



## 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.

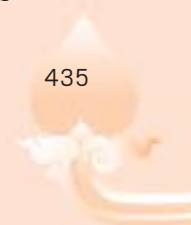
Regarding the devolution of health activities, the MoPH has undertaken the following:

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.







Major mission	Mission	Agency	No. of missions			Remarks
			Total	Transferred	Remaining	
	- 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.

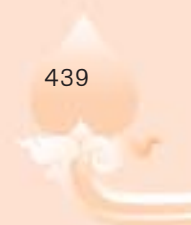
**4.3) Transfer to an autonomous public organization (APO).** An APO may be specifically established to manage health services in collaboration with a LGO in each locality; any health facility or network of health services may be set up as an APO; or an AHB may be set up as an APO.

**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

