Decentralization of the Health Sector in Thailand

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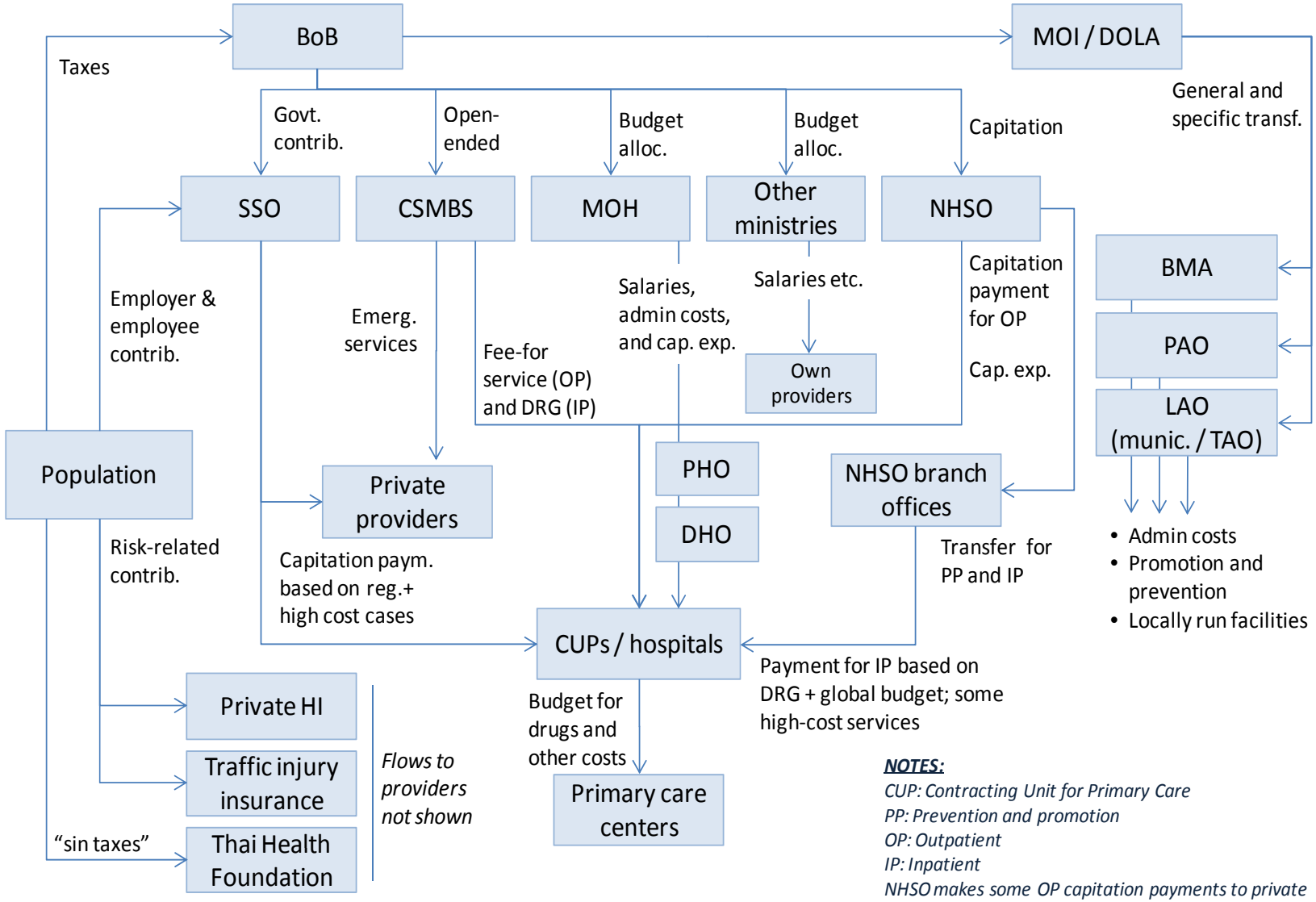
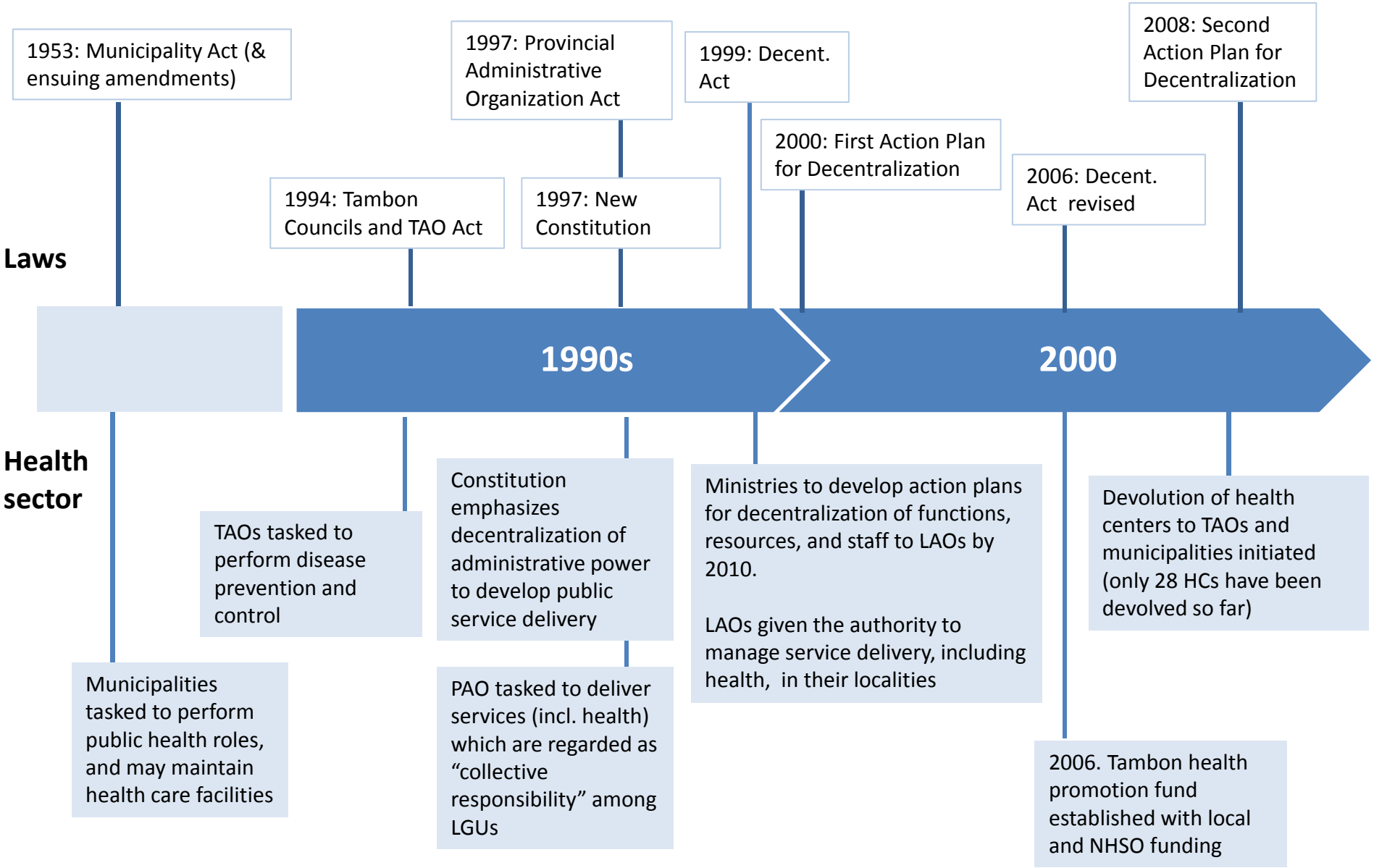
Financing Arrangements in Health is Complex



The evolution of central local relations



Health sector decentralization to date

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

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

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

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

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