

Devolution of Health Centers and Hospital Autonomy in Thailand: A Rapid Assessment

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Abstract

This research was undertaken to evaluate the devolution of health centers and hospital autonomy in Thailand. The assessment team conducted literature and document review and interviews with the Provincial Health Office (PHO), District Health Office (DHO), Provincial Governor's Office and Department of Local Administration (DLA), the Contracting Unit for Primary Care (CUP) Hospital, Tambon Administrative Organization (TAO) and health center (HC) staff in five devolved health centers and five non-devolved health centers and a hospital-owned primary care unit (PCU) in six provinces. In relation to the three stated objectives of decentralization, the team's findings concerned changes in flexibility, responsiveness and participation following devolution of health centers to TAOs.

Findings on the devolution of health centers were as follows: (1) increased management flexibility: three of the devolved health centers had positive perceptions of improvement in management flexibility, in the sense that future decision-making is expected to be faster and there should be greater scope for initiative; (2) increased responsiveness to the community and to patients: three devolved health centers could point to a number of ways in which service delivery had improved and new services had been provided in response to the needs and preferences of the community; and (3) increased participation of the community: all five TAO CEOs and Councils were active in obtaining community input on health and health service delivery.

Findings on hospital autonomy were as follows: (1) the Ban Phaeo Hospital model was found to be well-designed, clear and consistent. Its performance in improving service quality and increasing its revenue had been highly successful; (2) community support for the hospital has been a major success factor but mechanisms for patient and community feedback on priorities and service delivery performance could be strengthened to improve accountability and better align service priorities with the needs and preferences of users; (3) this model should be replicable in other MOPH hospitals, except small community hospitals serving small, dispersed populations.

Key words: evaluation, devolution of health centers, hospital autonomy

บทคัดย่อ

การศึกษาแบบเร่งด่วนในการถ่ายโอนสถานีนอมาัยและโรงพยาบาลออกนอกระบบ

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การศึกษาประเมินผลการถ่ายโอนสถานีนอมาัยจากกระทรวงสาธารณสุขไปยังองค์กรปกครองส่วนท้องถิ่น (อปท.) และโรงพยาบาลออกนอกระบบในครั้งนี้ เป็นการศึกษาแบบเร่งด่วน ใช้เวลา ๑ สัปดาห์ตั้งแต่ ๑๘ มีนาคมถึง ๗ เมษายน

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๒๕๕๒. วิธีการศึกษาประกอบด้วย การทบทวนเอกสารและการสัมภาษณ์ผู้เกี่ยวข้อง ซึ่งได้แก่ นายแพทย์สาธารณสุขจังหวัด (สสจ.), สาธารณสุขอำเภอ (สสอ.), เจ้าหน้าที่สถานีอนามัย, นายกองค้การบริหารส่วนตำบล (อบต.), รองผู้ว่าราชการจังหวัด และผู้เกี่ยวข้องในหน่วยงานส่วนกลาง คือ กระทรวงสาธารณสุข, สำนักงานหลักประกันสุขภาพแห่งชาติ (สปสช.), กรมส่งเสริมการปกครองส่วนท้องถิ่น, กรมบัญชีกลาง และคณะกรรมการกระจายอำนาจสู่ท้องถิ่น (กคถ.). ได้ทำการศึกษาสถานีอนามัย (สอ.) ที่ถ่ายโอน ๕ แห่ง และโรงพยาบาลออกนอกกระบะบ ๑ แห่งในพื้นที่ ๖ จังหวัด คือ จังหวัดอุดรธานี, เชียงใหม่, ภูเก็ต, นครศรีธรรมราช, สมุทรสาคร และสมุทรสงคราม เป็นการประเมินตามวัตถุประสงค์ของหลักการกระจายอำนาจ คือ มุ่งประโยชน์สูงสุดต่อประชาชน ด้วยระบบที่ยืดหยุ่นและมีพลวัต และเน้นการมีส่วนร่วมของประชาชน.

จากการศึกษาพบว่า สามารถบรรลุวัตถุประสงค์ของการกระจายอำนาจด้านสุขภาพ; ด้านการตอบสนองต่อความต้องการของประชาชนและชุมชน พบว่า สอ. ที่ถ่ายโอน มีบริการตามความต้องการของ อบต. และชุมชน และได้รับงบประมาณมากขึ้นจาก อบต. ในการเพิ่มการบริการ; ด้านความยืดหยุ่นในการบริหารจัดการ พบว่า สอ. ถ่ายโอน ๑ แห่งสามารถตัดสินใจในเรื่องต่างๆ ได้รวดเร็วขึ้น สามารถคิดริเริ่มได้มากขึ้น; ส่วนสอ. อีก ๒ แห่งยังอยู่ในช่วงการเปลี่ยนผ่านระบบ ยังมีประเด็นเรื่องกฎหมาย กฎระเบียบ โดยเฉพาะเรื่องงบประมาณถ่ายโอนล่าช้า ยังต้องได้รับการแก้ไข; ด้านการมีส่วนร่วมของภาคประชาชน พบว่า นายก อบต. และสภา อบต. มีความกระตือรือร้นที่จะทราบความต้องการของชุมชน ด้านสุขภาพและบริการสาธารณสุข; ส่วนผลการศึกษาเกี่ยวกับโรงพยาบาลออกนอกกระบะบ พบว่า รูปแบบของโรงพยาบาลบ้านแพ้วได้รับการออกแบบมาอย่างดี มีความชัดเจน และสอดคล้องกับบริบท โรงพยาบาลประสบความสำเร็จในการพัฒนาคุณภาพการให้บริการและการเพิ่มรายได้. ความใกล้ชิดกับชุมชนเป็นปัจจัยแห่งความสำเร็จที่สำคัญของโรงพยาบาลบ้านแพ้ว โรงพยาบาลสามารถใช้การมีส่วนร่วมของชุมชนช่วยพัฒนาความโปร่งใส และความรับผิดชอบต่อการดำเนินการ และผลงานในการให้บริการ.

คำสำคัญ: ประเมินผล, การถ่ายโอนสถานีอนามัย, โรงพยาบาลออกนอกกระบะบ

Background and rationale

The Plans and Process for Decentralization to Local Administrative Organizations Act⁽¹⁾ of 1999 called for Thailand's government ministries, including the Ministry of Public Health (MOPH), to develop action plans for the decentralization of functions, resources and staff to the elected Local Administrative Organizations (LAOs) by 2010. The Act also set a target for increasing the share of the central government budget that should be transferred to LAOs from 9 to 35 percent by 2006. In 2006, the law was amended to remove the 2006 deadline, and set the minimum share of national budget to be transferred of 25 percent, with a target of 35 percent.

Devolution of health centers (HCs) to the lowest level of local government—Tambon Administrative Organizations (TAOs) and municipalities was initiated before the second Action Plan for Decentralization,

prepared in 2006. Under the guidelines for devolution developed by the MOPH, devolution of HCs occurs only where the following criteria are met: (1) the TAO/municipality meets "readiness" criteria to manage the HC: the LAO must have received a good governance award, and demonstrated capacity for and commitment to health by establishing a Public Health Section and contributing funds to a Community Health Fund (an initiative of the National Health Security Office (NHSO) to encourage local governments to lead and commit resources to disease prevention and health promotion activities, with NHSO co-financing); (2) at least 50 percent of HC staff, including the HC head, support devolution of their HC and are willing to transfer to an LAO for employment. Additionally, the local community is surveyed or consulted to ensure there is majority community support for devolution.



Organization and responsibilities for Health Centers prior to devolution: Thailand's public health system, although formally centralized, exhibits significant local variation as a result of deconcentrated decision making in the MOPH and the NHSO and as a result of a variation in local government involvement in health. As a result the scope of health responsibilities of HCs and the accountabilities and incentives of HCs differs in different localities, even before devolution.⁽²⁾ The creation of the Universal Coverage (UC) health financing scheme in 2002, managed by the National Health Security Office (NHSO), brought about a partial purchaser-provider split in the functions of the MOPH and in the management of tax-financed public expenditure on health. This also introduced dual accountability for the MOPH's HCs. Most of the non-salaries operating budget for HCs now comes from the NHSO (and to a lesser extent from the Civil Service Medical Benefits Scheme (CSMBS) and Social Security Scheme (SSS) for formal sector employees). The MOPH budget, supplemented by a central top-slice from NHSO funds, equivalent to 65 percent of the salaries budget, pays the salaries of all of the government officers who work for it, including those who work in HCs. This complex arrangement was put in place because payment of civil servants from the budget is guaranteed under the constitution. The NHSO's payments to HCs cover some personnel costs (such as contractual staff, overtime payments, a performance bonus scheme), as well as other operating costs: utilities, fuel, maintenance, supplies, equipment, etc.

Transfer of staff and assets: The devolution process transfers the HC's physical assets to LAO ownership, and transfers willing MOPH government officers and contractual staff working in the HC to employment by the LAO.

Transfer of health responsibilities: A memoran-

dum⁽¹⁾ of transfer is signed by the permanent secretary of MOPH, the PHO and LAO chief executive officer (CEO) formally documenting the transfer of the "public health duties and responsibilities" of the HC to the LAO, and committing the LAO to "administer and manage the health center according to regulations, criteria, standards, and public health work set by MOPH" and the relevant PHO.

Fiscal transfers: The devolution process transfers the MOPH's budget allocation for HC salaries to the LAO, via the Ministry of Interior (MOI), as a specific (earmarked) grant. This budget allocation covers the basic salaries and benefits of government officers in the HC – typically two to three staff. Funds will continue to be transferred as a conditional grant to guarantee salary payment for ex-MOPH employees until they retire. Any newly hired HC staff will be paid from the LAO's general revenues (which consist of a general grant, shared tax revenues and varying amounts of local revenues).

Changes in decision rights: LAOs – whether or not the HC is devolved – have some freedom to develop new health services using their own revenues, as long as they comply with MOPH regulations. Major developments, such as the establishment of new health facilities, however, are subject to licensing approval by the MOPH. Additionally, the Office of the Auditor General discourages LAOs from spending on any curative care services that are deemed to duplicate the MOPH's mandate. Following devolution, LAOs have rights and power to hire, promote, reward and discipline HC personnel. Local government officers enjoy protection of employment; firing permanent LAO staff is difficult, just as it is for people's permanent MOPH permanent staff. However, LAOs may hire and fire contractual staff. LAOs also have financial decision-making authority over HCs in relation to their use of LAO revenues, includ-

ing authority over procurement and capital investment within delegated limits set by regulation. LAOs have some latitude to determine the level of delegated authority they give to HC heads in relation to personnel and financial decisions. LAOs do not have authority over how devolved HCs use NHSO, CSMBS, and SSS funds, which continue to be governed by regulations set by these organizations. As a result of these multiple sources of finance, HCs have significant financial autonomy before and after devolution. The MOI sets personnel and financial policies at the national level, that apply to LAOs, and more detailed regulations are adopted by the MOI's provincial administration (under the authority of the provincial governor). These regulations define limits to salaries and bonuses. For some decisions (such as creation of new permanent LAO posts, or more major investments), the LAO CEO requires approval of the provincial committee.

Changes in accountability, supervision and oversight: Devolved HCs retain their accountability to the MOPH for compliance with technical policies, standards and regulations. They retain an obligation to report public health data to the MOPH. The DHO and PHO continue to supervise and advise devolved HCs on technical matters. They retain accountability to the NHSO, CSMBS and SSS for use of funds and service delivery to patients covered by these schemes, and report to them. In addition, the HCs become accountable to the LAO for personnel and budget management previously the responsibility of the MOPH, and LAOs are able to monitor performance and demand improvement.

Changes in market exposure and in financial incentives for HCs: The exposure of HCs to competition is determined by the policies of the CUP Board, (which manages the NHSO budget for prevention, promotion and curative primary health care for HCs

in the catchment area of the local public hospital and for the hospital's outpatient department), CSMBS and SSS, rather than the LAO; that is, devolution does not change the exposure of HCs to market pressure (or the lack of it). The MOI is putting in place regulations that will ensure that HCs are able to continue to retain unspent balances of revenue that they receive from NHSO, CSMBS, SSS and user fees. This will preserve the existing incentives that HCs have to maximize these sources of revenue and the existing freedom they have to use such revenue. Because the LAOs currently have more discretionary "budget space" than the MOPH's PHOs, devolved HCs have more scope to negotiate increases in budget allocation. Additionally, the Ministry of Interior (MOI) stands ready to receive requests from LAOs for additional funds if needed, and has an interest in supporting newly devolved services. Devolved HCs are thus likely to perceive a softer budget constraint.

Methodology

The assessment team conducted interviews with staff of Provincial Health Offices (PHO), District Health Offices (DHO), Provincial Governor's Office and Department of Local Administration (DLA), a Contracting Unit for a Primary Care (CUP) hospital, Tambon Administrative Authorities (TAO) and health centers in five devolved health centers and five non-devolved health centers and a hospital-owned primary care unit (PCU). In relation to the three stated objectives of this decentralization, the team's findings are described below. With regard to changes in flexibility, responsiveness and participation following devolution of health centers to TAOs, the criteria for assessment were derived from the stated objectives of decentralization of service delivery, based on the Plans and Process for Decentralization to Local Administrative Organizations Act of 1999, following the Thailand Con-



stitution of 1997.

Interviews were also conducted with current and former managers of the Ban Phaeo Autonomous Public Organization (APO) Hospital, with the director of the Patong Hospital (which applied for APO status), and with members of the management team of the Phuket International Hospital. Discussions with policy makers, advisers and researchers from the MOPH, National Decentralization Committee (NDC), and Bureau of Budget also covered questions related to hospital autonomy.

Results

Findings on the devolution of health centers were as follows:

Increased management flexibility: HC staff and TAO leaders in three of the devolved health centers (Naphu, Salabangpoo, and Pakpoon) had positive perceptions of improvement in management flexibility, in the sense that future decision-making was expected to be faster and there should be greater scope for initiative, as a result of the much shorter chain of command for most decision-making. However, all noted transitional problems with finalization of regulations and some unresolved regulatory issues, such as licensing public health officers to provide curative medical care. Two of the devolved centers (Don Kaew, Banprok) noted positive and negative changes, though both perceived net benefits. Some centers experienced delays in regulatory changes that led to delays in fund flows or delays in gaining approval for filling a new permanent post from the Provincial LAO'S personnel committee. Delays seem to reflect the fact that the agencies involved are dealing with these procedure for the first time, and were not able to draw upon the expertise of the MOPH.

Increased responsiveness to the community and to patients: Three devolved health centers (Naphu,

Salabangpoo, and Pakpoon) could point to a number of ways in which service delivery had already improved and new services had been provided in response to the needs and preferences of the community. Those included a stronger client service orientation, increased in all services, curative, preventive and promotive. However, in one TAO, some of the planned changes in service delivery did not appear to be evidence-based and might not have been cost-effective. The Don Kaew TAO had asked the HC staff to increase outreach and initiate annual health checks for villagers within the same budget, and it was providing closer supervision. The transferred HC had very low utilization prior to devolution; the CUP hospital operated a competing PCU opposite the HC; the CUP board decided that the HC should focus primarily on promotion and prevention (P&P), leaving curative care to the hospital and its PCUs. The TAO has limited power to influence these decisions by the CUP Board. Banprok introduced a new dental service, but decreased its outreach services after devolution.

Increased participation of the community: All five TAO CEOs and Councils were active in obtaining community input on health and health service delivery. Naphu, Salabangpoo and Pakpoon HCs had increased activities that involved community participation and increased activity of the village health volunteers (VHVs). Don Kaew's TAO-CEO used systematic community participation in identifying need for health services and providing feedback on health services, though it is too early to assess whether the HC staff themselves will engage more actively with the community. Banprok HC staff are promoting their services and the benefits of devolution to the community, and reported increased utilization by people outside their catchment area.

It is too early to assess the lasting effects of

devolution on outputs of health centers, and it was not yet possible to assess any effect on outcomes. Nonetheless, the rapid assessment gathered information on changes in major inputs, outputs and processes in the first year of devolution. It should be borne in mind that it is common for major organizational change to lead to some loss of productivity for a period of 6-18 months, before benefits of the change emerge.

Efficiency and appropriateness of increased spending: Four out of five HCs had received increases in resources financed from the TAO budget. This included civil works to upgrade the HC buildings. In three cases, the civil works had already or would improve physical accessibility and would provide greater patient privacy. As had been noted above, in one case, there were some questions about the efficiency and effectiveness of proposed civil works expenditures. In the fifth case, the HC had very low utilization and low levels of outreach prior to devolution, and the TAO quite reasonably had asked for increased output (a tripling of outreach) within the same level of resources, before any increase in resources would be provided by the TAO. This would increase efficiency.

Output levels: Four out of five devolved HCs had increased either utilization or outreach, or both. One HC had experienced a transitional reduction in output (about a 5% reduction in visits) because three out of five government officers had been transferred to other MOPH posts rather than to LAO employment. In spite of this transitional challenge, this HC still had high utilization and a very visible patient/community service orientation. The HC was in the process of arranging back-up staffing from the CUP hospital.

Equity: In two of the TAOs visited, only one of two HCs in the TAO had been devolved, because the

majority of staff in the other HC voted against devolution. In one case, people in the catchment area of the non-devolved HC had complained about the fact that the non-devolved HC was now receiving less support than the devolved HC. In the second case, the TAO had provided support to both HCs prior to devolution, and had maintained the same level of support to the non-devolved HC after devolution. However, it is not clear that the perceived inequity in the first case arose from the decisions of the TAO. The devolved HCs are benefiting from substantial capital expenditure from the MOI budget for upgrading of building and equipment. Non-devolved HCs so far are receiving much smaller allocations of capital expenditure from NHSO and MOPH budgets.

Accountability: The potential benefit of devolution is that direct local supervision and a shorter chain of accountability could improve service performance. This potential benefit had to be weighed against the potential disadvantages arising from the lower technical capacity of LAOs for managing health services. Two of the TAOs visited have taken actions that point to increased accountability for "patient perceived quality," and had initiated processes to increase accountability for meeting community health needs. One TAO provides feedback to HC staff based on patient complaints; in one case negative feedback on the performance of one staff member did not lead to improvement in performance, and was handled by a request to transfer the staff member out of the HC to another MOPH position. Another TAO asked the HC staff to increase outreach from once a week to daily, in response to very low rates of HC utilization, and evidence of community need for more pro-active services (to address late presentation to health facilities by villagers when ill). That TAO uses supervision by the Public Health Section Head and village feedback meetings to ensure that these



services are provided. Those two TAOs have also initiated surveys of community health status and health determinants, as a basis for establishing realistic local health plans that could be monitored by follow-up surveys.

Discussion

The devolution of health centers

The assessment team found that the devolution of HCs in the sites visited was producing early positive results. Our over-riding impression is that this is a very limited, incremental change in the ownership and governance of HCs, which has the potential to produce benefits, and which carries relatively little risk in the short term. The major sources of financing and process for health resource allocation remain with the NHSO. The major sources of technical support, training and supervision of the HCs remain divided between the DHO and PHO on one hand and the CUP hospital, on the other. The PHOs and CUP Boards are thus in a very strong position to prevent and manage any potential risks of devolution – to offset any risks arising from the limited capacity of the TAOs, to ensure coordination, and provide some incentives and sanctions for performance using the “purchasing” mechanism of the CUP Board. The PHOs and CUP Boards that adopted the mind-set that devolved HCs are still part of the health system in the same way as before, continue to take responsibility for ensuring that health services are delivered continuously and appropriately in the devolved HCs. The devolved HCs and TAOs welcome this continuity in the role of the PHO and CUP Board.

The criteria and process for HC devolution

There have been some calls to relax the criteria in the MOPH guidelines for HC devolution to enable

more transfers to go ahead. Given the incremental nature of the change, the capacity of the MOPH and CUP Board to manage the risks involved, and the potential benefits illustrated by the experience of the first pilots, there is a prima facie case for reviewing the guidelines.

The “LAO readiness” and good governance criteria are prudent as a means for managing the risks of transition. There is empirical backing for these criteria: a Philippines study found an inverse relationship between local government governance indicator scores and basic health indicators. A number of interviews identified the problem that small TAOs face in meeting the LAO readiness criteria because they have inadequate budget to establish a public health section without breaching the statutory limit on the share of budget spent on staff compensation. There seems to be a case for revising this percentage limit for LAOs that undertake health and education responsibilities. In both sectors, it is common for staff compensation to account for over half of the budget in middle-income countries, and a higher share in upper-income countries. In the case of HC transfer, the case for reviewing this limit is even stronger because only the cost of salaries of the HC staff is transferred to the TAO. The rest of the HC’s operating costs are met by NHSO funds, and other sources. For the smallest TAOs, in the longer term, devolution may be difficult unless policies are developed to promote TAO mergers or provide a legislative basis for public service delivery organizations owned by more than one TAO.

The community survey or consultation on community support for devolution provides a means for providing additional local democratic legitimacy to the implementation of decentralization, which was described by a number of interviewees as a “top-down” initiative. Community members are also well

placed to judge whether their LAO will give priority to health, and this presents an opportunity for them to signal whether they have confidence in local governance and in management capacity for health services. In one of the provinces visited, community members reportedly gave considerable weight to the view of the HC head before deciding whether to vote in support of HC devolution.⁽⁴⁾

Under the “HC staff willingness” criteria, devolution takes place only if at least half the staff agree (including the HC head) to transfer to the LAO’s employment. The staff who do not wish to transfer to LAO employment can request for transfer to another MOPH post. In practice, this criterion has most often been the barrier to going ahead with devolution of HCs. This step of the process has the effect of combining two distinct decisions. The first decision – whether or not devolution should take place – is a policy decision that should be made based on public interest criteria, drawing upon analysis, evidence, wisdom and consultation with those affected. The second decision – on the staff member’s future employment status – is a personal choice that staff should feel free to make on the basis of “private interest” criteria such as financial security, career aspirations, and family concerns. Because the devolution process uses such personal decisions of the staff as one of the criteria that determine whether or not devolution takes place, it has the effect of combining both a public interest and private interest decision in a way that is leading to decisions about devolution being based on an unclear mixture of public interest concerns (such as whether or not devolution would mobilize more resources for the HC, or the risk of politicization or corruption), and private interests (e.g. their chances of being promoted to Public Health Section Head, their personal/familial/political affiliations with the TAO leadership

or to the opposition political party). Consideration could be given to revising this criteria for HC devolution, and developing alternative transition processes to manage situations where most HC staff choose not to transfer to LAO employment. The provisions in the MOPH guidelines, which allow staff the choice of transferring to LAO employment, or transferring to another MOPH post elsewhere provided assurance of protection of staff employment rights and career opportunities. The HSRI evaluation^(5,13) of the devolution pilots found that many HC staff are reluctant to vote to transfer to the LAO unless there is a clear policy on devolution from MOPH management.⁽³⁾

The field visits identified particular issues that arose from the implementation of the “HC willingness” criteria in the case of TAOs with two HCs where staff in one HC voted to devolve, while staff in the other HC voted not to devolve. Consideration could be given to revising the guidelines so that decisions on devolution are made for both/all the HCs in the LAO, not for selected HCs. Such an approach could strengthen the message that devolution involves a transfer of responsibility for health objectives and health services for all of the citizens in the tambon, without regard to political or personal affiliation.

Hospital autonomy under the autonomous public organization law

Ban Phaeo Hospital was a 200-bed MOPH community hospital in 1999 at the time the decision had been made to convert it into an APO – a form of government-owned, autonomous, non-profit organization, under a new law adopted in 1999.⁽⁶⁾ It is now a 300- bed hospital offering services at primary and secondary levels, with some tertiary-level services. It is seeking to upgrade its status to that of a general hospital. It is one of three public hospitals in Samut



Sakhon Province – a densely populated peri-urban province with a registered population of about 400,000 and an actual resident population of over 1 million.

The model of autonomy implemented at Ban Phaeo was developed drawing upon preferred features from autonomous and corporatized hospitals in a range of countries, including Australia, New Zealand, Singapore, and the United Kingdom. The model represents a marked and generally consistent shift in the key dimensions for influencing organizational performance, as described in Preker and Harding,⁽⁷⁾ from those appropriate for core government ministry functions to those appropriate for an autonomous, non-profit service provider. Such changes create a strong set of incentives for improved performance and expansion of the business. The changes at Ban Phaeo Hospital in these key dimensions that influence organizational performance are as follows:

- Management decision rights over organizational structure, organization of services, human resources, finances, logistics, and capital investment are shifted to the hospital board and the hospital director, with the partial exception of decision rights over capital. Disposal of surplus land granted by the government or donors, and “equity injections” and borrowing rights for financing of major capital investment are not fully shifted to the hospital; such decisions require Cabinet approval. The hospital is also free to contract in or out and enter into partnerships with the private sector and non-health sectors.

- Residual claimant status is fully with the hospital. However, there is no clear regime in the event of financial failure or bankruptcy, although there is a precondition for demonstrating financial sustainability before APO status is granted. The Board is reported to be quite focused on ensuring that losses are avoided. The hospital retains the proceeds of

most forms of efficiency gain, with the exception of efficiencies in the management of granted and donated land and buildings.

- Market exposure is quite high because the revenues of the hospital are derived from fee-for-services (from CSMBS, which is the largest revenue source), case-based payment systems of SSS and NHSO, and specific service contracts and project finance from NHSO, and other public health sector institutions. The location of the hospital in a densely populated area creates considerable potential to attract out-of-area patients, which increases its revenue from CSMBS and NHSO. Unlike MOPH hospitals, there is no top-slice from salaries taken from the UC payments. The hospital is paid by UC at 100 per cent of the case-based payment and capitation rate. The MOPH budget does not guarantee payment of staff salaries, as is the case for MOPH health facilities. Staff remuneration comes from the revenues generated from the services delivered. The hospital manages the CUP for a defined catchment of UC patients, which gives it a somewhat protected market for this group of patients. Additionally, the neighboring CUP for the provincial general hospital has a policy of not charging out-of-area self-referrals, which in theory could foster cost-shifting, though in practice, this does not seem to be a concern.

- Accountability is to the purchaser (NHSO, CSMBS and SSS) with regard to service delivery under the provider payment policies and regulations of these agencies. Accountability for performance, for service development, and for financial sustainability is to the Board.

- Social functions (unfunded mandates and community participation): the hospital has a policy of providing exactly the same clinical care, including access to medicines, to UC patients as to other socially insured and private patients. Its main unfunded

mandate is providing medical treatment for illegal migrants. On humanitarian grounds, the hospital does not refuse them treatment, but has progressively taken a tougher stance, i.e. reporting them to immigration authorities. The hospital has extensive engagement with its community, both in consultation over service development and hospital development, and in raising donations and accounting for their use. It undertakes some corporate social responsibility initiatives from its surplus.

Preker and Harding,⁽⁷⁾ in drawing on evaluations of a range of country case studies, posit that reform is more likely to achieve benefits and minimize risks of unintended adverse effects if it makes changes to these five dimensions in a coordinated and consistent way. Reforms that make radical changes to some of these dimensions while neglecting others have been found to run the risk of loss of financial control, loss of efficiency, or reduction in delivery of social obligations such as equitable access for the uninsured. Figure 1 maps the position of the Ban Phaeo model on these five dimensions, and illustrates the coherence and consistency of the organizational reform.

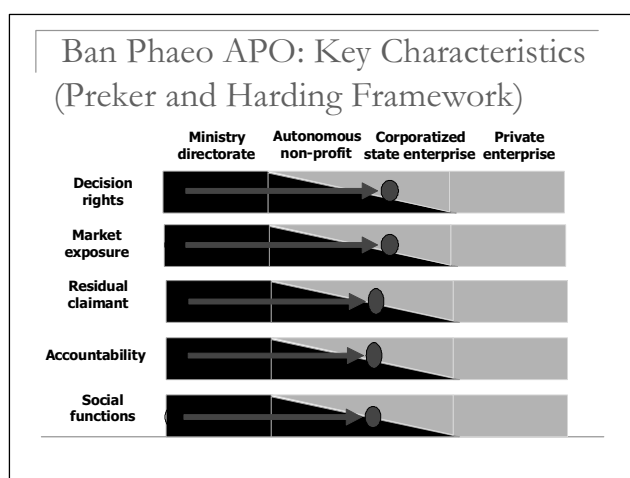


Figure 1 Critical Factors Influencing Organizational Behavior

It is useful to supplement the Preker and Harding framework by looking at changes in the internal incentive environment for management and staff following autonomy. The incentive framework for management and staff adopted by the hospital's Board appears to be strongly focused on aligning the incentives of staff with the objectives the board has for the hospital. The Director has a fixed four-year term contract, renewable for only one term, and is subject to annual performance targets and review by the Board, which can decide on the level of the Director's bonus based on this assessment. Staff are no longer civil servants, and no longer participate in the civil service pension and medical benefits schemes. They are employed by the hospital itself under the private sector employment law, and their contracts can be terminated for poor performance more readily than is the case for civil servants. Doctors are paid a combination of salary, shared fees for service and performance rewards, and are subject to annual performance review. Medical staff are not permitted to work part time for other private sector hospitals or clinics; in return, their staff are paid a substantially higher salary than that paid by the MOPH. They are permitted to earn additional fees for service in treating private patients after hours within the hospital. The hospital also hires on a part-time basis specialists who are full-time employees of other public hospitals. Prescribing is controlled by a hospital formulary, set by the Pharmaceutical and Therapeutic Advisory Committee, which is somewhat broader than the EDL and UC formulary (it includes more brand-name medicines). All patients, including UC patients, receive drugs based on this formulary. The hospital does not make a profit on medicines and does not have any partnerships or profit-sharing arrangements with private pharmacies.



By contrast, conventional MOPH hospitals are constrained in the level of salaries and allowances they pay medical staff by national public sector salary regulations that keep remuneration substantially below the level earned by private sector doctors, and the higher levels of private sector remuneration for other categories of workers. As a result, over 73 percent of MOPH doctors and 9.5 percent of professional nurses worked part time in the private sector in 2005 – up from 55.4 percent and 8.2 percent respectively in 2003. Although MOPH hospitals have had considerably increased financial freedom since 2005 (they can retain income from UC, SSS, CSMBS and user fees, and can offer private beds with enhanced quality of “hotel” services), they do not have the freedom Ban Phaeo has to use such revenue to increase staff remuneration.

Linkages and integration of the hospital with the public health system: The hospital functions within the public health services network in the same way as other community hospitals, although it has now expanded its capacity and range of services to a higher level than is typical for community hospitals. It manages the CUP for outpatient services (largely curative primary care) and P&P for its district catchment area like any MOPH hospital. It has set up three PCUs/CMUs to provide PHC, which will supervise and support HCs in the catchment area as well as provide curative care. Two of the three PCUs also provide P&P. The hospital provides some P&P staff to work in HCs. Interviews with HCs in the catchment area found perceptions that the hospital is somewhat “less generous” than other CUPs of which they are aware, but this perception may be influenced by the fact that Ban Phaeo provides more support in kind and less in cash than most CUPs.

Ban Phaeo’s staff – like devolved HC staff – are cut off from career mobility through the MOPH. The

hospital plans career paths for its medical staff over a period of 9-10 years in the case of doctors, and provides scholarships in return for contracts to return to the hospital, but so far, it does this on its own, not as an integral part of MOPH hospital career paths. However, it has some linkages to the junior doctor training system. The hospital employs interns from public medical schools after graduation in the same way as other MOPH hospitals, and is seeking agreement of MOPH to also be assigned medical registrars who are providing public services in their first three years after graduation from a public university.

Governance structures and external accountability of the APO to its owners and other government stakeholders: The Ban Phaeo Hospital is legally subordinate to the MOPH. However, it may be more accurate to describe it as subordinate to the Cabinet, as the Cabinet holds some key decision rights, such as approval of board membership and of capital finance or borrowing. There is no dedicated unit or agency in the MOPH or any other part of government responsible for independent monitoring and regulatory oversight of good corporate governance, or of the financial performance of APOs or their performance in improving the value of the business. The Bureau of Budget reviews and provides advice to the Cabinet on any requests by APOs for capital finance. The criteria used by the Bureau are the same as for APOs in other sectors: low priority is given to APOs with substantial own-source revenue (this has been the main reason for rejecting Ban Phaeo’s application for capital finance to date); high priority is given to APOs responsible for investments that are part of a government strategy or policy.

The composition of the APO board includes ex officio the permanent secretary of the MOPH and PCMO, as a direct mechanism for enabling the MOPH

to monitor and participate in decisions of the hospital, and the provincial governor who has a mandate to ensure local coordination of central and local government administration. The processes for appointing the other board members of the APO hospital involve a number of stakeholders and build in some checks and balances to seek to ensure both meritocratic selection and political accountability. The Royal Decree establishing the hospital as an APO specifies the composition of a search committee to identify candidates for the board. The search committee is chaired by the provincial governor, and is appointed with the agreement of the provincial governor, PAO CEO, CEOs of the TAOs and municipalities making up the district, the district officer and the PCMO. The Royal Decree specifies that the board should include three community representatives and three experts in addition to the three ex officio members. The search committee is obliged to identify two candidates for the positions of chair (who may not be a government employee), and six community and six expert candidates for the three board posts for these categories. The Minister of Public Health selects candidates from the short-lists proposed by the search committee, and submits the final board membership list to the Cabinet for approval. Interviewees who had reviewed lessons from experience with the Ban Phaeo Board concluded that the composition of the board could be strengthened by inclusion of only professional board members, on the basis of their skills as directors (including hospital management and service delivery skills). The hospital does not have LAO representation on the board, and reportedly has had little take up from LAOs in response to initiatives to enlist their engagement in supporting the hospital or working with it on joint initiatives.

The board, which meets for 3-4 hours every

month, is described as an “activist” board. Its decisions are usually made by consensus, rarely going to a vote. Where there is disagreement among 1-2 members, usually the proponent of a recommendation provides more information to address the concerns raised until consensus is reached. MOPH’s role on the board is characterized as more passive, and mostly focused on providing input and information on government and MOPH policy matters. The Board is reported to be focused on service delivery performance and new development of the hospital, but is not particularly focused on efficiency or cost containment, although it is concerned to ensure that the hospital avoids losses.

Social accountability to the community served by the hospital: In addition to community representation on the board, Ban Phaeo raises donations from the community and consults and reports to the community on how donated resources are used. In addition, the hospital’s board has chosen to adopt some other forms of community participation, although these are not mandated by law or Royal Decree. It sends representatives to meetings of community leaders at the district, tambon and village levels to provide information about the hospital, consult and seek support for service development and receive feedback. The board also commissions the (independent) Thailand Rating Information System to conduct annual patient satisfaction surveys. These practices in Ban Phaeo are not unique to APOs, and may not be linked to APO status: a survey of 209 MOPH hospitals found that many have some form of community participation in hospital consultative committees, primarily focused on fund-raising for the hospital, though Ban Phaeo is the only one with formal community representation in governance. A number of other MOPH community hospitals have committees and processes for community participation in their development



plans, for coordinating between the hospital and the community, for management of the infrastructure and non-medical activities, and for community support for health service implementation.

Performance and evaluation of processes and results:

The Ban Phaeo Hospital APO has been highly successful in increasing the outputs, range of services, and turnover of the hospital, as has been documented in a series of before-after evaluation studies. Some early studies noted some transitional issues in developing management capacity and systems, but found generally appropriate development of capacity to manage autonomously. A study of quality found no adverse effect on clinical practices or outcomes of care in the three clinical areas studied, though record-keeping deteriorated. Patient satisfaction rates rose after autonomy, then flattened and decreased slightly in the last 2-3 years. Declining satisfaction is perceived to be due to increased utilization, giving rise to increased waiting. However, satisfaction remains high at 86 percent. It should be mentioned that it is the only APO hospital, and that it was a self-selected candidate for APO status. The initiative and final decision to grant the hospital APO status involved strong advocacy by the hospital's management and many doctors at the hospital for reasons that may be associated with successful performance under any status. It is viewed by some of those interviewed as a unique or atypical case. However, its former and current managers believe that the model is replicable in other larger community, general and regional hospitals with a diversity of revenue sources. In smaller community hospitals serving small or dispersed populations and reliant almost entirely on UC and MOPH finance, the positive dynamic achieved in Ban Phaeo that led to a virtuous cycle of revenue growth and expansion

would be difficult to achieve, and such hospitals would best be given autonomy as part of a larger network of hospitals.

Scaling up the APO Model

A survey of 209 MOPH community hospitals found that 25 percent were interested in pursuing autonomous status. In 2006, a formal invitation to the hospitals to express interest in gaining autonomous status attracted about 45 expressions of interest, although only one of these (Patong Hospital) pursued this process to the stage of submitting a formal proposal for a decision. In this process, a semi-autonomous "Service Delivery Unit" status within the MOPH was also on the agenda.

In the context of deliberations on implementation of the decentralization law, the NDC and Commission on Public Sector Reform have expressed concern about the creation of additional APO hospitals because they do not regard APO status as a form of decentralization. Under current law, it is not possible to transfer APOs to LAO ownership. There is no inconsistency in principle, however. Transferring a well-functioning autonomous hospital should be less of a financial risk and managerial concern for a PAO and the MOPH than transferring a conventionally managed ex-MOPH hospital.

More recently, the Commission on Public Sector Reform and the Cabinet have halted any further creation of APOs. This decision was taken in response to cases in which some of the many non-health-sector APOs established in the period 2002-2005 have performed poorly; some have run into financial difficulty and some have applied questionable policies regarding the level of remuneration for board members, relative to the duties performed. It appears that the Royal Decree establishing Ban Phaeo APO Hospital and the draft Royal Decree for Patong APO

Hospital incorporated many important features, drawing upon lessons from hospital autonomy in other countries, including appropriate focus on social objectives, criteria and processes for selecting a professional board, and role of the board, that were not adopted by other sectors that created APOs.

If at some point in the future, there is renewed interest in scaling up hospital autonomy to include significant numbers of hospitals, there are some further elements of the policy and institutional framework that would need to be developed.

Supervision of APO boards

As the experience of APOs in other sectors illustrates, the APO model cannot rely on an assumption that boards of such organizations will always be competent, and motivated to act in the interest of the organization as a whole, or on wider public interest. Upper income countries with large numbers of APO-type organizations have established arms-length monitoring, oversight and regulation units for APOs as a safeguard against board failure. In countries such as the United Kingdom, where all public hospitals are organized as APO-type organizations, the health sector has long had its own specialist monitoring and oversight functions. Monitor, the British regulatory agency established to regulate National Health Service (NHS) Foundation Trusts, is one relevant example to consider. The Ban Phaeo model has similar autonomy in many respects to NHS Foundation Trusts, though Ban Phaeo has more diverse revenue sources, greater human resource autonomy and less autonomy over land and buildings than Foundation Trusts.

Systems for managing capital finance

If over time Thailand were to adopt an APO model for a large number of MOPH hospitals, it would be necessary also to establish more systematic policies and dedicated capacity to review capital invest-

ment and borrowing proposals. Private capital markets would view loans to APOs as implicitly government guaranteed, even if there is no explicit guarantee. APO borrowing would be viewed as a component of government debt, under broad definitions. Accordingly, it would be necessary to carry out the same kind of economic and financial appraisal of major investment proposals as are appropriate for conventional public sector investment. To provide some increase in capital autonomy within prudent limits, consistent with fiscal policy, the UK gives NHS Foundation Trusts freedom to borrow up to a modest limit, defined and supervised by Monitor.⁽¹¹⁾

Career paths and human resources mobility

As with decentralized systems, health systems with predominantly or entirely autonomous public providers usually develop human resources policies that facilitate the movement of staff between autonomous hospitals. More "liberal" regimes (e.g. Estonia, New Zealand 1993-2000) for achieving this usually involve portable pension rights, open advertisement of all posts in certain occupational and grade categories in a common health sector journal/website; a common occupational classification system, and a broad-banded common grade structure; coordinated policies for posting and rotating junior doctors and doctors in specialization training.

More "regulated" regimes (e.g. UK NHS, Australian states) may also have a nationally negotiated scale of pay and allowances for the main occupational groups, with individual hospitals having freedom over hiring, placement of new hires in the scale, promotion, and discipline. These regimes may give hospitals some freedom to pay bonuses and pilot various reforms.

Networks

In scaling up APO policy, consideration would need to be given to autonomizing networks, rather



than individual facilities. Within the public sector, networks offer the advantage that they de-concentrate decision-making about how to adjust the organization and configuration of health service delivery and internalize this task within a single organization (assuming the necessary managerial competence, authority, motivation and incentives exist for making optimal changes). This gives the network more freedom to respond to some of the trends and drivers of change in health systems, such as the increasing concentration and specialization of hospital services combined with the shift out of hospital to community settings of a larger range of curative care services.⁽⁸⁾ Some countries have adopted a geographic catchment area approach to the establishment of autonomous networks. Others (notably the State of Victoria, in Australia, in the 1990s) attempted to design networks in such a way as to permit inter-network competition. Some interviewees advocated that it would be more efficient to give autonomy to district or provincial networks, rather than individual hospitals.

There is no strong evidence base for the commonly expressed preference for bringing the network of facilities into a single legal entity. The presumption that coordination and communication between organizations is inferior to coordination and communication within organizations may not be true, in case of large, complex multisite organizations with delegated/de-concentrated management. There is some evidence of diseconomies of scale in very large hospitals, and some studies postulate that these may arise from the additional costs for coordination and communication in large campuses or multisite facilities. There is some theory and evidence,^(9,10) however, that networks of organizations with differentiated and heterogeneous nodes (a characteristic of the Thai public sector health facilities network) require local, de-concentrated and personal coordination as

distinct from formal coordination based on rules, processes, and impersonal information exchange. The CUP hospital and CUP board already provides this type of coordination, to varying degrees, at the district level, even though the management hierarchy for non-devolved HCs is to the DHO, rather than the CUP hospital. The PCMO and PHO already play this role at the provincial level, and their coordination role already encompasses private and local government health providers that participate in UC in a number of cases. This provides a natural opportunity for research to assess whether network coordination functions are more or less effective across organizational boundaries or within the MOPH in the Thailand context.

Some see stronger potential for improving HC performance, developing primary care and decongesting the hospital outpatient departments if HCs are under the managerial control of the CUP hospital. For example, with APO status, Ban Phaeo would be very strongly placed to improve staffing and the motivation of staff in HCs, after a transition period. There is little evidence on the effects of integrating primary care under the management of autonomous hospitals. Most countries that have autonomized their hospitals have either private provision of primary care with public finance, or decentralized provision of primary care at a lower level of government from the hospitals. Additionally, strong advocacy movements for primary health care or family medicine in a number of countries have opposed proposals for any form of merger of primary and secondary care, out of concern that primary care will have less power over negotiation for the hospital's discretionary resources (such as capital investment) and receive lower priority for management attention than higher profile specialist services. Some countries (e.g. parts of Australia, Canada and New

Zealand), have broadened the role of their public hospitals to become “area health boards” with responsibility for ensuring the provision of primary care and P&P in a defined geographic catchment. In areas where (dominant) private sector provision of primary care is absent (e.g. in sparsely populated rural areas, some deprived urban locations), these boards sometimes provide primary care and a range of community P&P services directly, though this has become less common. Increasingly, boards have contracted NGO providers or used incentives to attract or partner with private providers.

Community participation

Finally, there is potential to develop the role of community participation in hospital APOs, though there is limited evidence about the benefits of citizen participation in hospital governance among OECD countries.⁽¹²⁾ The complexity of hospital management makes community boards relatively weak in influencing the performance of more expert, more powerful managers and senior clinicians in the hospital.

It may be more effective to separate the role of citizen and patient feedback from the role of the governance board. Some countries (including both UICs such as the Netherlands, and some developing countries where there is a much lower level of trust in public institutions) have experimented with having a second community board to supervise the hospital. Successful cases of hospital community oversight or supervision boards commonly enlist “altruistic, expert elites,” with sufficient power to challenge hospital performance, rather than ordinary patients and citizens that are not able to influence the hospital. These powerful community boards can act as a channel for patient and citizen complaints. However, rather than relying on direct community participation, many upper income country governments have established

independent expert commissions with a mandate to inspect hospitals both routinely and proactively, and in response to patient complaints, and design these institutions with substantial lay representation so as to avoid “professional capture.”

In the shorter term, it would be possible to build incrementally on the Ban Phaeo model of community participation in governance, and evaluate the effects of these changes. Community participation processes could be expanded to encompass accountability for use of public as well as donated funds. This might entail community consultation on service strategy, more in-depth patient and community surveys and focus group feedback on service delivery, and community participation in reviews of annual financial and service performance.

Future reform of MOPH hospitals: Issues and questions for further exploration

Although the Ban Phaeo model has demonstrated success, there is not yet a clear consensus that this model of autonomy is appropriate for most MOPH hospitals in Thailand.

In 2005, all MOPH hospitals were granted increased autonomy in a number of dimensions. They now enjoy freedom to retain revenues from UC, CSMBS, SSO and user fees (from out-of-area patients and private patients) and have considerable freedom about how they allocate these revenues. They are free to establish private-paying beds offering a higher standard of services, and their staff can earn additional income by part-time work in such private units. They are able to raise donations from the community and have considerable freedom over how they spend donated funds. They have some capacity to earn additional revenues by, for example, entering into joint ventures with the private sector, including retail pharmacy. They are free to out-source some services. They can use their additional income to increase staff



salaries through bonuses of up to 25 percent, and are free to hire contractual staff.

The international evidence base for adopting one form of hospital governance over another is difficult to interpret and apply to a specific country context, and so does not generate unequivocal recommendations for the future reform of Thailand's public hospitals. The nature of both the positive drivers of hospital performance and the dysfunctions of public hospitals in any specific country context interact in complex ways with the design of the health system, the system of public administration and finance, other institutions (such as the power and ethos of professional associations and trade unions for different cadres of health workers), the relationship between the public and private health sectors, and the relationship between and among patients, citizens and communities and the hospital.

Since the wave of piloting and scaling up of various models of hospital autonomy in the 1990s in many OECD countries, there has been a second wave of reform of hospital governance in the last 5-10 years. This new wave of reform is quite diverse in the governance models that different countries are adopting. Each country is forging solutions based on the specific nature of their problem diagnosis for their country's public hospital system – there is no “blue print.” Thus, for example, the United Kingdom Foundation Trust reforms in the past five years have increased autonomy more decisively, cutting more of the ties with the MOPH that progressively reversed the changes brought about by the first wave of autonomization in the early 1990s. The United Kingdom has also introduced community and staff participation in hospital boards in order to respond to public and political perceptions of an over-centralized and unresponsive NHS bureaucracy. By contrast, the French

Hospital 2007 Plan appears to strengthen the role of doctors in hospital governance and management, and reduce the role traditionally played by trade unions representing other staff groups. There is no focus on community representation or participation in the French Plan, and a centrally determined model for organizational reform of all public hospitals has been adopted.⁽¹¹⁾ However, there are some common themes in the more recent wave of reforms, which may be relevant in further development of hospital policy in Thailand. Clinical and safety-related dimensions of governance receive greater emphasis than in the reforms of the 1990s. Methods and institutional arrangements for performance assessment and monitoring are much more elaborate. As a result, accountability and oversight of public hospitals has become increasingly multifaceted.

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