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Full Length Research Paper

Universal coverage health care reforms of Thailand: researching the role of the local fund health security in local government purchasers in the north-eastern region of Thailand

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The health insurance system cannot achieve health systems goals of efficiency and equity. According to the decentralisation act, the majority of the public health service facilities may be devolved to the local authorities. The objective was to study the role of the local fund health security (LFHS) in local governments as a component of Thailand's universal coverage healthcare reforms in Thailand. This study using a mix method. A survey section used a cross-sectional approach within 190 samples in local governments. The qualitative data were focused on an After Action Review (AAR) of the LFHS. The LFHSs could manage healthcare services in different levels, 1) providing supports 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. The results suggest that the LFHS will be proposed to policy makers of the local government and the National Health Security Office for further improvement of healthcare services and health decentralization.

Keywords: Universal coverage, health care reform, role of local fund health security, local government purchaser, Thailand.

INTRODUCTION

The government of Thailand recently introduced a health insurance system for the most disadvantaged fraction of the population. The system has been governed by centralized agencies and tends to be given into the hands of local administrations according to a governmental direction that the system should be decentralized (National Decentralization Committee Office, 1999). This study attempted to investigate how the local administration can cope with the task and what will be the after-effects of the decentralization of the system.

The Decentralization Act became effective in November 1999 to define the roles and responsibilities of the National Decentralization Committee (NDC) (National Decentralization Act 1999, 1999). A primary responsibility of the NDC is to produce a decentralization plan, defining relationships and functional responsibilities between central and local governments. It also defines local revenue sources and identifies 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).

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The National Health Security Act B.E. 2545 (A.D. 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 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) (Chunharas et al., 1998). This provision of the law forced the NHSO to coordinate activities with local governments for co-matching fund (Pannarunothai et al., 2004).

This study aimed to investigate the impact of new funding arrangements affecting local government, and specifically municipalities and the Tambon Administrative Organisations (TAOs), in the north-eastern of Thailand. 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.

The overall objective of the research was to describe the policy process on 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.

METHODS

Study Design

This study aimed to examine the policy process of the local fund health securities (LFHS) and the new roles developed by local government organisations using a mix of qualitative and quantitative methods. A policy formulation was an analysis of policy documents. A policy implementation was described using questionnaires and interviews on the LFHS in Thailand that established from 2006 - 2010 (B.E. 2549 to B.E. 2553). Study samplings were 190 organisations of both the TAOs and municipalities spread across the northeast region.

Study Setting

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 TAO (Khonkaen Branch of National Health Security Office, 2010). Out of these organisations a sample size calculation was drawn by using the equation as given below (Wayne, 1995):

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

This study was conducted in four types of organisations in the northeast of Thailand. One was the TAO, and three were types of municipalities, specifically examples of the City Municipality, the Town Municipality, and the Tambon Municipality.

Data Collection Methods

Questionnaires were completed by a member of the LHSF committee at each site. Both municipal and TAO 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 organization was the member nominated by the committee chair.

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 Organization (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.

Data Analysis

Descriptive statistics were analysed to explain demographic characteristics using frequency (e.g. number and percentage) and central tendency (e.g. mean, mode and median). Qualitative data was analysed using content analysis (Polit and Hungler, 1995; Burns

and Grove, 2001).

RESULTS

The research findings show an analysis of policy documents and policy implementation which were relevant to the issues of the LFHS.

1. Policy Formulation

The research findings are presented 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.

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.

Local government is the nearest organization to the people and generally possesses a good understanding of local issues. It should have the capacity to manage a local fund health security 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.

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 covering in every sub-district in all the LAO in Thailand. Also the NHSO had determined strategies relating to the LFHS management based on a concept as health promotion and disease prevention is 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.

2. Policy Implementation

The research findings show an analysis of policy implementation which was relevant to the issues of the LFHS. Then, study results on policy of the LFHS are presented.

Characteristics of the Local Fund Health Security

Most participants were health officers (65.2%) and the others were chief executive of the TAO, chief administrators of the TAO, council members, and members of the TAO. They had worked on those positions varied from 1 year to 33 years (Median 4 yrs). They were chairman, vice-chairman, committee, and committee with secretary. The LFHS in Thailand was established in 2006, but almost half of study samples established in 2008. One hundred and twenty local funds were already evaluated which 8 funds passed at level A+. Before established, there were health data in terms of health community data, health community plans, and strategy maps. Most of committee boards had attended the training programs for preparations of local funds. In budget year 2010, each local fund got budget allocation from the NHSO varied from 20,000 to 3,424,240 bahts. Budgets were allocated mostly in January to March 2010. The majority of samples had reporting systems via online of http://tobt.nhso.go.th/ completely and currently. Data on local fund management program included data bases, activity reports and budget reports. (See table 1)

Committees and Management of the Local Fund Health Security

Most local funds had appointed subcommittee delegations following the NHSO criteria, to do administrative work, finance, account, project, assistant secretary, etc. Secretaries of the LFHS usually were the municipal and the TAO clerks. Most board committees had management processes for planning on community health plans. The majority of boards knew the committee roles in relation to a local health fund management from training courses, conferences, seminars, etc. They then imparted that understanding to their local funds by meetings. Thus, they believed their local funds had potentialities to manage in problem bases and community

Table 1. Characteristic of samples relating the LFHS

Variables	Number (n=190)	(%)
Position		
Mayor	5	2.6
Municipal clerk	3	1.6
Members of municipality	3	1.6
Chief executive of the TAO	25	13.2
Chief administrator of the TAO	24	12.6
Member of the TAO	6	3.2
Health officer	124	65.2
Committee Position in the LFHS		
Chairman	32	16.8
Vice-Chairman	2	1.1
Committee	54	28.4
Committee and Secretary	36	18.9
Subcommittee	66	34.8
Level of Local Government		
City Municipality	1	0.5
Town Municipality	2	1.1
Tambon Municipality	25	13.2
TAO	162	85.2
Information of the LFHS		
Never received	3	1.6
Received	187	98.4
Performance Training of the LFHS		
Never received	25	13.2
Received	165	86.8

needs effectively. (See table 2)

Plans of the Local Fund Health Security

Made plans were divided into two periods; before and after budget allocations from the NHSO. Seventy-two local funds made plans before budget allocations which were mostly from October to December 2009. Not only board committees participated in plan makings, but also other people were allowed to arrange for the LFHS including health volunteers, community leaders, healthcare officers, teachers, and ordinary people, etc. Most local funds employed community health plans for planning because they consisted of community data which were approved by community agreements. The majority of local funds did problem analyses and priority settings initially to guide making plans of the LFHS. Thus, their plans could solve the community problems precisely, and urgent and severe problems were solved properly. Some plans could be conducted by communities themselves and used recourses from communities. Some were integrated with local government plans and got support from other organizations. (See table 3)

Budget Payment and Accounts of the Local Fund Health Security

A transfer banking was the most way that local funds received money from the LFHS. They had payment evidences and did autograph on them. The majority of local funds did not keep cash with the committees because keeping cash personally was not mentioned in the local fund regulations. 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

Table 2. Committee of the LFHS

Variables	Number (n=190)	(%)
Subcommittee Delegation		
Yes	149	78.4
No	36	18.9
Local Fund Health Security Secretary		
The municipal clerk/The TAO clerk	154	81.1
Others	35	18.4
Frequency of Committee Meeting		
Every month	32	16.8
Every 2 month	43	22.6
Every 3 month	81	42.6
Other	31	16.3
Management Process of Health Community Plan		
Yes	173	91.1
No	15	7.9
Accepting Role of Committee		
Confident	157	82.6
Not Unconfident	30	15.8
Do not know	1	0.5
Need Assessment		
Yes	154	81.1
Not confident	28	14.7
No	6	3.2
Training and Seminar on Knowledge Management		
Never	9	4.7
Someone	135	71.1
Everyone	45	23.7
Knowing about Budget Payment		
Do not know	1	0.5
Do not confident	32	16.8
Confident	156	82.1
Regulations of LFHS Budget Passing Committee		
No	4	2.1
Yes	183	96.3

chairman or a committee or a secretary of the LFHS. 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 LFHS. In consequence, those paper reports were always signed by local fund accountants. An annual report of the LFHS mostly consisted of general data of local funds, project performance and financial reports. (See table 4)

Supported Activities from the Local Fund Health Security

This study found that the local funds had done activities and projects on health service core package purchasable in five groups of target people which consisted of mother and child (80% of study funds), aging people (71.1%), disable 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 centers in 4 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 included 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.

Table 3. Planning of the LFHS

Variables	Number (n=190)	(%)
Made Plans Before Allocation (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
ade Plans After Allocation (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
Planning Coordination		
Only LFHS Committee	83	43.7
Other people	102	53.7
Unknown	5	2.1
Planning Instrument		
Health Community Plan	123	64.7
Strategy Mapping	67	35.3
Problem Analysis and Priority Setting		
Did not	20	10.5
Done	163	85.8
Types of Plan and Project		
Processing by community	97	51.1
Integrate with plans of local government	107	56.3
Projects and plan which supported from others	20	10.5
Payment Methods for Plans		
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 the LFHS		
Health service core package purchasable	158	83.2
Support health centre	165	86.8
Health promotion and prevention for communities	169	88.9
Manage and develop LFHS	172	90.5

3. Results of After Action Review (AAR) 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.

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

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

Table 4. Budget Payment from the LFHS

Variables	Number (n=190)	(%)
Getting Budget from 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
Saving Cash		
Never	159	83.7
Yes	24	12.6
Account Book of the LFHS		
Separating from local government account	180	94.7
Within local government account	4	2.1
Account book at http://tobt.nhso.go.th/		
Yes	171	90.0
Not yet	14	7.4
Frequency of Account Book Report		
Every week	2	1.1
Every 15 days	1	0.5
Every month	100	52.6
Every 2 months	30	15.8
Others	52	27.4
Account Book Printing		
Done	140	73.7
Not yet	41	21.6

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, 2) Support health centre services, 3) Health promotion and prevention for communities, and 4) Manage and develop Local Fund Health Security

Implementation Phase for Supported Pattern of WSLFHS Plans

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

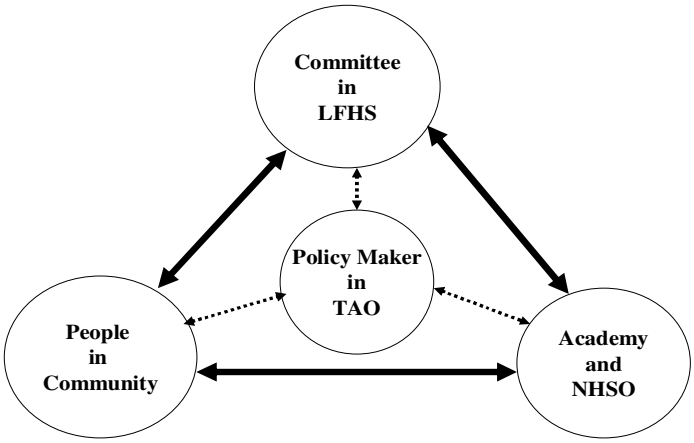

Figure 1. The model of the WLFHS stakeholders

mellitus and hypertension), and Iodine salt support.

Evaluation Phase of Wungsang Local Fund Health Security

Overall satisfactions about information of the Local Fund Health Security were good (81.7%) and 18.3% reported 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.

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 municipality and 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.

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 1.

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 prepa-

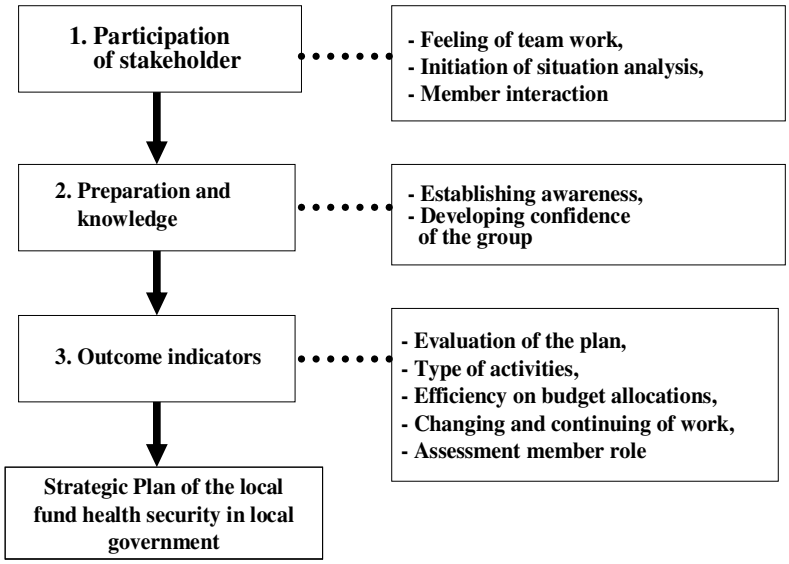

Figure 2. Implication of Practical guide line of the WLFHS process

ration 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 2.

DISCUSSION

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 2009).

Following along these lines, Dixon and Harrison (1997) 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.

CONCLUSION

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 or develop appropriate health plan at local level.

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

1. Publicising countrywide the enough information about local health security project to make 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 inconvenient 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 more 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. 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.

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