district health office, and the health centre, at its own level.

6) Major Conditions of the Transfer Operations

In the operation of health decentralization, there are major conditions and rights as well as the transfer system that have to be discussed and agreed to as follows:

6.1) Health personnel. The decentralization and mission transfer greatly affect the livelihood and future of health personnel. Thus, the operation in this aspect has to be carried out carefully and clearly to ensure that, after the transfer, **their rights and dignity will not diminish**. The personnel will have to be **continuously developed; their transfer to another agency will have to be conveniently processed in the same manner as before**. Most importantly, the personnel at all levels have to be thoroughly informed about these matters and there must be a system/mechanism to make this operation move forward smoothly.

6.2) Financial management system. The sources of budget from the LGO, community, central agencies or NHSO will have to be **clear so as to ensure the system's sustainability**. However, there might be some differences in the funding sources for decentralized activities in each locality.

6.3) Establishment of health system in emergency and crisis situations. The mobilization of health resources from various agencies has to be properly undertaken whenever an emergency or crisis occurs such as during a major disease epidemic or disaster. **There must be a system that will ensure a rapid and efficient mobilization of resources for relief purposes**.

6.4) Establishment of health service system. There must be linkages among health promotion, disease prevention, curative care and rehabilitation services at the individual, family and community levels. The service systems for special localities must be set up such as those for border areas, highlands and remote areas with a small population including areas with a lot of migrant workers.

7) Progress of the Decentralization Operations

7.1) Transfer of health centres to TAOs. A committee as well as three subcommittees has been set up to lay down mechanisms, process, criteria and methods for readiness assessment of LGOs that will take over health centres. A transfer operations manual containing the mechanism, process and monitoring/evaluation guidelines has been prepared. It is expected that the actual transfer operation can be undertaken on a pilot scale by mid-2007, beginning with the TAOs that have received the outstanding good governance awards and participated in the health development programmes (e.g. co-financing with NHSO in community health development funds or providing scholarships for local students to study/train at health institutions and taking them back to work in their own local organizations).

7.2) Development health facilities under their supervision as public organizations. A committee has been set up to develop a system for establishing/operating MoPH health facilities as public organizations and service delivery units (SDU). The committee is working on the criteria and

selection of health facilities that are ready to do so; and it is expected that a royal decree on establishing certain hospitals as public organizations will be enacted in mid-2007.

Figure 9.3 Conceptual framework of health decentralization