THAILAND UNIVERSAL COVERAGE HEALTH CARE REFORMS: RESEARCHING THE ROLE OF THE LOCAL FUND HEALTH SECURITY IN LOCAL GOVERNMENT PURCHASERS IN THE NORTHEASTERN REGION OF THAILAND

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บทบาทขององค์กรปกครองส่วนท้องถิ่นต่อการดำเนินงานกองทุนหลักประกันสุขภาพในระดับท้องถิ่น ในภาคตะวันออกเฉียงเหนือ ภายใต้บริบทของการปฏิรูประบบหลักประกันสุขภาพถ้วนหน้าในประเทศไทย

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VORAPOJ PROMASATAYAPROT: THAILAND UNIVERSAL COVERAGE HEALTH CARE REFORM: RESEARCHING THE ROLE OF THE LOCAL FUND HEALTH SECURITY IN LOCAL GOVERNMENT PURCHASERS IN THE NORTHEASTERN OF THAILAND. THESIS ADVISOR: ASSOCIATE PROFESSOR SATHIRAKORN PONGPANICH, Ph.D., 321 pp.

This thesis is to study the role of the local fund health security in local government as a component of Thailand's universal coverage health care reforms in the North-eastern region of Thailand.

This study was conducted in 190 subjects of the Local Administrative Organisations (LAOs). These comprised the sample for investigation of the policy process, the approaches to strategic planning, and description of the local context in which local fund health securities are developed. The research used two main primary data collection methods: a (mainly quantitative) cross-sectional survey based on the questionnaires and a qualitative interview/focus group study conducted in a smaller subset of the sites. Data collection process took over a year from September 2008 to October 2010.

The LFHS in Thailand was established in 2006. However, this study found almost half of the samples were established in 2008. LFHS plans were made both before and after budget allocations from the NHSO. Health community plans were used more than strategy maps for processing the LFHS. Activities and projects of the LFHS were divided into 4 mainly domains including health service core package purchasable, health centre support, health promotion and prevention, and management and development of the LFHS. All activities and projects targeted to five groups who were mother and child, aging people, disable and crippled people, occupational risk workers, and chronic disease patients. The activities and projects covered health domains including health promotion, disease prevention, rehabilitation, primary medical care, and folk wisdom promotion. Transfer banking was the most way for allocations of the LFHS. Some problems occurred according to management processes of the LFHS which mainly were on man, material, method and money aspects.

This research suggests that, the budget administration should not be obligated with budget year as usual because of some inconvenient that induced the operation lack of smoothness and continuity. Lastly, the public relations about the service of fund, particularly rights benefit package emphasizing various target groups should be continuously propagated and collected an action for health promotions association in their lives.

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วรพจน์ พรหมสัตยพรต : บทบาทขององค์กรปกครองส่วนท้องถิ่นต่อการดำเนินงานกองทุนหลักประกันสุขภาพในระดับท้องถิ่น ในภาคตะวันออกเฉียงเหนือ ภายใต้บริบทของการปฏิรูประบบหลักประกันสุขภาพถ้วนหน้าในประเทศไทย (THAILAND UNIVERSAL COVERAGE HEALTH CARE REFORM: RESEARCHING THE ROLE OF THE LOCAL FUND HEALTH SECURITY IN LOCAL GOVERNMENT PURCHASERS IN THE NORTHEASTERN OF THAILAND) อ. ที่ปรึกษาวิทยานิพนธ์หลัก : รศ. ดร. สถิรกร พงศ์พานิช จำนวน 321 หน้า

ในการศึกษาครั้งนี้มีวัตถุประสงค์เพื่อศึกษาบทบาทขององค์กรปกครองส่วนท้องถิ่นต่อการดำเนินงานกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ ในภาคตะวันออกเฉียงเหนือประเทศไทย ซึ่งการศึกษานี้ใช้วิธีการวิจัยเชิงปริมาณ (Quantitative Approach) และเชิงคุณภาพ (Qualitative Approach) โดยศึกษาจากแบบสอบถาม (Questionnaires) และการสัมภาษณ์ (Interviews) จากองค์กรปกครองส่วนท้องถิ่น คือ องค์การบริหารส่วนตำบล (อบต.) และเทศบาล จำนวน 190 แห่ง ในประเด็นเกี่ยวกับการสนับสนุนการดำเนินงานการส่งเสริมสุขภาพ การป้องกันและควบคุมโรค

ผลการศึกษา พบว่า บทบาทในการดำเนินงานของกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ ตามหลักการประกันประกันสุขภาพถ้วนหน้า ขององค์กรปกครองส่วนท้องถิ่นนั้นขึ้นอยู่กับผู้กำหนดนโยบายคือผู้บริหารท้องถิ่น นอกจากนี้ยังขึ้นอยู่กับการกำหนดแนวทางในการดำเนินงานของสำนักงานหลักประกันสุขภาพแห่งชาติ (สปสช.) อีกด้วย ทั้งนี้ เพื่อให้สอดคล้องกับหลักการประกันสุขภาพแห่งชาติ และทิศทางการกระจายอำนาจของประเทศ โดยที่องค์กรปกครองส่วนท้องถิ่น สามารถกำหนดบทบาทในการดำเนินงานสร้างเสริมสุขภาพที่เหมาะสมกับระดับของท้องถิ่น ไม่ว่าจะเป็นองค์การบริหารส่วนตำบล (อบต.) เทศบาลตำบล เทศบาลเมือง และเทศบาลนคร นอกจากนี้ องค์กรปกครองส่วนท้องถิ่นก็จะต้องสนับสนุนงบประมาณสมทบร่วมกับสำนักงานหลักประกันสุขภาพแห่งชาติ (สปสช.) ในการดำเนินงานส่งเสริมสุขภาพ การป้องกันและควบคุมโรค แก่กลุ่มเป้าหมายต่าง ๆ

ดังนั้น องค์กรปกครองส่วนท้องถิ่น จะต้องกำหนดบทบาทการทำงานของกองทุนหลักประกันสุขภาพใหม่ เพื่อให้สอดคล้องกับบริบทด้านสุขภาพของท้องถิ่นในแต่ละระดับในการดำเนินงานสร้างเสริมสุขภาพต่อไป

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ABBREVIATIONS

AAR	After Action Review
AH	Autonomous Hospital
AHB	Area Health Board
APB	Area Purchaser Board
BHCN	Bureau of Health Care Network
BHPP	Bureau of Health Policy and Planning
BMA	Bangkok Metropolitan Administration
CUP	Contracting Units for Primary Care
CSMBS	Civil Servant Medical Benefit Scheme
CTC	close-to-client
DOR	Division of Registration
HCRO	Health Care Reform Office
HCS	Government Health Card Scheme
HIO	Health Insurance Office
IGO	Inspector General Office
ISTEA	Intermodal Surface Transportation Efficiency Act
LAO	Local Administrative Organisations
LGO	Local Government Organisation
MoPH	Ministry of Public Health
NBD	National Board of Decentralisation
NDC	National Decentralization Committee
NHIB	National Health Insurance Board
NHIO	National Health Insurance Office
NHSO	National Health Security Office
PAO	Provincial Administrative Organisation
PBBS	Performance Based Budgeting System
PHO	Provincial Health Office
POH	Public Organisation Hospital
P&P	Prevention and Promotion of Health

SSS	Social Security Scheme
TAO	Tambon Administrative Organisations
TEA21	Twenty-first Century Act
UC	Universal Coverage
WCS	Workmen Compensation Scheme
WSLFHS	Wungsang Local Fund Health Security
WSTAO	Wungsang Tambon Administrative Organisation

CHAPTER I

BACKGROUND AND SIGNIFICANCE

The first chapter is an introduction that describes the health insurance system in Thailand. The current study investigated the role of the local health fund holding by local government as a component of universal coverage provision in the north-eastern region of Thailand. Therefore, the background of the policy and reform agenda regarding decentralisation and devolution in the health sector is explained initially. The second section of this chapter presents the rationale for focusing on the role of the local health fund in local government in terms of the research questions, overall objective of the study, hypotheses, and the benefits of this study. Finally, the conceptual framework is outlined.

1.1 Introduction

The Kingdom of Thailand is situated in continental Southeast Asia with an area of 513,155 km^2, just north of the equator, and is part of the Indo-Chinese Peninsula. The population of Thailand was 62.3 million in the year 2000, and is growing at 1.1 percent per year. The proportion of the elderly population (over 60 years) was 8.6 percent in the same year and is expected to grow to 15.0 percent in 2020 (Wibulpolprasert, 2000). Thailand is a democratic country with a constitutional monarchy. Thailand's administrative system comprises three major tiers, i.e., central administration, provincial administration and local administration. There are 76 provinces, 876 districts, 1,129 municipalities, and 6,397 Tambon Administrative Organisations

(TAO), within four geographical regions; the Northern, North-eastern, Central, and Southern regions.

Thailand is a country in economic and social transition. This also applies to the health sector. It appears that chronic diseases such as cardio-vascular disease, metabolic disease and cancer show statistically significant increasing trends. Furthermore, infectious diseases including HIV are still health problems. As a result improving and modernizing the health sectors are necessary in order to assure that, the disadvantaged fraction population can afford the health care system.

In the past, the health care system in Thailand has evolved from self-reliance using local wisdom for health promotion and curative care. The current system usually depends on modern medical care and health technology. While the main service providers are within the public sectors, the private for-profit and not-for-profit sectors participate actively in what is a pluralistic health care system. Meanwhile, many people still depend on the traditional healing methods. With the expansion of modern health care delivery systems both in the public and the private sector, Thais are moving toward using more health facility-based services. The percentage of self-care and self medication reduced from 54.10 percent in 1970, to 48.00 percent in 1991, and to 17.62 percent in 1996. During the same period, the use of public health services increased from 15.5 percent over 28.9 to 44.0 percent, while the use of private sector services changed only marginally from 22.7 to 24.3 percent (Office of the National Statistics, 2000).

The 1999 Health and Welfare Survey found that 21.2 percent of the population resorted to self care and self medication while the use of rural health centres was 19.2 percent, more or less equal to those who went to ambulatory private clinics (19.0 percent). The percentages using district hospitals, provincial hospitals and private hospitals were 14.9, 15.6 and 4.8 percent respectively. People living in urban areas are more likely to use private clinics and hospitals than public facilities, while in rural areas; public facilities are the main sources for care. In a similar vein, the Office of National Statistics (2000) reported that 38.1 percent of the urban population use private clinics and hospitals and 28.4 percent use the public facilities, as compared to 20.1 and 55.3 percent respectively for rural people.

For health personnel-manned facilities, public facilities outnumbered private facilities, particularly in rural areas. Most of the rural public facilities are under the central Ministry of Public Health (MoPH). In regard to facilities of primary care, the 9,704 rural health centres cover all sub-districts, and the 724 community hospitals (10-120 beds) cover all the rural districts. In the municipal areas, there are more than 12,000 private clinics, 132 municipal health centres, and the outpatient departments of public and private hospitals. Rural health facilities have expanded and developed extensively in the past two decades. Despite the economic recession in the years 1982 to 1986, the government decided to freeze the expansion of all urban hospitals, so that the budget was reallocated to expand the coverage of rural districts with hospitals and health centres. The budget for district health services increased at a faster rate than that for provincial health services. It remains the same way until now. Thus, this achievement resulted in the shift so that relatively less outpatient service work was performed in

provincial hospitals and more in the district hospitals and the rural health centres (Wibulpolprasert, 2000).

In 1999, two important Acts were promulgated consisting of the Public Organization Act and the Decentralization Act. All public universities (including medical schools and their hospitals) became independent public organizations in 2002. A 120-bed MoPH hospital had already become independent in October 2000. If this experiment proves a complete success, there will be more public independent hospitals. According to the Decentralization Act, the majority of public health service facilities would be devolved to the local authorities by 2010.

The 1997 Constitution of the Kingdom of Thailand, section 52, had stated that *"individuals shall have equal rights in receiving standard health service…as provided by law"*. This provision of the constitution forced the government to develop the standard of the health care system, but initially not rapidly enough to correct the variable standards of health care or solve the problem of incomplete insurance coverage. Subsequently, the policy of the Thaksin government as known as "the 30 Baht policy" introduced "universal coverage" in health care. Then, the Prime Minister delivered his speech on the policy at the parliamentary session on 26 February 2001, stating that *"the government will establish the universal coverage scheme to reduce the national and people's health expenditure, by paying 30 bahts per visit and providing accessibility to health care institutions of good standard equitably".* This was one of 9 prioritized policies (Policy statement of the Cabinet delivered by the Prime Minister to the Parliament on 26 February 2001).

The 1997 Constitution provided a crucial re-orientation for the health of Thais. Health was stipulated as a human right, which must be protected by the state. An egalitarian standpoint was emphasized in the context of health for the first time of political philosophy in Thailand. An equal entitlement to health was introduced for a wide range of marginalized population groups, i.e., elderly people, disabled people and disadvantaged children etc. Consumer protection, particularly in health-related areas, was another area of increased government attention.

The Thai Rak Thai government implemented its universal health insurance system in all provinces of Thailand in 2001. Despite the fact that plans were for a single unified scheme, the universal coverage in Thailand consisted of four major schemes in practice, namely:

1. Civil Servant Medical Benefit Scheme (CSMBS)
2. Social Security Scheme (SSS) and Workmen Compensation Scheme (WCS)
3. 30 Baht Scheme
4. Car-accident Compensation Scheme

(NaRanong, et al., 2002)

The 30 Baht Scheme was the new component that filled the coverage gap left for people who were not under the CSMBS or SSS schemes. Over time responsibility for the Scheme has shifted from the Ministry of Public Health (MoPH) to a new body, the National Health Security Office, with the MoPH acting as the administrator in the transitional period until 2006. The scheme started as a pilot project in six provinces in April 2001 and then expanded to twenty-one provinces in June. The scheme

consolidated all existing health insurance programmes which were undertaken by the MoPH, including the Health Welfare Program for the Low Income and disadvantaged and the Health Card Scheme (voluntary) (better know as the 500 Baht Health Card for families). While the phrase *"universal coverage"* and the slogan *"30 baht treats all diseases"* have been high in the government's discourse, the major reform that affected health care providers after 2001 was the health care financing reform that aimed to redistribute resources and physicians throughout the deprived areas on a more equal basis. The financing reform allocated three-fourths of the MoPH budget based on capitation, resulting in sharply increased funding for under-staffed hospitals in highly-populated rural areas. Large hospitals in major cities which previously attracted most physicians, found themselves in difficulties as their costs were high compared with those receiving budgets. They could no longer charge patients as they had in the past.

Contrary to popular beliefs, the 30 Baht scheme has not cost the taxpayers dearly. In FY 2002, the scheme added about 10 billion baht to the MoPH regular budget (approximately 16 percent increase from 60 billion baht in FY 2001) while providing health coverage to additional 25 million people. Data for recent years was not available at the time of conducting this study, but projections suggested a continuing modest increase, likely to be less than the increment in the SSS.

It is unlikely that the three major health insurance schemes will be merged in the near future, because of opposition from affected interested groups. This has caused concerns about equity and overlapping coverage. Part of the overlapping coverage is due to incentive problems, for example, multiple cardholders still benefit from having

more than one card as there has been no one dominant scheme under which the benefit package is better than other schemes in every aspect. One plausible measure to solve the perverse incentive problem is to elevate certain benefits under the CSMBS that are still below than these of the SSS, and which are still below those of the 30 Baht Scheme. In addition, a reform of the payment mechanism is needed to curtail perverse incentives for health providers to develop double or multiple standards in treating patients under different schemes.

The Decentralization Act became effective in November 1999. This Act defined the roles and responsibilities of the National Decentralization Committee (NDC). A primary responsibility of the NDC is to produce a decentralisation plan that will define the relationships and functional responsibilities between the central and local governments, as well as among local governments. It will define local revenue sources and identify means to improve the mobilization of local tax and revenue. The plan outlines the stages and means to transfer certain functions from central government to local governments, as well as recommendations regarding the means to coordinate the transfer of public officials from central government to local governments, and state enterprises involved in the new assignments of functions and resources (World Bank Thailand Office, 2000). In view of the profound political changes in the Kingdom of Thailand between 1999 and the present date, it remains unclear whether these provisions will take effect. According to what time scale is, the Decentralization Act provided that the central government had to transfer more than 35 percent of the annual budget to local government by 2006. However, only 26 percent of annual budget had in fact been transferred to local government by 2007, including a small

element of the UC funding. Nevertheless this remains a significant background factor influencing a current policy.

According to the Decentralisation Act, the public health mission and hospital mandate must be devolved on local governments. Therefore, a crucial re-orientation needs to be undertaken by both central government officers and local government officers. The central authority has to shift its mission from top-down administration and policy control to technical and quality assurance of health care. At the same time, the local government has to be empowered so that it will be capable of providing equitable and efficient health care, which will be accountable for those people in their own community.

Under the current Constitution of the Kingdom of Thailand B.E. 2550 (2007), rights to health care for ordinary people will occur if anything has been strengthened. Section 51 provides that *"a person shall enjoy an equal right to receive standard public health service, and the indigent shall have the right to receive free medical treatment from a State infirmary ... as provided by law"*. This provision of the new Constitution, together with the requirements of other recent legislation, forced the government to take new steps to improve the standard of the health care system. The National Health Security Act B.E. 2545 (2002), required government *"to set up national health security for people in local areas by encouraging the process of participation according to the readiness, reasonableness, and need of people in such areas, the Board shall support and cooperate with local government organizations determining regulations so that the said organizations shall implement and manage the national health security system in local areas by earning expenses from the Fund as provided*

by law" (s. 47). This provision of the law forced the National Health Security Office to coordinate activities with local governments for co-matching fund according to section 18 *"to prescribe the health service provided by a health care unit and network of health care units and to prescribe the standard of implementation, regarding national health security, to be effective" … "to prescribe the rules of fund management and implementation" ... "to encourage and cooperate with local government organizations in implementing and managing the health security system in local areas by considering their readiness, reasonableness, and need, in order to establish national health security residents of such areas as prescribed in section 47" … "to encourage and prescribe rules making it possible that non-profit community organizations, non-profit private organizations and non-profit private sectors implement and manage local funds by considering their readiness, reasonableness, and need, by means and encouraging procedures of participation in order to establish national health security residents of such areas as prescribed in section 47".*

It is clear that local governments in the developing world are currently facing serious and urgent problems. Poverty, failing infrastructure, and the lack of human and financial resources have impacted negatively on local governments' capacity to perform their mandated functions. The decentralisation movement with the mandate to devolve to the local administration consequently posed a continuing challenge to the authorities concerned. Authorities need to avoid stirring up disproportionate anxiety and creating unnecessary resistance to change. On the other hand, many crucial issues need to be clarified to ensure that a wide range of stakeholders participate in creating the new system. Since the present health system is satisfactorily serving the majority of

the population, this issue has been even more crucial. Last but not least, the system needs to identify the needs for capacity building to ensure the emergence of an effective decentralized system with various parties properly carrying out their new roles and functions.

It is obvious that there is a need for additional research studies to fill the gap in knowledge particularly concerning administrative and management aspects of the reform process. At a minimum, there should be adequate information about the emerging role of local governments as a component of universal coverage provision in Thailand. There are 3,935 local fund health securities in local government. There are 1,480 local fund health securities in local government in the north-eastern region of Thailand, and 216 local fund health securities in municipalities (4 in the City Municipalities, 19 in the Town Municipalities, and 193 in the Tambon Municipalities), and 1,264 local fund health securities in the Tambon Administrative Organizations (TAO) (Khon Kaen Branch of National Health Security Office, 2010).

The local government is the nearest organisation for people to generally possess a good understanding of local issues. It should have the capacity to manage a local health fund for a small community and, at later stage, expand to cover larger local communities. Requiring a financial contribution from local government will increase awareness of health issues and augment the accountability of the local government.

The UC Scheme is presently governed by centralised agencies, in practice the NHSO with some continuing influence exercised by the NHSO. According to the governmental direction mentioned previously, the system should be decentralised and

passed into the hands of local administrations. As stated above, it is unclear how far this process will be in practice going ahead and with what timescale, but some changes, including the creating of local fund health securities are already being implemented. This study attempted to investigate how the local government could cope with the task and what would be the after effects of (partial) decentralisation of the health system.

This study aimed to investigate the impact of new funding arrangements affecting local government, and specifically the municipalities and Tambon Administrative Organizations (TAO), in the north-eastern region of Thailand. Currently local fund health securities have been introduced in some but not all local government organisations in the region. Results of this research could be used to suggest certain adjustments in the handling of the administration to the government; and how to enhance community participation so that people's voices have an influence on local health care financing arrangements. As a first step, community participation projects linked to the local funds could be developed in some areas and then subsequently "rolled out" to other localities.

1.2 Objectives of the study

General Objective

The overall objective of the research was to study the role of the local fund health security in local government as a component of Thailand's universal coverage health care reforms in the north-eastern region of Thailand.

Specific Aims

The general objective encapsulated to a number of more specific aims including**:**

1. To describe the policy process affecting local fund health securities in the following aspects:

1.1 Policy formation: how the central policy blueprint was developed, enforced and monitored by the central authorities and whether local government had the capability to comply

1.2 Policy implementation: the real nature of the management of the local fund health securities by local government, iteration with central authorities, and the scope for local variations in policy

1.3 Policy evaluation: the extent of efforts to evaluate, feed back information to the central government, and adjust policy design as local fund health securities "settle", including moves to amend central rules, guidance and local implementation strategies.

2. To describe the implementation situation and influencing factors on the local fund health securities seeking

3. To describe the relationships among personal, organizational, institutional and political factors on the implementation of local fund health securities.

1.3 Research questions

The aims set out above gave rise to a number of specific research questions.

1. What are the policy agenda setting and formulation of the local health fund in each level of local government?

2. What is the management for the implementation of the local fund health securities on the universal coverage by local government?

3. What are the rules, guidance and local implementation strategies, so that people can participate in their Health care system on the local fund health securities?

4. How innovative patterns of working alliances have been developed and how have they functioned?

1.4 Benefits of the study

The benefit of this investigation would increase knowledge about:

1. What are the composition and mandates of the local health boards which oversee the local fund health securities:

- Is there a need for a legal framework to formally establish the local health boards or can they function as part of an existing local administration unit, (this is especially crucial for the Tambon Administration Organisation (TAO) and municipality.

- How can the committee of the local health fund best function to plan and allocate resources as well as monitor and evaluate the outcome of their decision making?

- What types of human resources, capacities and information systems will be needed?

- Is there a need for additional manpower to carry out these crucial functions or can the additional workload be supported by the provincial and district health offices?

- If there is a need to transfer additional personnel into this sector and how can the personnel management system be tackled?

2. Health service facilities

- Should health service units be government agencies with independent administrations and should they receive budgets from the local administration, so that they will respond to local needs? If so, what should be the criteria and conditions of the budget allocation?

- In the case that the local health board is responsible for managing the health service network, what system should be applied for efficient budget utilization and human resource administration?

- Is it feasible to apply the performance-based budgeting system (PBBS) in the service agencies, with the administrator as the sole authority to independently manage the budget and human resources?

- What should be the process and scope of the local health board in controlling service agencies under given conditions?

- What system for the internal administration of the service network should be applied so that other service units at different levels in other areas can participate?

- What forms of decentralization and collaboration on decision making should be developed within the service network?

3. The budget and financial aspect

- In the long run, what would be the implication for the locally available budget, versus the central budget from the NHSO to the local administration, if the

present level of central government spending is maintained as the minimum requirement after decentralization?

- What should be the procedures and processes required to ensure that the budget is made available to the local administration?

- Another crucial issue is how much locally available health budget should be allocated to each local administration (the Tambon Administrative Organisation (TAO) and the municipality) and be used by them directly to implement health development activities and projects.

- Yet another issue is how the budget should be allocated to service providers to ensure that they will be motivated to provide a proper mix of preventing, promoting and curative services.

- Local administration (the Tambon Administrative Organisation (TAO) and the municipalities) should be involved by granting subsidies to create an additional financing source, as local administrations have powers to collect extra taxes and particularly have discussions with the National Health Security Office (NHSO), regarding potential new sources of finance for further consideration.

The result from the assessment can be used for further improving the relationships between the central and the local administrations, and the service providers. It can point out shortcomings in the budgetary processes and practices of the central government as well as the local administration.

CHAPTER II

LITERATURE REVIEW

Introduction

The purpose of this chapter is to discuss main ideas that relate to the local health fund in the local government of Thailand's universal coverage in the north-eastern region of Thailand. The literature was reviewed to provide background and context of a study structure. It is comprised of several topics that begin with definitions of health insurance system which gives a perspective on the approach towards universal coverage adopted in Thailand. Then, it examines the literature on the policy concerning decentralisation and devolution and the associated health sector reforms agenda, and the role of the local health fund in local government, respectively. The final part of this chapter lays out a conceptual framework of this study.

2.1 Health insurance system in Thailand

2.1.1 Overview of health insurance system in Thailand

Health insurance provides two basic functions which are an accessing to effective health care services when needed, and an effective protection of family income and assets from the financial cost of expensive medical care. Traditional voluntary private health insurance involves an actuarial calculation of risk and an adjustment of individual premiums accordingly. In the past, private insurance is most important in systems that leave a proportion of the population without coverage, either through choice or because they lack the means to purchase insurance. Social health insurance schemes involve a different model where funding from employment

contributions, often with some government subsidy, are used to purchase cover for most or all of the population, with some transfer from richer to poorer beneficiaries on the basis of the "solidarity" principle. In such a system, risks are pooled, so that the insurance fund provides coverage for all beneficiaries without consideration of their individual risks. Tax-based welfare schemes are also considered by some economists as a form of health insurance. They again pool risks, so that aggregate funding covers all eligible persons without exclusions. The Thai system includes both social insurance (contribution-based) and tax-funded elements. Writing some years ago about the system that has now been superseded, Supachutikil (1995), identified four categories separated accordingly to their nature and objectives.

1. Medical Welfare Scheme (MWS)

This tax-funded scheme (now defunct) provided free medical care for the indigent for example the poor, the elderly and children up to secondary school and the disabled. It also extended to monks, community leaders, health volunteers and their families.

2. Civil Servant Medical Benefit Scheme (CSMBS)

This is a fringe benefit to government employees and dependents to compensate for low public salaries. As there is no direct staff contribution, this is akin to a tax-funded benefit.

3. Compulsory Social Insurance

- Social Security Scheme (SSS); a tripartite contribution scheme funded by the employer, the employee and the government ensures health security for formal sector employees.

- Workmen Compensation Scheme (WCS); this is an employer liability scheme to protect the employee from work-related injuries, illnesses and funeral grants. This is funded through a contribution from employers.

- Traffic Accident Insurance; ensures access to care by traffic accident victims through compulsory premium paid by all car owners to private insurance firms.

4. Voluntary Schemes

- Private Health Insurance; this is a voluntary, risk-related premium contribution covering mainly the better-off, but it continues to account for a fairly small proportion of overall health expenditure in Thailand.

- Government Health Card Scheme (HCS); this now defunct scheme was a voluntary alternative for the uninsured, e.g. rural informal sector workers who were not eligible for low income scheme, the self-employed and employees in small firms of less than 10 employees who are not eligible for the social insurance scheme (more than one employee).

Several small scale community financing, saving schemes provide limited health benefits to its members. Payments are made retrospectively to members at the end of the year according to the funds available. Self-help funeral grants are more common than health benefits.

Supachutikil's typology is now in need of updating, and apart from removing the discontinued MWS and HCS schemes, we need to note the importance of the "30 Baht scheme" mentioned in Chapter 1. This scheme was initially funded by a combination of tax funding and user co-payments. However, the 30 baht co-payment

only accounted for a small proportion of revenues, so that this may be considered as a fairly conventional tax-funded scheme. In late 2006 the co-payment was ended and the 30 baht scheme is now known as the Universal Coverage (UC).

2.1.2 Problems of the health insurance

The current health insurance system is characterized by fragmentation and duplication of administration and provision. There are still question marks concerning the adequacy of coverage in some schemes, especially the 30 baht scheme. This raises doubts about how far the system can realize the goals of efficiency and equity. The continued existence of multiple schemes does not allow collective financing to exert its monopolistic purchasing power and send the right signals to health care providers regarding incentives favouring efficiency. Fee-for-service, which continues to operate in the CSMBS, exacerbates cost containment problems, as seen in the period before the recent major reforms (Pongpanich et al., 2000). With the continuing inadequacies of primary care, most of the poor are still taken care of by hospitals which are expensive, have long waiting lines and unsatisfactory services.

The CSMBS consumes more resources than any other scheme. With its fee-for-service reimbursement model, neither CSMBS beneficiaries, nor public or private providers are overly concerned with costs or efficiency. The capitation payment system in SSS admirably contains costs, but may lead to cost quality trade-offs which require further scrutiny. Prior to the 2001 reforms, Social Security was seen as having a high potential for coverage extension to dependents, non-formal workers and the self-employed. This may be less of a concern now when these groups are covered by the 30 baht scheme. The policy focus has shifted more to a harmonization of benefits under the different

schemes, and some continuing discussion of the long-term feasibility of eventual merging of the three main schemes.

Looking back on the past decade there has been a progressive trend towards increased coverage of Thai people via the extension of health insurance schemes. In 1998, approximately 80.3 percent of the Thai people were covered by health insurance of either one scheme or another. By 2005 the figure has risen to over 95 per cent.

The major policy change, as mentioned in Chapter 1, which transformed this document, was the implementation of universal coverage in a series of steps starting in 2001. The central component was a new insurance scheme – the 30 baht scheme – which filled the coverage gap left by the pre-existing schemes and quickly brought more people under the umbrella of low cost health care. However, there were also importantly associated financial reforms involving capitation based funding, and new mechanisms for channelling resources first to primary care and then on to secondary and tertiary care.

2.2 Universal Coverage (UC) in Thailand

Introduction

Universal coverage, also known as universal healthcare, refers to a healthcare system that provides coverage to all individuals. Most industrialized nations offer universal coverage to all residents. The United States, however, has a piecemeal system of coverage that leaves approximately 46 million residents uninsured at any given time. Healthcare reform efforts with the goal of achieving universal coverage are currently underway.

Many developed countries, such as United Kingdom, Sweden, Canada, Australia, France, and the Netherlands have already launched policies of universal healthcare coverage. Some like the UK and Sweden did so via tax-based funding, while others like France and the Netherlands did so through the Social Insurance contributory route, and some systems involve a mix of both. Such a policy provides their people with access to high standard health services and in many cases their personal health expenditure has become more affordable than before. We should ask whether Thailand has introduced universal health care coverage at the right time, whether the reforms are sustainable and how they can be developed. The main objectives for universal coverage are as follows:

1. Equity: An equal sharing of health care expenditure and equity of access to the same quality of health services.

2. Efficiency: Efficient use of resources by good administrative and management practices.

3. Good health for all: Universal healthcare coverage aims not only to provide curative care but also to provide disease prevention and health promotion where appropriate.

The Thai Ministry of Public Health has been examining the feasibility of this idea for several years.

4. Choice: Although choice is not a necessary feature of all UC-based systems, it is increasingly seen as an aspect of the modernization of such systems in countries such as England and the Netherlands. In UC systems choice is not necessarily linked to market competition, but may nevertheless function as a mechanism for improving the responsiveness and quality of services.

In Thailand the emergence of the UC policies was preceded by extensive policy debate and investigation of international experiences. The senior intellectuals within the MoPH and experts from other sectors gave much thought to the form the new system should take. Based on research, discussions and brainstorming sessions, they determined that ideal universal coverage health system should have the following characteristics:

- Easy access and simplicity in order to benefit from the programme.

- People should feel a sense of ownership, overseeing, accessing and perhaps sharing the costs of health services.

- The universal healthcare coverage system should reduce the problem of overlap and inequity of pre-existing healthcare schemes.

- It should be a transparent system. The providers, consumers and third parties/ payers/ purchasers must be able to check the effectiveness of the system, and administrative power should be balanced among the three partners.

- It should make provision for efficiency and equity in budgeting, planning, and development of health services based on evidence and information.

- It should have appropriate methods of co-payment

- It should institute a reasonable role for insurers in order to pool the risks.

- Lastly, it should be an accountable, reliable and acceptable scheme.

In 2001 based on the above, the Universal Coverage Committee suggested three alternative strategies to move toward universal health care coverage, as follows:

1. Expansion of existing systems

By the end of the 1990s there were several health insurance/welfare schemes in Thailand, including for example, Voluntary Healthcare Card Scheme, Civil Servants Medical Benefit/Welfare Scheme (CSMBS), Social Security Scheme (SSS; compulsory scheme for formal sector) and Health Welfare for the low income group, the elders, children under 12 and other underprivileged groups. The problem with this framework was that population coverage was incomplete and there were serious efficiency and equity problems. The Committee reflected that an incremental expansion of the existing schemes to cover all would necessitate a series of major readjustments.

- Government would need to set the universal standard regulation of health for all.

- The schemes would need to change their philosophy to offer more similar benefits.

- Government would need to readjust the legislation related to health insurance, especially private health insurance.

- It would need to adapt the registration information system.

- It would need to introduce a standard payment mechanism and reimbursement standard to operate in the same way.

- It would need to set up a more appropriate accreditation system and consumer protection system.

It was argued that the expansion of the previous health schemes would save costs in the initial stage and would not greatly affect the structure of government

services. Furthermore, another strong point was the comparability among health schemes. However, the limited nature of the changed need was also a disadvantage because of the schemes' different funding mechanisms and different philosophies. There are several weaknesses of the expansion concept. Firstly, there would be inequity in health care access and financing systems in between the differing health schemes. Secondly, there would be differences in the technical efficiency of the schemes because each was an individual independent system administered by a different Ministry. Some schemes were mandatory, other were not. Consequently, many people were not eligible for insurance. At the same time, some people belonged to more than one health scheme to provide necessary gap coverage because of practical difficulties on both consumer and provider sides. Lastly, some commercial groups might oppose the plan and try to block legislation which they saw as being against their interests.

2. Single-payer system

This approach was based on the idea of a national health insurance scheme, managed by government. Such a system is suitable for reforming a health care system when no existing health insurance schemes exist. In this system, the government can organize health legislation so that all people can access the same basic health services, with pooling of risks for providers and vertical equity of health financing. The difficulty in a country which already has existing health insurance schemes lies in the transition stage and the question of how to integrate all existing health insurance schemes together, since each scheme has their own funding, founding concept, benefits package and payment methods.

The Committee argued that the strength and weakness of the single-payer system should be analyzed in three parts including equity, efficiency and choice/quality of system. They suggested that the strong point lies with equity, in that all people can gain access to the same basic health services. With respect to efficiency, such a system can reduce the adverse selection problem, reduce the overlap/gaps between previous health schemes and introduce uniform standards of administration and information system management. Lastly, with respect to choice and quality of care, the Committee believed that such a system offered a way to stimulate providers to compete with each other in order to increase the quality of services. A weakness is that, if the administration of the legislation is not adequate, it will lead to inequitable care. This system would possibly fail if the administration were not appropriate since it is based on a centralised funding system. Moreover, there is no competitive pressure on the financing side to help maintain efficiency or budgetary control.

3. Dual health insurance system for formal and informal sectors

In the third system identified by the UC Committee, they drew a parallel between the formal sector, (e.g. civil servant and state enterprise officers' health insurance) and the informal sector (e.g. insurance for farmers, the self-employers, elders, monks and children). For formal–sector health insurance, the methodology would be the same as previously, but this would expand so that spouses and children less than 18 years were included in the Social Security Scheme. The arrangements for the Civil Servant and State Enterprise Medical Benefit Scheme should change to the same direction as the Social Security Scheme with respect to part contributions to funding. Turning to the new component, the informal-sector health insurance would be

managed under the universal coverage health fund with the support of government, locality organisations and resident co-payment. Poor groups might be exempted from the co-payment.

A perceived strong point of this system was that it avoided the problems of the single payer system, and could be compared with each existing health scheme and adjusted accordingly to save costs and to improve the system. Even though this system seemed to be appropriate, it still had some weaknesses. Thus, it might encompass some of the inequity and inequality in benefits and budget present in the pre-existing health schemes. Secondly, the lack of administrative experience in the informal sector funding may lead in the initial stages to overlap of benefits paid to the families of formal sector health insurance recipients. Lastly, it would be very difficult in the political and administrative sense to bring each system of funding together.

In summary, the UC Committee's study suggested that the appropriate way to move towards universal health care coverage was to start from the dual health insurance system for formal and informal sectors before shifting to the single-payer or national health insurance model in the future.

Proceeding from the above, on 26th February 2001, the government launched the 30 Baht health policy. The first phase was established in six pilot provinces — Nakhonsawan, Phayao, Patum Thanee, Samut Sakhon, Yasothon and Yala — on 1st April 2001. The insured members were all of the people who were not in any existing health scheme and whose names were in the house registrations in those provinces. These people received a universal health entitlement card, known as the

gold card. This card had to show consistency with the individual's identity card every time they accessed health services, which could include government health services or private sector health services registered with the project. Those accessing health services had to follow the referral system from the primary health centre or community hospital, registered under the project, to secondary or tertiary care. For emergencies and accidents, the insured could access any government health services. To access required health services, insured members had to contribute a co-payment of 30 Baht per episode. It was emphasized in official statements that under the 30 Baht scheme, insured members would receive the same quality health services as offered by other health schemes, but lingering doubts about an inferior twin-track service remained. Initially, the service package includes most health services except cosmetic care, obstetric delivery beyond two pregnancies, drug addiction treatment, haemodialysis, organ transplantation, infertility treatment, and other high cost interventions. However, it was stated that with more resources, this could be extended over time and indeed areas like haemodialysis and anti- retroviral therapy have since been added to the benefits package.

One novel feature of the scheme was that the allocation from government to fund the system was paid by capitation. The total payment per capita rose from 1,202 baht in 2001 to 1,899 baht in 2007. Nowadays, the total payment per capita is 2,546.48 baht in Fiscal Year 2011.

This money was paid to local health care facilities, according to the number of local residents who are registered with them, and eligible for health services. This capitation

payment includes the costs for the curative, preventive, promotional care as well as the administration. It can be divided into (In 2001)

- 574 baht for out-patient care

- 303 baht for in-patient care

- 175 baht for prevention and control of diseases

- 32 baht for high cost care. This amount of money will accumulate in the central office of budget. In the case of high cost care, such as neurosurgery, cardiac surgery, chemotherapy, radiotherapy, etc. the reimbursement can be done by following the price schedule.

- 25 baht for emergency and accident care. The system is the same as for high cost care.

- 88 baht for structural investment. This money will accumulate at the central level and will be distributed to the healthcare facilities in the appropriate way.

- 10% of the total package for central and regional administration, developing the information system and quality assurance.

- 10% of the out-patient and in-patient services budget for contingency funds.

In the early years of the UC reforms there were a variety of criticisms from policy commentators, which can be summarised as follows:

1. Loss of services due to inadequate finances; in the first 5 years of the new system, some hospitals would face the problem of bankruptcy and have to shut down. This problem might occur due to poor management of the budget, or sometimes

because of adverse patient distribution, for example, some hospitals have a high percentage of chronic patients, which is costly.

2. Quality of services; quality of care is still a questionable problem for many experts. Similar to the past, there are still some criticisms of the health care quality in some health schemes, such as the Social Security Scheme and 30 baht scheme. At this point, the government is attempting to compel all hospitals to participate in the Hospital Accreditation Programme to provide assurance of the quality of care. Presently, a Clinical Practice Guideline is now being developed to assure the same quality of services.

3. Lastly, this system is criticized in regard to the role of the locality in administrative decision-making. In this context the government still has not set up a tangible methodology to develop the capacity of lower level actors.

To sum up, at the present time Thailand is in the transitional stage of establishing universal healthcare coverage. The success of this programme depends on many factors and many players: consumers, providers and third parties/payers/purchasers. Beside the Ministry of Public Health and the NHSO, other Ministries and Public/Private Enterprises are also providers or funders in health sector in Thailand. With the existing multiple schemes, funders and providers, the harmonization process toward a new scheme will take time. The road toward a full implementation of the Universal Coverage Policy will be long and will require assessment, re-assessment, improvement and dynamism over time. However, now that health policy has recently become, for the first time in Thailand, high on the political agenda with votes at stake

and strong political commitment, it is possible to anticipate a health system which will provide quality health services more efficient, equitable and accountable.

2.2.1 The Government Health-related Policies from 2001 onward

The Thaksin government, the first administration elected under the provisions of the 1997 Constitution, moved quickly after its election in 2001 to introduce the UC policies which were mandated by the majority of the electorate. However the reforms were supported by a wide policy coalition including intellectuals in the Ministry of Public Health, who played a vital role in pushing the policy forwards and civil society groups.

2.2.2 The Universal Health Care Coverage Policy

The health service benefit package includes inpatient/outpatient treatment at registered primary care facilities and referral to secondary and tertiary care facilities (except emergency cases), dental care, health promotion/prevention services, and drug prescription. To ease the financial burden of reform, the Bureau of Policy and Strategy Ministry of Public Health required users to make an out-of-pocket payment of a flat-rate fee of 30 baht (approx. US$ 0.78 or Euro 0.64 at 2006 rates) per visit, with the exception of the very poor for whom this fee was waived. However, since the end of 2006, the fee of 30 baht per visit has been waived for all.

The efforts to introduce a social security system in Thailand went back to the early 1970s. The Social Security Act was enacted and Social Security Health Insurance started providing medical benefit throughout workers in companies with more than 20 workers in 1991. Later in 1996, the law extended to cover workers in companies with

more than 10 workers and at present it covers even single worker enterprises or the self-employed. Moreover, there were various schemes providing medical benefits, including free medical care for the low-income scheme subsidized by the government from the 1970s until 2001, and the voluntary health card scheme which was prepaid with partially subsidization by the Ministry of Public Health from 1987 until 2001.

2.2.3 Launching of Universal Coverage (UC)

Before 2001, the fragmented funding and provision of health care made it difficult to provide equitable services, and contributed to inefficiencies and variable levels of quality of care. The implications for the reform of the Thai health care system were taken into consideration by the government in 2001, with regard to financing, delivery of services, and consumer rights.

The main objectives and characteristics of the Universal Health Care Coverage Policy are: universal coverage, single standard, and sustainable system. To ensure the effectiveness of the system, strong emphasis has been placed on both resource and technology efficiencies, underpinned by adequate and stable budget allocation to secure the system's financial affordability. Legislation was initiated so as to ensure policy sustainability. The government drafted a law, the National Health Security Act, which was duly enacted in November 2002, to ensure sustainability in terms of policy, financing, and institutional support.

2.2.4 Implementation of the Universal Health Care Coverage Policy

In its start-up phase, beginning in April 2001, the Universal Health Care Coverage Policy covered six provinces. Coverage was expanded to include 21

provinces, as of June 2001, followed by its expansion, in October 2001, to all but one province. Finally, the province with the capital city of Bangkok was included, in January 2002. As of December, 2006, a total of 47 million people were covered by this scheme. The remainder is comprised of eight million people who include civil servants and their dependents (spouses, parents, and children) and eight million workers covered under the Civil Servant Medical Benefit Scheme (CSMBS) or the Social Security Health Insurance Scheme (SSS), respectively. The above three schemes differ with regard to eligible population segment, services provided, and financing as well as payment systems.

Under the UC, beneficiaries receive coverage for inpatient and outpatient care at the registered primary care facility and referral secondary and tertiary care facilities (except in emergency cases); dental care; health promotion and prevention services; and drug prescriptions.

As a funding mechanism, a capitation grant was chosen to finance the Universal Health Care Coverage Policy (UC). A capitation grant based on a rate of 1,202 baht per registered capita per year was prepaid to the contracted health care facility to cover the benefit package during the first two years. The budget under the UC Policy was allocated to provinces according to the registered population. The payment mechanism was applied to both public-sector and participating private-sector facilities. Highest priority was given to channelling allocations to the primary care units based on the registered population figure. Secondary and tertiary hospitals were funded from the budget of and through primary care units for inpatient care, commensurate with their

services as determined by the number and type of referred cases. The capitation grant rate was increased to 1,899 baht for the fiscal year 2007 starting in October 2006.

2.2.5 First Year Implementation of the Universal Health Care Policy

During the first year of implementation, the processes at the central and provincial levels were monitored and evaluated in order to make the scheme sustainable. Primary results of the evaluation revealed that in a comparison of three major health-benefit schemes (the Civil Servants' Medical Benefit Scheme, the Social Security Health Insurance Scheme and the Universal Health Insurance Coverage Scheme), the UC scheme still faced low compliance rates (65%). However, the indigent had a higher compliance rate than the rich. This means that the policy has at least achieved its objective of targeting the underprivileged.

These differences and the rapid implementation of the UC scheme led to obstacles in access and provision of services. The health care system, from coverage to provision, has been closely monitored to properly predict the effects and properly provide the best quality health care to the Thai people.

2.2.6 Second Year Implementation of the Universal Health Care Policy

After the first year of rapid implementation, evaluation data in 2003 showed both higher utilization and higher satisfaction (84%). However, there were still problems of under-funding, distribution of health personnel and quality of medical services. The capitation rate was still 1,202 baht for the fiscal year of 2003. The implementation of primary care unit of the UC scheme was assessed and it was found that appropriate supply of health personnel was the crucial key success factor for this

policy in order to provide quality care with a close-to-client concept. There were many hospitals facing financial burdens and it was necessary to use the central contingency fund to help these balance their budgets due to high health personnel costs.

2.2.7 Third Year Implementation of the Universal Health Care Policy

During January April 2002, a study was carried out to revise the capitation rate using updated morbidity information from the Health and Welfare Survey 2001. The study proposed an allocation 212 baht higher than the previous rate as shown in Table 8. However, the government approved only 1,308 baht capitation rate for the 2004 fiscal year. The result of this inadequate funding became clear when it was later shown that 265 hospitals out of the total of 819 hospitals were in debt (to a total of 1,387 million baht).

2.2.8 Fourth and Fifth Year of Implementation of the Universal Health Care Policy

The capitation rate was increased to 1,396.30 baht for the 2005 fiscal year although an independent study calculated the appropriate capitation rate at 1,510 baht. The target population under UC was 47 million and the total budget for UC was 65,626,768,000 baht. A National Health Security Office report showed the coverage of different schemes as of September 2005. There are 47.34 million people registered under 825 contracting primary care units of the Ministry of Public Health, this accounted for 91.44% of the total eligible UC population. There were 74 contracting primary care units under other ministries with 1.976 million registered (4.17%) and the rest (2.076 million of the UC population) were registered with the 63 private health facilities (4.39 %).

2.2.9 Problems and Limitations of the Universal Coverage (UC) Scheme

Universal health care coverage has been implemented on a nationwide scale for more than three years. There is no doubt that there is a need to generate evidence for policy amendment in order to achieve the goals of the scheme effectively and to satisfy both beneficiaries and service providers. The introduction of universal coverage dissolved a number of other schemes into the UC scheme, leaving three public health insurance schemes: the UC scheme, the Social Security Scheme (SSS), and the Civil Servant Medical Benefits Scheme (CSMBS). One of the main concerns regarding the Universal Coverage scheme is the sustainability of the program and consequently, the financial stability of hospitals and other health care providers. The funds annually allocated to each programme limit the financial reimbursement available to providers throughout the system. If a hospital or other provider is not confident that they will receive compensation for their work and to cover its operating costs.

Both Social Security and Universal Coverage pay a capitation rate, but under Social Security, most hospitals are reimbursed for more complex procedures and in-patient stays through a diagnosis related group system. Wealthy individuals, regardless of their health insurance, can opt to purchase out-of-pocket care, thus providing revenue to some premium private providers. In its first year, the Universal Coverage Scheme set aside a contingency fund for expensive procedures and tertiary care. Due to low use and an expectation of financial independence and sound planning, the contingency fund has been phased out of the UC scheme. Without a contingency fund, hospitals and physicians cannot ensure that their costs will be covered.

It is extremely important that health care providers are financially viable, particularly in rural areas, where medical facilities are already inadequate and facing closure of one health care facility. This is likely to have significantly negative effects on health status. The government needs to provide a capitation payment that is high enough to cover most costs of the primary care. Nevertheless, it must also instil safeguards to prevent any public provider from incurring losses and carrying a large burden of debt. With such protection in place, hospitals can be certain that, regardless of their costs, there will be some conditions under which the government will reimburse the costs of providing its services.

Maintaining a standard for quality of care is another important issue. Under the new health care schemes, the whole Thai population is covered by some form of government provided health insurance. It is unethical for a physician to deny service based on a person's ability to pay; indeed, the UC scheme was created to avoid this situation. On the other hand, capitation payment schemes will not necessarily guarantee that all costs are covered. If losses are large, and no one is paying for additional precautionary tests, a physician may opt not to administer the test to reduce hospital costs. It is then important that both the financial viability of the hospital and the quality of clinical care are protected.

The UC scheme attempts to follow the CMH report's recommendation to make close-to-client (CTC) services available, particularly to the poor. An emphasis on CTC care requires an abundance of nurses and primary care physicians. Primary care physicians, however, make up only 10% of the physician population. There is an urgent need to

provide more nurses and primary care physicians to attain the quality care at the primary care units.

2.2.10 Future Challenges

Thailand may be one of only a few countries who have tried to achieve universal coverage of health care policy during the economic slowdown period. Attempts to achieve universal coverage have had a long evolution but they have been speeded up during the past couple of years. The policy has been adopted and implemented incrementally, in terms of area and comprehensiveness of the policy package. National coverage has been achieved within one year. The policy content seems to have a sound direction which is a result of accumulated experience and knowledge in Thai society. However, rapid policy implementation has threatened the policy sustainability to some extent since existing health infrastructures, including health personnel, have limited capabilities to perform their new roles and functions. Moreover, there are still problems of under-funding and less-than-ideal quality of medical services. The challenge is how to keep the system sustainable and to meet the people's expectations of health services.

2.2.11 Summary

Both developed and developing countries have been seeking a means to establish the right to health. Thailand's Universal Health Care Coverage Policy is an example of how a middle-income country manages to pursue equity in health-care with remarkable achievements. It is obvious that this policy is welcomed by the public and is fully supported by politicians, thus ensuring a governmental commitment. Both successes and future challenges have been identified. The Thai experience may be

shared with other countries facing similar challenges. The lessons learned might be useful to other developing as well as developed countries in paving the way to increased investment in health-care and treating public health as a core concern of development.

2.3 Local Government in Thailand

2.3.1 Introduction

The promulgation of Royal Thai Constitution of 1997 and the Decentralisation Plan and Process Act of 1999 has expanded the obligations of Thai local government to provide public services. According to these documents, there are six core functions and 245 tasks to be devolved to local governments by the year 2010. While some were already devolved to localities, most of them are presently undertaken by national government agencies although they are due to be transferred to local authorities. Consequently, enhancing the capacities of local government to handle more complex responsibilities has become a high priority.

Fortunately, some local governments are well equipped to adapt to the changing environment. They realize that their previous hierarchical administrative structures and top-down decision making are no longer sufficient to respond efficiently and effectively to all public service obligations. Though challenged with limited financial resources, these localities successfully applied modern concepts of democratization and new public management to re-conceptualize their ways and means of handling more complex tasks. Studying the experience of successful cases of adaptation and innovation will benefit capacity building in other localities.

Local government practices in Thailand have become more participatory or governance oriented since the promulgation of the Constitution of 1997 and the Decentralisation Plan and Process Act of 1999. Several local governments have applied modern concepts of New Public Management and participatory approaches in performing their tasks. This article aims to describe and analyze local administrative initiatives to increase participation in recent years.

Local government comprised both regular territorial administrative units and self-governing bodies. Local autonomy was limited, however, by the high degree of centralisation of power. The Ministry of Interior controlled the policy, personnel, and finances of the local units at both provincial and district levels. Field officials from the ministry as well as other central ministries constituted the majority of administrators at local levels.

In 1987 there were seventy-three provinces (*changwat*) including the metropolitan area of Bangkok that had provincial status. The provinces were grouped into nine regions for administrative purposes. As of 1984 (the latest year for which information was available in 1987), the provinces were divided into 642 districts (*amphoe*), 78 subdistricts (*king amphoe*), 7,236 communes (*tambon*), 55,746 villages (*muban*), 123 municipalities (*tesaban*), and 729 sanitation districts (*sukhaphiban*).

Each province was under a governor (*phuwarachakan*), who was assisted by one or more deputy governors, an assistant governor, and officials from various central ministries, which, except for the Ministry of Foreign Affairs, maintained field staff in the provinces and districts. The governor supervised the overall administration of the

province, maintained law and order, and coordinated the work of ministerial field staff. These field officials carried out the policies and programmes of their respective ministries as line administrators and also served as technical advisers to the governor. Although these officials were responsible to the governor in theory, in practice they reported to their own ministries in Bangkok and maintained communication with other province-level and district-level field staffs.

The governor also was responsible for district and municipal administration, presiding over a provincial council composed of senior officials from the central ministries. The council, which served in an advisory capacity, met once a month to transmit central government directives to the district administrators. Apart from the council, an elected provincial assembly exercised limited legislative oversight over provincial affairs.

District administration was under the charge of a district officer (*nai amphor*), who was appointed by the minister of interior and reported to the provincial governor. Larger districts could be divided into two or more sub-districts, each under an assistant district officer. The district or the sub-district was usually the only point of contact between the central authority and the populace; the central government had no appointed civil service officials below this level.

The district officer’s duties as overseer of the laws and policies of the central government were extensive. He supervised the collection of taxes, kept basic registers and vital statistics, registered schoolchildren and aliens, administered local elections at the commune and village levels, and coordinated the activities of field officials from Bangkok. Additionally, the district officer convened monthly meetings of the headmen

of the communes and villages to inform them of government policies and instruct them on the implementation of these policies. As the chief magistrate of the district, he also was responsible for arbitration in land disputes; many villagers referred these disputes to the district officer rather than to a regular court.

The commune was the next level below the district. Averages of nine contiguous, natural villages were grouped into one commune, whose residents elected a headman (*kamnan*) from among the village headmen (*phuyaibun*) within the commune. The commune chief was not a regular government official, but because of his semi-official status, he was confirmed in office by the provincial governor. He also was entitled to wear an official uniform and receive a monthly stipend. Assisted by a small locally recruited staff, the *kamnan* recorded vital statistics, helped the district officer collect taxes, supervised the work of village headmen, and submitted periodic reports to the district officer.

Below the commune level was the village government. Each village elected a headman, who generally served as the middleman between villagers and the district administration. The headman's other duties included attending meetings at the district headquarters, keeping village records, arbitrating minor civil disputes, and serving as village peace officer. Generally the headman served five years or longer and received a monthly stipend. In the 1980s, the importance of a village headman seemed to be declining as the authority of the central government expanded steadily through the provincial and local administrations.

Municipalities in Thailand included Bangkok, seventy-two cities serving as provincial capitals, and some large district towns. According to the 1980 census, municipalities had a combined population of 7.6 million, or about 17 percent of the national total. The municipalities consisted of communes, towns, and cities, depending on population. Municipal residents elected mayors and twelve to twenty-four municipal assemblymen; the assemblymen chose two to four councillors from among their number, who together with the mayors made up executive councils.

In theory, the municipal authorities were self-governing, but in practice municipal government was an administrative arm of the central and provincial authorities. The Ministry of Interior had effective control over municipal affairs through the provincial administration, which had the authority to dissolve municipal assemblies and executive councils. Moreover, such key officials as the municipal clerk and section chiefs were recruited, assigned, and retired by the ministry, which also had the power to control and supervise the fiscal affairs of the perennially deficit-ridden municipalities.

Until 1985 Bangkok’s governor and assemblymen were appointed by the central government. In November of that year, however, for the first time an election was held as part of the constitutionally mandated effort to nurture local self government.

At the next lower level of local government, every district had at least one sanitation district committee, usually in the district capital. This committee's purpose was to provide services such as refuse collection, water and sewage facilities, recreation, and road maintenance. The committee was run by ex-official members headed by the

district officer. Like municipalities, the sanitation districts were financially and administratively dependent on the government, notably the district administration.

Local governments in the developing world are currently facing serious and urgent problems. Poverty, failings of infrastructure, and the lack of human and financial resources have impacted negatively on local governments' capacity to perform their mandated functions.

For most people in Thailand, government is experienced primarily through centrally appointed officials who hold posts in local administration, the main units of which are provinces (*changwat*) and districts (*amphur*). In the 1990s three new provinces were carved out of the existing ones, resulting in a total of 76. Nowadays, — 23 March 2011 — there are 77 provinces in Thailand, Bueng Kan is a new province. (Act Establishing Changwat Bueng Kan, B.E. 2554 (2011)).

A marked devolution of power has taken place since the 1980s. By far the most significant of the local governing bodies are those in the major cities, including Bangkok, Chiang Mai, and Pattaya. Locally elected provincial assemblies have little power, but they serve as incubators for local politicians who may later be elected to the National Assembly. In 1997, communes (*tambon*), units consisting of several villages, were given increased powers and the authorization to elect members of *tambon* administrative organisations. With new administrative and financial authority, these bodies have become the most important local democratic units in Thailand. Headmen of villages (*muban*) are also elected, but their authority is circumscribed by centrally appointed district officers and the *tambon* administrative organisations.

Thailand is divided into 77 provinces, which are then grouped together into five regions for administrative purposes. The provinces themselves are often based around historic small kingdoms and princely states of the old Kingdom of Siam, with the office of governor previously in the gift of local ruling families. However, the curbs placed on the King's power in 1932 saw the old system dissolved. Each province is named after its capital city, which is generally the largest city in the province.

The 77 provincial governors are appointed by the Ministry of the Interior from the civil service rather than elected, like the French prefect system, except in two cases. The capital city Bangkok is governed by a Metropolitan Authority, headed by an elected Governor. In 1976, the city of Pattaya was also given special administrative area status, and elected a mayor and council manager to supervise its local affairs, primarily due to demands to tackle central government inertia over crime and sex tourism issues.

The 1997 Constitution affirmed the status of the monarch as a ceremonial figurehead and vested legislative power in the 500-member House of Representatives and 200-member Senate. The House of Representatives is the primary body, elected by proportional representation, while the Senate acts as a non-partisan revising chamber. The Prime Minister is appointed by the King as the leader of the emerging coalition from lower house elections.

Beneath the provinces exists a sub-tier of 795 districts known as *amphur* and 81 minor districts known as *king amphur*. The king amphur are created in remote rural areas. Each amphur is headed by a chief officer appointed from the Ministry of the Interior. Below this are *tambon*, loosely translated as communes, of which there are currently

7,254. Larger units (over 10,000 populations) are known as *Mueang*, while other cities (over 50,000 populations) are referred to as *Nakhon*. All of these are further sub-divided into *muban* (villages), currently 69,307 in number. The process of structuring local government began in the 19th century with the creation of sanitation districts and the 1914 Local Administration Act specified the powers of district-level bodies in urban and rural areas. The 1994 Tambon Council and Tambon Administrative Authority Act and the 1997 constitution state the elected nature of the tambon. Bangkok's 50 district areas are known as *khet*, which is roughly the equivalent of the amphur.

2.3.2 Local Government Structure and Decentralisation of Autonomy

Thai Public Administration

Until 1991, the National Public Administration Act was promulgated to provide three basic levels of public administration in Thailand: central, provincial, and local administration. (Tummakird, 2001)

Central Administration

The central administration falls under the basic concept of centralisation and consists of 15 ministries. Various departments, offices, bureaus, divisions and subdivisions are established in each ministry.

Provincial Administration

This form of administration comes under the concept of deconcentration, which means that the central government delegates some of its power and authority to its officers who work in provinces and districts. These officers form various ministries

and departments and carry out their work according to laws and regulations assigned by the central government.

Local Administration

Local Administration in Thailand is based upon the concept of decentralisation, which allows local people to participate in local affairs under concerned laws and regulations. At present, there are 2 types of local administrative organisation in Thailand. The general type, which exists in every province, is composed of: 1) Provincial Administration Organisation, which covers all areas in the province, 2) Municipalities, urban areas with a crowded population and level development; and 3) Sub-district or Tambon Administrative Organisation (TAO) whose jurisdiction is over the area of a particular sub-district outside the boundaries of municipalities. The special type consists of two forms of local government: 1) Bangkok Metropolitan Administration; and 2) the City of Pattaya.

Decentralisation

Under the country's existing administrative structure, authority is delegated from the capital to the region and then to local areas. In general, development policy and planning in Thailand is a combination of top-down and bottom-up approaches, while the public administration system of the country is highly centralised.

Thailand has gradually strengthened the capacity of local government. During the 5th and 6th National Plans, local government played a greater role in setting development priorities. Nevertheless, the proposed development plans still have to be agreed upon and the budgets approved by the central government.

To further enhance the role of local government and local development efficiency. The 7th and 8th National Plans called for the decentralisation of fiscal authority and asset holding as important mechanisms to help strengthen local administrative capacity.

As the structure and management system of the local government have been put in place by the end of the 8th National Plan, the 9th National Plan (2002 – 2006) will concentrate upon improving the development capability of the local administrations. Development plans will integrate all aspects, monitoring systems will be enhanced, information system will be upgraded, and human resource capability will be increased.

Institutional Framework

Thai local governments are classified into two main categories; general and specific. In the general form, there are three types of local authorities located throughout all seventy-five provinces except Bangkok. They are (1) Provincial Administrative Organisation (PAO), (2) Municipality and (3) Sub-district or Tambon Administrative Organisation (TAO). In the specific form there are two special units of local governments governing specific areas; namely, Bangkok Metropolitan Administration (BMA) and Pattaya City.

The three general forms of local governments are divided into two tiers. The lower-tier governments, municipality and TAO, function as a single operating unit, which is very close to local residents, providing local public services within their defined territory. While municipalities are located in urbanized areas, TAOs are mostly established in less-developed rural communities. By contrast, PAO is the upper-tier local government which covers an entire province and is responsible for administering local public

services at the provincial level as well as for working in development projects that need collaboration among several municipalities or TAOs within the provincial territory. In other words, the service functions that cross the boundaries of any single municipality or TAO are held by PAO.

Political and administrative structures of Thai local government are similar to those of other nations. Each local government consists of the executive body and the local council, each of which is headed by locally elected persons from local residents and serves a four-year term. BMA has a rather unique administrative structure, however. It covers the whole Bangkok provincial territory and has partitioned its administration to 50 district units. Though each district is composed of the executive branch and the council, only the council members are locally elected by Bangkok dwellers. The district heads are permanent staff and indeed appointed by the BMA governor.

Local Responsibilities

According to two major laws, the Constitution of 1997 and the Decentralisation Plan and Process Act of 1999, several tasks and responsibilities are mandated to local government. Section 282 of the Constitution mandates that the state shall give autonomy to localities in accordance with the principles of self-government and the people's will. In the subordinate law, the Decentralisation Plan and Process Act lays down that the Municipality, TAO, and Pattaya City shall perform the following tasks:

(1) Local and community plan and development.

(2) Promotion of local economic development, investment, employment, trade, and tourism.

(3) Local public services provision; including local roads, walkways, public transportation system and traffic light engineering, public markets, ports and docks, waste treatment, water drainage system, public utilities, parks and recreation, garbage collection, pet controls, slaughtering, public safety, natural resource and environmental protection, disaster control, sanitation and cremation services.

(4) Social welfare services provision; including education, social welfare for children and for the elderly and disable, primary health care and medical services, housing and restoration, arts and cultures.

(5) Promotion of democratic values, civil rights, public participation, laws and order, and conflict resolution.

The Provincial Administrative Organisation (PAO) should carry out these following tasks:

(1) Provincial development planning with respect to the principle of economic growth and efficiency.

(2) Large-scale public services provision; the services that cannot be executed by any other smaller localities within a provincial territory. Their benefits should accrue to communities in a province-wide area. For example; province-scaled infrastructures, waste water treatment, solid waste disposal, large public transportation.

(3) Human services provision of public education, public health, social securities, and social welfare at the provincial level.

(4) Natural resource and environment protection in inter-local government activities.

(5) Promotion of trade and investment in a province, tourism, culture and art.

(6) Provision of technical and financial supports to lower-tier local authorities.

The Bangkok Metropolitan Administration (BMA) is a special case. It performs both lower-tier and upper-tier local government responsibilities. In short, its functions include municipality's urban services and TAO's rural services as well as the Bangkok provincial services like those of PAO.

Civic Participation

In recent years, many scholars have argued for an enhancement of public participation in the policy making process (Krueathep, 2004). Public participation is a political and social arrangement in which people can have access to various stages of decision-making in government agencies. Participation can be exercised in several forms, ranging from the narrow conception of political participation through voting, to the broader conception of self-initiative and self-mobilization. In other words, participation can range from a passive to proactive movement of local residents in communal affairs. Yet, how to design institutional structures and procedures to allow citizen inputs into policy agendas is not a simple task.

Present directions for civic participation in Thailand were derived partly from the institutional and social changes after the financial crisis of 1997 and partly from the promulgation of the 1997 Constitution (Krueathep, 2004; UNDP, 2003). An economic boom from the mid-1980s preceded the crisis but tended to an urban bias and had

several devastating effects on the country's sustainable development such as depletion of natural resources, environment deterioration, industrial pollution, and a growing income gap. When the economy collapsed in 1997, the crisis suddenly raised the awareness of local communities against the domination of state controls over economic and human resources planning. The faith in the superiority of national government and in the reliability of urban-based economy was shaken. The number of public movements toward more community concerns multiplied. Communities had sought alternative ways to express their views and defend their rights to give their voices to the state's public policy making. Ideas of community empowerment thus gained much attention from several parts throughout the country, including ministerial and departmental administrations, local communities, NGOs, and international development agencies.

The promulgation of a new Constitution in 1997 also forced the institutional and legal shifts toward more transparent public administration. Sections 76 to 79 mandate the state to strengthen local participation in both national and local government decision making processes. People have the right to be involved in developing public policies, making decisions on local issues, providing views and information on economic, social, and political development plans, and inspecting the exercise of state power at all governmental levels. This has laid the foundation for more accessible government administration.

2.4 Decentralisation in Thailand

2.4.1 Decentralisation and changing local politics in Thailand: Different Outcomes among the Regions

Introduction

Thailand as a modern nation-state, located in mainland Southeast Asia, has been historically composed of two contrasting characteristics, namely homogeneity and diversity of society and statehood. The former one has been strongly emphasized by the centralist and conservative camp. This group propagated the lineage of Thai people from the past to the present. By contrast, the latter one tends to belong to parochialism and simply the liberalist camp. This second camp always insists that Thai means “free” and “independent” and consists of multi-ethnic groups. According to this perception, Thais have always had differences among themselves from one region to another.

There are also some widely known dichotomies, with which Southeast Asian and Thai specialists frequently equipped for their research works, such as the ideas of unity and diversity, centre and peripheries and the conventional framework of so-called high or court and low or common civilisations. These ideas aimed to explain political and social structures of Thailand, insisting that there would be one centre, on both idealistic and concrete terms, for ever during each certain period and beyond. It also claims that the centre always enjoyed invisible powers, the concentration of cultures, higher of belief system, and some kinds of authority to connect its powers within their own peripheries. In this perception, all peripheries have been comprised together like

clusters which are put together with names of communities, villages, local authorities, and regions and so on.

Examples of conventional wisdoms mentioned above seem to be not only attractive but also coincidental with another theoretical working notion of centrifugal and centripetal ideas of political forces. Such a working notion has been analyzed by some leading political scientists and local government theorists both in the West, such as in Italy, and in the East, for example in Japan. The balancing and unbalancing of centrifugal and centripetal forces could be very crucial to verify meanings, functions, substances, and values of local governments and decentralisation in each society.

Following this working hypothesis, the meanings of decentralisation and actual transformation of politics in Thailand will be described and discussed in this Chapter, by bringing it back into the milieu of two such main political and social forces. These two forces, namely the centrifugal and centripetal ones, were, unavoidably, not static but fluctuated during several decades in the past and is still seeking its perceivable equilibrium at the present time.

1. Background and history of locality in Thailand

The examination of a long period of local histories and cultures of people living in present Thailand could reveal the fact that there were around 20-30 power-centres at least, before the emergence of the modern nation state about 100 years ago. The habitants in the Northeast and Northeast regions in the past were mainly the Laotians, while in the Central region were composed of Siamese, Mon and Chinese. Apart from these main groups, there were various types of Mon-Khmer ethnic groups,

Chams, Chongs. Karens, Malays, Shans, Indians, Arabs, Vietnamese, and plenty types of Tai-speaking ethnic peoples. Tracing history back in this way, it is, therefore, so astonishing to see how 5-6 million habitants one century ago could be merged and blended from various ethnic groups to be the "oneness," namely Thai.

It is certain that the process of modern state and nation building was hardly smooth and peaceful. The centralisation of powers was led by strong Siamese central forces without any consultation with local elites one century ago. Resistance and rebellions took place mainly in the North, Northeast and South. In the North, small local princes of Nan, Prae and Payao mobilized their serfs and followers to fight against the Bangkok centralism. In the Northeast, not only small Laotian noble class, but also local monks attached to the forest Buddhist school, played their vital roles in their battles against the Bangkok power. The situation was highly complicated in the South, since local princes, noble class, farmers and Islamic elements formed their movements. Depending on these circumstances, the centralist camp always emphasized successful stories of Thailand's centralisation, disseminating official discourse of being Thai from the past to the present. Such a simplistic perception not only neglected but also underestimated anti-centralism; they politically and discursively deceived themselves, in the sense that anti-centralist movement was happening only in the past, about one hundred years ago.

Transformation of provincial and local politics in modern Thailand could be traced back to one century ago. The Bangkok central government has seized nearly total power from the Northern, North eastern and Southern local elites. Around the turn of the early 20th century, the modern system of regional, provincial, district, Tambon and

village administrations were set up with the system of appointed government officials, who were sent from the centre to govern the whole country. The new system of military recruitment, taxation, education, police, administrative jurisdiction, irrigation, road and highways etc, has gradually penetrated into all localities. This new picture of the Thai government and administration has remained somehow on the top of the so-called bureaucratic power structure for one century until today. The number of the central government's personnel has increased during the past century, from 30,000 to 2,000,000 officers.

The establishment of the highly centralised state and government briefly described above is only one side of the story. We have seen the decline and subsequent collapse of outstanding leaders, such as Chiang Mai, Roi-Et and Pattani princes in the North, Northeast and South respectively step by step. However, we detected the adaptation of the middle-level locally-born aristocrats taking place during the same period. From 1932 onwards, because of the establishment of new parliament under the democratic regime, some locally-born middle-level aristocrats took opportunities to run for elections voluntarily in 1933, 1937, 1938, 1945, 1946, 1949, 1952, 1957 and 1958 respectively. Needless to say, successful candidates could become members of the house. Members of Na Chiangmai, Na Lampang, Na Nan, Na Kalasin, Na Ubon, Na Mahasarakham, and Na Ratchasima families provides us good examples of how Thai provincial and local politics from the 1930s onwards altered their way of life to accommodate the Thai centralism. Locally-born, elite-turn-politicians played important roles in the Thai national unicameral house. Some worked well with the People Party's members who dominated Thai national politics in that period. Others,

especially strong local leaders with patriotic sentiments, became powerful opposition not only in the unicameral house but also outside the national assembly, as they formed the so-called anti-centralist and anti-Field Marshall Pibul Songkram regime's movements which were activated mainly in the Northeast, North and South to different degrees.

Thai centralist and authoritarian leaders cruelly responded to anti-government's demands and voices. In the 1950s, local leader-turn-national politicians, such as Tieng Sirikhan and Thong-in Puripat, were killed by secret policemen. The state killing and suppression had apparently continued through the late 1950s and the 1960s, after Field Marshall Sarit Thanarat successfully took power from Field Marshall Pibul Songkram. The new junta aimed to transform not only national politics but also local level politics as well into the so-called Thai style democratic one.

In consequence, this suppression and the centralist policies had pushed many people from cities to rural areas, to be allied with the communist party, directly and indirectly. All remote areas in the North and Northeast were altered from peaceful and undeveloped communities to be strong bases of guerrilla warfare in Thailand from the 1960s till the late 1980s. Hence, they governed the country by military decrees without an elected parliament. In the meantime, they suspended all local municipal council elections. In fact, they selectively cooperated with 120 mayors around the country.

2. The Development Decade: Changing local economy and politics

Thai economy has changed dramatically from the 1960s onwards at least because of three reasons. First, a huge military spending during the 1960s and the

1970s by US army bases together with the Thai government was made with regard to infra-structures, such as roads, canals, electricity stations, hospitals, and so forth. At the same time, so-called "containment policy" was pursued in aiming to lift up the general living standard of Thai people in the countryside for fighting against communism. Second, the foreign direct investment (FDI), aiming to promote import-substitution industrialization, took place in the Central region from the beginning of the 1960s, especially in such industrial sectors as textile, garment and primary consumer products. And third, the commercialization of Thai agriculture and the rise of cash crops were seen in some provinces, especially in the newly opened lands and upland areas which were well-suited for transportation and factory construction. Cash crops, such as sugar canes, tobaccos, cassavas, pineapples, and so on, required not only huge immigrant labour forces but also tough local leaders with money and political networks.

Economic dynamism easily and logically paved ways to the new social and political settings. From the middle of 1970s, we started to notice local politicians being wealthier than bureaucrats and even provincial governors. These local politicians worked in all provinces, because some of them were former traders with the US military bases to provide transportation, such as in Sattahip, Takli, Ubol Ratchathani and Udorn Thani. From this period, members of the Provincial Administrative Organisations (PAOs) became widely recognized as local construction bidders, because small and medium sized construction works were promoted and expanded by huge government's development projects. In this setting, some outstanding PAO council members, who successfully bid construction works beyond his or her

provinces, could own modernized transportation companies and get construction works even in Laos and Cambodia.

In this period, infrastructure of Thailand changed immensely due to the development policy by the Thai government and by the US military assistance. From the late 1960s, we thus witnessed increasing popularity and quantity of the road-transportation and bus-transportation, replacing river-transportation and railways. Some local businessmen, who were brave and aggressive, could successfully run mass transportation companies in the North, Northeast and South. This was an actual changing scenario of Thai local politics, as it crucially grounded new portfolio of mayors and local councillors. In some provinces where bus transportation was promoted, we saw that owners of local bus transportation companies turned out to be outstanding mayors and local councillors.

Some provinces such as in the Eastern region experienced the rapidest structural change of local economy from cash crop production to tourist site, which was mixed with new industrial zones within 3 decades. In this region, the wealth and the power of local politicians were highly interconnected. The separation between the wealth, as sources of power, and the power, as source of wealth, then was blurred because they were mixed up from various and unclear activities. Needless to say, under the growing informal and underground economic sectors, these activities could easily be done in the cities, border towns, tourist sites and remote areas of Thailand. Amongst others, gambling, prostitution, smuggling, sex trading, lottery, money borrowing, money laundering, and drug trading were notable in modern Thai public sphere. Responding to this changing setting, Thai academia in the late 1980s adopted the notion of Thai

local “godfather”, as it obviously appeared in some leading articles, thesis, books, and, became one discussion topic even in international conferences on Thai studies as well. Such a notion revealed that local politicians, including mayors and PAO councillors, have already changed themselves from weak and passive men to be active and, perhaps, “tough” guys to a certain extent since the 1980s.

3. Different contexts of local politics in the regions of Thailand

The rise of tough guys in localities has tremendously been influenced by some heritages of each region’s local and political cultures. In the case of the Central region, it was largely moulded by the Thai (or Tai) notion of “Nakleng” or local strong men culture. According to this notion, being perfect men comprised cycle and passage of life from the present one to the higher stage. Stealing and robbing from rich men in outside communities for themselves and for their relatives was one prerequisite for the passage of men’s life. In addition, brotherhood and generosity were crucial component of being gentlemen in the Central region’s traditional ways. Other notion rooted in Chinese communities was “Tue-hia” or big Chinese men’s brother culture. The two sources of local culture were mixed together in some areas, especially in the big communities where the populace had half-Thai and half-Chinese origins. In this circumstance, local tough guy culture became cultural equipments and, perhaps, skills with which wealthy local mayors exercised for their powers. Some leading scholars argued that tough guys’ manner was local cultures in transition from traditional to modern one. Such phenomena were condensed by socio-economic factors and special cultures of some localities. But later on, they should be declined when urbanization and a modern educational system fully emerged.

In the North, the notion of “Pho Lieng” (literary means adopted father), or big men, has been developed from two kinds of local cultures. First, it was a person who had magical powers. Second, it means the brave guy who could travel across the border such as to China or to Myanmar for trading, logging and so on. The two ideas were mixed together later on and related specifically to the tough guys, who could equip cultural “weapons” for the benefits of both public and private works.

The situation in the Northeast is quite similar to the North. The notion of tough guy in the Northeast was remarkably influenced by these two ideas of “Mo Tham” (literary means Dharma doctor) and “Nai hoi” (literary means master of hundreds). The first meant men who could read Buddha texts or some magical texts that were technically useful in healing diseases. The second notion meant brave men who were capable of crossing the mountains or big rivers safely with hundreds of cows and buffalos.

In the South, we could find the notion of “Nai hua” (literary means the master of head) which was historically derived from locally-born Chinese and Malay cultures. It meant especially big men who could lead labour forces to do hard jobs, such as mining and even some big local festivals. These men must possess wisdom, skills and, perhaps, arts of leadership. Some experts in the Southern culture explained that the Southern people loved public debating and questioning as they could find who could be a real master of “head”. So, they voted for local politicians and representatives who could talk and lead (local) wisdom; otherwise let the dog bite any animals that should be the best, as one Southern local proverb says.

What is briefly described above might reveal distinct personalities, characteristics and attitudes of local leaders as well as local politics in respective regions. Northern and North eastern cultures clearly emphasized the importance of men who had Dharma and magical powers in their minds and, more importantly, the brave persons who could connect localities with the outside world. Their good and, perhaps, the best leaders should play the role of a "broker" or middleman. They must go out to get wealth, money and even something beneficial to localities. Local people will follow them whenever such local leaders could do the courageous and prosperous things for local people from outside their communities. According to this understanding, Northern and North eastern people kindly and frequently welcomed "strangers," to be with their communities, particularly those who possessed wealth and had connection with outside. Such kinds of hospitalities were more notable in the North and Northeast rather than in the Southern or even the Central communities.

By contrast, local leaders in the South have to perform in different ways through their own cultural rules. Connecting with the centre is less emphasized than their vital and spiritual roles in communities. More importantly, local leaders must show their local wisdom through talking and debating with local people. In this context, Southern local politics has comprised of closeness, trust and associated characters. The close relationship between leaders and followers is crucial in Southern cultural rules. Perhaps, it is less materialistic culture than the North and especially Northeast regions.

4. Decentralisation and Development of local politics

The 1990s marked a decade of structural political change especially in terms of decentralisation and local politics of Thailand. It started by PAO supporters

who strategically urged to have directly elected governors (there were 72 provinces in early 1990s and now increased to 77 provinces), replacing an appointed system that had been practiced for nearly one century. Political and public debates by some groups of stake holders took place for more than 2 years and it ended up with the establishment of some 6,000 units of the Tambon Administrative Organisation (TAO) for the whole country. It should be noted that about 1,000 urban areas had already practiced three types of Municipalities and one type of sanitary districts for over several decades. The rest, approximately 6,000 Tambon units, were said to be rural and poor, so that the government could not have any policies to lift them up to the local governments in the past. Yet in 1994 it reached the perfect time for the Democrat party-led coalition government to actively launch a new policy, changing all 6,000 rural Tambons into a new type of local authority, namely Tambon Administrative Organisation (TAO).

However, in this period of establishing the TAO, it should be noted that TAO chairman was Kamnan or headmen of compound-village (Tambon). This arrangement was similar to the case of the PAOs and the sanitary districts, because governors and districts officers were chiefs of PAOs and sanitary committee chairmen respectively. Following such guided structure, compound-village headmen or Kamnan were then chiefs of Tambon as state organs, and at the same time were chiefs of TAOs as local authorities.

The 1997 Constitution, which was promulgated three years after establishing the TAO, aimed at changing the local government system. First, it determined that all state officers, namely governors, districts officers, Kamnan, village headmen etc., could be

neither chiefs nor even ex-officio members of local authorities at the same time. This law notably separated state-led organisations from citizen-led organisations. Second, the 1997 Constitution stated clearly that Thai local government could not adopt a committee form of structure. The separation of power between two branches, namely executive and legislative branches, was preferred.

However, these two types of separated system seem to have created, intentionally and unintentionally, a weak system of local government. Confrontation took place not only inside the local authorities but also outside. Chiefs of local authorities or executive sides must contest with councillors in some aspects; in the meantime, they also have frequent activities against their village headmen and their assistants in the same localities to a certain extent.

Third, the 1997 Constitution aimed to increase the local government revenues as well as to guarantee somehow the local autonomy. This measurement, coupled with the enactment of the Decentralisation Act and the establishment of decentralisation committee in 1999, paved the new way for the full scale of decentralisation. We then expected that all local governments, about 7,850 units in the whole country, were equipped with budgets and their own staff to make locally delivered service functions benefit to the people.

There are five types of local governments in Thailand, namely PAO, Municipalities, TAO, Bangkok Metropolitan Administration and Pattaya City. The majority of local governments are approximately 6,000 units of TAOs. In reality, however, there is a big gap between TAOs in the Central region and those in the North eastern region. In the

Central region, some TAOs are richer, by almost ten times, than PAOs. Thai municipalities also suffer from a similar gap between the old generation established many decades ago and the new generation established in 1999 and afterwards.

PAOs and TAOs in the Northeast region were actively engaged in changing internal structure from indirectly-elected executive to directly-elected one. The North region also joined the bands. The South and Central regions seems to be inactive, as they said that indirectly-elected executives were good enough to manage and run their offices.

In 2002, when the PAO association had an annual meeting and also discussed positive and negative sides of directly elected executives, the present author argued that this system should be experimental and should implement only in big cities not in small towns or in small TAOs. However, in the following year (2003), the TRT government led by Prime Minister Thaksin Shinawatra decided to adopt the directly-elected executive system in the whole country.

2.4.2 The policy and reform agenda

In 1997, the constitution, driven mainly by the civil society movement, was promulgated. This policy established an enormous opportunity for further progress in restructuring the relationships between the state and civil society, in further democratising the development process, and in creating new institutions and mechanisms that provide greater accountability, transparency, representation and participation. Initiatives in these areas have roots in law and are guided by far-reaching principles pertaining to basic human rights. It is of the utmost importance that these opportunities be seized to the full and remain central issues in the policy and reform

agenda. Their full and effective utilization will allow civil society organisations to further flourish and to serve as a positive force for change as well as to enable them to serve more effectively as a countervailing force against the negative impacts of globalization.

The 1997 constitution provided a crucial re-orientation for the health of Thais. Currently, health is stipulated as a human right, which must be protected by the state. An egalitarian standpoint is emphasized in the context of health for the first time in Thailand's political philosophy. An equal entitlement to health was introduced for a wide range of the marginalised population, i.e., the elderly, the disabled and abandoned children etc. Consumer protection, particularly for the sake of health, is another area for government support.

The Decentralisation Act became effective in November 1999. This Act defines the roles and responsibilities of the National Decentralisation Committee (NDC). A primary responsibility of the NDC is to produce a Decentralisation Plan that will define the relationships and functional responsibilities between the central and local governments, as well as among local governments. It will define local revenue sources and identify means to improve local tax and revenue mobilization. The plan outlines the stages and means to transfer functions from the central government to local governments as well as to recommend means to coordinate the transfer of public officials from the central government, local governments, and state enterprises that are related to the new assignments of functions and resources (World Bank Thailand Office, 2000).

According to the Decentralisation Act, the public health mission and hospital mandate must be devolved on local governments. Hence, a crucial re-orientation needs to be undertaken by both the central government's officers and local government's officers. The central authority has to shift its mission from logistic administration and policy control to technical and quality assurance of health care. At the same time, the local government's authority has to be empowered so that it will be capable of providing equitable and efficient health care, which will be accountable for those people in their own community.

2.4.3 Decentralisation and devolution in the health sector

1. The legislative background

Reforming public hospitals with the introduction of the concept and model of the autonomous public hospital was still an unresolved issue when the House of Parliament passed the Act on Operationalisation of Decentralisation in 1999. The Act was an organic law of the new constitution adopted in October 1997 (Constitution of the Kingdom of Thailand 1997). It mandated that all ministries involved, including the MoPH, draw up detailed plans to devolve their functions, facilities and personnel to the local administration, mainly the Tambon Administrative Organisation (TAO) and the municipalities within the next 10 years (2010). It was clear that the large public hospital network including the health centres under the MoPH will have to be turned over to the approximately 9,000 local administrations.

Devolution of crucial public services to the local administration is but one of the points of the Decentralisation Act. The more important component of the legislation is the goal to increase the proportion of revenue of the local administration from the present

level of nine percent of total public revenues to 20 percent in 2001 and to 35 percent in 2006 (National Decentralisation Act 1999). Such redistribution would enable the local administration to take up an active role in providing various social services under their responsibility as mandated by the Act. There are six major groups of functions to be carried out by the local administration. They include the building of essential infrastructure, the improvement of the quality of the life (health services and education are the major two among this group), and social and community management, planning and local investment and tourism, environmental, civil, natural resources management, culture and local wisdom (National Decentralisation Committee Office, 1999). The government plans to increase local revenues by allowing local government organisations to collect more tax locally and also by allowing them to retain a larger portion of the tax collected to be used locally. Such an arrangement will reduce the revenue at the central level and will alter the roles and function of the central ministries. This will then correspond with the need to devolve facilities and manpower to local government.

2. The Debates about Decentralisation and Health

In order to meet the goal of decentralisation, the MoPH could simply transfer the various health services facilities and manpower as well as the available budget to the local administrations. This will result in shifting about 80 percent of the annual budget of the MoPH and 90 percent of its staff to the local administration units.

2.1 The Concern over Fragmentation of Services

The two basic agencies of local administrations, the TAO and the municipalities, cover delimited geographical areas with slightly different population

sizes. The basic criteria for differentiating between the two are historical. Municipalities are those local administrative units established before the introduction of the TAO (Chunharas et al., 1998). They were presented only in those selected locations with more developed economies. The TAO was introduced only in 1995 to establish local administration units all over the country (Tambon Administrative Organisation Establishment Act 1994). Both are smaller in size than a district. However because of the more developed nature of the municipalities, they have been the sites of many community hospitals and general or regional hospitals under the MoPH. For most TAO, there are health centres with only about three to five auxiliary health personnel. Both TAO and municipalities will generate more revenue to independently carry out their designated social functions without the need to coordinate with each other. There was a concern that such a mandate will lead to fragmentation and poor coordination as well as an uncontrolled growth of the system. Moreover health centres, community hospitals, general and regional hospitals are expected to coordinate closely for effective patient referral. If operated independently under separate local administrations, the chain of patient referral will become even more fragmented.

Putting different health facilities under separate administrations will not pose problems in terms of patient referral if the financial mechanism is efficient. In the absence of such mechanisms, the alternative is to put various levels of health facilities under the same administration. However, the existing local administration is too small to take care of multiple level health facilities. Hence there is a need to create a larger local

administrative unit for health by combining various local administrations in nearby localities to create a local Area Health Board (AHB) (Health Technical Office, 2000).

2.2 Concern over efficiency

The local administration would continue to manage the transferred facilities in the conventional command and control manner, imposing various rules and regulations that would not allow enough flexibility in the use of available resources for service provision. The transformation of public hospitals into autonomous hospitals and the introduction of a performance-based budgeting system (PBBS) are two of the initiatives proposed with the aim of improving efficiency within public facilities (World Bank, 1999).

2.3 Concern over future employment status and conditions

Like all changes, the call for transfer of personnel to the local administration created panic and a sense of instability among the health personnel. As civil servants they were guaranteed their life long employment with a pension, as well as many other welfare benefits. The concern over the lack of transparency of the local administration further aggravated the issue for fear of being unjustly discharged from service. Moreover, the present civil service system guarantees the possibility of transfer to any province throughout the country. With the new system it is likely that any health professional working within a local administration has to remain there (Local Personnel Administration Act 1999). The detailed plan for the Decentralisation Act has to be finished within one year so as to have a master plan for the next 10 years. There are too many issues to be settled before the deadline is met.

The decentralisation movement with the mandate to devolve to the local administration consequently posed a classic challenge to the authorities concerned. There should not be any disproportionate amount of anxiety to create unnecessary resistance. On the other hand many crucial issues need to be clarified to ensure the creation of a new system. Since the present health system is satisfactorily serving the majority of the population, this issue is even more crucial. Last but not least, the system needs to identify the needs for capacity building to ensure the emergence of an effective decentralised system with various parties properly carrying out their new roles and function.

It is obvious that there is a need to have more information from additional research studies to fill the gap in knowledge, particularly in administrative and management aspects. At a minimum, there should be more information about the roles of local governments within the universal coverage in Thailand.

2.4.4 Summary

The study aimed to set up a project especially for a managerial system that had a clear-cut role of actors, those who were regulators, purchasers, health service providers, and consumers in the Northeast region, Thailand. The national insurance system should be a government-managed social insurance system. Although the system consisted of both public and private plans, which thus offered alternatives to the consumers, insurance was still compulsory. The public sector should provide a basic essential health care package for all Thai citizens, but each person had a choice to buy additional health care services from the private insurance sector.

According to the Decentralisation Plan Act in 1999, the authority of local government should be increased so that it will be capable of providing equitable and efficient health care, which will be accountable to people in local communities. The local government should have a role in the universal health insurance, and should bear a portion of the financial cost.

Based on in-depth interviews of local administrators, more active roles were within reach of local governments. For instance, the central government could grant an additional subsidy (based on capitation) to the local government to protect the poor or less poor, by absorbing high hospital fees. The local government could decide who should be included as beneficiaries of the package, as usually they have a good knowledge of the socioeconomic status of local people. Local government organisations had proved that they could collect tax effectively because many of them had had experience with the tax map to increase tax efficiency. The major concern and worry of local administration had been that health care has never been explicitly stated, in law, as the primary responsibility of local government (Pannarunothai et al., 2004).

Local governments are the nearest organisations to the people and have a good understanding of local issues. It should be easy to provide the local health fund on the universal coverage to its small community and, at later stage, expand to coverage larger local communities. Taking some money from the local government will raise concerns over health issues and accountability of the local government. So they should provide sufficient health personnel.

2.5 The Nature of Policy

A policy is a plan or course of action designed to define issues, influence decision-making and promote broad community actions beyond those made by individuals. Policy development, therefore, is the process by which society makes decisions, selects goals and the best means for reaching them, handles conflicting views about what should be done and allocates resources to address needs.

Policies can have two sources -- the private sector or the public sector -- and together they have a significant and long-lasting impact on both individual and community health.

Private Policy

Private policies consist of a series of actions intended to persuade private sector decision-makers -- people working in hospitals, community health centres, business groups and members of the faith community, for example -- to address a local problem. Private policies can support expanding a service by increasing or redirecting monetary and human resources. They can work toward initiating a new service using existing community resources in new ways, such as creating new referral linkages or building a community coalition.

Public Policy

Not every health issue can be addressed by the private sector. This is where public policies come into play. Public policy is a set of rules (policy) that people (the public) must abide by. They can be documented and enacted through a statute (law),

regulation, executive order, court order or official letter that explains a policy decided by federal, state, county or local officials.

Policies and their development depend on partnerships between many stakeholders, including: governmental and private agencies, public health agencies, employers, healthcare providers and community-based organisations. Policy-making is not always a rational and orderly process; instead, it is a political process, which is propelled by dynamic negotiations between groups with competing societal priorities and conflicting social ideologies.

Forms of Public Policy

Public policies are enacted at many levels, through for example national or local laws, regulations, organisational guidelines, etcetera. However, in countries with written constitutions, such as the United States and Thailand, the Constitution itself will provide the foundation for public policy since it contains the parameters of government policy as well as the procedures for additional rule-making. Statutes are formal, written laws enacted by a legislature. Statutes may take the form of either an act or a resolution, as opposed to unwritten or common laws, which are usually determined by custom or by court decision.

Who Makes Policy?

Public policy-makers are people who work at national or local levels of government. They establish the rights and standards for entire groups of people. In contrast, private policy-makers are individuals you meet in your community every day. They are the people who sit on hospital boards, represent the business community or

work as community organizers. They are often charged with changing the private policies of community institutions.

2.5.1 The Policy Process

1. Problem Definition

Policies are developed in response to the existence of a perceived problem or an opportunity; they never exist in a vacuum. The context is extremely important because it will shape the kinds of actions considered. For example, who has identified the problem? Is it widely recognized by society as a whole or is it limited in scope to a local pressure group for example? In the case of the former there may be a greater willingness to intervene than in the latter, depending on the political power exerted by the pressure group. Do the public authorities have the interest or will to respond? There are usually many more problems than the policy makers are willing to address. Many issues remain unaddressed. Do the public authorities wish to wield the instruments necessary to carry out a policy response? The problem may be recognized, but public authorities may have little ability to effect change. Such is the problem of many environmental problems that require global solutions. What is the timescale? How pressing is the problem, and how long a response would take. Policy makers are notoriously prone to attempt only short-term interventions, since their mandates are usually of relatively short duration. Long term issues may not attract policy makers because the results of any policy intervention may be decades away.

These questions lie at the heart of the need to correctly identify the problem or opportunity. No policy response is likely to be effective without a clear definition of the issue. The following elements need to be considered in defining a problem:

- Who has identified the problem, and why should it be seen to be a problem? Many problems exist, but few are taken up because they are not brought before a wide audience.

- Is there agreement on the problem? If there is no agreement that a problem exists, it is unlikely that a strong policy response will be forthcoming. Effective policies are more likely to be formulated if there is widespread recognition of a problem and its causes. A problem for the Kyoto Accord on global warming is that decision-makers in the US have not been convinced that the problem is due to human-induced carbon dioxide emissions.

- Is it an issue that can be addressed by public policy? The price of oil is regarded by many as a problem, but individual states have no power to affect the price of this commodity.

- Is it too soon to develop a policy? This argument was used by the lobby in California that opposed stricter emission controls on vehicles, based on the argument that the technology of alternative energy for vehicles was not sufficiently advanced.

- Is the problem seen differently by groups with different values? Environmentalists see many transport issues differently than many other interest groups. Divergence of opinions may affect how the problem is addressed.

- Is the problem fully understood? Do we know the causal relationships that may be necessary to provide a solution? Transport and development is one such relationship around which there is a debate.

- Can the relationships between the factors that make up the problem be quantified? Problem definition is better when it is possible to measure the scale and scope of the issues involved.

In defining the problem or opportunity and to help address the questions above, background studies are required. The state of affairs needs to be provided which will identify the actors, the issues and the possible means that are available. It is also important to forecast trends in order to identify whether the issue is likely to change.

2. Policy Objectives and Options

The eventual success of a policy depends upon establishing clear goals. If there are multiple objectives they must be consistent. They must be flexible enough to change over time as the circumstances evolve. In simple terms the objectives must:

- Identify the present conditions and situation.
- Indicate what the goals to be achieved are.
- Identify the barriers to achieving the goals.
- Identify what is needed from other agencies and the private sector.
- Determine how success will be judged and measured.
- Identify what steps are required to achieve success.

Having defined the problem and objectives, policy options must be formulated and evaluated. In many cases more than one solution has to be considered for policy adoption. The objectives may be realized in many different ways. Best practices from other jurisdictions may be considered, and all other possible solutions need to be considered. By evaluating the options it may be possible to identify the one that best

meets the goals that have been established and at the same time is the best fit for local circumstances. These types of evaluations are referred to as ex ante, because the outcomes are being assessed even before the policy is put into practice. Although one can never completely anticipate the outcome of different prospective policy options, ex ante evaluations are capable of bringing to light what problems may develop when the preferred option is implemented. Thus, when the future policy is to be evaluated (ex post), problems of data, reporting, and identification of success criteria may have been already anticipated and resolved through an earlier ex ante assessment.

Many types of evaluation methods are employed in both ex ante and ex post assessments. These include cost-benefit analysis, multi-criteria analysis, economic impact and Delphi forecasting. Because evaluation takes place at several of the steps in the policy process, it is now regarded as a critically important issue. New ideas involving managing the policy process include performance based management, where evaluation is built into the entire process. It means in the policy process, a great deal of attention has to be paid as to how the goals, results, and beneficiaries are to be measured. The selection of indicators has to be agreed upon by policy managers from the inception.

3. Policy Implementation

The implementation of the selected option represents a critical aspect of the policy process. The most carefully crafted policy that is widely accepted by those it affects can flounder because of improper implementation. It is impossible to define an optimal implementation procedure because of the wide range of socioeconomic circumstances that are applied to policies, and also because of the diversity of policies

themselves. However, a ten step model of policy implementation can be considered (Hogwood and Gunn, 1984):

1. Policies must not face insurmountable external constraints. This means that the policy must not exceed the jurisdictional or constitutional limits of the agency. This is a common issue in federal states, where different transport modes may be under different jurisdictions. One of the factors that impeded the success of Montreal's second airport at Mirabel was that the Provincial government, which had opposed the site selected by the Federal government, refused to build an expressway to provide better access to the city. Other examples include cases where the transport issue cannot be resolved because of international borders. However, transnational agreements, especially within the European Union have considerably reduced external constrains in transport policy implementation.

2. In implementing the policy there must be an adequate time frame and resources. The policy may be appropriate, but may fail because its implementation took longer or was more expensive than budgeted. A recent example is that of airport and port divestiture in Canada, where the two policies had similar goals but different implementation procedures (Dion et al, 2002). Airports had access to much greater financial assistance to carry out the transfer process; that of the ports was much smaller. As a result the port policy took much longer to be carried out.

3. The implementing agency must have adequate staff and resources to carry out the policy. A growing problem with environmental legislation is that the agencies do not have the means to ensure guidelines and standards are enforced. This has been a particular problem for many of the East European countries being admitted into the EU in 2004 that have to adopt stricter standards than before.

4. The premises of policy and theory must be compatible. At one time public ownership was seen as a valid policy alternative. Today it may be a valid option in theory in some circumstances, but it is not politically acceptable.

5. Cause and effect relationships in the policy must be direct and uncluttered. A successful policy must be seen to be based on clear and unambiguous relationships. Complex policies are more likely to be misunderstood. It took many years for the new urban transport policy of the US to be implemented. The Intermodal Surface Transportation Efficiency Act of 1991 (ISTEA) was an extremely complex piece of legislation that left many local agencies who were required to carry out the Act quite perplexed. It required simplification under the 1998 Transportation Efficiency Act for the Twenty-first Century (TEA21) Act.

6. Dependent relationships should be kept to a minimum. If the agency in charge of implementing the policy has to rely on others to it carry out, the more fragmented will become the authority. The implementing agency will become more dependent on others with not necessarily the same interests.

7. The basic objectives of the policy need to be agreed upon and understood. All actors in the policy process must possess a clear understanding of the policy and what is required to carry it out. It goes without saying that all those involved must understand the policy and have knowledge about their roles in carrying it out. Information and training are essential elements in the policy process.

8. Tasks must be specified in an appropriate sequence. Implementation is a process with connected steps from conception to the end. If the steps are not carried out in the correct sequence the policy may fail. Difficulties may arise, for example, if evaluation is completed without the indicators of success being agreed upon

beforehand, or if another agency is involved before necessary pre-conditions for its participation have been completed.

9. Communication and coordination need to be on the same wavelength. Those implementing the policy have to possess the same information base, have to interpret it in the same way, and to communicate well with each other.

10. There must be compliance. Those agencies involved in implementing the policy must work towards total compliance. Many times policies are formulated but their compliance is lacking (see 3 and 7 above).

4. Policy Evaluation and Maintenance

The implementation stage is not the final step in the policy process. The effectiveness of the policy needs to be assessed after a certain period of time, and steps must be taken to ensure that there are resources and means to maintain a successful policy. In the past, this tended to be overlooked, and after a while policies would be sidetracked by other newer initiatives. The long term effect was the presence of many different policy initiatives frequently with conflicting goals. Prior to the ISTEA, US federal highway policy was marked by an accumulation of interventions, the so-called ‘entitlements’ that were added one after the other, with little thought as to compatibility or integration with other funding (Paaswell, 1995). The result was that policies in place frequently conflicted with each other in terms of goals or implementation measures.

On-going programme evaluation is thus central to the maintenance of policy. This has tended to be a difficult issue for managers who today find their programmes being assessed by methods and data requirements that were never built into the policy

initially. Performance Based Management has become an essential tool in the policy process as a result. Under this system evaluation is built into all stages of the policy process, and indicators are agreed upon by the managers who carry out the programmes as well as the units that undertake evaluation.

Summary, a policy is a plan or course of action designed to define issues, influence decision-making and promote broad community actions beyond those made by individuals. Policy development, therefore, is the process by which society makes decisions, selects goals and the best means for reaching them, handles conflicting views about what should be done and allocates resources to address needs.

2.5.2 How Public Policy Is Made

The judicial system, especially those at the highest level, makes public policy when judges rule on disputes about how laws should be interpreted. These rulings are called "case law" or common law, and they have the same weight as laws enacted by the legislature and approved by the governor of a state.

At national or local level, the legislative body meets regularly to consider new laws or amendments. These laws or amendments to existing laws are considered to respond to a current problem or as a result of problems brought to the fore by people both inside and outside the legislature. Nations have legislatures or assemblies. Cities have city councils and towns have town meetings. Local governments are important because over the past 30 years, there has been a growing trend to place more responsibility at the local level.

A nation’s legislative process involves a newly elected body first selecting its leaders, then taking up issues, sponsoring legislation and holding hearings according to dates set at the beginning of each legislative session. Once a bill is assigned to a legislative committee, most of the work is performed there. For example, legislative committees authorize funding for programmes; they develop the rules for new programmes and activities. Appropriations committees consider actual spending authorization, or the means by which programmes are funded. Budget committees set out broad budget resolutions, which establish goals for spending and revenues for the next fiscal year. Committee decisions are then presented to the full legislature for approval.

Policy-making by the executive branch occurs through executive orders, regulations and management decisions. Ministers and local government officials issue executive orders to avert lengthy public debate of controversial new issues. On other occasions, they are issued so that the administration can “own” a new initiative or policy. In the USA, Governors frequently use the budget development process to promote new gubernatorial initiatives. For example, Governor Davis of California developed new initiatives on children's education as part of his budget proposals.

Public managers make public policy when they develop regulations to implement new laws or decide how an existing regulation should be interpreted. There is an extensive literature on how “street level bureaucrats” (Lipsky – check reference) operationalise policies at local level and decide what they mean in terms of the application of organisational rules.

2.5.3 Citizen Participation in Policy Making

Despite the fact that public policy information is widely available to citizens, only a portion participates in policy by voting during general and special elections. Others become involved as they participate in unions, neighbourhood groups, professional associations and consumer advocacy groups. Increasingly, initiatives, referendums and recalls offer citizens new mechanisms for civic participation. An initiative lets citizens bypass legislatures and propose new statutes or changes in charters. A referendum gives voters the opportunity to approve or reject statutes or constitutional changes that have been proposed by the legislature. Least used is the recall, which calls for the removal of a public official.

Elected officials have a powerful need to connect with their constituents: they would like to remain in office and most desire to know the issues facing their communities. Citizens often are invited to participate in legislative hearings, and many send letters or visit their representatives to make their needs known; a sample testimony and sample letters to legislators are available. As individuals from a community become more involved in educating their representatives, they run the risk of becoming involved in lobbying. Direct lobbying is any attempt to influence legislation via direct contact. Grassroots lobbying is any attempt to affect legislation by influencing public opinion.

2.5.4 Monitor Progress

Evaluation is the process by which we separate the efforts and activities that promote health and prevent disease and injury from those that don't. It is the single best way to demonstrate to decision makers the wisdom in making a particular investment to improve community health. Evaluations are especially valuable in helping advocacy

groups understand what has been tried, what works, what doesn't and, more importantly, why.

2.6 The Evaluation

Evaluation is the systematic investigation of a product or activity to determine its merit (quality), worth (cost-effectiveness), or significance (importance). When applied to organized activities intended to promote and protect health, an evaluation usually determines whether specified "outcomes" or health goals were reached and whether or not those results can be attributed to the programme.

Evaluations are also useful complements to ongoing programme management. For example, evaluations gather information that assists managers in assessing whether or not important programme milestones and deadlines are being reached. If targets are not being met, then evaluation information helps guide changes in programme functions and objectives so that goals can be realized.

Evaluation is an integral part of programme planning, but one that is often overlooked in a programme's initial planning phases. In the United States, the Centres for Disease Control and Prevention's Framework for Programme Evaluation in Public Health states that the following evaluation questions should be addressed at the beginning of a programme and revisited throughout its implementation:

- What will be evaluated?

- What aspects of the programme will be considered when judging programme performance?

- What standards (i.e., type or level of performance) must be reached for the programme to be considered successful?

- What evidence will be used to indicate how the programme has performed?

- What conclusions regarding programme performance are justified by comparing the available evidence to the selected standards?

- How will the lessons learned from the inquiry be used to improve public health effectiveness?

Considering these questions in advance of initiating programme activities will guide an organisation in determining feasible goals and demonstrating whether cost-effective programmes made a real difference in comparison to other evidence of success.

2.6.1 Evaluation Steps

There are six general steps that are taken in any evaluation. Since evaluation is really an ongoing process, many of the steps overlap or may occur out of order. Still, completing the six steps can help you, as well as policy-makers and decision makers, gain a solid understanding of your programme's context.

Step 1: Engage Stakeholders

Any evaluation of efforts to improve the public's health begins with considering the value systems of the partners. Stakeholders must be involved to ensure that their perspectives are considered. Key stakeholders are those involved in programme operations; those served or affected by the programme; and those primary users of an evaluation. Failure to consider stakeholders' perspectives can mean that

your evaluation will not address important objectives, operations and outcomes. It can also mean that the results of your evaluation might be ignored or criticized as flawed.

Step 2: Describe the Programme

Programme descriptions set the stage for evaluation decisions. A good description of your programme's goals, objectives and strategies will allow evaluators to compare your programme to similar programmes and their effects. A programme description should take into account your programme's capacity to affect change and how it fits into the larger organisation or community. Programme descriptions should also describe the problem being addressed by programme activities, the expected effects, the resources used, the programme's context and a “logic model” which is a flow chart or table portraying the sequence of steps leading to the results you want to achieve.

Step 3: Focus the Evaluation Design

Because of time and funding, all evaluations must be narrowed down to focus on the issues of greatest concern to the stakeholders. An evaluation design or plan anticipates intended uses if it focuses on articulating the purpose, users and uses of the evaluation. The design must identify the questions to be answered, describe the methods used to get the answers, and encompass agreement on the procedures, roles, and responsibilities of those who will execute the evaluation plan. Since changing an evaluation design mid-stream is costly, if not impossible, discussion of each of these points before launching the evaluation increases the evaluation's utility and accuracy, and will help stakeholders minimize ethical issues and costs.

Step 4: Gather Credible Evidence

The evaluation must be seen as credible by its primary users. To do that, it must collect information that will give a well-rounded picture of the programme. Having credible information (i.e., evidence) strengthens judgements and recommendations for future action. Aspects of data gathering that affect credibility include: the indicators (measures of change) and sources of information selected; the quality and quantity of data gathered; and the logistics of data gathering.

Step 5: Justify Conclusions

Conclusions are justified when they are linked to evidence and judged against agreed upon values or standards set by the stakeholders. Using standards will allow you to establish comparison points by which the programme can be judged. Analysis and synthesis of findings may allow you to detect patterns or isolate other findings. Interpreting findings is the effort to determine what your findings mean and can lead you to judgements concerning the merit, worth and significance of the programme. Finally, recommendations are actions for future consideration and require you to understand how your efforts compare with other effective alternatives.

Step 6: Sharing Lessons Learned

Lessons learned do not automatically translate into informed decision making and action unless you take deliberate steps to disseminate results. If the needs of stakeholders have been adequately addressed during planning, then it is more likely that this group will use your findings. Another strategy for sharing evaluation results involves obtaining ongoing feedback from stakeholders throughout the entire process and following up with participants after they receive evaluation findings.

2.6.2 Evaluation Standards

Evaluation standards help avoid creating an unbalanced evaluation and are considered to be important especially if you plan on publishing your findings. Ensure your evaluation is balanced by considering these four areas:

- Utility Standards; these ensure that the needs of users are met;

- Feasibility Standards; these ensure that the evaluation is pragmatic and do-able;

- Propriety Standards; these ensure that the evaluation is ethical; and,

- Accuracy Standards; these ensure that the findings are considered correct.

2.6.3 Group Work

Forming an evaluation team is one approach to conducting an evaluation. A diverse team is better able to address common concerns and stands a greater probability of conducting a culturally competent evaluation. A strong evaluation takes advantage of community resources and partner collaborations.

2.6.4 Summary

In summary, if policies focus too closely on content (on what), and do not address questions of process, actors and context (who, how), then it is possible that they will fail. In this session we explore the use of a framework that takes particular account of processes, actors and the conditions within which they work. This analytical framework can be used retrospectively, for understanding policy failure, but also prospectively, for helping policymakers to be more strategic, to plan for the execution of policies thus ensuring that policies are effectively implemented.

2.7 Local Health Maintenance Fund

2.7.1 Local health maintenance fund established

The local health maintenance funds are to be established for the purpose of providing local health boards with funds to provide public health services. The fund shall be administered by the state department and consists of:

(1) Appropriations by the general assembly; and

(2) Penalties paid and deposited in the fund.

The expenses of administering the fund shall be paid from money in the fund. The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. Interest that accrues from these investments shall be deposited in the fund. Money in the fund at the end of the state fiscal year does not revert to the state general fund.

2.7.2 Funding local health boards

The state department shall provide funding each year from the local health maintenance fund under the following schedule to each local board of health whose application for funding is approved by the state department. For purposes of determining the amount of a grant to a multiple county health board, the state department shall regard each county of the multiple county health departments the same as a separate county. A grant to a multiple county health board must equal the total of grants that would be made to the separate counties based on the population of each county. A local health board that desires to receive funding from the local health maintenance fund must file an application with the state department before May 1st of each year. The application must state how the funds will be spent. The state

department may extend the deadline for filing an application upon a showing of good cause by the local board of health.

If a county has more than the local health department, the county fiscal body shall adopt an ordinance to allocate the funds provided to the county under subsection. This ordinance must provide that each local board of health in the county must receive an allocation of funds granted under subsection. The county fiscal body shall file a copy of the ordinance with the state department before May 1st of each year. By June 1st of each year, the state department shall:

(1) allocate money in the local health maintenance fund (for distribution the following January) to each local board of health whose application is approved in accordance with the schedule in subsection; and

(2) determine how much money in the local health maintenance fund has not been applied for.

The state department may use the money that has not been applied for or otherwise allocated to fund joint plans entered into by two or more local health boards or by a multiple county board as provided in subsections. If two or more local health boards cooperate in providing any of the services, those health boards shall file a joint plan that must be approved by the state department. The joint plan must specify the following:

(1) The services to be provided under the plan.

(2) The cost of each service to be provided under the plan.

(3) The percentage of the total cost of services to be provided under the joint plan by each local board of health.

If two or more local health boards join together to provide services in accordance with a joint plan filed with the state department of health under subsection, and the state department determines that the services to be provided under the joint plan are eligible for funding from the local health maintenance fund, the state department shall grant (in addition to the funds provided to each county in which the local boards of health are located under subsection) an amount not to exceed fifteen thousand dollars ($15,000) to fund the joint plan. The state department shall grant money to fund joint plans that most effectively accomplish the following goals in accordance with standards adopted by the state department:

(1) Benefit the greatest number of people.

(2) Provide services in a cost effective manner.

(3) Address the most serious health care needs of the area served.

(4) Provide additional public health services in a medically underserved or economically distressed area.

This money shall be allocated directly to each local health board participating in the joint plan in the same percentages specified in the joint plan under subsection. A multiple county health board may file a plan under this section to provide any of the services. If the state department determines that the services to be provided under the plan submitted by a multiple county health board are eligible for funding from the local health maintenance fund, the state department shall grant (in addition to the funds provided under subsection to each county in which the local boards of health are located) an amount not to exceed fifteen thousand dollars ($15,000) to fund the plan.

Services funded must be in addition to, and not in place of, services funded at the local level.

2.7.3 Use of funding by local health boards

Funding provided to a local board of health may be used by the local board to provide any of the following services:

(1) Animal and vector control,

(2) Communicable disease control, including immunisations,

(3) Food sanitation,

(4) Environmental health,

(5) Health education,

(6) Laboratory services,

(7) Maternal and child health services, including prenatal clinics and well-child clinics,

(8) Nutrition services,

(9) Public health nursing, including home nursing visitation and vision and hearing screening, and

(10) Vital records.

Money granted to a local board of health from the local health maintenance fund may not be used for any purpose other than for the services listed in this section.

2.7.4 Provision of funded services; cost to recipient; use of fees

Except as provided, the services funded shall be provided without cost to a recipient. If a recipient has insurance or any type of public indemnification that would

in part pay for any services funded, then the recipient shall assign the recipient's rights to that insurance or public indemnification to the local board of health. The insurer, upon notification from the local board of health, shall pay for those services covered under that recipient's insurance policy or public indemnification. The legislative body of the unit in which a local board of health has jurisdiction may adopt an ordinance that requires the local board of health to do either or both of the following:

(1) Charge individuals for services on a sliding fee schedule based on income that is adopted by the state board under rules adopted.

(2) Charge corporations, partnerships, and other commercial concerns for services funded under this chapter.

The fees for services collected shall be used only for public health purposes and shall be used in addition to, and not in place of, funds allocated for public health purposes before the ordinance described became effective.

Summary

To sum up, health policy analysis is the process of assessing and choosing among spending and resource alternatives that affect the health care system, public health system, or the health of the general public. Health policy analysis involves several steps: identifying or framing a problem; identifying who is affected (stakeholders); identifying and comparing the potential impact of different options for dealing with the problem; choosing among the options; implementing the chosen option(s); and evaluating the impact. The stakeholders can include government, private healthcare providers (e.g. hospitals, health plans and office based clinicians), industry groups

(e.g., pharmaceutical, biotechnology and medical device manufacturers), professional associations, industry and trade associations, advocacy groups, and consumers.

2.8 Research Literature Review

Dixon and Harrison (1997); They were study "Funding the NHS: a little local difficulty?". The media have been full of reports of crisis in the NHS. Although national analyses suggest that the NHS should be able to cope within the increases in spending it has been given, local pressures can leave parts of the service struggling. Firstly, the change to allocation of funds on the basis of population needs has meant that some authorities and trusts have had effective cuts in their budgets, requiring them to trim services. Secondly, the government's insistence on an annual 3.0% increase in efficiency may have resulted in authorities taking short term measures that actually decrease efficiency in the long term. Thirdly, health authorities have had to bear the costs of national targets such as reducing waiting lists and junior doctors' hours as well as local problems such as higher numbers of mentally disordered offenders. However, all these factors can be controlled by national or local management and so their impact is not inevitable. The financial stress experienced by some health authorities and trusts is related not only to low underlying increases in NHS funding but also to the requirement to increase activity and to absorb the costs of national directives or other local demands. All of these factors, however, can be controlled by the government, the NHS Executive, or locally.

Maynard and Bloor (1998); The UK NHS has a number of important strengths. Its costs are relatively low compared to the health care systems of other developed

countries due in part to cash limited central budgeting. It is extremely popular with the electorate and surveys show overall satisfaction with the NHS despite some dissatisfaction with waiting lists and a public perception of under funding. The NHS model of general medical care provided by independent contractors has been acclaimed as “a British success”. The role of the UK GP combines providing primary care and acting as a gatekeeper to secondary care. This increases equitable access to care for the population and assists in cost containment. As a model, it is currently being emulated in other countries including Sweden and US Health Maintenance Organizations but, as in these countries, the UK primary care model has been evaluated poorly. There are of course continuing weaknesses in the UK health care system. There is insufficient knowledge upon which to base health care services and increase efficiency. In the future, if a knowledge-based health care service is to be created, a considerable amount of research and evaluation is required to identify "what works" in health care (i.e., what is effective) and also the cost effective ways of altering provider behaviour to maximise the amount of health gain which can be achieved using a limited budget. The NHS reforms created a lot of enthusiasm and energy but its effects are difficult to disentangle from the simultaneous increases in funding. There is little evidence from the UK or elsewhere that competition in health care produces efficiency or improvements in resource allocation. Evaluation is required to identify which of the reforms are increasing efficiency. Competition needs to be used with caution and recognised as a mean and not an end in itself. It is remarkable how both clinical practice and health policy reform, in the UK and elsewhere, is poorly evaluated. Medical practice varies substantially locally, regionally, and internationally, e.g., patients with similar age and stage of cancer

receive very different levels of radiotherapy across Europe. For most interventions, the appropriate level of treatment may be asserted but is not based on cost effectiveness knowledge. Health policy analysts, like clinicians, make assertions about competition and other health care reforms which are value- rather than knowledge-based. Both groups of decision-makers should be more cautious, informing their choices with research rather than relying on unsubstantiated optimism.

Pannarunothai et al. (2004); Research title is Universal health coverage in Thailand: ideas for reform and policy struggling. This research aimed to study inequality in health between rich and poor in Thailand and was well documented; millions of informal workers and their families lacked health insurance; and the poor paid more proportionately in income for health care. The universal coverage is conceived as one of the means to redress the situation. But the term 'universal coverage' may have a different meaning among different groups of stakeholders. This paper, based on empirical research of health policy reform, collected perceptions and ideas from stakeholders and discusses the ways and strategies that universal coverage might take shape in Thailand. Two sources of information were taken: one from the questionnaire survey (according to the Delphi technique, two rounds of survey were taken), another from in-depth interview. Obtained information for policy formulation included how best, as conceived by stakeholders, to implement the universal coverage, sources of finance, fiscal implication for Thai government, ways to prevent higher demand for unnecessary services, and involvement of local government. Recent policy move in Thailand (the so-called 30 *baht for all diseases*) emerged in 2001 generated hot debate nationwide. The programme is currently in its early phase and is likely to evolve

overtime—i.e. whether or not this programme will be financed by certain types of taxes or from annual government expense is still unclear; and budget allocation among different health providers is still unsettled. Anyhow this programme may be interpreted as a policy shift away from the pro-market based toward a government-supported egalitarianism.

Hughes and Leethongdee (2007); Research title is Universal Coverage in the Land of smiles: lessons from Thailand's 30 baht health reforms. Thailand became one of a handful of lower-middle-income countries providing universal health care coverage when it introduced reforms in 2001. Following the 2006 military coup, the coverage reforms are being reappraised by Thai policymakers. In this research we took the opportunity to assess the programme's achievements and problems. We described the characteristics of the universal insurance programme—the 30 Baht Scheme—and the purchaser-provider system that Thailand adopted. Thailand introduced reforms in 2001 that combined universal coverage with a relatively comprehensive benefit package. Recently, the national press of Thailand featured the reforms prominently, as commentators pondered the effects of the military coup that ousted Prime Minister Thaksin Shinawatra on 19 September 2006. Policymakers and academics have been weighing the achievements and shortcomings of the reforms and offering prescriptions for change. This research assesses the balance sheet and considers what lessons the Thai reforms offer for the broader health policy community.

Tangcharoensathien et al. (2007); Research title is Achieving Universal Coverage in Thailand: What Lessons Do We Learn? This research reviewed the policy process of achieving universal coverage of health care (UC) in Thailand and critically assess how

the reform achieve policy objectives of improving equity and efficiency of the health care system with sustainable health care finance. Findings from the study indicate that bureaucrat-led reformists played an important role in bridging researchers and policy makers. While agenda setting was vested in the political leadership and commitment to achieve universal coverage, the system design and monitoring and evaluation were guided by researchers; and successful policy implementation was based on the health system capacity. Evidence played a strong foundation of the health sector reform. Several lessons were drawn. First, the strength of health care infrastructure and geographical distribution of well-functioning primary care services in rural and urban areas serves as a strong basis for success in the smooth implementation of the UC policy. The availability of qualified human resources for health at district and provincial health facilities is also a key factor enabling the capacity of the health care system to provide essential health services to the whole population, and cope with the increasing demand for health care. Second, financial feasibility of the country influenced by a long period of internal peace and the economic growth, coupled with appropriate health financing arrangements of the UC scheme, makes it possible to implement the UC policy. Third, relevant knowledge and evidence for policy formulation and implementation, and skills in the estimate of budget requirement was acquired through the establishment of effective knowledge management mechanisms and sufficient long term investment in human resources in health system research and international linkage to keep abreast. Also, the national capacity coordinates data producers (i.e. the National Statistical Office) and data users (i.e. the MOPH), and has the ability of researchers to communicate with health care reformists and policy makers to support the conception of "The triangle that moves the mountain".

Ekman et al. (2008); Vietnam is undertaking health financing reform with a view to achieve universal coverage of health insurance within the coming years. To date, around half of the population is covered with some type of health insurance or prepayment. This review applies a conceptual framework of health financing to provide a coherent assessment of the reforms to date with respect to a set of key policy objectives of health financing, including financial sustainability, efficiency in service provision, and equity in health financing. Based on the assessment, the review discusses the main implications of the reforms focusing on achievements and remaining challenges, the nature of the Vietnamese reforms in an international perspective, and the role of the government. The main lessons from the Vietnamese experiences, from which other reforming countries may draw, are the need for sustained resource mobilization, comprehensive reform involving all functions of the health financing system, and to adopt a long-term view of health insurance reform. Future analysis should include continued evaluation of the reforms in terms of impacts on key outcomes and the political dimensions of health reform.

Glied (2008); The health insurance reform enacted in Massachusetts in 2006 and the proposals of the leading Democratic presidential candidates seek to achieve universal health insurance coverage while relying primarily on private insurance. Achieving universality is a challenge in any system that assigns insurance coverage, whether private or public, to identifiable individuals. The difficulties of finding, enrolling, and accounting for all eligible participants escalate when most of the financing for coverage is expected to come from premiums paid directly to multiple insurers rather than from funds collected centrally by the government through taxation. To address

this problem, some reform models incorporate an individual mandate, a legal requirement that every person obtains insurance coverage. The Massachusetts health plan mandates coverage for both adults and children, as Senator Hillary Clinton's proposed plan would do nationally; Senator Barack Obama's plan would require parents to obtain coverage for their children. Universal coverage that relies on private health plans is hardly unprecedented; several other countries, including Germany, whose health system dates back to 1883, as well as Israel, the Netherlands, and Switzerland, use this model. Neither is the individual mandate unique to the United States. The Dutch and Swiss systems, which, like the U.S. models, rely relatively heavily on premium payments rather than payroll taxes, incorporate such mandates. The individual mandate in the U.S. plans, however, has become a flash point for controversy. The idea of an individual mandate as a means of achieving universal coverage dates back to the 1993 Clinton health plan. At that time, conservative proponents of expanded coverage argued that the availability of free or subsidized care for the uninsured would generate what they called free riders — people who were aware that inexpensive care would be available in the case of an emergency or a health catastrophe and who would therefore choose to forego the purchase of private insurance. Though such conservatives rejected a substantial role for government in providing health insurance, they asserted that the free-rider problem legitimated a requirement that everyone hold basic insurance coverage. The free-rider problem remains a central element in the argument for an individual mandate. Research verifies the existence of such a problem but suggests that its magnitude is quite small. Funds diverted from uncompensated care would not be sufficient to pay for the subsidies needed to cover most uninsured people. Eliminating the free-rider problem through

universal insurance might make the health care system fairer, but it wouldn't make it less costly.

Thiptengtae et al. (2008); Research title is a Consequence of Local Health Insurance Fund of Suanluang Sub-district Municipality. The main purpose of this qualitative research was to paraphrase the consequence of local health insurance system of Suanluang Sub-district Municipality, Amphur Kratumban, Samutsakorn Province. The data from 24 informants were collected on 14-19 February, 2008 through in-depth interview, focus group including observation and then analyzed by using content analysis. The vision and structure of administration of Suanluang Sub-district Municipality facilitated the operation of local health insurance fund; here by the committee of this fund were both appointed and elected due to standard regulated by National Health Security Office. Moreover, to enhance strength in practical level, an ad hoc committee was appointed for cooperating in planning and carrying on tasks related with problems and contexts in area as well as developing the staffs', potential. As for health service, it included four activities covering five target groups. These activities consisted of evaluation, reflection of evaluation and inspection of the project operation: product, output and impact. It was found that all target groups can access the service broadly but there was no covered evaluation. As for the target groups, satisfaction, the clients satisfied all services that they received. The project innovation was figured as the model in administrating and encouraging the multilateral alliance to participate in local health insurance fund and carrying on the own mission of each alliance. In addition, the leader has vision that concerned the importance of health promotion and illness prevention. All of these findings were integrated and directed to

similar intentions, that is, promoting public to access health insurance and achieving quality of life. Hereby, the committee was the co-operator for health promotion and illness prevention covering rights benefit for all target groups together with using the resources to maximize the most benefits. As regards policy of administration, the researcher suggests that, the budget administration should not be obligated with budget year as usual because of some inconvenience that induced the operational lack of smoothness and continuity. As for the practical level, the manual of financial operation should be determined as a guideline for practicum. Furthermore, owing to the misunderstanding of personnel about duplication of projects from fund and their own mission, therefore, this topic should be better clarified to carry on. Lastly, the public relations about the service of fund, particularly rights benefit package emphasizing various target groups should be continuously propagated.

Nuaon et al. (2009); Research title is Factors Affecting Responsiveness of Local Health Security Committee to Local Health Security Fund in Krabi Province. This research aimed to describe responsiveness to the local health security fund, and explain predicting factors of the responsiveness of the local health security committee in Krabi Province. All of 166 committee members were recruited. Data collection was performed using questionnaires. The content validity of the instrument was tested by three experts. The reliability test of the knowledge questionnaire on local health security fund using Kuder and Richardson method yielding a value of 0.97; whereas the perceived benefit, perceived role of the committee, and the responsiveness of the committees using Cronbach’s alpha coefficients were 0.92, 0.86, 0.98 respectively. The descriptive statistics and multiple regressions analysis were in data analysis. The

results revealed that the level of responsiveness of the local health security committee to the local health security fund in Krabi Province was at a high level (Mean = 2.34, S.D. = 0.40). Three predicting factors of the responsiveness of the committee were perceived benefit of the local health security fund, perceived role of the committee and sufficiency of the committee numbers that collectively explained 51% of the variance (adjusted R2 = 0.51, $p < 0.05$). The perceived benefit of the local health security fund was found to be the best predictor of the committee's responsiveness (adjusted R2 = 0.47, $p < 0.05$). Recommendations to assure the local health security committee on the benefit of the local health security fund were made as the first priority. In addition, supportive plans on increasing their role perception and managing the manpower were proposed.

Patmasiriwat et al. (2009); According to an evaluation of the local fund health security, Dr. Direk Patmasiriwat, a lecturer of Faculty of Economics, Thammasat University, stated that the local fund health security has enhanced the health promotion activities in many local areas. It is clear that these activities will be extremely successful, if the local administrators have the enthusiasm, and local officials also have strongly supported. So the chief executive of the TAOs and the mayor of municipalities have opportunities to create a local fund health security relating public relations. The collaboration among the TAOs, municipalities, local communities and health centres has been established. Several areas provide new tasks, such as welfare for the patients; a shuttle or an emergency ambulance car. Health behaviours have been dramatically changed such as stopping cigarettes and drugs, reducing salt, controlling weight and using corrected medicines. These activities have affected people clearly

because they have got benefit lives. As a result, the LFHS is a good start of the health promotion and disease prevention for Thai citizens.

Leethongdee (2011); Research title is the Implementation of Health decentralisation: Progress Evaluation and Impact Analysis. This is part of the decentralisation of health and is an important and concrete result in a major transformation of the Thai health care reform. Data from the study and follow-up operations shows that after promulgation of the decentralisation plan (first edition) in the year 2543 was the decentralisation of health, there is yet no clear and concrete progress as such. Despite the fact there were some public health activities to be transferred to local governments. However, the evaluation was not operating in accordance with the procedures and methods set forth in the Plan. As a result, the Ministry of Health-MoPH has a fine way for the decentralisation of health in the year 2549, from which important issues arise. The proposed models of transferring the mission to the local government on a variety of forms to suit the availability and circumstances of each area of four types: 1) transfer Split 2) transfer to Network 3.) establish a public organisation, and 4) establishment of the Service Delivery Unit. In case of split transfer model as a separate unit has offered to transfer facilities in areas under the LGOs at different levels. This is an important turning point and was an idea that is proposed to transfer the health centre to the LGOs at the different levels. The decentralisation plan in Volume 2, published in the Year 2551 issue of the health centre has to transfer to the LGOs has been clearly defined in the Plan. The Health centre-HC determination the complete the final phase of the plan is that the end of year 2553 should proceed to completion, and then be transferred to the Provincial Administration Organisation- PAO. The direction of

health decentralisation is to focus on health centre transferred to local governments is critical to that time have undergone significant changes. The NBD has approved the transfer of the health centre to local governments then in the late of year 2550 has been seriously driven and living an intensely driven political leadership of the senior administrators of the MoPH were successfully completed on issue of the Health Centre transfer to the LGOs. Perfectly targeted transfers by the total number of 35 and has transferred 22 of the Health Centre has completed at the first time and followed for 6 of the later included as a transfer 28 of the Health Centre to the LGOs. Overall progress on the issue of health decentralisation was beginning to change slowly and has accelerated in the late plan. The health decentralisation that occurred in the Thai health system will have been trying to format a variety of models, such as the Local Area Health Broad-LAHB, public organisation hospitals-POH, the Local Health Fund-LHF, etc. With regard to the Health Centre under the local governments, this is a form of decentralisation by transferring a separate facility that have received attention and watch over both may have the option of decentralised system for health care appropriate to the context and reality. In the beginning, in the process of decentralisation of health, this is an issue that might be a solution that should be analysed and taken to a form appropriate to the context of each area. The health decentralisation is based on knowledge, evidence and a participation of stakeholders at all levels.

2.9 Conceptual framework of the research

The Policy Process (Walt, 1996)

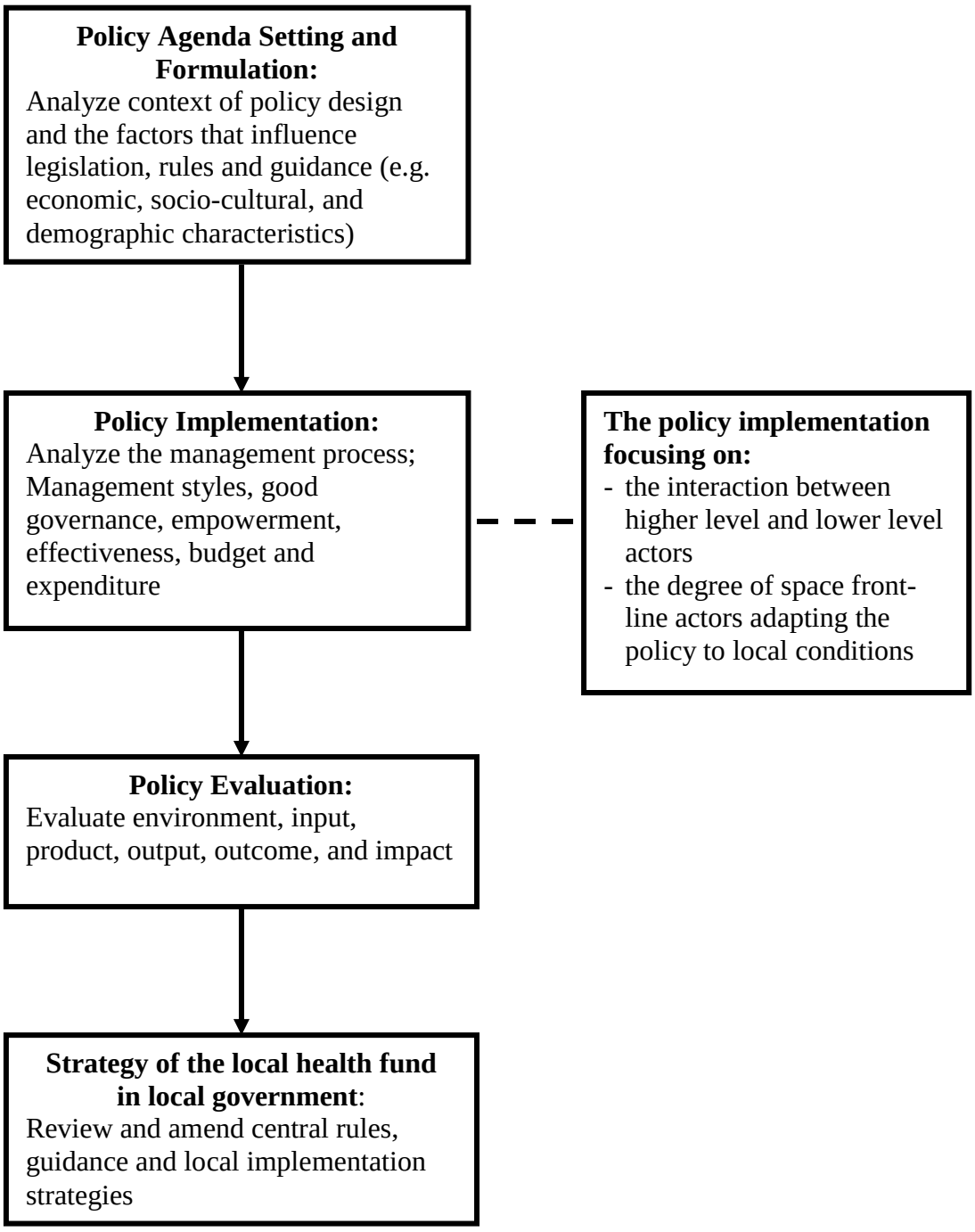

Figure 2.1: Conceptual Framework

2.10 Conclusion of Literature Review

This study aimed to investigate the change in funding so that money should follow patients and how the new arrangements were implemented by local government organisations, including the municipalities and Tambon Administrative Organisations (TAO). Results of this research could be used to suggest certain adjustments in the handling of the administration to the government; how to enhance the community so that people can participate in the role of the local fund health security in local government as a component of Thailand's universal coverage health care reforms in the north-eastern region of Thailand.

CHAPTER III

METHODOLOGY

Introduction

This study aimed to examine the early working of local fund health securities and the new roles developed by local government organisations. To this end, the study has utilized both quantitative and qualitative data on the setting up and operation of local fund health securities. This chapter presents the practical details of how the study was conducted; in terms of the research design, population, sample, settings, instruments, and research procedures.

The study consisted of three components: firstly, documented analyses of policies regarding the issues of local fund health securities which have been published since 2006; secondly, an examination of policy implementation in the North East Region based on questionnaires, interviews and documentary analysis; and thirdly an evaluation of the operation of policy on local fund health security to date.

Methodology

3.1 Research design

This was a descriptive study of the policy process using a mix of qualitative and quantitative methods. The study samplings consisted of 190 organisations, including both Tambon Administrative Organisations (TAO) and municipalities spread across North East Region. They were identified as being representative the local governments in this region. These comprised the sample for investigation of the policy process, the approaches to strategic planning, and description of the local context in which local

fund health securities are developed. The research used two main primary data collection methods: a (mainly quantitative) cross-sectional survey based on the questionnaires and a qualitative interview/focus group study conducted in a smaller subset of the sites.

The two methods were used in parallel in this study and carried out at the same time. Because of the desire to sample a wide range of organisations across the region, it was necessary to research a larger number of cases than would usually be examined in qualitative research (Williamson, 2005). As a result, the approach adopted was to first administer a quantitative questionnaire to the 190 organisations, and then invited some participants to take part in a qualitative phase using interviews and focus groups. The samples, the questionnaire instrument, the interview schedule and the focus group guide topics were determined before data collections were begun. Following ethical approval the research was conducted from September 2008 to October 2010. There was an uninterrupted period of fieldwork until the data collection was completed.

3.2 Research sites

This project was an investigation of how the Tambon Administrative Organisations (TAOs) and the municipalities manage the implementation of local fund health security and depends on sampling an appropriate range of such organisations in North East Thailand.

3.3 Population and Sample Group

In the North East Region and counting both the Tambon Administrative Organisations (TAOs) and the municipalities, there were 1,480 organisations managing local fund

health securities. This could be split into two groups including 216 local fund health securities in the municipalities, and 1,264 local fund health securities in Tambon Administrative Organisations (TAO) (Khonkaen Branch of National Health Security Office, 2010). Out of these organisations a random sampling was drawn by using the equation as given below (Wayne, 1995):

$$n = \frac{NZ^2_{\alpha/2}pq}{d^2(N-1) + Z^2_{\alpha/2}pq}$$

Whereas n = Number in sample

N = Number of population (1,480 organisations)

$Z_{\alpha/2}$ = The standard value under the normal curve at 95% (= 1.96)

p = The proportion of the municipality : the Tambon Administrative Organisation (TAO) (216 : 1,264 = 0.17)

q = (1 – 0.17) = 0.83, d = Acceptable error (= 0.05)

It could be calculated that

$$n = \frac{1{,}480 \text{ x } (1.96)^2 (0.17) \text{ x } (0.83)}{(0.05)^2 \text{ x } (1{,}480 - 1) + (1.96)^2 (0.17) \text{ x } (0.83)} = 189.21$$

The required size of the sample in this research is 190 organisations.

3.4 Sampling

This study used stratified random sampling by divided the organisations into four types. One was the Tambon Administrative Organisation (TAO), and three were types of municipalities, specifically examples of the City Municipality, the Town Municipality, and the Tambon Municipality. The chosen focus on North East, Thailand

has allowed the researcher to study the relationships between levels and the interaction of organisations in a defined geographical area.

The stratified random sampling of this study shows the proportion of sample sizes of each organisation type as a table 3.1 below.

Table 3.1: The number of local fund health securities in the North-eastern region of Thailand and sample size organisations.

Areas Branch of NHSO	**City Municipality** (Places/ Sample)	**Town Municipality** (Places/ Sample)	**Tambon Municipality** (Places/ Sample)	**TAO** (Places/ Sample)	**Total** (Places/ Sample)
Khonkaen	1/NA	5/1	65/8	373/48	444/57
Nakornratsasima	1/NA	3/NA	34/4	304/39	342/43
Udonthani	1/1	4/NA	52/7	321/41	378/49
Ubonratchathani	1/NA	7/1	42/6	266/34	316/41
Total	**4/1**	**19/2**	**193/25**	**1,264/ 162**	**1,480/ 190**

The respondents of 190 sampling organisations who administered the questionnaires were the representatives of those organisations. The representatives were the chairman of the local fund health security and/or the members of the local fund health security who could answer the questionnaires. The members of the local fund health security included:

- The mayor, the municipal clerk, and the council member or members of municipality.

- The chief executive of the TAO, chief administrator of the TAO, and the council member or member of the TAO

- The health officer, the community leader, and people representing local areas both in the municipality and the Tambon Administrative Organisation (TAO).

The total sample for the questionnaire study will therefore be 190 subjects from a sample of 190 organisations in the North-eastern region of Thailand.

As the calculation above, the total number of samples was investigated as 190 organisations.

3.5 Settings

The quantitative study data were collected by questionnaires from 190 respondents from 190 organisations drawn from all four organisation types in local government. Questionnaires were completed by a member of the LHSF committee at each site. In both municipalities and TAOs respondents included health officers, community leaders, and locality representatives. For municipalities, they included the mayor, municipal clerk, and municipal council members. For TAOs, respondents included the chief executive, chief administrator, and TAO council members. 190 questionnaires were sent to the committee chairs of local fund health security. Then, the respondent completing the survey in each organisation was the member nominated by the committee chair.

The qualitative study data were collected in four types of organisations (the Tambon Administrative Organisation (TAO), and the three municipality types) as mentioned above. The working of the local fund health securities in local government will be studied using documentary analyses, interviews and focus groups with the representatives of TAO and the municipalities, as follows,

1. Within the Tambon Administrative Organisation (TAO) the research focused on:

- The chief executive of the TAO, chief administrator of the TAO, council member or member of TAO, the health officer, the community leader, the local fund health security committees, and people representing local areas.

2. In the municipality attention was divided as follows:

- The mayor, the municipal clerk, the council member or members of municipality, the health officer, the community leader, the local fund health security committees, and people representing local areas.

Also the health officers of the TAO and municipality who are concerned with the local fund health security on the universal coverage for each level of the local government, the community leader, and people representing local areas will be considered for inclusion.

Each question had both the checklist answers and the open-ended answers, thus the respondents could explain more details about their checklist answers. These qualitative data were analyzed using content analysis.

There were also the qualitative study data that focused on an After Action Review (AAR) of local fund health security system operated by Tambon Administrative Organisation (TAO) in Wungsang sub-district, Kaedam district, Maha Sarakham province, Thailand. The working of the local fund health securities in Wungsang was studied using documentary analyses, interviews and focus groups with the representatives of Wangsang-TAO.

3.6 Data collection

Data were collected on the policy process concerning local fund health securities in the four types of local government organisations. This study was conducted in two parts.

In the first part, mixed methods, including quantitative and qualitative approaches, were applied. The quantitative data were employed questionnaires, while the qualitative data were dependent on in-depth interviews and focus groups. As a supporting exercise, certain documentary materials were also collected.

In the second part, baseline data were collected on financing sources that are available so as to examine the total budget and expenditure of a given local fund health security using financial reports or annual local administrative budgets. It was a case study in Wungsang Local Fund Health Security (WLFHS).

The quantitative approach was focused on the implication of the scheme at the local level and used questionnaires completed by representatives of the local government to cover the following issues:

1. The implementation situation and factors influencing the decision to set up local fund health securities.

2. The approaches of local government organisations to the management of local fund health securities, in respect to:

2.1 The process of setting up and running the local fund health security and their capability to support the universal coverage scheme.

2.2 The availability of the budget from local government versus that of the central budget allocated to local organisations from the National Health Security Office (NHSO).

3. The relationships between personal factors, organisational and other factors in determining the approach to implementation.

4. The comparison between the different levels of the local government regarding the implementation and approach taken with local fund health securities and their relationship to the wider universal coverage scheme.

3.7 The informants

Various kinds of information were derived from focus group discussions, in-depth interviews and questionnaires. The executives and field staff who are working in the health sector of the local government, the community leaders and the health personnel who are involved in health care decentralisation and people being representative the local areas will be questioned.

Financial reports or annual local government budgets were used to collect financing sources and fiscal implication available to examine the total budget and expenditure of the local fund health security on the universal coverage of each the local government. These were collected from local fund health security action plan.

3.8 Data analysis

3.8.1 Quantitative data analysis

Descriptive statistics

Demographic characteristics of the participants were presented using frequency (e.g. number and percentage) and central tendency (e.g. mean, mode and median) which may depend on the type of measurement scales; nominal, ordinal, interval, and ratio scales (Duffy & Jacobsen, 2001).

3.8.2 Qualitative data analysis

An analysis of the qualitative data was undertaken concurrently with data collection using verbatim transcripts. Transcription was undertaken as soon as possible after interviews and focus groups, and was performed by the researcher. The main steps were based on qualitative content analysis in which open coding was used to develop relevant categories for analysis. The selection of categories or codes was related to the domains of the study. Therefore, the organisation of data, selection of specific elements of the data for categories, and the exploration of the content of these categories were reflected common practice in qualitative studies (Burns & Grove, 2001; Polit & Hungler, 1995).

3.9 Research Variables

The variables that are useful for the implementation of the local fund health security on the universal coverage in the local governments are:

- Policy Agenda Setting and Formulation: analyze context of political, economic, socio-cultural, and demographic. Such as, decentralization policies, universal coverage of health care (UC) policy, and the policy formulation of the local fund health security.

- Policy Implementation: analyze the management process; Management styles, good governance, empowerment, effectiveness, budget and expenditure. For example, demographic of the sample, establishing of local fund health security and supporting budgets, the committees of the local fund health security, and plans of the local fund health security.

- Policy Evaluation: evaluate environment, input, product, output, outcome, and impact. Such as, activities supported from the local fund health security, and budget payment of the local fund health security.

3.10 Participatory action research

This qualitative study focused on an After Action Review (AAR) of local fund health security system operated by Wungsang Local Fund Health Security (WSLFHS), Wungsang Tambon Administrative Organisation (WSTAO), Wungsang sub-district, Kaedam district, Maha Sarakham provinces, Thailand. The study consisted of 4 phases; preparatory phase, pre-implementation phase, implementation phase, and evaluation phase. The participatory action research of this study has been shown as a flow table in table 3.2 below.

Table 3.2: The participatory action research

Administration and Activities	Methods	Target groups	Time study
1. Preparatory phase			
- Building connections and explain objectives research - Selecting stakeholders - Collect general data and health information - Analyze data and situation of community - Document analyses the policy formulation of the local fund health security	- Collect primary data and secondary data from Health Centres and TAO	- Local fund health security committees and sub-committees - Community leaders - People representing local areas	September to December 2008

Table 3.2: (Continued) The participatory action research

Administration and Activities	Methods	Target groups	Time study
2. Pre-Implementation phase			
- Community needs assessment - Training target group, group process dynamic, campaign activities - Preparing data and gather data for the local fund health security planning instrument by health community plan and strategy mapping	- Discussion and focus groups - Participatory learning - Collect primary data and secondary data from Health Centres and TAO	- Local fund health security committees and sub-committees - Community leaders - People representing local areas	January to April 2009
- Planning the local fund health security action plan	- Participatory planning		
3. Implementation phase			
- The operation of projects and activities on local fund health security plan to support; 1. Health service core package purchasable 2. Support health centre 3. Health promotion and prevention for communities 4. Manage and develop local fund health security	- Follow up the local fund health security action plan via; to observe, interviews, and focus groups	- Local fund health security committees and sub-committees - Community leaders - People representing local areas - The local fund health security action plan	May to December 2009

Table 3.2: (Continued) The participatory action research

Administration and Activities	Methods	Target groups	Time study
4. Evaluation phase			
- Analyze and results of the local fund health security implementation strategies	- Evaluate the local fund health security action plan by After Action Review (AAR) via; interviews, and focus groups - Questionnaires	- Local fund health security committees and sub-committees - Community leaders - People representing local areas	January to June 2010
- Analyze perceptions and satisfactions of the local fund health security implementation		- The local fund health security action plan	

CHAPTER IV

RESULTS

Introduction

The research findings are presented in this chapter including section 4.1 that shows an analysis of policy documents. The document analysis was relevant to the issues of the local fund health security which has been published since 2006. This study aimed to examine the policy process, as policy of the local fund health security formulation.

The section 4.2 reports quantitative and qualitative results of the study on policy of the local fund health security implementation. Moreover, the policy evaluations of the local fund health security in relation to the role of the local fund health security in the local government as a component of Thailand's universal coverage health care reforms in the north-eastern region of Thailand are detailed. Finally, the section 4.3 explains the qualitative data studying on an After Action Review (AAR) of local fund health security system operated by Tambon Administrative Organisation (TAO) in Wungsang sub-district, Kaedam district, Maha Sarakham provinces, Thailand. Moreover, survey data of satisfactions of communes about Wungsang Local Fun Health Security are also involved in the final section.

4.1 The Analysis of Policy Formulation

This section reviews a policy process of achieving the universal coverage of health care (UC) in Thailand. The current study critically assessed how the reform achieved policy objectives of improving equity and efficiency of the health care system with sustainable health care finance. Moreover, an understanding with regard to roles and responsibilities of all organisations needs to be concerned so that the local decentralisation process could proceed to an effective manner.

It is clear that the policy analysis is a multi-disciplinary approach to public policy that aims to explain the interaction between institutions, interests and ideas in the policy process. It is useful both retrospectively and prospectively, to understand previous failures and successes of policies and to plan for future policy implementation.

Consequently, the health policy analysis was conducted in this study because it was a process of assessing and choosing among spending and resource alternatives that affect the health care system, the public health system, or the health of the general public. The health policy analysis consists of various steps: identifying or framing a problem; identifying who is affected (stakeholders); identifying and comparing the potential impact of different options for dealing with the problem; choosing among the options; implementing the chosen option(s); and evaluating the impact. The stakeholders can include government, private healthcare providers (e.g. hospitals, health plans and office-based clinicians), industry groups (e.g., pharmaceutical, biotechnology, and medical device manufacturers), professional associations, industry and trade associations, advocacy groups, and consumers. The results of the document analysis are displayed in the following subsections.

4.1.1 Decentralisation Policy

Thai Public Administration: Until 1991, the National Public Administration Act was promulgated to provide three basic levels of public administration in Thailand: central, provincial, and local administration.

1. The central administration falls under the basic concept of centralization and consists of 15 ministries.

2. Provincial Administration comes under the concept of deconcentration, which means that the central government delegates some of its power and authority to its officers who work in provinces and districts. These officers are from various ministries and departments and carry out their work according to laws and regulations assigned by the central government.

3. Local administration in Thailand is based upon the concept of decentralisation, which allows local people to participate in local affairs under concerned laws and regulations.

Decentralisation: Under the country's existing administrative structure, authority is delegated from the capital to the region and then to local areas. In general, development policy and planning in Thailand is a combination of top-down and bottom-up approaches, while the public administration system of the country is highly centralized.

Thailand has gradually strengthened the capacity of the local government. During the 5th and 6th National Plans, the local government played a greater role in setting development priorities. Nevertheless, the proposed developments of plans still have to be agreed upon and the budgets approved by the central government.

To further enhance the role of local government and local development efficiency, the 7th and 8th National Plans called for the decentralisation of fiscal authority and assets to holding as important mechanisms to strengthen local administrative capacity.

As the structure and management system of the local government has been put in place by the end of the 9th National Plan, the 10th National Plan (2007 - 2011) will concentrate upon improving the development capability of the local administrations. Development plans will integrate all aspects, as the results, monitoring systems will be enhanced, information system will be upgraded, and human resource capability will be increased.

This chapter reviews the policy process of achieving the universal coverage of health care (UC) in Thailand, and critically assesses how the reform achieve policy objectives of improving equity and efficiency of the health care system can be achieved with sustainable health care finance.

Findings from the study indicate that bureaucrat-led reformists played an important role in bridging researchers and policy makers. While agenda setting was vested in the political leadership and commitment to achieve universal coverage (UC), the system design and monitoring and evaluation were guided by researchers; and successful policy implementation was based on the health system capacity. Evidence played a strong foundation of the health sector reform.

Several lessons were drawn. First, the strength of health care infrastructure and geographical distribution of well-functioning primary care services in rural and urban

areas served as a strong basis for success in the smooth implementation of the UC policy. The availability of qualified human resources for health at district and provincial health facilities was also a key factor enabling the capacity of the health care system to provide essential health services to the whole population, and could cope with the increasing demand for health care. Second, financial feasibility of the country influenced by a long period of internal peace and the economic growth, coupled with appropriate health financing arrangements of the UC scheme, made it possible to implement the UC policy. Third, relevant knowledge and evidence for policy formulation and implementation, and skills in the estimate of budget requirement was acquired through the establishment of effective knowledge management mechanisms and sufficient long term investment in human resources in health system research and international linkage to keep abreast. Also, the national capacity coordinated data producers (i.e. the National Statistical Office) and data users (i.e. the MoPH), and abilities of researchers to communicate with health care reformists and policy makers support the conception of "The triangle that moves the mountain".

Place an emphasis on local revenue collection and decentralisation of fiscal power to local authorities in order to achieve budget management that is more independent, taking into consideration the needs and appropriateness for development of the localities.

Encourage clear, appropriate and step-by-step decentralisation of power from the central government to the local authorities. At the same time, the potential of local civil service administrations and local governmental organisations must be

strengthened and further developed in line with the activities of each locality. There must be greater independence with regard to local budget management and allocation, income acquisition and management of local properties.

Encourage the local people, civil society and private organisations to participate in local administration thereby providing for inspection, monitoring, and evaluation of the local administration. Such participation ranges from the decision-making process, policy formulation, and procurement to the appointment and removal of the local authorities for the sake of transparency and efficiency as well as in response to the needs of the local people. Promote better understanding with regard to the roles and responsibilities of all the organisations concerned so that the local decentralisation process can proceed in an effective manner.

4.1.2 Universal Coverage of Health Care (UC) Policy

Why Universal Coverage of Health Care

Information from various sources indicated that, during 1998-1999, about 20- 30% of the Thai population was still uninsured on health care coverage. It has been increased rapidly during the last decade due to the establishment of the Social Security Scheme (SSS), the increasing coverage of Health Welfare Scheme (HWS), and the Health Card Scheme (HCS). Before the implementation of universal coverage of health care (UC) policy, the majority of population was covered by the Health Welfare Scheme. The existing insurance schemes are quite different in benefit packages, payment mechanisms, government subsidies which result in different quality of care.

Universal coverage of health care has become an issue of increasing concern for the public because of many reasons. First, the people under less privileged health insurance schemes (HWS and HCS) and the uninsured started to complain more about the quality of care provided and their inaccessibility to necessary care. In 1999, the Foundation for Consumers conducted a research project, supported by the Health System Research Institute (HSRI), to document cases who suffered from the existing health care system. These documents were published and distributed in the first National Forum on Health Care Reform, organised by the Health Care Reform Office (HSRO), and created a lot of public criticism and public concern about the quality and equity in access to care under the existing health care system. Second, the Constitution of 1997, which was the result of political reform, clearly stipulated health as a human right, which must be protected by the State. Health services under the new constitution must respect equity, efficiency and quality, as well as transparency and accountability. The constitution also permits the submission of law to the Parliament through the collection of 50,000 signatures. This constitution provides ground for civic groups to move further in getting their rights.

Health Security in Thailand: The Road to Universal Coverage

Although the 1997 economic crisis had caused severe impacts in many sectors in Thailand, its impact on the public health system was rather mild. The major impacts include: (a) A decrease in import volume of pharmaceutical products and an increase in pharmaceutical prices (approximately 25-27 percent increased in wholesale prices); (b) The Ministry of Public Health's (MoPH) budget was cut down in 1998-1999, but the health budget for the poor and the disadvantaged was maintained (and

also supplemented by a foreign loan through the Social Investment Programme: SIP); (c) More patients switched from private to public hospitals, but had not created financial problems in the public hospitals since most of these patients were able to pay for the services; (d) The private hospitals many of which were dependent on foreign loans for their pre-crisis (over) investment suffered from both foreign exchange loss and from losing their patients to the public hospitals.

Shortly after the crisis, the new government led by the Thai Rak Thai (Thais love Thais) Party implemented the "30 Baht Health Care Scheme." The scheme expanded public health insurance coverage to the last quarter of the Thai citizen who had not yet been under any public health insurance schemes. Therefore, at least theoretically, the scheme completed the universal health coverage in Thailand. On the surface, the scheme is merely an expansion of the former Low-income Card ("Sor Por Ror") Scheme. It turns out, however, that the scheme has been very successful in making Thai people aware of their rights, and has helped to reduce health-related poverty significantly, arguably more effectively than its predecessor Low-income Card Scheme. The scheme's popularity has ensured its continual existence even after the recent Coup de tat that when the new government abolished many of the former government's populism schemes.

The scheme, however, has been plagued by the under-funded problem since its inception. This causes lots of people to propose alternative or supplemental sources of fund to finance the scheme. Recently, some academics proposed that the local authorities should shoulder some (significant part) of the burden. However, historical review of the Thai health system in the past century reveals that Thailand had already

gone through that road for nine decades, and has since moved in the opposite direction to use the central budget to build and finance public hospitals throughout the country, and, in latter years, to gradually expand the public health insurance toward universal coverage. The result has been that Thailand now has a workable public health-service network system distributed throughout the country, even though there are still large discrepancies between Bangkok and other regions.

At present, there are some well established self-help organisations such as village credit unions (“*Kloom Sajja Orm Sup”* or savings groups) which have created some funds that are used to compensate their members in the events of their hospitalisations (some funds also cover outpatient costs). However, these funds are rather limited, and they may be more suitable as supplementary rather than main insurance. As for local authorities, some have already provided supplementary supports to local public health-facilities. Under the existing fiscal system, most of the local authorities would not have sufficient income to shoulder the significant part of health care costs. Although it is possible to revise the fiscal system so that the local authorities can raise more revenue, the government should be very cautious in transferring the main financial responsibility on health care to them, as this could result in more inequities across regions, or, even worse, in that some poorer areas would be unable to provide or maintain standard-quality healthcare due to lack of local funding (NaRanong, 2006).

Previous Attempts to Achieve Universal Coverage of Health Care (UC)

In fact, during the last decade, the Ministry of Public Health (MoPH) has made many attempts to achieve universal coverage of health care. In 1996, the first draft of the National Health Insurance Act was prepared by a subcommittee of the

Parliament for its consideration. Unfortunately, because of inadequate policy support, this attempt failed to achieve the stage of policy consideration and adoption. Many efforts were made to increase the coverage of the Health Card Scheme (HCS) to cover the uninsured. However, because of the voluntary basis of the HCS which led to its being a non-recovery scheme, the HCS could only achieve limited population coverage. Fee exemption for persons who could not afford public health facilities could help improve the access to care of uninsured, but with unacceptable quality. Several research studies focusing on financing and managing health care system under UC policy have been supported by various research institutes for example, the Health System Research Institute (HSRI), the Health Care Reform Office (HSRO) and the National Health Foundation (NHF). This accumulated knowledge and experiences have provided several options for the implementation of UC policy in the future.

Recently, after the first National Forum on Health Care Reform in December 1999, a network of civic groups was established to campaign for the UC policy. This network of civic groups started to draft their own law, the National Health Insurance Act, with the support of some technical people. The campaign for 50,000 signatories in favour of this law was started in October 2000 and could get more than 50,000 signatories in March 2001. The draft law has already been submitted to the Parliament, with all the signatures, for its consideration.

In January 2001, the current government won a landslide vote using universal coverage of health care as one of its major public policy gains. Campaign of the leading political party, Thai Rak Thai Party, used the slogan of “30 Baht per visit/episode for every disease” or “30 Baht Scheme” as representative of their UC

policy. The policy was implemented in six pilot provinces in April 2001 and incrementally expanded to another 15 provinces in June 2001. In October 2001, the scheme could cover all provinces and part of Bangkok and it is planned to cover the entire country in April 2002.

Affording for the Cost of the UC Policy

At the beginning of the year 2001, there were at least three proposals on needed resources for the UC policy.

(1) Proposal using unit cost of autonomous hospital (AH): Due to the economic crisis in 1997, an autonomous hospital had been proposed as an alternative management model of a public hospital to improve its efficiency and responsiveness. Since the universal coverage of health care has been one aspect of the AH model and the needed budget for AH, 782 Baht per capita, had already been proposed. This unit cost has been used for further calculation by adding the unit cost of health centre which was 120 Baht per capita (Pitayarangsarit, 2000). Therefore, it was proposed that the needed resource for UC is 900 Baht per capita.

(2) Proposal of Pannarunothai et al: In this proposal, the research team used sickness episode and health service utilization of population, obtained from the national survey in 1996-Health Welfare Survey 1996, and unit cost of health facilities at different levels for the calculation (Pannarunothai, 2000). Health service utilization in 1996 had been adjusted by using the change of population structure in 2001, increasing of insurance coverage, etc. The team proposed that needed resources for the UC in 2001 is 91,930 - 148,650 million baht or 1,482 - 2,397 baht per capita based on the way the health care system, including provider payment method, has been

organised. If unregulated health care system is selected with fee-for-service payment, the per capita of needed budget will be at the high end.

(3) Proposal of the MoPH: The MoPH submitted another proposal regarding the budget needed for the UC policy. This proposal used an approach similar to the previous one, using the pattern of health service utilization without any adjustment and unit cost of health facilities from the most updated study for calculation. The MoPH also used the experience of high cost care and accident and emergency care from the Social Security Scheme (SSS) to add to the calculated unit cost.

According to the MoPH proposal the budget needed for the UC policy in 2001 was 1,202.40 baht per capita (Tangcharoensathien, 2001).

All proposals were considered in the workshop arranged by the MoPH, which was chaired by the Prime Minister, on 17 March 2001. The Prime Minister accepted to use 1,202.40 baht per capita as the starting estimated budget for the UC policy in Thailand.

Presently, there are 6 million people who are covered by the SSS, and about 7 million people are covered by the CSMBS. Considering the rest of the population of 48 million people, most of whom are already covered by the HWS and HCS, and who will be covered by this UC policy, the country needs to pay at least 57.7 billion bahts to cover the uninsured. The country has already paid 8.7 billion bahts for the SSS (1,450 bahts per capita per year) and 16.44 billion bahts for the CSMBS (2,349 bahts per capita per year). Therefore, the total cost for this UC policy will be 82.84 billion bahts. In fact, Thailand had already spent 179.69 billion bahts on health in 1998 and 70.5% of this health expenditure or 126.77 billion bahts was the cost of personal health

care. Public sources of finance were responsible for 49.2% of total personal health care expenditure or about 62.4 billion bahts (Pongpanich et al., 2000).

By adjusting this figure for the year 2001, public sources of finance would increase to 76.55 billion baht and an additional 7.29 billion bahts would be needed for the UC policy. (Health System Research Institute, 2001). It is arguable whether Thailand's current fiscal space could accommodate an approximately increased 10 percent in public health expenditure on account of this UC policy. Considering the country's economic recovery after the serious crisis in 1997, there were warning signals about the country's economic slowdown due to the delay of its structural adjustment and the slowdown of the world economy, especially the US economy (National Economic and Social Development Board, 2001). The US economy started to slow down in the third quarter of 2000. The terrorist attack on the US in September 2001 even made the world economy worse than before. At the beginning of 2001, it was estimated that economic growth rate of Thailand would be 3.5 - 4.0%. This estimation had been adjusted many times because of changes in the situation in the National Economic and Social Development Board (NESDB), who announced that the country's economic growth rate for 2001 would be 1.5% and will increase to 2% in 2002 (National Economic and Social Development Board, 2001.) Under this condition, the government may have to reprioritise their previous budget plan and improve the efficiency of government's budget spending, in order to get additional resources for the UC policy.

Ultimate Objectives and Main Characteristics of the UC Policy

In addition to the finalisation of budget needed for the UC policy, the workshop in March 2001 also considered the main objectives and characteristics of the

UC policy in Thailand. There was consensus among key stakeholders that the ultimate objectives of the UC policy are;

(1) Universal coverage: All Thai citizens should be entitled and should have equal access to quality care according to their needs, regardless of their socioeconomic status and religion etc.

(2) Single standard: The benefit package and quality of care providing for all Thai citizens should be of the same/single standard.

(3) Sustainable system: system under the UC policy should be sustainable in terms of policy, financial and institutional sustainability. An efficient system, both allocated and technical efficiency, as well as an adequacy and stability of budget are needed for the financial sustainability. Legislation can be used to ensure the policy sustainability and, therefore, the government started to draft the law, the National Health Insurance Act, and submitted it to the Parliament for consideration. Institutional sustainability can be secured only if the system, including personnel under the system, is well prepared and additional resources are needed for this preparation.

In summary, the proposed main characteristics of system under the UC policy are: (Ministry of Public Health, 2001)

(1) promoting the use of primary care;

(2) the use of close end provider payment method;

(3) ensuring quality of care by using accreditation;

(4) the use of standard benefit package and payment method;

(5) merging of existing health insurance funds;

(6) decentralisation of fund management to the province.

Promoting the use of primary care

Primary care in Thailand has been neglected for a long time and this result in poor and unacceptable quality of care provided by primary care and overcrowding of outpatient departments of big hospitals due to bypassing of unnecessary cases (Srivanishakorn et. al., 1996). During the last decade, there have been continuous efforts made to strengthen primary care in Thailand. In 1992, the first demonstrating model of primary care has been established in Ayutthaya province and has become a successful model (Pongsuparb, 1996). The concept and management model of primary care has been gradually accepted nationwide. Recently, the Consortium of the Deans of Medical Schools has organized a national conference on medical education in April 2001 and has reached a consensus that changing medical curriculum to serve primary care is a priority issue. Unfortunately, the existing incentive system, which still favours medical specialists in hospital, makes the reorientation of health care system more difficult. The establishment of the Social Security Scheme in 1990 could be leverage for the change of health care system. However, because of the immaturity of primary care at that time, the Social Security Office (SSO), then, decided to contract big hospitals with more than 100 beds, as a main contractor and financial incentive remained focusing on hospital care.

Primary care has been identified as a key mechanism for providing health care in UC policy, because of two main reasons. First, primary care is a provider with the best setting for providing quality care based on holistic approach (Valayasewee et. al., 1999). Its location close to the community helps the provider to realise the socio-cultural context of the people. Primary care provider also has better opportunity to

perform their proactive role in the community. Second, it is expected that a system with primary care as a gatekeeper will have lower overall health care cost (Martin et. al., 1989). Strengthening and promoting the use of primary care in the UC policy has been done through many policy details as follows:

(1) primary care is the main contractor and unit for population registration: instead of assigning a big hospital as a main contractor, a primary care unit will be a main contractor and a unit for population registration in the UC policy. Primary care provider is entrusted for the provision of comprehensive care for their registered population.

(2) primary care is a gatekeeper: direct access to hospital care is not permitted, except in case of accident and emergency care.

(3) primary care is a fund-holder: in addition to the provision of comprehensive care by their own health facilities, primary care providers can use their budgets to contract other health facilities to provide care for their catchment population a fund-holder approach. This will promote the network of primary care providers.

A primary care unit will be responsible for no more than 10,000 registered population and minimum requirements of primary care provider who would like to be a main contractor in the UC policy.

The use of close end provider payment method

Experiences of countries with universal coverage policy confirm that health care cost of those countries would increase because of the moral hazard unless appropriate provider payment method and cost sharing system have been adopted. Cost sharing, as a demand side intervention, has limited effect on cost control especially

when compared with supply side interventions. Introducing only co-payment of 30 Baht per visit, therefore, may not be enough to contain the health care cost. Thailand has quite impressive experiences in using capitation payment to control the cost of the Social Security Scheme (SSS) since all the financial risk has been transferred to the provider. Recently, the proposal on the reform of the Civil Servant Medical Benefit Scheme (CSMBS) has proposed a further modification of capitation payment by splitting payment for ambulatory care and payment for inpatient care. Capitation payment is proposed for ambulatory care while case payment, Diagnostic Related Groups (DRGs) with global budget, is proposed for inpatient care (Sriratanaban, 2001). Inclusive capitation, as still used in the Social Security Scheme (SSS), and the new proposal, exclusive capitation, become the two main provider payment methods proposed for the UC policy. Payment in the UC policy can be divided into two levels.

(1) Budget allocation from central to province: Budget needed for the UC policy will be allocated to the provinces on a capitation basis according to their registered population. Adjusted capitation rate, according to morbidity and mortality of provincial population and other related factors, was also proposed in the policy but it has been postponed for the implementation.

(2) Paying providers in the province: There are two options, inclusive and exclusive capitations, which the provincial committee can choose for paying providers in the province. It's expected that there will be a single provider payment method in the future.

Ensuring quality of care by using accreditation

The use of capitation payment to control cost of health care system may have negative consequences on quality of care. The Social Security Scheme (SSS) has encountered the quality impairment under the capitation payment by using additional fee-for-service and lump sum payments for some specific services for example; accident, emergency and high cost care. Accreditation is also needed for the participating hospitals to ensure good quality of care.

In fact, quality assurance and quality improvement of public health facility has become an issued concern by the MoPH for the last two decades. The MoPH has tried many approaches but until recently hospital accreditation (HA) has been accepted as a main approach for quality assurance and quality improvement for both public and private health facilities (Supachutikul & Sriratanaban, 2000). Hospital Accreditation Institute has been established for this long-term mission. HA is also accepted as a basic requirement of health facility who would like to participate in the UC.

The use of standard benefit package and payment method

As mentioned earlier, one of the ultimate objectives of the UC policy is to have a single standard of health care for every Thai citizen. Standardization of benefit package of people under different health insurance schemes may be the first priority. However, this needs legislation change and may create a lot of resistance. Standardization of benefit package, therefore, has started from the schemes under the responsibility of the MoPH i.e., Health Welfare Scheme (HWS), Health Card Scheme (HCS) and 30 Baht Scheme. All these schemes cover the majority of Thai population, more than 75% of total population. The proposed benefit package has been derived

from the benefit package of the SSS but includes personal preventing and promoting services as part of its package. It is expected that this proposed benefit package would be a standard for the adjustment of other schemes in the future. Standardization of provider payment method is also necessary since it determines the quality of care provided. At the moment, there is a tendency that all schemes are going to reform their provider payments to a more acceptable one.

Merging of existing health insurance funds

Merging of existing health insurance funds is expected to increase the management efficiency and also to decrease problem of overlapping. Although single payer system is accepted as the most appropriate model, proposals on the optimal number of health insurance funds during the transitional period are quite controversial. Network of civic groups proposed to have only single health insurance fund while the academic people proposed that dual health insurance system for formal and informal sectors might be more appropriate during the transitional period. Following along these lines, the government eventually agrees to have dual health insurance system during the transitional period and even proposes in the law that merging funds to be a single fund would be done on the voluntary basis.

Decentralisation of fund management to the province

The UC policy proposes that the National Health Insurance Fund will act as a fund-holder while the purchaser will be a decentralised office. There are a lot of debates about what should be an appropriate level for this decentralised office. The academic people purposed that a decentralised office, Area Purchaser Board-APB, should be located in areas with more than 3 million populations to ensure adequate risk

sharing and economy of scale. According to this proposal, APB will be a regional office and there will be APBs nationwide. The MOPH proposed to have a decentralised office at the provincial level where a devolved health structure, Area Health Board-AHB, is located. AHB has been established, according to the Decentralisation Act of 1999, to manage all public services, including health service, in the province. Assigning AHB as a provincial purchaser will help to improve the integration of personal health care and public health programmes. The government decides to decentralise the fund management to the provincial level during the transitional period. The Provincial Health Office (PHO) is assigned to be a provincial purchaser while the AHB is just an advisory board due to its immaturity.

It is clear that the proposed system under the UC policy during the transitional period will be a dual health insurance system for both formal and informal sectors. The National Health Insurance Board (NHIB) will be the main mechanism to steer all reform processes of each scheme to ensure a single standard health care for every Thai citizen in the future. The National Health Insurance Office (NHI) will be the secretariat office of the National Health Insurance Board (NHIB) and perform all supporting and coordinating tasks.

Policy Development and Policy Implementation before the Establishment of the National Health Insurance Board (NHIB)

Although it has been proposed that the UC policy is a national policy and should be responsible by a national body which can coordinate all related organisations, the MoPH may have conflict of interest in performing this role since it has owned the majority of public health facilities. Assigning the MoPH to be a national

purchaser/fund-holder will create a system without purchaser provider split and it would be difficult for the MoPH to be an effective health care purchaser under this situation. However, because of the delayed establishment of the National Health Insurance Board (NHIB) and the National Health Insurance Office (NHIO), it needs to have a rapid implementation of the policy. The MoPH, then, has become the most appropriate responsible agency for the implementation of the UC policy in the early stage.

At the beginning of the year 2001, the MoPH set up a core team responsible for the policy development. A proposal developed by the core team has been considered in the workshop in Government House on March 17th, 2001 and has been used as a framework for further policy development. After the workshop, the MoPH set up working groups, comprising of people from various sectors including representatives of consumer groups and private health care providers, to develop detail policy. The result of this participatory policy development process has been used as a guideline for further policy implementation.

The main responsible organisations in the MoPH include the Health Insurance Office (HIO), the Bureau of Health Policy and Planning (BHPP), the Bureau of Health Care Network (BHCN), the Inspector General Office (IGO), the Health Care Reform Office (HCRO) and Division of Registration (DOR). Since there are several organisations involved in this policy implementation, the MoPH decided to set up a committee, called War Room, to coordinate and monitor policy implementation and to solve obstacles of policy implementation.

The policy has been implemented in 6 pilot provinces in April 2001 and expanded to another 15 provinces in June 2001. Health care providers were limited only the MoPH's providers in the first six provinces but extended to other public health care providers and private providers in subsequent provinces. The policy has been implemented almost nationwide, 75 provinces and part of Bangkok, in October 2001. The rest of Bangkok will be incrementally covered in January and April 2002. Policy implementation in Bangkok has been delayed because of its system complexity.

Immediate Effects of the UC Policy

Population coverage and health service utilization of beneficiaries under the universal coverage (UC) policy

In the first six provinces, the scheme could cover about 1.47 million people or about 40.7 percent of population in those provinces. In the second phase of policy implementation in June 2001, it could cover additional 4 million people or 28.9 percent of population in provinces in the second phase. There were 97.6 percent of registered populations registered with public providers while 2.4 percent of them registered with private providers. In October 2001, the scheme could cover 37.3 million people in 75 provinces and part of Bangkok and private providers still shared the same proportion, 2.3 percent of registered population. The MoPH's providers are the main public health care providers and are responsible for 95 percent of registered population (MoPH, Bureau of Health Policy and Planning, 2001).

Health service utilization of beneficiaries in the first 6 provinces found that health service utilisation of those who were covered by the scheme was quite low, 0.58 visits per capita per year for ambulatory care and 0.03 admissions per capita per year for

inpatient care, when compared with other schemes. Reported health service utilisation of beneficiaries in the second phase in the first month was also low, 0.67 visits per capita per year for an ambulatory care and 0.03 admissions per capita per year for an inpatient care. For the uninsured group, who should be the beneficiaries of the UC policy, the national survey in 1996 found that utilization of an ambulatory care by noninsurance was 1.9 visits per capita per year and admission rate was 0.05 admissions per capita per year. It means that some beneficiaries of the UC policy still utilize services outside the assigned health facilities. Explanation for this low utilization may be because the beneficiaries do not realized their rights and are also hesitate about the quality of care provided by the scheme (MoPH, Bureau of Health Policy and Planning, 2001).

Effect on public and private health care providers

Public and private health care providers are extremely affected by the provider payment mechanism adopted by the UC policy. The specific changes of provider payment method which effect providers are: (MoPH, Bureau of Health Policy and Planning, 2001).

(1) The change of resource allocation criteria from supply to demand side: The sudden change of provider payment method from supply to demand side resource allocation, capitation payment, makes providers face difficulty in adapting themselves since there are serious misdistributions of health facilities among regions and among urban and rural areas. Health facilities in areas with over supply, therefore, will face the problem of budget deficiency. It was found that hospitals in big cities were forced to downsize their structures and to increase their management efficiency.

(2) The change of main contractor from hospital to primary care unit: According to this change, resource will be re-channelled to the primary care unit first based on registered population. Secondary and tertiary hospitals will be paid, from primary care unit or provincial fund for inpatient care, according to their performances determined by number and type of referred cases. Hospitals are forced to provide primary care because of two main reasons. Firstly, there are severe shortages of primary care providers in urban areas where hospitals are located. Secondly, hospital managers are afraid of inadequate budget allocations to hospitals based on performance criteria. Performing dual functions, providing primary and hospital cares, of hospitals is expected to increase hospital revenue and to ensure hospital financial viability. However, because of limited experiences of hospital personnel in providing primary care, especially those in private hospitals, this will affect quality and coverage of basic services in some areas. It is anticipated that with the new payment method there will be at least 26 provinces where the MoPH health facilities will face the financial problems. The MoPH has realized this foreseeable problem and has requested a special additional budget, contingency fund, for solving this problem in public health facilities. In November 2001, there were requests from 29 provinces for contingency funding in the amount of 3.2 billion Baht. Public health facilities who request for contingency funding need to submit plans to reform their health facilities to ensure long term survival.

Effect on the role of provincial health office

During the transitional period, the Provincial Health Office (PHO) is assigned to perform as a provincial purchaser. This is quite a new role of the PHO and

the present PHO now has no experience and very limited capability in performing this role. In addition, the rapid policy implementation and inadequate preparation of provincial health personnel even make the situation worse than expected. The PHO can be only a passive health care purchaser under this situation.

Effect on the MoPH budgeting system

Since budget for the universal coverage policy has already included part of fiscal budget plan which used to be allocated directly to public health facilities according to proposed projects or programmes. In order to follow the new provider payment method, it is necessary to have a clear separation of the previous fiscal budget plan for which part should be a budget for universal coverage policy (UC budget) and which part should not be (non-UC budget). The non-UC budget will be managed and allocated to the public health facilities in different ways. All budgets for providing personal care are identified as budgets for universal coverage policy and will be allocated to provinces according to the registered population, per capita resource allocation. The budget separation which leads to different ways of budget management according to their purposes, UC and non-UC budgets, creates another management difficulties.

(1) Limited space for vertical programmes related to personal care: since all budgets will be allocated to and managed by the provinces in a decentralised way. This affects some vertical programmes which central management feels is still necessary because of its efficiency. Purchasing and managing vaccines to ensure their availability for the National Expanded Immunization Programme (EPI) is an example of this

necessity and it is agreed to separate cost of vaccines, 14.70 Baht per capita, from budget allocated to provinces and to manage it at the national level.

(2) Limited budget for administration and supporting activities: at the provincial level, normally the PHOs will keep part of the budget, intentionally prepared for public health facilities in the provinces, and manage by themselves to cross subsidize their inadequate budgets for administration and supporting activities. In the new budgeting system, UC budget is clearly specified for health facilities and the PHOs cannot use it for other purposes. Budgets for administration and supporting activities are separated budgets but their amounts are quite low when compared with the previous budgeting system. The same situation also occurs at the national office and limits the flexibility to mobilize supports for the policy implementation.

Conclusion

Thailand may be one of a few countries who try to achieve universal coverage of health care policy during the economic slowdown period. The attempt to achieve universal coverage has had a long evolution but it has been speeded up during the past couple of years. The policy has been adopted and implemented incrementally, in terms of area and comprehensive of policy package, and has reached the national coverage rapidly within one year. The policy content seems to have a sound direction which is a result of accumulated experience and knowledge in the society. The policy development and policy decision making was a participatory process at the beginning but is limited to the MoPH personnel at the present time. Rapid policy implementation may threaten policy achievement since the existing structures have limited capabilities to perform their new roles and time is needed for the preparation. Time is also needed

for the development of policy details and at the moment, there is limited technical support for this.

Resource needs for all these preparations are also limited because most of them are mobilized to health facilities for providing services for the beneficiaries. It is too early to conclude whether the universal coverage policy in Thailand is successful or a failure. It is obvious that this policy is welcomed by the public and is also well supported by the politicians, both from the government side and the opposition parties. However, good intention may not be enough to make the policy succeed if it does not have a good management system. Assigning the whole responsibility, for policy development and policy implementation for the universal coverage policy, to the MoPH may limit the system capacity to handle this challenging policy.

Despite the fact that the MoPH may have a conflict of interest in performing this role since it owns the majority of public health care providers, the bureaucratic system of the MoPH will also limit its flexibility and efficiency to manage the whole system. Establishment of the National Health Insurance Office, a new national body which does not own any health care provider and has an efficient management system indicated by law, can be an immediate solution to face all difficulties.

4.1.3 Document analyses of the policy formulation of the local fund health security

In Thailand, health insurance system was divided into three schemes as follow; 1) civil servant medical benefit scheme, CSMBS 2) social security scheme, SSS and 3) 30 baht scheme. The 30 baht scheme was a transformed scheme by

combining two existing projects at that time (Health card and Health welfare project) together and expanded to cover the rest of population who are not under CSMBS and SSS including any uninsured persons.

Almost four years after the universal coverage of health insurance system implementation, these systems still have some problems such as inequity and equality of financing, complicated and inefficiency of administrative and management systems etc. Those factors give effect to the quality of health care service provision, the equality of accessibility and the medical technology development in health care facilities.

The results of situation analyses founded that there were five main problems of service delivery systems under the universal health care coverage. First of all, it was the limitation of primary care service on quantity, area coverage, service quality differentiation, network and referral system, and lacking of continuous development because of low supported budget for infrastructure, limitation of human resource development system. The next finding was inappropriate motivation of referral system, which included lack of care modification in chronic patients, and variously limited opportunities to promote network building between public and private sector. Moreover, the budget allocation to health facilities especially in ministry of public health affiliation could not improve the efficiently of health care facilities and health personnel motivation. Fourth, the capital investment plan and distribution of infrastructure in health service delivery system of public sector were not joined together with the private sector in the whole country. And the last issue was a lack of covering information which was given to population. The important information was

about service uses, benefit package, health facility choices for prevention of the over expectation and conflict between patients and health facilities.

From those findings, we concluded into eight main factors including:

1) Budget allocation system did not really support primary care unit system,

2) Too many models in primary care provision which caused the hospital exception to provide primary care services,

3) Inadequate potential management of health facilities in both public and private,

4) Lack of mechanisms set up to mobilize health facilities of public, local and private for linkage service network together both urban and rural areas,

5) Policy of financing allocation and management under ministry of public health was not clear and consistent annually,

6) Lack of mechanisms to solve personnel management problems,

7) Health facilities pressure by law such as article 41st and 42nd of national health security act 2002.

The recommendations for service delivery system under universal health care coverage include two points. Firstly, it should focus on system development of primary care, which emphasise to provide prevention, promotion and reconstruction more than curative service by integrated those services together, thus, people could access quickly, conveniently, and continually in their community. In order to develop the service delivery system, the recommendations should be as follow:

- Developing fundamental infrastructure and human resource management in terms of suitable capacity or quality, and appropriate amount with population in

their area including workload. That development management should be joined together between public, local government and private sector.

- Improving financial allocation for health promotion and prevention service units, for example; in health promotion unit belonging with nursing services, their activities such as chronic disease services, annual physical examination service could receive capitation budget. Other obvious activities of health promotion services such ANC, family planning could allocate capital budget by quantity and quality of work. Health promotion service was behaviour modification of population and in disease control part; therefore, it should set the budget separately from universal coverage budget. Therefore, it should allocate to the well performance of health facilities by global budget with clearly planning and monitoring.

- Service provides by primary care unit should focus on integrated service of health promotion, prevention and reconstruction including medical care service. Moreover, they should make a clear and continual service care plan for the people in their catchment area.

- Administrative system in primary care unit should not concentrate on business profits or free competitive systems because the service will be provided for benefit searching more than for healthy.

Secondly, the recommendation for health delivery system development ways included:

- Separating non-universal coverage budget (Non-UC budget) from UC budget for services purchasing under health insurance schemes. Ministry of Public Health (MoPH) and health insurance fund managers should develop a plan together, then they could prevent financial burden and reduce gap in the future.

- Improvement financing allocation and management of MoPH in which:

2.1) Budget allocation to community hospital or Contracting Units for Primary Care (CUP) at district level should not cut off their salary at central level and the budget allocation criteria should follow the agreement between Ministry of Public Health (MoPH) and National Health Security Office (NHSO).

2.2) Set up reinsurance mechanism in province and/or national level to take risk or improve risk distribution for health facilities.

2.3) Develop health care service system network which combines public, local government and private sector in all levels, including long-term plan for capital investment and human resource distribution.

2.4) Create model to allocate contingency fund for prevent low morale and enthusiasm of health personnel in the transitional period.

2.5) Develop information systems to reflect the costs of service provided under universal health care coverage with transparency and efficiency.

2.6) Develop more efficient patient care process within health facilities such as “case management” and create a long distance consultation system.

- Develop mechanism to improve working process in local health facilities and central unit and solve the article 42nd of National Health Security Act 2002 as soon as possible together with comprehension enhancement among the people and health personnel in article 41st.

- Improve information system to enhance potential of patients and their colleges about quality and efficiency of health facilities.

- Co-operate with other responsible organisations to develop strategies to perform the service delivery system under the Decentralised Act 1999 and encourage people to contribute in health system management.

The local fund health security policy analysis is a multi-disciplinary approach to public policy that aims to explain the interaction between institutions, interests and ideas in the policy process. It is useful both retrospectively and prospectively, to understand past policy failures and successes and to plan for future policy implementation. According to the Decentralisation Act, the public health mission and hospital mandate must be devolved on local governments. So, a crucial re-orientation needs to be undertaken by both the central government officers and local government officers. The central authority has to shift its mission from top-down administration and policy control to technical and quality assurance of health care. At the same time, local government has to be empowered so that it will be capable of providing equitable and efficient health care, which will be accountable for those people in their own community.

Under the current Constitution of the Kingdom of Thailand B.E. 2550 (2007), ordinary people will have rights to health care if anything has been strengthened. Section 51 provides that "a person shall enjoy an equal right to receive standard public health service, and the indigent shall have the right to receive free medical treatment from a State infirmary … as provided by law". This provision of the new Constitution, together with the requirements of other recent legislation, forced the government to take new steps to improve the standard of the health care system.

The National Health Security Act B.E. 2545 (2002), requires government “to set up national health security for people in local areas by encouraging the process of participation according to the readiness, reasonableness, and need of people in such areas, the Board shall support and cooperate with local government organisations determining regulations so that the said organisations shall implement and manage the national health security system in local areas by earning expenses from the Fund as provided by law” (s. 47).

This provision of the law forced the National Health Security Office to coordinate activities with local governments for co-matching fund according to section 18 “to prescribe the health service provided by a health care unit and network of health care units and to prescribe the standard of implementation, regarding national health security, to be effective” … “to prescribe the rules of fund management and implementation” ... “to encourage and cooperate with local government organisations in implementing and managing the health security system in local areas by considering their readiness, reasonableness, and need, in order to establish national health security residents of such areas as prescribed in section 47” … “to encourage and prescribe rules making it possible that non-profit community organisations, non-profit private organisations and non-profit private sectors implement and manage local funds by considering their readiness, reasonableness, and need, by means and encouraging procedures of participation in order to establish national health security residents of such areas as prescribed in section 47”.

Local governments in the developing world are currently facing serious and urgent problems. Poverty, failing infrastructure, and the lack of human and financial resources

have impacted negatively on local governments' capacity to perform their mandated functions. The decentralisation movement with the mandate to devolve to the local administration consequently posed a continuing challenge to the authorities concerned. Authorities need to avoid stirring up disproportionate anxiety and creating unnecessary resistance to change. On the other hand many crucial issues need to be clarified to ensure that a wide range of stakeholders participate in creating the new system. Since the present health system is satisfactorily serving the majority of the population, this issue is even more crucial. Last but not least, the system needs to identify the needs for capacity building to ensure the emergence of an effective decentralised system with various parties properly carrying out their new roles and functions. Therefore, the Local Fund Health Security (LFHS) has established by the National Health Security Office (NHSO) since 2006.

The National Health Security Office (NHSO) has supported capita budget 40 bahts to the Local Fund Health Security (LFHS). On the other hand, the local government must support budget from local government depend on each level. For example, the three municipality types and large TAOs must support budget at least 50%, medium TAOs at least 30%, and small TAOs at least 20%. Therefore, they have three health promotion projects by the locals; and a funding management project; as support activities of health promotion and disease prevention was covered in four main activities; such as support health service core package purchasable, support health centre, support health promotion and prevention for communities and support manage and develop local fund health security.

This study aimed to analyse policy documents relevant to the issue of local fund health securities published since 2007, the results are:

National Health Security Office (NHSO): Power Decentralisation the Key to Health-for-All Success

Area health security sub-committees in the 75 provinces have stressed the importance of the government's policy to expand health security coverage to all Thais. They said promotion of health volunteers' roles, upgrading health centres into sub-district hospitals, allowing private-run clinics to join the health care network, and supporting the local administrative organisations to lead a role in health personnel development were altogether a key to success. The sub-committees also said the key responsibility for them was to follow up the works of the National Health Security board in a way that was regarded as a reform of the country's health system.

As a matter of fact, members of the National Health Security board and Area health security sub-committees come from many concerned sides especially the civil groups, and join hands to manage the country's health security system.

On 27 July 2010, Public Health Minister Witthaya Kaewparadai presided over an annual seminar of the area health security sub-committees that was held at Rama Garden Hotel in Bangkok. The title of this year seminar was "Directions of Building up Health Security in Areas''. The minister has also delivered a special speech entitled "Government's Policies and Building up Health Security for Public Health Betterment''.

Mr. Witthaya said the government has aimed to improve public health in several areas including expanding health security to cover all members of the public, improving the quality of and access to health care, promoting healthy habits among the people, reducing risk factors leading to chronic diseases, and striving to make Thailand an international hub of medical services. To achieve these goals, he said, the government will promote the roles of health volunteers in conducting proactive work to promote good health, upgrade the health centres into sub-district heath promotion hospitals, and allow privately run clinics to be part of the National Health Security Office's health care network.

As well, he said, it was also important for supporting the hospitals in some specific areas to adopt a public organisation management style as well as supporting the local administrative organisations to take part in producing health and medical personnel by providing a scholarship to students committed to returning to work in their communities after graduating in health care or medicine programmes. The minister also said the area health security sub-committees that were in every province were very crucial in terms of promoting participation of several sides in managing the health security system especially participation of the civil society. He said that was an ideal way of reforming the health system with the area health security sub-committees working together with the National Health Security Committee whose main duty was to design the framework and guidelines for the health security management.

Therefore, the health security work at the area level will be heading in the right direction under the NHSO's policies, he said. This will lead to achievement in the NHSO's goals of public health development particularly the goal of providing quality

and universal health security, he said. An important duty of the area health security sub-committees was to follow up the implementation of the National Health Security Committee's polices and missions.

Basically, the sub-committees are responsible for ensuring equal access to necessary health services and protection stipulated under the National Security Health Act 2002, said by Mr. Prawing Nuchaem, a member of the National Health Security Committee who represents the *tambon* (sub-district) administration organisation.

As the area health security sub-committees are closer to the people in the communities, they should understand the people better than anyone else, so can they better respond to the people's needs, said Mr. Prawing.

In Area 12 or Songkhla province in which Mr. Prawing is also a member of the sub-committee, the sub-committee has a very active role in educating the people about how to seek help and protection under Article 41 of the National Security Health Act 2002 when it comes to suspected medical malpractice, he said.

Dr. Winai Sawasdivorn, secretary-general of the National Health Security Office (NHSO), said the term of the area health security sub-committee is two years and the sub-committee consists of members from several concerned sides, especially the civil society that will ensure universal coverage of the national health security. The sub-committee is responsible for creating the framework and direction of the health security management at the local level such as registration of health service providers in the health care network and the patient transferring system, said by Dr. Winai.

The sub-committee also oversees guidelines for management of the health security fund at the local level and support supervision of the area health security committee, he said. The sub-committee is authorized to create guidelines for the implementation of the designated missions and there always are forums for the committee to share their experience with their counterparts and learn from each other, Dr. Winai said.

4.1.4 Conclusion Policy Analysis

It can be said that a public health concept in Thailand is based on a concept of "good health generation, not restoration". This concept is due to a belief that good health generation or public health promotion means a chance is provided for all people to select a proper way to achieving good health. The good health for this concept has the broad meaning of "well-being" which not only means being in good health because of not having illness and disability but it also means being good health in mind, socializing, spirit and wisdom. The main change of good health aspect from the past to the present time is that good health is generated by people for themselves, for their family and community while governmental agency such as local administrative organisation (LAO) and other agencies take action only by being a supporter. A health promotion strategy clearly appeared in Thai society is "Local Fund Health Security (LFHS)" which was launched firstly in 2006 by the National Health Security Office (NHSO). The NHSO announced a policy to persuade people to generate the health promotion and disease prevention throughout every sub-district in all local administrative organisations (LAO) in Thailand. Also the NHSO had determined strategies relating to local fund health security (LFHS) management based on a concept of health promotion and disease prevention is a focused area, integration is

needed to connect all concerned parts, learning process is generated and all findings applied properly to health situation in each local community.

Therefore, the health care and financial systems from the local fund health security (LFHS) should aim to promote:-

1. Proper health care according to health needs, especially clients of P&P (prevention and promotion of health), clients of chronic diseases, and the disable,
2. Easy access and appropriate referral and payment systems,
3. Appropriate care for both in- and out-migrants,
4. Efficient operation, adaptation, networking and financial sustainability.

4.2 Quantitative and Qualitative Results of the Policy Implementation

Introduction

This section reports the quantitative and qualitative results of the study on Thailand's universal coverage health care reforms in relation to researching the role of the local fund health security in local government purchasers in the north-eastern region of Thailand. The demographic of local government data are initially presented. The second subsection demonstrates when the local fund health security had been established, and budget supports of those local funds. The third subsection details the committee of the local fund health security, and then the fourth subsection shows the local fund health security plans. The fifth subsection describes public health activities which were supported from the local fund health security. The sixth subsection explains the allocations of budgets from the local fund health security. Then, problems and obstacles of the local fund health security are finally presented.

4.2.1 Demographic and characteristics of the local fund health security

The demographic and characteristics of the local fund health security are summarized in Table 1 and 2. The frequencies of the variables are described by the number and the percentage. The interval scale variables, such as age and income, were analyzed by mean, median, and range. The total sample consisted of 190 subjects who were male 78 people (41.1%) and female 112 people (58.9%). Age varied between 25 and 66 years old and age average was 40.24 (S.D. 8.92). The marital statuses were mostly couples (68.4%). The majority of participants had completed bachelor's degrees (70.0%) and some participants graduated master degrees (16.4%) which were

different programmes such as public health, nursing, education, administration, law and sociology. (See table 4.1)

Table 4.1: Demographic of samples

Variables	Frequency (n=190)	Percentage (%)
Gender		
Male	78	41.1
Female	112	58.9
Age (yrs)		
25-29	18	9.5
30-39	77	40.5
40-49	58	30.5
50-59	26	13.7
60+	6	3.2
Unknown	5	2.6
Mean 40.24, S.D. 8.92, Max. 66, Min. 25		
Marital Status		
Single	46	24.2
Widows/Divorced/Separated	10	5.3
Couple	130	68.4
Unknown	4	2.1
Education Level		
Junior high school	4	2.1
Senior High school	12	6.3
Diploma	9	4.7
Bachelor’s degree	133	70.0
Master’s degree	31	16.4
Unknown	1	0.5

Characteristics of the local fund health security

In relation to the local fund health security, most participants were health officers (65.2%) and the others were chief executives of the Tambon Administrative Organisation (TAO), chief administrators of the TAO, council members, and the TAO members. They had worked in those positions varying from 1 year to 33 years (Median 4 years, Range 32 years). It was found there were 149 subjects giving data about their monthly salary from local government. The data shows that the minimum salary was 1,000 bahts per month, and the maximum was 33,560 bahts per month (Median 11,400 bahts). The participants who gave data of this study, 65.2% were committee including chairman, vice-chairman, committee, and, committee with secretary. The others participants (34.8%) had positions within the Local Fund Health Security as subcommittees. (See table 4.2)

Table 4.2: Characteristic of samples relating the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Position		
Mayor	5	2.6
Municipal clerk	3	1.6
Council member/Members of municipality	3	1.6
Chief executive of the TAO	25	13.2
Chief administrator of the TAO	24	12.6
Council member/Member of the TAO	6	3.2
Health officer	124	65.2

Table 4.2: (Continued) Characteristic of samples relating the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Period of Position (yrs)		
1-10	142	74.7
11-20	37	19.5
21-30	7	3.7
31+	1	0.5
Unknown	3	1.6
Median 4, Max. 33, Min. 4		
Income (Bahts)		
1,000-9,999	41	21.6
10,000-19,999	78	41.1
20,000-29,999	24	12.6
30,000+	6	3.2
Median 11,400, Max. 33,560, Min. 1,000		
Committee Position in Local Fund Health Security		
Chairman	32	16.8
Vice-Chairman	2	1.1
Committee	54	28.4
Committee and Secretary	36	18.9
Subcommittee	66	34.8

The local government offices participating in this study consisted of Tambon Administrative Organisations (85.2%), Tambon municipalities (13.2%), town municipalities (1.1%) and a city municipality (0.5%). The participants who gave data

of this study, 47.3% were committee including committee with secretary, and some participants were subcommittee and chairman. Almost all participants showed that they had the information on local fund health security from various sources such as Branch of National Health Security Office (NHSO), Provincial Public Health Office and District Health Office. It should be highlighted that three participants did not receive the local fund health security information. Most local funds attended training courses where were conducted by Provincial Health Office (PAO) and National Health Security Office (NHSO). The topics of training courses included budget management. (See table 4.3)

Table 4.3: Characteristic of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Level of Local Government		
City Municipality	1	0.5
Town Municipality	2	1.1
Tambon Municipality	25	13.2
Tambon Administrative Organisation (TAO)	162	85.2
Local Fund Health Security Information		
Never received	3	1.6
Received	187	98.4
Local Fund Health Security Performance Training		
Never received	25	13.2
Received	165	86.8

4.2.2 Establishing of Local Fund Health Security and supporting budgets

It is clear that the Local Fund Health Security in Thailand was established in 2006. However, this study found almost half of the samples were established in 2008, there were only 18.9% which began in 2006. One hundred and twenty local funds were already evaluated of which 8 funds passed at level A+, 45 funds passed at level A, 17 funds passed at level B, and 7 funds passed at level C. It should be noted that there were 43 funds which did not report the evaluating results. There were health data in terms of health community data (63%), health community plans (57.9%), and strategic route maps (40.5%) before the Local Fund Health Security was established.

In relation to a preparation, most of the chairmen of the committee, or healthcare officers, or secretaries had attended the training programmes before their local funds were begun. Some local funds were unable to attend, the reasons were given; for example because the committees were changed, or they did not receive the information. (See table 4.4)

Table 4.4: Establishing of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Local Fund Health Security Established		
2006	36	18.9
2007	26	13.7
2008	86	45.3
2009	34	17.9
2010	2	1.1
Unknown	6	3.1

Table 4.4: (Continued) Establishing of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Local Fund Health Security Evaluation		
Unknown	8	4.2
Not Passed	62	32.6
Passed	120	63.2
Level A+	8	4.2
Level A	45	23.7
Level B	17	8.9
Level C	7	3.7
Unknown Level	43	59.5
Health data before Local Fund Health Security established		
No	44	23.1
Yes	143	75.3
Unknown	3	1.6
Health data type (could have more than one)		
Community Health Data	121	63.7
Community Health Plans	110	57.9
Strategic Route Maps	77	40.5
Preparation Training		
No	32	16.8
Yes	158	83.2

Supporting budgets of the Local Fund Health Security

In budget year 2010, each local fund got budget allocation from the National Health Security Office (NHSO) which varied from 20,000 bahts to 3,424,240 bahts. Most of them got budgets 120,000 bahts. Not only budgets from the NHSO that the LFHS had been supported, but they also got from local governments and communities. The percentages of budgets from local governments mainly were more than 20% with mode at 30%. These financial supports varied from 15,000 to 1,712,120 bahts which mode was at 100,000 bahts. Eight local funds reported that they had budget supports from their communities. These budgets extremely varied from 100 to 100,000 bahts which were contributes from the robes offering ceremony, people investments, village bank project, and garbage fund project. The budgets were allocated from the NHSO mostly during January to March 2010. The majority of local funds in this study had reporting systems via online of http://tobt.nhso.go.th/, which data were recorded completely and currently. Data on local fund management programme included data bases, activity reports and budget reports. Six local funds did not use the online system because their networks were inaccessible. (See table 4.5)

Table 4.5: Supporting budgets and data reporting of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Budget allocated from NHSO in 2553	**(n=166)**	
20,000 – 99,999 Bahts	10	6.0
100,000 – 199,999 Bahts	66	39.8
200,000 – 499,999 Bahts	82	49.4
500,000 – 999,999 Bahts	6	3.6
1,000,000 – 1,999,999 Bahts	1	0.6
≥ 2,000,000 Bahts	1	0.6
Median 221,360, Mode 120,000, Min. 20,000, Max. 3,424,240		
Percentage of budget subsidize from local	**(n=160)**	
government	34	21.2
1 – 20 %	73	45.6
21 – 30%	42	26.2
31 – 50%	11	7.0
≥ 51%		
Median 30 Mode 30 Min. 3 Max. 100		
Amount of budget subsidize from local government	**(n=176)**	
≤ 99,999 Bahts	106	60.2
100,000 – 199,999 Bahts	48	27.3
200,000 – 499,999 Bahts	20	11.4
500,000 – 999,999 Bahts	1	0.6
1,000,000 – 1,999,999 Bahts	1	0.6
Median 82,116 Mode 100,000 Min. 15,000 Max. 1,712,120		

Table 4.5: (Continued) Supporting budgets and data reporting of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Percentage of budget subsidize from community	**(n=8)**	
1 – 20 %	5	52.5
21 – 30%	2	25.05
31 – 50%	0	0
≥ 51%	1	12.5
Median 14 Mode N/A Min. 1 Max. 78.7		
Amount of budget subsidize from community	**(n=14)**	
100 – 9,999 Bahts	4	28.6
10,000 – 49,999 Bahts	5	35.7
50,000 – 99,999 Bahts	1	7.1
100,000 – 199,999 Bahts	2	14.3
≥ 200,000 Bahts	2	14.3
Median 22,925 Mode 20,000 Min. 100 Max. 400,000		
Period of Budget allocation from NHSO		
October – December 2009	21	11.1
January – March 2010	133	70.0
April – June 2010	23	12.1
July – September 2010	3	1.6
Unknown	10	5.2
Report management programme online		
No	6	3.2
Yes	179	94.2
Unknown	5	2.6

Table 4.5: (Continued) Supporting budgets and data reporting of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Local Fund Health Security data record		
Completed and Present	143	75.3
Completed but Not present	22	11.6
Uncompleted but Present	13	6.8
Uncompleted and Not present	6	3.2
Unknown	6	3.2
Data record on online programme		
Data bases	174	91.6
Activity report	174	91.6
Budget report	173	91.1

4.2.3 The committees of the Local Fund Health Security

Tables 4.6 - 4.7 show the committee of the Local Fund Health Security in a local or a community level. It was found that most local funds had appointed subcommittee delegations to do administrative work, finance, account, project, assistant secretary, etc. Some local funds did not have a subcommittee because of unnecessary, enough committee, unimportant point, or small sub-district, etc. Almost the committees of local funds were appointed following the National Health Security (NHSO) criteria. Except for 2 local funds because they thought there were more organisations that could participate in local fund management. As a result, they asked the NHSO for approving an extra criterion.

Table 4.6: Committee of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Local Fund Health Security Subcommittee		
Delegation	149	78.4
Yes	36	18.9
No	5	2.6
Unknown		
Local Fund Health Security Committee Delegation		
of National Health Security Office (NHSO)		
Criteria	187	98.4
Yes	2	1.1
No	1	0.5
Unknown		

Secretaries of the Local Fund Health Security

It appears that secretaries of the Local Fund Health Security usually were the municipal clerks and the TAO clerks. However, some local funds appointed health workers to be the secretaries because they understood well about the management of the Local Fund Health Security. Last year, there were some committees resigned from the Local Fund Health Security with the reasons such as completed position period, early retirement, death, no time to work, etc. (See table 4.7)

Table 4.7: Secretaries and committee resignation of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Local Fund Health Security Secretary		
The municipal clerk/The TAO clerk	154	81.1
Others	35	18.4
Unknown	1	0.5
Local Fund Health Security Committee		
Resignation	168	88.4
No	21	11.1
Yes	1	0.5
Unknown		

Management of the Local Fund Health Security

Each local fund had different frequencies of meeting; monthly, every 2 months, every 3 months or 3 times a year. However, they could set a meeting if they had a rush activity to be considered by a committee. Most boards of local fund committees (91.1%) had management processes for planning on community health plans. For some who did not have, the reasons were given, for example they were new local funds, they run projects by projects, and they lacked of understandings. (See table 4.8)

Table 4.8: Meeting and planning of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Frequency of Local Fund Health Security Committee Meeting		
Every month	32	16.8
Every 2 month	43	22.6
Every 3 month	81	42.6
Other	31	16.3
Never	0	0
Unknown	3	1.6
Management Process of Health Community Plan		
Yes	173	91.1
No	15	7.9
Unknown	2	1.1

Management ability of the Local Fund Health Security

Although the majority of boards of local fund knew the committee roles in relation to a local health fund management, 30 funds were not confident about the roles and one fund did not know. Those boards knew the roles because they learnt the roles from training courses, conferences, seminars, etc. Then, they always imparted that understanding to their local funds by committee meetings. Thus, they believed that their local funds had the potential to manage problem bases and community needs effectively.

Interestingly, not all local fund committees had attended training courses, or meetings, or conferences about the Local Fund Health Security. There were 23.7% of local funds in this study where every committee had attended those programmes. The reasons for unattended subjects were such as lacking budgets, inappropriate times, and limited attendances. (See table 4.9)

Table 4.9: Management abilities of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Accepting Role of Local Fund Health Security Committee		
Confident	157	82.6
Not confident	30	15.8
Do not know	1	0.5
Unknown	2	1.1
Management Ability of Local Fund Health Security on need assessment and problem in community	154	81.1
Yes	28	14.7
Not confident	6	3.2
No	2	1.1
Unknown		
Training and Seminar on Knowledge Management for Local Fund Health Security Committee		
Never	9	4.7
Someone	135	71.1
Everyone	45	23.7
Unknown	1	0.5

Budget management of the Local Fund Health Security

Boards of local fund committees usually understood purposes and target groups to spend budgets of local fund because they were attended training courses of local fund management and were informed by meetings, for example. The results of this study show that almost all local funds had regulations of funding budget which were approved from boards of committee. (See table 4.10)

Table 4.10: Budget management of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
To know how to pay Local Fund Health Security Budget	1	0.5
Do not know	32	16.8
Do not confident	156	82.1
Confident	1	0.5
Unknown		
Regulations of Local Fund Health Security Budget to pass resolution committee		
No	4	2.1
Yes	183	96.3
Unknown	3	1.6

4.2.4 Plans of the Local Fund Health Security

This section details study findings about plan makings of the Local Fund Health Security. Made plans were divided into two periods; before and after budget allocations from the National Health Security Office (NHSO). Seventy-two local funds made plans before budget allocations which were mostly from October to December 2009. Fifty-six local funds made plans after budgets were allocated which were mostly between January and March 2010. It was found that not only boards of local fund committees participated in plan makings, but also 53.7% of local funds in this study allowed other people to arrange for the Local Fund Health Security.

Those people included health volunteers, community leaders, healthcare officers, teachers, and ordinary people, etc. Most local funds employed health community plans for making plans of the Local Fund Health Security (64.7%). The main reasons of using health community plans because they consisted of community data and data were approved by community, agreements. The others used strategic route maps (35.3%) as the instruments to make the plans because strategic route maps were run by people in community, therefore the problems in community could be solved effectively. (See table 4.11)

Table 4.11: Planning of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Period of doing Local Fund Health Security Plan		
1. Before allocate budget from National Health Security Office (NHSO) (n=125)		
October – December 2009	78	62.4
January – March 2010	30	24.0
April – June 2010	8	6.4
July – September 2010	8	6.4
2. After allocate budget from National Health Security Office (NHSO) (n=113)		
October – December 2009	16	14.2
January – March 2010	60	53.1
April – June 2010	24	21.2
July – September 2010	12	10.6
Local Fund Health Security Planning Coordination		
Only Local Fund Health Security Committee	83	43.7
Other people	102	53.7
Unknown	5	2.1
Local Fund Health Security Planning Instrument		
Health Community Plan	123	64.7
Strategic Route Maps	67	35.3

Plan analysis of the Local Fun Health Security

The majority of local funds did problem analyses and priority settings initially to guide making plans of the Local Fund Health Security. As the results, they had the plans which could solve the community problems precisely. Moreover, the urgent and severe problems could be solved properly. Some local fund had their plans which could be conducted by communities themselves and also used recourses from their communities. Some plans and projects of the Local Fund Health Security were integrated with local government plans. Some plans could get support from the other organisations. (See table 4.12)

Table 4.12: Plan analysis of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Problem Analysis and Priority Setting		
Did not	20	10.5
Done	163	85.8
Unknown	7	3.7
Types of Local Fund Health Security Plan and Project	97	51.1
Processing by community and used resources in community	107	56.3
Integrate with projects and local government plan	20	10.5
Projects and plan which supported from others		

Payment methods that each local fund used for supporting activities of those plans were cash, transfer banking and cheque. The activities and projects in relation to plans were divided into 4 main domains including health service core package purchasable, supporting health centre, health promotion and prevention for communities, and management and development of the Local Fund Health Security. (See table 4.13)

Table 4.13: Financial management of plans of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Payment methods for running plans of Local Fund Health Security		
Cash Payment	66	34.7
Transfer Banking	34	17.9
Cheque Payment	27	14.2
Others (More than one method)	63	31.0
Projects and Activities on Local Fund Health Security Plan	158	83.2
Health service core package purchasable	165	86.8
Support health centre	169	88.9
Health promotion and prevention for communities	172	90.5
Manage and develop Local Fund Health Security		
Percentage supporting to health service core package purchasable (%)	Mean 31.44, S.D. 1.38 Min. 6%, Max. 85%	
Percentage supporting to health centre (%)	Mean 28.83, S.D. 1.69 Min. 2%, Max. 100%	

Table 4.13: (Continued) Financial management of plans of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Percentage supporting health promotion and prevention for communities (%)	Mean 33.92, S.D. 1.61 Min. 5.49%, Max. 90%	
Percentage supporting to manage and develop Local Fund Health Security (%)	Median 10.00 Min. 0.58%, Max. 100%	

4.2.5 Supported Activities from the Local Fund Health Security

The following table displays numbers of activities which had been supported budgets from the Local Fund Health Security. This study found that the local funds had done activities and projects in five groups of target people which consisted of mother and child (80% of study funds), aging people (71.1%), disabled and crippled people (56.8%), workers in high-risk occupations (44.2%), and chronic disease patients (69.5%). The activities and projects had supported health centres in relation to four health domains which were health promotion (74.7%), disease prevention (76.3%), rehabilitation (34.7%), and primary medical care (33.2%). For community participations, there were activities and projects run by communities including health promotion (74.2%), disease prevention (74.7%), rehabilitation (30.0%), and folk wisdom promotion (32.1%). There were activities according to manage local funds and develop management systems, and most local funds (80.5%) spent budgets on compensation for meetings. (See table 4.14)

Table 4.14: Supported activities from the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Activities and project from purchasing core health service package		
Mother and child	152	80.0
Aging people	135	71.1
Disable and crippled people	108	56.8
Occupational risk workers	84	44.2
Chronic disease patients	132	69.5
Activities and project from budget which support health centre		
Health promotion	142	74.7
Disease prevention	145	76.3
Rehabilitation	66	34.7
Primary medical care	63	33.2
Activities and project from health promotion and prevention for communities		
Health promotion	141	74.2
Disease prevention	142	74.7
Rehabilitation	57	30.0
Folk wisdom promotion	61	32.1
Activities and project from budget which manage and develop Local Fund Health Security		
Compensation for meeting	153	80.5
Buy durable articles	49	25.8
Others compensation	71	37.4
Paid for develop Local Fund Health Security committee	96	50.5

4.2.6 Budget Payment of the Local Fund Health Security

This subsection presents data about budget distributions from the Local Fund Health Security for conducting activities and projects of each local fund. It was found that transfer banking was the most popular way that local funds received money from the Local Fund Health Security (78.4%). Some local funds got budgets both by cash and transfer banking (12.1%). Almost all local funds in this study had payment evidences and did autograph on these evidences. Only one local fund reported doing this sometime because a banking statement was used to replace the payment evidences. The majority of local funds did not keep cash with the committees because keeping cash personally was not mentioned in the local fund regulations. Some local funds detailed that there were banks near their offices which were very convenient for doing budget payments. Twenty four local funds used to keep cash with a chairman or a committee or a secretary. The amounts of money varied from 1,200 to 100,000 bahts (Mode 10,000 bahts). (See table 4.15)

Table 4.15: Budget Payment from the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
How to get budget of the LFHS		
Cash	10	5.3
Bank	149	78.4
Cheque	8	4.2
Others	23	12.1
Evident on receipts		
Every time	182	95.8
Sometime	1	0.5
Never	2	1.1
Unknown	5	2.6
Saving cash with chairman or committee or secretary of the LFHS		
Never	159	83.7
Yes	24	12.6
Unknown	7	3.7

Budget accounts of the Local Fund Health Security

Local fund accounts were usually separated from local government accounts, because those two accounts were spent on different projects and purposes. Moreover, separated accounts would be easy and convenient for checking and evaluating the payments. According to the NHSO website, 90 local funds had recorded payment data on an online system via http://tobt.nhso.go.th/. Some local funds could not do this report on the online system because their net works were inaccessible. Most

local funds had monthly reported the payment accounts to a chairman or a committee or a secretary of the Local Fund Health Security. However, it was found that there were a few local funds had reported every week and every fortnight. Although online accounts were conducted, most local funds had to do paper of payment reports for a chairman or a committee or a secretary of the Local Fund Health Security. In consequence, those paper reports were always signed by local fund accountants. An annual report of the Local Fund Health Security mostly consisted of general data of local funds, project performance and financial reports. (See table 4.16)

Table 4.16: Budget Accounts of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
How to make account book of Local Fund Health Security		
Separating from local government account book	180	94.7
Making together with local government account book	4	2.1
Others	3	1.6
Unknown	3	1.6
To do account book by web side http://tobt.nhso.go.th/		
Yes	171	90.0
Not yet	14	7.4
Unknown	5	2.6

Table 4.16: (Continued) Budget Accounts of the Local Fund Health Security

Variables	Frequency (n=190)	Percentage (%)
Frequency of account book record report to chairman or committee or secretary of Local Fund Health Security	2	1.1
Every week	1	0.5
Every 15 days	100	52.6
Every month	30	15.8
Every 2 months	52	27.4
Others	5	2.6
Unknown		
Print account book every month report to chairman or committee or secretary of Local Fund Health Security	140	73.7
Done	41	21.6
Not yet	9	4.7
Unknown		
To sign by who responsible of account book		
Done	156	82.1
Not yet	24	12.6
Unknown	10	5.3
Significant factors for an annual report of the LFHS		
General data	158	83.2
Results project performance	180	94.7
Financial situation report	172	90.5

4.3 Results of Wungsang Local Fund Health Security

This qualitative study focused on an After Action Review (AAR) of local fund health security system operated by Tambon Administrative Organisation (TAO) in Wungsang sub-district, Kaedam district, Maha Sarakham province, Thailand. Data were collected from 30 key informants including the chief executive of the TAO, chief administrator of the TAO, council members of TAO, health officers, community leaders, and people representing local areas by using in-depth interviewing, focus group and observation. However, some information was given by a committee and a sub-committee of Wungsang Local Fund Health Security (WSLFHS). A method of content analysis was applied to analyse those data.

4.3.1 Preparatory phase for supported pattern of WSLFHS Plans by an organisation and individuals

These results have explored in phenomenon which was designed to reflect the empirical data in real time that it was a community unit of analyses both individual and social. The research focused on key informants in Wungsang Local Fund Health Security (WLFHS) including a chief executive of the TAO, a chief administrator of the TAO, council members or members of TAO, health officers, community leaders, committees of the WSLFHS, and delegations from a commune.

A supported pattern by organisation covers a way that a plan has been supported by the Tumbon Administrative Organisation (TAO), after that plan has been formally sent for approval through people participation process or any process. A pattern supporting by individuals has clearly shown in form as committees of Wungsang Local Fund Health Security (WLFHS). They provide some budgets cutting from budgets of the TAO

which to be a budget for health promotion and disease prevention, due to the fact that they are also committees, community leaders, and delegated people of the local fund health security. For example, they have more projects according to health promotion and disease prevention, as follow projects and activities on Wungsang Local Fund Health Security (WLFHS) in 4 parts;

1. Health service core package purchasable

1.1 Health promotion projects for child developing centre of the Wungsang Tumbon Administrative Organisation (WTAO),

Activities;

- Health improvement according to standard criteria of child health

2. Support health centre services

2.1 Diabetes and Hypertension Screening Test by Health Professionals,

Activities;

- Blood testing, Blood pressure measurement
- Metabolic screening by questionnaires
- Behavioural changes

3. Health promotion and prevention for communities

3.1 Reducing and Stopping Alcohol and Drugs,

Activities;

- Public relations
- Screening surveys
- Selection a model person
- Yaowachon Ton Kar

3.2 Supporting disable and crippled people,

Activities;

- Health assessment

- Health promotion

3.3 Health promotion of elderly and chronic disease people,

Activities;

- Nutrition support for elders with chronic disease in Wungsang Health Centre

- Nutrition support for elders with chronic disease in Nongbua Health Centre

3.4 Supporting iodized salt for households,

Activities;

- Distribute iodized salt every household

3.5 Supporting exercise projects,

Activities;

1. Exercise patterns

- Aerobic dance

- Sports

- Long stick (Plong Thai) dance

2. Exercise competition

3.6 Home visit,

Activities;

Home visit of

- Mother and child
- Chronic disease people
- Disable people

4. Manage and develop Local Fund Health Security

4.1 Competency developments of committee of WLFHS

Activities;

1. Competency developments;
   - Knowledge of LFHS
   - Health promotion and prevention
   - Processing of LFHS
   - Management of LFHS
   - Roles of LFHS committee
2. Monthly meeting system

Finding and lesson learned from supportive process of Wungsang Local Fund Health Security (WSLFHS) of Wungsang Tambon Administrative Organisation (WTAO) based on health promotion and disease prevention plans. Finding shows that supportive process for health action plan of local fund health security based on health promotion and disease prevention has not provided clearly yet, even there are some concerned persons such as, chief administrator of the TAO and council member or member of TAO, to join in the process as helpers. Theoretically, the supportive process should be

provided formally in one year of health action plan. In fact, plan and project of local fund health security nearly closes to the need of people in community and being under health promotion and disease prevention which focuses on sufficiency, rationality and balance. Integration between policy of local administrative organization and need of people in community is public participation process which provides a chance for people, mainstay persons of every social group and mainstay committees of local fund health security to join in community's master plan preparation. The participation process is accepted as a moral process which is based on local fund health security patterns from the National Health Security Office (NHSO) also.

In the preparation of Wungsang Local Fund Health Security planning, There were health data in terms of community health data, community health plans, and strategic route maps because these causes as follow;

1) require a further making a pile of local fund health security every year,

2) as the information matches the context of the community,

3) no cumbersome and complicated,

4) which is simple and immaterial

5) aware of the actual problems of the people, and

6) through the community, so can be taken as guidelines in making plans.

4.3.2 Implementation phase for supported pattern of WSLFHS Plans

The study found that Wungsang Tambon Administrative Organisation (WSTAO) established a local fund health security included its regulations according to the National Health Security Act B.E. 2545 (2002) and announced in 2553 B.E. (2010). As a health committee, representatives of Wungsang people and organisations managed together under the precise policies while another sub-committee inspected that all expenses were spent strictly through the fund's regulations. Every plan setting of local fund health security of Wungsang Tambon Administrative Organisation (WSTAO) was based on the people's needs. In the fiscal year 2553 B.E. (2010), Wungsang Local Fund Health Security (WSLFHS) planned nine main projects consisting of five projects related to facility-based services for adults, people with disabilities and 6-25 years old youths; three health promotion projects by the locals; and a funding management project; as support activities of health promotion and disease prevention was covered in four main activities; such as support health service core package purchasable, support health centre, support health promotion and prevention for communities, and support manage and develop local fund health security.

All projects proceeded successfully (100.0%). The fund was spent 100.0% from the full amount of 246,500 Baht. An outstanding achievement was a network of health party which encouraged people to realise the importance of self-care, leaded a better relationship and cooperated integrally between people and government. The results showed that perception of key informants about health was covered in four health dimensions such as physical health, mental health, social health, and spiritual health.

They have been promoting health care belief holding such as nutrition for children in Day Care of Wungsang TAO, chronics disease patients (i.e. diabetes mellitus and hypertension), and Iodine salt support.

The vision and structure of administration of Wungsang TAO facilitated the operation of local fund health security; hereby the committee of this fund were both appointed and elected due to standard regulated by National Health Security Office.

Moreover, to enhance strength in practical level, ad hoc committees were appointed for cooperating in planning and carrying on tasks related with problems and contexts in area as well as developing the staffs, potentially. As for health service, it included four activities covering five target groups. These activities consisted of evaluation, reflection of evaluation and inspection of the project operation: product, output and impact. It was found that all target groups could access the service broadly but there was no covered evaluation. As for the target groups, satisfaction, the clients satisfied all services that they received. The project innovation was figured as the model in administrating and encouraging the multilateral alliance to participate in local fund health security and carry on the own mission of each alliance. In addition, the leader has vision that concerned the important of health promotion and illness prevention. All of these findings were integrated and directed to similar intentions, which are, promoting the public to access health insurance and achieve quality of life. Hereby, the committees were the co-operators for health promotion and illness prevention covering rights benefit for all target groups together with using the resources to maximize the most benefits.

As mentioned above, it is clear that the Wungsang Local Fund Health Security (WSLFHS) has been conducted extremely successfully since establishing. This could be supported by survey data about satisfactions of this local fund as presents in the following paragraphs.

4.3.3 Evaluation phase of Wungsang Local Fund Health Security

4.3.3.1 Satisfaction of people about Wungsang Local Fund Health Security

The survey findings of 65 Wungsang people included 37 men and 28 women. They varied in age between 26 and 67, and an average age was 47 years (*S.D.* = 9.13). All of them completed education which were primary school (38.5%), junior high school (17.0%), senior high school (41.5%), and higher education (2%). Most participants were agriculture (69.2%) and the others were officers, employees, independent businesses, and housewives. Four participants were health volunteers.

Satisfaction level was good as the results of these;

1) Increasing knowledge of health promotion and disease prevention,

2) Welfare of health insurance,

3) Establishing regular exercise in community,

4) Commune could get health information,

5) All agencies are well providing support to local,

6) Making the community has an awareness in health promotion and disease prevention such as, exercise and others health behavioural changes

7) Getting opportunities to have health promotion,

8) The local fund health security has appropriate purposes,

9) People in local have been healthy,

10) Individuals could learn various lessons from participations in planning

Satisfaction was at an improved level as the results of these;

1) Lack of information for people

2) Budget was allocated lately to manage the LFHS

3) Some people do not know the main offices of the National Health Security Office and the Local Fund Health Security, due to lack of public relation,

4) No continuity in some projects,

5) Need to improve better health for a commune,

6) Need training courses,

7) Some projects have been delayed.

4.3.3.2 Perceptions and Satisfactions of Wungsang Local Fund Health Security

All participants perceived the Local Fund Health Security of Wungsang Tambon Administrative Organisation (WSTAO). Almost of them (96.6%) understood that their WSTAO conducted projects and activities for health promotions of communes. It was only 3.3 percent supposed that the WSTAO supported community welfare.

It was clear that most people in Wungsang had been serviced from the Local Fund Health Security. Exercise projects were the most health promoting activities that this community had achieved. The communes also had obtained educational health of disease preventions and received disease screening tests. Although the majority of

participants reported that the Wungsang Local Fund Health Security (WSLFHS) belonged to the National Health Security Office (NHSO), some understood that the WSLFHS belonged to the Tambon Administrative Organisation (WSTAO) and local health centres.

Additional comments about operations of the local fund health security;

1) The main local fund health security with operations like this forever,

2) Public relation to explain about the local fund health security to people in the community

3) Community should participate in the processes of assessment and information presenting,

4) Request to increase budgets,

5) Asking the committees and health volunteers for reporting to project directors every month,

6) Should have more financial support,

7) All health volunteers should work together,

8) The LFHS is good and need to be conducted continuously to keep people healthy,

9) Training courses should be run regularly,

10) Financial support should be allocated on time,

11) Need to have university lecturers for supervision every 2 months.

4.3.3.3 Satisfactions of an operating of Wungsang Local Fund Health Security

The findings revealed that most participants had good satisfied (85.7%) and some of them (14.3%) satisfied the operations of the WLFHS at an adjusted level. The reasons for the good level were, for example, people had health insurance, increasing knowledge about health and disease preventions, commune alerting to health promotion (i.e. exercise), increased participations among communes, and becoming healthy community. There were some comments which were given from the adjusted level, for example, lacking of some information, lately allocating budgets, no continued project, and some activities were conducted lately.

Satisfaction on public relations of information about the major local fund health security;

A good level, with the following reasons:

1) Increased newer knowledge which was unknown,

2) People in villages have done exercise together and this could sort out a social conflict,

3) Officers and personnel have well provided knowledge and training for the community,

4) Received cooperation from the Tambon Administrative Organisation,

5) Leaders of villages have distributed news,

6) Citizens have knowledge, news, information about major local fund health security,

7) All agencies have well provided supports,

8) There is the public relation consisting of various media.

An improved level with some following reasons;

1) Public relation is not distributed through the consumers,

2) Lack of good public relations, most people do not understand the term of health insurance

3) Need the committees more relating to the people,

4) Need a brochure or a book of guidelines for trainees.

Additionally, there were some suggestions for further improving the Local Fund Health security which included;

1. wanting the Local Fund Health Security to go on the same as before,

2. there should be some communes participate in an assessment process of projects,

3. budgets of projects and activities need to be increased,

4. training programme about health should be run regularly, and

5. every chairman of health volunteer of each village should have an opportunity to participate in a committee of the Local Fun Health Security.

Overall satisfactions about information of the Local Fund Health Security were good (81.7%) and 18.3% reported that that information needed to be improved. Participants received information about the Local Fund Health Security from health volunteers of a village, health officials, and community leaders.

4.4 Chapter Summary

This study, a UC policy of local fund health security is provided according to health promotion and disease prevention as the integrated health policy covering 6 main practical ways as 1) mechanism construction to support network concept and strong health 2) local government master plan generation based on integration concept 3) community health strengthening by participation from all stakeholders 4) “Friend helps friend” health system provision 5) volunteer mind’s network generation support for all types of career and 6) support for local administrative organisation to take action more on health promotion and disease prevention.

Therefore, the Local Fund Health Security (LFHS) should accordingly play its roles in various key areas which are:-

1. To set policies regarding the provision of primary health care and the referral system to compliment the universal coverage. In addition, goals, objectives, indicators, policies towards health promotion and issues such as risk reduction, emergency care, treatments of chronic diseases, rehabilitation, and health communication must also be determined and put across.

2. To provide facilities or to pave the ground for the efficient operation. An organisational restructuring also in terms of culture and the development of information system at the local administrative organisation (LAO) in each level may well be the first step to achieve the desirable health care system in the long run.

3. To facilitate the proper allocation of resources to ensure adequacy of resources, including a cost study, a cost accounting system, a budgeting and financial

system for services, as well as development of an accrual accounting system, manpower and their competencies and supply of medicine.

4. To provide technical support by developing academic strength at least in areas, such as clinical practice guidelines for primary care in the local area, a model for primary care services in the local area, and leadership training.

5. To assess and assure quality of services. It is recommended that all health care providers must be visited by the Health Centre, Community Hospital, and the National Health Security Office (NHSO).

Moreover, it is important to set up a data base system which allows the collection of information about standards and quality of care, especially amongst chronically ill patients and the survey of satisfaction and health problems of people in the community.

CHAPTER V

DISCUSSIONS

In this chapter, the research findings are summarised, discussed, and concluded, starting with a summary of the health insurance system in Thailand. The current study investigates the role of the local fund health security held by local government as a component of universal coverage provision in the north-eastern region of Thailand. Then, it summarises and discusses the policy concerning decentralisation and devolution and the associated health sector reforms agenda, and the role of the local fund health security in local government, respectively.

5.1 Summary

This summary shows the analysis of policy documents relevant to the issue of local fund health securities that has been published since 2006. This thesis has explored the policy process, as a policy of the local fund health security formulation.

It is clear that a policy is a plan or a course of action designed to define issues, influence decision-making and promote broad community actions beyond those made by individuals. Policy development, therefore, is the process by which a society makes decisions, selects goals and the best means for reaching them, handles conflicting views about what should be done and allocates resources to address needs.

Health policy analysis is a process of assessing and choosing between spending and resource alternatives that affect the health care system, public health system, or the health of the general public. Health policy analysis involves several steps: identifying

or framing a problem; identifying who is affected (stakeholders); identifying and comparing the potential impact of different options for dealing with the problem; choosing among the options; implementing the chosen option(s); and evaluating the impact. The stakeholders can include government, private healthcare providers (e.g. hospitals, health plans, and office based clinicians), industry groups (e.g., pharmaceutical, biotechnology, and medical device manufacturers), professional associations, industry and trade associations, advocacy groups, and consumers.

The local fund health security policy analysis is a multi-disciplinary approach to public policy that aims to explain the interaction between institutions, interests and ideas in the policy process. It is useful both retrospectively and prospectively, to understand past policy failures and successes, and to plan for future policy implementation. According to the Decentralisation Act, the public health mission and hospital mandate must be devolved on local governments. Thus, a crucial re-orientation needs to be undertaken by both central government officers and local government officers. The central authority has to shift its mission from top-down administration and policy control to technical and quality assurance of health care. At the same time, local government has to be empowered so that it will be capable of providing equitable and efficient health care, which will be accountable for those people in their own community.

Under the current Constitution of the Kingdom of Thailand B.E. 2550 (2007), ordinary people having rights to health care has, if anything, been strengthened. Section 51 provides that “a person shall enjoy an equal right to receive standard public health service, and the indigent shall have the right to receive free medical treatment from a

State infirmary … as provided by law". This provision of the new Constitution, together with the requirements of other recent legislation, forced the government to take new steps to improve the standard of the health care system.

Almost ten years of decentralisation have brought forth several contentious issues concerning the state of local governance in Thailand. The main questions were these: has Thailand's decentralisation really promoted local democracy, and has it responded to the increasing demands from local residents? Assuming that local democracy has been promoted during the past decade, which factors have been responsible for achieving the desired results?

There were also technical questions: how can we quantitatively measure the degree of improvement of local governance in an objective and impartial manner? The capability of a LAO and the capability of its head can be two different matters.

Moreover the capability of a LAO cannot be measured simply by its financial capacity. What is more, so far as LAOs are concerned, independence in decision-making and in policy implementation does not automatically guarantee good results: in assessing effectiveness, some people place the emphasis on 'independence' from external groups, while others stress the importance of the 'result-base'. In short, there is no easy way to measure a LAO's capability.

The National Health Security Act B.E. 2545 (2002), requires government "to set up national health security for people in local areas by encouraging the process of participation according to the readiness, reasonableness, and need of people in such

areas. The Board shall support and cooperate with local government organisations determining regulations so that the said organisations shall implement and manage the national health security system in local areas by earning expenses from the Fund as provided by law" (s. 47).

This provision of the law forced the National Health Security Office to coordinate activities with local governments for co-matching fund according to section 18 "to prescribe the health service provided by a health care unit and network of health care units and to prescribe the standard of implementation, regarding national health security, to be effective" … "to prescribe the rules of fund management and implementation" ... "to encourage and cooperate with local government organisations in implementing and managing the health security system in local areas by considering their readiness, reasonableness, and need, in order to establish national health security residents of such areas as prescribed in section 47" … "to encourage and prescribe rules making it possible that non-profit community organisations, non-profit private organisations and non-profit private sectors implement and manage local funds by considering their readiness, reasonableness, and need, by means and encouraging procedures of participation in order to establish national health security residents of such areas as prescribed in section 47".

Local governments in the developing world are currently facing serious and urgent problems. Poverty, failing infrastructure, and the lack of human and financial resources have impacted negatively on local governments' capacity to perform their mandated functions. The decentralisation movement with the mandate to devolve to the local administration consequently posed a continuing challenge to the authorities concerned.

Authorities need to avoid stirring up disproportionate anxiety and creating unnecessary resistance to change. On the other hand, many crucial issues need to be clarified to ensure that a wide range of stakeholders participate in creating the new system. Since the present health system has been satisfactorily serving the majority of the population, this issue has been even more crucial. Last but not least, the system needs to identify the needs for capacity building to ensure the emergence of an effective decentralised system with various parties properly carrying out their new roles and functions. As a result of this, the Local Fund Health Security (LFHS) has been established by the National Health Security Office (NHSO) since 2006.

The National Health Security Office (NHSO) has supported capita budget 40 baht to the Local Fund Health Security (LFHS). Furthermore, the local government must support budget from local government depending on each level. For example, the three municipality types and a large TAOs must support budget at least 50%, a medium TAOs at least 30%, and a small TAOs at least 20%. Therefore, they have three health promotion projects conducted by the locals, and a funding management project. Both supporting budgets also support the same activities of health promotion and disease prevention, which covered four main areas in relation to supporting health service core package purchasable, supporting health centre services, supporting health promotion and prevention for communities, and supporting management and development of the local fund health security.

5.2 Discussions

5.2.1 Discussion of Decentralisation

Decentralisation is a fundamental part of the state policy; it is a one of main scheme that dedicated in the Constitution of the Kingdom of Thailand B.E. 2540 (1997). The plan and the process of Decentralisation to local government Act B.E. 2542 (1999), was enacted as a sub-constitution law under the Constitution Act. The important principles are the determining procedures and timing period to transfer power from the central government to the local government organisation (LGOs). The Decentralisation plan is an important and a systematic mechanism of the successful Decentralisation policy. Although later it was announced the new Constitution in the year of 2550 (B.E.) (2007), the principle of decentralisation is to remain unchanged additionally. It is a major reason that has been given the decentralisation occurring in the health care reform.

The concept of decentralisation in health, as shown in the decentralisation plan B.E. 2543 (2000), it was the first issue, stated that a public health was a priority, one of which appears in the promotion of quality of life function. The mission identified that several public health activities need to be transferred to the LGOs. This is a part of the decentralisation of health, which is an important and concrete result in a major transformation of the Thai health care reform. Data from the study and follow-up operations shows that after promulgation of the decentralisation plan (first edition) in the year 2543 (2000) was the decentralisation of health. There was yet no clear and concrete progress as such, despite the fact that there were some public health activities to be transferred to local governments. However, the evaluation was not operating in

accordance with the procedures and methods set forth in the Plan. The National Board of Decentralisation (NBD) as a national policy organisation who has acted as supervising and monitoring body of the policy are often called for an operations on the issue of decentralisation in health. As a result, the Ministry of Health (MoPH) has found a way for the decentralisation of health in the year 2549 (2006), from which important issues arise. The proposed models of transferring the mission to the local government on a variety of forms to suit the availability and circumstances of each area of four types: 1) transfer Split 2) transfer to Network 3) establishing a public organisation, and 4) establishment of the Service Delivery Unit.

In case of split transfer model as a separated unit has offered to transfer facilities in areas under the LGOs at different levels. This is an important turning point, and was an idea that is proposed to transfer the health centre to the LGOs at the different levels. The decentralisation plan in Volume 2 was published in the Year 2551 (2008), an issue of the health centre has to transfer to the LGOs where has been clearly defined in the Plan. The Health Centre determines the completed final phase of the plan, is that if the end of year 2553 (2010) can not proceed to completion, and then would be transferred to the Provincial Administrative Organisation (PAO). The direction of health decentralisation is to focus on health centres being transferred to local governments, where it is critical to that time to have undergone significant changes. The NBD has approved the transfer of the health centre to local governments. Then late in the year 2550 (2007) there has been seriously driven and living an intensely driven political leadership of the senior administrators of the MoPH that was successfully completed on issue of the Health Centre transfer to the LGOs.

Regarding on evaluation, found that in the first phase of the transfer of the obstacles in the nature of the connection that many unsettled, however, it was solved by approach manage well on a certain level. Yet the problem is a lack of planning and problem solving in a systematic way is to develop the strength and capabilities of the LGOs staff both the executive and operative level.

The later stage of the Health Centre transfers to local governments scheme has not been driven strongly and clearly enough, especially in the central policy of the MoPH. Additionally, in the local governments administrators that there are unclear in the uncertainty and ensure the sustainability of policies. There are many areas that have changed the attitude of those willing to transfer to the staff recruit plan themselves. As well as finding a way to produce and develop their own staff which would widely affect the overall efficiency and fairness of the health resources allocation and distribution in the countries.

Overall progress on the issue of health decentralisation began to change slowly and has accelerated in the late plan. The health decentralisation that occurred in the Thai health system will have been trying to format a variety of models, such as the Local Area Health Board (LAHB), public organisation hospitals (POH), the Local Fund Health Security, etc. With regard to the Health Centre under the local governments, this is a form of decentralisation by transferring a separate facility that has received attention and watch over both may have the option of decentralised system for health care appropriate to the context and reality. Due to health services that are specific and public goods that greatly affect society. Therefore, they should work together under the

Local Fund Health Security between the Local Administrative Governments (LAO), Health Centres, Community Hospital, and people in community.

Leethongdee (2011) produced a report entitled 'The Implementation of Health Decentralisation: Progress Evaluation and Impact Analysis'. Decentralisation is a fundamental of the state policy; it is one of a main scheme that dedicated in the Constitution of the Kingdom of Thailand B.E. 2540 (1997). The plan and the process of Decentralisation to local government Act B.E. 2542 (1999), was enacted as a sub-constitution law under the Constitution Act. The important principle is to determine the procedures and timing period to transfer power from the central government to the local government organisation (LGOs). The Decentralisation plan is an important and a systematic mechanism of the successful Decentralisation policy.

The direction of health decentralisation is to focus on health centre transferred to local governments is critical to that time have undergone significant changes. The NBD has approved the transfer of the health centre to local governments then in the late of year 2550 (2007) has been seriously driven and living an intensely driven political leadership of the senior administrators of the MoPH were successfully completed on issue of the Health Centre transfer to the LGOs. Perfectly targeted transfers by the total number of 35 and has transferred 22 of the Health Centre has completed at the first time and followed for 6 of the later included as a transfer 28 of the Health Centre to the LGOs. It is an interesting and has been watching a lot of people involved. Regarding on evaluation found that in the first phase of the transfer of the obstacles in the nature of the connection that many unsettled, however, it was solved by approach manage well on a certain level. Yet the problem is a lack of planning and problem solving in a

systematic way to develop the strength and capabilities of the LGOs staff both at the executive and operative level. Including uncertainty and policy advocacy that is not good enough that result of the Health Centre from 7 to target the transfer of the first stage had to cancel the transfer with caused both by reason of the transferor and the transferee of the same. In later stage of the Health Centre transfers to local governments scheme has not been driven very strongly and clearly enough, especially in the central policy of the MoPH.

Additionally in the local governments administrators that they are no clear in the uncertainty and ensure the sustainability of policies, there are many areas has changed the attitude of willing to transfer to the staff recruit plan by them. As well as finding a way to produce and develop their own staff which would affect the overall efficiency and fairness of the health resources allocation and distribution in the countries. So far, there have been some changes on the issue of health decentralisation which tend to be accelerated in new plans. It has been reported that various models, such as the Local Area Health Broad-LAHB, public organisation hospitals-POH, the Local Health Fund-LHF, etc, have been integrated to enhance the health decentralisation. With regard to the Health Centre under the local governments, this is a form of decentralisation by transferring a separate facility that has received attention and watch over both may have the option of decentralised system for health care appropriate to the context and reality. Due to the fact that health services are specific and public, social effects could be aware. Consequently, this study proposed concernedly to review and select a form of decentralisation with a careful analysis and is very comprehensive. It should not be the single blueprint as a model nationwide.

This is an important topic that should be studied and analysed in terms of actual practice in each model carefully. An alternative of the area health administration is one of health decentralisation and would be the alternative of interest can be integrated guidelines and in form decentralisation in different areas but problems and resource are similar constraints. Each form of decentralisation has been a body of knowledge and developed a certain level in Thai society. In the beginning, in the process of decentralisation of health, this is an issue that might be a solution that should be analysed and be taken to a form appropriate to the context of each area. The health decentralisation is based on knowledge, evidence and a participation of stakeholders at all levels.

It should be suggested that the decentralisation cannot be only the single blueprint as a model nationwide, but also can be analysed carefully and comprehensively. Moreover, an actual practice of each model needs to be studied and explored thoroughly. It appears that health administration is one vital aspect of health decentralisation. There are some areas of this aspect which consists of similar problems and resource constraints, that can be integrated and form an alternative interest of decentralisation. As a result, there are emerging forms of decentralisation including knowledge to develop a certain level in Thai society. In the beginning, in the process of decentralisation of health, this is an issue that might be a solution that should be analysed and be taken to perform appropriate context of each area. Thus, to decentralise health, knowledge, evidence and participations of stakeholders at all levels needs to be considered.

5.2.2 Discussion of Universal Coverage (UC)

Achieving universal coverage (UC) is more important as a mean of improving the functions of the insurance markets. A fundamental problem in health insurance is that people know much more about their own health than insurers do. Prospective purchasers can — and do — use this information when making decisions to obtain or retain coverage. Insurers respond to this behaviour by aggressively seeking out healthier purchasers and discouraging the enrolment of those who seem likely to require costly medical care. This inevitable response drives up the costs of marketing and underwriting coverage, which are substantial components of the very high administrative costs of insurance purchased in the non-group market. Compelling everyone — whether healthy or sick — to participate in the insurance market may diminish the use of these wasteful insurer tactics. Mandated participation may also make it easier for insurance regulators to limit the extent to which sicker people pay higher premiums by reducing the risk that healthy people will be driven out of the market. Proponents of an individual mandate hope that such a policy would help to reduce the administrative costs of health insurance in the United States to the considerably lower levels found in other private-insurance–based universal systems.

Although the desire to curtail free riding and strategic behaviour by insurers provides the philosophical underpinnings of the individual mandate, policymakers' interest in the mandate option owes as much to its fiscal implications. Universal coverage achieved through an individual mandate could cost much less than achieving the same result by giving people subsidies for buying coverage voluntarily.

According to Hughes D. and Leethongdee S. researched the universal coverage in Thailand on lessons from Thailand's 30 baht health reforms. Thailand became one of a handful of lower-middle-income countries providing a universal health care coverage when it introduced reforms in 2001. Following the 2006 military coup, the coverage reforms are being reappraised by Thai policymakers. In this research that took the opportunity to assess the programme's achievements and problems. Study findings described the characteristics of the universal insurance programme—the 30 Baht Scheme—and the purchaser-provider system that Thailand adopted. Thailand introduced reforms in 2001 that combined universal coverage with a relatively comprehensive benefit package. Recently, the national press of Thailand featured the reforms prominently, as commentators pondered the effects of the military coup that ousted Prime Minister Thaksin Shinawatra on 19 September 2006. Policymakers and academics have been weighing the achievements and shortcomings of the reforms and offering prescriptions for change. This research assessed the balance sheet and considers what lessons the Thai reforms offer for the broader health policy community (Hughes and Leethongdee, 2007).

The individual mandate responds to two lessons learned from previous efforts to expand coverage. First, although most uninsured people would like to have health insurance, the protection it offers against a potential adverse event is not an urgent priority for all of them. Many in this group are healthy. Most have relatively low incomes and many other demands on their pockets. A decade and a half of incremental expansion efforts have demonstrated that inducing all uninsured people to take up

coverage will require very substantial subsidies — subsidies that might well exceed the cost of the coverage itself.

Compounding this “take-up” problem is a second characteristic of insurance coverage. As the graph shows, even in the group with incomes between 100 and 199% of the federal poverty level, more people currently hold private insurance than are uninsured. Almost all of those who hold private insurance now pay at least a portion of the premium for that coverage. If substantial subsidies were made available for the purchase of new coverage, many who now pay for their own coverage would (eventually) make use of these subsidies instead. Subsidized coverage would crowd out existing private spending, greatly increasing the public cost of an expansion program.

The individual mandate gives policymakers a new tool with which to respond to the take-up and crowd-out problems. Increasing the cost of remaining uninsured by imposing penalties in association with a mandate can promote coverage while keeping subsidy levels in check so that they do not lure the privately insured into the subsidised program. The individual mandate offers new options, but it also introduces risks. The mandate is in many respects analogous to a tax. It requires people to make payments for something whether they want it or not. One important concern is that the government will provide insufficient funds for the subsidies intended to accompany the mandate. In that case, the mandate will act as a very regressive tax, penalizing uninsured people who genuinely cannot afford to buy coverage. This concern has led Massachusetts to create a hardship exemption for its mandate — an escape clause that effectively undoes the mandate if subsidies are insufficient. The ease with which it is

possible to lift the mandate if the legislature fails to appropriate funds may make the individual mandate a rather rickety form of universal coverage.

The tax analogy explains another concern about mandates. Conservative proponents of small government fear that special-interest groups will urge legislatures to broaden the minimum mandated benefit package. The relative invisibility of the mandate "tax" may make it easier for special interests to achieve their goals. The mandate, then, would become a means through which special interests use the government to force transfers of funds from consumers to the health care sector.

A final concern about mandates relates to their administration. Like taxes, a mandate requires enforcement if it is to be effective. Compliance with taxes, as well as with other mandates in current operation, is never perfect. It varies with the rules and procedures governing enforcement. The nature of insurance makes a health insurance mandate particularly tough to enforce. Taxes can be collected retroactively, but to be effective, an insurance mandate should be in place at the beginning of an insurance term, ensuring that people have coverage when an adverse event occurs. Developing a system to promptly identify and penalize scofflaws will take effort and ingenuity, particularly in our diverse and mobile country. It may require a degree of intrusiveness and bureaucracy that some will find unpalatable. If subsidies are generous and benefits valued, voluntary participation will be high and enforcement problems will be manageable. If subsidies are insufficient or benefits are inappropriate, the mandate will be very difficult to enforce and draconian in effect. The risks associated with individual mandates suggest that they are no panacea.

Perhaps the most important benefit of mandates is symbolic. By mandating the purchase of health insurance, governments signal to their citizens that coverage is critical. For many uninsured people as well as their families, communities, and elected representatives, this public commitment to coverage may lead to a reassessment of priorities. Although making mandates functional will be demanding, just passing a mandate may serve an important purpose by moving health insurance higher on the agendas of all these constituencies.

5.2.3 Discussion of Local Fund Health Security

A supportive process this research for health promotion and disease prevention administration of local administrative organisation (LAO) based on local fund health security is the process providing chance for people to join UC policy in local community strengthening and integrating with the community life style and culture. Also the process is integrated with projects and activities on local fund health security plan such as health service core package, purchasable support health centres, health promotion and prevention for communities, and management and development of local fund health security. At the same time, local administrative organisation as municipalities and Tambon Administrative Organisations (TAOs) take the main role on taking care and providing good welfare for people. Thus, health promotion and disease prevention run by these organisations is beneficial for all groups of people to achieve their good health for example mainstay people in community, mainstay people in health promotion group, public health volunteer, elderly people, youth, housewife and woman group etc.

These above people can generate good health development for other people in areas they live in the future. So that local fund health securities which local people help together to plan, establish and manage it by themselves under supporting of other persons and organisations such as health centres, hospital, municipalities, TAOs, etc. Findings from this study led to the health promotion and disease prevention getting continual support from local administrative organisation (LAO) due to it having a social network which brings in any support being available.

According to an evaluation of the local fund health security, Dr. Direk Patmasiriwat, a lecturer of Faculty of Economics, Thammasat University, stated that the local fund health security has enhanced the health promotion activities in many local areas. It is clear that these activities will be extremely successful, if the local administrators have the enthusiasm, and local officials also have strongly supported. So the chief executive of the TAOs and the mayor of municipalities have opportunities to create a local fund health security relating public relations. The collaboration among the TAOs, municipalities, local communities and health centres has been established. Several areas provide new tasks, such as welfare for the patients; a shuttle or an emergency ambulance car. Health behaviours have been dramatically changed such as stopping cigarettes and drugs, reducing salt, controlling weight and using corrected medicines. These activities have affected people clearly because they have got benefit lives. As a result, the LFHS is a good start of the health promotion and disease prevention for Thai citizens (Patmasiriwat et al., 2009).

Following along these lines, Dixon J. and Harrison A. studied “Funding the NHS: a little local difficulty”, found that the media has been full of reports of crisis in the

NHS. Although national analyses suggest that the NHS should be able to cope within the increases in spending it has been given, local pressures can leave parts of the service struggling. Firstly, a change to allocate funds on the basis of population needs has meant that some authorities and trusts have had effective cuts in their budgets, requiring them to trim services. Secondly, the government's insistence on an annual 3.0% increase in efficiency may have resulted in authorities taking short term measures that actually decrease efficiency in the long term. Thirdly, health authorities have had to bear the costs of national targets such as reducing waiting lists and junior doctors' hours as well as local problems such as higher numbers of mentally disordered offenders. However, all these factors can be controlled by national or local management and so their impact is not inevitable. The financial stress experienced by some health authorities and trusts is related not only to low underlying increases in the NHS funding but also to the requirement to increase activity and to absorb the costs of national directives or other local demands. All of these factors, however, can be controlled by the government, the NHS Executive, or the local (Dixon and Harrison, 1997).

Similarly, Ekman et al., (2008) found health financing reform in Vietnam where is undertaking health financing reform with a view to achieve universal coverage of health insurance within the coming years. To date, around half of the population is covered with some type of a health insurance or a prepayment. This review applies a conceptual framework of health financing to provide a coherent assessment of the reforms to date with respect to a set of key policy objectives of health financing, including financial sustainability, efficiency in service provision, and equity in health

financing. Based on the assessment, the review discusses the main implications of the reforms focusing on achievements and remaining challenges, the nature of the Vietnamese reforms in an international perspective, and the role of the government. The main lessons from the Vietnamese experiences, from which other reforming countries may draw, are the need for sustained resource mobilization, comprehensive reform involving all functions of the health financing system, and to adopt a long-term view of health insurance reform. Future analysis should include continued evaluation of the reforms in terms of impacts on key outcomes and the political dimensions of health reform (Ekman et al., 2008).

In addition, the local fund health security (LFHS) in local administrative organisations (LAOs) can manage public health in different levels, such as 1) Providing support on the existing public health services, 2) Establishing a new public health service system, and 3) Purchasing of the existing public health services to be fully run at local level. Participation among multi-sectors, which include government agencies, local authorities, service providers, and community, is a suggested mechanism to develop the public health system and manage the role of health promotion and disease prevention in the local areas.

5.3 Conclusions

In conclusion, it is necessary to strengthen capacity building of local administrative organisations and capability development of public health personnel to support a good public health system at the local levels. Revision of laws and regulations also need to be focused and done together with the decentralisation process among well-prepared local organisations. For monitoring of the outcomes, the ultimate goal of “healthcare

services with equity, good governance, efficiency, good quality, and satisfactory standard" should be used as indicators for the evaluation. Moreover, it is suggested that some issues still need to be further studied for some more clarification and information. These issues are - equity in accessibility to healthcare services, type and cost of the services provided, impacts of the provided services, factors influencing the services quality and standard, public participation and roles of organisations in the public health decentralisation process and system, capacity and capability of local administrative organisations (LAO) on public health system management through their laws and regulations, achievement or failure factors influencing local administrative organisations in providing healthcare services, and information system related to health and healthcare system management.

The research result showed that support by local administrative organisation (LAO) to the health promotion and disease prevention based on local fund health security policy in terms of planning is quite clear on supportive pattern under the UC policy of the organisation. The supportive pattern is rational, sufficient and generates on self care for the people locally. The research suggests that general participated model easily applied for every type of local administrative organisation (LAO) on community project planning is needed. This model should be able to apply by local fund health security in municipality and TAO. At the same time, health promotion and disease prevention understanding and health agreement is needed more formally in terms of activity participation, planning, and supportive policy, especially the supportive policies joined between Local Administrative Organisation (LAO); municipality and

TAO, and Ministry of Public Health; Health Centre, Community Hospital, and Provincial Public Health Office and National Health Security Office (NHSO).

This study showed the role of the local fund health security committees in local government should change and develop knowledge, skill, and training local fund health security management. The interactive of the various components gives rise to a particular strategy, each of which could be shaped and made to function in a variety of ways. Some useful tips are given when shaping up the above-mentioned components, viz.

1. The target committees; emphasis is on the refinement into sub-committees using social criteria. This group is the starting point in the definition of roles and interplay of the other components.

2. The service provider and facilitator; there will be role changes subservient to the new role and responsibility of the people in community.

3. The individual as a society or community member; they should be prepared to take more active role and responsibility in items of health promotion and disease prevention.

4. The local government should have the capability to develop appropriate health plan at local level.

According to the results, some points are recommended to develop as below:

1. Publicising countrywide enough information about local health security project to give people and committee's a fundamental understanding;

2. Providing any Tambon Administrative Organisations (TAOs) which first join the local health security project with a mentoring system to operate their business;

3. Organising the meetings or seminars to the fund committee focusing on writing projects, setting the criteria and indicators to evaluate their projects and outcomes; and

4. Arranging data to be information or database for improvement and development.

As regards policy of administration, this research suggests that, the budget administration should not be obligated with budget year as usual because of some inconvenience that induced the operation lack of smoothness and continuity. As for the practical level, the manual of financial operation should be determined as a guideline for practicum. Furthermore, owing to the misunderstanding of personnel about duplication of projects from fund and their own mission, therefore, this topic should be clarified further before carrying on. Lastly, the public relations about the service of fund, particularly rights benefit package emphasizing various target groups should be continuously propagated.

Interviews reveal that the health service and financial administrations of the Local Fund Health Security (LFHS) and the National Health Security Office (NHSO) should be further developed in areas listed below so as to accommodate demands of the universal coverage (UC):-

(1) Efficient administration system of a municipality and the TAO: including clear administrative policies, cooperation amongst health care providers, continual assessments of available resources and distributions of work load, a supportive culture conducive to adjustment and adaptation of the organisation, and a

provision of training in areas such as planning, service management and information system.

(2) Effective primary care and patient referral systems: including an appropriate work load particularly in health centres and community hospitals, a referral protocol, standards of care, a connectivity and sharing of information, a service planning, and situational adjustments in the local areas.

(3) Human resource management: including an effective utilisation of manpower, fair employment and management of manpower, a provision of on-the-job training, and a promotion of egalitarian working culture in the community.

(4) Financial management: including a development of transparent financial system which promotes fair budget allocation and in time payment systems for health care service in the community, health centre, and community hospital.

(5) Governance of the system: including a good supervision system for quality of care and a continuation of policies and practices from the community leader, health officers, and local government officers.

(6) Good knowledge and true understanding: including a dissemination of correct information about, for instance, insurance status and a promotion of positive attitudes towards health problem solving and local fund health security planning.

In addition, the community networking relationship has collected an action for health promotions association in their lives. There is shared knowledge within their communities, such as: exercise health association has established a health system in order to encourage health coaching in rural families.

Recommendations to assure the local fund health security committee on the benefit of the local fund health security were made as the first priority. In addition, supportive plans on increasing their role perception and managing the manpower were proposed.

The findings of this study could emerge the model of the WLFHS stakeholders. It is clear that the policy marker in the TAO must cooperate with committees of the LFHS, people in a community, and also the academy and NHSO branch as a following figure 5.1;

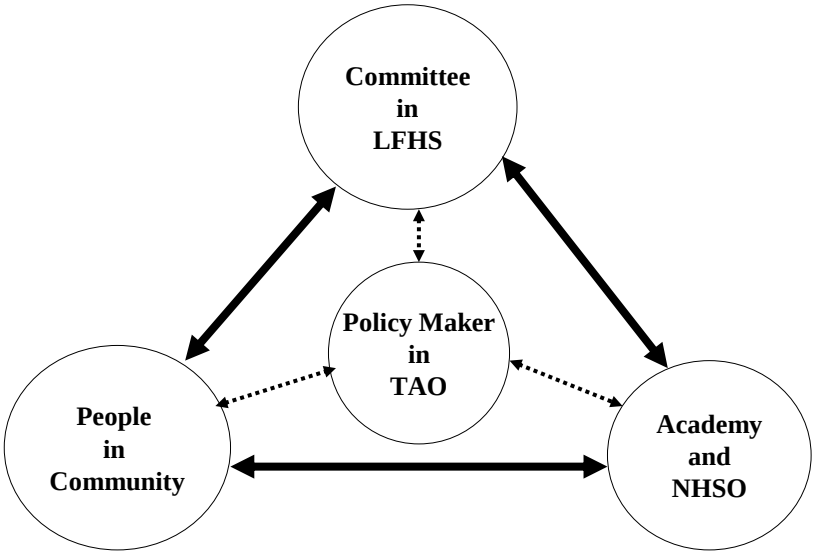

Figure 5.1: The model of the WLFHS stakeholders

Consequently, this study argues that to be successful in the WLFHS process it should look at not only the participation of stakeholders as mentioned above, but also preparation and knowledge are need to be highlighted. Moreover, outcome indicators should be concerned because all activities in relation to the WLFHS have to be

evaluated and reported. The cooperation between stakeholders of the WLFHS has been smooth through out the process because every agency feels as a team, a situation analysis is a prior activity, and there are interactions among members. There must be a preparation stage because the awareness of individuals has been transformed. In addition, the relevant indicators of all performances need to be conducted regarding such as plans, activities, budget, and role. This study could perform the implication of the practical guide line of the WLFHS process as a follow figure 5.2;

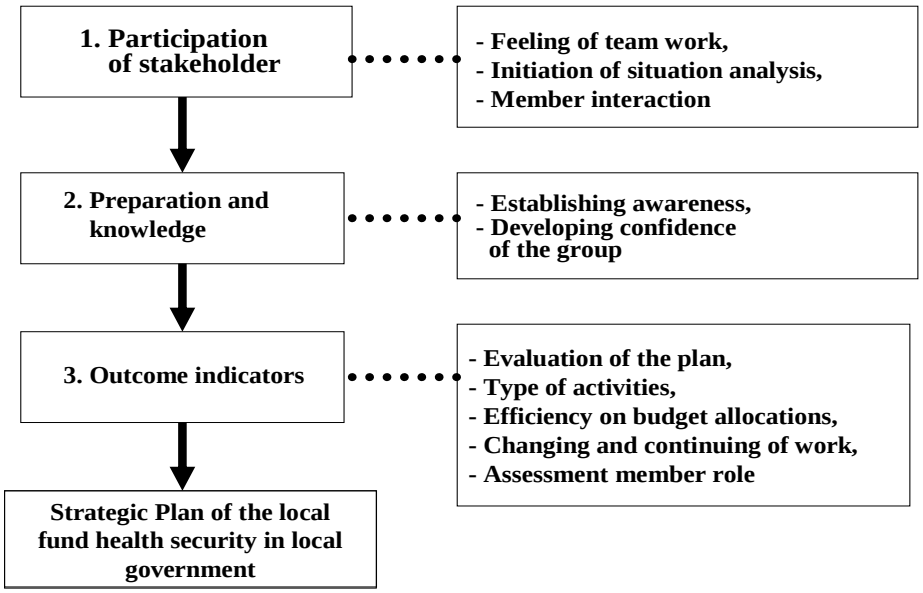

Figure 5.2: Implication of Practical guide line of the WLFHS process

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APPENDICES

Appendex I

Questionnaire

Thailand Universal Coverage Health Care Reforms: Researching the Role of the Local Fund Health Security in Local Government Purchasers in the Northeastern region of Thailand

Information

This project aims to study in the Thailand's Universal Coverage Health Care Reforms: Researching the Role of the Local Fund Health Security in Local Government Purchasers in the North-eastern region of Thailand. The results of this study will be applied to the role of the local fund health security in local government — the Tambon Administrative Organisations (TAOs) and municipalities — as a component of Thailand's universal coverage health care reforms in the North-eastern region of Thailand. You have been chosen because you have had experiences of working in the local fund health security. Please administer the questions from you perceptions. The answers are not right or wrong and will be kept strictly confidential. There are 7 parts;

Part 1 Demographic data of the local government 12 questions

Part 2 Establishing and budget supporting of the Local Fund Health Security 9 questions

Part 3 Committee of the Local Fund Health Security 11 questions

Part 4 Planning of the Local Fund Health Security 7 questions

Part 5 Supported Activities from the Local Fund Health Security 4 questions

Part 6 Budget Payment of the Local Fund Health Security 9 questions

Part 7 Problems and obstacles of management process of the Local Fund Health Security (0pen – ended question)

Thank you very much for your participation.

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Thailand Universal Coverage Health Care Reforms:

Researching the Role of the Local Fund Health Security

in Local Government Purchasers in the North-eastern region of Thailand

****

Please answer all of the questions yourself by put ✓in a box (❒), or fill in a gab.

Part 1 Demographic data of the local government

1. Gender ❒ 1. Male ❒ 2. Female

2. Age …… years …… months

3. Marital status ❒ 1. Single ❒ 2. Marriage ❒ 3. Widow/Divorce/Separation

4. Education ❒ 1. No education ❒ 2. Primary school

❒ 3. Junior high school ❒ 4. Senior high school

❒ 5. Diploma…… ❒ 6. Bachelor degree (programme)….

❒ 7. Post-graduation degree (programme)……

5. Position ❒ 1. Mayor ❒ 2. Municipal clerk

❒ 3. Chief executive of the TAO

❒ 4. Member of the TAO

❒ 5. Chief administrator of the Municipality

❒ 6. Chief administrator of the TAO

❒ 7. Director of health department

❒ 8. Health officer

❒ 9. Other……..

6. Positional period……..years……..months

7. Income from local government……..bahts/month

8. Level of the local government

❒ 1. Small TAO

❒ 2. Medium TAO

❒ 3. Large TAO

❒ 4. Tambon Municipality

❒ 5. City Municipality

❒ 6. Town Municipality

9. Position of the committee on the Local Fund Health Security

❒ 1. Chairman ❒ 2. Vice-chairman

❒ 3. Committee ❒ 4. Committee and Secretary

❒ 5. Other……..

10. Receiving information about the Local Fund Health Security

❒ 1. Never received ❒ 2. Received from… (Can answer more than 1 choice)

❒ 2.1 Office of the local government

❒ 2.2 Other offices ……..

❒ 2.3 Information

❒ 2.4 Radio/Television

❒ 2.5 Newspaper

❒ 2.6 Others…….

11. Local Fund Health Security Performance Training

❒ 1. Never received ❒ 2. Received from…

Host of training courses

……..

……..

Topics of training courses

……..

……..

12. Local Fund Health Security Evaluation

❒ 1. Never evaluated

❒ 2. Passed evaluation at level ❒ 1. A+ ❒ 2. A ❒ 3. B ❒ 4. C

Scores.....

Part 2 Establishing and budget supporting of the Local Fund Health Security

1. When the Local Fund Health Security was established.....

2. Having health data before Local Fund Health Security established

❒ 1. Not have

❒ 2. Have (Can answer more than 1 choice)

❒ 2.1 Community health data

❒ 2.2 Community health plans

❒ 2.3 Strategy maps

❒ 2.4 Others.....

3. Preparation training of chair, health officer and security before establishing

❒ 1. Yes

❒ 2. No, because.....

……

4. Budget allocation from National Health Security Office (NHSO) in budget year 2553

…….. bahts

5. Budget subsidize from Local Government and community

❒ 1. Municipality or the TAO……(%) (…….bahts)

❒ 2. Community or other local funds (…….bahts), from

❒ 2.1 Robes offering ceremony ❒ 2.2 People investment

❒ 2.3 Sujja community fund ❒ 2.4 Village bank project

❒ 2.5 Garbage fund project

❒ 2.6 Others.....

6. Period of Budget allocation from National Health Security Office (NHSO)

❒ 1. October–December 2009 (2552) ❒ 2. January – March 2010 (2553)

❒ 3. April – June 2010 (2553) ❒ 4. July – September 2010 (2553)

7. Report management program online via http://tobt.nhso.go.th/

❒ 1. Yes

❒ 2. No, because ……

8. From 7. the Local Fund Health Security data record

❒ 1. Completed and Present ❒ 2. Completed but Not present

❒ 3. Uncompleted but Present ❒ 4. Uncompleted and Not present

9. Data type recorded online via http://tobt.nhso.go.th/

❒ 1. Data bases

❒ 2. Activity report

❒ 3. Budget report

❒ 4. Others.....

Part 3 Committee of the Local Fund Health Security

1. Local Fund Health Security Subcommittee Delegation

❒ 1. Yes, because.....

❒ 2. No, because..

2. Local Fund Health Security Committee Delegation Following Criteria of National Health Security Office (NHSO)

❒ 1. Yes

❒ 2. No, because..

3. Local Fund Health Security Secretary

❒ 1. Municipal clerk/TAO clerk

❒ 2. Others, position.....

4. Frequency of Local Fund Health Security Committee Meeting

❒ 1. Never, because.....

❒ 2. Every month

❒ 3. Every 2 months

❒ 4. Every 3 months

❒ 5. Other.....

5. Local Fund Health Security Committee Resignation

❒ 1. No

❒ 2. Yes, because…….....**.....**

6. Management Process of Health Community Plan

❒ 1. Yes

❒ 2. No, because.....

7. Accepting Role of Local Fund Health Security Committee

❒ 1. Do not know, because.....

❒ 2. Not confident, because.....

❒ 3. Confident, because.....**.....**

8. To know how to pay Local Fund Health Security Budget

❒ 1. No, because.....

❒ 2. Not confident, because.....

❒ 3. Yes, because.....**.....**

9. Management Ability of Local Fund Health Security on need assessment and problem in community

❒ 1. No, because.....

❒ 2. Not confident, because.....

❒ 3. Yes, because.....**.....**

10. Committees of the for Local Fund Health Security Attend Training and Seminar on Knowledge Management

❒ 1. Nobody, because.....

❒ 2. Someone, because.....

❒ 3. Everyone, because.....

11. Regulations of the Local Fund Health Security Budget from Agreement of Committee

❒ 1. Yes

❒ 2. No, because.....

Part 4 Planning of the Local Fund Health Security

1. Period of doing Local Fund Health Security Plan

❒ 1. Before allocate budget from National Health Security Office (NHSO)

❒ 1.1 October – December 2552 ❒ 1.2 January – March 2553

❒ 1.3 April – June 2553 ❒ 1.4 July – September 2553

❒ 2. After allocate budget from National Health Security Office (NHSO)

❒ 2.1 October – December 2552 ❒ 2.2 January – March 2553

❒ 2.3 April – June 2553 ❒ 2.4 July – September 2553

2. Payment methods for running plans of Local Fund Health Security

❒ 1. Cash payment

❒ 2. Transfer banking

❒ 3. Cheque payment

❒ 4. Bill of exchange

❒ 5. Postal money order

❒ 6. Others.....

3. Local Fund Health Security Planning Coordination

❒ 1. Only Local Fund Health Security Committee

❒ 2. Other people.....

4. Local Fund Health Security Planning Instrument

❒ 1. Health Community Plan, because……

❒ 2. Strategic Route Maps, because……

5. Problem Analysis and Priority Setting for Planning

❒ 1. Did not analyze, because ……

❒ 2. Analyze, because.……

6. Types of Local Fund Health Security Plan and Project

❒ 1. Processing by community and used resources in community

❒ 2. Integrate with projects and local government plan

❒ 3. Projects and plan which supported from others

❒ 4. Others.....

7. Projects and Activities on Local Fund Health Security Plan (Can answer more than 1)

❒ 1. Health service core package purchasable (……..%)

❒ 2. Support health centre (……..%)

❒ 3. Health promotion and prevention for communities (……..%)

❒ 4. Manage and develop Local Fund Health Security (……..%)

❒ 5. Others..... (……..%)

Part 5 Supported Activities from the Local Fund Health Security

1. Activities and project from purchasing core health service package

❒ 1. Activities or Projects about Mother and Child

.....

❒ 2. Activities or Projects about Aging people

.....

❒ 3. Activities or Projects about Disable and Crippled People

.....

❒ 4. Activities or Projects about Occupational Risk Workers

.....

❒ 5. Activities or Projects about Chronic Disease Patients

.....

2. Activities and project from budget which support health centre

❒ 1. Activities or Projects about Health Promotion

.....

❒ 2. Activities or Projects about Disease Prevention

.....

❒ 3. Activities or Projects about Rehabilitation

.....

❒ 4. Activities or Projects about Primary Medical Care

.....

3. Activities and project from health promotion and prevention for communities

❒ 1. Activities or Projects about Health Promotion

.....

❒ 2. Activities or Projects about Disease Prevention and

.....

❒ 3. Activities or Projects about Rehabilitation

.....

❒ 4. Activities or Projects about Folk Wisdom Promotion

.....

4. Activities and project of management and development of the Local Fund Health Security

❒ 1. Compensation for meeting

❒ 2. Buy durable articles, such as…….....

❒ 3. Others compensation, such as……

❒ 4. Paid for develop Local Fund Health Security committee, such as……

❒ 5. Others……

Part 6 Budget Payment of the Local Fund Health Security

1. Getting budget of the Local Fund Health Security

❒ 1. Cash payment ❒ 2. Transfer banking

❒ 3. Cheque payment ❒ 4. Bill of exchange

❒ 5. Postal money order

❒ 6. Others.....

2. Evident on receipts when payment

❒ 1. Every time

❒ 2. Sometime, because.....

❒ 3. Never, because.....

3. Saving cash from chairman or committee or secretary of the LFHS

❒ 1. No, because.....

❒ 2. Yes, because……... Amount.....bahts

4. How to make account book of Local Fund Health Security

❒ 1. Making together with local government account book, because……

❒ 2. Separating from local government account book, because……

❒ 3. Others.....

5. Recording account book by web side http://tobt.nhso.go.th/

❒ 1. Done

❒ 2. Not yet, because.....

6. Frequency of account book reporting to chairman or committee or secretary of the Local Fund Health Security (LFHS)

❒ 1. Every week ❒ 2. Every 15 days

❒ 3. Every month ❒ 4. Every 2 months

❒ 5. Others.....

7. Print account book every month report to chairman or committee or secretary of the Local Fund Health Security (LFHS)

❒ 1. Done

❒ 2. Not yet, because.....

8. Printing account from online system was signed by a responsible person

❒ 1. Done

❒ 2. Not yet, because.....

9. Significant factors to performance an annual report of the LFHS

❒ 1. General data

❒ 2. Results of project performance

❒ 3. Financial situation report

❒ 4. Other.....

Part 7 Problems and obstacles of management process of the Local Fund Health Security (LFHS)

.....

.....

.....

.....

.....

.....

Thank you very much

เลขที่แบบสอบถาม ❐❐❐

แบบสอบถามการวิจัย

“การปฏิรูปหลักประกันสุขภาพแห่งชาติ : บทบาทขององค์กรปกครองส่วนท้องถิ่นในการดำเนินงานกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ ในภาคตะวันออกเฉียงเหนือ ประเทศไทย”

(Thailand Universal Coverage Health Care Reforms: Researching the Role of the Local Fund Health Security in Local Government Purchasers in the Northeastern region of Thailand)

คำชี้แจงในการตอบแบบสอบถาม

1. แบบสอบถามนี้มีทั้งหมด 14 หน้า
2. แบบสอบถามแบ่งออกเป็น 7 ส่วน คือ

   ส่วนที่ 1 ข้อมูลลักษณะทางประชากรของเทศบาล และองค์การบริหารส่วนตำบล (อบต.)

   ส่วนที่ 2 ข้อมูลเกี่ยวกับการจัดตั้งและการสนับสนุนงบประมาณของกองทุนระบบประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่

   ส่วนที่ 3 ข้อมูลเกี่ยวกับคณะกรรมการของกองทุนระบบประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่

   ส่วนที่ 4 ข้อมูลเกี่ยวกับการจัดทำแผนงานของกองทุนระบบประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่

   ส่วนที่ 5 ข้อมูลเกี่ยวกับประเภทของกิจกรรมที่ขอสนับสนุนงบประมาณจากกองทุนระบบประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่

   ส่วนที่ 6 ข้อมูลเกี่ยวกับการใช้จ่ายงบประมาณของกองทุนระบบประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่

   ส่วนที่ 7 ปัญหาและอุปสรรคของกระบวนการบริหารจัดการในกองทุนระบบประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่

3. ขอให้ท่านตอบตามความเป็นจริงและตอบทุกข้อ โดยข้อมูลที่ได้จะปกปิดไว้เป็นความลับ และไม่มีผลต่อการดำเนินงานของท่าน ซึ่งข้อมูลที่ได้นั้นจะนำเสนอในภาพรวม เพื่อเป็นประโยชน์ต่อการดำเนินงานเกี่ยวกับกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ อันจะเป็นข้อมูลเพื่อนำเสนอผู้เกี่ยวข้องในการแก้ไขปัญหาต่อไป

ขอขอบพระคุณที่ท่านให้ความกรุณาตอบแบบสอบถาม

คำชี้แจง : ให้ทำเครื่องหมาย ✓ลงใน ❒ หน้าข้อความที่ตรงกับความเป็นจริงของท่าน

ส่วนที่ 1 ข้อมูลลักษณะทางประชากรของเทศบาล และองค์การบริหารส่วนตำบล (อบต.)

1. เพศ ❒ 1. ชาย ❒ 2. หญิง

2. อายุ ..... ปี ..... เดือน

3. สถานภาพสมรส ❒ 1. โสด ❒ 2. สมรส ❒ 3. ม่าย/หย่า/แยก

4. ระดับการศึกษา ❒ 1. ไม่ได้เรียน ❒ 2. ประถมศึกษา
❒ 3. มัธยมศึกษาตอนต้น ❒ 4. มัธยมศึกษาตอนปลาย
❒ 5. ประกาศนียบัตร/อนุปริญญา สาขา.....
❒ 6. ปริญญาตรี สาขา.....
❒ 7. สูงกว่าปริญญาตรี สาขา.....

5. ตำแหน่งปัจจุบัน ❒ 1. นายกเทศมนตรี
❒ 2. สมาชิกสภาเทศบาล
❒ 3. นายกองค์การบริหารส่วนตำบล
❒ 4. สมาชิกสภาองค์การบริหารส่วนตำบล
❒ 5. ปลัดเทศบาล
❒ 6. ปลัดองค์การบริหารส่วนตำบล
❒ 7. ผู้อำนวยการกองสาธารณสุขและสิ่งแวดล้อม
❒ 8. เจ้าพนักงานสาธารณสุขชุมชน
❒ 9. อื่น ๆ ระบุ.....

6. ระยะเวลาในการดำรงตำแหน่งปัจจุบัน.....ปี.....เดือน

7. ปัจจุบันท่านมีรายได้จากการปฏิบัติงานในองค์กรปกครองส่วนท้องถิ่น.....บาทต่อเดือน

8. องค์กรปกครองส่วนท้องถิ่นของท่านนั้น เป็นหน่วยงานที่มีขนาดหรือระดับใด

❒ 1. อบต. ขนาดเล็ก ❒ 2. อบต. ขนาดกลาง
❒ 3. อบต. ขนาดใหญ่ ❒ 4. เทศบาลตำบล
❒ 5. เทศบาลเมือง ❒ 6. เทศบาลนคร

9. การดำรงตำแหน่งคณะกรรมการบริหารกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่

❒ 1. ประธานกรรมการ

❒ 2. รองประธานกรรมการ

❒ 3. กรรมการ

❒ 4. กรรมการและเลขานุการ

❒ 5. อื่น ๆ ระบุ……..

10. ท่านได้เคยรับข้อมูลข่าวสารเกี่ยวกับกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่จากที่ใด

❒ 1. ไม่เคยได้รับ ❒ 2. เคยได้รับ โดยได้รับจากแหล่งใด (ตอบได้มากกว่า 1 ข้อ)

❒ 2.1 หน่วยงานของตนเอง

❒ 2.2 หน่วยงานอื่น ระบุ……

❒ 2.3 ป้ายประชาสัมพันธ์

❒ 2.4 วิทยุ/โทรทัศน์

❒ 2.5 หนังสือพิมพ์

❒ 2.6 อื่น ๆ ระบุ…….

11. ท่านได้เคยเข้ารับการฝึกอบรมเกี่ยวกับการดำเนินงานเกี่ยวกับกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ หรือไม่

❒ 1. ไม่เคย ❒ 2. เคย

หน่วยงานที่จัดอบรมคือ

……..

……..

……..

หัวข้อที่จัดอบรมคือ

……..

……..

……..

12. กองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ของท่าน ได้ผ่านการประเมินกระบวนการบริหารจัดการของคณะกรรมการแล้วหรือไม่

❒ 1. ยังไม่ผ่านการประเมิน

❒ 2. ผ่านการประเมินแล้ว โดยได้ระดับ ❒ 1. A+ ❒ 2. A ❒ 3. B ❒ 4. C

โดยได้คะแนนจำนวน.....คะแนน

ส่วนที่ 2 ข้อมูลเกี่ยวกับการจัดตั้งและการสนับสนุนงบประมาณของกองทุนระบบประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่

1. หน่วยงานของท่านได้เริ่มดำเนินการจัดตั้ง “กองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่” มาตั้งแต่ เดือน.....พ.ศ. .....

2. ท่านมีข้อมูลสุขภาพชุมชน แผนสุขภาพชุมชน หรือแผนที่ทางเดินยุทธศาสตร์ ก่อนมีการจัดตั้งกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่หรือไม่

❒ 1. ไม่มีเลย

❒ 2. มี ได้แก่ (ตอบได้มากกว่า 1 ข้อ)

❒ 2.1 มีข้อมูลสุขภาพชุมชน

❒ 2.2 มีแผนสุขภาพชุมชน

❒ 2.3 มีแผนที่ทางเดินยุทธศาสตร์

❒ 2.4 อื่น ๆ ระบุ.....

3. ประธานกรรมการ เจ้าหน้าที่สาธารณสุข และเลขานุการ ได้เข้ารับการอบรมเตรียมความพร้อม ก่อนมีการจัดตั้งกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ของท่านหรือไม่

❒ 1. ได้เข้ารับการอบรม

❒ 2. ไม่ได้เข้ารับการอบรม สาเหตุเพราะ.....

……

4. ในปีงบประมาณ 2553 กองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ของท่านได้รับการจัดสรรงบประมาณจากสำนักงานหลักประกันสุขภาพแห่งชาติ (สปสช.) เป็นจำนวนเงินทั้งสิ้น .....บาท

5. หน่วยงานของท่านและชุมชนได้สมทบเงินอุดหนุนหรืองบประมาณให้กับกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่อย่างไร

❒ 1. จากหน่วยงาน (เทศบาล หรือ อบต.) ร้อยละ.....(จำนวนเงิน.....บาท)

❒ 2. จากประชาชน ชุมชน หรือกองทุนอื่น ๆ ในชุมชน ร้อยละ.....(จำนวนเงิน.....บาท)

ซึ่งเป็นแหล่งเงินจากที่ใด (ตอบได้มากกว่า 1 ข้อ)

❒ 2.1 จากการทอดผ้าป่า ❒ 2.2 จากการระดมทุนจากประชาชน

❒ 2.3 จากโครงการกองทุนเงินสัจจะหมู่บ้าน ❒ 2.4 จากโครงการธนาคารหมู่บ้าน

❒ 2.5 จากโครงการกองทุนขยะ

❒ 2.6 อื่น ๆ ระบุ.....

6. กองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ของท่านได้รับการจัดสรรงบประมาณจากสำนักงานหลักประกันสุขภาพแห่งชาติ (สปสช.) ในช่วงระยะเวลาใด

❒ 1. เดือนตุลาคม – ธันวาคม 2552 ❒ 2. เดือนมกราคม – มีนาคม 2553

❒ 3. เดือนเมษายน – มิถุนายน 2553 ❒ 4. เดือนกรกฎาคม – กันยายน 2553

7. กองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ของท่าน มีระบบรายงานของกองทุนผ่านโปรแกรมบริหารจัดการกองทุนในระบบออนไลน์ http://tobt.nhso.go.th/ หรือไม่

❒ 1. มี (ให้ตอบข้อ 8. ด้วย)

❒ 2. ไม่มี สาเหตุเพราะ.....

.....

8. จากข้อ 7. กองทุนของท่านได้มีการบันทึกข้อมูลครบทุกรายการและเป็นปัจจุบันหรือไม่

❒ 1. ครบทุกรายการและเป็นปัจจุบัน

❒ 2. ครบทุกรายการแต่ไม่เป็นปัจจุบัน

❒ 3. ไม่ครบทุกรายการแต่เป็นปัจจุบัน

❒ 4. ไม่ครบทุกรายการและไม่เป็นปัจจุบัน

9. กองทุนของท่านได้มีการบันทึกข้อมูลเกี่ยวกับอะไรบ้าง ผ่านโปรแกรมบริหารจัดการกองทุนในระบบออนไลน์ที่เวบไซต์ http://tobt.nhso.go.th/ (ตอบได้มากกว่า 1 ข้อ)

❒ 1. ข้อมูลพื้นฐาน

❒ 2. รายงานกิจกรรม

❒ 3. รายงานด้านการเงิน

❒ 4. อื่น ๆ ระบุ.....

ส่วนที่ 3 ข้อมูลเกี่ยวกับคณะกรรมการของกองทุนระบบประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่

1. มีการแต่งตั้งคณะอนุกรรมการหรือคณะทำงานอื่น ๆ ในกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ หรือไม่

❒ 1. ไม่มี สาเหตุเพราะ.....

❒ 2. มี ได้แก่.....

2. การแต่งตั้งคณะกรรมการบริหารกองทุน เป็นไปตามหลักเกณฑ์ที่ สปสช. กำหนดหรือไม่

❒ 1. เป็นไปตามเกณฑ์ที่กำหนด

❒ 2. ไม่เป็นไปตามเกณฑ์ที่กำหนด สาเหตุเพราะ.....

……

3. กองทุนของท่านได้มีการแต่งตั้งใครทำหน้าที่เป็นกรรมการและเลขานุการ

❒ 1. ปลัดเทศบาล/ปลัดองค์การบริหารส่วนตำบล

❒ 2. เจ้าหน้าที่อื่น ตำแหน่ง.....

เหตุผลในการแต่งตั้งบุคคลดังกล่าว.....

4. มีการประชุมคณะกรรมการบริหารกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ อย่างไรบ้าง

❒ 1. ไม่เคยประชุม สาเหตุเพราะ.....

❒ 2. ประชุมทุกเดือน

❒ 3. ประชุมทุก 2 เดือน

❒ 4. ประชุมทุก 3 เดือน

❒ 5. อื่น ๆ ระบุ.....

5. ในช่วงระยะเวลาดำเนินงานของกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ ในหนึ่งปีที่ผ่านมานั้น มีกรรมการท่านใดลาออกหรือไม่

❒ 1. ไม่มี

❒ 2. มี ได้แก่ผู้แทนจากตำแหน่งอะไร.....

สาเหตุในการลาออก เพราะ.....

6. คณะกรรมการบริหารกองทุน มีกระบวนการจัดทำแผนสุขภาพชุมชนหรือไม่

❒ 1. มี

❒ 2. ไม่มี สาเหตุเพราะ.....

7. คณะกรรมการบริหารกองทุน รู้ถึงบทบาทหน้าที่ของกรรมการในการบริหารในกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่

❒ 1. ไม่รู้ สาเหตุเพราะ.....

❒ 2. ไม่แน่ใจ เนื่องจาก.....

❒ 3. รู้ เนื่องจาก.....

8. คณะกรรมการบริหารกองทุนมีความรู้ ความเข้าใจในเรื่องวัตถุประสงค์ กลุ่มเป้าหมาย และการใช้จ่ายงบประมาณในกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่

❒ 1. ไม่มี สาเหตุเพราะ.....

❒ 2. ไม่แน่ใจ เนื่องจาก.....

❒ 3. มี เนื่องจาก.....

9. คณะกรรมการบริหารกองทุน มีศักยภาพในการบริหารจัดการให้เป็นไปตามวัตถุประสงค์ของกองทุนสอดคล้องกับสภาพปัญหาและความต้องการของชุมชนหรือไม่

❒ 1. ไม่มี สาเหตุเพราะ.....

❒ 2. ไม่แน่ใจ เนื่องจาก.....

❒ 3. มี เนื่องจาก.....

10. คณะกรรมการบริหารกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ของท่าน ได้ผ่านการอบรมหรือประชุมหรือสัมมนาหรือเวทีแลกเปลี่ยนเรียนรู้หรือไม่

❒ 1. ไม่มีใครเคยผ่านการอบรมหรือประชุมหรือสัมมนาหรือเวทีแลกเปลี่ยนเรียนรู้ สาเหตุเพราะ.....

❒ 2. มีบางคนเคยผ่านการอบรมหรือประชุมหรือสัมมนาหรือเวทีแลกเปลี่ยนเรียนรู้ สาเหตุเพราะ.....

❒ 3. ทุกคนเคยผ่านการอบรมหรือประชุมหรือสัมมนาหรือเวทีแลกเปลี่ยนเรียนรู้ สาเหตุเพราะ.....

11. คณะกรรมการบริหารกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ของท่าน ได้มีการจัดทำระเบียบการใช้เงินกองทุน ที่ผ่านมติเห็นชอบจากคณะกรรมการกองทุนหรือไม่

❒ 1. มี

❒ 2. ไม่มี สาเหตุเพราะ.....

ส่วนที่ 4 ข้อมูลเกี่ยวกับการจัดทำแผนงานของกองทุนระบบประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่

1. คณะกรรมการบริหารกองทุนได้จัดทำแผนงานกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ในช่วงระยะเวลาใด

❒ 1. ก่อนได้รับการจัดสรรงบประมาณจากสำนักงานหลักประกันสุขภาพแห่งชาติ (สปสช.) ในช่วงระยะเวลาใด

❒ 1.1 เดือนตุลาคม – ธันวาคม 2552 ❒ 1.2 เดือนมกราคม – มีนาคม 2553

❒ 1.3 เดือนเมษายน – มิถุนายน 2553 ❒ 1.4 เดือนกรกฎาคม – กันยายน 2553

❒ 2. หลังจากที่ได้รับการจัดสรรงบประมาณจากสำนักงานหลักประกันสุขภาพแห่งชาติ (สปสช.) ในช่วงระยะเวลาใด

❒ 2.1 เดือนตุลาคม – ธันวาคม 2552 ❒ 2.2 เดือนมกราคม – มีนาคม 2553

❒ 2.3 เดือนเมษายน – มิถุนายน 2553 ❒ 2.4 เดือนกรกฎาคม – กันยายน 2553

2. กองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ของท่าน มีวิธีการจ่ายเงินในการดำเนินงานตามแผนงานของกองทุนอย่างไร (ตอบได้มากกว่า 1 ข้อ)

❒ 1. จ่ายเป็นเงินสด

❒ 2. จ่ายโดยการโอนผ่านทางธนาคาร

❒ 3. จ่ายเป็นเช็ค

❒ 4. จ่ายเป็นตั๋วแลกเงิน

❒ 5. จ่ายเป็นธนาณัติ

❒ 6. อื่น ๆ ระบุ.....

3. ในการจัดทำแผนงานกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ มีใครที่เข้ามามีส่วนร่วมในการจัดทำแผนงานดังกล่าว

❒ 1. มีแต่คณะกรรมการบริหารกองทุนเท่านั้น

❒ 2. ให้บุคคลอื่นเข้ามามีส่วนร่วมด้วย ได้แก่ใครบ้าง.....

4. ในการจัดทำแผนงานกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ ท่านได้ใช้แผนสุขภาพชุมชน หรือแผนที่ทางเดินยุทธศาสตร์หรือไม่

❒ 1. ใช้แผนสุขภาพชุมชน สาเหตุเพราะ.....
……

❒ 2. ใช้แผนที่ทางเดินยุทธศาสตร์ สาเหตุเพราะ……
……

5. ท่านได้มีการวิเคราะห์ปัญหาและจัดลำดับความสำคัญของปัญหา เพื่อใช้เป็นแนวทางในการจัดทำแผนงานกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่หรือไม่

❒ 1. ไม่ได้วิเคราะห์ สาเหตุเพราะ.....
……

❒ 2. วิเคราะห์ สาเหตุเพราะ…….....
……

6. การเขียนแผนงาน/โครงการของกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ ของท่านเป็นแผนงาน/โครงการประเภทใด

❒ 1. แผนงาน/โครงการที่สามารถดำเนินการได้เองโดยชุมชน โดยใช้ทรัพยากรที่มีในชุมชน

❒ 2. แผนงาน/โครงการที่บูรณาการกับแผนงาน/โครงการของหน่วยงาน

❒ 3. แผนงาน/โครงการที่ขอรับการสนับสนุนงบประมาณจากองค์กรต่าง ๆ

❒ 4. อื่น ๆ ระบุ.....

7. ในแผนงานกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ มีกิจกรรมหรือโครงการในการดำเนินงานครอบคลุมอะไรบ้าง และเป็นสัดส่วนเท่าไรของงบประมาณกองทุน (ตอบได้มากกว่า 1 ข้อ)

❒ 1. การจัดซื้อบริการสาธารณสุขตามชุดสิทธิประโยชน์ (ร้อยละ.....)

❒ 2. การสนับสนุนงบประมาณแก่หน่วยบริการสาธารณสุข (ร้อยละ.....)

❒ 3. การสร้างเสริมสุขภาพโดยประชาชนและชุมชนท้องถิ่น (ร้อยละ.....)

❒ 4. การบริหารจัดการกองทุนและพัฒนาระบบบริหารจัดการ (ร้อยละ.....)

❒ 5. อื่น ๆ (ระบุ)..... (ร้อยละ.....)

ส่วนที่ 5 ข้อมูลเกี่ยวกับประเภทของกิจกรรมที่ขอสนับสนุนงบประมาณจากกองทุนระบบประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่

1. ในกิจกรรม **“การจัดซื้อบริการสาธารณสุขตามชุดสิทธิประโยชน์”** กองทุนของท่านได้ดำเนินงานเกี่ยวกับกิจกรรมหรือโครงการอะไรบ้าง ให้กับกลุ่มเป้าหมายดังต่อไปนี้

❒ 1. กลุ่มแม่และเด็ก

มีกิจกรรมหรือโครงการ.....

❒ 2. กลุ่มผู้สูงอายุ

มีกิจกรรมหรือโครงการ.....

❒ 3. กลุ่มผู้พิการและทุพพลภาพ

มีกิจกรรมหรือโครงการ.....

❒ 4. กลุ่มผู้ประกอบอาชีพที่มีความเสี่ยง

มีกิจกรรมหรือโครงการ.....

❒ 5. กลุ่มผู้ป่วยโรคเรื้อรัง

มีกิจกรรมหรือโครงการ.....

2. ในกิจกรรม **“การสนับสนุนงบประมาณแก่หน่วยบริการสาธารณสุข”** กองทุนของท่านได้ดำเนินงานเกี่ยวกับกิจกรรมหรือโครงการอะไรบ้าง

❒ 1. การส่งเสริมสุขภาพ

มีกิจกรรมหรือโครงการ.....

❒ 2. การป้องกันควบคุมโรค

มีกิจกรรมหรือโครงการ.....

❒ 3. การฟื้นฟูสมรรถภาพ

มีกิจกรรมหรือโครงการ.....

❒ 4. การรักษาพยาบาลระดับปฐมภูมิ

มีกิจกรรมหรือโครงการ.....

3. ในกิจกรรม **“การสร้างเสริมสุขภาพโดยประชาชนและชุมชนท้องถิ่น”** กองทุนของท่านได้ดำเนินงานเกี่ยวกับกิจกรรมหรือโครงการอะไรบ้าง

❒ 1. การสร้างเสริมสุขภาพ

มีกิจกรรมหรือโครงการ.....

❒ 2. การป้องกันควบคุมโรค

มีกิจกรรมหรือโครงการ.....

❒ 3. การฟื้นฟูสมรรถภาพ

มีกิจกรรมหรือโครงการ.....

❒ 4. การส่งเสริมภูมิปัญญาพื้นบ้าน

มีกิจกรรมหรือโครงการ.....

4. ในกิจกรรม **“การบริหารจัดการกองทุนและพัฒนาระบบบริหารจัดการ”** กองทุนของท่านได้ดำเนินงานเกี่ยวกับกิจกรรมหรือโครงการอะไรบ้าง

❒ 1. การจ่ายค่าตอบแทนในการเข้าร่วมประชุมให้แก่คณะกรรมการ และอนุกรรมการหรือคณะทำงานอื่น ๆ

❒ 2. การจัดซื้อครุภัณฑ์ ได้แก่.....

❒ 3. การจ่ายค่าตอบแทนอื่น ๆ ได้แก่.....

❒ 4. การจ่ายเพื่อพัฒนาศักยภาพคณะกรรมการบริหารกองทุน ได้แก่.....

❒ 5. อื่น ๆ ระบุ.....

ส่วนที่ 6 ข้อมูลเกี่ยวกับการใช้จ่ายงบประมาณของกองทุนระบบประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่

1. การรับเงินเข้ากองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ของท่านรับในลักษณะใด

❒ 1. รับเป็นเงินสด

❒ 2. รับเงินโดยการโอนผ่านทางธนาคาร

❒ 3. รับเป็นเช็ค

❒ 4. รับเป็นตั๋วแลกเงิน

❒ 5. รับเป็นธนาณัติ

❒ 6. อื่น ๆ ระบุ.....

2. ในการจ่ายเงินให้บุคคล กลุ่มบุคคลหรือนิติบุคคล กองทุนได้ทำหลักฐานใบสำคัญการจ่ายเงิน และให้ผู้มีสิทธิรับเงินลงลายมือชื่อไว้เป็นหลักฐานทุกครั้งหรือไม่

❒ 1. ทำทุกครั้ง

❒ 2. ทำเป็นบางครั้ง สาเหตุเพราะ.....

❒ 3. ไม่เคยทำ สาเหตุเพราะ.....

3. กองทุนของท่านเคยมอบหมายให้ประธานกรรมการ หรือกรรมการและเลขานุการ เก็บรักษาเงินสดไว้เพื่อสำรองจ่ายหรือไม่

❒ 1. ไม่เคย สาเหตุเพราะ.....

❒ 2. เคย โดยให้เก็บรักษาเงินสด จำนวน.....บาท

4. กองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ของท่าน ได้จัดทำระบบบัญชีกองทุนอย่างไรบ้าง

❒ 1. จัดทำ**รวม**กับระบบบัญชีขององค์กรปกครองส่วนท้องถิ่น
สาเหตุเพราะ.....

❒ 2. จัดทำ**แยก**กับระบบบัญชีขององค์กรปกครองส่วนท้องถิ่น
สาเหตุเพราะ.....

❒ 3. อื่น ระบุ.....

5. กองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ของท่าน ได้มีการบันทึกจัดทำบัญชีการรับ การจ่ายเงิน ในระบบออนไลน์ที่เวบไซต์ http://tobt.nhso.go.th/ หรือไม่

❒ 1. ทำ (ให้ตอบข้อ 6. ด้วย)

❒ 2. ไม่ได้ทำ สาเหตุเพราะ.....

6. ความถี่ที่กองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ของท่าน ได้มีการรายงานผลการจัดทำบัญชีการรับ การจ่ายเงิน ต่อประธานกรรมการ กรรมการและเลขานุการ อย่างไร

❒ 1. รายงานทุกสัปดาห์ ❒ 2. รายงานทุก 15 วัน

❒ 3. รายงานทุกเดือน ❒ 4. รายงานทุก 2 เดือน

❒ 5. อื่น ๆ ระบุ.....

7. กองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ของท่าน ได้มีการจัดพิมพ์รายงานการรับหรือจ่ายเงินจากระบบออนไลน์ เสนอต่อประธานกรรมการ กรรมการและเลขานุการ ทุกเดือนหรือไม่

❒ 1. ทำ

❒ 2. ไม่ได้ทำ สาเหตุเพราะ.....

8. ผู้รับผิดชอบการจัดทำรายงานการรับหรือจ่ายเงินในกองทุน ได้ลงลายมือชื่อไว้เป็นหลักฐานในรายงานการรับหรือจ่ายเงินที่มีการจัดพิมพ์จากระบบออนไลน์หรือไม่

❒ 1. ทำ

❒ 2. ไม่ได้ทำ สาเหตุเพราะ.....

9. องค์ประกอบสำคัญในการจัดทำสรุปผลการดำเนินงานประจำปีของกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ของท่าน มีองค์ประกอบอะไรบ้าง (ตอบได้มากกว่า 1 ข้อ)

❒ 1. ข้อมูลทั่วไป

❒ 2. สรุปผลการดำเนินงานตามแผนงานโครงการ

❒ 3. รายงานสรุปสถานการณ์การเงิน

❒ 4. อื่น ๆ ระบุ.....

ส่วนที่ 7 ปัญหาและอุปสรรคของกระบวนการบริหารจัดการในกองทุนระบบประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่

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ขอขอบคุณทุกท่านที่ได้เสียสละเวลาในการให้ข้อมูล

ผู้ช่วยศาสตราจารย์ วรพจน์ พรหมสัตยพรต
คณะสาธารณสุขศาสตร์ มหาวิทยาลัยมหาสารคาม
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Appendix II

National Health Security Act B.E. 2545 (A.D. 2002)

National Health Security Act B.E. 2545 (A.D. 2002)

BHUMIBOL ADULYADEJ, REX
Given on the 11th Day of November B.E. 2545
Being the 57th year of the Present Reign

His Majesty King Bhumibol Adulyadej is graciously pleased to proclaim that:

Whereas it is expedient to have the law on national health security; Some provisions of this Act may limit personal rights and liberties, which are imposed by Section 29, Section 35, and Section 48 of the Constitution of the Kingdom of Thailand to be enacted by virtue of law.

Be it, therefore, enacted by His Majesty the King, by and with the advice and consent of the National Legislative Assembly, as follows:

Section 1

This Act shall be cited as the "National Health Security Act, B.E. 2545".

Section 2

This Act shall come into force from the day following the date of its promulgation in the Government Gazette.

Section 3

In this Act
"Health service" means medical and public health services directly provided to a person aimed at promotive, preventive, and curative cares, diagnosis, rehabilitation, and the Thai traditional and alternative medicine pursuant to Medical Registration law.
"Health facility" means public and private health facilities, health facilities under the Red Cross Association, and such other health facilities as additionally prescribed by the Board.
"Health care unit" means enrolled health care unit under this Act.

“Network of health care units” means health care units merging and enrolling to be a network of health care units under this Act.

“Cost sharing” means copayment paid by beneficiaries to a Health care unit per visit for the Health service.

“Health service expenses” means any expense born by a Health service provided by a health care unit as follows:

(1) prevention and promotion services;

(2) diagnosis and investigation services;

(3) ante-natal care;

(4) therapeutic items or services;

(5) drugs, biologicals, supplies, appliances, and equipment

(6) delivery;

(7) bed and board ;

(8) newborn care;

(9) ambulance or transportation for patient;

(10) transportation for a disabled person;

(11) physical and mental rehabilitation;

(12) other expenses necessary for the Health service as prescribed by the Board.

“Fund” means the National Health Security Fund.

“Board” means the National Health Security Board.

“Standard and Quality Control Board” means the board controlling the standard and quality of the Health service.

“Secretary General” means Secretary General of the National Health Security Office.

“Office” means the National Health Security Office or its subsidiary offices, as a case may be.

“Official” means any person appointed by the advice of the Board or Quality Control and Accreditation Board, as the case may be, to perform duties for the execution of this Act upon the promulgation in the Government Gazette.

“Minister” means the Minister in charge of the execution of this Act.

Section 4

The Minister of Public Health shall be in charge and control of the enforcement of this Act and shall have powers to enact the Ministerial Regulations or Notifications for the execution of this Act.

The foregoing Ministerial Regulations and Notifications shall come into force at the time of its promulgation in the Government Gazette.

Chapter 1
Right to Health service

Section 5

The Thai population shall be entitled to a Health service with such standards and efficiency as prescribed in this Act.

The Board shall have beneficiaries jointly pay cost sharing as prescribed by the Board to the Health care unit per visit, except such persons as prescribed by the Board who shall be entitled to Health service without joint payment.

Types and limits of Health service for beneficiaries shall be as prescribed by the Board.

Section 6

Any person with the purpose of enjoying the rights pursuant to Section 5 shall request for an enrollment at the Office, the Office's subsidiaries, or such other offices as prescribed by the Office to select his personal Health care unit.

Enrollment request to select a personal Health care unit or to change personal Health care unit shall be pursuant to such regulations, procedures, and conditions as prescribed by the Board, having mainly regard to the personal convenience and necessity.

In the case where any person is entitled to select a Health care unit pursuant to other rules in receiving medical welfare or pursuant to his right under other laws, rules, regulations, notifications, resolutions of the Cabinet, or orders, he shall enjoy his right of Health service at a Health care unit pursuant to such rules in obtaining medical welfare or his personal rights.

Section 7

Enrolled persons shall receive Health service at their personal Health care unit, primary care unit within the relevant network of Health care units, or other Health care unit, to which he is referred by his personal Health care unit or network of Health care units.

Except, in case of reasonableness, accident, or emergency illness, an enrolled person shall receive Health service at such other health facility as prescribed by the Board, having mainly regard to their convenience and necessity. A health facility providing such service shall be entitled to the reimbursement from the Fund pursuant to such rules, procedures, and conditions as prescribed by the Board.

Section 8

Any person entitled to the right pursuant to Section 5, who has not made an enrollment pursuant to Section 6, shall receive his first Health service at any Health care unit. A health care unit providing such service to the said person shall provide them the enrollment to select the personal Health care unit pursuant to Section 6 and notify such event to the Office within a period of thirty days from the first day of service. For this event, such a Health care unit shall be entitled to the reimbursement from the Fund pursuant to such regulations, procedures, and conditions as prescribed by the Board.

Section 9

Limits of the right of Health service of the following persons shall be pursuant to such laws, rules, regulations, notifications, resolutions of Cabinet or other orders as

prescribed for the public sector, local government organizations, state enterprises or other state agencies. The said right shall be enjoyed pursuant to this Act.

(1) Government Official or employee of the public sector

(2) Official or employee of local government organizations

(3) Official or employee of state enterprises, persons working for other government agencies, or persons entitled to medical care service from the government budget

(4) Parent, spouse, child or anyone entitled to medical care service under the right of persons pursuant to (1), (2) or (3)

In the case of paragraph one, the Board shall have duties to provide such a person the access to Health service pursuant to the agreement between the Fund and the government, local government organizations, state enterprises or other state agencies, as the case may be.

When a person pursuant to paragraph one shall enjoy the right of Health service pursuant to this Act, it shall be as prescribed by the Royal Decree.

In the case where the Royal Decree pursuant to paragraph three comes into force, the government, local government organizations, state enterprises, or other state agencies, as the case may be, shall allocate the budget of medical care services for such a person as prescribed in the Royal Decree to the Fund pursuant to regulations, procedures, and period under the agreement they make with the Board.

Section 10

Limits of the right to Health service of beneficiaries pursuant to the Social Security Law shall be as prescribed by the Social Security Law. The extension of Health service pursuant to this Act to beneficiaries pursuant to the Social Security Law shall be pursuant to the agreement between the Board and Social Security Board.

The Board shall make Health service available for beneficiaries pursuant to the Social Security Law. After entering into an agreement on making Health service available with the Social Security Board, the Board shall submit recommendations to enact the

Royal Decree defining the period of Health service provided by the Health care unit to beneficiaries under this Act to the government.

After the enactment of the Royal Decree pursuant to paragraph two, the Social Security Office shall provide the expenses of medical care services of the Social Security Fund to the Fund pursuant to such amount as agreed between the Board and the Social Security Board.

Section 11

In the case where an employee, who is entitled to medical care service pursuant to the Workman's Compensation law, enjoys the right of Health service of a Health care unit pursuant to this Act, the Health care unit providing Health service shall notify such event to the Office. The Office shall be entitled to the reimbursement from the Workman's Compensation Fund, not exceeding such amount as prescribed in the Workman's Compensation Law, and shall submit such amount of reimbursement to the Fund in order to be transferred to the said Health care unit.

Spending Health service expense pursuant to this Section shall be deemed spending part of medical care expenses pursuant to the Workman's Compensation law.

Section 12

In the case where a victim, caused by a motor vehicle under the Protection for Motor Vehicle Accident Victims Law, whenever, enjoys the right of Health service from a Health care unit pursuant to this Act, the said Health care unit shall notify such event to the Office. The office shall be entitled to the reimbursement from the Victim Compensation Fund, not exceeding such amount as prescribed in the Protection for Motor Vehicle Accident Victims Law, and shall submit such amount of reimbursement to the Fund in order to be transferred to the said Health care unit.

In the case where an insurance company or the Road Victims Protection Company is liable to pay the compensation to a motor vehicle accident victim who has enjoyed the right of Health service in accordance with paragraph one, the Office shall have powers

to issue an order requesting the said company to pay such Health service expenses, not exceeding the amount in accordance with the conditions of the insurance policy.

Payment of Health service under this Section shall be deemed payment of the medical care compensation pursuant to the Protection for Vehicle Accident Victims Law.

Chapter 2
National Health Security Board

Section 13

There shall be a board called the "National Health Security Board" made up of:

(1) The Minister of Public Health as a Chairman,

(2) The Permanent Secretary for Defense, Permanent Secretary for Finance, Permanent Secretary for Commerce, Permanent Secretary for the Interior, Permanent Secretary for Labor and Social Welfare, Permanent Secretary for Public Health, Permanent Secretary for University Affairs, and the Director of the Office of the Budget,

(3) a representative of each Municipality, a representative of each local Provincial Administrative Organization, a representative of each local Tambon Administrative Organization, and a representative of other local government organizations elected by executives of its organization,

(4) five representatives of, elected by, representatives each of which from a non-profit private organization implementing activities for the following groups:

(A) Children and adolescents

(B) Women

(C) Elderly

(D) Disabled or mental health patients

(E) HIV or other chronic disease patients

(F) Labor

(G) Populous communities

(H) Agriculturists

(I) Minorities

(5) Five representatives of health professionals each of which shall be from the Medical Council, the Thailand Nursing Council, the Pharmaceutical Council and the private hospital association;

(6) Seven qualified persons appointed by the Cabinet each of which shall be experts from the fields of health insurance, medical science and public health, Thai traditional medicine, alternative medicine, finance, law and social sciences;

Private organizations pursuant to (4) shall be implemented not less than one year and shall make enrollment with the Office within fifteen days from the day of the event causing the appointment of the member. In the case where any organization has implemented more than one activity, it shall make enrollment for the election for only one activity. Rules and procedures of electing members pursuant to (3) and (4) shall be as prescribed and promulgated by the Minister.

Members pursuant to (1), (2), (3), (4) and (5) shall search and elect qualified persons and submit to the cabinet for appointment to be members pursuant to (6).

Rules and procedures of searching and electing qualified members pursuant to paragraph four shall be as prescribed and promulgated by the Minister.

The Secretary General shall be the Secretary of the Board.

Section 14

Members of the Board holding office pursuant to Section 13 shall not hold office pursuant to Section 48 at the same time.

Section 15

Members pursuant to Section 13 paragraph one (3), (4), (5), and (6), shall hold office for a term of four years. A retiring member may be re-appointed, but shall not successively hold office more than two terms.

Upon the expiration of the term of office, if a new member is not elected pursuant to Section 13 paragraph one (3) (4) and (5) or a new member pursuant to Section 13 paragraph one (6) is not appointed, the member vacating office pursuant to a term of the office shall hold office to perform duties until the new member is elected or appointed, but not exceeding ninety days from the date of expiration of the term of office.

In the case where a member pursuant to paragraph one vacates office during the term of office, a new member of the same category shall be elected or appointed within thirty days from the day of vacating office, by an election or appointment of a replacement member, and the newly elected or appointed member shall hold office for a period equal to the remainder of the term of office of the member they replaced.

In the case where a member vacates office during the term of office and the remainder of term of office is less than ninety days, a new member may not be elected or appointed to be a replacement member. In this event, the Board shall be made up of the remainder of the members.

Section 16

In addition to vacating office upon expiration of the term of office pursuant to Section 15 paragraph one, a member pursuant to Section 13 paragraph one (3), (4), (5) and (6) shall vacate office upon:

(1) death;
(2) resignation;
(3) becoming bankrupt;
(4) becoming an incompetent or a quasi-incompetent person;
(5) being sentenced to imprisonment by final judgment, except a penalty for an offense board in negligence of misdemeanor;
(6) being convicted to vacate office by the Board’s decision with the votes not less than two third of all members due to his/her improper behavior on performance of duties.

Section 17

At a meeting of the Board, there shall be members present in a number not less than a half of the total number of members to constitute a quorum.

The Chairman shall preside over the meeting. If the Chairman is absent, the members present shall elect a member among themselves to preside over the meeting.

A decision of the meeting shall be by a majority of votes. One member shall have one vote. When votes are tied, the meeting Chairman shall give the casting vote.

In the meeting, a person who is an interested party shall have the right to express his opinion relating to an issue of the meeting but shall have no right to give his vote.

Procedure of the meeting and performance of the duties of the Board shall be pursuant to the rules prescribed by the Board.

Section 18

The Board shall have powers and duties as follows:

(1) to prescribe the Health service provided by a Health care unit and Network of health care units and to prescribe the standard of implementation, regarding national health security, to be effective;

(2) to provide advice to the minister on the appointment of officials and the enactment of ministerial regulations and notifications on execution of this Act;

(3) to prescribe limits and types of Health service necessary to health, sustainability, and the rate of Cost sharing pursuant to Section 5;

(4) to prescribe the rules of fund management and implementation;

(5) to prescribe rules, procedures, and conditions in discharging the Secretary General and to prescribe qualifications and forbidden qualifications of the Secretary General;

(6) to issue rules on money receipt and payment, saving money, and making benefit of the Fund pursuant to Section 40;

(7) to prescribe rules, procedures, and conditions on payment of preliminary assistance to reimburse a beneficiary who is subject to damage or injury caused by any service provided by a Health care unit where the wrongdoer is non-apparent or the wrongdoer is apparent but such beneficiary can not be reimbursed within a period deemed appropriate in accordance with section 41;

(8) to encourage and cooperate with local government organizations in implementing and managing the health security system in local areas by considering their readiness, reasonableness, and need, in order to establish national health security residents of such areas as prescribed in Section 47;

(9) to encourage and prescribe rules making it possible that nonprofit community organizations, nonprofit private organizations and nonprofit private sectors implement and manage local funds by considering their readiness, reasonableness, and need, by means and encouraging procedures of participation in order to establish national health security residents of such areas as prescribed in Section 47;

(10) to prescribe rules in hearing opinions of providers and beneficiaries in order to improve the quality and standard of Health service;

(11) to prescribe rules on the punishment of administrative fines and revocation of enrollment.

(12) to create reports on implementation and obstacles to implementation of the Board, and all accounts and finances of the Board in order to annually submit to the Cabinet, the House of Representatives, and the Senate within 6 months from the last day of the fiscal year;

(13) to hold an annual meeting to make it possible that the Board hears general opinions of providers and beneficiaries;

(14) to perform such other duties as prescribed by this Act, the Minister, or other laws;

Section 19

The Board shall have powers and duties to control and supervise the Office to be implemented in accordance with the prescribed objectives as follows;

(1) to prescribe the policy of management and consent of the Office's implementation;

(2) to approve the financial plan of the Office;

(3) to control the implementation and general management, to issue rules, by-laws, notifications, or provisions concerning general and personnel management, budgeting, finance and properties, to monitor and evaluate, and other implementations of the Office;

Section 20

The Board shall have powers to appoint Sub-boards to perform duties pursuant to this Act or such duties as prescribed by the Board.

Section 17 shall apply mutatis mutandis to the meeting, procedure of the meeting, and performance of Sub-boards or their members.

Section 21

The Board shall appoint an Inspection Sub-board to have powers and duties to inspect fund management and implementation of the Office in order to enable the implementation to comply with the relevant laws, rules, and regulations, and to be effective and transparent, where accountability shall be taken hereto. This shall be as prescribed by the Board.

Members of Sub-board pursuant to paragraph one shall be deemed office-bearers, forbidden to have personal interests conflicting with the public interests pursuant to the Organic Act of the National Counter Corruption Commission.

Section 22

In performing duties under this Act, the Board or a Sub-board, as the case may be, shall have powers to summon any state agency or any person to testify to submit statements or to furnish an object, document or evidence for its consideration.

Section 23

In performing duties, members of the Board and a Sub-board shall earn the allowance of the meeting, traveling allowance, and such other expenses as prescribed by the Minister.

Chapter 3
National Health Security Office

Section 24

There shall be a "National Health Security Office" to be the state agency as the juristic person under control and supervision of the Minister. Affairs of the Office are not under the Labor Protection, Labor Relations, Social Security, and Workman's Compensation laws. Officials and employees of the Office shall be paid consideration and other benefits not less than such rates as prescribed by the Labor Protection, Social Security, and Workman's Compensation laws.

Section 25

The Office shall be situated in Bangkok or in a vicinity province.

The Board shall have powers to establish, merge, or liquidate the Office's subsidiaries by promulgating in the Government Gazette.

In establishing the Office's subsidiaries, the necessity and worthiness of the implementation after comparing with the expenses shall be considered. In this regard, the Board shall have powers to assign any state or private agency to perform duties as

the Office's subsidiary by being paid for the expenses of implementation pursuant to such regulations as prescribed by the Board.

Section 26

The Office shall have powers and duties as follows;

(1) to be responsible for the administration of the Board, the Standard and Quality Control Board, and Sub-boards of the Board and Standard and Quality Control Board;

(2) to collect, gather, analyze information concerning the implementation of the Health service;

(3) to create the records of beneficiaries, Health care units, and Networks of health care units;

(4) to manage the Fund for the execution of such rules prescribed by the Board;

(5) to provide the expenses of such Health service as prescribed by the Board to Health care units and Networks of health care units pursuant to Section 46.

(6) to inspect documents and evidence of claims submitted by Health care units for Health service expenses;

(7) to have people obtain personal Health care units or change personal Health care units, upon their request, and to launch public relations to make it possible that people have access to information about Health care units;

(8) to control and supervise Health care units and Networks of health care units in providing Health service to gain such standard of services as prescribed by the Board and to facilitate the lodging of complaints;

(9) to be entitled to ownership, possession, and other realty;

(10) to create the rights, to enter into the juristic act or any agreement concerning property;

(11) to charge fees or service charges for operation of the Office;

(12) to assign other organizations or other persons to act under the powers and duties of the Office;

(13) to create an annual report as to the performance and obstacles in implementation of the Board and the Standard and Quality Control Board;

(14) to perform other duties for the execution of this Act or other laws, or other duties assigned by the Board or Standard and Quality Control Board;

Section 27

Properties of the Office shall not be subject to the execution.

Section 28

The Office shall be entitled to the ownership of immovable properties donated to the Office, purchased by the Office, or acquired by means of exchanging.

The Office shall have powers to administrate, supervise, maintain, exercise, and supply the interest from properties of the Office.

Section 29

The Board shall submit a request for the budget of annual expenditure to the Cabinet to spend for the administration of the Office.

Section 30

The Office shall save and spend budget of the Office pursuant to such rules as prescribed by the Board.

Accountancy of the Office shall be set up pursuant to such forms and regulations as prescribed by the Board and shall be subject to an internal inspection on finance, accountancy, and inventories of the Office. Result of such inspection shall be annually reported to the Board at least once per year.

Section 31

There shall be a Secretary General of the Office to be in charge of the Office's administration for the execution of laws, rules, by laws, provisions, policies, resolutions, and notifications of the Board and to be the commander of all officials and employees of the Office.

The board shall appoint and discharge the General Secretary.

In employing and appointing the General Secretary, the Board shall elect five members of an Election Committee with qualifications and without forbidden qualifications as prescribed by Section 32 (1), (3), (4), (5), (6), (9), (10), (11), and (12)

The Election Committee shall have duties to select persons who have appropriate knowledge and expertise for the position of Secretary General, with qualifications and without forbidden qualifications as prescribed by Section 32 (1), (3), (4), (5), (6), (9), (10), (11), and (12).

The selected persons shall not be one of members of the Board and shall not be over 60 years of age on the day of submitting an application to the Board for consideration to enter into an employment contract to be appointed to be the Secretary General. The Election Committee may select and nominate more than such one appropriate person.

Members of Election Committee shall not be nominated to be the Secretary General.

Members of Election Committee shall elect a member among themselves to be a Chairman and shall elect another member among themselves to be a Secretary.

The Office shall have duties to be the Administrative Unit in searching and electing Secretary General.

Section 32

Secretary General shall have qualifications and shall not have forbidden qualifications as follows;

(1) be Thai;

(2) be able to work full time for the Office;

(3) not be insane or mentally infirmed;

(4) not be bankrupt;

(5) not have been imprisoned by a final judgment to a term of imprisonment, except for an offence committed through negligence or a petty offence;

(6) not have been subject to a judgment or court order to nationalize his property due to irregular opulence or getting tremendous property;

(7) not be an executive or an official of another state enterprise or other profit transaction.

(8) not be a government official, an official, or an employee who has position and regular salary from the central public sector, local public sector, or other state agency;

(9) not be a political official, a member of the House of Representatives, senator, a member of a local assembly, or a local executive.

(10) not be a committee member or consultant of a political party or not be an official of a political party;

(11) never having been dismissed or discharged or expelled from a state agency, a state enterprise, or a public limited company due to bad faith on duties.

(12) not be or not have been, in the past 1 year before appointment, a committee member, an executive, or an authorized person in managing or being interested in a juristic person who is a contractual party or a coworker or a juristic person who is interested in the affairs of the Office;

(13) such other qualifications and forbidden qualifications as prescribed by the Board.

Section 33

The Secretary General shall vacate office upon:

(1) death;

(2) resignation;

(3) lacking in qualifications or having forbidden qualifications pursuant to Section 32;

(4) being imprisoned by a final judgment to a term of imprisonment, except for an offence committed through negligence or a petty offence;

(5) being absent from the meeting for more than 3 consecutive times without reasonable excuse;

(6) being discharged due to defective performance, misconduct, or inefficiency;

(7) employment contract being terminated.

Section 34

The Secretary General shall hold office for a term of four years. The retiring Secretary General may be re-appointed, but shall not successively hold office more than two terms.

In the case where the Secretary General vacates office or is temporary not able to perform duties, the Board shall appoint one of the Office's officials to be in charge of his/her functions.

Such appointed official being in charge of the functions of the Secretary General shall have the same powers and duties as Secretary General's.

Section 35

The Secretary General shall be a government official, who is deemed an office-bearer, and forbidden to have personal interests conflicting with the public interests pursuant to Organic Act of the National Counter Corruption Commission.

Section 36

The Secretary General shall have powers and duties as follows;

(1) to appoint or promote officials and employees of the Office, to reduce or cut down salaries or wages of officials and employees of the Office,

to dismiss the officials and employees of the Office pursuant to such bylaws prescribed by the Board but to consider the opinions of the Inspection Sub-board in the case where officials or employees perform duties in the Bureau of Inspection;

(2) to issue rules or notifications, not contrary to rules, bylaws, notifications, provisions, policies, or resolutions of the Board, on implementation of the Office.

For affairs concerning a third party, the Secretary General shall be a representative of the Office or may authorize any official of the Office to perform specific duties in his stead pursuant to such bylaws as prescribed by the Board.

Section 37

There shall be a Bureau of Inspection to be the Office of the Secretary to the Inspection Sub-board which shall be under the command of the Inspection Sub-board and shall report to the Secretary General pursuant to such rules as prescribed by the Board.

Chapter 4
National Health Security Fund

Section 38

There shall be a fund in the National Health Security Office called the “National Health Security Fund” aimed at expenditures to promote and encourage the arrangement of the Health service of Health care units.

To encourage access by persons to universal and efficient Health service, money of the Fund shall be spent by considering the development of the Health service in local areas, in which Health care units are insufficient or Health care units are not appropriate distributed.

Section 39

The Fund shall be made up of;

(1) money from the annual expenditure budget;

(2) money from local government organizations as prescribed by law;

(3) money earned by providing Health service pursuant to this Act;

(4) administrative fines pursuant to this Act;

(5) money or property donated to the Fund;

(6) interest or benefit earned by money or property of the Fund;

(7) other money or property earned by affairs of the Fund;

(8) other contributions as prescribed by law.

Money and property of the Fund shall not be submitted to the Ministry of Finance to be national income pursuant to the Treasury Balance and Budgetary Procedure Law.

In submitting a request for the annual expenditure budget pursuant to (1), the Board shall submit the application to the Cabinet by considering the report of Standard and Quality Control Board's opinions, accounts, finance, and property of the Office at the time of application.

Section 40

Money receipt and payment, saving money, and making benefit of the fund shall be pursuant to such rules as prescribed by the Board.

Section 41

The Board shall earmark an amount of money, not exceeding 1 percent of money to be paid to Health care units, as preliminary assistance to reimburse beneficiaries who are subject to damage or injury caused by any service provided by the Health care unit and the wrongdoer is non-apparent or the wrongdoer is apparent but such beneficiaries can not be reimbursed within a period deemed appropriate.

This shall be pursuant to such rules, procedures, and conditions as prescribed by the Board.

Section 42

In the case where a beneficiary is subject to damage or injury caused by any service provided by the Health care unit and the wrongdoer is non-apparent or the wrongdoer is apparent but such beneficiary can not be reimbursed within a period deemed appropriate pursuant to section 41, after payment of preliminary assistance to the said beneficiaries, the Office shall exercise a right of recourse against such wrongdoer.

Section 43

Within three months from the last day of the fiscal year pursuant to the Treasury Balance and Budgetary Procedure Law, the Board shall submit last-years balance sheet and report on money receipt and payment of the Fund of which shall be certified by Office of the Auditor-General to the Cabinet for acknowledgement.

The Minister shall submit the foregoing balance sheet and report on money receipt and payment to the House of Representatives and the Senate for acknowledgement and to be promulgated in the Government Gazette.

Chapter 5
Health Care Unit and Standard of Health service

Section 44

The Office shall organize the enrollment of Health care units and Networks of health care units and set up public relations to people in order that they shall make enrollment to select personal Health care unit pursuant to Section 6.

The enrollment of Health care units and Networks of health care units and procedure of public relations pursuant to paragraph one shall be in accordance with such regulations, procedures, and conditions as prescribed by the Board.

Section 45

The Health care unit shall have duties as follows:

(1) to provide qualified and standard vaccines, medicines, medical supplies, and medical equipment with equity and facilitation of the necessary Health service as well as respect for personal rights in dignity of humankind and religious beliefs;

(2) to provide health information requested by beneficiaries, and pursuant to any notification concerning patient and beneficiary rights on procedures, alternatives, and result of diagnosis as well as side-effects which may occur without distortion so that beneficiaries can make their decision to utilize the Health service or to be referred;

(3) to provide sufficient information, concerning names of physicians, sanitarian, or person responsible for physical health and society, to relatives or close persons of beneficiaries before discharging;

(4) to strictly keep confidence of beneficiaries known by performing duties pursuant to (1) and (2) except disclosing to government officials performing duties pursuant the law;

(5) to set up a Health service information system to facilitate a quality and service inspection as well as a request for Health service expense;

Health care units shall provide Health service to beneficiaries and set up an information system of Health service information pursuant to such regulations as prescribed by the Board and Standard and Quality Control Board.

Section 46

Health care units and Networks of health care units pursuant to Section 44 and Health care units taking referral shall earn Health service expenses from the Fund pursuant to such regulations, procedures, and conditions as prescribed by the Board.

Opinions in Section 18 (13) shall be considered for the issuance of regulations prescribing Health service expenses and such issuance of regulations shall be at lease pursuant to the following conditions;

(1) to be based on the Standard Prices of all diseases pursuant to the proposal of Standard and Quality Control Board;

(2) to cover expenses of Health care units in salaries and considerations for personnel;

(3) to consider the differences of Health care units' missions

(4) to consider the differences of beneficiaries and the differences of the sizes of Health care units' responsible areas;

Section 47

To set up national health security for people in local areas by encouraging the process of participation according to the readiness, reasonableness, and need of people in such areas, the Board shall support and cooperate with local government organizations determining regulations so that the said organizations shall implement and manage the national health security system in local areas by earning expenses from the Fund.

Chapter 6
Standard and Quality Control Board

Section 48

There shall be a board called the "Standard and Quality Control Board" consisting of

(1) The Director General of Department of Medical Services, the Secretary General of the Food and Drug Administration, the President of the Hospital Development and Accreditation Institute, and the Director of Division of Medical Registration;

(2) a representative of the Medical Council, a representative of the Thailand Nursing Council, a representative of the Pharmacy Council, and a representative of the Law Society of Thailand;

(3) a representative of private hospitals who is a member of the Private Hospital Association;

(4) a representative of the Municipality, a representative of the Provincial Administrative Organization, a representative of the Tambon Administrative Organization, and a representative of other local government organizations elected by executives of its organization;

(5) a representative of professional nurses, a representative of midwives, a representative of dentists, and a representative of pharmacists;

(6) representatives of the Royal College of Medical Specialty, each of which is from the field of obstetrics and gynaecology, surgery, internal medicine, and paediatrics;

(7) three representatives elected by, among, representatives of health care professionals, each of which is from the field of applied traditional medicine, physical therapy, medical technique, radiological technology, occupational therapy, cardio-thoracic therapy, and communicative disorders;

(8) five representatives of, elected by, representatives each of which is from a non-profit private organization implementing activities for the following groups:

(A) Children and adolescents

(B) Women

(C) Elderly

(D) Disabled or mental health patients

(E) HIV or other chronic disease patients

(F) Labor

(G) Populous communities

(H) Agriculturists

(I) Minorities

(9) six qualified persons appointed by the Minister, each of which, at least, is a qualified person in tropical family medicine, a qualified person in mental health, and a qualified person in Thai traditional Medicine;

Private Organizations pursuant to (8) must have implemented their activities for more than one year and shall make enrollment with the Office within 15 days from the day of the event causing election of a member of the Standard and Quality Control Board. If any organization implements several activities, it shall make enrollment to be elected for only one activity.

Regulations and procedures of election shall be pursuant to (3) (4) (5) (6) (7) and (8) and shall be as prescribed and promulgated by the Minister.

Members pursuant to (1) (2) (3) (4) (5) (6) (7) and (8) shall search and elect qualified persons and submit to the Minister for appointment pursuant to (9).

Regulations and procedures of searching and election pursuant to paragraph four shall be as prescribed and promulgated by the Minister.

Members pursuant to paragraph one shall elect a member among themselves to be the chairman of Standard and Quality Control Board.

The Secretary General shall be the secretary of Standard and Quality Control Board.

Section 49

Section 14, Section 15, Section 16, and Section 17 shall apply mutatis mutandis to office holding, office vacation, and the meeting of the Standard and Quality Control Board.

Section 50

The Standard and Quality Control Board shall have powers and duties as follows:

(1) to control the standard and quality of Health care units and Networks of health care units pursuant to Section 45;

(2) to monitor the Health service provided by Health care units to meet the standard and quality in the case where such Health care units provide a level of services higher than the Health service pursuant to Section 5;

(3) to prescribe the measurement, controlling, and encouraging of quality and standard of Health care units and Networks of health care units;

(4) to submit standard prices of all diseases to the Board to set up regulations prescribing expenses of Health service to Health care units pursuant to Section 46;

(5) to prescribe rules, procedures, and conditions for the complaint of a person if their right is violated due to the Health service, procedures for

such complaint, and rules and procedures for assisting a person if their right is violated due to the Health service, as well as to determine a Complaint Unit to facilitate people in freely submitting complaints, irrespective of the person who is complaining;

(6) to report the results of inspecting and controlling quality and standard of Health care units and Networks of health care units to the Board, and notify such result to Health care units or their authorizing agency in order to improve, modify, monitor, and evaluate the effect of quality and standard improvement;

(7) to encourage people' participation in inspecting and controlling Health care units and Networks of health care units;

(8) provide payment of preliminary assistance to a beneficiary who is subject to damage or injury caused by any service provided by a Health care unit and the wrongdoer is non-apparent or the wrongdoer is apparent but such beneficiary can not be reimbursed within a period deemed appropriate pursuant to such regulations, procedures, and conditions as prescribed by the Board;

(9) to encourage establishing of an information system for decision making of people to get health service;

(10) to perform other duties for the execution of this Act and other laws or such duties as prescribed by the Board.

Section 51

The Standard and Quality Control Board shall have powers to appoint a Sub-Standard and Quality Control Board to perform duties as assigned by Standard and Quality Control Board.

Section 17 shall apply *mutatis mutandis* to the meetings, procedures of the meetings, and procedures for performing the duties of Sub-Standard and Quality Control Board.

Section 52

The Standard and Quality Control Board or Sub-Standard and Quality Control Board shall have powers to summon any state agency or any person to testify, to submit statements or to furnish an object, document or evidence for its consideration.

Section 53

In performing duties, members of the Standard and Quality Control Board and Sub-Standard and Quality Control Board shall earn the allowance of the meeting, traveling allowance, and such other expenses as prescribed by the Minister.

Chapter 7
Officials

Section 54

In performing duties on execution of this Act, an official appointed by the Board or Standard and Quality Control Board shall have powers to enter the premises of Health care units or Networks of health care units during official times to interrogate for the fact, inspect property, documents, and evidence, to photograph or to copy relevant document for inspection, and to do other reasonable matters to obtain the fact for execution of this Act.

For the implementation pursuant to paragraph one, if an offence pursuant to paragraph one is detected, the official shall have powers to sequester documents, property, or belongings for consideration.

Procedures in performing duties shall be pursuant to such regulations as prescribed by the Board or Standard and Quality Control Board, as the case may be.

Section 55

In performing duties, an official shall display an identification card to the relevant person.

The identification card of the official shall be as prescribed by the Minister by promulgating in the Government Gazette.

Relevant persons shall reasonably facilitate the official on duties.

Section 56

On the execution of this Act, the official shall be an official pursuant to the Criminal Code.

Chapter 8
Health Care Unit Standard Control

Section 57

In the case where the Office inspects and observes that any Health care unit fails to comply with the prescribed Health service standard, it shall report such inspection to the Standard and Quality Control Board to appoint an Investigation Committee for consideration.

The Investigation Committee pursuant to paragraph one shall have a reasonable number of members, made up of representatives of state agencies in the fields of medical science, public health, and law, representatives of private organizations, or other qualified persons not interested in such investigation to conduct investigation and provide opinions to Standard and Quality Control Board.

The Standard and Quality Control Board may appoint several Investigation Committees in advance to conduct investigation in a short time.

The investigation shall be completed within 30 days and can be extended to thirty more days. If the investigation can not be completed within the extended period, it shall be reported to the Standard and Quality Control Board to be considered and ordered extending to another more reasonable period.

In performing the execution of this Act, the Investigation Committee shall be official pursuant to the Criminal Code and shall have powers to summon Health care units, complainants, or any relevant persons to testify, to submit statements, or to furnish an object, documents or evidence for its consideration.

After completing the investigation, the Investigation Committee shall submit such account and its opinions to the Standard and Quality Control Board for consideration.

The Standard and Quality Control Board shall issue orders pursuant to Section 58 or Section 59, as the case may be, within 30 days from the date of receiving such account from the Investigation Committee.

Section 58

In the case where the result of investigation indicates that the Health care unit fails to comply with the prescribed standard, the Standard and Quality Control Board shall

(1) issue an order advising such Health care unit to comply with the Standard and Quality Control Board, in the case of an unintentional act;

(2) issue an order for such Health care unit to be liable to an administrative fine not exceeding one hundred thousand Baht per act, in case of an intentional act and to apply provisions concerning administrative enforcement pursuant to public administrative procedure; in the case of the lack of an official for the enforcement of the order, the Secretary General has the power to enter an action in the court to enforce the fine and the Administrative Court has the power to sentence and enforce seizing and attaching property to be sold by auction to pay the penalty;

(3) notify relevant agencies to investigate and judge the allegation or incrimination to health professionals who may be partly liable for an offence of the Health care unit and to proceed with disciplinary procedures in the case of a public official;

Section 59

A beneficiary who is not provided reasonable facilitation or facilitation pursuant to his or her right under this Act from a Health care unit, being overcharged fees for service exceeding the rate as prescribed by the Board, being charged fees for service by a Health care unit without authority, or can not be reimbursed for damage or injury caused by the Health service provided by the Health care unit within a period deemed appropriate, shall lodge his complaint to the Office for investigation and Section 57 shall apply *mutatis mutandis*.

If the result of investigation indicates that the Health care unit has not committed an offence as it was complained, the Secretary General shall notify the complainant of the result of the investigation within 15 days from the date of issuing such result.

If the result of investigation indicates that the Health care unit has committed an offence as it was complained, the Standard and Quality Control Board shall have powers to

(1) advise the Health care unit in writing to treat the complainant properly complying with his or her rights and benefits, in the case of the complaint for facilitation or benefit pursuant to the complainant's right.

(2) to issue an order in writing requesting the Health care unit to return monies exceeding Cost sharing or unjust money with 15% per year interest from the date of charging to the date of return.

Section 60

In the case where the Health care unit's offence pursuant to Section 58 or Section 59 is serious or re-committed, the Secretary General shall report to the Standard and Quality Control Board in order to consider proceeding to

(1) issue an order revoking the enrollment of such Health care unit;

(2) notify the Minister in charge of the execution of Health Facility Law to consider proceeding pursuant to such law.

(3) notify the controlling and monitoring Minister to proceed disciplinary procedure against executives of the Health care unit, in the case of a Health care unit;

(4) notify relevant agencies to investigate and judge such allegation or incrimination to health professionals who may be partly liable for such offence of the Health care unit and to proceed disciplinary procedures in the case of a public official;

Section 61

The complaint or Health care unit receiving an order of the Standard and Quality Control Board pursuant to this Chapter, shall have the right to appeal such order to the Board within 30 days from the date of receiving or acknowledging the said order, as the case may be.

The decision of the Board shall be final.

Rules and procedures of appeal pursuant to paragraphs one shall be as prescribed by the Board.

Section 62

After the Appeal Committee adjudicates an appeal lodged against the order pursuant to Section 61, the Secretary General shall report such adjudication of appeal to the Standard and Quality Control Board to be acknowledged.

Chapter 9
Penalties

Section 63

Any person who violates or fails to comply with an order of the Board, Standard and Quality Control Board, Sub-board, Standard and Quality Control Sub-Board, Investigation Committee, or Official pursuant to Section 22, Section 52, Section 54, or

Section 57 shall be liable to imprisonment for a term not exceeding six months or a fine not exceeding ten thousand Baht, or both.

Section 64

Any person who obstructs or does not provide reasonable facilitation to an official to perform duties pursuant to Section 55 paragraph three shall be liable to imprisonment for a term not exceeding six months or a fine not exceeding ten thousand Baht, or both.

Transitory Provision

Section 65

On the commencement of this Act, Section 6, Section 7, Section 8, Section 11, and Section 12 shall not apply unless preparation for the availability of Health service provision has already been set out.

After preparation for the availability of Health service provision pursuant to paragraph one, the Minister shall prescribe and promulgate the starting time of Health service in the Government Gazette, not exceeding one hundred and eighty days from the effective date of this Act.

In spending Health service expenses pursuant to Section 46 for Health care units under the Ministry of Public Health, the Office shall provide prior such expenses to the Ministry of Health for three years from the starting date of the Health service pursuant to paragraph two.

Section 66

Royal decrees pursuant to Section 9 and Section 10 shall be enacted within one year from the effective date of this Act.

If this cannot be done, such period shall be extended to one more year at a time. The Office and the Social Security Office, as the case may be, shall report the reason why

the investigation cannot be completed within the extended time to the Minister for acknowledgement and shall distribute such report to the public.

Section 67

The Ministry of Public Health shall elect and appoint members pursuant to Section 13 (3) (4) (5) and (6) and shall search and elect the Secretary General to set up the National Health Security Board pursuant this Act within one hundred and eighty days from the effective date of this Act.

While the Board pursuant to paragraph one is not set up, there shall be a committee consisting of the Minister as Chairman, Permanent Secretary for Defence, Permanent Secretary for Finance, Permanent Secretary for Commerce, Permanent Secretary for the Interior, Permanent Secretary for Labor and Social Welfare, Permanent Secretary for University Affairs, the Director of Office of the Budget, and five other qualified persons, four of which shall be representatives of the Consumers.

The Minister shall appoint a Deputy Permanent Secretary for Public Health to temporarily perform duties as Secretary General until the inauguration of the Secretary General appointed in accordance with this Act.

A person appointed by the Minister pursuant to paragraph three shall be the secretary of the Committee pursuant to paragraph two. The Minister shall appoint two government officials of the Ministry of Public Health to be assistant secretaries.

Section 68

The Minister shall arrange electing and appointing the Standard and Quality Control Board pursuant to Section 48 (2), (3), (4), (5), (6) (7) (8) and (9) within one hundred and eighty days from the effective date this Act.

While the Board pursuant to paragraph one is not set up, there shall be a committee consisting of the Director General of the Department of Medical Services, Secretary General of the Food and Drug Administration, President of the Health Facility Development and Accreditation Institute, Director of the Division of Medical

Registration, Secretary of the Dental Council, Secretary of the Medical Council, Secretary of the Thailand Nursing Council, Secretary of the Pharmaceutical Council, President of the Law Society of Thailand, and seven other qualified persons appointed by the Cabinet, three of which shall be representatives of private organizations implementing consumer protection activities, and four qualified persons in medical science and public health, as members.

Members pursuant to paragraph two shall have a meeting electing a member among themselves to be Chairman and the elected Chairman shall appoint a secretary from assistant secretaries pursuant Section 67 and appoint two government officials of the Ministry of Public Health to be assistant secretaries.

Section 69

The ownership of businesses, properties, rights, obligations, liabilities, and budget of the Ministry of Public Health relevant to health security pursuant to this Act, as well as the revolving fund of the Health Insurance Card Project shall be assigned to the Office on the effective date of this Act.

Section 70

Any government official or employee of the public sector, who voluntarily to become an official or employee of the Office shall apply in writing to the Commander and shall be required to be elected and evaluated by such rules as prescribed by the Board.

A government official who becomes an official of the Office pursuant to paragraph one shall be deemed to have resigned from the public sector because of the termination or dissolution of his position pursuant to Gratuity and Pension for Officials Law or Gratuity and Pension for Official Fund Law, as the case may be.

An employee who becomes an employee of the Office pursuant to paragraph one shall be deemed to have resigned from the public sector because of the dissolution of his position by the public sector or the termination of employment without liability and

shall be entitled to gratuity pursuant to the Rule of the Ministry of Finance on Employee's Gratuity.

For the calculation of benefit pursuant to bylaws of the Office, a government official or an employee of public sector, who becomes an official or an employee of the Office pursuant to this Section shall not successively count his public working period or working time when he was a government official or employee of public sector, as the case may be, into his working period at the Office unless waiving his right of gratuity or pension.

Waiving gratuity or pension shall be performed within thirty days from the date of transference of the official or employee. In the case of a government official, his or her waiving of gratuity or pension shall be as prescribed by the law of Gratuity and Pension for Officials or the law of Gratuity and Pension for Official Fund, as the case may be. In the case of an employee, his or her waiving of gratuity or pension shall be performed in writing with his or her signature and submitted to the employer in order to be passed on to the Ministry of Finance for acknowledgement.

Countersigned by

Pol.Lt.Col. Taksin Chinnawat

Prime Minister

Remarks: The reasons for the promulgation of this Act are as follows: Whereas Section 48 of the Constitution of the Kingdom of Thailand provides that the Thai population shall enjoy an equal right to receive standard Health service and the indigent shall have the right to receive free medical treatment from Health centers of the State, as provided by law. Health service by the State shall be provided thoroughly and efficiently and, for this purpose, participation by local government organizations and the private sector shall be promoted insofar as it is possible. Section 82 of the Constitution of the Kingdom of Thailand also provides that the State shall thoroughly provide and promote standard and an efficient Health service. For this ground, a

Health service system essential to health and sustainability shall be organized to meet the medical treatment standard.

There shall be a control and monitoring organization implemented with the participation of public and civil sectors in order to establish an efficient medical treatment system throughout the country. In addition, the Thai population shall have the right to receive the standard Health service. At present, there are several systems of medical treatment assistance, thus rendering a recurring payment. Therefore, it is essential to enact this Act to merge such medical treatment assistance in order to reduce expenses in general health preventing the said recurring payment and to reorganize the Health system for more efficiency.

Appendix III

Health Action Plan Fiscal Year 2010

Health Action Plan

PP COM Budget
From Khonkaen Branch of National Health Security Office (NHSO)

Fiscal Year 2010

The Local Fund Health Security
of
Wungsang Tambon Administrative Organisation (WSTAO)

Kaedam district, Maha Sarakham province, Thailand

Health Action Plan, Fiscal Year 2010

Wungsang Local Fund Health Security (WSLFHS) Kaedam district, Maha Sarakham province

(Health service core package purchasable)

Projects/Activities	Target Group	Indicators	Time	Operating Budget	Budget Sources			Responsibilities
					NHSO PP 40	TAO	Others	
1. Health promotion projects for child developing centre of the Wungsang TAO **<u>Activities</u>** - Health improvement according to standard criteria of child health	Childhood at Child health Centre of the Wungsang TAO	Children 3-5 years have developing growth as standard criteria 80.0%	June 53 – 30 Sep. 53	1. Activities of health improvement developing according to standard criteria of child health - Remuneration of Oral health examination Child health screening 10,000 Bahts (Ten thousand bahts) ***Expenditure can be shared**	**10,000**			**Committee of the child developing centre of the Wungsang TAO**

Health Action Plan, Fiscal Year 2010

Wungsang Local Fund Health Security (WSLFHS) Kaedam district, Maha Sarakham province

(Support health centre services)

Projects/Activities	Target Group	Indicators	Time	Operating Budget	Budget Sources			Responsibilities
					NHSO PP 40	TAO	Others	
2. Diabetes and Hypertension Screening Test by Health Professionals **<u>Activities</u>** - Blood testing, Blood pressure measurement - Metabolic screening by questionnaires - Behavioural changes	People 35+ years in Mu 1-20 of Wungsang Sub-district	People 35+ years have screening tests of DM and HT as 60.0%	June 53 – 30 Sep. 53	1. Metabolic forms 7,000 Bahts 2. Activities of behavioural changes - Meal - Coffee break - Trainers 15,000 Bahts Total 20,000 Bahts (Twenty thousand bahts) ***Expenditure can be shared**	**20,000**			**Wungsang Health Centre and Nongbour Health Centre**

Health Action Plan, Fiscal Year 2010

Wungsang Local Fund Health Security (WSLFHS) Kaedam district, Maha Sarakham province

(Health promotion and prevention for communities)

Projects/Activities	Target Group	Indicators	Time	Operating Budget	Budget Sources			Responsibilities
					NHSO PP 40	TAO	Others	
3. Reducing and Stopping Alcohol and Drugs **<u>Activities</u>** - Public relations - Screening surveys - Selection a model person - Yaowachon Ton Kar	People in Mu 1-20 of Wungsang Sub-district	80.0% of Household have screening	June 53 – 30 Sep. 53	1. Public relation posters 2. Remuneration of surveys 3. Certifications 4. Slogan competition rewards 5. Meal 6. Remuneration of evaluation 30,000 Bahts (Thirty thousand bahts) ***Expenditure can be shared**	**30,000**			**Chief of villages of Mu 1-20**

Health Action Plan, Fiscal Year 2010

Wungsang Local Fund Health Security (WSLFHS) Kaedam district, Maha Sarakham province

(Health promotion and prevention for communities)

Projects/Activities	Target Group	Indicators	Time	Operating Budget	Budget Sources			Responsibilities
					NHSO PP 40	TAO	Others	
4. Supporting disable and crippled people **<u>Activities</u>** - Health assessment - Health promotion	Disable and crippled people in Wungsang Sub-district	80.0% of disable and crippled people have increased health	June 53 – 30 Sep. 53	1. Activities of health promotion - Meal - Coffee break - Trainers 15,000 Bahts 2. Remuneration of evaluation 5,000 Bahts Total 20,000 Bahts (Twenty thousand bahts) ***Expenditure can be shared**	**20,000**			**Union of Disable and crippled people in Wungsang Sub-district**

Health Action Plan, Fiscal Year 2010

Wungsang Local Fund Health Security (WSLFHS) Kaedam district, Maha Sarakham province

(Health promotion and prevention for communities)

Projects/Activities	Target Group	Indicators	Time	Operating Budget	Budget Sources			Responsibilities
					NHSO PP 40	TAO	Others	
5. Health promotion of elderly and chronic disease people					**20,000**			**Wungsang Health Centre and Nongbour Health Centre**
Activities								
5.1 Nutrition support for elders with chronic disease in Wungsang Health Centre	Chronic disease patients of 12 villages	100.0% of chronic disease patients have breakfast at two health centres after doing fasting blood sugar tests	June 53 – 30 Sep. 53	1. Breakfast for 50 people, 50 bahts/person, and 4 days 10,000 Bahts				
5.2 Nutrition support for elders with chronic disease in Nongbour Health Centre	Chronic disease patients of 8 villages			2. Breakfast for 50 people, 50 bahts/person, and 4 days 10,000 Bahts Total 20,000 Bahts (Twenty thousand bahts) ***Expenditure can be shared**				

Health Action Plan, Fiscal Year 2010

Wungsang Local Fund Health Security (WSLFHS) Kaedam district, Maha Sarakham province

(Health promotion and prevention for communities)

Projects/Activities	Target Group	Indicators	Time	Operating Budget	Budget Sources			Responsibilities
					NHSO PP 40	TAO	Others	
6. Supporting iodized salt for households **<u>Activities</u>** - Distribute iodized salt every household	5,805 houses in 20 villages in Wungsang Sub-district	100.0% of households have iodized salt for consume	June 53 – 30 Sep. 53	1. Buying iodized salt for 5,805 houses 15,000 Bahts (Fifteen thousand bahts) ***Expenditure can be shared**	**15,000**			**Committee of the WLFHS**

Health Action Plan, Fiscal Year 2010

Wungsang Local Fund Health Security (WSLFHS) Kaedam district, Maha Sarakham province

(Health promotion and prevention for communities)

Projects/Activities	Target Group	Indicators	Time	Operating Budget	Budget Sources			Responsibilities
					NHSO PP 40	TAO	Others	
7. Supporting exercise projects **<u>Activities</u>** 7.1 Exercise patterns - Aerobic dance - Sports - Long stick (Plong Thai) dance 7.2 Exercise competition	People in Mu 1-20 of Wungsang Sub-district	100.0% of people in Wungsang Sub-district are healthy	June 53 – 30 Sep. 53	1. Activities of exercise in relation to commune lifestyles in 20 villages 70,000 Bahts 2. Activities of competitions - Meal - Rewards - Referees 15,000 Bahts Total 85,000 Bahts (Eighty-five thousand bahts) ***Expenditure can be shared**	**85,000**			**Leaders and health volunteers in Wungsang Sub-district**

Health Action Plan, Fiscal Year 2010

Wungsang Local Fund Health Security (WSLFHS) Kaedam district, Maha Sarakham province

(Health promotion and prevention for communities)

Projects/Activities	Target Group	Indicators	Time	Operating Budget	Budget Sources			Responsibilities
					NHSO PP 40	TAO	Others	
8. Home visit **<u>Activities</u>** Home visit of - Mother and child - Chronic disease people - Disable people	Chronic people in Wungsang Sub-district	Visiting: - 95% of mother and child - 80% of chronic disease patients - 100% of disable people	June 53 – 30 Sep. 53	1. Remuneration for 20 villages, 5 times, 200 bahts/visit Total 20,000 Bahts (Tweenty thousand bahts) ***Expenditure can be shared**	**20,000**			**Health volunteers**

Health Action Plan, Fiscal Year 2010

Wungsang Local Fund Health Security (WSLFHS) Kaedam district, Maha Sarakham province

(Manage and develop Local Fund Health Security)

Projects/Activities	Target Group	Indicators	Time	Operating Budget	Budget Sources			Responsibilities
					NHSO PP 40	TAO	Others	
9. Competency developments of committee of WLFHS **<u>Activities</u>** 9.1 Competency developments; - Knowledge of LFHS - Health promotion and prevention - Processing of LFHS - Management of LFHS - Roles of LFHS committee 9.2 Monthly meeting system	Committee of the WLFHS, 16 people	- Every committee attend 2 training courses per year - Meeting of committee at least once a month	June 53 – 30 Sep. 53	1. Remuneration for meeting and training , 16 people, 6 times/person, 200 bahts/event 9,600 bahts 2. Meal 4,000 bahts 3. Trainers 3,000 bahts 4. Documents 1,500 bahts 6. Office supplies 6,400 bahts Total 24,500 Bahts (Twenty-four thousand and five hundred bahts) ***Expenditure can be shared**	**24,500**			**Committee of the WLFHS**

*** Budget for management the Local Fund Health Security, in the Fiscal year 2553 were totally 246,500 Bahts**

แผนปฏิบัติการด้านสุขภาพ
งบ PP COM จากสำนักงานหลักประกันสุขภาพแห่งชาติ เขต 7 จังหวัดขอนแก่น
ปีงบประมาณ 2553

กองทุนระบบหลักประกันสุขภาพ องค์การบริหารส่วนตำบลวังแสง
อำเภอแกดำ จังหวัดมหาสารคาม

แผนปฏิบัติการพัฒนาด้านสุขภาพ ปีงบประมาณ 2553

กองทุนระบบหลักประกันสุขภาพระดับพื้นที่ องค์การบริหารส่วนตำบลวังแสง อำเภอแกดำ จังหวัดมหาสารคาม (หมวด ซื้อบริการชุดสิทธิประโยชน์)

โครงการ/กิจกรรม	กลุ่มเป้าหมาย	ตัวชี้วัด	ระยะเวลา	งบประมาณดำเนินการ	แหล่งงบประมาณ			ผู้รับผิดชอบ
					สปสช. PP 40	อบต.	อื่น ๆ	
1. สนับสนุนโครงการส่งเสริมสุขภาพแก่เด็กศูนย์พัฒนาเด็กเล็ก อบต.วังแสง **<u>กิจกรรม</u>** - พัฒนาสุขภาพเด็กตามเกณฑ์มาตรฐาน	เด็กปฐมวัย ศูนย์พัฒนาเด็กเล็ก อบต.วังแสง	เด็ก อายุ 3 - 5 ปี มีพัฒนาการเจริญเติบโตตามเกณฑ์มาตรฐาน ร้อยละ 80.0	มิ.ย. 53 – 30 ก.ย. 53	1. กิจกรรมการพัฒนาสุขภาพเด็กตามเกณฑ์มาตรฐาน - ค่าตอบแทนการปฏิบัติงาน - ตรวจสุขภาพช่องปากเด็ก - ประเมินสุขภาพเด็ก **เป็นเงิน 10,000 บาท** **(หนึ่งหมื่นบาทถ้วน)** *ค่าใช้จ่ายทุกรายการถัวเฉลี่ยได้	**10,000**			คณะกรรมการศูนย์พัฒนาเด็กเล็ก และ อบต.วังแสง

แผนปฏิบัติการพัฒนาด้านสุขภาพ ปีงบประมาณ 2553

กองทุนระบบหลักประกันสุขภาพระดับพื้นที่ องค์การบริหารส่วนตำบลวังแสง อำเภอแกดำ จังหวัดมหาสารคาม (หมวด สนับสนุนหน่วยบริการจัดบริการ)

โครงการ/กิจกรรม	กลุ่มเป้าหมาย	ตัวชี้วัด	ระยะเวลา	งบประมาณดำเนินการ	แหล่งงบประมาณ			ผู้รับผิดชอบ
					สปสช. PP 40	อบต.	อื่น ๆ	
2. โครงการตรวจคัดกรองโรคเบาหวานและความดันโลหิตสูงโดยเจ้าหน้าที่สาธารณสุข **<u>กิจกรรม</u>** - เจาะเลือด วัดความดันโลหิต - ประเมินโดยใช้แบบคัดกรอง Metabolic - ปรับเปลี่ยนพฤติกรรม	ประชาชนอายุ 35 ปีขึ้นไป ในหมู่ที่ 1 – 20 ตำบลวังแสง	ประชาชนอายุ 35 ปีขึ้นไป ได้รับการตรวจคัดกรองเบาหวานและความดันโลหิต ร้อยละ 60.0	มิ.ย. 53 – ก.ย. 53	1. ค่าเอกสารแบบฟอร์ม Metabolic **เป็นเงิน 7,000 บาท** 2. ค่าจัดกิจกรรมปรับเปลี่ยนพฤติกรรม ได้แก่ - ค่าอาหาร - ค่าอาหารว่าง - ค่าวิทยากร **เป็นเงิน 15,000 บาท** **รวมเป็นเงิน 22,000 บาท** **(สองหมื่นสองพันบาทถ้วน)** *ค่าใช้จ่ายทุกรายการถัวเฉลี่ยได้	**22,000**			สถานีอนามัยวังแสง และสถานีอนามัยหนองบัว

Appendex IV

Ethical Approval

แผนปฏิบัติการพัฒนาด้านสุขภาพ ปีงบประมาณ 2553

กองทุนระบบหลักประกันสุขภาพระดับพื้นที่ องค์การบริหารส่วนตำบลวังแสง อำเภอแกดำ จังหวัดมหาสารคาม (หมวด สร้างสุขภาพโดยชุมชน)

โครงการ/กิจกรรม	กลุ่มเป้าหมาย	ตัวชี้วัด	ระยะเวลา	งบประมาณดำเนินการ	แหล่งงบประมาณ			ผู้รับผิดชอบ
					สปสช.	อบต.	อื่น ๆ	
3. โครงการลด ละ เลิก สุรา ยาเสพติด **<u>กิจกรรม</u>** - ประชาสัมพันธ์ - สำรวจข้อมูลพื้นฐาน (โดยการคัดกรอง) - คัดเลือกบุคคลต้นแบบ - เยาวชนต้นกล้า	ประชาชน ในหมู่ที่ 1 – 20 ตำบลวังแสง	- ทุกหลังคาเรือนได้รับการสำรวจคัดกรอง ร้อยละ 80.0	มิ.ย. 53 – ก.ย. 53	1. ค่าจัดทำป้ายไวนิล จำนวน 20 ป้าย **เป็นเงิน 10,000 บาท** 2. ค่าตอบแทนการปฏิบัติงาน สำรวจข้อมูล **เป็นเงิน 5,000 บาท** 3. ค่าวัสดุจัดทำประกาศเกียรติคุณ **เป็นเงิน 5,000 บาท** 4. ค่าประกวดคำขวัญเยาวชนต้นกล้าฯ **เป็นเงิน 5,000 บาท** 5. ค่าอาหารสำหรับการดำเนินโครงการ **เป็นเงิน 3,000 บาท** 6. ค่าตอบแทนการปฏิบัติงานติดตามประเมินผล **เป็นเงิน 2,000 บาท** **รวมเป็นเงิน (สามหมื่นบาทถ้วน)** *ค่าใช้จ่ายทุกรายการถัวเฉลี่ยได้	**30,000**			ผู้ใหญ่บ้านหมู่ที่ 1 - 20

แผนปฏิบัติการพัฒนาด้านสุขภาพ ปีงบประมาณ 2553

กองทุนระบบหลักประกันสุขภาพระดับพื้นที่ องค์การบริหารส่วนตำบลวังแสง อำเภอแกดำ จังหวัดมหาสารคาม (หมวด สร้างสุขภาพโดยชุมชน)

โครงการ/กิจกรรม	กลุ่มเป้าหมาย	ตัวชี้วัด	ระยะเวลา	งบประมาณดำเนินการ	แหล่งงบประมาณ			ผู้รับผิดชอบ
					สปสช. PP 40	อบต.	อื่น ๆ	
4. โครงการช่วยเหลือผู้พิการ **<u>กิจกรรม</u>** - ประเมินสภาวะสุขภาพ - จัดกิจกรรมการส่งเสริมสุขภาพ	ผู้พิการในตำบลวังแสง	กลุ่มคนพิการมีภาวะสุขภาพดีขึ้น ร้อยละ 80.0	มิ.ย.53 – ก.ย. 53	1. ค่าจัดกิจกรรมการส่งเสริมสุขภาพสำหรับผู้พิการ ได้แก่ - ค่าอาหาร - ค่าอาหารว่าง - ค่าวิทยากร **เป็นเงิน 15,000 บาท** 2. ค่าตอบแทนการติดตามประเมินสภาวะสุขภาพ **เป็นเงิน 5,000 บาท** **รวมเป็นเงิน 20,000 บาท** **(สองหมื่นบาทถ้วน)** *ค่าใช้จ่ายทุกรายการถัวเฉลี่ยได้	**20,000**			ชมรมผู้พิการในตำบลวังแสง

แผนปฏิบัติการพัฒนาด้านสุขภาพ ปีงบประมาณ 2553

กองทุนระบบหลักประกันสุขภาพระดับพื้นที่ องค์การบริหารส่วนตำบลวังแสง อำเภอแกดำ จังหวัดมหาสารคาม (หมวด สร้างสุขภาพโดยชุมชน)

โครงการ/กิจกรรม	กลุ่มเป้าหมาย	ตัวชี้วัด	ระยะเวลา	งบประมาณดำเนินการ	แหล่งงบประมาณ			ผู้รับผิดชอบ
					สปสช.	อบต.	อื่น ๆ	
5. โครงการส่งเสริมสุขภาพชมรมผู้สูงอายุกลุ่มผู้ป่วยโรคเรื้อรังตำบลวังแสง **<u>กิจกรรม</u>** 5.1 สนับสนุน/ส่งเสริมอาหารแก่ผู้สูงอายุที่เป็นโรคเบาหวานที่เข้ารับบริการจากสถานีอนามัยวังแสง 5.2 สนับสนุน/ส่งเสริมอาหารแก่ผู้สูงอายุที่เป็นโรคเบาหวานที่เข้ารับบริการจากสถานีอนามัยหนองบัว	กลุ่มผู้ป่วยโรคเรื้อรัง จำนวน 12 หมู่บ้าน ต.วังแสง กลุ่มผู้ป่วยโรคเรื้องรัง จำนวน 8 หมู่บ้าน ต.วังแสง	ร้อยละ 100.0 ของชมรมผู้สูงอายุที่มาเจาะเลือดตรวจหาน้ำตาลในเลือดได้รับอาหารเช้า ทั้ง 20 หมู่บ้าน	มิ.ย.53 – ก.ย. 53	1. สนับสนุนค่าอาหารเช้าแก่ผู้สูงอายุที่นัดตรวจเจาะเลือดตรวจหาน้ำตาลในเลือด จำนวน 1 แห่ง ๆ ละ 50 คน ๆ ละ 50 บาท จำนวน 4 ครั้ง **เป็นเงิน 10,000 บาท** 1. สนับสนุนค่าอาหารเช้าแก่ผู้สูงอายุที่นัดตรวจเจาะเลือดตรวจหาน้ำตาลในเลือด จำนวน 1 แห่ง ๆ ละ 50 คน ๆ ละ 50 บาท จำนวน 4 ครั้ง **เป็นเงิน 10,000 บาท** **รวมเป็นเงิน 20,000 บาท** **(สองหมื่นบาทถ้วน)** *ค่าใช้จ่ายทุกรายการถัวเฉลี่ยได้	**20,000**			- สถานีอนามัยวังแสง - สถานีอนามัยหนองบัว - อสม.

แผนปฏิบัติการพัฒนาด้านสุขภาพ ปีงบประมาณ 2553

กองทุนระบบหลักประกันสุขภาพระดับพื้นที่ องค์การบริหารส่วนตำบลวังแสง อำเภอแกดำ จังหวัดมหาสารคาม (หมวด สร้างสุขภาพโดยชุมชน)

โครงการ/กิจกรรม	กลุ่มเป้าหมาย	ตัวชี้วัด	ระยะเวลา	งบประมาณดำเนินการ	แหล่งงบประมาณ			ผู้รับผิดชอบ
					สปสช. PP 40	อบต.	อื่น ๆ	
6. โครงการสนับสนุนเกลือไอโอดีนในครัวเรือน					**15,000**			คณะกรรมการกองทุนฯ
<u>กิจกรรม</u> - จัดซื้อเกลือไอโอดีนให้ทุกหลังคาเรือน	หมู่ที่ 1 -20 ต.วังแสง จำนวน 5,805 หลังคาเรือน	ร้อยละ 100.0 ของทุกหลังคาเรือนได้รับเกลือไอโอดีนไว้บริโภค	มิ.ย.53 – ก.ย. 53	1. ค่าจัดซื้อเกลือไอโอดีน จำนวน 5,805 หลังคาเรือน **เป็นเงิน 15,000 บาท** **รวมเป็นเงิน 15,000 บาท** **(หนึ่งหมื่นห้าพันบาทถ้วน)** *ค่าใช้จ่ายทุกรายการถัวเฉลี่ยได้				

แผนปฏิบัติการพัฒนาด้านสุขภาพ ปีงบประมาณ 2553

กองทุนระบบหลักประกันสุขภาพระดับพื้นที่ องค์การบริหารส่วนตำบลวังแสง อำเภอแกดำ จังหวัดมหาสารคาม (หมวด สร้างสุขภาพโดยชุมชน)

โครงการ/กิจกรรม	กลุ่มเป้าหมาย	ตัวชี้วัด	ระยะเวลา	งบประมาณดำเนินการ	แหล่งงบประมาณ			ผู้รับผิดชอบ
					สปสช.	อบต.	อื่น ๆ	
7. สนับสนุนส่งเสริมโครงการออกกำลังกาย **<u>กิจกรรม</u>** 7.1 จัดรูปแบบการออกกำลังกาย ได้แก่ - เต้นแอร์โรบิก - การแข่งขันกีฬา - รำไม้พลอง 7.2 จัดประกวดการออกกำลังกาย	ประชาชนตำบลวังแสง ม.1 - ม.20	ประชาชนตำบลวังแสงมีสุขภาพแข็งแรง ร้อยละ 100	มิ.ย.53 – ก.ย. 53	1. ค่าจัดกิจกรรมรูปแบบการออกกำลังกายให้สอดคล้องกับวิถีชุมชนแต่ละหมู่บ้าน จำนวน 20 หมู่บ้าน **เป็นเงิน 70,000 บาท** 2. ค่าจัดประกวดการออกกำลังกาย ได้แก่ - ค่าอาหาร - ค่าเงินรางวัล - ค่าวิทยากร **เป็นเงิน 15,000 บาท** **รวมเป็นเงิน 80,000 บาท** **(แปดหมื่นห้าพันบาทถ้วน)** *ค่าใช้จ่ายทุกรายการถัวเฉลี่ยได้	**85,000**			กำนัน/ผู้ใหญ่บ้าน หมู่ที่ 1 - 20 อสม./อสด./ส.อบต.

แผนปฏิบัติการพัฒนาด้านสุขภาพ ปีงบประมาณ 2553

กองทุนระบบหลักประกันสุขภาพระดับพื้นที่ องค์การบริหารส่วนตำบลวังแสง อำเภอแกดำ จังหวัดมหาสารคาม (หมวด สร้างสุขภาพโดยชุมชน)

โครงการ/กิจกรรม	กลุ่มเป้าหมาย	ตัวชี้วัด	ระยะเวลา	งบประมาณดำเนินการ	แหล่งงบประมาณ			ผู้รับผิดชอบ
					สปสช. PP 40	อบต.	อื่น ๆ	
8. โครงการเยี่ยมบ้าน **<u>กิจกรรม</u>** - เยี่ยมบ้านเพื่อประเมินสภาวะสุขภาพของผู้ป่วยเรื้อรัง	ผู้ป่วยโรคเรื้อรัง ใน ต.วังแสง	- มารดาและทารก ได้รับการเยี่ยมตามเกณฑ์ ร้อยละ 95.0 - ผู้ป่วยเรื้อรัง ได้รับการเยี่ยม ร้อยละ 80.0 - ผู้พิการได้รับการเยี่ยม ร้อยละ 100.0	มิ.ย.53 – ก.ย. 53	1. ค่าตอบแทนการปฏิบัติงาน จำนวน 20 หมู่ ๆ ละ 5 ครั้ง ๆ ละ 200 บาท **เป็นเงิน 20,000 บาท** **รวมเป็นเงิน 20,000 บาท** **(สองหมื่นบาทถ้วน)** *ค่าใช้จ่ายทุกรายการถัวเฉลี่ยได้	**20,000**			อสม./อสด.

แผนปฏิบัติการพัฒนาด้านสุขภาพ ปีงบประมาณ 2553

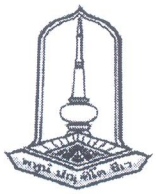
กองทุนระบบหลักประกันสุขภาพระดับพื้นที่ องค์การบริหารส่วนตำบลวังแสง อำเภอแกดำ จังหวัดมหาสารคาม (หมวด บริหารจัดการ)

โครงการ/กิจกรรม	กลุ่มเป้าหมาย	ตัวชี้วัด	ระยะเวลา	งบประมาณดำเนินการ	แหล่งงบประมาณ			ผู้รับผิดชอบ
					สปสช.	อบต.	อื่น ๆ	
9. โครงการพัฒนาศักยภาพคณะกรรมการบริหารกองทุนฯ **<u>กิจกรรม</u>** 1. พัฒนาศักยภาพคณะกรรมการกองทุนฯ ในประเด็นเกี่ยวกับ - ความรู้เรื่องหลักประกันสุขภาพ - การส่งเสริมสุขภาพ และป้องกันโรค - แนวทางในการดำเนินงานระบบหลักประกันสุขภาพท้องถิ่น - แนวทางการบริหารจัดการกองทุน - บทบาทหน้าที่คณะกรรมการ - อื่นๆ ที่เกี่ยวข้อง 2. พัฒนาระบบการประชุมประจำเดือนของคณะกรรมการกองทุนฯ	คณะกรรมการบริหารกองทุนฯ อบต.วังแสง จำนวน 16 คน	- คณะกรรมการทุกได้รับการอบรมอย่างน้อย ปีละ 2 ครั้ง - ประชุมประจำเดือนอย่างน้อย 1 ครั้ง/เดือน	มิ.ย.53 – ก.ย.. 53	1. ค่าตอบแทนการประชุมและฝึกอบรม จำนวน 16 คน ๆ ละ 6 ครั้ง ๆ ละ 100 บาท **เป็นเงิน 9,600 บาท** 2. ค่าอาหาร **เป็นเงิน 4,000 บาท** 3. ค่าวิทยากร **เป็นเงิน 3,000 บาท** 4. ค่าเอกสาร **เป็นเงิน 1,500 บาท** 5. ค่าจัดซื้อวัสดุ/อุปกรณ์ ได้แก่ - จัดซื้อวัสดุสำหรับงานกองทุนฯ - จัดทำเอกสารและบัญชี **เป็นเงิน 6,400 บาท** **รวมเป็นเงิน 24,500 บาท** **(สองหมื่นสี่พันห้าร้อยบาทถ้วน)** *ทั้งนี้ อนุมัติให้ถัวจ่ายเฉลี่ยได้ทุกรายการ	**24,500**			คณะกรรมการกองทุนฯ

*** รวมเงินในการบริหารกองทุนระบบหลักประกันสุขภาพระดับพื้นที่ องค์การบริหารส่วนตำบลวังแสง อำเภอแกดำ จังหวัดมหาสารคาม ปีงบประมาณ 2553 รวมเป็นเงินทั้งสิ้น 246,500 บาท (สองแสนสี่หมื่นหกพันห้าร้อยบาทถ้วน) ***

Appendex IV

Ethical Approval



มหาวิทยาลัยมหาสารคาม

คณะกรรมการจริยธรรมการวิจัยในมนุษย์

ใบรับรองการอนุมัติ

เลขที่การรับรอง : 0100 / 2554

ชื่อโครงการวิจัย : การปฏิรูปหลักประกันสุขภาพแห่งชาติ : บทบาทขององค์กรปกครองส่วนท้องถิ่นในการดำเนินงานกองทุนหลักประกันสุขภาพในระดับท้องถิ่นหรือพื้นที่ ในภาคตะวันออกเฉียงเหนือ ประเทศไทย

ผู้วิจัยหลัก : นายวรพจน์ พรหมสัตยพรต

หน่วยงานต้นสังกัด : วิทยาลัยวิทยาศาสตร์การสาธารณสุข จุฬาลงกรณ์มหาวิทยาลัย

สถานที่ทำการวิจัย : ภาคตะวันออกเฉียงเหนือ

ข้อเสนอการวิจัยนี้ ได้รับการพิจารณาและให้ความเห็นชอบจากคณะกรรมการจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยมหาสารคามแล้ว และอนุมัติในแง่จริยธรรมให้ดำเนินการศึกษาวิจัยเรื่องข้างต้นได้ บนพื้นฐานของโครงร่างงานวิจัยที่คณะกรรมการฯ ได้รับและพิจารณา หากมีการเปลี่ยนแปลงใดๆ ในโครงการวิจัย ผู้วิจัยจักต้องยื่นขอรับการพิจารณาใหม่

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(รองศาสตราจารย์ ดร.ปรีชา ประเทพา)

ประธานคณะกรรมการจริยธรรมการวิจัยในมนุษย์

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CURRICULUM VITAE

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Education:

1. Cert. in Junior Health Worker
   North-Eastern Region College of Public Health, Thailand.
2. B.P.H. (Public Health Administration)
   Sukhothai Thammathirat Open University, Thailand.
3. B.Sc. (Health Education), Loei Teachers College, Thailand.
4. B.A. (Political Science), Ramkhamhaeng University, Thailand.
5. M.Sc. (Public Healh), Mahidol University, Thailand.
   Major in Medical and Public Health Law and Administration
6. Cert. Mini MBA in Health, Chulalongkorn University, Thailand.
7. Ph.D. (Candidate), (Health System Development),
   Chulalongkorn University, Thailand.

Professional Experience:

1. Study tour on Social Science in Tropical Diseases to Information and Reference Center of Tropical Medicine, Institute of Tropical Medicine, Nagasaki University, Japan.
2. Study tour on Health Management and Health Environment focus on water supplies to the NEWater, Singapore.
3. Research presentation at the Faculty of Medicine and Health Sciences, the University of Nottingham, the UK.
4. Research presentation at the School of Health Science, the University of Wales, Swansea, the UK.
5. Training on Health Economics and Econometrics at the University of Lausanne, Switzerland.
6. Training on SSES Annual Meeting 2009 Globalization: Patterns and Challenges at the University of Geneva, Switzerland.
7. Study tour on Health System and Health Products at Korea Health Industry Development Institute, Seoul, Republic of Korea.
8. Training the EORTC PROBE Course on "QUALITY OF LIFE AND PATIENT REPORTED OUTCOMES IN CANCER CLINICAL TRIALS" Brussels, Belgium
9. Study tour on Health System Management at the Seoul National University Hospital, Seoul, Republic of Korea.

10. Study tour on Health System Management at School of Public Health, University of California, Los Angeles (UCLA), USA.
11. Research presentation at 4th International Conference Health GIS 2011, New Delhi, India.
12. Research presentation at The Evidence 2011 Transforming Healthcare, by BMJ Group, London, UK.

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