Chapter 11
Health Decentralization

1. Background

The Determining Plans and Process for Decentralization to Local Government Organizations (LGOs) Act, B.E. 2542 (1999, or the 1999 Decentralization Act) and the Plan of Action on Decentralization to LGOs (No. 1, or the 1st Decentralization Plan), B.E. 2545 (2002), were enacted and created in accordance with the Constitution of the Kingdom of Thailand, B.E. 2540 (1997), aiming to transfer missions or responsibilities to LGOs that are prepared to take such responsibilities within the established 10-year period. At present, the implementation under the 2nd Decentralization Plan is underway to move this effort forward so that local residents will receive better public services with good quality, fairness and transparency, for their better quality of life.

The 2007 Constitution has provisions on key principles for decentralization to LGOs in Chapter 5 (Directive Principles of Fundamental State Policies), Sections 70 and 80, and Chapter 14 (Local Administration), Sections 281–290.

Under the 1st Decentralization Plan of 2002, two groups of details were elaborated as follows:

1.1 Establishing an Area Health Board (AHB) to take charge of the transfer of health-care facilities, on a network a cluster of services basis, as well as the health security scheme to AHB by 2003.

In 2002, the Ministry of Public Health (MoPH) appointed the AHB to serve as an advisory board in each of 52 provinces, focusing on the first 10 provinces. But the operations were suspended as the ministry had to undertake other urgent actions, i.e. the healthcare reform according to the universal coverage of healthcare policy and the public sector reform according to the Reorganization of Ministries, Sub-ministries and Departments Act, B.E. 2545 (2002).

Later on, the Committee on Decentralization to Local Government Organizations (CDL) passed a resolution on 25 April 2007 requiring that MoPH transfer subdistrict health centres to LGOs. As the Decentralization Act requires that 35% of the national budget had to be allocated to LGOs, all state agencies were requested to accelerate the transfer of missions including budget to LGOs. In this regard, MoPH transferred 28 health centres to LGOs including Tambon (subdistrict) Administrative Organizations (TAOs) and municipalities in December 2007 and August 2008.

1.2 Transferring the responsibilities for health services to LGOs. A total of 34 health programmes from 7 MoPH's departments were to be transferred, but to date only 7 have been transferred, i.e:

1) Provision of subsidies for health behaviour development
2) Resolution of underweight problem among children
3) Prevision and development of water supply
4) Promotion of maternal and child health
5) Promotion of school-age and adolescent health
6) Promotion of health for the working-age group
7) Promotion of health for children and the elderly

1.3 The CDL issued the 2nd Decentralization Plan of 2008 as endorsed by the Cabinet on 2 January 2008 and reported to the National Legislative Assembly, with which all state agencies are required to follow. As for MoPH, the plan specifies the scopes of health programmes that have to be transferred as follows:

1.3.1 Public health service system: including the systems of health promotion, disease prevention, rehabilitation and medical services.

1.3.2 Missions to be transferred:

1) Missions and budget for public health services including health promotion, disease prevention, rehabilitation, basic medical care, as well as health centres and personnel to LGOs that are ready to undertake such responsibilities.

2) Missions related to medical care at community and general hospitals as an option for any LGO that is ready to take the transfer according to the criteria established by CDL and MoPH, or they may operate such missions together with relevant state agencies.

3) Regional, specialized or higher-level hospitals are to be run by MoPH or jointly run with a LGO or transferred to a LGO with a higher level of readiness.

4) Missions related to the prevention and control of dangerous infectious diseases. LGOs may cooperate in such missions within their respective provinces as per the policy, and under the supervision, of the Provincial Health Board, the Provincial Public Health Office, MoPH, and other relevant ministries or departments.

5) The minister of public health shall appoints administrators of LGOs, competent officials and LGOs' health Officials as public health officials under the Communicable Diseases Act, B.E. 2523 (1980) to be functioning under the supervision of MoPH.

6) The minister of public health shall appoint LGOs' health officials as public health officials under the Public Health Act, B.E. 2535 (1992).

7) The minister of agriculture and cooperatives shall appoint LGOs' administrators and public health officials as competent officials under the Animal Epidemics Act, B.E. 2499 (1956).

1.3.3 In the first phase, the transfer shall be done according to the readiness of each LGO and

in the final phase, for any LGO that is not ready, the transfer will be done to the Provincial Administrative Organization (PAO).

2. The Transfer of Health Centres to TAOs

According to the 1st Decentralization Plan of 2002, MoPH was prepared to transfer 35 health centres to LGOs that had passed the readiness assessment. But during the process, some TAOs were upgraded as subdistrict/town municipalities. So, the transfer was rather slow and only 28 health centres could be transferred, 22 on 1 December 2007 and another 6 on 28 August 2008.

MoPH held a ceremony transferring 22 health centres to LGOs on 30 November 2007 in the Paichit Pawabutr Conference Room, Building 7, 9th Floor, of the Office of the Permanent Secretary chaired by Dr. Mongkol Na Songkhla, the then Minister of Public Health. At the ceremony, Dr. Suwit Wibulpolprasert, acting permanent secretary, was assigned as a signatory in the document transferring the missions and property to the representatives of LGOs, while the Ministry of Interior was represented by Mr. Somporn Chaibangyang, Director-General of the Department of Local Administration, serving as a witness of the transfer.

2.1 Principles of health decentralization.

In this regard, MoPH operates according to the principles and purposes of the 1997 Constitution and the 1999 Decentralization Act as well as Decentralization Plan No.1 of 2002 as follows:

2.1.1 Aiming for the maximum benefit of the people, allowing LGOs to have long-term capacity to make decisions and revolve health problems to achieve better results than before the decentralization and to have a health system that is equitable and efficient and of good quality.

2.1.2 Aiming to have a flexible and dynamic system leading to a continuous and sustainable decentralization process for health development.

2.1.3 Aiming to have a participatory system by creating a strong participatory mechanism and process at the central, regional, local and popular levels.

2.2 Implementation guidelines

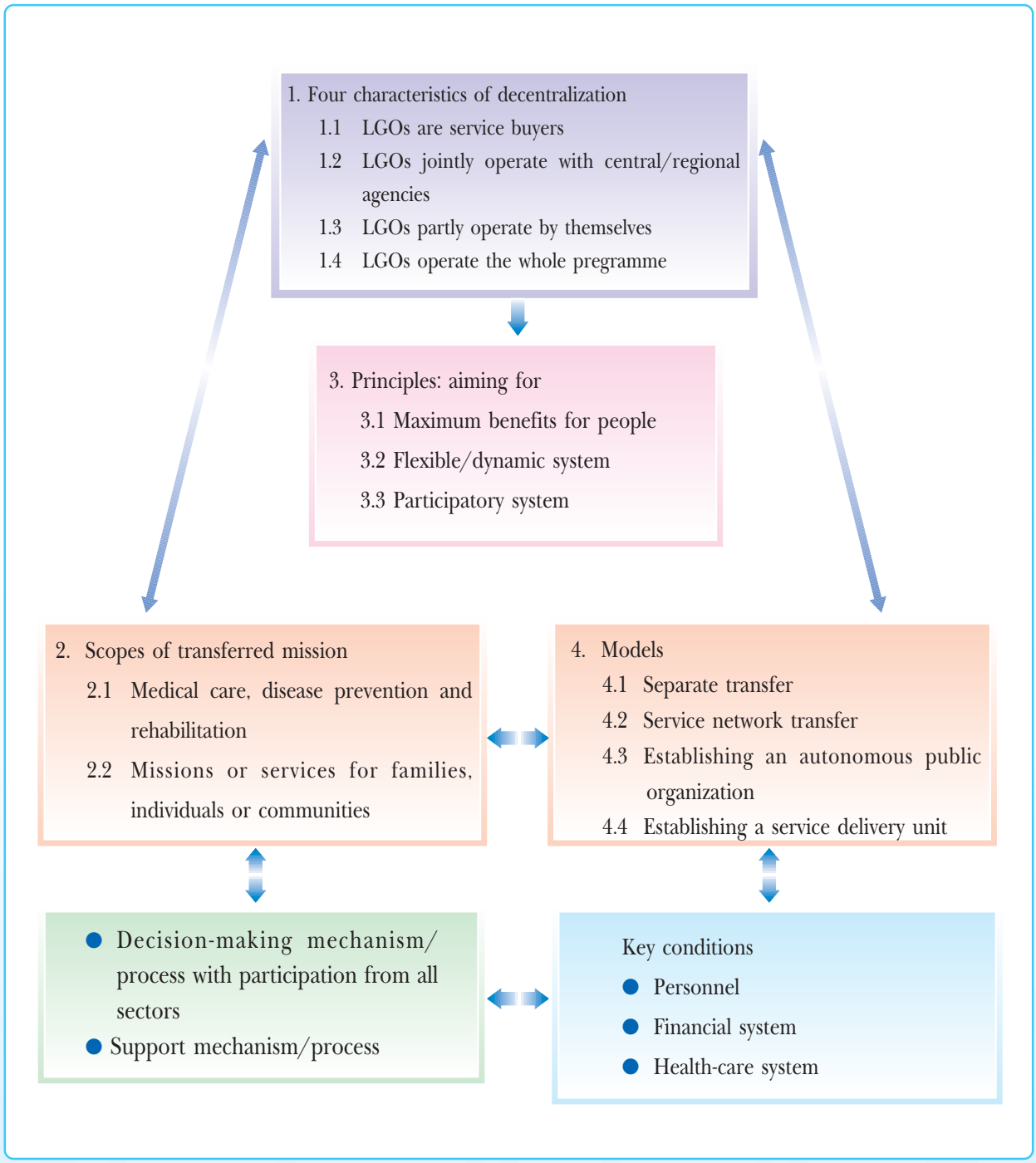
MoPH deployed the participatory approach in developing the health decentralization guidelines through consultative meetings extensively with all concurred at all levels. The guidelines were endorsed by the MoPH's ministerial meeting and then by the CDL as briefly illustrated in Figure 11.1. Besides, for the transfer to be undertaken efficiently with the readiness and satisfaction of all parties, three conditions were set for the transfer of health centres to LGOs as follows:

2.2.1 To guarantee that the receiving LGOs had a transparent and efficient operating system, the transfer would be done only to those that received a good management award in 2005 or 2006.

2.2.2 To guarantee that the receiving LGOs were interested in undertaking health programmes, the transfer would be done only to those that participated in the subdistrict health security fund.

2.2.3 For the operations to be carried out by health centre staff with willingness to do so, the transfer would be undertaken only for the health centres with at least 50% of the staff willing to be transferred.

Figure 11.1 Guidelines for health decentralization



Source: Bureau of Policy and Strategy, Office of the Permanent Secretary, MoPH.

2.3 Steps and process for transferring health centres to LGOs

Subcommittees on decentralization of health mission to LGOs at the provincial level for receiving the transfer of health centres develop mechanism, process, criteria and procedures for assessing readiness of LGOs in taking the transfer: 3 subcommittees were set up

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Submission to the ad hoc subcommittee on management of health mission transfer to LGOs for approval

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Submission to the Committee on Decentralization to LGOs for approval and issuance of notification on mechanism, criteria and procedures; and notification to the Department of Local Administration

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Department of Local Administration notifies LGOs and sends the notification on mechanism, process, criteria and procedures for LGO's readiness assessment to take the transfer of health centres

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LGOs send applications for readiness assessment in the established format together with supporting documents and venues

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The 18-member subcommittee on decentralization of health missions to LGOs reviews the applications; the 9-member working group on LGO readiness assessment carries out the pretransfer and post-transfer assessments

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Subcommittee on decentralization of health missions to LGOs prepares a report as per the prescribed format to the central level for approval

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The central administration (MoPH) reviews and approves, and then notifies the provincial administration as well as delegates authority

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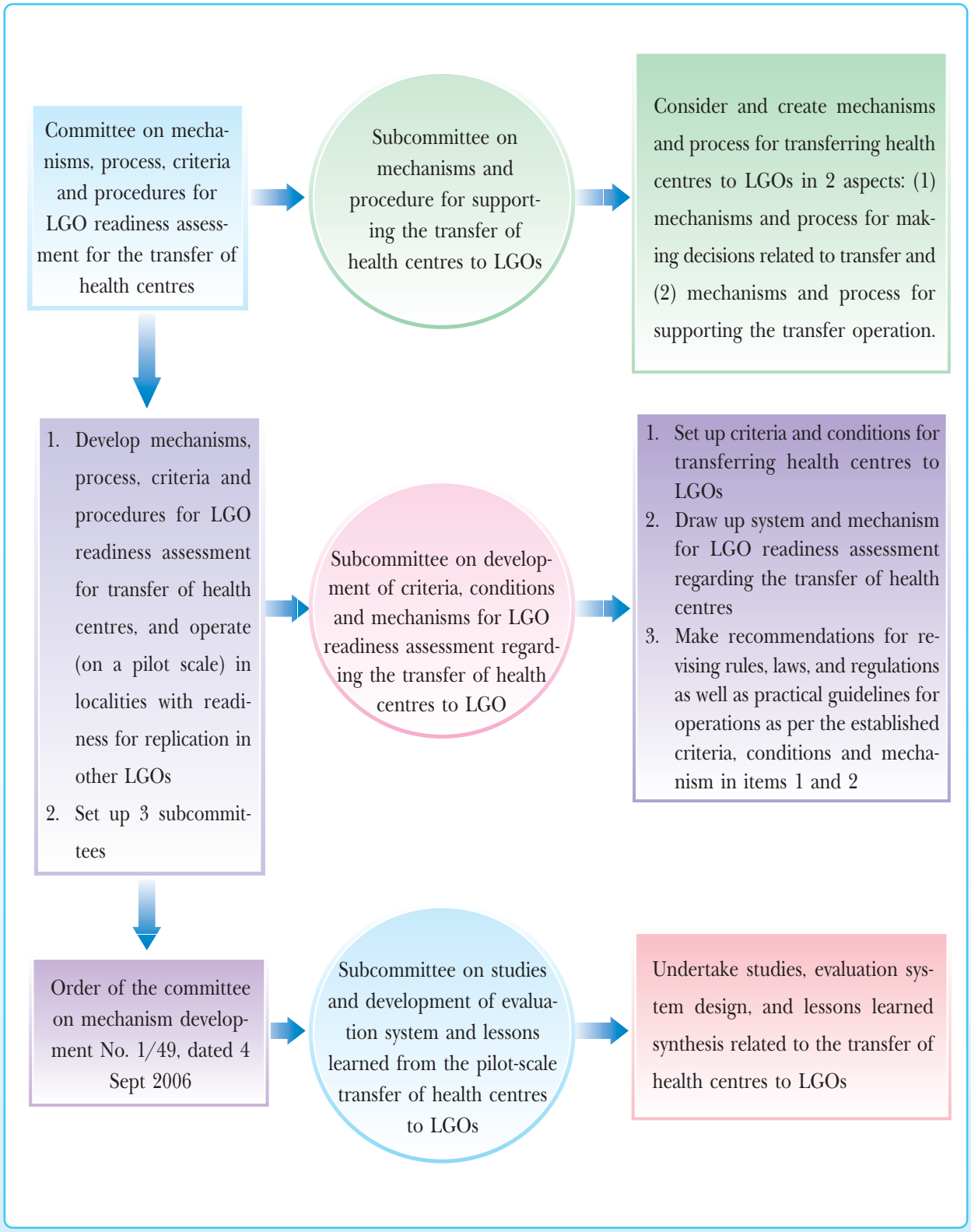
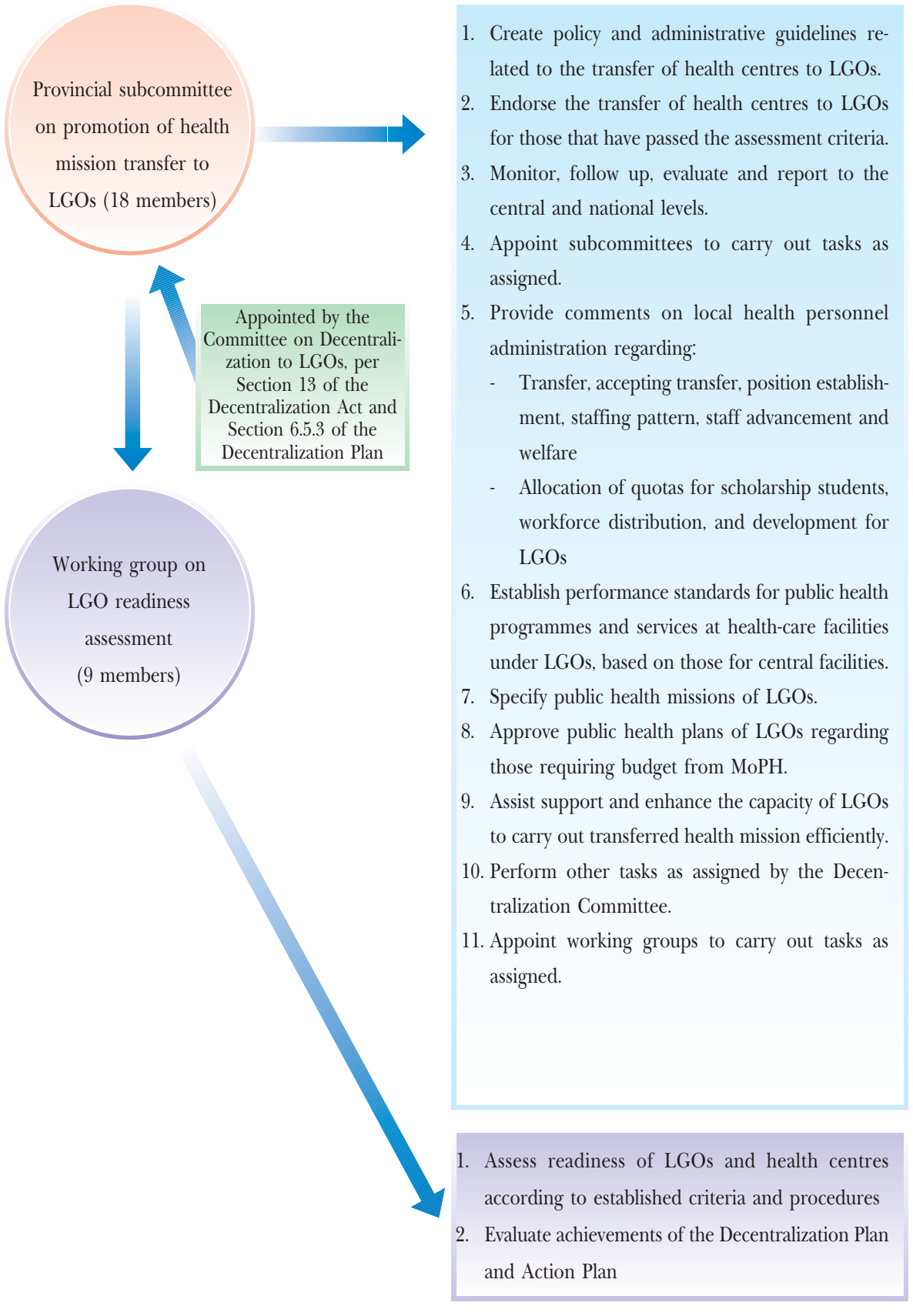
Subcommittee on decentralization of health missions to LGOs provincial level by its secretariat (provincial public health office) notifies the approved LGOs with the date of transfer, and undertakes the transfer according to the prescribed criteria and procedures

2.4 Development of mechanisms and process for transferring health centres to LGOs



2.5 Steps for the transfer of health centres at provincial level



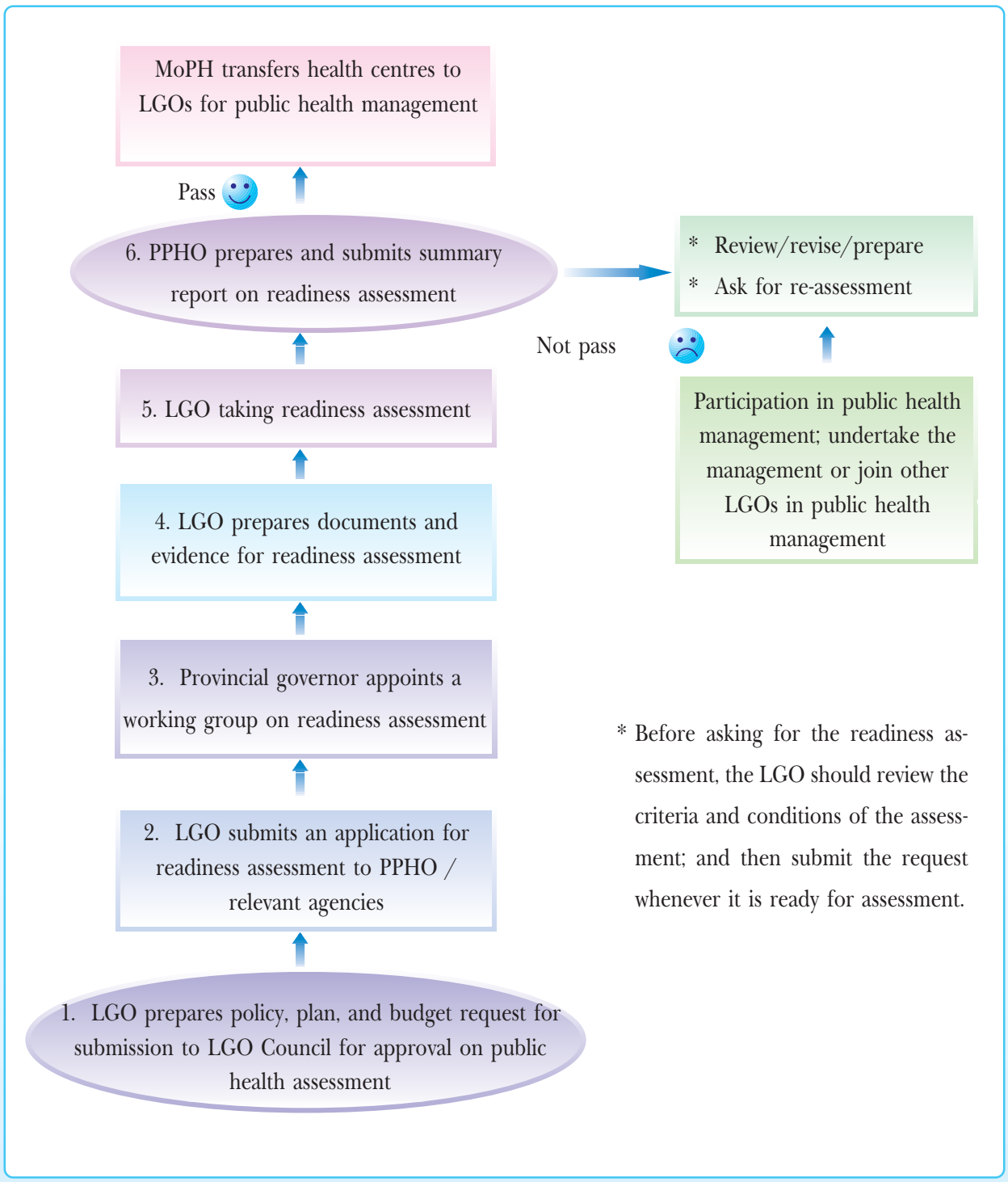
2.6 Criteria and procedures for LGO readiness assessment: 5 elements and 8 indicators

Element	Indicator
1. Experience of the LGO in managing or taking part in public health activities	1. Time period that the LGO has managed or participated or supported public health activities until the year of assessment. 2. Results of public health activity implementation. 3. Community participation in LGO's public health activities. 4. Promotion and support for health centres before applying for taking the transfer such as resources, technical affairs activities, and others.
2. Preparedness plans for public health management of the LGO, showing preparedness in various aspects that are suitable for the types and models of public health management	5. Having a strategic plan, programmes, projects or activities, or referral system development plan, preparedness plan for emergency and epidemic situations, and/or plan for developing a control, monitoring and examination system leading to the confidence in the management of standard health system.
3. Public health administration and management procedures	6. Procedures for public health administration and management.
4. Allocation of budget for public health	7. Proportion of budget (including general subsidies and loans, excluding specific subsidies from the government) for public health on average for the past three years.
5. People's and stakeholders' opinions on TAO's readiness in public health management	8. Opinions of the people and stakeholders in the LGO's jurisdiction on its readiness for public health management.

2.7 Criteria for passing the readiness assessment on LGO's public health management and features of public health management as assessed

Average score	Readiness level	Recommendations on LGO's public health management
Less than 50%	Low	- Continue to participate in public health management to be better prepared in the future. - May join other LGOs in public health management. - MoPH assists the LGO to be prepared for the transfer.
50– <70%	Medium	- Be allowed to provide disease control and health promotion services. - May join other LGOs in public health management. - MoPH assists the LGO to be prepared for the transfer.
≥70%	High	- Be allowed to receive the transfer of health centre and undertake all four dimensions of public health missions, namely disease prevention and control, health promotion, medical care, and rehabilitation.

Figure 11.2 Steps for LGO's readiness assessment on public health management



Source: Bureau of Policy and Strategy, Office of the Permanent Secretary, MoPH

2.8 List of LGOs and 28 transferred health centres

	Province	LGO, district	Health centre (HC)
1	Lampang	1. Lampang Luang TAO, Ko Kha	1. Lampang Luang HC
2	Tak	2. Wang Man TAO, Sam Lao	2. Wang Wai HC
3	Kamphaeng Phet	3. Wang Khaem TAO, Khlong Khlung	3. Wang Khaem HC 4. Bo Thong HC
4	Uthai Thani	4. Hat Thanong TAO, Mueang	5. Hat Thanong HC
5	Buri Ram	5. Nong Waeng Municipality, Lahan Sai	6. Nong Ta Yao HC 7. Nong Wa HC
6	Udon Thani	6. Naphu TAO, Phen	8. Naphu HC
7	Ayutthaya	7. Bang Nomkho, Sena	9. Bang Nomkho HC
8	Phathum Thani	8. Buengyitho Municipality, Thanyaburi	10. Buengyitho HC
9	Lop Buri	9. Khao Samyot Municipality, Mueang	11. Khao Samyot HC
10	Kanchanaburi	10. Wang Sala Municipality, Tha Muang	12. Wang Sala HC
11	Sumut Songkhram	11. Ban Prok TAO, Mueang	13. Ban Prok HC
12	Chanthaburi	12. Ko Khwang TAO, Mueang	14. Ko Khwang HC
13	Ratchaburi	13. Dan Thaptako TAO, Cham Bueng 14. Ban Khong Municipality, Photharam	15. Dan Thaptako HC 16. Ban Khong HC
14	Phetchaburi	15. Ban Mo, Mueang	17. Ban Mo HC
15	Sa Kaeo	16. Phra Phloeng TAO, Khao Chakan 17 Khlong Hinpun TAO, Wang Nam Yen	18. Na Khanhak HC 19. Khlong Tasut HC 20. Khlong Hinpun HC
16	Nakhon Si Thammarat	18. Pak Phun, Mueang	21. Ban Sala Bang Pu HC 22. Ban Pak Phun HC
17	Kalasin	19. Thung Khlong TAO, Kham Muang	23. Ban Duea Kao HC
18	Chiang Mai	20. Suthep Municipality, Mueang 21. Tha Pha TAO, Mae Chaem 22. San Nameng TAO, San Sai 23. Don Kaeo TAO, Mae Rim	24. Suthep HC 25. Ban Pa Daet HC 26. Ban San Na meng HC 27. Don Kaeo HC
19	Surat Thani	24. Ko Phangan TAO, Ko Phangan	28. Ban Chalok Lam HC

2.9 Evaluation. The MoPH's Committee on Health Decentralization assigned HSRI to evaluate the transfer of health centres to LGOs, from the beginning stage until the transfer of all 28 health centres was complete. In such an undertaking, HSRI had academics from Khon Kaen University conduct the evaluation 3 months, 6 months and 1 year after the transfer. In addition, other agencies including the CDL and the MoPH's Bureau of Policy and Strategy also followed up, and conducted the evaluation. The evaluation results are briefly presented in the table below.

Analysis of the monitoring and evaluation of the transfer of health centres to LGOs by 3 agencies

HSRI	Bureau of Policy and Strategy, MoPH	Committee on Decentralization to LGOs	Analysis and recommendations
1. Personnel **1.1 Advantages** (1) The personnel were adequate, taking good care of service recipients in a transparent manner.	(1) The personnel were very knowledgeable about the transfer, criteria and guidelines of transfer, benefits, professional practice at health centres (reviewing unchanged).	(1) Personnel's morale was enhanced as they receive more bonuses.	
1.2 Issues that should to be resolved (1) In the case of transferred personnel, not all are coming as expected and some were from other areas; they needed some time to adjust themselves and learn about the new context and how to work with the new partners or networks.	(1) The number of transferred personnel was too small, not consistent with the workload; so, they had to work harder. (2) During the transitional period, health personnel lost the chance for promotion and changing positions. (3) Eligibility for	(1) If the number of transferred personnel was smaller than before and the transfer was delayed, the efficiency and quality of work would be lower. (2) The transferred personnel were inadequate. (3) There was no	- At the meeting on transfer preparedness, issues clarified included the direct payment for medical services; LGOs had been requested to make advance payments for personnel and their family members with chronic diseases. So, MoPH and relevant

HSRI	Bureau of Policy and Strategy, MoPH	Committee on Decentralization to LGOs	Analysis and recommendations
	welfare for transferred personnel was unclear.	career advancement for staff; for instance, they were ineligible for level promotion under the health centre restructuring of MoPH.	agencies need to hold a meeting on this matter every time before the transfer.
	(4) Former agency of transferred personnel did not support their operations, resulting in the lack of capacity building and the chance to participate in MoPH's meetings as before	(4) The right to direct payment for medical services was lost.	- Public health personnel are still eligible to get reimbursements of medical expenses like civil servants, but they have to make advance payments first.
	(5) Some LGOs did not fairly give the annual salary increase.	(5) The personnel were afraid that they would not get technical support from MoPH after the transfer, which affected their morale.	
		(6) LGOs still had inadequate health personnel.	
		(7) LGOs lacked experience in public health management.	
		(8) Lack of clarity in the practices related to personnel after transfer.	- Request the Department of Local Administration to issue clear guidelines for all LGOs.

HSRI	Bureau of Policy and Strategy, MoPH	Committee on Decentralization to LGOs	Analysis and recommendations
2. Budget, supplies and equipment **2.1 Advantages**		(1) Give a chance for community organizations to take part in the management of funds allocated from NHSO with LGO's matching funds. (2) Health centres receive additional budget from LGOs, making them run health activities more efficiently with better quality for better benefits for the people. (3) Medicines and medical supplies can be obtained from the hospitals with convenience and flexibility.	- LGOs understand and participate in the management of programmes on health promotion, disease prevention and rehabilitation for the people with better coverage. - The benefits are delivered directly to the people; they received the services that are not different from those provided by MoPH's health facilities.
2.2 Issues that should to be resolved (1) In a subdistrict that has more than one health centre but not all were transferred to the LGO, there was some confusion in operations such as budget and resources.	(1) Financial regulations were unclear, especially for self-generated revenue; the revision has not been finished. (2) Some LGOs lacked the knowledge and understanding of criteria for budget allo	(1) Lack of clarity of LGO regulations such as on budget. (2) Lack of clarity in budgetary procedures after the transfer.	- The Department of Local Administration should draw up a training curriculum on financial administration for LGOs and support staff training.

HSRI	Bureau of Policy and Strategy, MoPH	Committee on Decentralization to LGOs	Analysis and recommendations
	cation to health centres; some were unaware of such criteria. (3) The budget received is too little. (4) Procedures for managing different funds were unclear. (5) Public health personnel lack the knowledge and understanding about the financial management of LGOs; and there are no clear guidelines for accounting, financing and financial reporting.	(3) Lack of budget for public development as no budget had been earmarked for such purposes.	- MoPH has no budget to be allocated to LGOs; there is only capitation budget from NHSO. - If the transfer is undertaken before the annual budget preparation period, LGOs will prepare their annual budget regulations on a timely basis.
3. Operations **3.1 Advantages** (1) For the transfer of health centres, when all personnel have been transferred, they will cooperate and assist each other in doing their work as they have known each other before; at the community level, there are VHVs coordinating the activities for unity in the operations.		(1) Work can be done faster with more flexibility and local problems can be solved on a timely basis.	- The Department of Local Administration has prepared a curriculum on LGO financial administration; all public health personnel at all levels should be supported to attend the training.

HSRI	Bureau of Policy and Strategy, MoPH	Committee on Decentralization to LGOs	Analysis and recommendations
(2) Specific space has been provided for health-care delivery with modern equipment and an opportunity for modernization. (3) The service and referral systems have been better. (4) LGOs can participate in health programme planning with the people; so, problems can be discussed, their causes are analyzed; evaluations can be undertaken and achievements of such programmes or projects can be presented.		(2) Contacts for co-operation with executives of LGOs can be done with more recognition and friendliness. (3) Patient referrals are more efficient as LGOs can provide an ambulance and personnel when making a referral. (4) The people are satisfied with cleaner facilities. (5) It is more convenient for the people to seek health care with health providers' attention. (6) Public health personnel agreed than the transfer helps the people to get better services and the health centre's premises will be improved.	

HSRI	Bureau of Policy and Strategy, MoPH	Committee on Decentralization to LGOs	Analysis and recommendations
3.2 Issues that should to be resolved (1) Personnel's unconfidence in LGOs causing management problems in the first phase. (2) In the some locality with only some health centres transferred to an LGO, resulting in confusion in the operations, supervision, referrals and cooperation between MoPH and LGO agencies. (3) The partial transfer of health centres and personnel has resulted in unsolidarity of operations as the policy of each agency is different; the working periods are also different, resulting in disparities in operations.	(1) The administrative systems of MoPH and LGOs are different; there are no common operating guidelines. (2) There is no support for certain operations; that seems like being cut off from MoPH. (3) Operations and revision of rules and regulations are slow. (4) Too little has the doctor come to provide medical services at health centres; there are no dental services in some localities. (5) Not all kinds of services are provided; no dental services in some areas.	(1) Health centre staff want to get support from LGO executives in terms of adequate staffing, supplies and equipment as well as continuing education opportunities and technical support.	- The staffing pattern together with justification for health centres should be proposed to the Provincial Local Administration Committee. - To date the Department of Local Administration has issued the Regulation on Use of **Revenue of LGOs' Health Centres, B.E. 2552 (2009),** which replaced the MoPH's regulation on this matter.
4. Management **4.1 Advantages** (1) The LGO and the health centre have good	(1) Having a faster management mechanism	(1) Policies can be set for working beyond the	

HSRI	Bureau of Policy and Strategy, MoPH	Committee on Decentralization to LGOs	Analysis and recommendations
working relations as some staff may be relatives and from the same locality. (2) The LGO and the health centre have common experience and faiths in operations. (3) The budget approval process is shorter resulting in faster operations and increased efficiency.	with a shorter line of command and more independent management. (2) Having career advancement within their line of work, which can be changed more easily. (3) Health centres have been improved in terms of structure, supplies and equipment.	frame set by MoPH, which can respond to people's needs more to the point. (2) Referral system for patients is more efficient as LGOs can provide an ambulance and staff for such purposes.	
4.2 Issues that should be resolved	(1) Management regulations are still unclear especially those related to personnel and budget. (2) The linkages of networks, operations and services between MoPH and LGO agencies are unclear. (3) Former parent agencies (under MoPH) did not give any support as before as the transferred health centres	(1) The government should set a clear policy and guidelines for the transfer. (2) MoPH's policy on the transfer of the removing health centres is unclear; some provinces do not support the transfer, resulting staff's unconfidence. (3) Some LGOs have not established a Public Health Division or Section to get prepared for the transfer.	- At present, only Ko Phangan TAO has not establish a Public Health Section; so, public health and environmental activities have to be handled by the Office of the TAO Chief Administrator. As the TAO is a special area as a tourist destination on an island, it is hard to recruit personnel and 40% of the TAO budget is spent on personnel, the estab

HSRI	Bureau of Policy and Strategy, MoPH	Committee on Decentralization to LGOs	Analysis and recommendations
	have got the budget from the receiving LGOs. (4) Guidelines for resource management of MoPH and LGOs are different. (5) Revision of relevant rules and regulations are slow and unclear. (6) Executives of some LGOs do not understand the work of MoPH as expected. (7) Executives of some LGOs have little participation in the management and operations of health centres.	(4) LGOs lack the readiness in management as they have no experience in this matter. (5) The criteria for LGO readiness assessment are difficult and complicated. (6) Personnel lack the understanding of rules and regulation for operation especially for budget and personnel.	lishment is deferred. - The guidelines for LGO readiness assessment were actually prepared jointly by MoPH and LGO networks and approved by CDL.
5. Clients' satisfaction **5.1 Advantages** (1) The people are satisfied with the standard of health centres with better health services, such as referral systems, service equity (queue card), daily services, home visit, dental service, lab service, faster service, emergency care within and outside office hours.	(1) Better service systems, faster services with accuracy and coverage; more supplies of medicentres and equipment; more services form physicians and dentists at health centres.	(1) Most people in the locality are aware of the transfer of health centres to LGOs and agree on the transfer.	- The benefits of the transfer go directly to the people, who also help monitor local health activities.

HSRI	Bureau of Policy and Strategy, MoPH	Committee on Decentralization to LGOs	Analysis and recommendations
(2) Specific places have been designated for each activity; service areas are suitable with modern equipment readiness to provide services and development of modern services.	(2) More support for public health from LGOs.	(2) Most people are satisfied with the better cleanliness of health centres.	
(3) Personnel are adequate with proper attention to clients, spending more time on service delivery and working with transparency.	(3) Better health centres with regard to structure, supplies and equipment.	(3) The services are more convenient and faster with more attention from staff.	
(4) Services (medical care) and referral systems are suitable which changes towards betterment.		(4) Equipment, tools and medicines are adequate for health-care delivery.	
(5) The people participate in creating health development plans, raising problems and jointly analyzing causes of problems.		(5) Opportunities are open to the people to participate in undertaking public health activities.	
		(6) The people are satisfied with the cleanliness of the premises.	
		(7) The people get health services with convenience and attention of health personnel.	
5.2 Issues that should be resolved			

HSRI	Bureau of Policy and Strategy, MoPH	Committee on Decentralization to LGOs	Analysis and recommendations
6. Opinions of LGO executives			
6.1 Advantages		(1) LGO executives are enthusiastic about receiving the transfer of health centres with visions and experience in public health.	- The transfer is carried out smoothly; the support for public health is acceptable to local personnel as the transfer directly provides maximum benefits for the people.
6.2 Issues that should be resolved		(1) LGO executive would like to have officials of transferring agencies continue to provide support for LGOs for some time as well as budgetary and technical assistance for LGOs and health personnel, and facilitate the transfer of staff who wish to move to LGOs.	- MoPH (through PPHO, district health offices and community hospitals, are currently providing good support for the transfer of health centres. However, only some district health officers (DHO) misunderstood that they were not supposed to oversee the transferred health centres. And in the future, DHO is still a member of the District Health Coordination Committee.

In 2010, the last year of the Decentralization Plan (No. 2) of 2008, 173 LGOs submitted a request for LGO readiness assessment for receiving the transfer of health centres; 35 of which passed the assessment criteria and at least 50% of health centre staff are willing to move to LGOs. Meanwhile, another 8 LGOs and 8 health centres in 6 provinces are awaiting MoPH's approval of the transfer.

3. Conclusion

The health decentralization operations over the period of almost 10 years have not progressed as expected, mainly due to MoPH's concept of retaining centralized authority over subdistrict health facilities. Thus, there has been no continuity in the operations together with unclear direction and policy on such effort. As a result, the LGOs that do not want to wait for such a transfer have set up their own health-care facilities, which is a redundant investment.

Besides, in connection with the linkages for operations between state and local agencies after the transfer, state agencies still have to duties to monitor their operations and provide technical assistance, as a supporter for local agencies. But, apparently there have been no cooperating mechanism or thinking process in a clear manner and LGOs have to help themselves, which has negatively affected the people.