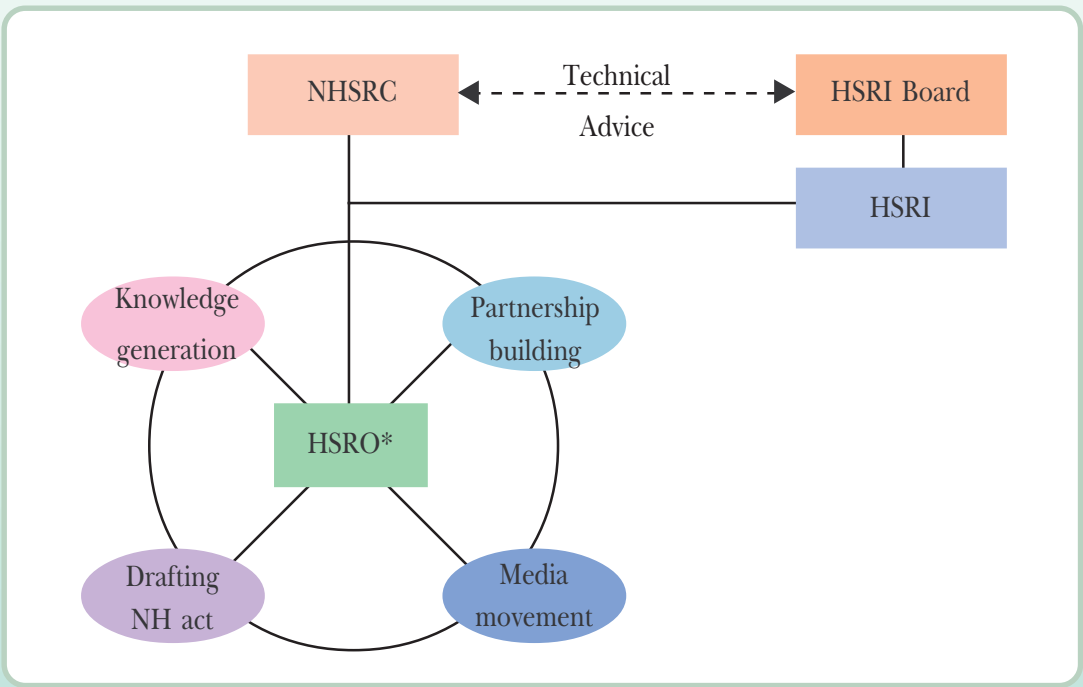
CHAPTER 11
Health Systems Reform and Decentralization

1. Overall movement of Health Systems Reform

The cabinet approved a national agenda for Health Systems Reform on May 9th, 2000. The Prime Minister Office's Regulation, entrusted the Health Systems Research Institute (HSRI) to establish a Health Systems Reform Office (HSRO), as the secretariat office for National Health System Reform Committee (NHSRC) under the chairmanship of the Prime Minister. The Committee's aims include drafting a National Health Bill to guide national health systems development, mobilizing the civil society and interest groups to re-orient their health needs and responsibility, and proposing essential health infrastructure to sustain the new health systems (Figure 11.1).

Figure 11.1 Mechanism for health systems reform



* HSRO is set up under HSRI's regulation

NHSRC = National Health System Reform Committee

HSRI = Health Systems Research Institute

HSRO = Health Systems Reform Office

1.1 Philosophy of the health systems

1.1.1 **Holistic approach**: Health should be defined as a dynamic state of complete physical, mental, social and spiritual well - being.

1.1.2 **Participatory**: To comply with the new constitution, all stakeholders must be regarded as partners in executing the health systems of the country.

1.1.3 **Healthy Public Policy**: Public policy promulgated in the country should be conductive to health development.

1.1.4 **Equity**: There should be an equitable distribution of health and health care services as well as fairness of financial contribution.

1.1.5 **Efficiency**: To achieve highest outcome from limited resources.

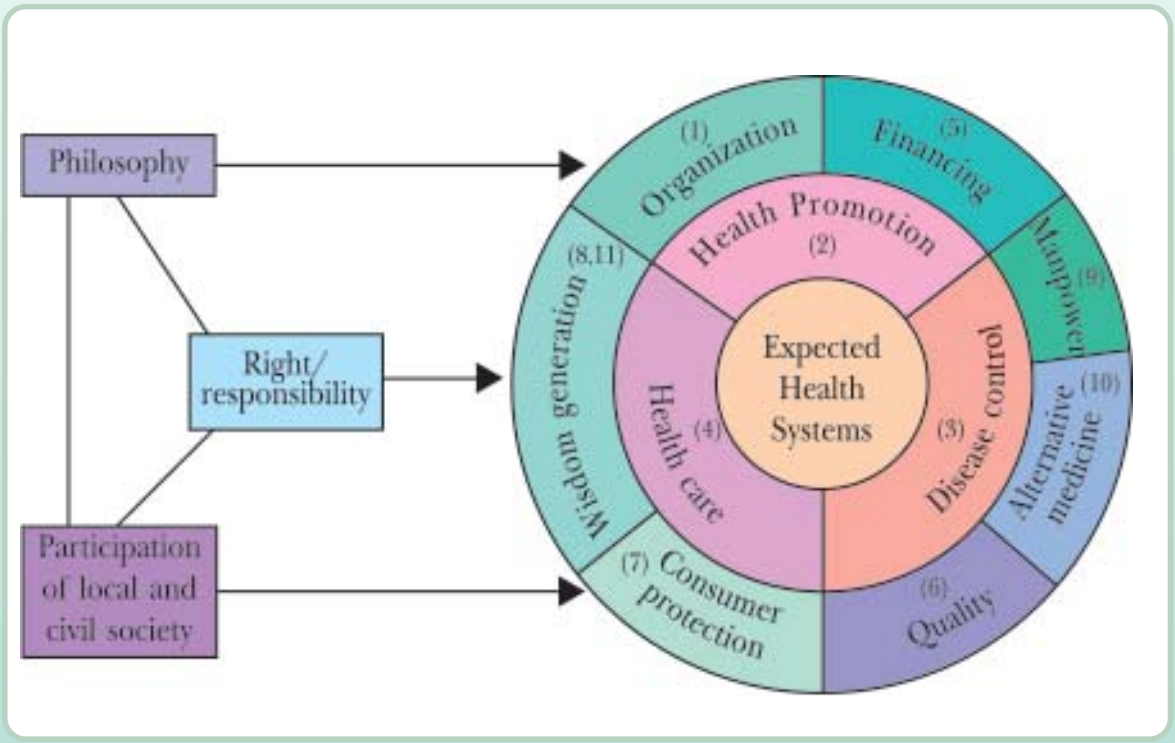
1.1.6 **Quality**: Quality accreditation should be undertaken by the state so that unqualified health care will not be disguised by distorted advertisement.

1.1.7 **Consumer empowerment**: Consumers should be empowered to be capable of safe-guarding themselves from unjust propaganda and delivery of health services and products.

1.1.8 **Self-reliant**: To strengthen self care capacity and capacity on Research and Development of local wisdom.

1.2 Issues for health systems reform (Figure 11.2)

Figure 11.2 Main issues for Health Systems Reform.



1.2.1 Mechanism for Health Systems Governance: A national health committee will be set up to coordinate all the national health policies, which may influence people's health. This multi-stakeholder committee will be chaired by the Prime Minister.

1.2.2 Health promotion: Create mechanisms and environment which can proactively build up a healthy life style for people.

1.2.3 Disease control and prevention: Emerging diseases, which include infectious diseases, non-communicable diseases, injuries, and human toxic substances, should be effectively monitored under the national surveillance system. The national authority to provide technical support to the local government as well as network with other countries in disease control and prevention should be created.

1.2.4 Health care: The aim is to achieve efficient, equitable health care systems, which is holistically responsive to the demand in normal and crisis situation.

1.2.5 Health care finance: Aiming at a financial system, which guarantees universal access to essential health care without economic banners.

1.2.6 Quality improvement: A new mechanism to support quality development and accreditation of all level of health facilities will be established.

1.2.7 Consumer protection: The system to safeguard the consumers' rights, investigate any violation, as well as compensate the litigation should be created.

1.2.8 Technology assessment: A central institute for technology assessment will be recommended to create wisdom for optimization of technology use.

1.2.9 Human Resources for Health development: A national mechanism would be established to take on the responsibility of planning and regulating the production and service of human resources for health.

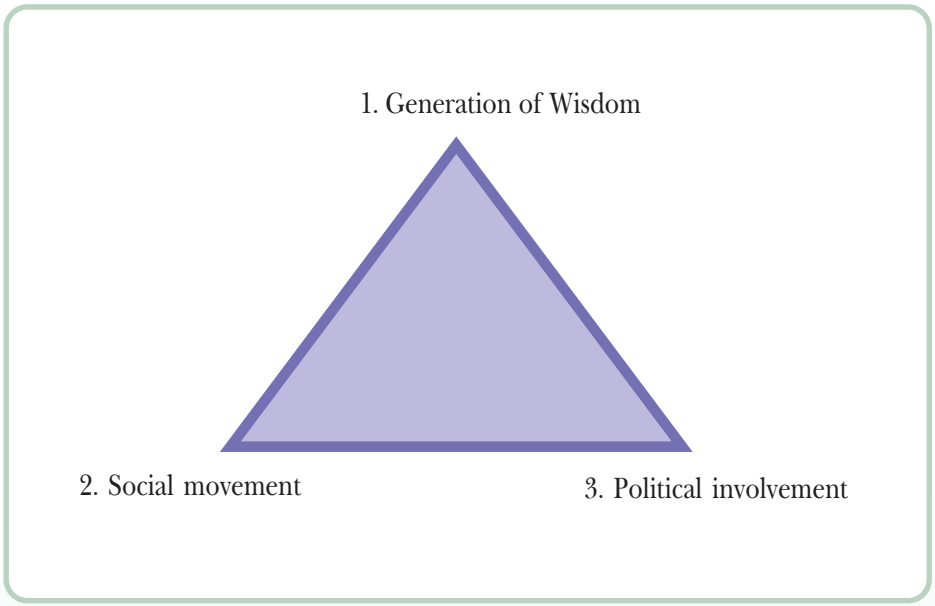
1.2.10 Thai Traditional and Alternative Medicine: Mechanisms to support and regulate the Thai traditional and alternative health services would be addressed.

1.2.11 Health Research Systems: A new structure for health research systems should be created to manage the national essential research agenda.

1.3 Strategy for Reform

Successful and sustainable reform requires appropriate wisdom, social and political support. Strengthening of these three essential elements forms the national strategy for social reform. The so-called strategy of "Triangle that Moves the Mountain" (Figure 11.3).

Figure 11.3 Triangle that Moves the Mountain



1.4 Progress

1.4.1 Strengthen health community

(1) Convening health assembly at district, provincial and national level since 2002.

(2) Support activities of health communities nationwide and collections of health building experiences for exchanging of wisdom.

1.4.2 Knowledge generation: Review of literatures to summarize appropriate wisdom in supporting civil society movements and drafting of National Health Bill.

1.4.3 Draft of National Health Bill: The cabinet approved the draft National Health Bill and the Judiciary Board has finalized the detail revision. The Bill is ready to be submitted to the Parliament in early 2005.

2. Public Hospital Reform

2.1 Pressure for Reform of Public Hospitals

Management in public hospitals is highly centralized. The staffing pattern, staff payment and many other manpower management practices are all determined by the central government agencies involving the Bureau of the Budget, the Office of Civil Service Commission, the General Comptroller Department and the MOPH. Although hospitals can generate its own revenue through user charges, such revenue can only be used for manpower expenditures through centrally determined rates, rules and regulations. Budgetary allocation to hospitals is determined by the central ministry through line-item budgets. More then 70 percent of this budget are for staff salaries and cannot be used for other purposes. The operating budget has to be used up at the end of the fiscal year or surrendered to the government. Hospital performance assessment is hardly implemented except through routine supervision and the reporting system. Accountability is low and responsiveness to the patients is inadequate.

There are a few questions: Should Thailand create a new type of public hospital that will encourage efficient management and responsiveness to the patients? And should the country create private management under public ownership?

2.2 The Move towards Public Hospital Reform

With the economic crisis in 1997, the Thai government was faced with the unavoidable needs for reform at all fronts. The Asian Development Bank (ADB) offered a social sector reform loan (SSRL) to the Thai government so that the government could reform public institutions and policies in three major social sectors - education, labour and health. Conditions for the health sector included, among others, the need to **autonomize public hospitals**, focussing mainly on **those in the MoPH**. The loan required that at least one public hospital is autonomized by the beginning of 1999.

2.3 The Concept and the Strategy for Public Hospital Reform

2.3.1 The possible spectrum for reform. The technical team of the ADB proposed to avoid the terms that may result in misinterpretation that the reformed public hospitals are private companies whose aims are for profit. Finally the term autonomous public hospital was adopted. Many of the key characteristics of the autonomous public hospitals included the need for the hospitals to carry out public functions, the possibility to have flexible management practices by setting its own rules and regulations with regards to manpower and financial resources management.

2.3.2 The organizational forms. Because of the Act of Public Organizations passed in 1999, it is easier to establish the reformed public hospitals as public organizations and thus achieve many of the desirable characteristics described earlier. Under such provisions, a hospital board would be established to represent the state in overseeing the management of each new public hospital.

2.3.3 Ensuring better responsiveness to the local communities. It was quite clear that many of the advocates for public hospital reform were trying to identify the model where the central control by the Ministry of Public Health would be effectively replaced by the community where the hospitals are located.

This has been incorporated into the structure for hospital governance, i.e. the hospital boards. Representatives from communities will form a crucial part of the governing board of the hospital.

2.3.4 Sources of finance. While the reformed public hospitals can still impose user charges, the aim will not be for the hospitals to be totally self-financed. The government will be required to provide budgetary support to the hospitals. This would better reflect the obligation of the hospitals to carry out the government's policies and avoid the conventional budgetary practices. They will have to be more performance-based with clearly established accountability. The actual amount of budgetary support from the government would be determined and worked out on a one on one basis rather than through a uniform formula.

2.3.5 Central control and coordination for the autonomous hospitals. Conceptually the aim of establishing autonomous public hospitals is not to create a highly fragmented health system with each hospital minding its own business. Consequently it was suggested that the government establish an effective

mechanism that will carry out active roles in coordinating these public hospitals. The minimal control and coordinating function is to ensure proper expansion of the hospital infrastructure.

2.4 The Chosen Model and Its Implication

Initially the Ministry of Public Health planned to have at least seven hospitals piloting the reform. This would cover a wide range of hospital sizes in various parts of the country. However due to skepticism of the public about the rationale for reform and the lack of concerted support from the political side and resistance from the health personnel, only one 120-bed community hospital has been made into an autonomous public hospital (Banphao Hospital, Samut Sakorn Province). Even though only one small community hospital has become autonomous, there are clear evidences that the present government system is poorly equipped to deal with the reform needed. The budgetary aspect posed immediate concerns. The conventional budgeting requirement needed to be changed but those involved were unprepared if not unwilling to change. The government could not successfully convince the public and the health personnel that the motive for reform is for better efficiency. There were actually conflicting views from government officials about the future of the autonomous hospital. The most crucial issue is the degree to which it is expected to be self-financed and its implication on the cost of services to the general public. Without clear directions and policies about health care financing for the population, it is not easy to convince the public that the new autonomous public status will not lead to increased user charges.

3. Decentralization and Devolution in the Health Sector

3.1 The legislative background

The Parliament passed the Act on Operationalization of Decentralization in 1999, as an organic law of the new constitution adopted in October 1997. It mandated that all ministries involved, including the MOPH, draw up detailed plans to devolve their functions, facilities and personnel to the local administration, mainly the tambon administrative organization (TAO) and the municipalities within the next 10 years (2010). The more important component of the legislation is the goal to increase the proportion of revenue of the local administration from the level of nine percent of total public revenue to 20 percent in 2001 and to 35 percent in 2006. Such redistribution would enable the local administration to take up active roles in providing various social services under their responsibility as mandated by the act. There are six major groups of functions to be carried out by the local administration. They include the building of essential infrastructure, the improvement of the quality of life (health services and education are the major two among this group), and social and community management, planning and local investment and tourism, environmental, civil, natural resources management, culture and local wisdom. The government plans to increase the local revenue by allowing them to collect more tax locally and also by allowing them to retain a larger portion of the tax collected to be used locally. Such an arrangement will reduce the revenue at the central level and will alter the roles and functions of the central ministries. This will then correspond with the needs to devolve facilities and manpower to the local governments.

3.2 The Debates about Decentralization and Health

In order to meet the goal of decentralizing, the MoPH can simply transfer the various health services facilities and manpower as well as available budget to the local administration. This will result in shifting about 80 percent of the annual budget of the MoPH and around 90 percent of its staff to the local administration units.

3.2.1 The Concern over Fragmentation of Services

The two basic units of local administration, the TAO and the municipalities, cover a limited geographical area with slightly different population sizes. The basic criteria for differentiating between the two are historical. Municipalities are those local administrative units established before the introduction of the TAO. They were present only in those selected locations with more developed economy. The TAO was introduced only in 1995 to establish local administration units all over the country. Both are smaller in size than a district. Both TAO and municipalities will generate more revenue to independently carry out their designated social functions without the need to coordinate with each other. Moreover health centers, community hospitals, general and regional hospitals are expected to coordinate closely for effective patient referral. Operated independently under separate local administration, the chain of patient referral will become even more fragmented.

Putting different health facilities under separate administrations will not pose problems in terms of patient referral if the financial mechanism is efficient. In the absence of such mechanism, the alternative is to put various levels of health facilities under the same administration. However the existing local administration is too small to take care of multiple level health facilities. Hence there is a need to create a larger local administrative unit for health by combining various local administrations in nearby localities to create a local area health board (AHB).

3.2.2 Concern over Good Governance

Most local administrations, especially the TAO, were recently established. Most local administrations deal with small local development projects and they are oriented in creating more infrastructures such as local roads and sources of water supply. However they have not been trained to carry out maintenance functions let alone carry out continuous service provision. Last but not least, corruption and lack of transparency plague local politics. These were the major arguments among government officers who are against the transfer to local administration.

In the health sector, with the introduction of the area health board (AHB) it was also proposed that a multi-party governance be created within the area health board. Rather than a mere combination of various local administration in the nearby geographical area, the area health board will consist of representatives from the MoPH and respected persons who have experience in health and management. This will help to bring more expertise in planning and decision making and help to build up transparency and confidence in the local health administration. It will also help to guarantee that local civic groups or communities will be better incorporated in overseeing or contributing to the local health development efforts rather than leaving them exclusively to the politically inclined local administration.

3.2.3 Concern over Efficiency

The local administration would continue to manage the transferred facilities in the conventional command and control manner, imposing various rules and regulations that will not allow enough flexibility in the use of available resources for service provision. The transformation of public hospitals into autonomous hospitals and the introduction of performance-based budgeting system are the two initiatives towards improving efficiency within public facilities. This can be supported by networking of all health facilities under the supervision of the AHB.

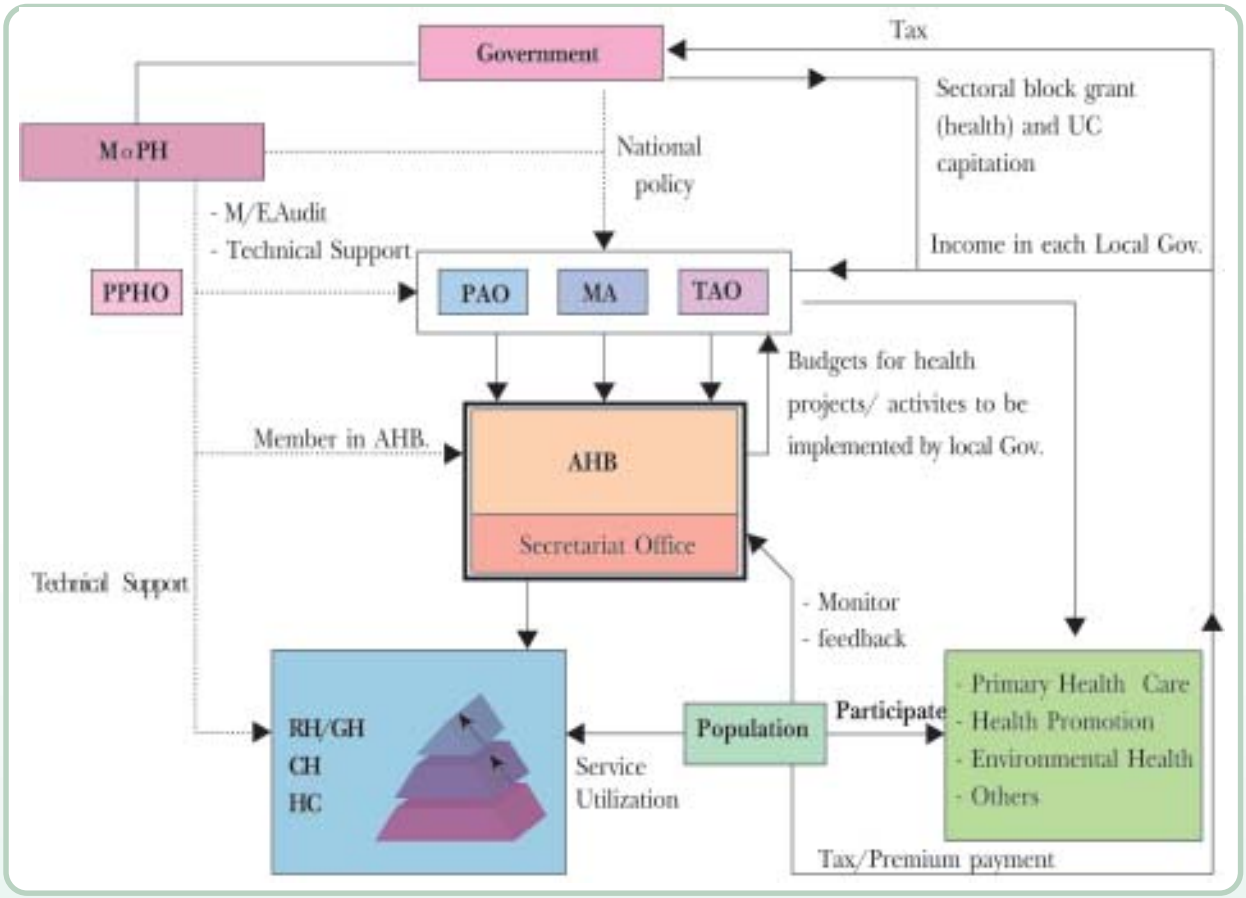
3.2.4 Concern over Future Employment Status and Conditions

Like all changes, the call for transfer of personnel to the local administration created panic and a sense of instability among the health personnel. As civil servants they were guaranteed their life long employment with pension as well as many other welfare and benefits. The concern over the lack of transparency of the local administration further aggravated the issue for fear of being unjustly discharged from services. Moreover the present civil service system guarantees the possibility of transfer to any province throughout the country. With the new system it is likely that any health personnel working at a local administration will have less possibility of transferring to another province or local administration.

3.3 The Proposed Aggregated Model and its Implication on the Future Health Care Financing System

It was proposed to establish a new local health administration, the area health board (AHB). The AHB will be responsible for health development activities in the local administration units involved. It was proposed that a number of nearby local administration be combined to form one AHB. The size of an AHB could be one district through the aggregation of local administration units within the boundary of a district or it could be larger than one district through a combination of a number of local administration units from a few districts. The main reason is to allow the economy of scale as well as the possibility of having a combination of health facilities of various levels within one local administration, thus allowing better referral and sharing of service responsibility among various levels of health providers (Figure 11.4).

Figure 11.4 The Proposed New Decentralized Health System



PHO	=	Provincial Public Health Office	PAO	=	Provincial Administrative Organization
MA	=	Municipalities	TAO	=	Tambon Administrative Organization
AHB	=	Area Health Board	RH/GH	=	Regional/General Hospital
CH	=	Community Hospital	HC	=	Health Centres

Source: Public Sector Reform and the future development of health insurance in Thailand.

The AHB will consist of a governing board and a secretariat office. Board membership will consist mainly of representatives from the concerned local administration units. There are representatives from MoPH. There are also members appointed from among the civic groups and those with expertise and experiences in health and planning and management. Such a unit will need to have legal status in order to make decisions on behalf of the local administration concerned.

The second important feature of the new decentralized health system is the combination of health facilities at various levels within the same AHB to form a single unit of service providers. Such health services facilities aggregation will require the new type of management structure and should not follow the present hierarchy of command within the MoPH. In this case the district hospitals and health centers within the same aggregation should have a role in the overall planning and management of the new organization. Thus it allows the possibility of sharing resources to achieve the set objectives while allowing day to day decisions to be made closest to where the action is.

The third feature is the allocation of a sectoral block grant from the central ministry to the AHB. Despite the increase in local revenue of up to 35 percent of total public revenue by the year 2006, it is **unreasonable to expect all budgets for health to be absorbed by the revenue generated locally**. It is therefore important for the central government to create a health sectoral block grant, which will be a mix of the central government block grant with a matching grant from AHB. The capitation budget of the Universal Coverage of Health Insurance can also be managed by the AHB.

The fourth feature is the relationship between the AHB and the service facilities. The service aggregation should not be required to follow all the rules and regulations of the local administration. They should be allocated financial resources based on the expected results and performances. They should then be entrusted to make their own decisions with regards to human resources requirement and management.

3.4 Comparison of the Alternative Models for Decentralization

The two extreme models of decentralization can be compared (Table 11.1).

Table 11.1 Comparing the two models using certain criteria

	Direct Transfer Mode 1	Network Model (AHB) 2
1. Equity	Low	High
2. Efficiency	Low	High
3. Service referral	Poor	Better
4. Good governance	Questionable	Possibly better
5. Direct control by LA	High	Medium
6. Responsiveness	High	Medium
7. Resistance	High	Medium
8. Smooth transition	Low	Medium

3.4.1 Equity. It is likely that the direct transfer of health facilities will lead to a poorly coordinated model with difficulties of shifting needed resources to the poorer areas. The network model will allow better possibility of resources reallocation to achieve more equity.

3.4.2 Efficiency. The network model creates a larger pool of resources, especially human resources, which result in better economy of scale.

3.4.3 Service referral. The direct transfer model will create barriers between various levels of health facilities due to a sense of different ownership. The network model proposed to tackle this by creating a new aggregated service provider unit that combines all levels of health facilities under one management.

3.4.4 Good governance. The joint management body, under the network model, may help to bring better governance. The local administrations will gradually develop their skill with the support of the central MoPH and the local civil society.

3.4.5 Control by and responsive to local administration. The direct transfer model will allow each local administration unit a better control over the health facilities that presumably will lead to better response to local needs. The network model also allows some control by the local administration, but not as much as the direct transfer model.

3.4.6 Resistance from health personnel. Direct transfer to the local administration created the highest resistance because of many skepticisms about the lack of transparency and the unsettled administration system. The network model may slightly improve this with the promise to give autonomy to the service providing units.

3.4.7 Transition. The direct system will likely to hold back the existing service due to worries among health personnel while the network model will have participation from personnel in Provincial Health Office who have worked for a long period of time. This will facilitate another transition.

3.5 Health Financing within the New Decentralized System

There are two major sources of funds for the AHB within the proposed decentralized health system, the centrally allocated sectoral block grant and the locally allocated budget. It was expected that the two sources combined should not be lower than the level spent by the central government within each locality. The funds available could be allocated to various groups working to improve the health of the people in the locality. It was proposed that a certain amount of budget be allocated to each local administration unit to carry out projects or activities that could be implemented locally to improve people's health. The remaining amount will then be allocated to the network health facilities to provide services based on the agreed results or outputs.

With the movement towards universal coverage, the AHB can also serve as a decentralized mechanism to implement the new scheme. The role of the AHB will vary depending on the design of the new scheme. The minimal role of the AHB is to ensure the collection of assessed contribution of various population groups based on the formula used. Part of the contribution may be kept and used by the AHB to ensure access to health services for each population within the locality. The extent of funds to be expended by the AHB will depend on the payment methods set by the central authority. The AHB may have to decide how many different packages will be made available to the population within each area and then collect the added contribution according to the assessed contribution determined by the central authority.

4. Implementing the Decentralization

4.1 The Needs for Research and Development

With the limited time frame before the detail operation plan is finalized and approved, one crucial strategy is to place the first phase of the operational plan in the period of intensive study on decentralization. During the period only a selected number of provinces is including the local administration units will be reorganizing and developing various aspects of the new decentralized health system. Many crucial issues will need to be addressed through research and development activities. Some of the more detailed issues include:

4.1.1 The area health board (AHB): There is a real need to study its mission, composition, legal status, method of work and status of personal.

4.1.2 Health service facilities: There is a need to study the status the facilities and their personnel, the financing mechanism, the coordination among facilities within network, the comprehensive care, and the conditions for final transfer to the local administration.

4.1.3 The budget and financial aspect: There is a need to study the appropriate proportion of various source of budget, accounting and information system for efficiency and equity of resources used.

4.1.4 The new provincial and district health offices: What should the limits of their new roles be in order to ensure equity, efficiency and quality? What are the steps toward new roles and the requirement for capacity building?

4.2 The Need for Capacity Building

4.2.1 The local administration units (including the AHB's)

The primary target for development is the local administration unit. Although municipalities have existed for more than five decades, they are still relatively inexperienced with regards to health development. Only a few municipalities have their own health service facilities and have been actively planning and allocating budget for health. Almost all Tambon Administration Offices have no experiences with health development activities of any kind. Thus, there is a need to strengthen capacity of the local administrations in the areas of priority setting, planning, budgeting, and resource allocation. They also need the capacity for setting their output and outcome as well as monitoring and evaluation.

4.2.2 The Service Providers network

The service providers in the new decentralized health system are expected to work in a multi-level network with a relatively larger size of organization and the new setting for joint decision making within the organization. Another aspect that will be required from the service providers is the ability to be more responsive to the needs of the local communities and to carry out a mix of health services aimed at health promotion, diseases prevention and curative services.

4.2.3 The provincial and district health officers

At present the two offices are mainly involved in budget allocation and logistics supports to the various providers. In the new decentralized system these functions are going to be taken over by the AHB and the secretariat office of the AHB. The provincial and district health offices will work to ensure the compliance with the national policies and the technical standard requirement, the roles that have not been well carried out at present. The officers in the two offices will have to be good communicators and advocators. There is a need to strengthen their monitoring and evaluation capacity including inventing new tools and methods.

4.3 Capacity for Central Monitoring and Support

Despite the first few years for research and development in selected provinces, there is a need for intensive support and monitoring as well as continuous learning for further improvement for the first 10

years of the decentralization effort. The process will involve various groups of people and decision-makers but **the MoPH will have to be responsible for the ultimate outcome.** The MoPH needs to strengthen its capacity in working closely with local administration. Its function as coordination between the concerned ministries can help the local administration and the AHB to improve their decision making and resource allocation. It can point out the needs for changes in the budgetary processes and practices of the central government as well as the local administration.

5. Progress of Implementation

Until December 2004, there was not much progress in decentralization of the health sector. Some activities, programs, and budgets, particularly those related to sanitation and water supply, are devolved to the local administration. There is still no movement in the devolution of rural health facilities, for example, the development of guidelines or conditions for devolution. The studies on the roles of AHB in certain provinces were halted.

In 2004, only 23.5 percent of national revenue was allocated to the local administration. There is a very high chance that the 1999 organic law on the operationalization of decentralization will be amended to allow more time for implementation.