Decentralization of the Health Sector in Thailand

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Financing Arrangements in Health is Complex

- **BoB**
  - Govt. contrib.
  - Open-ended
  - Budget alloc.
  - Budget alloc.
  - Capitation payment for OP

- **MOI/DOLA**
  - General and specific transf.

- **SSO**
  - Employers & employee contrib.
  - Emerg. services
  - Fee-for service (OP) and DRG (IP)

- **CSMBS**
  - Salaries, admin costs, and cap. exp.

- **MOH**
  - Salaries etc.

- **Other ministries**
  - Own providers

- **NHSO**
  - Capitation payment for OP
  - Cap. exp.
  - Transfer for PP and IP

- **Population**
  - Risk-related contrib.

- **Private providers**
  - Capitation payment based on reg. + high cost cases

- **CUPs/hospitals**
  - Payment for IP based on DRG + global budget; some high-cost services

- **Private HI**
  - "sin taxes"

- **Traffic injury insurance**

- **Thai Health Foundation**

- **PHO**

- **DHO**

- **NHSO branch offices**
  - • Admin costs
  - • Promotion and prevention
  - • Locally run facilities

- **BMA**
- **PAO**
- **LAO (munic./TAO)**

**NOTES:**
- CUP: Contracting Unit for Primary Care
- PP: Prevention and promotion
- OP: Outpatient
- IP: Inpatient
- NHSO makes some OP capitation payments to private providers that act as CUPs
The evolution of central local relations

1953: Municipality Act (& ensuing amendments)
1994: Tambon Councils and TAO Act
1997: Provincial Administrative Organization Act
1997: New Constitution
1999: Decent. Act
2006: Decent. Act revised
2006: Tambon health promotion fund established with local and NHSO funding
2008: Second Action Plan for Decentralization

1990s
- TAOs tasked to perform disease prevention and control
- Constitutions emphasize decentralization of administrative power to develop public service delivery
- Ministries to develop action plans for decentralization of functions, resources, and staff to LAOs by 2010
- LAOs given the authority to manage service delivery, including health, in their localities
- Devolution of health centers to TAOs and municipalities initiated (only 28 HCs have been devolved so far)

Health sector
- Municipalities tasked to perform public health roles, and may maintain health care facilities
- PAO tasked to deliver services (incl. health) which are regarded as “collective responsibility” among LGUs
- 2006. Tambon health promotion fund established with local and NHSO funding
## Health sector decentralization to date

<table>
<thead>
<tr>
<th>What</th>
<th>Where and when?</th>
<th>Issues and controversies</th>
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<tbody>
<tr>
<td>Devolution</td>
<td>Scattered LGU initiatives</td>
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<td>LAO establishment of own HCs &amp; hospitals</td>
<td>20 years + Increase in last 5-10 years</td>
<td>Duplication of functions Coordination with NHSO, MOPH</td>
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<td>Transfer of MOPH HCs</td>
<td>2\textsuperscript{nd} decentralization plan</td>
<td>Excessive barriers to transfers</td>
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<td>Deconcentration with local participation</td>
<td>Pilot sites selected by MOPH or NHSO</td>
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<td>Area health boards</td>
<td>1\textsuperscript{st} decentralization plan</td>
<td>1/10 pilots had poor governance</td>
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<td>NHSO regional purchasing boards</td>
<td>6/13 regions piloting</td>
<td>Limited delegation of authority Passive role for LAOs, NGOs</td>
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<td>Health promotion hospitals</td>
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<td>LAOs, HCs perceive little change</td>
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<td>Delegation (NHSO to LAO)</td>
<td>Joint LAO-NHSO initiative</td>
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<td>Community health promotion funds: NHSO matching grants</td>
<td>99% of TAOs &amp; municipalities participate</td>
<td>Positive perceptions from all stakeholders</td>
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<td>NHSO CUP</td>
<td>Municipalities with hospital &amp;/or multiple HCs</td>
<td>Success depends on cooperation of MOPH referral hospital</td>
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Why slow progress?

- Thailand’s pattern of small, multi-level local government makes health decentralization challenging compared to many countries.

- Lack of consensus on decentralization model:
  - Concern about TAOs capacity & health commitment
  - Concern about public health coordination
  - Many health experts advocate integrated provider networks
  - Concern about local political pressure increasing risk of wasteful investment & blocking shift from hospital to primary care
  - Focus has been on transfer of facilities not functions and resources: HCs have only part of primary care function & budget for population

- Implications for health sector personnel
  - Devolution could have large impact on compensation, benefits, career path, professionalism of management environment, etc.
Issues with existing voluntary, incremental asymmetric decentralization

• Unclear responsibilities of LAOs to provide P&P and health services: familiar problems arising from permissive, overlapping LAO mandates
  – Overlapping LAO and MOPH mandates and functions
• Economy of scale: over 3,000 TAOs have a population of less than 5,000, making it difficult for them to achieve economies of scale even in primary health care delivery.
• Unclear who is responsible for monitoring devolved LAO health functions
• Current model relies on good local relationships to solve policy ambiguities and overcome institutional interests
• If network models are preferred option, case for creating legal basis and incentives for these options before further transfers
• Desirable to unbundle P&P and primary health care funding and functions & clarify CUP hospital interface before transfer
• Desirable to clarify technical support, HR development and monitoring responsibilities before further transfers
• Desirable to formalize piloting/experimentation of alternative models to optimize design and build in learning
## Challenges in applying principles for efficient, effective decentralization in the health sector

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<tr>
<th>Ideal principle</th>
<th>Health sector challenges</th>
<th>Implications</th>
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<tbody>
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<td>Clear, non-overlapping assignment of functions</td>
<td>- Levels of the system are linked</td>
<td>- Many health responsibilities shared between levels</td>
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<td>- Boundary between levels of healthcare is complex, hard to monitor &amp; changes over time</td>
<td>- Need interlocal structures or coordination processes</td>
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<td>Assignment to lowest level that can maximize costs &amp; benefits of decisions, &amp;</td>
<td>- Patients cross boundaries</td>
<td>- Governance &amp; relationships important</td>
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<tr>
<td>achieve scale economies</td>
<td>- A single function may have components with different scale</td>
<td>- Need linkages across P&amp;P/1°/2°/3° boundaries</td>
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<td>Retain national power over national allocative goals</td>
<td>- National government may have safety &amp; health equity goals that affect all health functions</td>
<td>- Detailed regulation review needed for decentralization</td>
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<td>- Levers of national stewardship need change &amp; development</td>
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<td>Close linkage between accountability for financing/costs &amp; benefits</td>
<td>- Need higher level risk-pooling for financial protection &amp; equity goals, leading to some</td>
<td>- Need specific structures &amp; expert/information resources to catalyze accountability to LAOs,</td>
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<td>delinking of accountability &amp; moral hazard</td>
<td>citizens &amp; patients</td>
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<td>Group congruent and synergistic services</td>
<td>- Social determinants of health have synergies with many sectors</td>
<td>- Major potential area of benefit to health from devolution</td>
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Is decentralization just too hard in health...?

• Many of these challenges face the health system anyway – they are relevant to optimal de-concentration in the health system

• The status quo poses unresolved policy & management challenges
  – Already health system is fragmented: divided and unclear accountability; mismatches between accountability and authority/control of resources
  – Boundary between primary care and hospital care already needs reform
  – Increasing need for local participation in health improvement and monitoring health services already recognized
  – Many call for increased multi-sectoral focus on social determinants of health
  – Many in health system see need for increased autonomy of service delivery units and delegation to local level – whether de-concentration or decentralization
  – MOPH & UC already face a need to develop leadership & stewardship methods that are effective in an increasingly pluralistic health system
## Possible options for decentralization in health

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<tr>
<th>Option</th>
<th>P&amp;P</th>
<th>Primary care</th>
<th>Secondary / tertiary</th>
<th>Financing</th>
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<tbody>
<tr>
<td>Voluntary transfer &amp; LAO own-financed health services</td>
<td>Clearer devolved, shared</td>
<td>Increased pluralism in primary care; LAO participation in MOPH HC boards</td>
<td>MOPH managed</td>
<td>LAOs participate in NHSO regional boards</td>
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<td>2 tier model, LAO role in primary care</td>
<td>Clearer devolved, shared</td>
<td>HCs &amp; community hospitals devolved to LAOs or LAO cooperatives</td>
<td>MOPH managed</td>
<td>LAO participation in NHSO regional boards; CUP delegated</td>
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<td>2 tier model, PAO role in hospitals</td>
<td>Clearer devolved, shared</td>
<td>HCs devolved to TAOs and Municipalities OR devolved as part of provider networks</td>
<td>Devolved to LAO cooperatives or large municipalities &amp; PAOs, +/- MOPH retains regional hospitals</td>
<td>LAOs participate in NHSO regional boards OR delegation to PAOs OR regional LAO cooperatives</td>
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<td>Integrated network models</td>
<td>Clearer devolved, shared</td>
<td>HCs and hospitals together in district, province or regional boards, devolved to LAO cooperatives or PAOs</td>
<td>As above</td>
<td></td>
</tr>
<tr>
<td>Autonomous provider models</td>
<td>Clearer devolved, shared</td>
<td>Staff-owned or part of autonomous provider network</td>
<td>Autonomous hospitals or autonomous area-based networks</td>
<td>All above options could be considered</td>
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