

The Changing Local Health System in Northeastern Thailand after the Universal Coverage Reforms: Case Studies from Three Health Districts

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Background

Thailand Universal Coverage (UC) known as the '30 baht' health care reforms implemented by the Thaksin government in 2001. By early 2002, Thailand achieved UC of healthcare for the whole population by introducing a tax-funded health insurance scheme, so called "the universal coverage scheme" (UCS). (Tangcharoensathien et al., 2007). This scheme not only aimed to extend universal health insurance coverage to the whole Thai population but also put strong emphasis on strengthening primary care (Taytiwat et al., 2010). This was reflected in the resource allocation mechanism. The bulk of UCS funding was channeled through local contracting units for primary care (CUPs), mostly based in community hospitals, which then utilised part of that budget to fund upward referrals to provincial or tertiary hospitals and to support community and promotive/ preventative services in the local area. The UCS sought to develop health promotion and ill-health prevention alongside curative medicine (*sarng-nam-sorm*), and to build 'close to the home, close to the heart' (*glai baan, glai jai*) community health facilities in order to deliver health services to 65 million populations (Bureau of Policy and Strategy, 2007). In the early years of the reforms, the Ministry of Public Health (MoPH) attempted to reorganize the existing health centres into a system of primary care units (PCUs), and to encourage more qualified professional staff to work outside hospitals. A portion of the UC budget was separated off specifically to support 'promotion and prevention' (P&P) activities, largely undertaken by public health officers in district health offices and health centres.

However, early research on the implementation of the reforms in rural areas (Chamchan, 2007; Leethongdee, 2007; Hughes et al., 2010 ; Taytiwat et al., 2010) suggests that the strand of reforms concerned with community services achieved only limited success. Workforce shortages and tensions between hospital and community staff meant that many health centres remained poorly staffed and did not meet the requirements for PCU status. There were indications that directors of CUPs in some areas delayed or blocked the flow of monies from the CUP, both upwards to larger hospitals and downwards to the health centres and district offices. As a result of the perceived problems various policy adjustments were attempted which aimed to improve the management of local health care systems. In terms of resource allocation, and particularly after the National Health Security Office assumed responsibility for managing the UC budget, most monies for *outpatient treatments were channeled direct from the NHSO to*

provincial or tertiary level hospitals, bypassing the CUPs. Many provinces also introduced ring-fenced P&P allocations that went direct to PCUs or district health offices. This has been accompanied by attempts by the MoPH, PHOs and NHSO to strengthen performance management of the organizations making up the local health care system, and employ a range of 'new public management' tools to enhance accountability. To counter problems of staffing PCUs and health centres, alternative local organizations have been created. First community medical units (CMUs), located in larger health centres and using hospital staff and budgets, were established as an alternative to PCUs. More recently, there have been fresh initiatives linked to the long-term policy intention to allocate a higher proportion of health care expenditure via local government rather than the MoPH and NHSO. This is in line with the requirements of the Decentralisation Act 1999. Local government organizations at sub-district level can enter agreements with the NHSO to jointly administer and jointly finance local health funds to support promotion and prevention work. There are also moves to convert some health centres into tambon health promotion hospitals (THPHs), which will support primary care and health promotion work at sub-district level with mainly MoPH but also some local government funding.

These various initiatives seem likely to affect the working dynamics of local health care systems and the balance of power between the various actors. The UC reforms initially resulted in significant increase in the influence of the CUP and community hospital at the expense of the provincial and district health offices, as the 'power followed the money' (Leethongdee, 2007). A sharp reduction in funding for district offices and health centres left many of these in a very difficult position. Changes in resource allocation are likely to lead to changes in relations between the various bodies and possibly a change in the axis of power. This may have knock-on consequences for the distribution of resources between curative and promotive services in local areas and perhaps affect access to services and the equity of provision experienced by the local population. This is the general area addressed by the doctoral research study.

Research Questions

- What is changing and what is remaining constant in the management of local health care systems in rural North East Thailand?
- How far do recent initiatives to improve the management of the local health care system and decentralize decision making utilise 'new public management' techniques (such as performance review and benchmarking) and what mechanisms are being used?
- How are such initiatives affecting the operation of the system?
- How far are such changes affecting access to services and equity of provision for local rural populations?

Methods

The research study includes three case studies of contracting units for primary care (CUPs) in a Northeastern Thai province. The study is conceived as a qualitative, policy ethnography (Strong and Robinson, 1990), supported by some limited analysis of quantitative background data on the three districts. Each case study involves a mix of in-depth interviews, field observations and documentary analysis. Quantitative data have been extracted from official documents to describe the characteristics of the three districts.

The Case Study Areas

A purposive selection was made so as to include a large, medium and small CUP, with the populations covered ranging from around 17,000 to 135,000. The three CUPs selected are in one of the heartland provinces of central Isaan (the North-eastern region). The province concerned is divided into 18 health districts which are co-terminus with the local government districts (amphur). The districts are further divided for administrative purposes into sub-districts (tambon) of which there are 134 in the province. Urban sub-districts or municipalities (i.e the provincial city and towns) are administered by local government organizations known as tes-sa-ban, while rural tambon are overseen by tambon administrative organizations (in Thai, Ao Bo Taw). Both types of local government organizations have some limited health functions and co-ordinate their work with MoPH facilities operating at the district or sub-district level.

Although varying in size, each district selected for a case study contained a district health office, a community hospital and several primary care units (PCUs) based in health centres (numbers = 3, 12 and 13). There were also a large number of suk-sa-la (primary health care stations), staffed mainly by health volunteers. In recent years there have been several national or provincial initiatives to improve the management of local health care systems. Current government policy is to develop many health centres into tambon health promotion hospitals, and each of the three districts has one such facility, with plans for others in two districts. The districts also each have a community medical unit (CMU), an organization created in an earlier policy initiative. CMUs were created as an alternative to PCUs in some larger health centres, staffed by a doctor and funded partly out of hospital funds, at the time when PCUs in many areas were unable to recruit medical staff. Additionally the local government organisations within the districts have all signed Memoranda of Agreement with the National Health Security Office to establish local health funds to support promotion and prevention work. Currently these organisations are working with the NHSO outpost and PHO to develop local networks to coordinate fund decision making and the implementation of funded projects.

The organizations studied are overseen by one of the Northeastern regional outposts of the National Health Security Office (NHSO) and the Provincial Health Office (PHO) of the MoPH. They are subject to a common resource allocation process and expected to meet the same performance requirements. The Thai UC budget is split into inpatient (IP), outpatient (OP) and promotion and prevention (P& P) components. In the current system a large component of the IP allocation goes from the NHSO directly to provincial and tertiary care hospitals. The bulk of the remaining IP, OP and P&P monies is passed from the Regional NHSO via the PHO to the Contracting Unit for Primary Care, located in the community hospital in each district, while some ring-fenced P&P funding goes to community-based primary care (including a percentage to the local health funds). The Decentralisation Act, 1999 requires the transfer of a proportion of central government funds to local government (local government revenue was required to rise to 35% of total central government revenue by FY2006, though there has since been some slippage in the requirement), and the creation of local health funds can be seen as part of this process.

Data Collection

Data were collected from in-depth interviews, participant observation and documents.

In-depth interviews were conducted with a range of actors in each district, including staff from district health offices, community hospitals, primary care units (PCUs), community medical units (CMUs), tambon health promotion hospitals (THPHs), community health stations and local government staff overseeing community health funds. The interviews included the heads of the district health office and

the community hospital as well as a purposive sample of the heads of lower-level organizations, and a purposive sample of lower level staff (see Table 2 in appendix). The interviews were audio recorded and transcribed in full.

An interview guide was used to cover broadly similar ground with comparable respondents. The content of the guide was adapted to address the different issues affecting staff in different organizations (e.g. DHOs, community hospitals, PCUs, tambon health promotion hospitals, and local government). For most actors the interview guide included questions on the following issues:

- policy implementation (how new arrangements were 'rolled out')
- Examples of new public management techniques (devolved budgets, monitoring and review processes, use key of performance indicators, incentive payments)
- CUP organization and function
- CUP management structures and processes
- Economic support and management
- Allocation and distribution of resources
- Patterns of health care delivery

Field observations were carried out in selected organizations at each level in each of the three districts. The observations tended to fall into three categories:

- Key informants were recruited in each district (two in the large CUP and one each in the medium and small CUPs) who provided general information and also allowed the researcher to shadow them at work (in a hospital, district office, PCU and THPH) and at outside events like seminars or workshops.
- Apart from the above the researcher gained permission to observe work activities and meetings in the community hospitals, district offices, PCUs and THPHs in the three districts, as well as community health work in the villages.
- Additionally the researcher attended a number of district or province-wide workshops, seminars and planning meetings.

Observation sessions were carried out from August 2009 to September 2010. The researcher is a University Nursing lecturer with responsibility for supervision of students in community placements and was often able to tack research visits on to her work schedule. Most observation sessions lasted between one and four hours. Periodic meetings with the key informants were held to keep abreast of events. These persons range in seniority from hospital director down to a public health worker in the THPH. Access to most of the outside workshops or seminars attended (for example a seminar on quality monitoring organized by the NHSO regional outpost) was facilitated by key informants or other senior staff who had granted access.

Field notes were dictated into a small audio recorder and typed up by a secretarial assistant, or occasionally written directly into a note book.

A range of organizational documents was collected and used to extract background data. This included reports and guidance documents from the NHSO, the NHSO regional outpost, the MoPH health region (khet), the PHO, and the district health offices and community hospital in the three areas. Developments in the province were affected by a number of strategy documents (from local government, the PHO, and

the Royal development programme). Other documents collected related to the performance management framework and the system of KPIs and benchmarking.

Research access was negotiated initially via letters to the three main administrative bodies overseeing the local health care system: the Regional Office of the National Health Security Office (the administrator of the public insurance scheme), the Provincial Office of the Ministry of Public Health (the middle-tier MoPH body) and the relevant local government body (the tes-sa-ban or OBT with responsibility for overseeing local health funds and the THPHs). Copies of the correspondence were sent to lower-level organizations (the community hospitals, PCUs and THPHs) and, after higher-level approval, access to the selected sites was negotiated site by site. Ethical approval for the study was granted by the university research ethics committee. Individual consent forms were completed by individuals prior to interviews.

Data Analysis

The interviews were fully transcribed and analysed alongside fieldnotes based on the observations. Both interview and field note data were analysed inductively so as to identify relevant themes and differences in staff perspectives within different organizations. A simplified version of the constant comparative method (Glaser and Strauss, 1967) was used. Comparisons between the three districts and between data from the different types of settings were used to explore themes/categories and the differences in actors' perspectives. The analysis also took account of chronology and how policies changed in the course of implementation and as problems were encountered. The intention was to tell a story of how actors in different organizations in the three districts implemented the new policies affecting the local health care system.

The researcher tried to increase confidence in the interview data by sampling a wide range of participants and cross checking the accounts of staff members in similar positions, and also how accounts changed over time. Wherever possible, the researcher tried to verify factual information volunteered in interviews by seeking corroboration from other respondents or checking against direct observations and documents.

Some Findings

1. The balance of power between the PHO and the CUP has shifted back towards the PHO. Money from the regional NHSO outpost goes to the PHO and is then disbursed to various organizations in the local health system. The CUP no longer channels the inpatient (IP) budget to the provincial hospital and, although the allocation for PCUs/health centres goes through the CUP, it is ring-fenced for this purpose only. Together with the regional NHSO, the PHO is responsible for performance management using various new public management techniques. There is a provincial 5 year strategic plan with 13 health goals and a set of associated key performance indicators (KPIs) and benchmarks, against which performance is assessed. This is linked to a system of electronic information returns (e-claims), and staff also have to report performance against KPIs in regular face-to-face meetings. There is an attempt to implement TQM PMQA and a system of Primary Care Awards (PCAs) which aim to improve quality. This gives the PHO a powerful role in overseeing and monitoring performance, with the sanction of withholding funding where targets are not met.

2. Most of the time this new PHO role is supported by the NHSO regional office without major conflict, but there are occasional tensions. For example, the NHSO has not been able to implement certain new KPIs linked to a planned service improvement programme because of opposition from physicians in the local health care system whose position was supported by the PHO.

3. The process of decentralization and transfer of monies from central to local government required by the Decentralisation Act 1999 is going ahead slowly, but only affecting the local health care system at the margins. There is less top-down control than in the past and scope for regional NHSO outposts and PHOs to develop a distinctive local approach within a particular province. The case study province has developed an arrangement for joint planning between the provincial government and the PHO, which has no close equivalent in adjacent provinces. There is a distinctive programme to develop community health stations (suk-sa-la), staffed by volunteers at the level beneath the health centres (normally close to one suk-sa-la per village). The province has also initiated an innovative sponsorship and training programme whereby funds are provided to three Universities to train a specified number of nurses, pharmacists and public health officers for future service in the province.

4. Joint working between local government and the health sector is still developing. Local health funds have been implemented throughout the province, and there are about 30 tambon health promotion hospitals (which can draw on the funds for P&P work). Much of this work is project-based, with a range of community projects in operation, which focus on disability, rehabilitation and training as well as traditional P&P activities such as sanitation, food hygiene, mosquito control and exercise classes. Local government (the tes-sa-ban and OBD) are starting to work in partnership with the health sector to plan and co-ordinate P&P work in their catchment areas.

5. Recruitment of professional staff for primary care is still a major problem, which means that the PCUs and tambon health promotion hospitals are not developing as fast as planned. This has led to the training initiative described above, which has been funded by top-slicing 1% of the P&P budget. However, there has been criticism from community hospital directors that they have no clear information about how many staff the program will deliver, and accusations that the PHO is actually diverting more than the stated 1% of the budget for this purpose.

Discussion

Over the past 10 years, numerous international articles focus at community participation to empower local people sharing health program (Bartholomew et al., 2007; Broome et al., 2007; Courtney et al., 2007; Joe et al., 2007; Simpson and Flynn, 2007; Simpson et al., 2007; Valente et al., 2007; Dieleman et al., 2009; Bhattacharyya et al., 2010; Carlford et al., 2010; Rugs et al., 2011). Recent evaluations suggest that the Thailand UCS has brought significant benefits, such as improved access to care for poorer people and a reduction in catastrophic health expenditure for all (Tangcharoensathien, 2007; Damrongplisit and Melnick, 2009). Yet the Thailand reform package so far implemented differs in important respects from that originally proposed by policy architects such as Nitayaramphong, S. (2005) and Siamwalla, A. (2001). Lessons learned from Thailand UC had included the responsiveness to concerns of stakeholders and other influential partners who actively participated in the process of policy formulation and implementation (Tangcharoensathien et al., 2007). It now seems unlikely that the UCS will be merged with the Social Security Scheme (SSS) and Civil Servant Medical Benefits Scheme (CSMBS) to create a single national health insurance programme as first envisaged. Siamwalla's plan to use capitation funding to reallocate the medical workforce more equitably across the nation remains largely unrealised. The NHSO has still to develop its intended role as an active purchaser of services, and local government participation in the UCS is not as extensive as hoped. The detail of financing mechanisms and organisational roles varies geographically and has undergone much experimentation and change over time. The radical vision of transforming primary care through the financial empowerment of the CUPs has been diluted, partly to guarantee funding for provincial hospitals, and partly to counter the hoarding of funds for pet projects by community hospital directors. As the result shown, the relationship

between the PHOs and CUPs has been transformed so that the power accrued by the latter in the early years of the reforms has now largely been clawed back.

The swing of the pendulum of power back towards the PHOs has occurred as they have built up more stable relationships with the NHSO outposts and developed a new role as performance manager of the local health care system. This coincides with improved relationships and a more settled division of labour between the MoPH and NHSO at national level, after an earlier period of in-fighting and wrangles over control of resources. The PHOs have cemented their control over provincial health care systems by introducing rationalised management instruments, very much in the mode of the New Public Management tools widely implemented in Western countries to improve service delivery with policies to improve the managerial control, financial efficiency and performance accountability of health sector managers and workers (Hood, 1995; Kettl, 1998; Mill et al., 2001 ; Christensen and Lægheid, 2007). Methods such as use of the commercial private sector and greater reliance on not for profit providers are mooted (Bennett et al.,1997 ; Green and Matthias, 1997). Some management techniques have been become innovative use in a range of developing countries (Impagliazzo et al., 2009 ; Peter et al., 2008 ; Sarker, 2006).This is a new element, not foreshadowed to any great degree in early policy documents on the UCS reforms, which has now come to dominate service delivery and organisation at the local level.

While the UC reforms command broad support, detailed policies on matters like the organisation of primary care, the financing mechanism, and the respective roles of NHSO outpost, PHO and CUP remain controversial. Several recent initiatives, such as the establishment of the CMUs, THPHs and local health funds, pull in different directions and rely on support from different sponsors. Similarly the swings of power between PHOs and the CUPs arise in part from different visions of the local healthcare system. The drive to improve strategic planning and performance management, sits uneasily alongside the original vision of transforming primary care by devolving money and decision making authority to a local body – the CUP – unaffected by the vested interests of the big hospitals. Policy differences at this level are still not resolved and different interest groups continue to seek solutions that combine fair resource allocation with responsiveness to the needs of local communities.

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