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On the Road of Health Decentralization

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Preface

Several health system reform initiatives have been implemented in Thailand during the past decade. These include the establishment of Health Promotion Fund from sin tax, establishment of Universal Healthcare Coverage System and Emergency Medical Services System, enactment of the National Health Act, and etc. As a result, Thai health systems have been improved in many areas including access to essential healthcare, increase of people participation in health promotion activities and health policy process. Among all health reform initiatives, decentralization of healthcare management has less progress as compared to the others.

Thai Constitution of 1997 accelerated process of healthcare decentralization through the development of the Decentralization Action Plan. This plan indicates which public services should be transferred to be managed by local authorities. And because of these transferred responsibilities, related government budget and staff will be transferred accordingly. However, after 10 years of implementation, only 28 from more than nine thousand health centres have been transferred to sub-district or Tambon administrative organizations and municipalities. Most of public health facilities remain with the Ministry of Public Health.

Healthcare decentralization does not mean only the transfer of public health facilities to local authorities although it is the main focus as indicated in the Constitution. Health Systems Research Institute (HSRI) has supported many research projects to clarify this issue and also propose recommendation on appropriate model of healthcare decentralization. This document is part of our effort to review historical development of healthcare decentralization in Thailand. We believe that based on thorough review of past experience, both nationally and internationally, we can move forward with strong confidence that Thai people would benefit from this reform initiative.

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Table of Contents

List of Acronyms

AAR	after action review
AHB	Area Health Board
BMA	Bangkok Metropolitan Administration
CEO	Chief Executive Officer
CIPP	context-input-process-product evaluation model
CUP	contracting unit of primary care
ESAO	Education Service Area Office
HSRI	Health Systems Research Institute
HSRO	Health System Reform Office
LGO	local government organization
MOPH	Ministry of Public Health
NHCO	National Health Commission Office
NHSO	National Health Security Office
OBEC	Office of the Basic Education Commission
OSDH	Office for Support and Development of Decentralization in Health, MOPH
PAO	Provincial Administrative Organization
PCMO	Provincial Chief Medical Officer
PCU	Primary Care Unit
SARS	severe acute respiratory syndrome
SDU	Service Delivery Unit
TAO	Tambon (Subdistrict) Administrative Organization
TDRI	Thailand Development Research Institute
Thai Health	Thai Health Promotion Foundation
UC	Universal Coverage of Health Care
VHV	Village Health Volunteer

Chapter 1

The Relations of "Authority" and "Administration"

Authority or power has been related to administration or governance since the past until today and it will be so in the future as evident in the provisions of the Constitution of Thailand which is regarded as the supreme law for State administration under the democratic system with the King as the Head of State.

After the 1932 administrative revolution changing the government system from absolute monarchy to constitutional monarchy, the Constitution has been considered as the law of the people, by the people and for the people. The Constitution prescribes the relationship framework between the State authority which is detailed in the Organization of State Administration Act, including three levels of administration: central, provincial and local. The relationship between the State authority and the people is prescribed in the Local Government Act, under which *"kamnan"* (subdistrict headman) and *"phuyai ban"* (village headman) are regarded as government's tools rather than people's representatives.

A local government in Thailand was firstly established in 1933 (despite the fact that Tha Chalom Sanitary District was established for decentralization purposes on a pilot basis in 1905) according to the Municipality Regulation Act of 1933 (later amended as the Municipality Act of 1953. Since then municipalities have been established with self-administration by the people and are divided into three categories: subdistrict (tambon), town and city municipalities. In 1952, the government decided to use the sanitary district administration system again (previously used in the reign of King Rama V) in order that "local governments" could be more easily and widely established, although they would not be on a full scale as municipalities.

In 1955, the Organization of Provincial Administration Act (B.E. 2498) was enacted and, as a result, Provincial Administrative Organizations (PAOs) were established each as a juristic person under the provincial administrative system. The provincial governor took charge of the administrative branch of each PAO while the legislation was handled by the provincial council whose members were elected by the people. In the same year, Field Marshal Plaek Pibulsonggram, who was then the Prime Minister and the Minister of Interior, went aboard and saw that local residents in the United State of America and European countries had active participation in local administration. So he got an idea to establish a tambon (subdistrict) council in Thailand and thus the Order of the Ministry of Interior No. 222/2499 was issued on March 8, 1956; accordingly, 4,800 tambon councils

were established all over the country.

In the same year, the Organization of Tambon Administration Act of B.E. 2499 (1956) was enacted to establish Tambon (subdistrict) Administrative Organizations in large subdistricts or communities. The Tambon Administrative Organization, a form of local administrative organization, was a juristic person established for people to learn and practice the democratic principles all over the country; later all organizations of this kind were abolished due to unpreparedness in terms of revenue and personnel. But only Tambon Councils remained functioning.

In 1994, Tambon Councils and Tambon Administrative Organizations were established as juristic persons according to the Tambon Council and Tambon Administrative Organization Act, B.E. 2537 (1994), which was published in the Government Gazette on December 2, 1994. According to the Act, Tambon Councils were abolished but they were re-established as juristic persons on March 2, 1995; and many Tambon Councils with a three-year average budget of at least 150,000 baht were upgraded as Tambon Administrative Organizations (TAOs), which are local governments, on May 30, 1995. Moreover, there are special forms of local government, namely Bangkok Metropolitan Administration (BMA) established by the Bangkok Metropolitan Administration Act, B.E. 2518 (1975) and the City of Pattaya by the City of Pattaya Administration Act, B.E. 2521 (1978).

At the present, there are 75 PAOs, one in each of all 75 provinces, established by the Provincial Administration Act, B.E.2540 (1997) as juristic persons and take responsibility in their designated areas which may overlap with those of other local administrative organizations (municipalities, sanitary districts and TAOs in the provinces). Their responsibilities involve the cooperation among LGOs, the central government and representatives of other State agencies. The structure of Thai's local administration is divided into two levels as follows:

1. Provincial level which is the upper-level local government organization (LGO), i.e. PAOs.
2. Urban community and rural level which is the lower-level of LGOs, i.e. municipalities and TAOs.

Besides, there are other special forms of LGOs, namely BMA and the City of Pattaya.

Before the political reforms in the past, local government development lacked accountability and continuity; and there were many forms of LGOs which created confusion to the public with top-down directives of the centralized government system, without people's participation as in Western countries. So the Government powers were hold by the central and provincial administrations while very little was done for local administration development. Such a situation resulted in the unity and ease in administration, but there were some management limitations in

other aspects. For example, the centralized administration system had to deal with the overall picture of the country, but the problems at the local level were less important. Over the past 70 years, the changes in the country administration mainly emphasized the streamlining of official authorities or division of powers and responsibilities among State agencies. The Ministry of Interior is the core agency in the bureaucratic administration all over the country especially for the provincial level. When there were more national development activities expanded to the provincial areas, other ministries were also involved in such efforts. So the Ministry of Interior was not the only the State agency that was related to the people at the provincial, district and subdistrict levels as in the past. In the 1981 National Rural Development Plan, there were four core ministries involved, namely the Ministry of Interior, the Ministry of Education, the Ministry of Agriculture and Cooperatives and the Ministry of Public Health (MOPH). Later, undertaking such roles also were another two ministries: the Ministry of Commerce and the Ministry of Industry. This reflected the extended relationship between the state mechanism and the people.

However, the authorities were centralized to departments of the central administration rather than to the provinces. Agencies of the central administration expanded their territories by establishing sub-units in the provincial area. The Government budget was allocated for the expansion of central government agencies (ministries, sub-ministries and departments); the

proportion being greater than the socio-economic growth of the provinces. The effects of the centralized budget allocation were the weakness of provinces or cities and improper/incorrect solution of local problems such as fighting over local resources, solid waste pollution, crime, etc. At the same time, central administration agencies were unable to resolve many major national problems such as natural resources destruction, social inequalities, and poor income distribution. Such problems reflected the over-development of central-level departments and the underdevelopment of towns, hereunder meaning all provinces located outside Bangkok.

In 1997, Thai society moved for the promulgation of the Constitution as a tool for political reforms. The Constitution emphasized the decentralization of administrative powers to local governments as stipulated in section 78 (under Chapter 5, Directive Principles of Fundamental State Policies) that "The State shall decentralize powers to localities for the purpose of self-reliance and self-determination of local affairs, develop local economies, public utilities and facilities as well as information infrastructure in the localities thoroughly and equally throughout the country, and develop a province ready for such purpose as a large-sized local government organization, having regard to the will of the people in that province".

It is noteworthy that decentralization started from a technical concept and a policy recommendation whose purpose

was to solve the country's problems; and all cabinets have adopted it as a government policy. But the understanding of decentralization and the intention to implement the policy are not strong enough. In principle, decentralization includes the following:

- Decentralization of administrative powers, which means assigning responsibilities and operational powers to lower-level agencies, so that such agencies are able to make decisions and carry out their missions with the highest efficiency.
- Decentralization of political powers, which means the transfer of powers to local governments for decision-making and operations purposes; the goal is not limited to the increase in administrative efficiency, but also to facilitate the decision-making process, responsiveness to local needs, self-government and community empowerment.

Decentralization is a development tool, not the "goal", depending on the development goal and relevant social context. When the overall important development goal is people's quality of life, the most important feature of decentralization is the empowerment of individuals and communities, giving them the powers to make decisions on matters that affect them with self-reliance and self-governance purposes.

Chapter 2

Local Government Organizations: Expectations for Better Quality of Life

"The State shall decentralize powers to localities for the purpose of self-reliance and self-determination of local affairs, develop local economies, public utilities and facilities as well as information infrastructure in the localities thoroughly and equally throughout the country, and develop a province ready for such purpose as a large-sized local government organization, having regard to the will of the people in that province". That was the provision of section 78 of the 1997 Constitution of Thailand. Moreover, in Chapter 9 of the Constitution dealing with local government provides in sections 282 to 290 that the State must give freedom to localities according to the principle of self-governance based on the intention of the people in each locality. The State shall give the autonomy to local government (administration) organizations (LGOs) in setting up their own administrative, personnel, monetary and financial policies. The State shall monitor LGO operations within the legal framework

and constantly decentralize more authority to them. The LGO is the main mechanism for improving the quality of life of local people; and there has been a law on plans and process of decentralization for LGOs to develop and improve the administration of public services.

2.1 Determining Plans and Process of Decentralization to Local Government Organizations Act, B.E. 2542 (1999)

To implement section 284 of the 1997 Constitution, the Determining Plans and Process of Decentralization to Local Government Organizations Act, B.E.2542 (the 1999 Decentralization Act) was passed. The law has provisions on authority and responsibilities in running the public service systems between the central government and LGOs and among LGOs, particularly those related to tax and revenue sharing. The law also requires that the State transfer public service administration to LGOs within four years (2001–2004). However, in case any LGOs are not ready to take the transfer within 4 years, they have to be prepared to take such responsibilities within 10 years (2001–2010) with administrative and technical support from the central administration.

In order for LGOs to effectively take all the responsibilities which require budget, the 1999 Decentralization Act provides that at least 25% of the government budget from tax

revenue must be allocated to LGOs by 2001; and such an allocation must be increased to at least 35% by 2006. According to the law, a Committee on Decentralization to Local Government Organizations (the Decentralization Committee) was set up comprising 12 representatives of political and government officials, 12 LGO representatives and 12 qualified persons. The Decentralization Committee is charged with the responsibility for drawing up a decentralization plan and setting up an Office of the Decentralization to Local Government Organizations Committee to serve as the secretariat of the Decentralization Committee.

After the enactment of the 1999 Decentralization Act, many LGOs all over country were active in providing public services under their authority as prescribed in section 16 for municipalities, the City of Pattaya and TAOs, section 17 for PAOs, and section 18 for the Bangkok Metropolitan Administration (BMA). At the same time, the Decentralization Committee set up the 2000 Plan for Decentralization to LGOs (the Decentralization Plan) as a framework for such purposes so that it is carried out carefully and in harmony with Thai society's context. As decentralization is a delicate issue and involves all environmental factors, all concerned must realize that "decentralization to LGOs is just an important tool, not the goal, since the goal is the development of the quality of life of local residents".

2.2 Decentralization Plan, 2000

According to the vision of the 2000 Decentralization Plan, there are three phases. The first four-year phase covered the period of 2001–2004 and involved the internal administrative system improvement of LGOs, the central and regional administrations, the strategy development and preparation for accepting the transfer of missions, personnel, budget, and assets, and also, and the revision of relevant laws. Regarding the transfer of missions or responsibilities to LGOs, there will be a complete transfer, a partial transfer for joint undertaking by some LGOs, and a partial transfer for joint actions by LGOs and State agencies. And a certain number of personnel will be transferred to work under the supervision of LGOs. After the first phase, the second (transitional) phase covers the period of 2005–2010, involving the role adjustment of all agencies in the central and provincial administrations as well as LGOs and the communities in order to jointly learn about the mission transfer. The relationship between LGOs and the provincial administration will have to be adjusted harmoniously; and relevant laws will have to be amended so that LGOs will be able to run public affairs that are responsive to local needs. Moreover, the people will participate in the administration of LGOs so that all undertakings will be carried out in an efficient and transparent manner.

After the 10th year of the Decentralization Plan implementation (the third phase beginning in 2011), the local

people will have a better quality of life and have access to public services equitably and impartially. The people will fully have a role in decision-making as well as monitoring, inspecting and supporting LGOs, which will have their potential developed in both administrative and financial aspects for self-reliance and independence purposes. The local administrators and local councils will be knowledgeable and capable with visions in local administration. The provincial administration will change their role from being a public service provider to a technical supporter and monitor of LGOs as needed with a clearly defined role. So LGOs will ultimately and truly be self-governing bodies with people's active participation.

The Decentralization Plan consists of three important principles as follows:

Autonomy in policy-making and management: LGOs have freedom in policy-making, general administration, personnel administration and financial administration for themselves, while maintaining the unitary-state status and unity of the country with the King as the Head of State as well as national security and promoting people's participation in local politics and government under the democratic system.

State administration and local government administration: The State has to decentralize the authority to LGOs so that they can be self-reliant and make decisions on their own affairs. By changing roles and responsibilities of the central and provincial administrations and increasing the role of LGOs in taking responsibility for the above-mentioned administration, the central and provincial administrations should take responsibility for macro-level activities and those that cannot be handled by LGOs by providing supervisory advice related to policy and legal matters as needed, in addition to technical and evaluation support.

Administrative efficiency of LGOs: The State has to decentralize authority to LGOs to provide public services of better quality or at least of the same level or standard to the people. The management of LGOs must be transparent and efficient with more accountability to the people (even though there is public health section in the organization). They should also encourage the people, civil society and community to participate in decision-making as well as program operation and evaluation.

The Decentralization Plan has five objectives as follows:

1. Transferring the mission in public service management to LGOs according to section 30 of the 1999 Decentralization Act. The transfer essentially includes

the sharing of powers and responsibilities in handling public service systems between the central government and LGOs and among LGOs themselves and the sharing of tax revenue between the central government and LGOs and among LGOs. The transfer was expected to be complete within four years (2001–2004) for LGOs that were ready to do so; and within 10 years (2001-2010) for those that were not initially prepared.

2. Setting the proportion of tax revenue and subsidies to be allocated to LGOs consistent with the powers and responsibilities of each category of LGOs. The proportion should be at least 20% by 1999 and increased to at least 35% by 2006; the increase should be timely suitable and consistent with the mission transferred for LGOs to be able to manage the public services by themselves, taking into consideration the fairness and amounts of local revenue collected by each LGO.

3. Allocating the annual budget with State subsidies for public services provision in LGOs' designated areas, based on local needs.

4. Setting up a personnel transfer system in line with the transfer of powers and responsibilities.

5. Revising relevant laws and rules in line with the transfer of powers and responsibilities.

The Decentralization Plan also mentions about the guidelines for decentralization to LGOs especially the transfer of responsibilities, budget, and personnel; the development of systems for monitoring as well as public and civil society participation; the improvement of efficiency in LGO administration; the revision of relevant laws and rules; the creation of systems for monitoring the mission transfer action plan; and the creation of a quality assurance system for public services of LGOs. All these have been used in designing the action plan for mission transfer with details about time frame and types of public services that need to be transferred to LGOs; not all the services are to be transferred at the same time, but the transfer can be undertaken according to the readiness of each LGO.

Models of Mission Transfer

The transfer of missions to LGOs includes the transfer of authority and public services as prescribed by law and the revision of powers and responsibilities among State and local agencies in line with this effort. The transfer is actually carried out in three models as follows:

Model 1 : Missions that are undertaken by LGOs, comprising three categories:

1.1 Missions that are undertaken or produced by LGOs as authorized by law and/or implemented preciously; the transfer can be done immediately within the designated geographical area of each LGO.

1.2 Missions that are jointly undertaken several LGOs according to the powers and responsibilities of State and local agencies for the people not only in any certain locality but also for those in other localities; and when the mission needs a lot of investment or it is not worthwhile to carry it out by only one LGO.

1.3 Missions that are undertaken by LGOs, but they can buy such services from the private sector, a State agency or another LGO with experience in or having ever implemented such a mission.

Model 2 : Missions that are jointly undertaken by a LGO and a State agency; the mission is transferred to a LGO but partly remains under the responsibility of a State agency.

Model 3 : Missions that are still operated by the State, but LGOs can also carry them out in which there is duplication of effort.

Phases of Mission Transfer

There are two phases of mission transfer as follows:

Phase 1 : For a period of 1-4 years (2001-2004), the transfer of missions to the LGOs that were ready could be done according to section 30(1) of the 1999 Decentralization Act.

Phase 2 : For a period of 1-10 years (2001-2010), the transfer of missions to different types of LGOs can be done according to section 30(2) of the 1999 Decentralization Act.

For a period of 1-5 years (2001-2005), as the transfer had to take into account the readiness of LGOs, and it might take more than four years, the Decentralization Committee decided that certain LGOs might take only some responsibilities as prescribed in section 30(2) of the Decentralization Act.

For a period of 4-10 years (2001-2005), based on the readiness of LGOs and the time period required for mission transfer might be more than five years, or certain missions might not be urgently transferred, but some standard control mechanisms and systems have to be established as endorsed by the Decentralization Committee, certain LGOs might take only some responsibilities as prescribed in section 30(2) of the Decentralization Act.

The missions to be transferred to LGOs:

The Decentralization Plan specifies that an action plan has to be drawn up for the transfer of missions to LGOs in at least six aspects as follows:

1. The infrastructure
   - Land and water transportation
   - Public utility (water resources and rural water supply)
   - Public services (setting up markets as well as central markets)
   - Town planning
   - Building control

2. Quality of life promotion
   - Occupational promotion
   - Social welfare (for developing the quality of life of children, women, the elderly and the disadvantaged)
   - Recreation (sports promotion, recreational place provision)
   - Education (formal and non-formal)
   - Public health (public health and medical services, prevention and control communicable diseases)
   - Improvement of dwellings and urban slums

3. Public peace and order
    - Promotion of democracy and people's equality and freedom
    - Promotion of people's participation in local development
    - Prevention and mitigation public disasters
    - Maintenance of peace and order including safety for life and property

4. Planning, investment, commerce and tourism
    - Local development planning
    - Technology development planning
    - Investment promotion
    - Commercial promotion
    - Industrial development
    - Tourism promotion

5. Management and conservation of natural resources and the environment
    - Protection, preservation and utilization of forests, land, natural resources and the environment
    - Management of the environment and pollution
    - Safeguarding of public places

6. Art, culture, tradition, and local wisdom
    - Management and maintenance of historical sites and objects
    - Management and maintenance of museums and archives

After the Decentralization Committee announced the Decentralization Plan in January 2000, the central government started to review the missions to be transferred to LGOs and then developed an action plan with steps to be taken for this purpose. LGOs at all levels started to provide public services to the people, without any mission transfer from the State, such as those related to community cleanliness, environmental preservation, waste disposal, river/canal dredging, and child development center operations. It was noted that the roles of municipalities, the Pattaya City, and TAOs are very similar, while those for PAOs deal with the coordination of environmental protection. However, the Bangkok Metropolitan Administration has a full cycle of public health services as it has a large budget and high potential for self-governing purposes.

In late 2000, many LGOs prepared for the elections of local representatives including those of PAO, municipal and TAO councils with campaigns launched all over the country encouraging eligible people to cast their votes in early January 2001. The political activities in Thailand during that period were very lively with policy statements of candidates and political

parties seeking popular support and the hopes for a better quality of life of the locals.

Chapter 3

Public Services and Public Health Services

The Decentralization Plan specifies missions such as security work, foreign affairs, judicial adjudication, and public finance as public services of the country to be handled by the central government. For the missions that involve quality of life promotion and authority for public service provision in people's daily life are under the responsibility of LGOs. According to sections 16 to 22 of the Decentralization Act, a LGO can manage public health and environmental services without any mission transfer from the central government as shown in the table below.

Table 1: Powers and responsibilities for public health and environmental services of LGOs as per the Decentralization Act by LGO category

Powers and responsibilities for public health and environmental services of LGOs	BMA	PAOs	Municipalities, Pattaya City and TAOs
Health and family health	✓	-	✓
Curative care	✓	✓	✓
Prevention and control of communicable diseases	✓	✓	-
Quality of life development for children, woman, the elderly and the disadvantaged	✓	✓	✓
Sports and recreation places	✓	-	✓
Refuse and wastewater disposal systems	✓	✓	✓
Control of animal raising and slaughtering	✓	-	✓
Health and safety measures of entertainment venues and other public places	✓	-	✓
Urban slum improvement and housing management	✓	-	✓
Setting up and control of market places	✓	✓	✓
City cleanliness	✓	-	✓
Environment and pollution management	✓	✓	-
Control of cemeteries and crematoriums	✓	-	✓
Public utilities (water supply)	✓	-	✓
Other responsibilities prescribed by other laws	✓	✓	✓

In addition, the Decentralization Plan specifies "public health service" as one of the quality of life promotion missions which the MOPH has to transfer to LGOs. The public health service comprises health promotion, disease prevention, curative care and medical rehabilitation. One of the essential parts of the Decentralization Plan states that "The operations of LGOs in some fields need specialized expertise and unity in the management of public services such as education, public health service, natural resources and the environment. Therefore, it is essential to set up a provincial committee on each specific field to take responsibility for setting policies and public service standards for each provincial area, allocating resources, monitoring and auditing the operation of LGOs as well as coordinating joint efforts between State agencies and LGOs and among LGOs." Thus, MOPH has to carefully execute the preparation action for the mission transfer.

After the Decentralization Plan was passed and became effective, MOPH appointed a working group on developing guidelines for public health mission transfer to LGOs as per MOPH Order No. 338/2843 dated 21 April 2000. The working group is responsible for drawing up guidelines for mission transfer, according to the guidance of the Decentralization Committee, and creating readiness of personnel of MOPH and LGOs based on their new missions and roles.

In October 2000, MOPH established the Office for Support and Development of Decentralization in Health (OSDH) under the Permanent Secretary's Office and appointed a committee to monitor and supervise the health decentralization process in an efficient manner. The OSDH's functions are as follows:

1) To administer the pilot-scale implementation of health decentralization in a certain number of areas, by studying and collecting data in order to find weaknesses for further improvement as well as to find strengths and critical success factors for use in implementing the Decentralization Plan in other areas.
2) To conduct training and system development activities in all LGOs and provincial administration agencies especially those providing services to effectively serve the people with their full potential.
3) To set up a system for monitoring and evaluating the decentralization operations in all areas to ensure that the effort will lead to health development based on the principles of equality, efficiency, quality, and accountability.

Later on, after conducting public hearings in various groups of health professionals such as those from the Provincial Chief Medical Officers Club, the Rural Doctors Club, the Public Health Club of Thailand, the health decentralization committee

adopted the guidelines for the decentralization of health services to LGOs (9 November 2000) as follows:

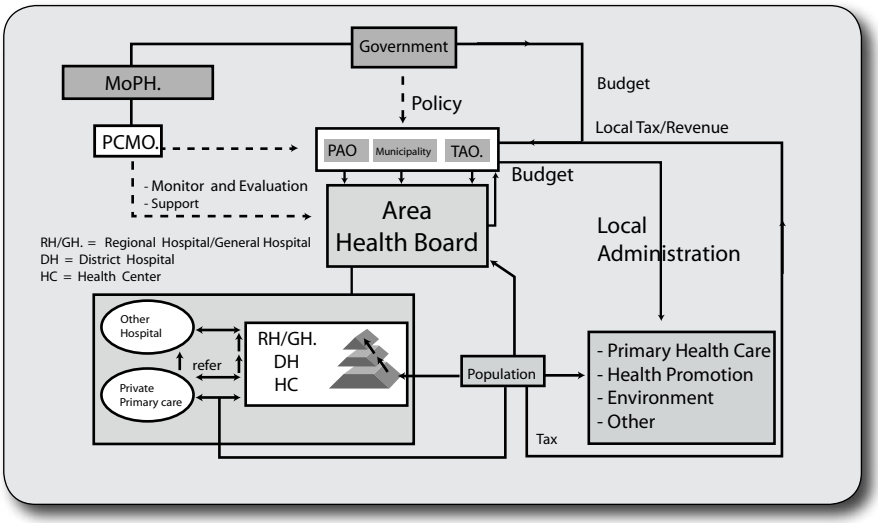
1) The transfer of health services in each province will be made to an Area Health Board (AHB) specifically for the entire provincial area. However, it can be transferred to a smaller area if necessary in line with the Decentralization Plan. The AHB is to be comprised of representatives from LGOs, professional administrators, qualified persons, and civil society organizations that will take part in the administration.
2) The missions and functions of the AHB are to set policies, design a health development plan for local area, allocate resources including budget and human resources, carry out administrative actions, determine rules and conditions in service provision under specified national standards, and examine/evaluate the implementation of health activities at the provincial level.
3) The structure of public health service units to be transferred will be the entire three-level network (of primary, secondary and tertiary care facilities) which is called a "cluster transfer". The missions/activities that can be operated by an LGO under AHB's supervision, such as health promotion, disease prevention, and environmental health, will be transferred to a TAO or a municipality, depending on its readiness. For medical

treatment that needs a referral system, a cluster transfer will be made within the same network under the administrative supervision of an AHB.

4) The future development of an AHB as a local autonomous body is a long-term goal or it may be turned into a juristic person under a LGO in a way that does not contradict the decentralization principle.

In the beginning of 2001, MOPH held a second technical seminar on decentralization and the future of Thai people's health with more than 2,000 participants attending. Later on, OSDH organized follow-on workshops in 17 provinces for representatives from three groups: LGOs, public health service personnel, and civic society. Four main points presented and discussed at the workshops were the model of AHB, the three-level service unit network, the roles of health-care facilities in provinces/districts in the context of decentralization, and the role of LGOs and civil society in health development. The conclusions and recommendations of each meeting were used in jointly designing a desirable health system including health service system for the people.

Fig. 1: Conceptual framework of health decentralization during the first phase



Source: Modified from "Preeda Tae-arak et al. "Health Decentralization to Localities".

On November 27, 2001, MOPH proposed the action plan for public health mission transfer to the Decentralization Committee, which accepted it as a detailed plan, but some points had to be mentioned as remarks. Then the plan was approved by the Cabinet and published in the Government Gazette, Vol 119, Part 23 Ngor, on 13 March 2002. The essentials of the plan are as follows:

1) The MOPH has the role in monitoring, evaluating and administering the health system, sustaining the equality in health status and resource allocation in

local areas, and determining universal standards as well as procedures for quality control and inspection.

2) The decentralization mechanism will be handled by an AHB (in each locality), whose composition and powers/responsibilities are mentioned in sections 1-3 of the action plan as proposed by MOPH. Regarding section 4 on the development of an AHB as a local autonomous body, clearly it will be a three-level service network, and later it may be a fully autonomous agency under the control of a LGO. However, the AHB will transfer health services to LGOs with readiness according to the criteria (jointly set by MOPH and the Decentralization Committee).

3) The idea to pass a law to make an AHB or a health service network become a juristic person (a local non-profit public organization) with the transfer of government officials to work under each AHB is not finalized. A joint committee comprising representatives from MOPH and the Decentralization Committee will be set up to consider this matter. (The Ad Hoc Subcommittee on Transfer of Health Mission to LGOs was appointed as per the order of the Decentralization Committee No. 8/2545, 24 July 2002.) The subcommittee is assigned to work out the details in establishing an AHB and determining the criteria as well as methods for evaluating the readiness of each LGO that will take the transfer.

4) The plans/projects of all MOPH's departments will be transferred in a similar manner: (a) the budget will be allocated to AHBs directly, based on the needs of each locality and the master action plan; (b) each AHB will allocate the budget to the LGOs under its responsibility according to the technical criteria, problems and needs detailed in the local action plan; and (c) a LGO will manage the procurement system according to the needs prescribed in the lower-level action plan with government and civic sector participation in the price negotiation with the selling company.

According to the 2002 action plan for health mission transfer to LGOs, there are two groups of health missions to be transferred as follows:

- The infrastructure including
  - Public utilities (water resources and rural water supply systems)
  - Public services (control of markets)
- The quality of life promotion such as public health services

From MOPH, there are 43 health missions that must be transferred to LGOs, including health promotion, medical care, and communicable disease prevention/control. All the missions belong to seven departments: Department of Health, Department of Mental Health, Department of Disease Control, Department of

Medical Services, Food and Drug Administration, Department of Medical Sciences, and Office of the Permanent Secretary. The mission transfer plan also mentions about the time frame, the agencies that will take the transfer, and the categories of work that must be transferred (compulsory transfer) or that will be freely chosen for transfer (free elective transfer).

The 2002 health mission transfer action plan adopts the concept and principle of having an AHB for accepting the decentralized missions. In principle, missions/activities to be directly transferred to LGOs must not require high-level technical or professional expertise, for example those related to improving/changing daily ways of life and nearby environmental surroundings, and those that directly affect the people and community and can be accomplished within the locality with no impact on any neighboring areas. Such activities are, for example: construction, training (of volunteers, community leaders, LGO officials, and other government personnel), public relations, monitoring, disease surveillance, procurement of medical supplies for distribution to target population, specific support for civic groups, etc.

For public health missions that require specialized skills and high-level expertise, the transfer has to be carried out carefully. Initially, an AHB will take the transfer and later forward such missions as appropriate to a LGO in each locality. There is no fixed decentralization formula, but there will be several beautiful decentralization models for all localities of Thailand.

Chapter 4

A Glance at Decentralization in Education

Education is one of the missions in the group of quality of life promotion, like public health, that has been specified to be transferred to LGOs. The education decentralization process has been more advanced than health, even though there were protests by a number of education officials and teachers dressed in black. However, an important education law was passed for educational development across the country, i.e. the 1999 National Education Act, similar to the Decentralization to LGOs Act. The Education Act has provisions on education quality and standards, dimensions of the final outputs of the education system and education management procedure, effectiveness, equality and fairness as well as the right to and freedom of education, which are considered as the main concept of educational reforms. A review of decentralization in education is regarded as an important lesson in the decentralization in health.

Even though the concept of education decentralization prescribed in the National Education Act aims to decentralize education services to the education service areas, which is different from that in the national Decentralization Plan with regard to the decentralization committee, model and method. However, the Ministry of Education and the Decentralization Committee have agreed to follow the National Education Act for a while and will operate in accordance with the national Decentralization Plan afterwards.

In the 2002 Decentralization Plan, the Decentralization Committee specifies that the scope for transferring preschool, primary school and secondary school education services is as follows:

1) The Ministry of Education shall determine the guidelines and methods for LGO's readiness assessment with the participation of people's representatives.
2) The LGO's readiness assessment shall be undertaken in accordance with the established guidelines and methods.
3) The Ministry of Education and the Office of Educational Service Area (in a specified geographical area) shall transfer schools to LGOs that have met the readiness assessment criteria.

4) The Ministry of Education and the Office of Educational Service Area shall conduct a follow-up/ evaluation of the result of educational management.
5) The Decentralization Committee shall establish a provincial educational service area committee according to the Decentralization Plan to set policies, plan and educational standards, supervise the school educational management, and allocate resources in the area.
6) Several LGOs may conduct a joint action in organizing educational services in their respective areas.

To obtain the operational results, the Decentralization Committee has determined the process of education mission transfer as follows:

4.1 Criteria and method for readiness assessment of LGOs in basic education management

The Ministry of Education issued the ministerial regulations on "Criteria and methods for readiness assessment of LGOs in basic education management" which cover the following matters:

1) The experience of each LGO in the operation of or participation in education management.
2) The education management readiness plan or education development plan showing the readiness to

manage the educational system in accordance with educational levels, categories and models.

3) Methods for education administration and management.
4) Allocation of income (resources) for education.
5) Levels and categories of education which are in compliance with community's problems and needs.
6) Opinions of the people and stakeholders on the readiness in the education management of the LGO.

Moreover, the Ministry of Education has determined the conditions for consideration together with the assessment including:

1) The sufficiency of income of the LGO
2) The decentralization of powers to educational institutions
3) The internal structure to support educational management
4) The existence of an advisory committee on education management of the LGO
5) The personnel management system for education.

Later on, the Ministry of Education developed the criteria, methods, conditions, indicators and quality for assessment of readiness in basic education management of LGOs. The score given to these factors will be used in determining which LGOs should be allowed to manage education services in their localities. For each LGO, the indicators include the time period in education management or participating in, or supporting, the management, results of the management, and community participation. All the criteria and conditions will be used by a nine-member assessment

committee comprised of three representatives from the LGO, three qualified persons selected by state agencies, and three qualified persons selected by the LGO.

In this regard, Mr. Udon Tantisunthorn, President of the Promotion of Local Administration Foundation, commented that we should keep an eye on the assessment committee's scoring for each LGO. It has been accepted that the assessment criteria are delicate and complex to use in considering whether there should be a mission transfer to any LGO or not. Moreover, the Ministry of Education also focuses on LGO's revenue as a required criterion for education decentralization. So this matter should be considered whether it is consistent with the intent of the Constitution which requires the decentralization of State powers to LGOs with the transfer of work, budget and personnel; if impractical criteria are established for this purpose, it might be hard for the self-governing process of an LGO to occur.

4.2 Steps and process for transfer of education management to LGOs

According to the Decentralization Plan, the steps for transferring education management to LGOs are as follows:

1. In case a LGO does not pass the transfer readiness assessment, the education service area office is to inform the LGO with no delay.

2. In case a LGO has passed the transfer readiness assessment, the education service area office is to do the following:

2.1 inform the LGO that requested the assessment;

2.2 inform the target educational institution;

2.3 coordinate with the LGO in determining the number of educational institutions to be transferred according to the Cabinet's resolution as shown on list no. 1, and for other educational institutions as shown on list no. 2;

2.4 submit the lists of educational institutions to the Secretary-General of the Basic Education Commission or chief of relevant government agency for review and approval with the following reasons or details:

2.4.1 categories of educational institutions;

2.4.2 recommendations for transfer or not transfer with justification;

2.4.3 opinions of stakeholders such as the institution board, teachers and parents of a majority of students;

2.4.4 opinions of the LGO; in case of a special educational institution, the agreement has to be made on a case-by-case basis;

2.5 the Office of the Basic Education Commission (OBEC) or responsible government agency informs the education service area office or relevant agency about the result of its consideration;

2.6 the education service area office for relevant agency informs the LGO and educational institutions of the result of the consideration for further transfer action.

4.3 The process for transferring the work, budget and personnel to LGOs for education management

4.3.1 Transfer of educational management function

1) The transfer of educational management function means that the LGO has taken over the management of one or several types or levels of educational institutions and has informed such institutions.

2) The educational institution prepares a list of missions transferred including the number of students, students' educational achievement records, and student activities.

3) The list of missions transferred should be prepared in three copies: one each for the education service area office or relevant government agency, the LGO, and the institution itself.

4) The report on mission transfer is to be submitted to the relevant department of the Ministry of Education and the Office of Decentralization to LGOs Committee.

4.3.2 Transfer of assets

The transfer of educational institution's assets to a LGO is to be undertaken as follows:

1) Conduct a survey of assets, item by item.

2) Transfer the asset items by:

2.1) checking the number/amount of asset items on the list of assets and specifying to which LGO the assets will be transferred;

2.2) making a list of assets that will be transferred;

2.3) informing the LGO about the transfer for signing the transfer document by the authorized officials (for the state agency: the director of the education service area office, the Secretary-General of OBEC, or the head of the relevant agency, as the case may be;

2.4) transferring the assets according to the government regulations on procurement (certain asset items need to be registered by law at a relevant agency, such as motor vehicles at the provincial transport office, and coordinating with the area treasury office for transferring government land to the LGO);

2.5) for an undisbursed budget amount, informing the relevant finance office to transfer such a budget to the LGO;

2.6) reporting to relevant government agencies upon completion of asset transfer.

4.3.3 Transfer of personnel

The personnel of the educational institution being transferred shall be transferred to become local government teachers based on their willingness. The transfer process is as follows:

1) Ask about the willingness of personnel.
2) Make a list of personnel in the following groups:

2.1) personnel who want to be transferred to the LGO;

2.2) personnel who do not want to move to the LGO, but want to move to another educational institution of the Ministry of Education or continue working on secondment before making a decision.

2.3) Send the list of transferees to the LGO within 30 days of the date of passing the assessment.

2.4) Send the list of personnel, from other educational institutions, who are willing to move to the LGO by exchanging positions with those who are unwilling to work under LGO.

3) Upon completion, submit the personnel transfer report to OBEC, the Teacher Civil Service Commission Office of the Ministry of Education, and the Office of Decentralization to LGOs Committee.

4) In the personnel transfer process, use the principle of "transferring institutions and personnel willing to move together with their position/salary numbers" in accordance with the missions transferred with flexibility, smoothness, benefits and career advancement that are not lower than before.

5) For personnel who are not willing to move to LGO, allow them to work on secondment for no more than five academic years with an extension of one academic year each, if necessary.

The transfer of educational institutions progressed amidst worries of teachers who were civil servants resulting in protests and confrontations with the pro-decentralization groups, while

some LGOs expressed their intention to take part in providing public services. For instance, in 2002, the Hua Dong TAO in Phichit province filed a lawsuit with the administrative court against the Secretary-General of OBEC and the Director of the Phichit Education Service Area Office (ESAO) in the case of accepting Wat Namchon Primary School, requesting that the OBEC's decision to delay the TAO readiness assessment be revoked, and that the Phichit ESAO undertake the TAO assessment as prescribed by the Decentralization Act. Finally, on June 6, 2007, the Supreme Administrative Court upheld the lower administrative court's judgment and ordered that the TAO assessment be carried out within 10 days of the Supreme Administrative Court's judgment (Case No. 2523/2545).

The educational missions that have been transferred according to the Decentralization Plan are: preschool education, supplementary food in the special education program, special educational development for disabled persons, educational welfare, supplementary food for hill-tribe students, new hopes development in five southernmost provinces, community education development for highland areas, pre-school children development centers, education program for hill-tribe people and those living in remote areas, school lunch program, village reading places, and subdistrict public libraries.

4.4 Quality of services: concerns of professionals

There is some doubt about the quality of service after transferring missions to LGOs, especially the services that need professional expertise like education and health care. With this concern, the 2000 Decentralization Plan specifies that the LGO management efficiency is to be improved by setting up a provincial committee on each specific area so that the decentralization of powers will be carefully undertaken in accordance with local situations.

The missions that need expertise and unity in service management such as education, public health, and natural resources and the environment require a special committee at the provincial level to be responsible for setting policies and standards for public services within the province, allocating resources, monitoring and inspecting the operation of LGOs as well as coordinating with State agencies and other LGOs. Therefore, the mission transfer processes for education and public health services need to be carried out with prudence and conciseness.

Later on, two specific committees were set up for resolving problems related to decentralization in education and public health. But, the Ministry of Education is also implementing the 1999 National Education Act which is a new law relating to education development. So, the direction of education

decentralization has to be in line with the new Act which has an education service area committee for each locality as the key mechanism.

Regarding health decentralization, the process is more complicated than that for education as there are many professionals as well as inter-connectedness of different levels of health services, especially when referring patients at the same level or to a different level of health-care facilities. Patient referrals may be made in two ways: sending a critically ill patient to a higher-level health facility for further treatment and sending a patient back for continued treatment at a primary care unit near the patient's home. All the above issues differ from the education mission transfer since for education there is only a transfer of students from a lower-level school to a higher-level one; and there is no emergency case as in health services. From this point of view, there has been an attempt to propose a mechanism to support health decentralization during the transitional phase, i.e. establishing an Area Health Board (AHB) at a certain level of locality.

To make the decentralization in health proceed in the right direction as stated in the 2002 Decentralization Plan, 10 provinces were selected to implement the plan on a pilot scale, including Chiang Mai, Phrae, Phayao, Nakhon Ratchasima, Maha Sarakham, Ayutthaya, Chon Buri, Songkhla, Phuket, and Pattani. The study aimed to determine the roles, responsibilities, and

structure of an AHB, adjust the paradigm of decentralized health care, and build up the capacity of personnel in all sectors in the locality.

However, it is generally accepted that decentralization is significantly associated with social context, politics and country's administrative direction. Health decentralization to LGOs has not progressed as expected because it was done during the period of major health care reform, based on the universal (30-baht) healthcare policy (a government's populist policy). Moreover, it was affected by the public sector reform efforts including the restructuring of MOPH, the government's results-based budgeting management policy, and the decentralization to each provincial governor as a chief executive officer (CEO). These have resulted in the uncertainties of the AHB approach as there is no law to support it. Although the Office of the Permanent Secretary for Public Health has appointed AHBs in 52 provinces with specific powers and duties, the AHBs have not been able to function as stated in the decentralization action plan even though OSDH has conducted a study on this matter and prepared a draft Area Health Board Act.

So since 2002, health decentralization to LGOs has been carried out according to the social context and willingness of all parties concerned in each locality. For instance, certain types of health services are provided by some LGOs with readiness, adding LGO's role in health promotion and disease prevention,

providing scholarships for nursing and dental nursing students in some localities, and transferring some health personnel to LGOs. Finally, the guidelines for public health mission transfer to LGOs were revised again in 2007.

Chapter 5

Think Anew and Act Anew: A Turning Point of Health Structure

In the beginning of 2001, Thailand held a general election and a new government was formed and came to power. The four-year Public Sector Reform Plan of Action was launched under the 1997 Constitution, and under which the 2002 Decentralization to LGOs Plan laid out a timeframe for the transfer of specified powers and duties to various levels of elected LGOs. To date, decentralization in Thailand tends to be more pro forma rather than substantial, and genuinely significant popular participation in local governance has proven to be an exception rather than a rule. This led to a big change in the local administration and decentralization as well as the health care structure as follows:

5.1 Health Promotion Foundation Act, B.E. 2544 (2001)

The Thai Health Promotion Foundation (ThaiHealth or Sor-Sor-Sor in Thai) was established by virtue of the Thai Health

Promotion Foundation Act, B.E. 2544 (2001). "ThaiHealth" is a state agency which is not part of the bureaucratic system but is under the supervision of the Prime Minister. Its responsibilities are to advocate, stimulate, and financially support health promotion activities of various organizations in society, with a view to reducing infirmity and premature death. ThaiHealth aims to trigger a change in behavioral patterns and beliefs as well as in our living environment in a way that is conducive to a better quality of life. Its main source of funding is the 2% tax imposed on alcohol and cigarette sales.

Over the past six years, ThaiHealth has made a major transition as mandated by the 1977 Constitution and the 1999 Decentralization Act; and a number of governmental and non-governmental sectors' collaborative actions have been predominantly implemented for health promotion movement. At the same time, subdistrict (tambon) health promotion plans embrace the transform of the health promotion concept into concrete actions. This is one of its basic strategies towards sustainable local health system development.

5.2 The Reorganization of Ministries, Sub-ministries and Departments Act, B.E. 2545 (2002)

As public service activities are not implemented only by public sector agencies, but other agencies including LGOs, private sector agencies and civil society organizations also have a

role to play in providing such services. The central government should have duties in undertaking essential activities and have to encourage and empower other agencies to take responsibility for other activities. The aim of this policy is to restructure and adjust the roles of government agencies both at the central and regional levels in which central agencies are the main actor while empowering provincial agencies and LGOs to implement activities at their respective levels. The public sector, however, has duties in setting guidelines for resource allocation and controlling, monitoring and evaluating lower-level operations so that the services are provided with high quality and standards. Regarding the financing and budgeting systems, mechanisms have been established for budget allocation according to the strategic plans and policies on personnel recruitment freeze and public sector downsizing. In addition, laws relating to national development will be revised or abolished if no longer needed.

5.2.1 Public sector reform

With the promulgation of the Reorganization of Ministries, Sub-ministries and Departments Act, B.E.2545 (2002), which came into force on October 2, 2002, there were dramatic changes within MOPH which has authorities and responsibilities for providing health promotion, disease prevention, curative care and rehabilitation services to the people. MOPH has been restructured into three clusters as follows:

- **Medical Services Cluster:** This cluster takes responsibility for developing the technical aspects of medical treatment and rehabilitation services through studies and research, transferring knowledge and technology related to medical treatment and rehabilitation services, and establishing the knowledge system and standards of Thai traditional and alternative medicine for use in the health care system so that the people will be healthy physically and mentally. The agencies in this cluster include three departments: Department of Medical Services, Department for Development of Thai Traditional and Alternative Medicine, and Department of Mental Health.

- **Public Health Development Cluster:** This cluster takes responsibility for developing the technical aspects of health promotion and disease prevention through studies and research and transferring knowledge and technology related to health promotion and disease prevention for use in the health care system so that the people will be healthy physically and mentally. The agencies in this cluster include two departments: Department of Disease Control and Department of Health.

- **Health Service Support Cluster:** This cluster takes responsibility for supporting the operations of health-care units by developing the systems and mechanisms suitable for providing health services, people's health system, and consumer protection in health and health products. This would enable people to have self-care abilities and receive quality health services. The agencies in this cluster include three departments: Department of Health Service Support, Department of Medical Sciences, and Food and Drug Administration.

Regarding the Office of the Permanent Secretary, its responsibilities involves health policy and plan development, plans management, human resources and budget of the Ministry, local health supervision and coordination, health financing system development, health manpower production and development, public health law development, and international health development. The agencies under this Office include five divisions/bureaus: Central Administration Bureau, Information and Communication Technology Center, Praboromarajchanok Institute, Inspection and Evaluation Bureau, and Policy and Strategy Bureau.

The MOPH's role adjustment and structural reform have influenced health decentralization required by the 2002 Decentralization Act (effective March 14, 2002). Meanwhile, the

Ministry of Interior, which has the statutory authority to direct and supervise LGOs, established the Department of Local Administration to take responsibility for promoting and supporting LGOs by enhancing their capacity and giving advice on local development plan formulation, personnel administration, as well as financial and general management. It is expected that all LGOs would have improved strengths and capacity in providing public services.

5.2.2 The integrated administration

Beginning in October 2003, the government instituted the so-called "provincial chief executive officer (CEO)-style governorship" in the administration of all Thai provinces to allow provincial governments to be run more efficiently, effectively and strategically – purportedly like a strategic business unit (SBU). Under this scheme, the provincial governor holds full management authority and the final say on all branches of provincial agencies and local governments in the province with regard to budget and personnel management as well as other official functions. The Cabinet approved the scheme to be adopted in all provinces nationwide beginning on October 1, 2003, except the Bangkok Metropolitan Administration. This is a type of decentralization to provinces which affects the devolution of authority to LGOs directly.

5.3 The National Health Security Act, B.E. 2545 (2002)

Achieving universal coverage (UC) of health care has been one of the high-priority policies of the government which has implemented the 30-baht healthcare scheme since 2001. As of 2003, about 70% of the population was provided with some form of healthcare services, constituting a significant achievement in universal coverage. Furthermore, the 1997 Constitution of Thailand clearly stated that health was considered as a basic right of Thai citizens and equal access to basic health services had to be guaranteed; in addition, health services for the poor had to be provided free of charge. As a basic right, the State had to be responsible for ensuring universal access to health care. Previously, health services for the poor and some underprivileged groups were provided on a charitable basis. According to the 1997 Constitution, access to health care became an entitlement and shall be protected by law. The National Health Security Act was thus enacted on November 18, 2002 and the National Health Security Office (NHSO) was established after November 2002 to take responsibility for the implementation of the Act and to ensure universal access to health care and to protect the rights of the people in this regard.

Since then, in pursuing the UC scheme, managing "health finance" has become the main focus of MOPH and the National Health Security Office (NHSO). To achieve sound health finance, new measures and technical processes have been developed,

involving information technology. These include the development of effective payment systems for health expenses, the integration of hospital management and unification of administrative work across all healthcare systems. The UC scheme is financed by general tax revenues and the budget is allocated on a per capita basis with different benefit packages, provider-payment mechanisms, and government subsidies. To enhance the program operations, a network of civic groups was established with the support of the Health Care Reform Office, MOPH, to campaign on the UC policy. In addition, the mobilization of community groups comprised of public and private agencies whose missions are relevant to resolving people's health problems and various community organizations ranging from the grassroots, local and provincial communities, to public (Ministry of Interior, Ministry of Finance, Ministry of University Affairs) and non-government (private hospitals and clinics) organizations has extensively emerged. This led to a concrete endeavor of the health sector reform, especially with strategic and action plans of various groups. As a consequence, a number of health services and development programs serving people's needs are implemented, such as Community Clinic, Private Dental Care Clinic, Heart Surgery Project, Denture Services for the Elderly Project, Contracted Private Tertiary Care Project, People's Self-selection of Primary Care Unit, Primary Care Unit Quality Development, Hospital Quality Improvement and Accreditation (HA) According to ISO Standards, Specialized Tertiary Care Development as Excellence Center, and Development of Health Care Benefits

under Universal Coverage Scheme for Uninsured People.

From the local level, representatives of local government officials were appointed as members of committees of various organizations at the local, provincial, and national levels, such as the National Health Security Board and the Health Services Standard and Quality Control Committee. In addition, section 47 of the National Health Security Act prescribes that: *"To set up national health security for people in local areas by encouraging the process of participation according to the readiness, reasonableness, and needs of people in such areas; the Board shall support and cooperate with local government organizations in determining regulations so that the said organizations shall implement and manage the national health security system in local areas by earning expenses from the Fund."*

As a result, a number local health security systems or funds have been set up as "Community Health Funds" at the community level. Each of the funds is managed by a local committee composed of representatives from the LGO in that locality, health officials, and local residents. Since 2006, as many as 2,680 LGOs have participated in creating the universal healthcare systems for their residents with full coverage and in an equitable manner.

5.4 The National Health Act, B.E. 2550 (2007)

With the movement towards health system reforms by the Health System Reform Office (HSRO), the National Health Act, B.E. 2550 (2007) was enacted. In this Act, *"health" is defined as a the state of human being which is perfect in physical, mental, spiritual and social aspects, all of which are holistic in balance"*. In this regard, health development and health care should be integrated and designed to respond to all of these dimensions. To comply with the new Act, all stakeholders must be regarded as partners in executing the health systems of the country and the National Health Commission Office (NHSO) was established as a State agency under the supervision of the Office of the Prime Minister to serve as the secretariat of the National Health Commission. Under the chairmanship of the Prime Minister and the vice-chairmanship of the Minister of Public Health, the National Health Commission has the following persons as members: ministers from other relevant ministries, representatives from LGOs, health professional groups, and civic groups as well as qualified persons selected from around the country. The National Health Commission has powers and duties to: draft a National Health System Constitution or Statue, organize or support the process for overall health policy and plan formulation on a continuous basis, prescribe rules and procedure on monitoring and evaluation in respect of national health system and the impact on health resulting from public policies, organize a national health assembly and support the organization of a health

assembly in a specific locality or on a specific issue, and give suggestions or advice relating to health policies and strategies to the Cabinet.

Organizing health assemblies of the NHCO is a way to support and open a forum for all sectors of society to participate in formulating healthy public policies and in sharing knowledge on the implementation of health-related activities systematically and continuously. So all LGOs can participate in the forums at all levels.

The decentralization process through the transfer of missions to LGOs has been affected by the public sector reform with structural and role changes within and outside MOPH as well as the emergence of various health organizations established by law such as the Thai Health Promotion Foundation (ThaiHealth), the Institute of Hospital Quality Improvement and Accreditation (HA), the National Health Security Office (NHSO), the National Health Commission Office (NHCO), and the National Institute for Emergency Medical Services.

However, the new health organizations have continuingly given opportunities for LGOs to play their roles in health activities and to participate in working with health-related agencies. In effect, LGOs have been involved in making national policies through their representatives being members of the National Health Security Board, the National Health Commission,

and the Emergency Medical Services Committee. Regarding health service delivery at the local level, many LGOs provide scholarships for selected local high-school graduates to study community nursing and dental nursing so that they will come back to work in their communities after graduation.

Chapter 6

Health Development at Local Government Organizations

Indeed, health service decentralization to local governments has been accepted as an important health care reform in Thailand. It has been notified as a strategy to make health care services more flexible, adaptable, effective and efficient. Under the health decentralization scheme, LGOs have more responsibilities as they are accountable to their communities. Even though their capabilities have been gradually developed and many activities under MOPH are targeted to be decentralized. Prior to 1999 or before the enactment of the 1999 Decentralization Act, there were limitations on health service provision, for example, shortages of human resources, organizational structure, planning and managerial skills, and so on. Since 2000, several research studies have shown that LGOs are competent and capable of managing health services and TAOs are ready to undertake health care responsibilities.

However, the readiness of some TAOs was seen only in some responsibilities/activities as many TAOs lacked the budget, organizational structure, technology, and knowledge or visions of holistic health administration. Nonetheless, there were some supportive factors that enable TAOs to be ready to take the health care role. Fore instance, some TAO council members had experience in community health development; some used to be village health volunteers (VHVs) or members of village committees. Besides, some studies indicated that the LGOs' levels of readiness were different: municipalities were better prepared than PAOs/TAOs. The LGOs' readiness was different depending on their levels, sizes, managerial capacity and financial status.

PAOs and TAOs have formulated health plans as part of the community people's quality of life improvement program without having any health service unit of their own. The majority of municipalities, especially city/town municipalities have their own health service units which are managed by themselves. These include Chiang Mai and Nakhon Si Thammarat city municipalities. The Bangkok Metropolitan Administration (BMA) and the Pattaya City, which are special administrative areas, provide one-stop health services including environmental health services, primary care services at public health centers, and secondary/tertiary health care services, and serve as medical and nursing schools (at Vajira and Klang hospitals in Bangkok).

According to sections 16–22 of the Decentralization Act, several activities related to health promotion, disease prevention, and customer protection have been transferred by MOPH to LGOs since 2000, especially drinking water provision and fresh market quality control. However, the transfer of health services, especially curative care and health personnel, has not been undertaken because of the complexities of the health care system, which requires professional specialty and unity for management that will affect the services as follows:

1. Quality of services

- *The connection of different levels of health-care facilities:* At present, health services are provided at different levels according to health problems commonly found in communities: primary care (at health centers), secondary care (at community hospitals), and tertiary care (at general and regional hospitals). All levels are linked to each other by the patient referral system which is called "integrated health service system". That is, a health center serves as the front-line healthcare provider based on the severity of health problems. If such a problem is severe and cannot be treated at the health center, the patient will be referred to the upper level of health facility. But, sometimes, it is difficult for the patient to know exactly when and which level of care would be needed for his/her illness. Therefore, health centers, community hospitals, and general/regional hospitals are expected to coordinate closely so that the patient referral system will be more effective.

- *Integration of services:* Curative, promotive, preventive, and rehabilitative services should be integrated for effective individual care across the life span of an individual from birth to pre-school age, school age, reproductive age, middle-age, and old age. The services are to be holistic in nature with physical, mental, and social care being integrated as the continuum of institution-based and home health care.

- *Technical quality of care:* Health services requires high-level professional capabilities of multidisciplinary health personnel such as physicians, nurses, auxiliary nurses, health specialists, health educators, nutritionists, pharmacists, medical scientists, physical therapists, radiation technologists, etc. working with suitable standards.

2. System efficiency

- *Optimal size efficiency:* Regarding the economical aspect of services, an appropriate size of a health care unit will help reduce the unit cost of health care as the investment cost will be shared among a large number of service recipients. Hence, it is important to take serious consideration when investing or building a small community hospital (at the subdistrict level) which has a high investment cost, but the number of patients requiring higher-than primary care is rather small, resulting in investment inefficiency.

- *Externalities (external effects):* Health services provided in one particular area may have a positive or negative effect on people's health in the adjacent area. For example, the control of a communicable disease or an epidemic in one area may fail if the adjacent area does not take any relevant action.

3. Responsiveness and accountability

- *Responsiveness to community needs:* The people's health needs may not be the real needs as some people may want some medication or a certain kind of diagnostic service such as a CT scan when they are ill. Actually, to relieve that kind of illness, they may just need some rest.

- *Community participation:* This matter is dependent on the health service system management of LGOs and how much the people are given an opportunity to participate in and examine the management process. It depends also on the people's consciousness about their rights and competency in performing such tasks.

4. Equity

Equity in health care includes equal access to health services and utilization of health services based on their health needs or the fact that the people have to bear the cost of health care according to their ability to pay. Thus, the government must set healthcare standards and control the overall health care system so that there would not be much difference in terms of healthcare

equity among residents in different localities.

5. Sustainability and acceptability

- *Management:* The LGO that will be responsible for health service management must be well prepared to a certain extent with administrative stability and capacity, financial sustainability, and community participation as well as governmental support. Then health decentralization will lead to a sustainable local health system.

- *Preparation:* The preparation must be done appropriately with details for each step or sub-system and well-prepared people in the system and community, based on people's health needs, which will gain trusts and acceptance of service recipients and health-care providers, minimizing barriers to decentralized health system development.

In short, health decentralization is challenging for all sectors. It is not the goal, but it is a tool/strategy to achieve the goal, i.e. improved health status of the people in all localities with LGOs playing a key role. Nevertheless, how much health decentralization would be implemented depends on the environmental situation and conditions of each country as well as the attention of the central government and community participation.

Bowornsak Uwanno, a well-known law professor, once

made a suggestion about health decentralization that local agencies should adopt the five principles as follows: (1) economies of scale at the level that the services would be provided with suitable efficiency; (2) a well-integrated health care system; (3) a competitive system with regard to quality, cost and efficiency; (4) ownership with clearly assigned role/responsibility to each person; and (5) quality and efficiency.

Jiruth Sriratanaban stated that there were two dimensions in health decentralization: (1) community participation, including empowering local residents, improving the coordination between various sectors in each area, and encouraging the people to participate in designing a local health plan responsive to local needs, and (2) being a mechanism for improving efficiency and management to be responsive to government health services. However, it must be noted that local authorities might see that curative care is more important than preventive care. Besides, the stakeholders must be concerned about incentives for promoting work efficiency, management and examination systems, as well as the mechanism for maintaining economies of scale resulting from health decentralization such as drug purchasing, research and development, and human resources development.

In conclusion, in accordance with the implementation of health decentralization, the efforts should benefit the quality of life and well-being of the people, as follows:

1. Quality and standard of health services
2. Equitable distribution of benefits among different groups towards the needs of local people
3. People's satisfaction
4. Good governance which encompasses effectiveness, transparency and accountability
5. People's participation in policy formulation, management, and expression of opinions
6. Health personnel are happy with their work

6.1 New era of LGO's concern for health

Even though several sectors have attempted to develop the capability of LGOs according to the 2000 Decentralization Act, since 2001 the government has adopted the CEO-style governorship in decentralization which affected LGOs' efficiency. For example, the proportion of budget to be allocated to LGOs was not in accordance with the Decentralization Plan which stated that the budget proportion must not be less than 35% of the national budget by the year 2006. But there was a revision of law decreasing the proportion to not less than 25% instead.

However, only in 2001 that the proportion of financial allocation for LGOs was increased from 13% to 20% which followed the goal of the Decentralization Plan which set the budget allocation for LGOs at not less than 20% of the national budget. But in 2006, LGOs got only 24%.

Table 2 : Proportion of LGOs' budget vs national budget, 2001–2007

Fiscal year	Budget allocation for LGOs(million baht)	Proportion in relation national budget (%)
2001	73,729.80	20.68
2002	77,273.30	21.88
2003	66,085.60	22.19
2004	91,438.00	22.75
2005	115,210.70	23.50
2006	126,013.00	24.05
2007	139,374.00	25.17
2008	149,840.00	25.22

Source: Office of the Decentralization to LGOs Committee (ODLC).

Along with the movement of decentralization, LGOs have made progress in improving their organizational structure and readiness to develop people's quality of life. However, as LGOs are different in categories, even PAOs, the top hierarchical level of local administration, their systems are still unclear with regard to the public health administration structure, but the transfer of functional responsibilities is underway. Hence, the vision of PAO leaders is essential for formulating their health administration structure.

The health administration structure was clearly evidenced in the existence of a division of public health and environmental

at municipalities and 1st class TAOs only. Although the LGOs' administrative structure is more flexible in setting up a unit with staffing pattern within the provincial committee's authority, there are some financial constraints at small TAOs.

However, some LGOs have set up their health administration units with staffing patterns and many health officials were transferred from MOPH to LGOs without any extra incentives. The Health Decentralization Support and Development Section of MOPH's Bureau of Policy and Strategy found that, from 2001 to March 2007, 693 health officials were transferred to LGOs. The trends were rising, i.e. 105 in 2003, 170 in 2005 and 277 in 2006. The majority of the transferred health personnel were from health centers (46%), followed by community hospitals (33%), provincial public health offices (PPHOs, 12%), and district health offices (DHOs, 9%); none were from regional or provincial hospitals. LGOs to which the health personnel were transferred include municipalities (65.4%) and TAOs (30.2%). Among the transferred officials, 27.5% were community health workers, 24.7% were health technical officers, 16.1% were health administrators, and 13.8% were registered nurses; regarding their position levels, 41.9% were at level 6, 31.6% at level 5, and 10.4% at level 4. These data might have some errors due to the limitations of secondary data.

Table 3 : MOPH personnel transferred to LGO, 2001–2007

Fiscal year	Number	Percent
2001	4	0.6
2002	61	8.8
2003	62	8.9
2004	105	15.2
2005	170	24.5
2006	277	40.0
2007	14	2.0
Total	693	100.0

Source: Bureau of Policy and Strategy, MOPH, March 2007.

In 2006, the Decentralization Committee reported on the progress of health decentralization and revealed that the transfer of functional responsibilities had not progressed as expected. This might be due to the effects of the change in the governmental system and new health laws (detailed in Chapter 5), and some tasks required more details and better preparation; and it was important to exchange experiences among themselves. As a result of this report, action plans and strategies were reviewed and revised.

6.2 Analysis of LGOs' readiness

With the government's increasing interest in a more decentralized system along with the political changes towards

openness and democracy, health decentralization has received greater attention in recent years, especially in 2006. Meanwhile, LGOs' capacity development has also continuingly progressed and they have assumed more responsibilities and collaboratively worked with other sectors in developing community health even though not in all dimensions of the health system or all LGOs' jurisdiction areas. However, this is said to be the step towards the practice of health decentralization. This also implies that health decentralization is not without risks; therefore, in order to implement it meaningfully, its strengths, weaknesses, opportunities, and threats were analyzed as follows.

Analysis of LGOs' capacity and health decentralization

Strengths

LGO leaders/administrators were more knowledgeable than ever before, LGOs' expenditures have increased with management flexibility and authority for decision-making and awareness of community health problems. More capable health personnel were transferred from the state health sector to LGOs which improves local performance in response to the needs of the local people and is meaningful for local accountability.

Weaknesses

Decentralization is at the heart of a range of reforms seeking to improve service delivery through paving a "short road to accountability". However, in practice, it is perceived lack of local accountability since the fulfillment of this important

condition depends on the prevailing traditions of political context. Hence, the problem regarding the lack of local accountability is corruption unless necessary corrective actions are taken. In addition, some elected local representatives use political will as a tool for expanding their power/authority and the leading voices for the future elections. Yet, most TAOs still lack health plans or health structure for the decentralized responsibility from the state health sector.

Opportunities

With the 2007 Constitution's emphasis on decentralization, public participation in government affairs and promotion of democracy and accountability in public policy-making at all levels. As a result, the people have been more aware of their rights. Therefore, LGOs must be more responsive to the needs of the local people. In addition, Community Health Funds have been established all over the country making many LGOs become able to expand their performance capacity to improve community's quality of life and well-being through public participation. Furthermore, LGOs have continuingly provided financial support for community health problem solving. Besides, local governance transparency and accountability may be more easily practiced than at the national level.

Threats

It has been over a decade that decentralization in Thailand has been implemented but it still lags far behind. This may be due

to the fact that there were no external circumstances pressing in this direction; and there was no serious process for transforming the concept into concrete actions. Additionally, "CEO-style" governorship scheme was not moving along with the LGOs' administrative structure. The move entailed a fundamental change in the traditional role of the provincial governor. Moreover, the "CEO-style" governors were made directly responsible to the Prime Minister rather than to the Minister of Interior. In such a case, if the relationship between the provincial governor and LGOs was low, it may lead to poor coordination between civil servants in various sectors at all levels. Furthermore, some health personnel are still unsure about their career advancement and the equitable work they will have when they are under LGOs.

6.3 LGOs' alternative approaches to health decentra - lization

LGOs must take responsibilities for two main health-related issues, including:

1) Responsibility for individual health-related services. This is a direct service for people individually both within and outside health centers. These services include curative care, individual health promotion, immunization or the arrangements for a nurse to care for paralyzed patients at home and so on. Health-care facilities must take full responsibility for these services because they require specialized services.

2) Responsibility in the community context. Services such as primary health care, disease prevention and control, environmental health, and health promotion require specialized skills, but less complicated than the former type of services; and LGOs can manage such services by themselves.

In accordance with the functions and responsibilities of local authorities, there are different levels of LGOs' responsibilities. These include: (1) **supporting health-care facilities** by allocating budget for management, in-kind resources, places and human resources; (2) **organizing a health service system** by setting up their own health service units; for example, hospitals and public health centers in BMA, 30-bed hospitals in Chiang Mai and Nakhon Si Thammarat municipalities, and health centers in some other municipalities; some have had their own, or plan to establish, health centers in their communities; and (3) **health service purchasing:** some community health funds have provided welfare for their members such as Jana Savings Group; and some TAOs attempt to allocate some budget for the people in their community.

LGOs' administrative feasibility for decentralization

Dimension 1: Organization depends on (1) the levels of LGOs which have different roles and responsibilities as well as willingness and (2) the communities' strengths, roles, activities, willingness and participation.

Dimension 2: Managerial patterns. The alternative approaches include resource support, service facilities, and management planning. The national alternative approaches should be single or multiple patterns which can be implemented at the same time nationwide or depending on readiness of LGOs.

As a whole, PAOs may take responsibility for health financing at the provincial level while municipalities and TAOs should partly take responsibility for health finance in case of primary health care. Although some PAOs are not readily prepared for health decentralization, it is important to directly prepare and improve their capacity. Generally, LGOs have already worked with government health personnel on health promotion and disease prevention and control; and most municipalities also provide curative services to their people. Good governance standards, which encompass honesty, transparency, and accountability, help develop capability of local government officials working on health programs.

Chapter 7

The First Step in Transferring Health Centers

The decentralization of missions from MOPH to LGOs during the first period (2000–2001) was carried out as planned to a certain extent based on the principle of creating a desirable health service system in the locality. The concept is to increase the role and participation of local residents especially LGOs in decision-making, without ignoring the people's sector. Moreover, such decisions must be in line with the policies and main directions of the central administration which have to be implemented on a pilot scale in the locality during the transitional stage. This is to help in the adjustment of the roles of the central government, the provincial administration, LGOs and the people, so that all concerned will jointly learn the lessons in mission transfer, formulating the scope of their relationship, sharing the knowledge, adjusting their roles consistent with each other, and revising laws on this matter, for them to run public affairs in

response to local people's needs. Then the people will be involved in the management of LGOs that will carry out their missions in an efficient and transparent manner.

MOPH selected 10 well-prepared provinces such as Chiang Mai, Phrae, Phayao, Nakhon Ratchasima, Maha Sarakham, Ayutthaya, Chon Buri, Songkhla, Phuket, and Pattani to join in the pilot project of public health decentralization. The health care development was implemented under the concept of participation by stakeholders. The experimental study in models/forms, roles, responsibilities and structures of the Area Health Board, personnel development, and paradigm shift reinforcement for the participatory work among health personnel, LGOs, civil groups and academia was carried out. Afterward an important constraint occurred because the indistinctness in MOPH's decentralization policy (after Dr. Mongkol Na Songkhla retired as permanent secretary for public health), and also, the new government highlighted the health system reform by improving the health financing system or "30-baht universal healthcare scheme" and the State decentralization policy was directed toward integration at the provincial level, i.e. CEO-style governorship. Such a direction created the worse situation in health decentralization, which was so serious that the preparation for LGOs to take the transferred missions based on the decentralization action plan was discontinued; many local agencies were hesitant to proceed as they were unclear about the direction. There were many questions about PAO's roles as it has

to take responsibilities for the people in the province as the promotion or cooperation with LGOs was not shown. There were no decentralization policies to LGOs in the government policy statement; and there were many concrete actions that reflect the de-emphasis on decentralization. The budget allocation to LGOs was absolutely different from what mentioned the Decentralization Plan, i.e. at least 35% of the government budget must be allocated to LGOs; but the actual allocation was only 24%.

7.1 Reviewing and changing the compass

At the end of 2005, MOPH arranged a brainstorming meeting among the stakeholders in order to improve the health decentralization process so that it was suitable for the changing context (having taken place since 2002). The meeting was attended by representatives from MOPH's central/regional/provincial offices such as provincial public health offices, central/general hospitals, the Rural Doctor Society, the Moh Anamai Association, LGOs, the Local Administration Department and other agencies concerned; its aim was to find the consensus for the new decentralization process in December 2005. After that MOPH cooperated with the Specific Mission Sub-committee on Public Health Mission Transfer to LGOs on February 10, 2006, in improving the health authority transfer procedures. On March 15, 2006, the Decentralization Committee approved those procedures. The important principles of health decentralization are:

(1) maximum benefits for people, (2) flexibility and dynamics, and (3) participatory system. The details of the above-mentioned are as follows:

1) Maximum benefits for people

LGOs are expected to have long-term potential in decision-making and problem-solving in health for a better contribution before the decentralization period and for the health service systems that are equitable and of good quality.

2) Flexibility and dynamics

The flexibility is related to LGOs' potential and changing situations; and learning from experiences is expected in order to continue the decentralization process for sustainable health development.

3) Participatory system

A strong participatory system must be established for central/regional/local officials and local residents to work together based on the good intention, love, liberality and endurance, and also, to avoid imposing the ego and self-centeredness for the purpose of the smoothness of mission transfer in line with the specific characters of the health service system.

The scopes of health missions to be transferred to LGOs are divided into two types as follows:

- Missions related to medical treatment, health promotion, disease prevention and rehabilitation.

- Missions or activities/services to be provided for individuals, families or communities, which LGOs are able to take responsibility for implementing such missions such as environmental development for disease control and health promotion.

There are at least four characteristics of health decentralization (which are able to be integrated) as follows:

1) LGOs are the service buyers and also the owners of funds (such as the local income or the budget from the health security fund that is transferred to LGOs) and are the service buyers from government/private sector's health services within and outside their respective localities. The potential of LGOs in financial management is expected to be developed so that they are able to control the service standard and quality.
2) LGOs collaborate with the central/regional agencies in such programs as 30-baht healthcare scheme (using community health funds) and health promotion, or with primary care units or hospitals in people's health system structural development.
3) LGOs partly operate by themselves such as taking responsibility for environmental development and health promotion in communities.
4) LGOs operate the whole program by being the owner and provider of health service units.

LGOs may proceed with the procedures based on the principles of health decentralization so that the transfer may have many models which are adjustable according to LGOs' readiness, suitability and situation:

1) Separate transfer by transferring the service units to LGOs at different levels such as transferring a health center to a TAO and transferring a hospital to a municipality or a PAO.
2) Service network transfer by linking health centers and hospitals in a certain locality as a network and transferring the whole network to an Area Health Board (AHB) with participation from LGOs.
3) Establishing an autonomous public organization (APO) with LGOs participating in the administration and the APO may be a service unit or service network or AHB).
4) Establishing a Service Delivery Unit (SDU) – each hospital is a SDU under a Health Facility Authority (or Hospital Authority) which is an autonomous public organization under the supervision of MOPH with LGOs' involvement in its administration.

For Models 1 and 4 above, they may not be a direct transfer as LGOs will participate in the administration, not as the owners.

Under the above principles, MOPH appointed a committee to determine the mechanism, process, criteria and LGO readiness evaluation procedures for transferring health centers according to the "separate transfer" model.

Later, the committee appointed three sub-committees as follows: sub-committee 1 on developing a mechanism and procedures in supporting the transfer of health centers to TAOs; sub-committee 2 on developing regulations, conditions and readiness evaluation procedures for transferring health centers to TAOs; and sub-committee 3 on studying and developing an evaluation system of the pilot-scale transfer and making policy recommendations on this matter.

7.2 Criteria for pairing in the transfer of health centers

After a brainstorming meeting on developing a manual for transferring public health missions to LGOs in January 2007, MOPH established the criteria for selecting LGOs to participate in the pilot project on transferring health centers; the participating LGO is to have the following characteristics:

- Being a LGO that participates in the local health security system or the community health fund.
- Being a LGO that provides scholarships for public health personnel development.

- Being a LGO that received a good management award (outstanding good governance) in 2005 or 2006.

Based on the above conditions, there were 110 qualified LGOs all over the country. However, the LGO that wants to join the project has to meet the above criteria and pass the LGO readiness assessment in public health management comprised of five elements (eight indicators) as follows:

1. Experience of the LGO in the management or participation in public health management, four indicators:
   - The period that the LGO has implemented or participated in or promoted the public health management until the present time.
   - The performance of health program operations.
   - The participation between communities and the LGO in public health management regarding assets, technical affairs, services and activities, etc.
   - LGO's promotion and support provided to the health center before the transfer with respect to assets, technical affairs, services and activities, etc.

2. Preparedness plans for public health management or development showing the suitable readiness in various respects, one indicator:

- Having a strategic plan or project/activity plan for public health management and/or a patient referral system development plan and a preparedness plan for emergency and epidemic situation, and/or a plan for developing a control, monitoring and examination system to create confidence in the management of standard health system.

3. Public health administration and management procedures, 1 indicator:
   - Having procedures for public health administration and management.

4. Allocation of budget for public health, one indicator:
   - The proportion of budget (including general subsidies and loan, excluding specific subsidies from the government) for public health in the past three years (not including the fiscal year being assessed).

5. People's and stakeholders' opinions on TAO's readiness in public health management, one indicator:
   - Opinions of the people and stakeholders in the locality on the TAO's readiness in public health management.

After the LGO passes the readiness evaluation criteria and at least half of the health center personnel are willing to transfer to the LGO, before the transfer action, the LGO has to undertake the following:

1. Delegation of LGO's authority to a health center
   - 1.1 Establish regulations on revenues of health service units under the LGO.
   - 1.2 Set up criteria, conditions and methods for payment of remuneration for personnel at health service units under the LGO.
   - 1.3 Set up criteria and guidelines for procurement to be carried out by health service units under the LGO.
   - 1.4 Set up guidelines for spending the budget for NHSO-funded projects carried out by health service units under the LGO.
2. Organization of administrative structure for public health administration and management
   - 2.1 Set up a structure for public health mission of the LGO with regard to both administrative and health service units.
   - 2.2 Develop a staffing pattern for health service units under the LGO.
3. Public health personnel management system
   - 3.1 Establish criteria and procedures for appointment, transfer, promotion, and qualification assessment

for reassignment in general, professional and specific professional positions.

It was found that there were 35 health centers in 30 well-prepared TAOs/municipalities in 22 provinces that joined the project. As assessed by the subcommittee on health mission transfer to LGOs according to the transfer manual, some LGOs were unable to operate because they had to wait for the formal announcement of LGO councilors election. Finally, MOPH decided to transfer only 22 health centers to 17 LGOs and 2 municipalities in 16 provinces in all regions of the country (see Table 4).

Table 4 : Health centers that were transferred to LGOs by region and province in fiscal year 2008

Region	Province	Health center	LGO/Transferee
Central	Kanchanaburi	Chaloem Phrakiat	Wang Sala TAO
	Samut Songkhram	Ban Prok	Ban Prok TAO
	Phetchaburi	Ban Mo	Ban Mo TAO
	Ratchaburi	Ban Khong	Ban Khong TAO
	Ratchaburi	Ban Krok Singkhon	Dan Thap Tako TAO
	Lop Buri	Khao Samyot	Khao Samyot Municipality
	Ayutthaya	Bang Khonom	Bang Khonom TAO
	Pathum Thani	Bueng Yitho	Bueng Yitho Municipality

Region	Province	Health center	LGO/Transferee
	Sa Kaeo	Khlong Hinpun	Khlong Hinpun TAO
	Sa Kaeo	Khlong Tasut	Khlong Hinpun TAO
	Sa Kaeo	Na Khanhak	Phra Phloeng TAO
	Chanthaburi	Ko Khwang	Ko Khwang TAO
	Uthai Thani	Hat Thanong	Hat Thanong TAO
Northern	Tak	Ban Wangwai	Wang Man TAO
	Kamphaeng Phet	Ban Bo Thong	Wang Khaem TAO
	Kamphaeng Phet	Wang Khaem	Wang Khaem TAO
	Lampang	Lampang Luang	Lampang Luang TAO
Northeastern	Buri Ram	Ban Nong Tayao	Nong Waeng TAO
	Buri Ram	Ban Nong Wa	Nong Wa TAO
	Udon Thani	Na Phu	Na Phu TAO
Southern	Nakhon Si Thammarat	Pak Phun	Pak Phun TAO
	Nakhon Si Thammarat	Ban Sala Bang Pu	Pak Phun TAO

MOPH organized a signing ceremony for the transfer of the health centers to the LGOs on November 30, 2007 in the Phaichit Pawabutr Conference Room, on the 9th floor of the MOPH building 7 (according to the resolution of the meeting chaired by the Minister of Public Health, on November 27, 2007, held in MOPH's 4th floor meeting room) amidst the confusion of the persons attending the ceremony such as the Director-General of the Local Administration Department (representing the

Permanent Secretary of Interior), presidents of LGOs, mayors, provincial chief medical officers (PCMOs), as well as relevant health center officials. As the Permanent Secretary for Public Health had to perform another urgent duty, the Public Health Minister (Dr. Mongkol Na Songkhla), by virtue of the State Administration Act, instructed that the senior expert on disease control and prevention (Dr. Suwit Wibulpolprasert), acting permanent secretary sign the transfer agreement instead. The Minister also issued an order assigning the PCMOs to act on behalf of the Permanent Secretary in transferring relevant assets and budget to the LGOs. And in December 2007, MOPH published and distributed a white paper, entitled "Ten important truths about the transfer of health centers to LGOs and the guidelines for health decentralization".

Chapter 8

Experts' and Stakeholders' Opinions

In 2006, section 30(4) on budget allocation to LGOs of the 1999 Decentralization Act was amended, changing the LGOs' revenue proportion of 35% by 2006 to "…from 2007 onwards, LGOs shall have a revenue in the proportion of not less than 25% of the government's revenue" as per the Decentralization Act (Amendment No. 2) of 29 December 2006. In this connection, MOPH planned to transfer health centers to LGOs (phase 1 in 2008). However, this issue brought about some concern among some stakeholders who did not agree with the decentralization issue. Therefore, a survey was conducted from September through November 2007 through interviews with experts, academics, and stakeholders on five main research questions as follows:

- the aims of health decentralization
- experiences in health decentralization in the past
- the transfer of health centers to LGOs

- the assessment of the success of health decentralization
- the suggestions for improving health decentralization

1. The aims of health decentralization

There is misunderstanding in the meaning of health decentralization. Different stakeholders understand and interpret the meaning of health decentralization in a different way. This has an impact on the aims of health decentralization. Hence, the interviews with experts, academics and stakeholders are one of the tools to review the understanding of health decentralization of stakeholders.

One senior expert compared health decentralization to the philosophy of democracy which refers to equality. Equality is very much close and related to health and education. For this reason, everybody has the right to get sick equally. However, the access to health service including prevention, promotion and rehabilitation is different. The access to health service is therefore the indication of equality of human being. Many health and medical academics have realized this fact on the importance of everyone's health; thus, they attempted to raise the "health issue" to the "public policy" level.

In view of experts, academics and stakeholders in health and political science, the objectives of health decentralization can be seen in two dimensions:

The First Dimension - Citizens recognize their own power and responsibility to take care of their health and get involved in health service management in their locality to maintain the well-being of the family, community and region.

The Second Dimension - LGOs are able to provide basic health services, such as health promotion, environmental control, basic medical treatment services or primary care, which are needed in each community thoroughly and equally.

The academics proposed that the "first dimension" was the final and ultimate objective which might be called the completeness of citizens' society, not of an individual. It involved the preparedness of the three main parts - state, society and wisdom.

"State" means state agencies that are connected with powers in a balanced manner, passing laws and regulations that facilitate participatory actions of all concerned.

"Society" means a group of citizens who are competent and able to take part in the management of health care for themselves, their families and their communities as provided in the National Health Act, which supports and endorses the full participation of all sectors in improving health.

"Wisdom" means information and knowledge that are up to date. It also refers to the ability to think, analyze, and synthesize the knowledge learned, particularly, under the current situation of the information overflow and consumerist society.

The second dimension deals with the legal aspects of the 1999 Decentralization Act under which the central government has to devolve some of its roles and responsibilities including personnel, resources and legal authority to regional, provincial and local authorities or local governments, established pursuant to the 1997 Constitution, to organize public services for the people in their respective localities.

Therefore, the transfer of authority from the central government to LGOs is an important action and has a relationship between the "transferors" and the "transferees", which may neglect the healthy condition or ultimate goal of decentralization. What academics of both sides agree upon is to have a plan and steps for decentralization because they believe that there will be no single formula for decentralization. The experiences of decentralization in other countries indicate that the decentralization should have the experience from field experiments in order to find an appropriate model that is suitable for each locality.

The objective of stakeholders in decentralization is only the transfer of health services for example hospitals and health centers to LGOs, which depends on the "capabilities" of LGOs.

Thus, we need to have to systematic support for strengthening

LGOs which have different income levels, leadership skills, and cultures. Large LGOs with readiness can operate their own health-care facilities; for example, the Bangkok Metropolitan Administration can run large hospitals (Vajira, Taksin and Klang hospitals), public health centers, and other health units.

Regarding the goal of transferring 35% of government income to LGOs within 10 years (by 2010), at the beginning, LGOs have to provide only basic or primary health care including health promotion and disease prevention for their people. In providing higher-level medical services, they need to consider the economies of scale as such services are costly. And apart from basic care in some areas, they need to pay attention to geographical differences, e.g. areas with a high risk of disease outbreaks.

Furthermore, the experts suggested that health decentralization should be carried out in a concrete manner with an action plan as required by the Constitution. Event though the overall potential and context of LGOs have improved in the right direction according to the good governance principles, there have been no declining trends in the incidence and prevalence of preventable infectious diseases such as AIDS and cholera. Rapid changes in life style, culture and information technology have an impact on our society. Therefore, the health system has to be

adjusted. In addition, it is a good sign if other organizations outside MOPH adjust their roles to focus on health services. The experts also suggested that if there is no appropriate model of decentralization, we need to implement and make adjustments during operation with the positive attitude of stakeholders. If there is no beginning, there will be no development.

2. The experiences in decentralization

The experts and stakeholders indicated that the main issues of health decentralization can be divided into two parts: the Area Health Board and the capability of LGOs.

2.1 Area Health Board (AHB)

The experts and academics of both health and politic sectors have agreed that the AHB approach is a new mechanism of decentralization for each locality. It has an essential role in particular to set up decentralization process according to the Decentralization Act. An AHB comprises all stakeholders including the transferors and the transferees, academics and citizens playing a role in managing health services. The AHB has an important role in providing health services for their people and suggesting local health authorities to provide health services. Furthermore, the AHB can make better understanding among all relevant authorities to achieve the same goal – providing public

health services to all needy people and building healthy conditions for the community.

Though the AHB is not responsible for all functions, it is better than transferring authority to only one LGO. The AHB is responsible for determining the budget to be allocated to LGOs as well as exploring appropriate and effective "professional services". Due to the fact that some public services cannot be directly transferred as it needs special and professional skills, academics believes that the AHB will be an effective mechanism for coordinating all relevant authorities. The AHB will be an out-of-the-frame and mixed mechanism that academics proposed as a starting point to coordinate between LGOs and MOPH. One problem of the AHB approach is the lack of experience in planning a coordination mechanism. If an AHB has a chance to run and test it, there might be a helpful lesson learned which might be able to be developed further. The AHB will help LGOs manage public health services which will lead to the provision of all primary care services in its locality and community. This will results in the economies of scale in management and development of public health and medical resources. For the high cost medical care, the central government is the responsible authority. The testing of the system or pre-running of AHB in each area will bring various results relating to budget, manpower and responsible areas and population due to diversity among individual LGOs. This may not be only a matter of transferring but may also change the face of public health services.

2.2 Readiness of LGOs for health services management

Medical and public health academics indicated that from the observation of 15 years of public health service since the enactment of the 1992 Public Health Act, LGOs' achievements are not strong enough. The first important thing to do is to emphasize and support LGOs to improve their capacity to perform their roles in accordance with the Act. On the other hand, some experts suggested that we should wait for the new government's policy. It is not the civil servant's roles to do that. The interesting suggestion is that the citizens should have an opportunity to measure the capacity of a LGO because they are affected directly by the LGO. In addition, one point that needs to be considered is that LGOs may need to be autonomous such as Ban Phaeo Hospital. However, MOPH has formulated key performance indicators of LGOs. These indicators can be used to assess the preparedness of LGOs in terms of decentralization in health services.

The experts as well as health professionals and politicians have suggested that there are three key factors of success in implementing decentralization. These include: (1) politicians, (2) structure of a LGO, and (3) operating staff.

- Politicians: They are elected by citizens and can be divided into two groups: administrators and members of local administrative councils. If the head of a LGO

who is on the administrative side and members of the local council understand health service management and place emphasis on stakeholders' participation in providing health services, health personnel will be able to work efficiently with motivation from them. As a result, they will provide appropriate care for the people in the area.

- Structure of LGO: There should be health personnel or proficient staff who have knowledge and experience in public health. Thus, they can manage the whole process of public health issue in their community such as health care planning, health service provision, environmental protection, surveillance on health problems in community, design of an appropriate development plan of their community, and community participation. However, there are some health care services that are not cost-effective; and the LGO needs to cooperate with other organizations to manage them in a better way.
- Operating staff: The LGO should have operating staff such as clerks, janitors, nurses and doctors who can provide health care according to the health problems in each area. However, they should receive salary according to their performance in order to reduce the long-term government spending in the long run.

At the present, some LGOs can provide health services for their people. However, academics were concerned about the fact that LGOs will copy the model and administrative style from the central government. This will cause deviation from the real concept of decentralization, whereby the health care system should be adjusted according to the needs of people in each area. If a LGO just copies the model of the central government, its people will not get any benefit from the decentralization approach. The resultant benefit will be the established power of the LGO only.

Experts in politics added that public health is not the duty that LGOs prefer. Politicians do not like a persistent commitment and a routine engagement. It is important to convince LGOs that resolving public health problems can bring popularity and trust from people. Many heads of LGO initiate work from surveying on pregnant women and distributing milk to those pregnant women, organizing child care centers, distributing books to students or giving donations to and providing health care for elders. Many projects of LGOs follow the government's uea-a-thon or low cost projects. Though not efficient in the sustainability standpoint, it is, in some ways, helpful for local people. It is important to make LGOs believe that managing health centers or primary care units is not a difficult task and it can bring popularity and people's votes to local politicians. We can see an example of success in the local municipality of Phitsanulok where it provides all kinds of services to people and

gain popularity in its community.

In terms of public health, the academics and experts divided LGOs into the following:

1. Provincial Administrative Organizations (PAOs)

Although the legal definition of "area" or geographical locality may cause some limitation and difficulty in managing programs in a designated area and due to the lack of manpower, a PAO has a considerable budget and is directly involved in systematic management in its area. Thus, a PAO should have roles in supporting health improvement activities, giving remuneration and incentives to physicians, nurses and medical/ health professionals who provide health services for a TAO, and building hospitals. A PAO should also give authority to small LGOs to provide services for the people with disabilities and chronically ill patients which may require high investment costs for equipment, consultants and service sites. For the prevention and control of diseases, MOPH remains in charge as it requires technical and special knowledge.

2. Municipalities

A municipality can provide public health services at its health centers because it has appropriate working structure, budget and designated area. Many municipalities have set up health service units, some of which are like a hospital, such as Nakhon Si Thammarat Municipality's hospital. However, there

are many levels of municipalities; some subdistrict municipalities have less budget and manpower or than some TAOs.

3. Subdistrict or Tambon Administrative Organizations (TAOs)

Heads of many TAOs including members of TAO councils have some knowledge of public health. Some of them used to be village health volunteers. Thus, they have experiences in and apprehend the tasks of community health care. Noticeable efforts of TAOs include exercise activities, provision of milk and food supplements to children, insecticide spraying and distribution of a larvicide (Abate) for mosquito control in the dengue fever prevention.

Leaders of many LGOs have a good relationship with health center staff. This results in efficient outputs. However, in some areas, the relationship between them may have changed due to the problem of uncertain duties of LGOs and the lack of clarity of budget allocation in the area. Therefore, program integration and good relations are needed for effective outcome.

Moreover, the experts and academics agreed that LGOs need not do the same tasks or work which the central government does. LGOs should be responsible for the following:

1. Health promotion, disease prevention and law enforcement of the 1999 Public Health Act: This

includes the control of fresh markets, water supply, environmental control, etc. At present, there are more than 7,000 LGOs, but only a little over 1,000 LGOs have issued rules and regulations on public health.

2. Provision of some primary and secondary healthcare services, particularly services at the community level such as services at health centers.
3. Special services according to problems in the area: This is also called "health care in crisis situations". Each area has different problems due to the diversity of socio-cultural and economic conditions as well as healthcare resources structure. For example, LGOs or TAOs in the southern border areas have to have emergency medical services with a referral system whereas those in urban areas have to emphasize health promotion activities such as organizing exercise activities and building parks or sports centers. Some areas where there are many elderly persons, their primary health care systems are to include chronic care. An example is seen in one of the TAOs in Khon Kaen province which cooperates with its community hospital to provide services such as home care for chronic disease or health check-ups to prevent health problems in family. The latter service is done by young local health workers who were granted scholarships to study community nursing or community dental nursing.

4. Provision of psychiatric and mental health services: The services include vocational support to earn more income for the elderly, prevention and control of drug problem in teenagers and adults, prevention of alcohol and smoking addiction, etc.
5. Community services: Examples include providing safety and protection to assets and lives, preventing community health threats, controlling threats and promoting positive health factors.

Moreover, experts added a suggestion that **"LGOs should prioritize their work on managing and developing communities with good governance to bring about participation from all sectors in a democratic way for the people in their communities".**

3. Transferring health centers to LGOs

According to transfer Model 1 of the agreed upon guideline no. 2 on health decentralization, health centers will be transferred to the LGOs that are ready and have passed the readiness assessment with the willingness of both parties. Special focus is made on the LGOs that have received a good governance award. However, the experts, academics and stakeholders had some observations as follows:

3.1 How can the people access health care?

Services provided by health centers are primary care in nature which is similar to LGOs' service. So that people shall have better public health service. Some experts and academics commented that some health centers have too much freedom and lack supervisor's attention. Some health center officials do not make any home visits or carry out any disease surveillance in community, but perform their tasks passively at the center; or close the center when going to a meeting in the district/provincial town. So the people are unable to count on them and sometimes they have to go to a community hospital instead. If the health center is under a TAO, the people shall have the services as they need especially those related to health promotion, home visit, community disease surveillance; and some TAOs are able to hire a doctor to work at the health center which will decrease the overcrowding at the community hospital.

However, some MOPH officials had a different opinion, saying that TAO's health officials are no longer able to provide curative care as they do not have a medical practice license because their health center is not under the supervision of the provincial public health office. Moreover, the structure of the LGO is divided into several sections: school health activities (health promotion for schoolchildren) under the education section, elderly health care under the social welfare section, while the public heath section handles only medical care and disease

prevention. The health experts further added that health centers are also expected to carry out activities directed by central agencies such as vertical programs assigned by MOPH for action by provincial public health offices. Such programs are for the benefit of the people in all localities. Although certain health centers are under LGOs, they should continue that kind of operations according to the local health system so that the level of essential health care will not be less than before.

In addition, health center staff commented that the health services might be inequitable due to political interference in order to maintain constituents' support; and if LGO administrators have no knowledge of specific issues in public health, especially in environmental control, workplace pollution control, neighborhood cleanliness (solid waste collection), and disease control/ prevention, with discriminatory practices, the confidence in health services and subdistrict health officials (moh anamai) might be affected.

Regarding medical rehabilitative care which involves follow-up support of domiciliary care should be continued using the home-visit approach. But for the care for disabled persons, which requires a large amount of budget for specialized personnel, prosthesis and orthosis and places, as well as the continuity of service, TAOs should have sufficient incomes and consider the cost-effectiveness of services.

3.2 LGOs' potential

When health centers are transferred from MOPH to LGOs, the administrators of LGOs will be closely related to local health problems; and their allocation of local resources including budget for resolving such problems will be done more promptly that when the health centers were the most peripheral units under MOPH. Previously under MOPH, the response to local problems was rather slow or nil. As each health center has only four or five staff members, the transfer to LGOs can be done more easily than transferring a district hospital. However, the budget and incomes of LGOs are an important constraint to the transfer of health centers. At present, it is recognized that generally the people's basic needs are public utilities such as roads, water supply and electricity while health services have been effectively provided by MOPH's health centers. So it is noted that many LGOs do not want to take over health centers which will create a budgetary problems for them in the long run.

3.3 The center for primary care standard development (at a health center)

Health-care facilities are basically linked in a systemic manner, requiring a transfer or exchange of operating techniques and information among all officials concerned at each unit. The referrals of patients include both referring for further treatment and transferring back for continuous treatment; so a good

understanding of relevant units is essential for cooperation in caring for patients despite being under different agencies. The aim is to provide humanized care to patients, not only symptomatic care for ill individuals. Therefore, health personnel development in keeping abreast of up-to-date health issues is essential in a continuous manner, particularly on emerging and re-emerging diseases such as avian influenza, severe acute respiratory syndrome (SARS), and hand, foot and mouth disease. So there should be a core agency (not the MOPH) that will be responsible for protecting health center staff when they face a problem related to healthcare provision, especially as their counsel in case of litigation. In addition, the core agency will be in charge of setting health center's performance standards, a practice licensing mechanism for health workers, and an accreditation system for health centers similar to that for hospital accreditation.

3.4 Participatory public health development

Transferring health centers to TAOs so that they will be in charge of primary care services is possible as health officials at the centers have been providing such services to local residents for a long time. If any LGO has a problem in undertaking a participatory activity, health development efforts in that particular locality might not be smoothly pursued. So the participatory administration is an important indicator in the transfer of a health center to the LGO; and a mechanism has to be established by

MOPH to strengthen and help LGOs for a paradigm shift. The transferor (MOPH) is to get the health center as well as the transferee (LGO) prepared for their new roles and appropriate use of authority, otherwise they might have a negative attitudes toward each other resulting in health officials feeling inferior, disheartened, and unconfident in performing their tasks.

One of the important suggestions in transferring health centers to LGOs is to hold public hearings in order to have the people participate in readiness assessment before the actual transfer. The assessment is not to be done by LGO administrators only. There are some LGOs that are willing to take the transfer because of personal relationship between LGO administrators and health center officials (being in the same family). In the long run, if there is a change in personnel, will the health service system be the same? And there is another problem in comparing the position level of health center chief (public health administrator) with the position of LGO's public health chief, which will need to pass an examination in order to get promoted to such a position.

The collaboration mechanism and decentralization support at the provincial level as authorized by the Decentralization Committee, the provincial decentralization committee is to justly resolve any problem that may arise without fears for local administrators' influence.

Furthermore, one of the health experts said: "We always talk about the transfer of existing health-care facilities, resulting in a leading trend in this regard but with an opposition from many MOPH officials. So far MOPH has built up reputation for Thailand which is regarded as being number one is many respects by WHO, signifying the strengths of the Thai public health system. Health decentralization is not just the transfer of health-care facilities or health centers. The important duty of MOPH is to find new technical information on directions of health systems and then inform the public to make a decision similar to the movement for passing the 2007 National Health Act.

On the contrary, some MOPH administrators expressed an opinion that "MOPH attempts to proceed with the transfer of health centers to TAOs to provide basic services, based on the willingness of both sides on an experimental basis. Research and development on this matter are needed. After political changes (general election and a new government is formed), will there be an effort to transfer health centers as politicians tend to favor centralization in parallel with non-comprehensiveness? Based on the knowledge gained from the transfer of the first group of health centers, the attainment of LGOs' performance goal is not in sight. A specific mechanism is to be established to empower LGOs together with research and development efforts so that they can seriously carry out health activities for the maximum benefit of the people, not just as a secondary task.

4. Assessment of the success of health decentralization

The assessment of health decentralization especially the transfer of health centers focused on the paradigm shift of LGOs as it has been noted that democracy through decentralization is a failure. The decentralization has been in effect for more than 8 years, even the goal is supposed to be reached within 10 years. When there was a coup in 2006, the decentralization had to be re-started as all parties concerned were not serious about getting this matter through according to the 1997 Constitution.

In assessing the operations of health decentralization, the people's needs and the system's responsibility had to be considered using the social audit technique. The assessment team was composed of researchers from the Thailand Development Research Institute (TDRI) in cooperation with the Health Systems Research Institute (HSRI). A sample of villagers (service recipients) was asked how they felt when the health center was transferred to a TAO. The consumers might not see any problems of the service providers, while the providers had to voice their concerns about job security, morale and happiness in working, flexibility, and knowledge development. For LGO officials, they were asked about the burden in taking the transfer of another health center or more in the future. The assessment should be done for a period of two or three years and again three or four years after that.

In the beginning of the program, a LGO took responsibility for only one or two health centers; the situation might be fine due to a bias factor like the life of a newly wed couple. But if they have to take responsibility for more health centers, there might be budgetary and management constraints of both parties; and the TAO might not be happy about that. For instance, the schools under the Department of General Education in the Nonthaburi area were transferred to the Nonthaburi PAO; and as much as 400 million baht was spent for school development, 30% to 50% higher than anticipated. Surely, their efficiency has improved, but what will happen when the budget for this purpose is less. So decentralization can be in many forms and there will be no single form or model that is applicable to every locality. The success of decentralization is up to LGOs and MOPH. The indicators of the success of health decentralization include customers' satisfaction, management success (use of information for problem analysis and participatory administration) and health standard indexes, etc.

5. Suggestions for health decentralization development

The law on decentralization was passed according to the Constitution but Thai people's paradigm has not changed accordingly. Thus, the decentralization process has to have steps designed in line with each locality's circumstances. The decentralization law is not a tool but a conceptual framework for

designing a system that responds to local needs. In the past, decisions were made by the central administration, despite differences in local situations; then the problems could not be resolved. To get local people involved in decision-making, a mechanism has to be established. After the 1997 political reform, the Constitution mandated that the administrative structure at the regional and local levels be revised. The public sector reform prescribed the linkage between the health system and LGOs which have got the local mechanisms. However, a narrow sense of interpretation that is usually practiced in developing countries resulted in a phenomenon after the mission transfer whereby many LGOs emulate what state agencies are doing - that is another form of centralization. How will the civic sector be more involved in the process? How will it be defined? How will their representatives be selected?

5.1 New mechanism and models of health decentralization

The new mechanism that was suggested by the academics according to the 2002 decentralization action plan is the Area Health Board or AHB, which has not been pilot-tested. The AHB mechanism was designed to provide health services within its designated or catchment area without sticking to the former service model and it can be adjusted according to local needs. As the public health service in Thailand is a mixed system, provincial-level hospitals operate all activities ranging from

health promotion to disease prevention, primary/secondary/tertiary treatment, excellence center services such as a heart center, a accident center, etc., and also, rehabilitation service. Some activities of the hospitals have to be transferred to LGOs. Some activities need to be managed by a specific executive agency (such as AHB) coordinating inter-provincial services and managing tertiary care (at regional hospitals). At the national level, there should be a national special service management agency responsible for coordinating specialized care because not all health-care facilities are under MOPH. This is to make use of resources more efficiently, revise laws to reflect the real situations, and protect health personnel so that they will work with confidence.

The health decentralization by transferring health centers to LGOs may have to be carried out in different forms in order to satisfy people's needs. But the services that need a high investment cost have to be under an AHB for a particular geographical area. The AHB will be responsible for coordinating health services across the service boundaries of several health facilities, tertiary care, or certain specialized services because some LGOs in Thailand are too small to invest in such services.

5.2 Communication campaigns for citizenship building

One of the important problems of health decentralization is the lack of seriousness in the undertaking of the transferors and the transferees with the conflict of thoughts. The academics, experts and stakeholders made a conclusion that decentralization requires: pattern creation, campaigns, forward pushing and step-by-step implementation. The lessons from aboard have shown that there are no developed countries that have never gone through the decentralization process even Japan.

Most health-care providers always consider that the system is not important for them so that they do not understand the core principle of decentralization. To make every party understand the systemic mechanism, their capacity has to be built up since currently only 3% to 5% of the Thai population are active citizens who actually realize their role as citizens. In order to make the people who are always "takers" become "strong citizens", the government has to enhance their capacity in systematic thinking. It is important for the people to make a "political view commitment"; for instance, the Brazilian constitution contains a section on local philosophy supporting local governments to provide public services by themselves – 90% of public services are operated by local governments while the central government takes care of legal processes, service standards, communicable disease prevention/control, and international relations through various ministries.

One of the public health experts stated that "To push this matter forward, we need to follow the "triangle moving a mountain" principle of Prof. Prawes Wasi which includes the powers of: (1) the academics and government officials with knowledge for problem-solving, (2) the people sector's participation, and (3) the political support". Academics have to disseminate the knowledge to society with the participation of the civic sector. The mass media is essential in the empowerment of society, pushing government officials and politicians for building a strong society.

5.3 LGOs: Alliances for health system development

During the period of the public sector reform and the passage of several laws on health (2001–2007), a few new health agencies were established, whose operations are based on the participation of various sectors including LGOs, especially in the policy-making process.

The National Health Security Act, B.E. 2545 (2002), is the law relating to health financing reform and the National Health Security Office (NHSO) was set up to create health security or insurance coverage for all Thai people to have access to health care equitably by pushing for the cooperation among public and private health facilities, LGOs and the civic sector, whose representatives also join the National Health Security Board. NHSO annually allocates the budget from the health promotion

and disease prevention fund to create a "Community Health Fund" in each subdistrict. This is to encourage LGOs to take a leading role in local health system administration. How much the people are involved in the process and their level of access to health services are to be assessed. It is hopeful that this system will be able to respond well to the people's needs with the flexibility of the modern agency. Moreover, NHSO has cooperated with MOPH in providing certain healthcare services successfully.

In addition, the National Health Act, B.E. 2550 (2007), is a law that significantly promotes decentralization through forums of "National Health Assembly" with the National Health Commission Office (NHCO) serving as the secretariat in the health system reform process. NHCO also supports all partners concerned to organize local health assemblies and public forums for discussions on specific technical or policy issues, and identifies clear issues for Cabinet's policy decision-making, formulates healthy public policies leading to the well-being of society. In all these processes, all sectors (public/private sectors, LGOs, and the people) are expected to be aware of their roles in creating a good health system. If more and more local health assemblies are organized, the overall health decentralization will automatically take place.

Chapter 9

Decentralization Direction under the 2007 Constitution

In the 2007 Constitution of the Kingdom of Thailand, the provisions on local administration are mostly derived from the 1997 Constitution as follows:

Section 80 (2) provides that the State shall promote, support and develop health system with due regard to the health promotion for sustainable health conditions of the public, provide and promote standard and efficient public health service thoroughly, encourage the private sector and the communities to participate in health promotion, and provide public health services.

In sections 281-290, relating to local administration, the State shall give autonomy to local government organizations with the principle of self-government according to the will of the people in a locality and shall encourage local government

organizations to be the principal public service providers (including public health services) and to participate in resolving any problem that occurs within their localities.

There shall be a standard to be applied to LGOs, upon their own selection, with regard to the appropriateness and differences in the levels of development and efficiency in the administration of each type of LGOs without prejudice to capability of LGOs in making decisions for the fulfillment of their requirements and there shall be a mechanism for the examination of performance thereof which is executed mainly by the people.

An auditing mechanism by people has to be set up and LGOs have to report annually about budgeting, expenditures and activities to their people.

As stated in section 303, at the initial stage, the Council of Ministers or Cabinet taking office after the first general election under the 2007 Constitution shall cause a preparation or amendment to laws in the matters and within the specific period as in the law relating to plans and process for decentralization, law on local revenue, law on establishment of a local government organization, law on local officials and other laws as referred to in Chapter 14 (relating to local administration) for the compliance with the Constitution; within two years as from the date its policy statement is presented to the National Assembly under section 176. Such a law may be complied in the form of Local

Administration Code. In the case where the laws enacted before the date of promulgation of the Constitution have compatible substances with the Constitution, the execution of this section to such laws is exempted.

Chapter 10

The Next Step

MOPH has nine important missions including: (1) to set health policies and strategies for the country in line with the change in every level; (2) to develop the health system and administration mechanism; (3) to follow up, control and monitor the health system as a whole and promote the participation from every sector; (4) to have laws for establishing, controlling and providing the needed standards and also for monitoring, controlling and developing the standard quality; (5) to provide health services by determining a basic benefit package and develop specialized services; (6) to establish systems for the prevention/control of diseases and health threats in an efficient manner in both normal and emergency situations; (7) to support all social sectors to participate in health promotion, develop the people's potentials in practicing health behaviors with health conscience; (8) to coordinate the policy formulation for health research and health management; and (9) to implement international health programs. So the missions related to health

decentralization especially the transfer of health centers to LGOs have to continuously monitored and evaluated in order to improve health status of the people throughout the country. This is the important objective of health decentralization.

10.1 The path of transferring health centers

After the Decentralization Committee announced the 2nd Decentralization Plan and MOPH developed the health decentralization procedure including the guidelines for assessing LGO's readiness for taking the transfer of health centers, the transfer will be based on three important criteria: maximum benefit for the people, flexibility of the system, and people's participation. The scope of missions to be transferred includes: (1) services related to curative care, health promotion, disease prevention and medical rehabilitation, and (2) the extent to which the services will be rendered, i.e. to individuals, families or communities. And LGOs will take the mission transfer in four aspects: LGOs being service purchasers, LGOs jointly operating services with central/provincial agencies, LGOs partly operating health services, and LGOs running the entire health services. The models of mission transfer will be as follows: (1) separate transfer, (2) service network transfer, (3) public organizations, and (4) service delivery units, based on the creation and development of a mechanism for decision-making and operational support system, taking into account the four important conditions related to: personnel, financial systems, health service systems, and

critical/emergency situations.

For the past two years of transferring health centers to LGOs, MOPH has carefully undertaken the transfer step by step at the central, provincial and subdistrict levels.

In 2007, MOPH transferred 22 health centers to LGOs that were ready to take the transfer with health center staff's willingness to do so in all four regions of the country: northern, northeastern, southern and central regions. At the same time, HSRI had a monitoring and evaluation program, using the context-input-process-product (CIPP) evaluation model for the after action review (AAR) process to study the patterns of the transfer.

AAR was firstly used in the US Army in 1970 in order to develop the potential of the Army; and later in 1990 the business sector adopted this approach as it is the sector with a high competition level at all times for organizational survival and further development with a higher market share and profit. So this technique has gained much interest until now.

Advantages of AAR

1. Learning the fact that the success in working should not be appreciated from one side, but arising problems should be accepted; and more attention should be paid to resolving the problems than appreciating the

success. That is the opportunity to develop human resources for work development.

2. Practicing listening to colleagues' opinions and advice which will make you learn that "for every problem there is a way out".
3. Practicing working as a team.
4. This technique is applicable to every task, even routine work that seems unimportant such as answering the telephone, organizing a meeting, and a long-term multi-billion-baht project.
5. The people who join AAR are colleagues or team members; that is different from a "peer assistance and review" that asks for advice from an expert from outside the group.

How to conduct AAR

The AAR has four questions and seven steps. The four questions are:

1. What is the expectation from work?
2. What actually happen in real life?
3. Why are they different?
4. What are the lessons learned or methods for decreasing or resolving the difference?

Seven steps in AAR

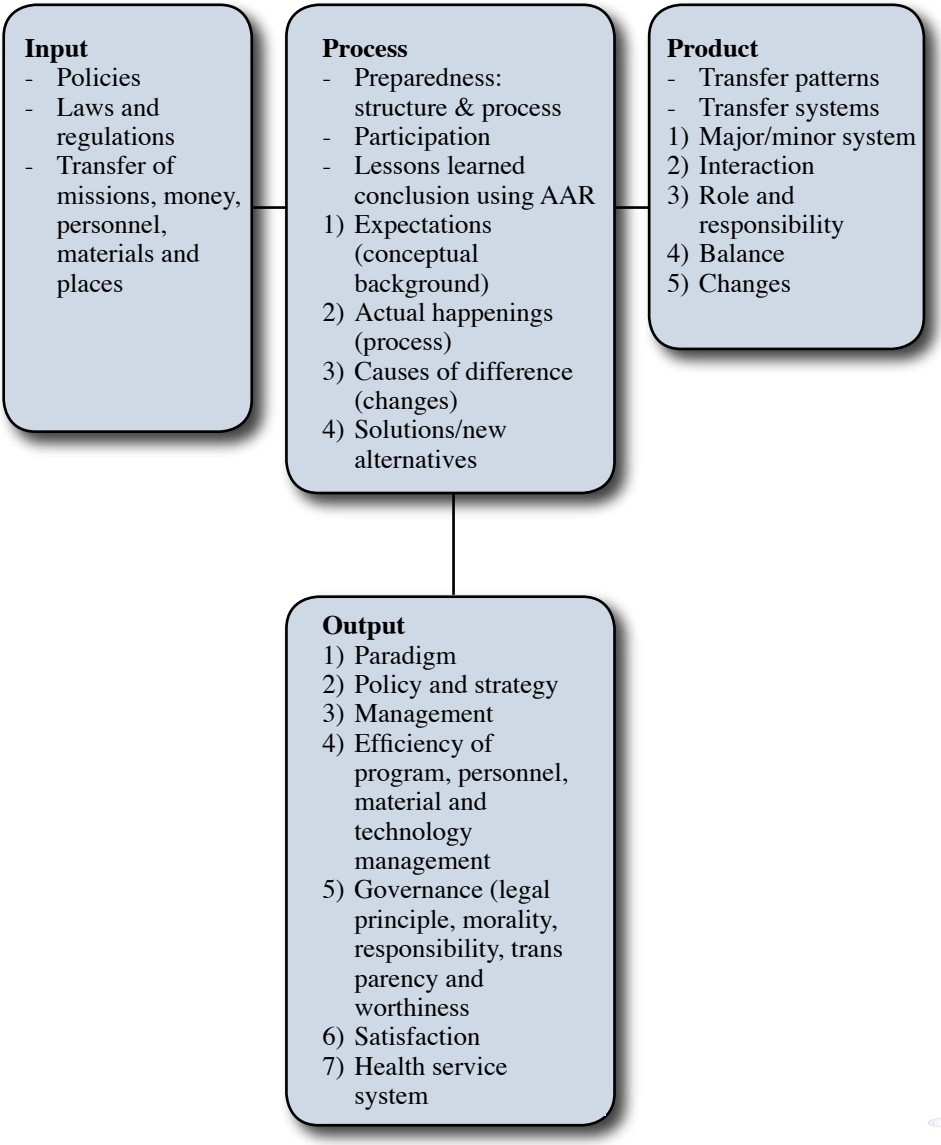
1. Perform an AAR as soon as the work is finished.

2. Do not blame each other; there is no boss-staff relationship but a friendly atmosphere.
3. Have "Mr. Facilitator" to facilitate and encourage discussions and ask questions to everybody so that they can express their views.
4. Ask for the things that we should have.
5. Turn back to look around and see what have actually happened.
6. What are the differences; and why are they different?
7. Take note for use as a reminder especially to see which methods have actually been used in problem-solving.

However, it should be noted that the answer or solution obtained from AAR is not the final answer. As time changes or the context changes, a new problem may arise at any time; and the solution may change too.

AAR is the way to review the work performance with regard to successes and problems with all officials concerned. It is the process for exchanging experiences, expectations, capabilities, and problem-solving methods while anything good can be retained. It is also a means for officials to express their feelings after the transfer, leading to an analysis to find out truths, differences, solutions or new alternatives for operations in the operating level's perspectives.

Fig. 2: Conceptual framework for evaluating the transfer of health centers to LGOs



10.2 The progress and obstacles in health decentralization to LGOs

In the health decentralization process with the transfer of health centers to LGOs, it was found that the local communities' contexts are different even though they have passed the transfer criteria jointly set by MOPH and the Local Administration Department. The transfer operations were carried out after each LGO had developed its preparedness plan following several steps by several committees at various levels.

However, there were some limitations in this matter such as the shortage of time, the communication with each locality, the information about locality, the work culture and attitudes, and the understanding of health system decentralization. The HSRI research team that conducted the follow-up evaluation in April 2008 found that, according to Mr. Somphan Techa-atik: "Overall, of all the transferred health centers, 20 were in good order with things running rather smoothly; a few problems were encountered in the transfer process. Only two places had a problem of non-confidence in the management capacity of LGOs; and thus they asked to be transferred back to MOPH. An interview with them revealed that they disagreed with the transfer as health programs require professional knowledge and skills and communicable disease outbreaks occur in a large area of more than one LGO requiring more budget and various mechanisms to cope with. Moreover, it was unclear about referring a patient to a hospital

that is under another agency, capacity building of health center personnel to keep up with new public health advancements, purchases/qualities of drugs and medical equipment/supplies under the situation of frequent changes in local politics and influence. These factors might affect the efficiency of health centers. For those who agreed with the transfer, they said that health services for the people would be better. Coping with health problems would be done more timely with people's participation in problem identification, plan submission, and budget allocation specifically for problem-solving. They can ask for the budget to build a new building and buy drugs and medical supplies in time without submitting a request to MOPH. The working process is smooth with fewer steps to follow. And they have a chance to get a higher position and salary. During the period of evaluation, many other MOPH health centers can express their willingness to get transferred LGOs".

In September 2008, HSRI organized a forum on lessons learned from the transfer of health centers to LGOs, at which Dr. Suwit Wibulpolpresert, Chairperson of the Health Decentralization Research and Development Committee, said that MOPH had set three conditions for the transfer. Firstly, the LGOs that would take the transfer must have been certified that they had practiced the good governance principles and the Decentralization Committee had agreed to that. All LGOs in the first round passed this criterion. Secondly, health center staff must be willing to be transferred, i.e. at least half of them must be willing to do so. And

thirdly, the LGOs had to jointly invest in health services. After that the MOPH commissioned an assessment of the transfer based on the standard of LGO's readiness so the lessons learned would be used in the next round of transfer. The MOPH was pleased to support the transfer concept if the operation was found satisfactory. However, if there are any health centers wishing to return to the old system, MOPH is pleased to take them back.

Mr. Somphan concluded that there were some problems of the transfer. For example, there was no one directly overseeing the transferred health centers; and the staff were unhappy about working as it was like they were cut off from MOPH, like being an excess unit of the TAO. At that time, they were using the budget from MOPH as there were no subsidies from TAOs as expected. LGOs had no information about what health officials had done. For instance, when the people lodged a complaint with the LGO about mosquito spraying, health officials would be ordered to do so immediately without inquiring whether such a thing had been done or not. That kind of practice had decreased the people's trust in health center staff, resulting in their being discouraged. For the paper work, especially the financial system was more complex, which consumed too much time of health officials, and thus they had no time to resolve health problems in the communities. Some health officials had a problem with providing health care to the patient requiring referral for medical consultation; there was a problem of coordination between the contracted unit for primary care (CUP) and the primary care units

(PCUs) as they felt that PCUs were cut off from the former healthcare system.

At the forum, recommendations were made for resolving such problems. For example, to resolve the problem of personnel shortages, high school graduates from each locality should be selected and given a scholarship to study in the field of public health so that they would come back to work in that area. The problems of policies, laws and regulations related to decentralization should be resolved by TAOs going directly to coordinate with central agencies (MOPH and the Ministry of Interior) and seek advice on the transfer process. Regarding the untimely budget transfer, especially operating and personnel costs, a rule should be issued to allow advance payments by TAOs and some money from the Government Pension Fund should be used for this purpose.

Most recently, the HSRI evaluation of the pilot scale transfer of health centers to LGOs (September 2007 – October 2008) revealed three major conclusions as follows:

1. The factors that affect the people, health centers and LGOs.
2. The problems and obstacles in the operation of transferring health centers to LGOs.
3. The suggestions for further development.

The factors that affect the people, health centers and LGOs comprise four issues: paradigm, policy and strategy, management, and efficiency.

Paradigm

All concerned should:

- See the value and importance of the transfer and expect the smooth operation.
- Have a perception of four dimensions of health: physical, mental, social and intellectual.
- Establish a better cooperation mechanism among LGOs, health centers, VHVs, and the people.
- Promote the continuous collaboration among existing health networks.

Planning and strategy

- Revise the policy, strategy, and activity plans for health and environmental development to become a good example of health mission transfer with personnel's capacity building.

Management of health programs, budget, personnel, assets, material and medical equipment/supplies

- Provide freedom in the administration of health centers as practiced previously.
- Conduct an audit and prepare lists of assets, equipment and supplies; and then get all of these handed over to the LGOs.

Efficiency

- The health services after the transfer as well as the satisfaction with health center's service standards are significantly better than before the transfer.

The problems and obstacles in the operation of transferring health centers to LGOs are related to the management at all levels: policy, administrative and operational:

Policy level

- MOPH administrators did not give a clear policy on health decentralization, resulting in a lack of unity and a halt in the transfer operation.

Administrative level

- The decisions and directives from the central and local administrators were unclear/unwritten and sluggishly communicated.
- Personnel had difficulty in asking for a transfer; some wanted to transfer back to MOPH.

Operational level

- The adjustments to the new system were problematic in the beginning with regard to the operational, financial, and personnel matters (related to instructions, receipts, and disbursements between contractual partners and NHSO).

- Personnel had more responsibilities but the number was insufficient.
- Job insecurity of health center employees and officials, contract extension, promotion, loss of right to changes in position, professional licensing, and assignments to provide medical services.
- Coordination problems between the transferred and non-transferred health centers.

Based on the evaluation of the operation of transferring health centers to LGOs, improvements are needed with regard to policy, mechanism and practice as follows:

Policy recommendations

1. The Ministry of Public Health and the Ministry of Interior should decentralize the authority to LGOs or community organizations in order to create administration efficiency in health service provision for the people.
2. MOPH should transfer health centers to LGOs at the municipal level.
3. MOPH and LGOs should develop and improve laws and regulations in order to facilitate people's health development at the local level.
4. MOPH and LGOs should jointly revise the health mission transfer manual so that the procedures are clear in practice.

5. For the next round of transfer, if any, MOPH should have a clear policy, procedures for every party to follow within a suitable time frame, and a clear annual transfer action plan.
6. MOPH and LGOs should set up a system for preparation and adjustments for the new situation.
7. MOPH and LGOs should set up a coordination center to support the transfer of health centers systemically and continuously.
8. MOPH and LGOs should prepare public relations media for the public and local communities emphasizing the values, ideology and benefits of health center transfer.
9. LGOs should develop health personnel systemically through having a health personnel development plan, sending local high school graduates to study in the health field required by the communities, and deploying those who have graduated to work in the communities with job security.
10. LGOs should set up a health development plan for implementation at least once a year with the participation of the academic, government, civic and local political sectors, based on the local health situation. And a system should be established for knowledge sharing in making policy recommendations for people's health promotion.

11. LGOs should collaborate with NHSO and the civic sector in systemically managing local health service systems for community well-being through, for example, developing a local health security fund and a community or subdistrict health fund.

Mechanism recommendations

1. Establish a technical support and coordination mechanism with the participation of all sectors.
2. Set up a coordinating committee comprised of repre - sentatives from the civic sector and experienced persons in various fields to monitor and examine subdistrict-level operations.

Practical-level recommendations

1. Before the next round of transfer
   - Study the organization culture and analyze the strengths and weaknesses of the transfer.
   - Organize a public forum to present the feedback about the transfer and seek people's opinions and joint decisions.

2. After the transfer of health centers
   - LGOs collaborate with civic groups in identifying local problems and needs.
   - Establish a policy and strategy for developing plans/projects to be submitted for inclusion in the LGO's annual budget appropriation rules.

As a result of health decentralization, it has been shown that in many areas this effort needs social movement and intellectual empowerment with adequate financial support as well as other resources in the existing social context. It is a desirable health system for local citizens living in many localities in Thai society. It is health decentralization which comes in many forms, not a fixed formula which can be used in all localities.

Appendix

Ten Important Issues about the Transfer of Health Centers to Local Government Organizations in Thailand and Guidelines for Health Decentralization
by the Ministry of Public Health, Thailand
December 2007

The Ministry of Public Health (MOPH) has been implementing decentralization for health in accordance with the Action Plan and Protocols for Health Decentralization to Local Governments, B.E. 2544 (2001), and the resolution of the Committee for Decentralization to LGOs at its 2nd meeting of 2007 (no.2/2550). Consequently, as of November 30, 2007, 22 health centers have been transferred to 14 LGOs at the subdistrict *(tambon)* level and 4 municipalities in 16 provinces. This development has led to many questions and issues raised by stakeholders from all levels including the management, implementers and academics which may have occurred from incomplete information.

Furthermore, there have been attempts to spread false information among public health officials which may have resulted from genuine misunderstanding or malicious intents.

In order to close the gap of understanding of this issue, MOPH has compiled all the issues raised and summarized into 10 main issues along with the facts and accompanied by relevant documents. This publication intends to accurately inform the public regarding the devolution of health centers to local government organizations and serve as guidelines for the next stage of policy implementation.

MOPH would like to emphasize that decentralization is the direction for this country's development which has been widely accepted by the public and explicitly stated in the Thai Constitution. As a result, solidarity is required from all public health officials in order to develop the infrastructure and mechanisms for the transfer of health centers with the aim of maximizing the benefit for the people.

Mongkol Na Songkhla, M.D.
Minister of Public Health

Ten Important Issues about the Transfer of Health Centers to Local Government Organizations in Thailand December 2007

Issue 1

Why did MOPH swiftly execute the transfer of health centers to local government organizations (LGOs)?

There have been letters circulated to all the provinces asking health center officials' opinions regarding this issue. Does this mean that decentralization or devolution is imminent?

Factual information

1.1 MOPH did not try to do this in hurry, but in fact wanted it to occur gradually and was even criticized for not following the 2001 action plan for decentralization which was prepared according to the 1999 Plans and Process of Decentralization to LGOs Act. This is particularly the case for the devolution of public health services as MOPH is yet to introduce a law for the setting up of Area Health Boards (AHBs) for enactment by the parliament, and no transfer of health centers had taken place since 2001. The standpoint of MOPH is that major structural adjustment as a result of the introduction of the Universal Healthcare Coverage (UC) scheme is needed. However, MOPH has been constantly pressured by the Decentralization to LGOs Committee to transfer health centers. As a consequence,

MOPH started to brainstorm and gather other information to develop appropriate guidelines in the current context which would be put forward to the Decentralization Committee for consideration.

1.2 At the meeting of the Decentralization Committee which was held on March 15, 2006, it concurred with the MOPH's proposed decentralization guidelines for the transfer of health centers and asked MOPH to press on with the devolution of public health services to LGOs that have the jurisdiction in their respective areas. However, MOPH decided to take some time to consider how to effectively implement the plan. By the end of 2006, the then government pushed forward with functional devolution of all ministries' powers and allocation of 35% of its revenues to LGOs. As a result, the Permanent Secretary for Public Health, Dr. Prat Boonyawongwirot, issued a directive (No. 715/2549) on August 17, 2006 to appoint a committee to set up appropriate mechanisms, processes and methods for assessing the readiness of LGOs to accommodate the transfer of health centers. The committee was chaired by Dr. Suwit Wibulpolprasert and three sub-committees were formed, consisting of representatives from the Provincial Chief Medical Officers Club, district health offices, community hospitals, general hospitals, health centers, local civic groups, the Office of the Permanent Secretary for Public Health, the Department of Health and LGOs at all levels.

1.3 More than 10 committee and sub-committee meetings were convened in order to develop a handbook for public health functional devolution to LGOs along with a plan to study the experience of this devolution. The handbook was put into practice in the field on more than 10 occasions in order to seek opinions for revising the guidelines. For this purpose, more than 300 people were invited to attend the meetings on 14–16 January 2007 in order to gather as much input as possible. The guidelines were finally approved on February 14, 2007 by the Minister of Public Health after a slight change had been made to improve the plan.

1.4 In order to facilitate the initial stage of transfer of health centers to LGOs, a pilot scheme was initiated. This involved the transfer of health centers only when more than 50% of the staff agreed to do so and the LGOs at the subdistrict level were classified as those with high performance, i.e. they must have received a good governance award and taken part in organizing community health funds. After screening, it was found that 35 health centers in 30 different subdistricts or municipalities met the criteria and were put forward to the Decentralization Committee for approval. The list was approved on April 25, 2007 (after the meeting 2/2549).

1.5 After the approval, the Decentralization Committee issued a directive (No.7/2550) on July 20, 2007 to appoint a sub-committee for supporting the public health functional devolution

to LGOs. As a result, MOPH circulated a letter to all the 22 provinces, where the 30 health centers were located, along with the above directive asking each province to assess the readiness of such LGOs and implement the guidelines once they have passed the readiness assessment criteria. Most of the provinces proceeded with the implementation except for some where they awaited the results of the election of local council members. As a result, MOPH decided to transfer only 22 of the original 30 health centers on November 30, 2007.

1.6 At the same time, other than transferring health centers, MOPH started to implement health decentralization in accordance with the Decentralization Plan, such as the drafting of law to change Patong Hospital in Phuket province to be a public organization like Ban Phaeo Hospital. The draft is currently under the consideration of the Public Sector Development Committee and the result is expected momentarily.

1.7 MOPH is pressured to act in accordance to the Constitution, the Decentralization Act, and the directives of the Decentralization Committee. As a result, it is in MOPH's view that the agency has acted and followed the protocols and laws. Also MOPH has taken into account the readiness and willingness of all stakeholders in order to ensure the maximum benefit for the people.

MOPH has spent two years to successfully initiate the transfer of the first batch of health centers which is much slower

than that undertaken by the Ministry of Education.

1.8 The Decentralization Committee and the Public Sector Development Committee have asked MOPH to develop an action plan which clearly stated the timeframe and objectives of the transfer of health centers and hospitals. The fact that MOPH asked the above provinces about the fact on the health centers and LGOs was merely for information purposes only. This would allow the implementation to occur smoothly and in stages according to the readiness and willingness of all parties involved, and if the staff did not want the devolution to take place or the LGOs did not pass the assessment criteria, then the pilot scheme could not take place there.

Issue 2

Was the transfer of 22 health centers to LGOs on November 30, 2007, done according to the 2007 Constitution and the 1999 Decentralization Act?

It has been mentioned that the 2007 Constitution does not include decentralization of public health in any of its articles; and the 1999 Decentralization Act does not have any plans about the devolution either.

Factual information

2.1 The 2007 Constitution clearly mentions about decentralization in Chapter 5 (Directive Principles of Fundamental

State Policies), Part 3 (State Administration Policy), and sections 281–283. Furthermore, the 1999 Plans and Process of Decentralization to LGO Act which is still in effect (except for the part which stated that at least 35% of State revenues must be allocated to LGOs). Because of this, the decentralization of public health functions was done in accordance with both of the above laws.

2.2 The 2001 Decentralization Plan is still in effect and states that regional health services should be devolved to become a health service network under an Area Health Board (AHB) or a regional health committee in each locality. The ABB would become a legal entity according the law to be drafted by MOPH. The legal entity would allow the committee to be able to accommodate the transferred health service providers and the supporting law was supposed to be drafted and enacted by October 1, 2005. However, MOPH has not taken any steps to implement this because of the major structural reform required following the introduction of the universal healthcare scheme, and because of this, MOPH was not able to follow the Decentralization Plan developed in 2001.

2.3 The Decentralization Committee has constantly and closely followed up on the implementation of health system decentralization in order to ensure that the law and the Decentralization Committee's policies are abided by. As a result, MOPH has organized four brainstorming meetings in order to

revise the guidelines for health system decentralization in compliance with the current context which may have been changed. Many participants attended the meetings including representatives from local health offices, hospitals, health centers, and local governments. The sessions took place between December 2005 and February 2006 and the last session, which was organized specifically for public health functional devolution to LGOs, was chaired by the Minister of Public Health himself.

After that, the secretary of the Decentralization Committee put forward the proposed guidelines to the Committee for consideration; the guidelines were later approved on March 15, 2006. As a result, the functional devolution can occur in different forms, such as the devolution to LGOs or the transformation of health centers into a network of service providers in a form of public organization.

The approval by the Decentralization Committee was within its power as this could be considered as an adjustment to the action plan related to MOPH which was legally supported by section 33 of the 1999 Decentralization Act. The Office of the Permanent Secretary, MOPH, has taken the steps to clarify the legal status of this action as authorized by the Decentralization Committee's chairperson as follows:

2.3.1 The action plan for decentralization to local governments of 2001 was still in effect.

2.3.2 Section 33 of the Plans and Process of Decentralization to LGOs Act prescribes that: "In the case of changes in circumstances during the period when the plan is still in effect, the committee is authorized to modify it to adapt to those changes".

2.3.3 MOPH could not implement the devolution in the form of network to the AHB and local governments according to the 2001 guidelines because of the major structural changes required following the introduction of the universal healthcare scheme.

2.3.4 In order to adapt to the changes in circumstances, MOPH has proposed a number of alternative methods to the existing guidelines to the Decentralization Committee which were approved on March 15, 2006. These methods include the devolution to tambon (subdistrict) administrative organizations (TAOs), in a form of a service network, a public organization or a service delivery unit (SDU) so that it will be flexible to adapt to the needs of the population.

2.3.5 The Decentralization Committee approved the recommendations proposed by the special sub-committee for public health functional devolution to local governments on April 25, 2007 which authorized the transfer of 35 health centers to the LGOs with a high level of performance and willingness to take the transfer. Each of the LGOs would also need to be assessed

inaccordance to the approved handbook before the devolution occurs.

The content of items 2.3.4 and 2.3.5 can be considered as adjustments to the existing plan in order to adapt to the changing environment during the period when the plan is still in effect as stated in item 2.3.2.

2.3.6 One of the basic principles in the 2000 Decentralization Plan is that budgeting, human resources and asset management should be taken into account when considering the functional devolution to LGOs. Because of this, the transfer of health centers would be regarded as the transfer of assets and staff for a specific mission. As a result, the staff would still enjoy all the rights and benefits as guaranteed by law.

2.4 As there were still doubts about this issue which required clarification, the Office of the Permanent Secretary, MOPH, issued another letter emphasizing the fact that everything was done in accordance with laws.

2.5 In order to create a clear understanding among MOPH's high-ranking officials, the Public Health Minister invited the permanent secretary, his deputies and other senior officials to attend a meeting on November 27, 2007 in order to bridge the gap of understanding and to clarify the issues on this matter.

Issue 3

What are the stages for implementing devolution and how it would be achieved? When would devolution be considered as complete?

Factual information

The Decentralization Committee specified that the process of devolution should occur at the provincial level. A directive from the Committee was issued to appoint a provincial sub-committee for supporting public health functional devolution on July 20, 2007, chaired by the provincial governor with the provincial chief medical officer as secretary, to authorize the devolution once the readiness assessment was passed.

In accordance with the 2000 Decentralization Plan, section 6.1.2(8) stated that the devolution to LGOs would involve the transfer of functions, budget, assets and human resources as follows:

1. The devolution of functions should be done in a way that can be managed at the provincial level. In this case the Permanent Secretary for Public Health would delegate the authority to the provincial chief medical officer to oversee and sign off on the process of devolution to LGOs. **As for the transfer of health centers to LGOs, the formal transfer will take place on November 30, 2007, and the MOPH Permanent Secretary will be signing off on the process himself.**

2. The transfer of budget/financial responsibility and other assets would be carried out in accordance with the devolution handbook, pages 132–136. The process is expected to be completed by December 2007.

3. The transfer of human resources would be achieved as stated in the handbook, pages 137–139 which would be quite similar to the previous transfer of other MOPH government officials to LGOs. The Office of the Civil Service Commission has issued a letter authorizing the transfer of government officials working in the health centers to LGOs. The list would then be approved by MOPH which would finalize the whole process. This is expected to be completed by December 2007.

Issue 4

The transfer of the first 22 health centers on November 30, 2007 which was overseen and signed off by the respective provincial chief medical officers, not by the MOPH Permanent Secretary. As it involved the transfer of MOPH's assets to LGOs, was the transfer legal?

Factual information

1. The meeting of high-ranking MOPH officials on November 27, 2007 concluded that the MOPH Permanent Secretary would be the person to sign off on the devolution process to LGOs on November 30, 2007 in order to signify clarity and confidence.

2. Unfortunately, the Permanent Secretary could not attend the ceremony as he was called for a Royal audience. As a result, Dr. Suwit Wibulpolprasert was assigned to replace the Permanent Secretary at the last minute. However, before a conclusion can be made, there was a loss in communication and it remained unclear at the time as to who would be responsible for the hand-over of health centers.

3. Because of the pressing and unclear nature of this matter as the Permanent Secretary failed to assign this responsibility to anyone in writing, The Minister of Public Health decided to exercise his power in accordance to the 1991 Organization of State Administration Act, as amended in 2007, and appoint Dr. Suwit Wibulpolprasert to take the responsibility on behalf of the Permanent Secretary for this mission.

As a result, the handover of the health centers to the LGOs was done in a manner which conformed to the laws.

Issue 5

Can a local government transfer health professionals who work at a transferred health center in accordance with the MOPH rules and regulations on health professional registration of 1996 (Document 11)? Also, can these health personnel be under the authority of professional regulators from MOPH?

Factual information

As this issue was of legal nature, MOPH set up a legal

committee chaired by Dr. Wichai Chokwiwat to clarify and facilitate the decentralization process. The committee convened a meeting on November 8, 2007 and concluded that the problems with human resources during the devolution process can be addressed by the following measures:

1. MOPH should issue a directive declaring the TAOs to become "other" LGOs in accordance with the 1996 MOPH regulation regarding personnel working under a number of agencies outside MOPH's jurisdiction. This is because TAOs are not listed in this MOPH regulation. This would not be a problem for municipalities and provincial administrative organizations (PAOs) as they are already covered by the aforementioned regulation.

2. MOPH should issue another directive authorizing provincial chief medical officers and hospital directors who have health centers under their supervision to be the responsible persons supervising the transferred health officials who work in the health centers in their areas. The two directives have already been circulated to all the provinces involved.

3. In order to create a common understanding of all stakeholders, MOPH has proposed that an agreement should be signed between MOPH and the LGOs regarding the direction of the management of health services. This would act as a means to promote understanding between both parties and not legally

binding. Because of this, the provincial chief medical officers would be able to sign the agreement without the delegation of authority from the Permanent Secretary.

Regarding the issue of professional violation, the LGOs would be the main responsible party similar to what would normally occur if the same thing happens under MOPH's jurisdiction.

Issue 6

There is an issue of subsidy and the accounting system of health centers because the state regulations specify that subsidies must be spent in accordance to the rules and regulations of the main ministry. As the health centers have been transferred to LGOs, MOPH has no direct control over them; so they will need to set their own rules and regulations for spending their subsidies as done at health centers under the Bangkok Metropolitan Administration.

Factual information

The Director-General of the Department of Local Administration circulated a letter to all of the provincial governors regarding the guidelines for managing transferred health centers which clearly specified that the management of budget and the spending of state assets would be carried out according to the rules and regulations of the Ministry of Interior. As for accounting and auditing, it should be done as set out by the Department of Local Administration which dictates that: *"When*

the health centers receive funds from hospitals which take part in the universal healthcare scheme in conforming to the announcement of the National Health Security Office, the funding for local governments and other subsidies will be accepted in accordance with the law, rules and regulations, or directives of MOPH until further notice."

At present, the Department of Local Administration is currently drafting new rules and regulations which are relevant to the transfer of health centers by working closely with the Bureau of Policy and Strategy (BPS), MOPH.

Issue 7

How would MOPH evaluate the devolution process?

Factual information

The committee responsible for selecting mechanisms, processes and methodology for LGO readiness assessment has set up three sub-committees. One of which is the sub-committee on studying and development of assessment system which is chaired by the deputy director of the Health Systems Research Institute (HSRI) and is responsible for the synthesis of research results on the experience of the initial transfer of all health centers. As there are already people working in the field, a preliminary progress report is expected to be produced in January 2008. This would allow the sub-committee to identify any urgent obstacles which the pilot project encountered and quickly find a solution. When the study is complete, the final report is expected to be used as an

input to further develop the transformation system for the subsequent transfers of health centers.

As the evaluation would be carried out from the early stages on all of the transferred health centers by HSRI in collaboration with universities, it will be of the highest standard without bias.

Issue 8

Once a health center has been transferred, how would it seek help and advice when a problem arises? If it cannot solve such a problem, would MOPH consider taking it back?

Factual information

MOPH has assigned the Health Decentralization Support and Development Section of the Bureau of Policy and Strategy to be the agency providing technical support and coordinating with other agencies in dealing with any problems that might occur during or after the transfer and give advice on other form of decentralization. The group can be reached via telephone and e-mail.

MOPH is confident that the devolution pilot scheme has been implemented carefully and prudently which involved a thorough screening process and allowed the staff to have their say about this issue. As a result, the implementation of the pilot scheme is expected to be relatively smooth and the experience from the scheme will be a major contribution to the development

of future health decentralization.

However, if there are any problems encountered during or after the implementation leading to widespread damages which cannot be resolved, MOPH are ready to step in and regain control of the health centers if all parties agree.

Issue 9

Would health personnel's benefits be reduced if their health centers are transferred as they are no longer with MOPH?

Factual information

1. The benefits for the transferred personnel are defined in clause 32(4) of the Decentralization Plan which will not be less than the benefits received before the devolution. There will be a guarantee for career advancement, remuneration, welfare and other benefits including being a member of the Government Pension Fund which is clearly stated in the handbook, pages 97–105.

2. The benefits of being a member of the funeral welfare fund will be upheld but the member will need to inform the funeral welfare office of the change in address. This is also the same with the membership of the MOPH Savings Cooperatives.

3. Other benefits include annual bonuses which are given in addition to the current wages.

4. The direct remuneration for providing health services cannot be applied to local government personnel because their financial source is from the local fund. However, local officials are entitled to the same benefits enjoyed by other central government officials.

Issue 10

At what stage of the 2nd draft of the decentralization action plan are we at? How likely is it that the transfer of health centers would occur according to the 2nd draft?

Factual information

1. At the meeting of the Decentralization Committee held December 3, 2007, the 2nd draft of the Decentralization Plan was approved and is now waiting for the approval of the Cabinet. Once it is cleared, the draft would be put forward to the parliament for endorsement.

2. The contents of the draft regarding health centralization are summarized below.

2.1 Functions and budgeting of health service, including health promotion, disease prevention, rehabilitation and primary health care, and health centers together with the staff are to be transferred to LGOs. However, if they fail the readiness assessment, these responsibilities should be transferred to the provincial administration.

2.2 The health care functions at the community or general hospital level will be decided by the LGOs whether they are ready to take these functions if they conform to the regulations set by the Decentralization Committee and MOPH, or to purchase these services from another provider, public or private.

2.3 Health services at the level of general hospital or above will be arranged by MOPH, or if the LGO is considered to have a very high performance level, MOPH may consider partnership between MOPH and the LGO in providing health services, or allow it to assimilate the functions and/or purchase them from another provider.

2.4 Other functions including disease control and health promotion are to be carried out by LGOs, in partnership with other LGOs, or in partnership with the central government.

2.5 The devolution will be carried out under the principle of "work progress (work done), money progress (increased income), and position progress (better career)" which also guarantees the rights and welfare of government officials to at least the same level as before.

Guidelines for Health Decentralization (2005)

1. History

1.1 The Plans and Process of Decentralization to LGOs Act of 1999 which was passed as a result of the 1999 Constitution led to the development of the Decentralization Plan of 2000 and the subsequent Action Plan which was endorsed by the parliament.

1.2 As for the decentralization of health care, the action plan of 2002 specified two forms of decentralization:

1.2.1 An Area Health Board (AHB) in each locality should be formed as a mechanism to accommodate the devolution of health services in a network form. The functional devolution of the universal healthcare scheme should be transferred to this entity by 2003.

In 2002, AHBs were set up in a majority of provinces; however, the implementation came to a halt because of a more urgent need in restructuring MOPH to accommodate the universal healthcare scheme.

1.2.2 The devolution of public health to LGOs including 34 functions from 7 different departments has been implemented to a certain extent but is still below the expectation of the 2002 action plan. The results of the implementation as of February 2005 are summarized below:

1) Functions which have been devolved: 7 missions.

1.1) The Office of the Permanent Secretary, MOPH, has transferred one function which is the provision of subsidies to promote health behaviors. The 2004 budget worth 525 million baht for the scheme was transferred to LGOs.

1.2) The Department of Health has transferred six functions:

1.2.1) Intervention to tackle problems of under weight in children for fiscal years 2001 and 2002 (286.8 million baht).

1.2.2) Provision and development of clean water supplies was transferred to LGOs and other functions to the Ministry of Natural Resources and Environment. The total budget for this function was 832.5 million baht.

1.2.3) Health promotion for mothers and children.

1.2.4) Health promotion for school-aged children and minors.

1.2.5) Health Promotion for the working-age population

1.2.6) Health promotion for children and the elderly

(Remarks: Functions 1.2.3-1.2.6 did not have any funds attached to them because the campaigns had already been done.)

1.3) Functions which have not been transferred: 27 functions (some of which may be altered during MOPH restructuring and the introduction of universal health care.)

1.3 In summary, even though progress has been made with regards to health system decentralization; however, the target set by the action plan of 2002 has not been met and a lot have changed since then. As a result, the guidelines for health system decentralization should be reviewed so that the implementation can be carried out effectively and efficiently in order to better serve the people.

1.4 In order to ensure clarity and continuity in the implementation process, MOPH organized four brainstorming sessions which are outlined below:

1.4.1 The 1st session on December 6, 2005 was limited to brainstorming of health professionals from health centers, community hospitals, and other hospitals. An alternative decentralization method was also proposed.

1.4.2 The 2nd session on December 22, 2005 included all stakeholders from all sectors including representatives from the central and local governments, and the Decentralization Committee which led to some revisions of the initial recommendations proposed at the 1st meeting.

1.4.3 The 3rd session on January 5, 2006 involved only high-ranking MOPH officials and further revision was made and the 4th session was organized at the request of the Minister of Public Health.

1.4.4 The 4th and final session involved all the stakeholders and was chaired by the Minister of Public Health. This session was also organized with the special sub-committee

for the management of the devolution of public health functions on February 10, 2006.

2. Principles of health system decentralization

This will be done according to the principles and objectives of the 1997 Constitution, the 1999 Plans and Process of Decentralization to LGOs Act, and the 2000 Decentralization Plan as follows:

2.1 Maximize the benefit for the people by stressing sustainable development of the capacities of local governments in decision-making, better addressing existing health problems before the pre-decentralization period in order to promote equity and high quality services within the health system.

2.2 Create a system which is dynamic, flexible and responsive to the changing environment leading to a learning process which will allow the decentralization process to occur naturally and continuously.

2.3 Create a system which has the mechanisms and processes to allow and strengthen participation from all stakeholders, especially the public. This means that the consultation process would be done based on the ideology and ability to reconcile.

It should be noted that the aim to allocate 35% of the central government revenues to local governments is not the main goal of health system decentralization.

3. The scope of function for devolution

The functions to be transferred to local governments can be classified into two groups:

3.1 Nature of functions such as curative care, health promotion, disease prevention and rehabilitation.

3.2 The scope of the functions which may be specific to a certain individual, household or it may be limited to a geographical area, such as to a certain area under the jurisdiction of a specific local government.

4. The types of decentralization

There are four types of decentralization which could be mixed as follows:

4.1 The local government acts as fundholder and purchaser of services from public and/or private providers which means that the local government must develop the capacity in resource gathering and to ensure good standard of health services.

4.2 The local government teams up with regional/central government units to provide services, such as joining the universal healthcare scheme or the social security fund.

4.3 The local government performs certain functions themselves such as taking responsibility for community health promotion schemes.

4.4 The local government performs all functions themselves by acting as the owner and manager of all health service functions.

The local government may choose to implement which scheme, to what extent, and when according to the principles laid down in 2.

5. Different forms of decentralization to local governments

Decentralization to LGOs can occur in many forms depending on the readiness, the suitability of the area and the situation, such as:

5.1 Partial devolution which can be done by transferring the functions of health centres to a TAO while transferring the functions of a community hospital to a PAO.

5.2 Devolution of services into a service provider network which consists of different levels of health care (primary, secondary, and tertiary) and the responsibilities are transferred to a LGO or another type of local agency.

5.3 Forming an autonomous public organization in partnership with the local government or transforming a providers' network into such an organization.

5.4 Setting up a service delivery unit (SDU) which would get hospitals transferred to the SDU or their functions transferred to a Health Facility Authority which would be an autonomous public organization under the supervision of MOPH and the local government.

The implementation of decentralization forms 5.3 and 5.4 may not be true devolution as the LGOs do not have ownership over those functions.

6. Supporting mechanisms and processes for decentralization

In order to effectively implement decentralization according to the principles, scopes, types and forms as set out in sections 2, 3, 4, and 5 above, the following mechanisms and processes have been identified as a supporting tool for decentralization:

6.1 Mechanisms and processes for decision-making which promote the participation of all stakeholders from different levels in order to consider and choose how a reform process should be carried out which will eventually lead to a form of decentralization which may differ from one area to another.

At the national level, this will be done by a special sub-committee on health system decentralization under the central Decentralization Committee.

At the provincial level, an Area Health Board (AHB) may be used; the AHB would be chaired by the head of the provincial government and consists of representatives from LGOs.

At the district level, a District Health Board may be set up with the mayor as chairperson.

At the tambon (subdistrict) level, a Tambon Health Board may be set up with the president of TAO as chairperson.

6.2 The supporting mechanisms and processes for the implementation of devolution which would support the tools in section 6.1 and promote capacity strengthening of LGOs are listed below:

6.2.1 General support which will facilitate all types of devolution, including: the capacity development of LGOs in

health, the development of health information system management, the development of IT network between health service providers, etc.

6.2.2 Special support according to the type and form of devolution, such as the enactment of an Autonomous Public Organization Act, the law which allows the AHB to become a juristic entity, and the development of rules and regulations for LGOs to manage the devolved functions.

6.3 Structures of mechanisms consist of the following:

6.3.1 Central agencies which consist of the Health Decentralization Support and Development Section of the MOPH Bureau of Policy and Strategy as the core agency which coordinates with other supporting agencies such as the Decentralization Committee and LGOs.

6.3.2 Regional agencies which will be coordinated by provincial public health offices (at the provincial level), district health offices (at district level) and health centers (at the tambon level).

7. Important conditions for implementation

In order to implement health system decentralization, the important conditions which will need to be addressed are related to benefits. The following measures are put in place before the handover as an effort to minimize its impact.

7.1 Health professionals might be affected by decentralization with regard to their lifestyle and career advancement; and so the implementation should be carried out

carefully, focusing on the fact that the rights and benefits enjoyed before the decentralization period will not be reduced in any way. And human resource development is a policy in which the government will continue to actively pursue. More importantly, the information must be communicated in such a way that they understand in order to ensure that the reform occurs as smoothly as possible.

7.2 The system for financial management will be required to manage funding from different sources in a clear and transparent manner in order to promote confidence and sustainability of the system.

7.3 Health system management during emergencies and crises, which would have an impact on national security, would require the mobilization of health resources from different agencies. For example, during an epidemic, there must be a system which can inspire confidence that the mobilization of resources can be done quickly and effectively.

7.4 Management of health service provision must be done in such a way that it promotes connectivity between providers which can provide a range of services including health promotion, disease prevention, curative and rehabilitative interventions to the community as a whole. This means that there may be a need for special service provision for certain areas, such as those along the border, highlands, etc.

8. The next phase of implementation

8.1 Revise the guidelines for the decentralization of health system as directed by the Decentralization Committee.

8.2 Make adjustment to the 2002 action plan for decentralization to conform to the above guidelines.

8.3 Develop an action plan and implement it accordingly once it has been revised and approved.

The guidelines for health decentralization are summarized in the diagram below: