A decade of health-care decentralization in Thailand: what lessons can be drawn?

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This paper reviews the progress of implementation of health-care decentralization in Thailand since the promulgation of the Decentralization Act 1999, draws lessons learnt and provides recommendations. This review was carried out because of the delay in health-care decentralization, as compared with what was indicated in the Decentralization Action Plan, and to identify the possible causes of delay. The review also analyses other issues that affected implementation of this policy such as consensus on models of health-care decentralization, and other government policies being implemented during the same period. It is recommended that decentralization is not a panacea for health system development and its concept should be applied carefully, based on the country context.

Key words: Decentralization, health care, health systems.

Introduction

Although health-care decentralization has been accepted globally as a means to improve efficiency and responsiveness of the health system, each country adopts and implements this policy differently. Most developed countries in Europe started implementing this policy after the second World War,[1] while developing countries in Asia started later in the 1990s.[2] In Thailand, despite many impressive successes in health system development,[3-5] the country implemented the decentralization policy slowly although it was clearly stated in the Constitution since 1997. From 1999 to 2012, the share of the local government (LG) budget in the central government budget increased from 9% to 26.8% although it was targeted at 35% by 2006. According to the Decentralization Action Plan, there was a need to transfer all public health facilities to the LG. However, there were only 28 health centres (HCs), which accounted for only 0.3% of total HCs being devolved to LGs in 2007–2008. This paper reviews the progress of health-care decentralization in Thailand since the promulgation of the Decentralization Act 1999 and draws lessons learnt from its implementation. Decentralization in this paper means devolution, which is a transfer of authority and responsibility from the central government to the LGs.

Methods

The source of information included a literature review and direct involvement of the authors in the policy process.

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Health-care decentralization in the Thai context

The health-care system in Thailand is a highly centralized and public dominant system. In 2000, health facilities owned by LGs accounted for only 2.74%, 0.41% and 5.23% of the total public health facilities at the levels of HC, district and general hospitals, respectively.[6] The Decentralization Act 1999, which was enacted according to Chapter 284 of the Thai Constitution of 1997, served as the backbone of decentralization. It mandated that all public services, including health services, should be the responsibility of the LGs. When there was a transfer of responsibility from the central government to LGs, related budget and personnel should be transferred accordingly. As per the Act, the Decentralization Action Plan had to be developed within one year and revised every five years with full participation of all stakeholders.

It was found since the beginning of the development of the First Decentralization Action Plan that an approach used to transfer a responsibility to LGs did not fit well with health services. This approach implied a transfer of responsibility from the central government to individual LGs, but did not guide clearly how to transfer responsibility to a group of LGs. The Ministry of Public Health (MoPH) insisted on maintaining an integrated health-care system while this approach forced a system to be fragmented by transferring different levels of health facilities to different LGs. The HC would be transferred to the Tambon Administrative Organization (TAO) at subdistrict level while the district hospital would be transferred to municipality and the general hospital to the Provincial Administrative Organization (PAO). It was found from the experiences of other countries in the region that this approach would create different ownerships of health facilities and discourage system coordination and integration.[7,8] At least two options were proposed to accommodate a need to maintain integration of the health-care system.

First, was to transfer all levels of health facilities as "a network of health facilities" to a big LG which is the PAO. However, this option would limit participation of TAOs and municipalities to manage health services for their respective populations and, of course, was considered not being politically feasible.

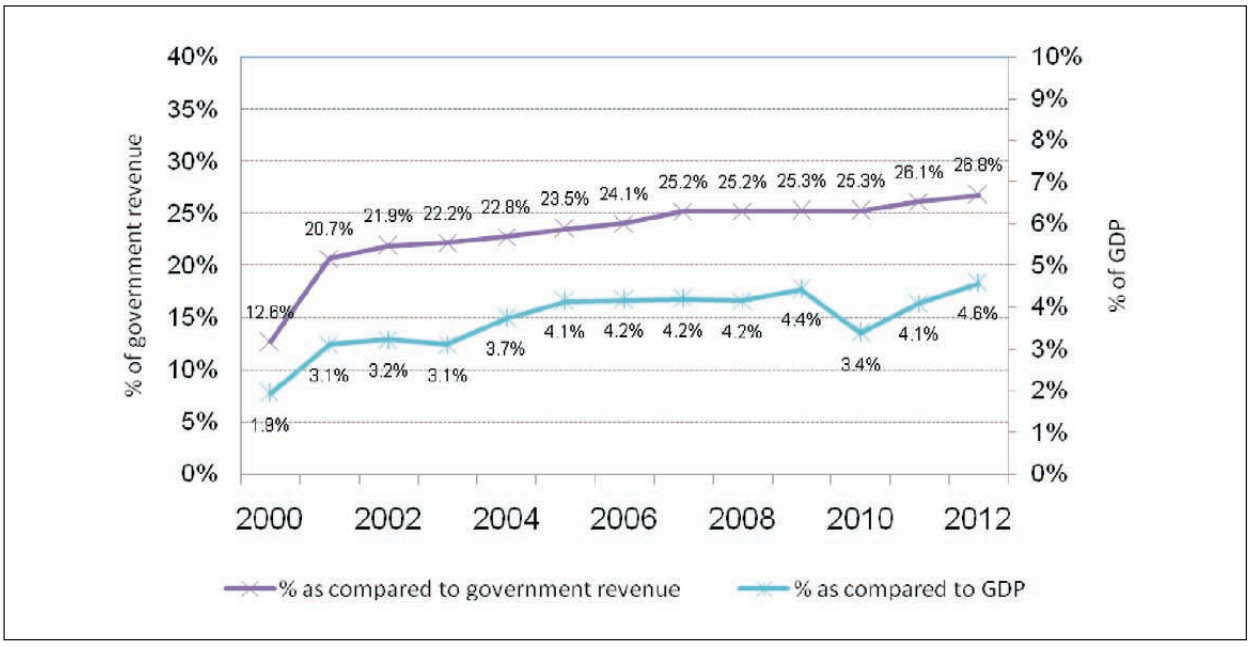
Second, was to transfer "a network of health facilities" to a new structure called, "Area Health Board (AHB)" at the provincial level. This AHB would allow participation of all LGs in the province as well as civic groups and local experts. The main criticism of this option was that AHB was not a LG and this could not be considered as health-care decentralization according to the law.

Finally, after a long discussion and negotiation between MoPH officials and representatives of LGs, the second option was adopted in the First Decentralization Action Plan in 2001. The MoPH actively implemented this plan by establishing functional AHBs* in 10 pilot provinces in 2002 with some success[9] and there was a plan to institutionalize AHB by law in 2005.

All health-care decentralization movements were suspended in late 2002 since there were changes of a leadership in the MoPH and government policy.[10] There was a slow progress of decentralization not only in the health but also in the education sector. Both sectors needed more than 500 000 staff to be transferred to the LGs. As a result, the share of the LG budget in the central government budget could reach only 24.1% in 2006 when the target was 35% (see Figure 1). Realizing

* Functional AHBs were established by using MoPH's regulation and performed as an advisory body to the Provincial Health Office to manage health services and public health in the province. It was planned to establish AHB as a jurisdiction to act as the provincial health authority to establish policy and allocate health resources as well as for monitoring and evaluation.

Figure 1: Local government budget: Fiscal year 2000–2012



Source: Office of Decentralization to Local Government Organization Committee

its implementation problems, the law was amended in 2006 to set the minimum share of LG budget in the central government budget at 25%, with a target of 35%. In addition to changing the target of the LG budget, the model of health-care decentralization as addressed in the Second Decentralization Action Plan (2008–onwards) was also changed. It seems that keeping all health facilities together as a network was less of a concern, and devolution of HC to TAO was defined as a target for health-care decentralization while district and provincial hospitals had more flexible options. Establishment of AHB was not mentioned in this plan[11] and previous pilot implementation of AHB was terminated.

The progress during the Second Decentralization Action Plan was only the devolution of 28 HCs from 9762 HCs nationwide to TAOs in 2007–2008 with some positive results such as increase of management flexibility, responsiveness to community and patients, and community participation.[12]

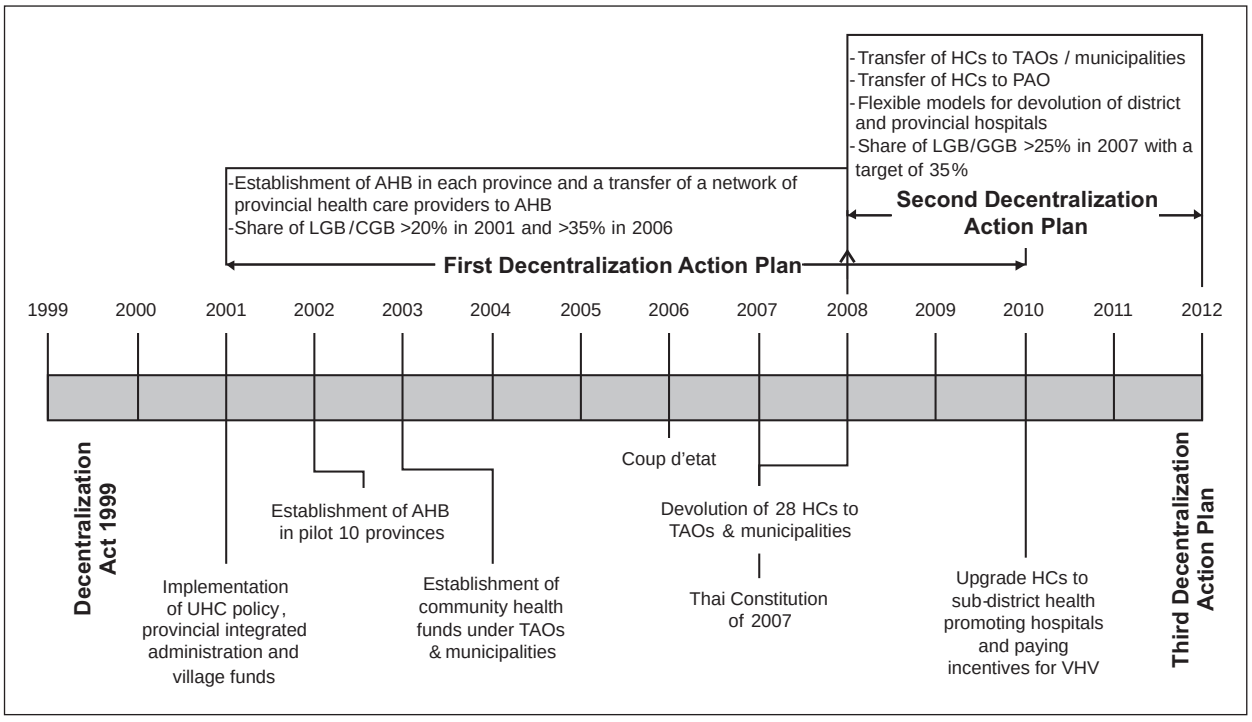
The Third Decentralization Action Plan has been approved recently in 2012 without major change except a model of transfer of a network of provincial health facilities to PAO in big provinces is proposed again as an alternative. The progress of health care decentralization and related policy interventions during the past decade are summarized in Figure 2.

Lessons learnt

Delayed decentralization: possible causes

Decentralization was addressed as a priority issue in the Thai Constitution of 1997 which later created a subsequent law called the Decentralization Act 1999 and Decentralization Action Plan. The Thai Constitution of 2007 did not change the priority of decentralization policy. However, having a constitutional and legal basis for decentralization could not guarantee the success of its implementation. During the past decade the progress of health-care decentralization which could be observed

Figure 2: Progress of health-care decentralization and related policy interventions



Source: Compiled by the author

included the establishment of AHBs in 10 pilot provinces in 2002 and devolution of 28 HCs to TAOs and municipalities in 2007–2008. Both occurred when there was a strong leadership in the MoPH. The leader was the Permanent Secretary of the MoPH in the first event and the Health Minister in the second.

Gradual implementation of the decentralization policy could be another cause of delay since it would be difficult to sustain political support in developing countries where most of them have political instability.[13] However, a "big bang" approach as in Indonesia and the Philippines has many negative consequences because of inadequate administrative preparation.[14] The First Decentralization Action Plan which set a target of share of LG budget in the central government budget from >20% in 2001 to >35% in 2006 was a good strategy to keep accelerating progress of policy implementation, but unfortunately this target was abolished in 2006 and slowed down its implementation.

Did the models of health-care decentralization matter?

Thailand spent a lot of time on developing models which could maintain integration of the health care system. The major concern was that different ownership of health facilities as a result of decentralization, would affect their coordination and lead to fragmentation of the health-care system. This concern was worth consideration since it was confirmed by many country experiences.[7,8] An initial model by establishing AHB was developed to solve this problem. However, the proposed model focused less on the use of other mechanisms to coordinate health facilities and maintain system integration. After the implementation

of universal health coverage (UHC) policy in 2001, the use of a financing mechanism to direct health services provision became more popular and initiated more alternative models of health-care decentralization such as the role of LGs as a health-care purchaser. The Second Action Plan which accepted a transfer of HCs to TAOs and municipalities which allowed flexible models of hospital devolution, could reflect a change from the initial model. The most recent recommendation was that the model should not be limited only to a transfer of ownership of health facilities to LGs but could be any model that reflected a transfer of responsibility to LGs.[15]

How did other policies affect decentralization?

From 2001 to 2012, Thailand had seven governments and one coup d'état.[16] Although every government addressed decentralization as one of their priority policies, five policies were being implemented and affected decentralization. The characteristics of each policy and their potential effect on health-care decentralization are summarized in Table 1.

In summary, these policies affected health-care decentralization in three aspects. First, they competed for resources which could be allocated to LGs and limited resource availability under their discretion. From 2001 to 2012, the budget allocated for these policies was 944 billion Baht which accounted for 24.7% of the total LG budget during the same period. Second, they created and demonstrated more alternative models of health-care decentralization such as the role of LG as a health-care purchaser, a community committee to oversee health-care providers and health development. Third, a model of de-concentration was proposed to replace devolution in many cases. This could reflect an attempt of the national politician to hold power at the central government and its delegations rather than to devolve to the local politician.

Transfer of human resources for health (HRH) to LG: an independent movement from devolution process

It was found that from 2001 to 2007, the number of health staff being transferred from the MoPH to LGs increased year by year. The total number of transferred health staff was 693 and most of them (96%) were from the HCs and district hospitals, and were transferred to municipalities and TAOs (95.6%.)[18] From 2008 to 2011 the number of transferred health staff increased year by year and the total number was 910. Municipalities and TAOs were the most popular places for transferred staff (91.2%).[19] The transfer of health staff which occurred even before a transfer of HCs to LGs in 2007–2008 could reflect some problems of HRH management system in the MoPH which became push factors for their mobility. These factors include limited career development, financial incentive, and operating budget of health staff especially at HC. Devolved HC staff expressed the same reasons for their decision to move to LGs.[20–22] As a result of these unsolved HRH management problems at HC level, it is anticipated that there will be more demand of HC staff to be transferred to LGs.

Conclusion and recommendations

Thailand has made a decision to move the country towards a decentralized system as promulgated in the Constitution of 1997. The country's approach to decentralization is categorized as a "cautious mover"[23] since there has been limited progress especially in health-care decentralization during the past decade. Although there are multiple causes of

Table 1: Characteristics of some policies during 2001–2012 and their potential effect on health-care decentralization

Policy (year started implementation)	Main characteristics of policy	Potential effect on health-care decentralization	Budget
Village and urban community fund (2001)	• Establishment of village funds in rural and urban areas, using government budget, to provide loans to villagers • Establishment of a village committee to manage a village fund but without a clear involvement of LG	• Competing for resources which could be allocated to LGs and limiting financial power of LGs • Initial budget investment per village was 1 million Baht.	Total budget was 80 billion Baht in 2010
Universal health coverage (UHC) (2001)	• Access to health care as a basic right and establishment of national authority (NHSB) to define benefit package and financing models for paying health-care providers • Contractual relationship between the health-care purchaser and providers • Transfer of health insurance management (health-care purchaser) to LGs when ready • Establishment of community health funds at sub-district level co-funded by LGs and NHSO	• Changing role of LG from a provider to a purchaser of health promotion services through an establishment of a community health fund • The MoPH becomes the main public health-care provider instead of functioning as a national health authority • More resistance from MoPH to health-care decentralization since there was a fear of losing power and control over the public health providers	From 2001–2012 the total budget was 709.9 billion Baht
Provincial integrated administration (2001)	• Provincial governor, appointed by Ministry of Interior, has full authority over budget and personnel in the province (provincial CEO governor) • Allocation of budget to the province as a block grant and the use of result based management system	• De-concentration not devolution • Competing for resources which could be allocated to LG and limiting financial power of LG	Budget allocated annually except during 2007–2008 and the total budget from 2001 to 2012 was 123 billion Baht

Policy (year started implementation)	Main characteristics of policy	Potential effect on health-care decentralization	Budget
Financial incentive for village health volunteers (VHVs) (2010)	• Payment for each VHV 600 Baht/ month using LG budget (the total number of VHV nationwide is approx. 1 million) • Performance of VHV and a reporting system was set up by the MoPH without involvement of LG	• Decrease amount of budget which LG could spend under their discretion • Although it was LG budget, the MoPH set a system to pay VHV directly through health personnel and maintained control over VHV[17]	• 2010 = 7.0 billion Baht • 2011 = 7.2 billion Baht • 2012 = 7.4 billion Baht
Subdistrict health promoting hospital (2010)	• Additional investment in infrastructure and human resources of HCs to meet national standard • Establishment of an administrative committee comprising representatives from health personnel, local government and civic groups to oversee the HCs	• Competing for resources which could be allocated to LG and limiting financial power of LG • Creating an alternative model of managing HCs through a committee comprising all stakeholders including representative of LG	From 2010 to 2012 the total budget was 9.8 billion Baht and 60% was capital investment

Source: Compiled by the authors from multiple sources

Note: NHSB = National Health Security Board, NHSO = National Health Security Office, NHSB and NHSO have been established under the National Health Security Act 2002 to implement the Universal Health Coverage System

delay, lack of political leadership is the most crucial. The implementation of other related policies during the same period competed for resources which could be allocated to LG, but created an opportunity to adopt a variety of models which could maintain health-care system integration. The new models also adopted more participation of civil society and local people by establishing a community committee to exercise power over the utilization of health resources and management of public health facilities. This could be a process to empower people and broaden the meaning of decentralization not limited to a transfer of authority and responsibility only to the LGs but also directly to the people. Moreover, this could overcome the limitation of representative democracy since elections are not a sufficient mechanism to ensure that governments will do everything they can do to maximize the citizens' welfare.[24] This civic participation had been supported strongly by the Constitution of 1997 which had adopted the role of civil society and enshrined the right of the people to petition and receive a response from the state.

The proposed range and degree of decentralization of health care in Thailand was diverse. It was agreed with less argument that the responsibility for provision of primary care could be transferred to LGs since it fitted their capacity and was consistent with health-care decentralization in developed countries.[1] Decentralization of hospital services was more complex and autonomous public organization was a preferred model by reformists although it was not regarded as a form of decentralization.[12] The recent recommendation to accept any model of health-care decentralization which reflected a transfer of responsibility to LGs based on learning experiences of all local partners could be the best solution.

Health-care decentralization could not be implemented effectively without the support of the central ministry. LGs staff need to have their capacity strengthened to handle the new responsibilities and this could be best done by the central ministry staff who were previously responsible for these. Recent studies have found variations in the level of understanding of decentralization and substantial opposition among MoPH staff towards decentralization.[12] These were major constraints for the MoPH to support health-care decentralization. Moreover, decentralization changes the roles of the central ministry staff from a line management to policy formulation, technical advice, coordination among national agencies and programme monitoring.[25–27] The central-level managers also require systematic retraining and reorientation which, however, many countries including Thailand have overlooked.

As a result of delayed decentralization, recently some LGs with sufficient financial availability started to build their own health facilities and recruited health staff for their operation. These infrastructures were duplicated with existing health-care infrastructures of the MoPH which should be devolved to LGs and became inefficient investments. Thailand has a shortage of health personnel as well as limited health-care infrastructure in remote areas. Unfortunately, these extra investments of LGs could not help in improving access to quality of care for people in the remote areas because of poor coordination among the MoPH and LGs.

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