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Health Sector Reform in Thailand: Policy Implementation in Three Provinces

Songkramchai Leethongdee

**A thesis submitted to the University of Wales Swansea in fulfilment of
the requirement for the degree of Doctor of Philosophy (Health Science)**



May 2007



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SUMMARY

This thesis examines the implementation of the universal coverage (UC) health care reforms in Thailand, introduced from 2001 onwards. It aims to investigate the interaction between top-down and bottom-up influences on policy implementation in the local health system, based on comparative case studies of three provinces. The study was conceived as a 'policy ethnography', an approach which uses mixed methods to investigate the perspectives of local policy actors.

The Thai Ministry of Public Health (MoPH) did not specify all aspects of the UC policy 'blueprint' in detail, and allowed provinces to make important decisions in certain areas, such as the choice of financing model. The research found that it was generally actors at the higher levels of the provincial health administrations who had actual potential to influence the way the reforms were implemented. However, there were interesting examples where middle-level provincial actors gained influence at particular junctures of the implementation process, usually either when they were in a strategic position with regard to the roll-out of a particular policy, or if they could get support from powerful allies higher up the MoPH hierarchy. The degree of engagement and knowledge of lower-level actors were more limited, and many at this level saw the reforms as overly top-down. Over the period covered by the study, the relative influence of top-down and bottom-up influences ebbed and flowed. There was a cycle whereby local adaptations usually led to a reaction at the centre, and further policy statements and top-down directions.

Many problems arose in implementing the UC reforms, including difficulties in achieving progress on the original objectives of reducing geographical inequalities of funding and workforce distribution, problems in allocating resources fairly within the local health system, lack of progress in developing primary care, and tension between curative and preventative approaches.

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LIST OF ABBREVIATIONS

ADHOH	Assistant District Health Office Head
AHB	Area Health Board
BOB	Bureau of the Budget
BHCN	Bureau of Health Care Network
BHPP	Bureau of Health Policy and Planning
BHI	Bureau of Health Insurance
BMA	Bangkok Metropolitan Administration
CSMBS	Civil Service Medical Benefit Scheme
CSO	Civil Society Organisation
CUP	Contracting Unit for Primary Care
CMO	Chief Medical Officer
DDCH	Doctor Director of Community Hospital
DDPH	Doctor Director of Provincial Hospital
DHO	District Health Office
DN-CM	Dental Nurse in Community Hospital
DN-PCU	Dental Nurse in Primary Care Unit
DPHED	Director of Public Health and Environment Division, Municipality
DRG	Diagnosis-related Group
EU	Commission of the European Union
GDP	Gross Domestic Product
GPP	Gross Provincial Product
HC	Health centre
HCO	Health centre officer
HIG	Health Insurance Group in Provincial Health Office
HIO	Health Insurance Office, Ministry of Public Health
HODHO	Health officer in district health office
HO-PCU	Health officer in primary care unit
HPCUM	Head of primary care unit in Muang municipality
HSR	Health Sector Reform
HSRI	Health Systems Research Institute
HSRO	Health Systems Reform Office
HCRO	Health Care Reform Office
IMF	International Monetary Fund

IPD	In-patient Department
KS	Kalasin
MK	Maharakham
MWS	Medical Welfare Scheme
MoPH	Ministry of Public Health
NGO	Non-Government Organisation
NCQS	National Committee for Quality and Standards
NESDB	National Economics and Social Development Board
NHSB	National Health Security Board
NHSO	National Health Security Office
OPD	Out-patient Department
PCIHI	Provincial Committee for Implementing Health Insurance
PSIHI	Provincial Sub-committee for Implementing Health Insurance
PCU	Primary Care Unit
PHC	Primary Health Care
PHO	Provincial Health Office
RE	Roi Et
SDH-PH	Senior Doctor Head in the Provincial Hospital
SAO	Sub-district Administrative Organisation
SAO-PHO	Senior Administrator Officer in Provincial Health Office
SHI	Social Health Insurance
SIP	Social Investment Project
SOHSD	Senior Officer of Health Service Department in Muang Municipality
SSO	Social Security Office
SSS	Social Security Scheme
TDRI	Thailand Development Research Institute
TRTP	Thai Rak Thai Party
UC	Universal Coverage of Health Care or Universal Coverage Scheme
UK	United Kingdom
UNICEF	The United Nations Children's Fund
US	United State of America
VHCS	Voluntary Health Card Scheme
WB	World Bank
WCS	Workmen's Compensation Scheme
WHO	World Health Organisation

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'...A study of implementation is a study of change: how change occurs, possibly how it may be induced. It is also a study of the micro-structures of political life; how organisations outside and inside the political system conduct their affairs and interact with one another; what motivates them to act in the way they do, and what might motivate them to act differently'.

Jenkins, W.I. (1978:203)

'...Street-level bureaucrats make policy in two related respects. They exercise wide discretion in decisions about citizens with whom they interact. Then, taken in concert, their individual actions add up to agency behaviour. (...) The policy-making roles of street-level bureaucrats are built upon two interrelated facets of their positions: relatively high degrees of discretion and relative autonomy from organisational authority'.

Lipsky, M. (1980:13)

'Top down only in the broad outlines of what they wanted. They haven't got a blueprint. The Ministry of Public Health... interestingly, the Permanent Secretary at the time said that to this group that I chair: the whole thing was implemented so rapidly that this became part of it, in more senses than one. In the end I think there was so much conflict at the top of the Ministry of Public Health that the issue was per force devolved to the provincial level. So it is 76 flowers bloom. Everybody had their own thing... '.

**(Senior Economist, Anonymous Think Tank,
Bangkok: 2003)**

Chapter 1

Introduction

Chapter 1: Introduction

1.1 The research idea

This thesis examines the implementation of Thailand's universal coverage (UC) health care reforms, introduced from 2001 onwards, using case studies from three north-eastern provinces. The thesis considers both the significance of these reforms in their own right, and what they show us about the importance of the 'implementation' phase in the health policy making process.

With respect to the latter, the thesis supports earlier work that highlights the complexity of real world health policy implementation, and the possibility that actors at lower as well as higher levels can influence the shape of policy as it is put into effect (Walt and Gilson 1994). The Thai case study sheds further light on the debate between 'top down' theorists who see the policy template and implementation strategy devised by higher level actors as the keys to successful roll-out of policy, and 'bottom-up' theorists who attach more importance to the influence of lower level actors, and portray implementation as a 'process of interaction and negotiation, taking place over time, between those seeking to put policy into effect and those upon whom action depends' (Barrett and Fudge 1981:4). As will be discussed in Chapter 2, various arguments have been advanced to support these two positions, and there has been further theoretical development in terms of mixed approaches. Probably the relative influence of top-down and bottom-up influences on policy implementation differs according to context and time. Empirical studies such as this one can help establish the extent of variation and the factors involved.

The specific interest of the Thai case lies in its significance as a rare example of UC reform in a lower middle-income country, which aims for equity and comprehensiveness at a time when many health care reforms seek to harness markets and the price mechanism. Since the 1980s major health sector reforms have been introduced in many countries throughout the world with the aims of improving overall health and client satisfaction, increasing technical and allocative efficiency, and sometimes with providing more equitable access (Berman 1995; Mills et al. 2001; Roberts et al. 2004). Economic pressures and the influence of donor agencies such as the World Bank (WB) and International Monetary Fund (IMF) meant that many reform efforts were concerned with developing mixed public and private systems, and promoting competition and economic efficiency

through the involvement of independent providers in secondary care (Cassels 1995; Gwatkin 1994; Xing-Yuan and Sheng-Lan 1995). To a large extent this displaced an earlier drive by bodies such as the World Health Organisation (WHO) towards 'health for all' and more inclusive coverage. The Thai case may be set alongside a small number of other middle-income countries which have 'bucked' this trend and introduced reforms in which Governments seek to engineer a planned expansion of coverage to the whole population. Arguably, this represents a second wave of health sector reforms whose objectives and methods are different from the earlier health sector reforms of the 1980s and 90s.

The rest of the chapter will: set out the research questions addressed in the study; examine the trends in policy development alluded to above in more detail; discuss the background to reform in Thailand, and describe the structure of the Thai health system and the specifics of the UC reforms.

1.2 Research questions and objectives

The general concerns outlined above lead into the research questions and objectives set out in Table 1.1.

Table 1.1 Research questions and objectives

Research Idea	Research questions	Research objectives
What is the nature of interaction between top-down and bottom-up influences on the implementation of UC policy in the local health system?	1. Who were the main actors involved in the processes of the UC policy implementation in local health system?	1. To map out the networks of actors and power relationships in the three provinces
	2. What were the channels of communication between lower level and higher level actors?	2. To examine how high level commands were communicated from the central departments to local actors, and whether feedback in the reverse direction occurred.
	3. What changes occurred in the organisation of local health services as the UC reforms were implemented?	3. To examine the changing of organisation of health services in the three case study provinces
	4. How much scope did local actors have to influence the content of the reforms or the approach to implementation taken?	4. To determine whether there are differences of approach between provinces and how far local actors influenced the content of health care reform in each area.
	5. Given the importance of the financing mechanism in the UC reforms, how was that mechanism adapted to local conditions?	5. To explore the financing frameworks applied in the three provinces.

Table 1.1 Research questions and objectives (continued)

Research Idea	Research questions	Research objectives
	6. What were the perspectives of local actors on the UC reforms, their feasibility and the implementation approaches adopted nationally and locally?	6. To examine the perspectives of local actors on aspects of the reforms, their feasibility and implementation.
	7. What were the problems encountered in implementing UC policies and how far did they differ in the three provinces?	7. To identify problems encountered and assess the extent of commonality and difference in the three provinces
	8. What are the areas of autonomy and the constraints affecting local actors?	8. To offer a perspective on implementation theory that assesses the relative importance of top-down and bottom-up influences, and the areas they affect. 9. To contribute to scholarly understanding of the relative significance of 'policy formation' and 'policy implementation' in health care reform.

Rather than treating these questions as separate issues that should be answered in serial order, the thesis will address them via a narrative account of the chronology of reform in the three case study provinces. Thus the networks of local actors, their relations with higher level actors, the changing organisation of local services, the space for local decision making and variation in financing regimes, perspectives on the reforms, problems encountered, and the balance between constraint and influence, will be described and analysed with reference to events in the three Thai provinces of Mahasarakham, Kalasin and Roi Et.

1.3 From primary health care to health sector reform and UC

The period preceding the formulation of the UC reforms in Thailand fits the general pattern described in the wider health policy literature of a shift in focus from developing primary health care (PHC) to systematic health sector reform (HSR), with the additional qualification mentioned above that the Thai reforms may be part of a second wave of reform which puts more emphasis on equity as opposed to markets and economic efficiency.

By the mid-1970s international health agencies and experts were beginning to reassess the usefulness of traditional disease-focused programmes and examine alternative approaches

to health system development in developing countries. New community-based health projects were seen to be achieving more promising outcomes than many conventional programmes. This led some analysts to propose a bottom-up approach, emphasising prevention and managing health problems in their social contexts, which they contrasted with the top-down, high-tech approach associated with the traditional medical science perspective.

A key event at this juncture was the international Conference on Primary Health Care, held in Alma-Ata, Kazakhstan in 1978, and sponsored by the WHO and UNICEF. This resulted in the famous Alma-Ata Declaration which endorsed the goal of 'Health for All by the Year 2000', to be attained mainly by improvements in primary care (WHO 1995), and set the direction of WHO strategy for more than 20 years. This approach quickly became known as the PHC approach.

The Conference declared that health is fundamental human right and that attainment of the highest possible level of health was an important worldwide social goal. This was incorporated into the WHO's Constitution, which defined the objective of the organisation as 'the attainment by all people of the highest possible level of health' (WHO 1981: p. 31). Much of the debate in the following years was concerned with what that level might be, and how it could best be achieved in developing countries. One important notion which arises from the definition of PHC is that it provides 'essential health care'. In its broadest sense essential health care may refer to all concerns, issues or factors that are necessary for ensuring people's well being and development. But for some analysts PHC could also refer to the basic or fundamental level of care offered in a particular system, which in the real world differed from country to country, depending in resources and national priorities. Analysts differed in their views of whether the goal should be a global effort to introduce comprehensive services as widely as possible or the more modest approach of first building primary care services to a basic standard. There were also questions about how far a selective approach should be taken to combating particular disease threats which might shape a country's health profile.

The more ambitious conceptions of primary care development were expensive and required extensive health care system development, so that results across the world were mixed and often disappointing. Some health analysts argue that comprehensive primary

health care was an experiment that failed, whilst others contend that it was never truly tested. Green (1999) has argued that there are many obstacles to implementation of a PHC approach, including resources but also a failure to translate the philosophy into concrete plans and strategies. Problems include the misinterpretation of the PHC concept, selective PHC strategies, resistance to change and centralised management and planning infrastructures which do not support community-based initiatives. While the PHC strategy did bring benefits in many areas, many long standing health problems continued to exist, including major inequities in access and health care delivery. The design of existing health programs and activities were often blamed for inefficiency and ineffectiveness, putting them under pressure to be re-oriented and re-organised (WHO 2004).

In the 1980s the emphasis began to swing away from gradual development of PHC towards more comprehensive health sector reform, largely under the influence of donor agencies. In 1980 the World Bank began direct support for health projects, and playing a more proactive role in deciding health policy (Walt 2001). Financing strategies and 'cost-effectiveness' moved to the centre of the policy agenda (Musgrove 1995; Hearst and Blas 2001; Blas and Hearst 2002). As the World Bank and IMF emerged as the largest funders for developing countries these organisations began to set conditions on health loans, and increasingly to link funding to compliance with 'structural adjustment' policies, which among other things required better control of public expenditure and more use of markets and competition in the health care system.

Generally, the health reforms of the 1980s and 1990s required greater use of markets and the overhaul of financing systems to improve efficiency and cost containment. The US 'managed care' model has exerted considerable influence on many health reform initiatives in developing countries, both at terms of the general private health insurance approach and specific micro-level reimbursement techniques, such as diagnosis-related groups (DRGs). Places as diverse as Brazil, Chile and Argentina, the Philippines and Hong Kong have used American-style market strategies and encouraged the involvement of international managed care companies like Aetna, EXXEL and Cigna (Stocker et al. 1999; Brudevold et al. 1999). Even the People's Republic of China, once an advocate of free treatment for all, has turned its back on this seemingly unattainable goal and moved towards a largely privatised system where access depends on ability to pay (Blumenthal and Hsiao 2005).

However, against this trend towards managed care, a number of middle-income countries, such as Taiwan (Lu and Hsiao 2003), South Korea (Anderson 1989), Turkey (Saltman and Figueras 1998) and Mexico (Knaul and Frenk 2005), introduced reforms that were more concerned with equity than economic efficiency, and explicitly aimed to achieve UC for their populations. Although this may be seen as in line with the long-standing WHO policy of 'health for all', this is a relatively untried policy in developing countries, which many critics have suggested may be unaffordable. The situation by the late 1990s was that most countries with established UC systems were developed nations, which had had those systems for some time. Rather than being associated with the recent wave of health sector reforms, these systems mainly dated back to an earlier era of more comprehensive welfare state reform after World War II. Tax-funded, publicly provided systems were introduced in the United Kingdom, most of the Scandinavian countries and some Mediterranean countries. In the two decades after the war many continental European countries that favoured a '*Bismarckian*' social insurance model, progressively extended coverage to the point where UC was achieved.

Thus the move by a number of middle-income countries to develop their health care systems in this direction was an interesting development without recent precedent, and involved considerable risk. Indeed, the UC reforms in the Philippines, due to be phased in over a number of years, have already proved to be unsustainable (Obermann et al. 2006). These reforms captured the attention of the policy community in several developing countries including Thailand (Nitayarumphong 1997; Nitayarumphong and Mills 1998). Thailand's decision to follow the same route is significant because, even if one discounts the failed reform attempt in the Philippines, the Thai case shows that the income threshold at which countries are achieving universal coverage is getting lower (Table 1.2).

Table 1.2: The income per capita GDP of middle-income countries with recent UC reforms

Country	\$ (WB Atlas Method)	World Rank this indicator
Mexico	6,790	70
Turkey	3,750	89
Thailand	2,490	104
Philippines	1,170	136

Adapted from: 2006 World Development Indicators, Table 1.1. Size of Economy. World Bank.
<http://devdata.worldbank.org/wdi2006/contents/Section1.htm> (Accessed 3 October 2006)

Admittedly the categorisation of diverse systems into the 'UC' box is not without problems. Sri Lanka, which has often been characterised as a UC system since moving in that direction under British influence, has been excluded from the list here because the services on offer did not extend far beyond basic primary care. Argentina, also often classed as a UC system, since the populist reforms introduced under Peron, appears to have been shifting in the opposite direction and its most recent reforms are about reinvigorating markets (Bertranou 1999, Lloyd-Sherlock 2005).

1.4 Thailand's movement from PHC to UC Reforms

As in many other countries, the concept of PHC was adopted and implemented nationwide after the Alma-Ata conference in 1978. In Thailand PHC policies were taken forward through a network of health volunteers, whose skills and supporting infrastructure were upgraded over time. Other initiatives included establishing a village drug fund, a multi-purpose village fund, and setting up Community Primary Health Care Centres (CPHCC). These schemes were implemented actively at the beginning but faced problems of sustainability. Despite the limited success of PHC in many areas, implementation of the PHC strategy started changing ways of thinking on the role of the public in health promotion and raising the importance of first-line health services.

The 'health for all' aspect of the PHC policies was reflected in a series of limited financing reforms to improve access to care for certain specific populations. In 1975, the Medical Welfare Scheme (MWS) was established to serve the poor. Then in 1980 the Civil Servant Medical Benefit Scheme (CSMBS) was launched to provide care for public employees, and from 1990 formal sector employees were covered by the Social Security Scheme (SSS). The MWS and CSMBS were financed from general tax revenues while the SSS relied on tripartite contributions. The Government advanced different rationales for the schemes depending on the different groups whom it tried to protect. The poor were protected because of their inability to pay for their health expenses and the need for redistributive policies to counter unequal access to care. Health benefits were provided to civil servants as a fringe benefit to compensate their relatively low salaries. The SSS, including its health benefits was seen as a necessary development to support the growth of an industrialized sector that was reckoned to be crucial to the national economy. Although all these schemes had different benefit packages, provider payments and government

budget subsidies, which would affect equity among the schemes, they developed to cover about 70% of the total population by 2000.

Thailand's period of incremental health system development lasted through most of the 1980s and 1990s without significant external pressure to change course, and no apparent appetite for radical financing or market reforms from the indigenous policy community. One theme from reform initiatives elsewhere that did attract domestic interest was decentralisation. This had a resonance with the PHC policies since these were often linked to ideas of community empowerment and a turn away from the top-down organisation of services. But it also appealed to analysts who favoured a more pluralistic system of providers, and the transfer of some MoPH hospitals to autonomous status. There was much debate in health policy circles about the pros and cons of decentralisation policies, with some expressing concern about issues such as:

- the possible fragmentation of local health providers networks and the effect on the referral system;
- governance, capacity and transparency in local politics and administration;
- the capabilities and efficiency of local administrations;
- the future employment status and security of the workforce.

With the economic crisis of 1997, it seemed that Thailand would at last be propelled into a cycle of health system reforms of the kind seen in many donor-assisted nations affected by the 'conditionality' of loans. Following the financial crash, the Asian Development Bank (ADB) offered a social sector reform loan (SSRL) to the Thai government covering education, labour and health. The loan conditions required the MoPH to allow MoPH hospitals to become autonomous starting in 1999, and to introduce other changes to scale down the central bureaucracy (such as forcing the public universities to become autonomous organisations). A bureaucracy reform policy was passed by cabinet in 1997 and soon began to impact on public sector organisations. The Civil Service Early Retirements Project launched in 1998 aimed to lose 90,000 posts in the public sector (CSCO 2000). The Decentralisation Act 1999 forced the MoPH to implement policies in line with the National Decentralisation Plan, mainly concerned with the transfer of functions to local government. Then in 2000 a national Health Sector Reform Office

(HSRO) was established in 2000 to prepare a draft of the National Health Bill and assist the Government in taking forward health sector reforms.

However, the events that followed gave the reforms a new direction more in line with the aspirations of local experts and Thai civil society groups than any reform agenda imposed by international bodies. A group of reformist civil servants and professionals who had long harboured plans for an extension of coverage to the whole population saw the Government's avowed commitment to health sector reform as the opportunity to bring this about. At the same time the HSRO began a campaign to engage with civil society groups in debate about the shape of the nation health system, which went well beyond the issue of decentralisation and again raised the issue of universal coverage. Another important piece in the jigsaw was the emergence of a new political party, the Thai Rak Thai ('Thai's Love Thai's'- TRT) Party, which promised to redraw the landscape of national politics and introduce policies for the benefit of the whole Thai population. Under its charismatic leader, Thaksin Shinawatra, the TRT party went into the 2001 general election with a series of radical policies, including one that past governments had said was unaffordable – the introduction of UC health care.

1.5 Organisational structure of the Thai health care system

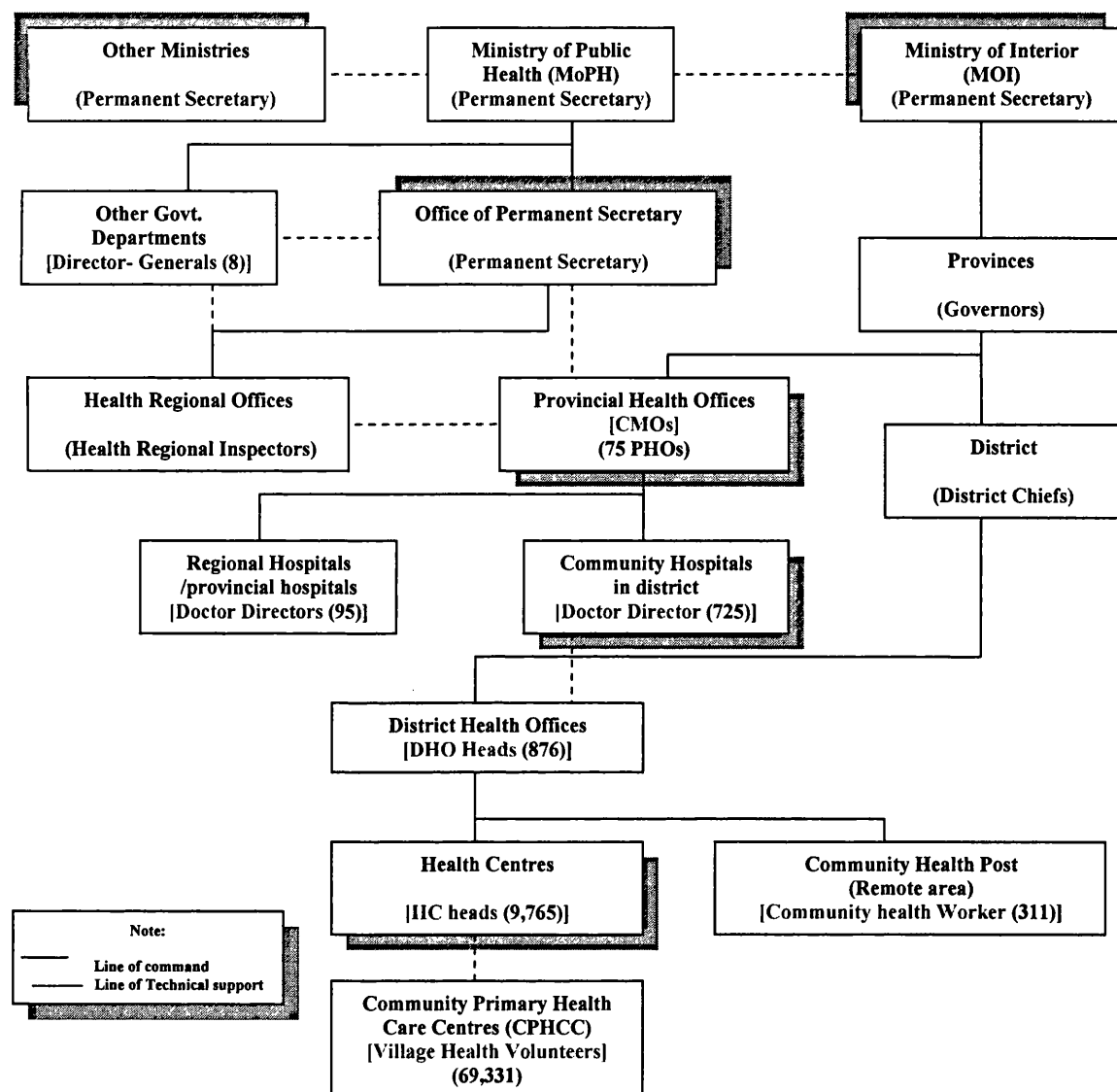
By 2001 the Thai health care system took the form of a tiered administrative structure, headed by a Ministry of Public Health (MoPH), with the administrative tiers extending down to the regional, provincial and district levels. This section will briefly describe that structure, which was under challenge from both the 2001 UC reforms and the earlier set of decentralisation reforms.

The MoPH is the principal agency responsible for promoting, supporting, controlling and coordinating health care for Thai citizens. Several other agencies have significant roles in medical and health development programmes, including the Ministry of Education, Ministry of Defence, the Bangkok Metropolitan Administration, certain State enterprises and the private sector. The facilities managed by these agencies include hospitals that provide primary, secondary and tertiary care. However, the mainstream health care system and the management of public sector facilities are under the general control of the MoPH.

The administration structure of the MoPH is divided into two levels: the central and provincial administrations. The central administration is comprised of 10 agencies: (1) the Office of the Minister; (2) the Office of the Permanent Secretary; (3) Department of Medical services; (4) Department for Development of Thai Traditional and Alternative Medicine; (5) Department of Mental Health; (6) Department of Disease Control; (7) Department of Health; (8) Department of Health service Support; (9) Department of Medical Science; and (10) Food and Drug Administration. In addition, the MoPH supervises certain other agencies which are not in the bureaucratic line of command such as the Health Systems Research Institute (HSRI), the National Health Security Office (NHSO) and the Government Pharmaceutical Organisation (GPO) (MoPH 2002b). These agencies are independent organisations, with duties specified under separate legislation. It should be noted that according to the Public Organisation Act, 1999, four categories of health units - regional, general, community hospitals and health centres - are expected to be transformed into autonomous public organisations when the necessary preparations are complete. To date, only one community hospital has achieved autonomous public organization status: Banphaew hospital in Samut Sakhorn province.

The provincial administration comprised the provincial health offices (PHOs) in Thailand's 75 provinces (excluding Bangkok); regional, provincial and community hospitals; district health offices (DHO) and the health centres. These are the public sector health agencies that oversee the health system at the local level. They are the main organisations responsible for the front-line implementation of health policy, including the UC reforms examined in this study. The relationship between the central and provincial administrations are shown in Figure 1.1

Figure 1.1: Organisational structure and the relationship between the central and provincial administrations in the health care system



Adapted from: (1) Wibulpolprasert (2005) "Thailand Health Profile 2001-2004"
 (2) MoPH (2002b) "Ministry of Public Health: a new mandate and structure"

1.6 The Universal Coverage Reforms: Health Sector Reform in Thailand

The UC policies were implemented in a series of stages starting in April 2001. Nevertheless, the policy marks a sharp break with the incremental approach of gradual increases in the health care coverage provided for the Thai population that had characterised the preceding two decades. As suggested earlier, the immediate factor precipitating the change of policy was the 2001 election victory of the TRT Party, which came to power on a populist manifesto in which health reform was an important element. In its electoral campaign the party had presented its new health policy to the people using the slogan: '30 baht treats all diseases'. This referred to the proposal that Thai citizens requiring health care would be able to obtain it in return for a co-payment of just over 40 new pence in British currency. The scheme quickly became known as the "30 baht treats all diseases project" or the '30 baht scheme'. The policy built on plans that had long existed among a reformist group in the MoPH for UC health care, and incorporated many of their specific technical proposals. However, the political origins of the policy had significant consequences in areas such as the speed of implementation, and the slow follow-up of the initial health care financing reforms with linked changes advocated by the MoPH reformists.

The MoPH experts had been examining the feasibility of an extension of coverage for many years. Thus certain specific features of the 2001 reforms, such as capitation funding and the contracting mechanism used, had emerged out of a lengthy policy formation process which paid careful attention to international experiences (Nitayarumphong et al. 1993; Nitayarumphong 1997; Nitayarumphong and Mills 1998; Pannarunothai et al. 2000; Tangcharoensathien et al. 2004), as well as the patterns of economic incentives and costs associated with different funding models (Tangcharoensathien et al. 1999; Pramualratana and Wibulpolprasert 2002).

The central plank of the reforms was a new public health insurance scheme which provides treatments within a defined 'core' benefits package to registered members for a co-payment of 30 baht per chargeable episode (Towse et al. 2004). Eligibility is established by presenting a gold registration card, issued by the local Contracted Unit for Primary Care (CUP) and entitling the holder to care in their home area. Older people, children and the

poor receive a special '*Taw Tahaan*' ('T') version of the registration card and pay no fee.¹ Drugs prescribed are limited to those on a national drugs list, certain high-cost or chronic disease treatments are subject to cost ceilings, and there was initially no entitlement to anti-retroviral therapy or haemodialysis (though these were later brought within the scheme). Treatment outside the area of registration is limited to accident and emergency care. Finance for the scheme comes mainly from public revenue paid to local contracted units on the basis of population. The reforms raised public health expenditure from about 66.25 billion baht in 2000/01 to 72.78 billion baht in 2001/02 (MoPH 2004), putting the first year cost of reform at a modest 90 million pounds sterling including inflation.

The 30 baht scheme filled the coverage gap left by the existing public health insurance schemes (NaRanong et al. 2002). By the 1990s Thailand was providing comprehensive health care to public servants and workers in larger enterprises through the Civil Servant Medical Benefits Scheme (CSMBS), the Social Security Scheme (SSS) and the Workmen's Compensation Scheme (WCS). About a fifth of the population were covered by a subsidized voluntary health card scheme (HCS), which offered care to families for an annual fee of 500 baht (£7.20 pounds sterling). There was also a more restricted Medical Welfare Scheme (MWS) for the poor, and the 'Type B Exemption Scheme' which waived payments for the uninsured poor at the discretion of public health staff (Suraratdecha et al. 2005). The 30 baht scheme superseded the HCS, MWS and 'Type B Exemption', and extended coverage to the whole registered population. Thus the Thai population was covered by the three main public financing schemes- the SSS, CSMBS and the UCS - with about three quarters covered by latter. Prior to the universal coverage reforms, the public schemes left about 30% of the Thai people without coverage, and a further 32% with only means-tested assistance under the MWS (Wibulpolprasert 2005).

1.6.1 The 'big bang' reform phase

Most commentators regard the Thai case as an example of 'big bang', rather than incremental reform. Although aspects of the reforms were phased, the 'big bang reform' is an appropriate description of the initial rapid effort to extend coverage within a short-time scale. Although several generations of reform-minded MoPH policy makers had sought to

¹ Taw Tahaan (๓) is the 23rd letter of the Thai alphabet, and in this context signifies 'tong' or gold

widen coverage and made modest progress in that direction, no Government had been willing to foot the bill for major reform. The January 2001 election victory of the Thai Rak Thai (TRT) Party opened the way for change, and brought in a government who wished to push for an early move to UC. Despite advice from senior economists in favour of pilots and gradual implementation over 3 years (Siamwalla 2001; HSRI 2001), a powerful coalition formed which supported rapid nation-wide implementation. The MoPH reformers who perceived a limited window of opportunity, lined up alongside TRT politicians keen to make good on election promises, and civil society groups. A pilot study already underway in 6 provinces in April 2001 was quickly re-labelled as the first stage of implementation of the UC reforms; 15 additional provinces were brought on board in June 2001 and the scheme was extended to cover all provinces (except some Bangkok districts) by October 2001. Finally, complete coverage of the country was achieved in April 2002.

The UC scheme is financed mainly by general tax revenues and the budget is allocated on a per capita basis to Contracted Units for Primary Care (CUPs). The payment per insured member was 1,202 baht (just over £17 sterling) in the FY 2001-02 and 2002-03, 1,308 baht in 2003-04 and 1,396 baht in 2004-05. The people are required to register with the CUP, which provides primary care services and arranges referrals to secondary care. Access to hospital care requires referral from the CUP, except in the case of accidents and emergencies. Providers are paid by the CUP on a capitation basis for the Out-patient Care (OP) and per case - based on Diagnosis-related Groups (DRGs) - for in-patient care (IP). Unlike the North American DRGs system, the payments for in-patient care are subject to a global budget. Personal preventive and health promotion (P&P) services are also part of the benefits package and are paid to providers on a capitation basis plus a performance-related element. Providers also keep the 30 baht co-payments, though it has been calculated that less than 2% of total receipts comes from this source (Tangcharoensathien et al. 2005).

The policy slogan of the reformers might have been: 'first achieve coverage'. The 30 baht scheme extended the insured population from about 25 million (40% of the population) in 2001 (Wibulpolprasert 2005) to above 59 million (95.5%) in 2004 (Jongudomsuk 2004). Although the original policy design called for a single fund, it was decided to delay merging the public insurance schemes so that universal coverage initially depended on a

patchwork of the new and old schemes (HSRI 2001). The initial plan was to pool resources from the existing four health insurance schemes into one UC scheme but this met resistance from quarters such as the civil service and the labour unions (Tangcharoensathien and Jongudomsuk 2004). The government therefore decided to fund the 30 baht scheme by pooling the MoPH budgets for public hospitals, other health facilities, and MWS and voluntary health card scheme and providing some additional money. This could be done without legislation, enabling progress to be made while legislation was prepared and debated. Some early problems attracted media criticism, such as the absence of provision to treat gold card holders away from their home area, and claims that the 30 baht scheme provided lower quality care than the traditional schemes² (Suraratdecha et al. 2005). However, the rapid expansion of coverage was widely perceived to be a major success story.

The initial nationwide roll-out represented the first steps necessary to get the gold card scheme working. However, as explained above, it was only part of a wider reform movement that developed momentum after the 1997 crisis had made radical change inevitable. In 1999 the Leekphai Government had established a national Health System Reform Office (HSRO) charged with preparing reform legislation within three years. By the following year, a coalition of grassroots activists, academics and policy actors worked with the HSRO to draft a comprehensive National Health Bill, which incorporated proposals for greater emphasis on health promotion and disease prevention, increased public involvement, and prohibition of for-profit private health care providers³ (HSRO 2002). Under a provision of the 1997 Thai Constitution which allowed for a draft law supported by 50,000 signatories to be submitted to the legislature, the Bill was laid before Parliament in March 2001. However, instead of supporting this Bill, the TRT Party enacted a narrower the National Health Security Act, that introduced the financing machinery required for the 30 baht scheme. The National Health Bill remains stranded without sufficient Parliamentary support to become law.

² A recent study found that around 15% of gold card holders seeking ambulatory care said that they used private rather than UC facilities as their first option during a recent illness. The reasons given included staff attitude, inconvenient clinic hours and long waits.

³ The Draft on National Health Bill in section 71 the Public Health service (...) shall not be for profit business

1.6.2 The longer-term implementation task

Although basic coverage was achieved remarkably quickly, the 30 baht project required a transformation of the resource allocation system that the reformers knew would take some years to complete. It is the beginning of this period that the thesis considers. The developments required by the reform plan included the creation of a purchaser-provider split, and a new system of capitation-based funding intended to strengthen primary care. Policy makers also needed to co-ordinate the health care reforms with cross-cutting legislative changes associated with the decentralisation and public organisation reforms.

In the period covered by the study, at least three major pieces of legislation affected health care units. Firstly, the Decentralization Act, 1999 mandated a larger role for local government in the decentralised administration of the health care system, and required that 35% of public finances be channelled to local government by 2006. Secondly, the Public Organization Act 1999 resulted in a push to transform government organisations into autonomous bodies, so that public hospitals under the control of the MoPH could gain autonomous status. Associated reforms led to a re-designation of many health staff as public service officers (*Pa-nak-ngan* – in Thai) rather than civil servants (*Kha-Rat-Cha-Kan* in Thai). Thirdly, the National Health Security Act, 2002 took account of these Acts, and made provision for local purchasing agencies which contained representatives from both health and local government. However, the details of local purchasing remained unclear, and policy makers recognised that further capacity building in local government would be necessary before this aspect of the reforms could be implemented.

The decentralisation reforms continued going forward even as a new UC reform agenda emerged. In 2000 a National Plan for decentralisation to local government was drafted, and the following year an operative plan came into effect. The plan stipulated that the functions, facilities and public workforces of departments such as the MoPH tasks must be devolved to local government by 2010. Oversight responsibilities would then be assumed by local government bodies such the sub-district administrative organisations (SAOs) and the municipalities. The 1999 legislation provided for the proportion of public revenues channelled to local government to rise from about 12% in 1999 to 20% in 2001 and 35% in 2006. One important element of the plan was a proposal to create Area Health Breads (AHBs) which would be responsible for health care in local administration units, and this

was one of the options discussed by the MoPH for applying the UC system at provincial level. Although many commentators assumed that the decentralisation reforms and the UC reforms would proceed in tandem, the implementation of the former after 2000 appears to have been slow. By 2006, only around 27% of the national revenue was being allocated to local government. The roles of the different local government administrative organisations, at municipality, district and sub-district levels, and how they would interface with other bodies in the new purchaser/provider split structure, remained unresolved issues. At the time of writing (2007) the transfer of funds to local government required by the Decentralisation Act has still not occurred. Currently there appears to be a high chance that the Decentralisation Act will be amended to allow much more time to implementation and to put limits on the increase in local government revenue. Nevertheless, the parallel existence of the decentralisation reforms has an important influence on the story of UC policy implementation, and will feature from time to time in later chapters.

1.6.3 Thailand's purchaser/provider split

The new Thai funding system was based on the idea of capitation-based payments channelled through a purchaser/provider split, but initially the split was not fully in place. The period covered by the study saw an initial phase when the MoPH oversaw both the purchasing and provision functions on the understanding that the purchasing role would soon be handed over to the National Health Security Office (NHSO) in line with the 2002 Act. There was then a time of uncertainty in government circles when the feasibility of an early transfer to the NHSO was debated. The outcome was that the transitional phase was extended, so that the powers of the new NHSO were limited and influence remained with the MoPH. Then towards the end of the research period health care staff began looking ahead to the time when the NHSO would exercise its full duties and the purchaser/provider split would take clearer shape.

Although based loosely on Western models, the Thai purchaser/provider system appears to be unique. Two features that departed markedly from UK and Scandinavian models were the creation of the NHSO as an autonomous purchasing agency separate from the MoPH, and the channelling of monies through the CUPs. The first signalled that the Thai purchaser/provider 'split' was intended to be more radical than, for example, the system in the British National Health Service where both purchasers and providers are overseen by

the central Ministry. The second was innovative because the system did not rely on a local purchasing body to determine patterns of district services but gave this responsibility to a co-ordinating organisation on the provider side – the CUP.

The original policy intention had been that the money used by the MoPH to support public hospitals, the MWS and the HCS would be transferred to the NHSO to fund the 30 baht scheme. At the same time the NHSO would assume responsibility for purchasing care for the CSMBS. The NHSO would channel monies to local purchasing offices, either new entities or bodies associated with local government, which would enter contracts with the CUPs on the provider side. Policy makers in the MoPH believed that a major weakness of the pre-existing SSS had been that the choice of large hospitals as the main contractors had led to an excessive focus on secondary care. They decided that the new scheme would take a different direction and channel the bulk of UC funds through contracting units closer to primary care – the CUPs.

One of the principal architects of the reforms, Sanguan Nitayarumphong (currently the General Secretary of the NSHO), has described the CUP as a ‘fund holder’ on the provider side: a ‘primary care provider is entrusted for (sic) the main provision of comprehensive care for their registered population’ (Nitayarumphong 2005:198). Each CUP serves the population of a local health district⁴, for which it receives capitation-based funding. The CUPs use their funds to support local service units and pay for referrals. Nitayarumphong argued that the main advantages of the approach are greater responsiveness due to the closeness of the decision makers to the local population, and cost containment via CUP gate keeping of referrals to larger hospitals. Referrals are reimbursed through DRG-based payments to provincial and tertiary hospitals, reflecting volumes and case mix, and adjusted according to the relative weights (RWs) pertaining to particular hospitals. The CUPs are required to employ specified numbers of professional staff, and provide comprehensive care, within 30 minutes travel time of the registered population, which includes both hospital and community services. Most CUPs were expected to be in the public sector, but accredited private providers could gain CUPs status if they were able to offer the full range of required services, including health promotion and disease prevention

⁴ The original plan was that CUPs would cater for a maximum population of 10,000 people. However, there were practical advantages of aligning them with the existing districts, which include urban districts with populations in excess of 100,000

(P&P). The concept was inspired in part by the British general practitioner fundholder scheme. However, the CUPs are significantly larger provider organisations which typically oversee a district community hospital, primary care units, and district staff engaged in promotion and prevention projects.

Many aspects of this plan proved to be highly controversial. Conservative elements in the MoPH fought a successful rearguard action to slow implementation and to delay passing control of the reforms to the NHSO. The 30 baht project was more than just another insurance scheme because it changed fundamentally the way funds were channelled to public hospitals. The system of block grants from the MoPH to hospitals ceased, and was replaced by a new capitation-based funding stream that went to CUPs. The MoPH won the key concessions that it would oversee the implementation of the reforms through an initial transitional period ending in May 2006⁵, and that in the interim it would disburse the UC budget via the Provincial Health Offices (PHOs), bypassing the NHSO. This meant that right from the start the system lacked a strong local purchaser. The PHOs continued as supervisory bodies in the line of command from the MoPH to the provider units, and simultaneously acted as local health insurance offices. The de facto responsibility for providing comprehensive district health services lay with the CUPs, creating the unusual situation in a purchaser/provider system that co-ordination depended on a body on the provider side.

1.6.4 Implementing the new financing system at provincial level

The NHSO began operations in late 2002, but initially its responsibilities under the 30 baht scheme were limited to purchasing high-cost care and accident and emergency services, and funding treatments away from the home area via the Emergency Medical Service. The NHSO quickly designated the PHOs as its local branches, but much of the steering of the emergent system continued to come from the MoPH, which was controlling the main UC budget. However, there were disagreements within the MoPH, which still had a direct line of command control over the PHOs, about how much control these should have over the spending of the budget at local level. Faced with a log jam, policy makers decided to

⁵ The transitional period was formally 3 years from the date of enactment of the Act. However, the Thai financial year runs until the end of September, and this effectively meant that the NHSO took over responsibility for the UC budget on October 1st 2006.

allow PHOs themselves to determine which funding ‘model’ to use at local level. As will be shown in later chapters, this was a highly significant development because it opened the way for local actors to influence provincial implementation strategies. Some provinces passed on the bulk of the UC budget to CUPs under the so-called ‘inclusive model’, whereby substantial decision making authority over how money was spent lay with the CUPs. Others used an ‘exclusive model’ whereby the PHO itself held a fund for inpatient activity, and let the CUPs disburse only the monies for out-patient and P&P activity. Under both models PHOs created a ‘clearing house’ to channel the inpatient fund, or the in-patient component of the CUP budget, to hospitals in line with the referrals coming from the CUPs. The PHOs were also allowed to decide whether to include the salaries component of the UC budget in the allocation to the CUP or themselves manage a top-sliced salaries budget.

Capitation funding was a radical departure intended to reduce the historic geographical inequalities in spending patterns that had bedevilled the Thai health system. Much of the medical workforce and hospital facilities were concentrated in the Central Region and a few large urban centres, while the rural South, North and North Eastern Regions were underserved in relation to their populations. The reforms used finance to try to engineer a reallocation of resources. A system in which money followed patients empowered rural hospitals and primary care units to recruit extra professional staff in line with local populations, while forcing ‘capitation-losing’ urban hospitals to reduce staff. The initial payment was set at 1,202 baht per insured member in FY 2001/02, in line with a proposal put forward by MoPH experts, and despite a competing proposal from Pannarunothai and associates who estimated the required per capita payment at between 1,482 and 2,397 (Pannarunothai et al. 2000, 2004). Despite some criticism from independent commentators, the 1,202 baht figure was regarded by insiders as adequate if the new policy was implemented ‘ruthlessly’, in the sense of imposing reduced budgets on previously ‘over-funded’ public hospitals.

1.7 Emergent problems

This purchaser/provider system quickly led to both a micro-allocation problem and a macro-allocation problem, which taken together resulted in a highly significant change in

the financing method in 2002 that largely undermined the re-distributive impact of the reforms, and re-imposed greater central control. The micro allocation problem concerned the way the CUPs distributed money within the local health care system; the macro allocation problem concerned the impact of the reforms on capitation-losing regions and centres.

The problem with CUPs in rural areas was that they rapidly came under the control of the doctor directors of community hospitals, who then used their power to allocate resources according to their own priorities. In the reformed system each CUP had to include both hospital and community services. Because health centres had no medical staff, and relied on community hospital doctors to provide clinics, these hospitals quickly emerged as the dominant players and almost all CUP Board chairs were hospital directors. Secondary and tertiary care hospitals depended on referrals from local service units for their share of UC funding, channelled to them via DRG-based payments from the CUPs. Unfortunately in Year 1 many community hospitals held on to patients so as to retain capitation-based income that would have been reduced by the cost of referrals, or were also late with referral payments. Consequently provincial and tertiary hospitals received less money than expected. The power of the community hospitals also affected primary care services. In many areas, health centres, PCUs and district health offices found that monies they had expected to receive were retained for community hospital projects.

As expected, capitation funding left many of the larger hospitals, particularly teaching and super-tertiary hospitals in the Bangkok Metropolitan Authority area, in a deficit situation. Many were unable to cover salary costs, yet unwilling to allow the workforce movements that architects of the reforms had envisaged. By November 2001, 29 provinces had made requests for help from the MoPH Contingency Fund and received support totalling 3.2 billion baht (Nitayarumphong 2005). What the architects of the reforms may not have anticipated was the power of professional groups affected by this change to mobilise support and influence Ministry decision makers.

The combination of the redistributive effect of capitation funding at national level and the referral and allocation problems at CUP level, provoked a backlash in the upper ranks of the medical profession and policy adjustments in the MoPH. In FY 2001/02 the problems were addressed by creating a central contingency fund, over and above the UC budget.

Additionally PHOs were given the option of choosing to hold both the in-patient budget and the salaries budget for the province centrally, thus helping to safeguard the position of larger provincial hospitals by guaranteeing their funding. In FY 2002/03, under a new, more conservative permanent secretary, the MoPH decided that the salary budget would be held and disbursed at national level, and provinces were also instructed to separate out the in-patient budget from the UC funds paid to CUPs. These changes reduced the impact of capitation-based funding. At national level, much of the funding lost by larger hospitals in Central Region was restored by re-directing the salaries budget. At provincial level, 'exclusive' funding strengthened the position of the larger provincial hospitals, whose funding now bypassed the CUPs. Rural community hospitals that had initially been cash rich found in Year 2 that their allocations were dramatically cut. The idea of a significant movement of doctors and nurses from over-served to under-served areas, as staff followed money, disappeared from the policy discourse.

The data presented in this thesis document the reaction of provincial level actors to this change, and also their behaviour in relation to further policy developments in the MoPH and the NHSO. During the transitional period with the MoPH as purchaser, the pattern of greater central control of finances continued. Larger hospitals were protected from the full impact of capitation funding through top-slicing of the budgets for salaries and in-patient activity, though they still suffered because of general under-funding of the new scheme. In each of the fiscal years from 2001 to 2006 the capitation payment agreed by government fell short of the figure requested by MoPH or NHSO experts (e.g. 1,308 baht against 1,447 in FY 2004; 1,396 against 1,510 in FY 2005 and 1,396 against 1,800 in FY 2006) (Leesmidt et al. 2005). The problem was accentuated because promised funds were often not allocated in full, especially at the CUP level. Community hospitals, Primary Care Units (PCUs) and health centres mostly received very limited funding, which affected their ability to develop promotion and prevention projects. The aim of building the capacity of rural PCUs to offer 'close to the home' care remains largely unrealised. Because most qualified staff still work in hospitals, many PCUs are based there and differ little from outpatient clinics. Some Thai commentators have argued that what has emerged is a safety-net scheme for poor people rather than a comprehensive service acceptable to the nation as a whole (NaRanong and NaRanong 2001).

On September 19th 2006, The Prime Minister, Thaksin Shinawatra, was ousted from power in a military coup. Although the stated reason was the corruption of the ruling group, many commentators suggested that the coup might put an end to the Thai Rak Thai Party's populist policies, including the UC reforms. At the time of writing it is still too early to predict the longer-term impact on Thai health policy. The new ruling military council moved quickly to say that universal coverage was not under threat, though aspects of the policy might be amended. The council appointed the former MoPH Permanent Secretary from the early 'radical' phase of the UC reforms as the new Minister of Public Health, and set up a review panel headed by a prominent pro-reform academic to suggest a way forward. The findings of the body are not yet available, but current debate in the Thai presses suggests that the 30 baht co-payment and aspects of the financing mechanism may be revised. The major unresolved issue is whether the principles of universality and comprehensiveness will be challenged by any proposal to link contributions and access to ability to pay.

1.8 Summary of chapter

This chapter has described the basic concerns addressed by the study and the research questions and objectives that follow from that 'research idea'. It has discussed the shift from PHC policies to health sector reforms, and how UC reforms represent a distinctive and interesting subset of such reforms. Finally it has described the background of health policy development in Thailand and the content of the Thai UC reforms.

Chapter 2
The literature on the policy process
and implementation

Chapter 2: The literature on the policy process and implementation

2.1 Introduction

This chapter considers areas of the policy literature relevant to the thesis. It contains a brief review of one of the main approaches to studying the policy process, a more detailed review of the large body of work on policy implementation, and a discussion of the more limited implementation literature on developing countries.

2.2 The health policy process

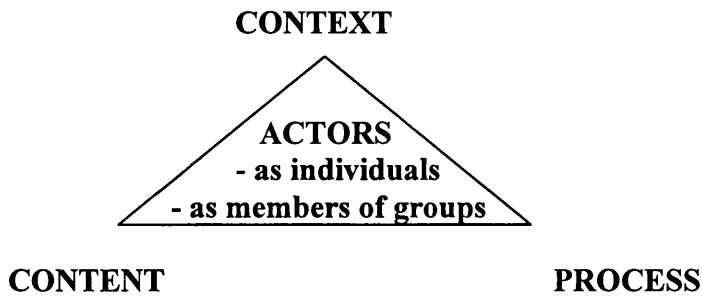
This thesis is concerned primarily with the implementation of health system reforms at local level, but before turning to that topic it is essential to understand the concept of health policy and the policy process. In the literature the term ‘policy’ has been used to refer to a range of related matters including expressions of purpose or intent, decisions, courses of action, laws, regulations, official guidance and administrative guidelines (Barker 1996; Hogwood and Gunn 1984; Walt 1994). Although there is no single definition of ‘policy’, one shared element in many definitions is that policy is not simply about intent but involves arriving at a working consensus that will allow planned changes to impact on the health care system, or other social systems that affect health (Barker 1996; Walt 1994). The point here is that policy or health reform is not just about an initial ‘idea’ or ‘blueprint’, but also about the steps that are taken to put the initial idea into effect and the changes in the idea that may occur as this process unfolds.

Walt and Gilson (1994) argued that health policy analysis traditionally concentrated on the formal content of policies and neglected other factors which influence policy development. This limited analysis of policy development resulted in ineffective implementation, with expected outcomes not being achieved. Walt and Gilson (1994) proposed a model for health policy analysis which includes four dimensions of policy that affect development and implementation.

- **content** what the policy states
- **context** the environment in which the statements were made
- **process** the steps involved in developing the policy
- **actors** individuals and groups involved in developing the policy.

The relationship between these four areas is illustrated in Figure 2.1.

Figure 2.1: Four dimensions of the policy process



Source: Walt and Gilson (1994)

Walt and Gilson (1994) argue that all these factors become involved at different phases of the policy process. Actors generally drive events but must take account of context and the dynamics of the policy process, as well as content (what one might term the policy blueprint). The importance of these factors and the relations between them may change at different stages of the policy process. There are times when the influence of different factors overlaps, as they are interrelated parts of the same process. Parsons (1995) has suggested that in order to obtain relevant information, we need to ask four questions at each stage of policy development: who, what, when and how? Parsons' questions map conveniently onto the categories for analysis suggested by Walt and Gilson (1994).

- Content - refers to the question *what?*
- Context - refers to the question *when?*
- Process - refers to the question *how?*
- Actors - refers to the question *who?*

If we take the broad conception of policy suggested above, we need to consider the significance of content, context, process and actors at each stage of policy development.

Various authors have outlined a number of stages in the development of policies. (Laswell 1956; Jenkins 1978; Lindbolm 1980; Anderson et al. 1984; Hogwood and Gunn 1984; Walt 1994; and Baker 1996) In an attempt to clarify the policy process the stages of policy development are summarised in the following table 2.1:

Table 2.1: Stages of policy development

AUTHORS	STAGES OF POLICY DEVELOPMENT
Lasswell (1956)	1. Intelligence, 2. Recommendations, 3. Prescription, 4. Invocation, 5. Application, 6. Appraisal, 7. Termination
Jenkins (1978)	1. Initiation, 2. Information, 3. Consideration, 4. Decision, 5. Implementation, 6. Evaluation, 7. Termination
Lindblom (1980)	1. Policy formation, 2. Policy preparation, 3. Policy formulation, 4. Policy implementation, 5. Policy evaluation
Anderson et al. (1984)	1. Problem or policy formation or policy agenda, 2. Policy formulation, 3. Policy adoption, 4. Policy implementation, 5. Policy evaluation
Hogwood and Gunn (1984)	1. Deciding to decide, 2. Deciding how to decide, 3. Issue definition, 4. Forecasting, 5. Setting objectives and priorities, 6. Option analysis, 7. Policy implementation, monitoring and control, 8. Evaluation and review, 9. Policy maintenance, succession and termination
Walt (1994)	1. Problem identification/ issue recognition, 2. Formulation, 3. Implementation, 4. Evaluation
Baker (1996)	1. Issue definition, 2. Setting objectives, 3. Priority setting, 4. Defining options, 5. Option appraisal, 6. Implementation, 7. Evaluation

In general, the stages of health policy development describe similar processes. Barker (1996) and Hogwood and Gunn (1984) identify a number of steps within the activities of problem identification and policy formulation. All seven authors also identify other activities within policy formulation, implementation and evaluation. It is evident however that there are no conflicts between the identified stages of policy development. Therefore, the stages of policy development could be easily summarised to include agenda setting, formulation, implementation and evaluation.

There has been a good deal of discussion in the policy literature about just how useful the ‘*stages*’ approach is, and whether it oversimplifies what happens in the real world. In the eyes of some it is too closely wedded to the rational systems approach, and risks reifying what they see as a fluid interplay between different aspects of the policy process (Nakamura 1987). Parsons (1995) is more sympathetic to the approach mainly because she argues that it provides a way of analysing the multiplicity of contextual factors that affect decisions doing the policy process. For her the idea of stages provides a useful way of conceptualising what influences enter the picture at different steps along the road from policy idea to rollout and evaluation. Other commentators such as Hill and Hupe (2002)

see the stages framework as a heuristic that can be useful as long as it is not applied too rigidly to what are likely to be complex and messy real world events.

The approach applied in this thesis holds that the content of policy is usually not fixed at the time when an initial policy blueprint is devised, and allows the possibility of further significant policy development. Hill and Hupe (2002) have proposed a useful distinction between ‘policy formation’ and ‘policy making’ which points to the way in which policy revision can continue over a period of time.

‘What is needed is a way of combining the analytical benefits offered by the “stages” model with a recognition of the interaction between the stages. We consider that this is best achieved by talking of policy formation (rather than making). This is then distinguishable in most cases, from an implementation process within which policy will continue to be shaped. If the term “policy making” stands for the policy process as a whole, then both implementation and policy formation refer to respectively “late” and “early” sub-processes to that process’ (Hill and Hupe 2002:8).

In this view policy implementation can shape the content of policy as the policy process proceeds.

2.3 Theoretical perspectives on implementation

2.3.1 Policy implementation

This section of the thesis will look at the implementation literature that has emerged since the early 1970s by highlighting the contributions of some key scholars. It will provide a brief review of the main contending perspectives in implementation studies. In particular it will discuss the debate between ‘top-down’ and the ‘bottom-up’ approaches, and also examine the contributions of scholars who have sought to synthesis the two perspectives.

2.3.2 The ‘discovery’ of implementation

Many scholars have suggested that ‘implementation’ remained neglected, when compared to policy formation, until it was ‘discovered’ in the early 1970s (see: Gogging et al. 1990; Parson 1995; Ryan 1995). According to this account, implementation was seen as a

relatively unproblematic administrative or managerial process. Policy formation was regarded as the key phase in determining successful outcomes. There was an assumption that policy makers formulated policy and that implementation would follow almost automatically. The seminal work that is said to have transformed the field is Pressman and Wildavsky's (1984)⁶ book, *'Implementation'*. This study described the failure of a large federal job creation scheme (the EDA) to meet its objective of providing employment for black people in Oakland, California. The authors found that the main obstacle to success was not poor policy, or local opposition, but lack of co-ordination between agencies charged with implementing policy. Pressman and Wildavsky's approach was quickly supported by Erwin Hargrove (1975), who wrote of implementation as the *'missing link'* in the study of public policy.

However, many later writers, such as Van Meter and Van Horn (1975), Hill (1997) and Hill and Hupe (2002) have contended that this image of *'discovery'* ignores a good deal of pre-existing scholarship in sociology and socio-legal studies that had examined the translation of policy into action. Among the earlier works identified are Philip Selznick's (1949) study of the Tennessee Valley Authority's efforts to engage with grassroots organisations, Peter M. Blau's (1955) study of goal setting in two government agencies, Lipsky's (1971) early paper on *'street-level bureaucracy'*, and the debate about discretion in the interpretation of legal rules (Davis 1969; Jowell 1973). Although the critics are right to say that Pressman and Wildavsky's message was not an entirely new one, it might be argued that much of this previous work had low visibility in mainstream policy studies, and that the Oakland study led to a significant shift in the focus of policy research.

2.3.3 The top-down model

At one level, Pressman and Wildavsky's study is concerned with barriers to implementation, and especially the possibility that local actors and agencies can stop policies from being applied as intended. Part of the subtitle of their book – *'How Great Expectations in Washington are Dashed in Oakland'* – points to potential conflict between high-level policy makers and front-line policy implementers. One theme of the study is that successful implementation depends on co-operation and communication between

⁶ The first edition of *Implementation* was published in 1973.

different organisations and departments at the local level. The authors argue that, if action depends upon a number of links in an implementation chain, then a very high degree of co-ordination between agencies is required if a series of small deficits are not cumulatively to create a large shortfall in the way policy is applied. They introduce the idea of 'implementation deficit' and suggest that this can be measured and analysed using quantitative techniques.

However, a second important theme of the study is concerned with how far high-level actors can influence or even control policy implementation. Pressman and Wildavsky (1984: xxi) state that: 'policies normally contain both goals and the means for achieving them'. They go on to say that 'implementation is a process of interaction between the setting of goals and actions geared to achieving them'. High-level actors need not only to set policy goals but to analyse what then makes the achievement of these goals difficult. They need to formulate a series of hypotheses specifying the predicted consequences of proposed policies, and the conditions necessary for policy to work. A governmental program needs to ensure that these conditions are met and the desired consequences follow. In order to achieve this, there must be a chain of command which is able to assemble and control resources, facilitate communication and ensure co-ordination. Although Pressman and Wildavsky later changed their position⁷, their book prompted a series of studies which focused on the steps needed to control policy implementation so that original policy objectives were achieved. The book thus came to be seen as an exemplar of the 'top down' approach to implementation: a prescriptive approach that tries to set out the practical steps needed to ensure that the policy blueprint is operationalised successfully.

There are already several excellent reviews of implementation research, including the early top-down approach, that would make a study by study account here redundant (Van Meter and Van Horn 1975; Van Horn 1979; Barrett and Fudge 1981; Sabatier 1986; McLaughlin 1987; Goggin et al. 1990; Ingram 1990; Fitz et al 1994; Maitland 1995; O'Toole 2000; Schofield 2001; Hill and Hupe 2002; Barrett 2004; Saetren 2005). One important development was that a number of largely descriptive case studies, including Pressman and

⁷ The third edition of *Implementation* (1984) contained a new final chapter called 'Implementation as Evaluation', which portrayed the relationship between policy formation and implementation as an interactive process.

Wildawsky's book, were followed by studies with a more conscious theoretical focus. These so-called 'second generation' studies (Goggin et al 1990) set out to construct analytical frameworks that would help high level actors develop systematic approaches to implementation. One early example was Van Meter and Van Horn's (1975) attempt to construct a model incorporating six interacting variables affecting implementation: standards for assessing performance; the resources and incentives made available; the quality of inter-organisational relationships; the characteristics of the implementation agencies, the economic, social and political environment; and the 'response' of implementers. Another influential study, Eugene Bardach's (1977) '*The Implementation Game*', also sought to develop an analytical perspective for policy makers and is noteworthy for its advocacy of careful 'follow-through' at the implementation stage. For Bardach, implementation is a political process which will often require higher-level actors to anticipate the 'games' that must be played with lower-level implementers and themselves to work actively to remove obstacles encountered during the implementation phase.

Many other important top-down studies followed (Sabatier and Mazmanian 1980, 1981; Mazmanian and Sabatier 1981; Sabatier 1986). A book worthy of special mention because of its subsequent influence on the field is Brian Hogwood and Lewis Gunn's (1984:199-206) '*Policy Analysis for the Real World*'. Although Hogwood and Gunn were well aware that 'perfect implementation' could never be attained, they considered it useful to construct a heuristic framework for policy actors defining the ideal pre-conditions that would facilitate that goal. Their oft-quoted ten preconditions for 'perfect implementation' are as follows:

1. The circumstances external to the implementing agency do not impose crippling constraints;
2. that adequate time and sufficient resources are made available to the program;
3. that not only are there no constraints in terms of overall resources but also, at each stage in the implementation process, the required combination of resources is available;
4. that the policy to be implemented is based upon a valid theory of cause and affect;
5. that the relationship between cause and effect is direct and that there are few, if any, intervening links;

6. that condition of '*perfect implementation*' requires that there is a single implementing agency that need not depend upon other agencies for success, or, if other agencies must be involved, that dependency relationships are minimal in number and importance;
7. that there is complete understanding of, and agreement upon, the objectives to be achieved, and that these conditions persist throughout the implantation process;
8. that in moving towards agreed objectives it is possible to specify, in complete detail and perfect sequence, the tasks to be performed by each participant;
9. that there is perfect communication among, and co-ordination of, the various elements involved in the program;
10. that those in authority can demand and obtain perfect compliance.

As with many other top-down studies, the aim was to provide high-level actors with a guide for action which would enable them to minimise the implementation deficit. The model of '*perfect implementation*' was seen as a heuristic device that could to help identify the preconditions for effective implementation and to provide tools for thinking more systemically about the reasons for implementation failures.

Overall, the '*top-down*' approach has characteristically focused on the implementation of policies developed at the centre in local environments. Parsons (1995:463) suggests that these studies were based on a '*black box model*' of the policy process inspired by systems analysis. Top-down theorists, in many cases, assume a direct causal link between policies and observed out-comes and tend to underplay the influence of implementers on policy delivery. Most follow a prescriptive approach that conceived of policy as input and implementation as output factors. Top-down research was concerned mainly with identifying the conditions which would maximise the translation of policy objectives into practice. The approach tended to erect an over-sharp distinction between policy formulation and policy implementation, and portray the two things as distinct phases that needed to be analysed separately as two distinct phases within the policy process.

2.3.4 The bottom-up model

The top-down model focused on the strategies that higher-level policy actors could use to ensure that the basic policy template was translated into a working operational reality.

Lower participants entered the picture mainly as subordinates whose compliance with policies needed to be controlled, or sometimes as sources of information feedback who might enable higher-level actors to make necessary policy adjustments. However, it was not long before a competing approach to implementation studies emerged which argued that lower-level actors might themselves operate as 'policy makers', at least in the sense that they shaped the detailed operationalisation of policy in local contexts.

Arguably the initial inspiration for the bottom-up approach came from outside mainstream policy analysis, and especially from the fields of socio-legal studies and organisational sociology. Two strands of research which were particularly influential were legally-oriented studies of discretion in rule use, and sociological research on '*street-level bureaucracy*'.

By the late 1980s, the theoretical debate about the possibility of reducing administrative discretion by more careful framing of legal rules (Davis 1972) had generated enough interest to prompt a number of empirical studies of rule use and administrative discretion in various organisational settings (Kagan 1978, Bardach and Kagan 1982; Mashaw 1983; Hawkins 1984; Bryner 1987; Hutter 1988). The thrust of much of this work is summed up in the following quotation from a review of Mashaw's '*Bureaucratic Justice*', a study which examined decision making by social security agency staff assessing disability benefit claims.

The great mass of official decisions in the legal system of the modern welfare-regulatory state are not made by judges, after considering the arguments of legal counsel, but by '*eligibility workers*' processing files in welfare and unemployment insurance offices, or by low-paid regulatory inspectors, tax auditors, licensing officials and assorted other bureaucrats. In theory, of course their decisions are subject to review by the courts, but in practice appeal often is unfeasible. The law, as applied, thus is a product of "the bureaucracy". (Kagan 1984, p.816)

Kagan's work in particular had an influence in the public policy field, including his 1982 study with the former 'top-down' theorist Eugene Bardach. Other later legally-oriented work contributed to both the legal and policy literatures (Baldwin, 1990; Baldwin 1995). This interest in the way bureaucrats interpret rules (and one might add, policies) comes close to the concerns of the second strand of writing on street-level bureaucracy (Lipsky 1971, 1980; Prottas 1979).

An earlier generation of scholars, such as Michel Crozier (1964) and Crozier and Friedberg (1980) had described how bureaucrats resist or slow change. Lipsky (1980) went a step further by arguing that street-level bureaucrats do not merely resist the implementation of policy but become involved in policy making. Chapter 2 of his classic study is entitled '*Street-level Bureaucrats as Policy Makers*'. Lipsky suggested that such workers make policy in two ways: 'They exercise wide discretion in decisions about citizens with whom they interact. Then, when taken in concert, their individual actions add up to agency behaviour' (p. 13). The need for discretion in interpreting administrative rules arises both from the difficulty of writing exhaustive rules that will cover all circumstances (the same point that the socio-legal writers had made), and also the '*human dimensions of situations*' (p.15) – the need to respond sensitively and flexibly to the special circumstances and problems of clients. In terms of shaping agency behaviour, street-level bureaucrats develop routines and coping mechanisms that allow them to process large amounts of work with limited resources, and which will affect the benefits or services available to clients.

Lipsky argues that there are features of work in bureaucratic organisations that make it very difficult to prevent the 'bottom-up' policy making that he describes.

'Most street-level work is not open to meaningful revision by limiting discretion, removing public employees from interaction with clients, or modestly altering bureaucratic structure. In street-level bureaucracies there is an irreducible requirement that public employees interact with citizens to determine the nature and extent of public services they should receive and provide those services through interactions with them' (Lipsky 1980, p 201).

Lipsky argues that 'the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out' (p. x). However, these practices are not necessarily a reflection of ideals of public service, but more usually are bound up with the coping strategies that front-line staff use to manage work pressures against a background of limited resources. Many of the routine practices that street-level bureaucrats use, such as client stereotyping, limited search strategies and de facto rationing, reflect the practical need to keep the system working in adverse circumstances – what Lipsky (1980:xiii) terms a '*corrupted world of service*'. It is not so much the case that the lower level actors frustrate the plans of higher level policy makers, but that they often make adjustments to

allow imperfect policies to work, or devise coping strategies to compensate for the inadequate resources provided.

The early street level bureaucracy work inspired many studies of discretion in government agencies and other organisations, including several with an explicit policy implementation dimension (Maynard-Moody et al. 1990; Scholz et al. 1991; Weissert 1994; Scott 1997; Ellis et al. 1999; Keiser 1999; Baldwin 1990; Evans and Harris 2004). Although some of the work took the form of micro case studies, the '*street-level*' perspective quickly influenced implementation theory. Berman (1978) suggested that policy implementation occurs at two levels: the macro-implementation level, where higher level policy actors devise an implementation strategy, and the micro-implementation level, where local organisations react to these plans, develop local strategies and implement them. He argued that most implementation problems arise from the interaction of the policy with micro-level settings. Because high-level policy makers have very limited influence over local actors, this results in considerable variation in how a given national policy is implemented in different places. The bottom-up theorists contend that in this situation top down control attempts will be relatively ineffective in pushing local actors towards greater compliance; instead local implementers need to be given freedom to adapt the policy to local conditions.

Some theorists attempted to deal with this problem by trying to model this micro-level policy implementation in detail so that these insights could be incorporated into a more sophisticated analysis of the policy formation process. Elmore (1980) proposed a re-focusing of implementation studies. In his view 'the important issue is not whether the framework of analysis is "right" or "wrong" , but whether it is sufficiently clear to be controvertible' (p.602). Elmore (1980) devised an approach termed 'backward mapping' to analyse the concrete steps and choices between alternatives facing local actors:

... 'backward reasoning' from the individual and organisational choices that are the hub of the problem to which policy is addressed, to the rules, procedures and structures that the closest proximity to those choices, to the policy instruments available to affect those things, and hence to feasible policy objectives. (Elmore, 1981, quoted by Hill and Hupe, 2002, p. 58)

The concept of 'backward mapping' involves concentrating on a specified problem, identifying the actions and choices that will arise in solving the problem, and then working backwards to specify the detailed policy provisions needed to support those steps.

One important consequence of the bottom-up approach was to change the unit of analysis for research studies. Where 'top-down studies had been concerned mainly with the apparatus of government, state departments and the legal system, the bottom-up studies examined a wider array of organisations and actors. Hjern and associates argued that research needed to extend beyond the formal authority structures of the central state to take account of a wider policy system. They contend that policy is applied through 'implementation structures' located 'within pools of organisations' and 'formed through processes of consensual self-selection' (Hjern and Porter 1981). They set out or identify these implementation networks empirically, and investigated how field-level policy actors carried out their activities without prior assumptions about the constraints that would apply. Hjern and Hull (1982:107) argued that research should be 'organisation-theory inclined', so that it does not privilege any specific actor or set of actors, but builds up a picture of patterns of influence from empirical data. Hjern's team found that top-down initiatives were often poorly adapted to local conditions, so that their successful implementation depended crucially on the ability of local actors to adjust policy to fit local conditions.

The 'implementation structure' or network analysis approach was supported by Barrett and Fudge's (1981) book *Policy and Action*. This contains ten case studies which examine the empirical variability of implementation processes at different levels and in different contexts. Two important issues that they identify are the 'multiplicity of linkages between actors and agencies' and their persistence of conflict rather than consensus in many real world implementation attempts (1981:253). They argue that the networks of linkages, and patterns of social relations and interest were inadequately theorised in previous work, and propose a framework of analysis based on Strauss's (sociological) 'negotiated order' perspective. Barrett and Fudge portray implementation as a negotiation process in which the relevance of control and compliance needs to be worked out in different contexts (1981:257-58). Negotiation, bargaining and compromise are seen as central elements in a process in which 'policy makers and implementers are more equal and the interaction between them becomes the focus for study' (1981:258). However, although they

emphasise the importance of the micro order, Barrett and Fudge also stress the importance of the interest-power structure and the constraints that this imposes on negotiations. While these writers can be seen as ‘bottom up’ because of their attention to micro-level processes, the emphasis on interest and power means that they recognise certain top-down influences, and bring their approach closer to the mixed approaches considered in the next section.

Several other bottom-up studies showed that political outcomes did not always relate in a one-to-one way with original policy objectives, and that the assumed causal link between policy and outcome was questionable. Beyond this, some pointed to the positive advantages of street-level discretion. Allowing flexibility to local actors nearer to the real problems than central policy makers was seen as a beneficial approach. There was also interest in exploring the limits of top-down power: a number of scholars such as Berman and McLaughlin (1978); Sarason (1982); and Fullan (1982) argued that top-down policies constrain but do not construct outcomes, and that local agencies should adapt policies rather than adopting them.

2.3.5 The main points of controversy

While the first wave of implementation researchers modified their models in response to internal critique and empirical testing (Sabatier 1986), real points of difference remained between the two approaches. Pulzl and Trieb (2006) suggest that they are characterised by different research strategies, contrasting goals of analysis, opposing models of the policy process, and conflicting models of democracy (see: Table 2.2)

Table 2.2: Comparison of top-down and bottom-up theories

Accounts of comparison	Top-down theories	Bottom-up theories
Research strategy	Top-down from political decisions to administrative execution	Bottom-up from individual bureaucrats to administrative networks
Goal of analysis	Prediction/policy recommendation	Description/explanation
Model of policy process	Stagist	Fusionist
Character of implementation process	Hierarchical guidance	Decentralised problem solving
Underlying model of democracy	Elitist	Participatory

Source: Pulzl and Treib, 2006

Top-down researchers typically started from a high-level policy decision and worked their way down-wards to implementers. Bottom-up scholars, in contrast, started by identifying the actors involved in front-line roll-out of policy at agency level, and then developed their analysis to move upwards and sideways to study the networks of implementing actors and their problem-solving strategies.

The goal of analysis of top-down scholars is to reach a general theory of implementation. This theory should be carefully enough to allow for predictions as to whether an individual piece of legislation is likely to be implemented effectively. Moreover, the theory should enable scholars to derive recommendations for policy makers with a view to improving implementation. The aim of bottom-up studies, in contrast, is to give an accurate empirical description and explanation of the interactions and problem-solving strategies of actors involved in policy delivery. Some like Hjern and Porter (1981) tried to move beyond description, in their case to develop a complex heuristic model of the actor network or 'implementation structure' (Hjern and Porter 1981) within which implementation takes place.

The two schools of thought put forward contrasting models of the policy process. As mentioned earlier, top-down theorists have been influenced by what has been called the 'textbook conception of policy process' (Nakamura 1987: 142), and the 'stagist' model. In the eyes of some, this means they do not examine the whole policy process, but merely 'what happens after a bill becomes a law' (Bardach 1977). By contrast, bottom-up writers argue that policy making continues throughout the whole policy process (what some call the 'fusionist' model).

The schools have differing views on the character of implementation process. Top-down theorists view implementation as an apolitical, administrative process. The real power rests with the high-level policy actors, who define policy objectives and use hierarchical command and control mechanisms to ensure that objectives are translated into practice. Bottom-up scholars argue that policy objectives are never completely definitive or closed to revision, and that the way policies are implemented can never be fully controlled from above. For them, there is a legitimate space for local policy adaptation rather than following a blueprint according to hierarchical command.

Finally, the two approaches are based on different models of democracy. The top-down models rest on a traditional, conception of representative democracy at the state level. In this view, elected representatives have a special status as the actors with legitimate authority to make binding decisions for the whole citizenry. The bottom-up argues that it is legitimate for lower level actors and agencies to have a voice about changes that will affect them, and that these perspectives must be taken into account alongside the intentions of the elite actors.

2.3.6 The synthesisers of implementation theory

Some bottom-up theorists came close to building top-down elements into their models. As mentioned above, Barrett and Fudge (1981) took account of differential power and the possibility that higher level actors would be involved in negotiations as policies were applied. Richard Elmore (1978), initially thought of by many as a ‘bottom-up’ theorist, was another writer who laid the ground work for a synthesis between the two positions. Elmore suggests that in the study of complicated events, there is value in using mixed research methods and different theoretical models, to produce an analysis that works at a number of different levels. He argues that one can distinguish various facets of the process, including ‘implementation as systems management’, ‘implementation as bureaucratic process’, ‘implementation as organisation development’ and ‘implementation as conflict and bargaining’. The previous section discussed the innovative approach of ‘backward mapping’ that Elmore developed. In a later (1985) article he proposed a complementary approach of ‘forward mapping’, whereby policy makers would identify the incentives affecting implementer behaviour. The emphasis on the simultaneous use of analysis at different levels opens the way to take account of both the needs of policy makers and the perspectives of lower-level implementers. Elmore suggested that there were many situations where policy makers should leave some areas of policy open for local actors to determine the details in the light of the experience of implementation, so overall this is a mixed approach which still puts a good deal of weight on bottom-up influences.

Sabatier (1986), already well-known as a top-down theorist, shifted his position in his later work, where he tried to develop a more sophisticated account of relationship between policy formation and implementation and the networks involved. He proposes an ‘advocacy coalition’ approach, which examines how actors at different levels become

involved in implementation. He argues that there is a policy subsystem, comprising a range of public and private organisations and actors who are involved in concerted action but are often in conflict, and that policy implementation depends on strategies devised by 'power brokers'. A kind of feedback loop operates whereby accumulated knowledge feeds into the revision of policy objectives. The sub-system is also affected by external events which impose constraints on action and limit the available resources. This takes him closer to the bottom-up perspective because the advocacy coalition can be seen as comprising actors from all levels. Apart from this Sabatier's contribution is noteworthy because of his clear statement of something not usually acknowledged in the bottom-up models, the continuing significance of higher level actors and their interventions as a factor which has an impact on lower-level actors, and over which they have little direct influence.

Several writers who attempted to synthesize the top-down and bottom-up positions, tried at the same time to re-theorise aspects of the policy process. For example, Lane (1987) argued that implementation involved both the idea of 'policy achievement' and 'a process of policy execution, which coincided respectively with responsibility for outcomes and trust in putting policy into effect. In his view top-down models are concerned mainly with the responsibility side and bottom-up models the trust side. Stoker (1991), writing explicitly about the United States federal system, introduces the interesting concept of 'implementation regimes', which looks at the shifting balance between use of state authority, market exchange and 'governance' (other more indirect regulatory mechanisms such as contract). This leads into an analysis of different patterns of 'centralised', 'shared' and 'diffuse' distributions of public authority in different contexts and the associated implementation approaches. Other studies ranged across such approaches as network analysis, institutional theory and governance theory.

Goggin and associates' (1990) book was noteworthy because it combined an attempt to synthesize the top-down and bottom-up approaches with a call for a more comprehensive, but parsimonious theory of the implementation process. Their self-proclaimed progression into 'third generation' implementation theory, represented an attempt to move beyond description, and what they saw as the fragmented analytical efforts of previous writers, to develop explanatory and predictive implementation theories. For these writers, implementation research had relied too much of case studies rather than systematic data on variables affecting implementation that would allow hypothesis testing. Third-generation

work involved a marked turn towards quantitative, multi-variate analysis techniques. Goggin et al's major study involved a complex design involving investigation of 27 variables, and a large number of other multivariate studies followed (see: O'Toole 2000). However, it is questionable about whether the quest for a 'parsimonious', middle-level theory of implementation was ever realistic given the range of policy domains and contexts involved. O'Toole (2000:283), himself one of the main advocates of this goal, concludes that 'the top-down and bottom-up debates are ended, superseded by a general recognition of the strengths of each.' Although still sympathetic to the 'larger-n studies', he notes approvingly that 'a range of complementary research initiatives is now underway'.

The period after the appearance of the 'third generation' studies saw a dip in the popularity of implementation research in the English language literature. In the 1990s and 2000s a number of commentators (for example, Hill 1997; Lester and Goggin 1998; Hill and Hupe 2002; Barrett 2004) commented on the decline of the sub-field. The reality of the decline across all the disciplines involved in implementation studies has been questioned, although it does appear to accurately characterise what has happened in the core social policy field (for a review see; Saetren 2005). There have been recent calls for a revival (for example, Schofield, 2001), and signs of a response in the form of a special issue of the *Journal Public Administration* (Schofield and Sausman 2004).

In the British context, recent empirical studies include some innovative work concerned with the implementation of policies designed to reduce health inequalities (Hunter 2002; Exworthy et al. 2002). Exworthy and Powell's (2004) study draws on Kingdon's (1984) work to propose a modified 'policy streams' approach, which is linked to the idea of multi-level governance. Exworthy and Powell suggest that it is necessary to move away from the traditional focus on the relationship between a single central department and a local agency (the centre/local relationship), to also consider centre/centre and local/local relationships. Paraphrasing Kingdon's language, they argue that implementation analysis needs to incorporate the 'little windows' at local level as well as the 'big' windows at national level. In their view implementation efforts are more likely to be successful when Kingdon's three

policy streams⁸ come into alignment across the three dimensions of centre/local, centre/centre and local/local.

One conclusion emerging from this literature is that the nature of the implementation process associated with a particular policy remains an empirical question. The current debate recognises the need to construct implementation models in different ways to reflect the different contexts. In many ways Berman (1980) anticipated the current position when he argued that there is considerable variation in real world implementation strategies, and that the relative importance of top-down and bottom-up drivers must be investigated in specific policy contexts. Although case studies are not the only method, they remain an important source of data. This is the approach that will be taken in this thesis.

2.4. Studying policy implementation in developing countries

Saetren (2005:564) puts the number of published implementation articles ('core', 'near-core' and 'non-core') at over 3,500, but relatively few of these relate to developing countries. This seems to be a serious omission in the light of suggestions that the Western studies of implementation processes may have only limited utility elsewhere (O'Toole 1994; 1997). Among a small number of studies that examine implementation processes in developing countries, most look at areas such as environmental policy, agrarian reform, community or rural development programmes, and housing or infrastructure projects, rather than health care (e.g. Cheema and Rondinelli 1983; Ross 1984; Chan et al. 1995; Brinkerhoff 1999). Grindle's (1980) edited collection includes a single chapter on implementation problems in a combined health/nutrition programme in India, while Grindle and Thomas's (1991) book which uses case study data to examine reform, contains only one health example relating to Mali.

Implementation studies in the health field in developing countries have been quite diverse. Some have used questionnaire methods to examine the implementation of policies such as a national pharmaceutical prescribing policy in Lao PDR (Tomson et al. 2005) and hospital accreditation (HA) standards in Thailand (Pongpirul et al. 2006). Another

⁸ Kingdon (1984) suggests that policy is made through three separate streams of processes - the problem stream, the politic stream and the policies stream. Policies come to the top of the agenda when a 'window of opportunity' opens up in each of the three streams at the same time.

approach has involved retrospective assessment of implementation of a health reform programme, either at the system or sub-system level, using secondary analysis of research findings and press reportage, perhaps with the addition of a small number of primary interviews (e.g. Hecht et al. 1993; Shakya et al. 2004; Ugalde and Homedes 2005; Lloyd-Sherlock 2005). Other studies use a case study approach more similar to that of the present study. For example, Mubyazi et al. (2004) used interviews, group discussions and analysis of policy documents to study the implementation of health decentralisation policies in four districts in Tanzania. Gilson and associates have employed a similar qualitative approach to look at a range of implementation cases in Africa. Some of this work takes the form of cross-national comparative studies of implementing financing reforms (Gilson et al. 2001; Gilson et al. 2003). Other research (Gilson and Erasmus 2004; Gilson et al. 2006) makes the case for applying findings from the literature on street-level bureaucracy and bottom-up implementation to health systems development and tackling health equity implementation gaps in South Africa.

Walt and Gilson (1994:354) remark on the high rates of failure of health programs in developing countries, which they attribute to a lack of consideration of factors that affect implementation. They argue that development experts have long been over preoccupied with the technical content of good policies, the 'what' of policy reform rather than 'how' they should be implemented, and 'why' in practice policies are not applied as intended. While there are many studies of health care reform in the developing world that focus on issues such as financing strategies and organisational transformation, there has been little systemic analysis of the problem of implementation (Walt 1994; Blaauw et al. 2003). Walt and Gilson (1994) suggest that bottom-up implementation theory in particular could be a useful corrective to over-reliance on the dominant rational planning approaches. The bottom-up approach highlights the complexity and messiness of real world policy-making, and the role of culture, power, politics and social networks. These authors emphasise the 'interactive' nature of implementation processes in which the front-line response may itself influence and change policy in the course of implementation, especially where negotiation and bargaining are necessary to make progress. In their view there is an important place for implementation studies that examine the relevant networks of actors and agencies and the forces that influence them.

Studies of the health sector in Thailand fit the pattern of relative neglect of implementation processes that Walt and Gilson (1994) describe. Generally the focus of research has been on policy formation or policy evaluation with little attention being paid to the intervening process.

Two recent studies by doctoral students working with Gill Walt have made a start in correcting this bias. Pitayarangsarit (2004) examined the questions of how Thailand's universal coverage health care reforms came about, and how likely the policy was to achieve its intended goals. The study uses a 'policy process' approach to examine the four elements of context, actors, process, and content. The research concentrates mainly on the policy formation phase, which is explored via interviews with high-level actors, and documentary and media analysis. The implementation phase is investigated by a single case study of 'Salaburi' province reported in Chapter 6. Data collection at provincial level included observations of five meetings involving public health staff, 24 semi-structured interviews and 4 focus group discussions with villagers (the lay perspective on the reforms). Pitayarangsarit suggests that Thailand has a tightly-knit, medically-dominated policy community, which includes bureaucrats, professionals and academics, and which continued to influence policy during both policy formulation and implementation. She suggests that implementation 'was a top-down process; however, there were some spaces for street level bureaucrats to adapt decisions to fit their context' (Pitayarangsarit 2004, p. 2). Provincial level authorities had some degree of autonomy in implementation decisions, but policy transfer from centre to local area was top-down. Pitayarangsarit (2004:164) reports that 'There was little consultation but allowance was made for flexibility, and it was given to the province to manage the process. At provincial level, the decision-making process was more interactive and it seemed to manage conflict partly due to the Thai culture, which resulted in compromises'. One conclusion of the study is that the nature of policy implementation reflected both managerial and political problems.

Tantivess's (2006) study investigated how anti-retroviral therapy (ART) came onto the Thai Government's policy agenda in the 1990s, how policies about widening access to ART fitted in with the universal coverage health reforms introduced in 2001, and the process via which ART policy then developed during the course of implementation. The study is concerned with policy making across both the policy formation and implementation phases, and benefits from the author's high-level contacts, which opened the way for interviews with senior policy makers in the Ministry of Public Health and the

Government Although much of the study concentrates on the networks of actors involved in policy formation, Chapters 6 and 7 investigate policy implementation through case studies in two provinces. The case study component involved just under 60 semi-structured interviews with staff in provincial Health Offices, hospitals, NGOs, civil society organisations and people with HIV and AIDS, and about ten ‘other informants’ provided additional information.

Both studies examine the policy process as a whole, and arguable the weight of analysis inclines towards policy formation rather more than implementation. Given the scale of the effort involved in following policies through both the formation and implementation stage in a single study, it is hardly surprising that the case studies of implementation are of limited scale. As will be discussed in Chapter 3, the present study has a different emphasis since it focuses primarily on implementation, and uses a larger data set than the earlier studies to concentrate on three case study settings.

2.5 Summary of chapter

This chapter has reviewed certain key areas of the literature relevant to the thesis. It has introduced the ‘policy process’ approach that guides the analysis, and foreshadowed the importance of the implementation phase and the role of lower level actors. The chapter has highlighted a number of past works that have argued for the value of case studies, and suggested that actors, networks and agencies and the local context may all influence the content of policies. It has summarised the debate between top-down and bottom up theorists, and highlighted the conclusion of some writers that the relative influence of top-down and bottom-up influences in relation to particular policies in particular local contexts is an empirical question. This will be one of the key issues that is explored in Chapters 5-8, which deal with how the three case study provinces implemented the 30 baht reform policy.

Chapter 3

Methodology

Chapter 3. Methodology

3.1 Introduction

This is a qualitative study based on a comparative case study methodology in which the ‘cases’ are represented by three case provinces and their approach to implementing the UC reforms. The case study data was collected using mixed methods, which include interviews, focus groups and documentary analysis; overall the approach can be called ‘policy ethnography’. This chapter provide an account of research methodology: it describes the policy ethnography approach and discusses case studies as one strategy for policy ethnography; it explains the three main phases of the study and the main data collection methods; it explains certain steps taken to maximise the validity of the findings; it discusses the ethical issues raised; and finally considers some limitations of the study

3.2 The ‘policy ethnography’ approach

This study is a ‘policy ethnography’; an approach that uses qualitative methods to investigate the perspectives of actors within a health care system that has been used in policy-oriented research on the British NHS and elsewhere since the 1990s. The term ‘policy ethnography’ was coined by Philip Strong and Jane Robinson (1990) in their study of the Griffiths management reforms - ‘The NHS: Under New Management’. A similar approach was adopted by other researchers, such as David Hunter and associates (Pollitt 1988; Harrison et al. 1992) at Leeds University, David Cox (1991) at Birmingham University, Chris Bennett and Ewan Ferlie (1994) at Warwick, and Rob Flynn and associates (Flynn et al. 1996; Flynn and Williams 1997) at Salford University, all of whom carried out major studies supported by mainstream funding agencies. It is also the approach used by David Hughes, Lesley Griffiths and associates in a series of Swansea studies (Hughes, Griffiths, and McHale 1997; Hughes, McClelland and Griffiths 1997; Hughes, McHale, and Griffiths 1997; Griffiths and Hughes 1998; Hughes and Griffiths 1999a; Hughes and Griffiths 1999b; Griffiths and Hughes 2002). Policy ethnography has been attractive to researchers because it uses flexible research designs, which are not de-railed by rapid and unpredictable organisational change. Although randomised controlled trials (RCTs) are still seen as the ‘gold standard’ by many British funding bodies, they do

not work well when organisational structures and boundaries are subject to constant re-jigging.

Although there is no single agreed definition of policy ethnography, Strong and Robinson (1990) point to four characteristics which distinguish this approach from conventional ethnography.

- It is multi-disciplinary: understanding policy involves drawing not only on sociology but also economics, organisation studies and health service research
- It is not written for an academic audience alone but needs to address the agendas of policy makers and practitioners
- It employs a sense-making framework shared with subjects, rather than being discovered by the ethnographer. Thus concepts used by the researcher will usually be ones that subjects recognise, as opposed to being made up by the ethnographer
- It relies mainly on ethnographic interviews which recognise the expert status of informants and take the form of a dialogue in which the subjects assist in the task of analysing ongoing events.

Hughes (2002) has argued that policy ethnography should include a significant observational component to complement interviews and documentary analysis. He suggests that the approach is especially suited to the study of policy implementation as it is 'worked out' in a range of health care settings, such as health authorities, hospitals and community units. The focus is on policy in action – the implementation of policy in real world situations at different levels within organisations. Beach (1999) suggests that policy ethnography involves research about the struggles over values and the material influences that underlie policy discourses and which relate policy texts to practice. In his view, research of this kind can highlight the processes by which lower-level actors mediate or re-contextual national policies, and the differences between intended policy and policy in use.

Policy ethnography differs both from traditional ethnographies that emphasise the authentic representation of subjective experience, and recent post-modernist work preoccupied with multiple realities and the problem of privileging one account over another. Policy ethnography rests on a realist epistemology and is more about obtaining information that is difficult to get by other means. It aims to look inside the 'black box' of

the organisation and ‘reach the parts others methods cannot reach’ (Hughes 2002). Table 3.1 summarises some distinguishing features of ethnography and policy ethnography.

Table 3.1: Distinguishing features of ethnography and policy ethnography

Research method	Definition	Distinguishing features
Ethnography	These studies focus on people’s own descriptions of their routine, daily lives, enabling the researchers to explore a number of views at the same time ⁽¹⁾	<ul style="list-style-type: none"> - the ethnographer is seen as expert observer or ‘loiterer’ ⁽²⁾ - goal is understanding subjective perspectives and cultural meanings
Policy ethnography	These studies examine policy implementation as it is ‘worked out’, and focused on policy in action in real world situations at different levels within organisations. ⁽³⁾	<ul style="list-style-type: none"> - the policy ethnographer is seen as multi-disciplinary narrator who puts together a story from available evidence. - Goal is understanding policy implementation and its enactment in organisational settings

Adapted from: (1) Hammersley and Atkinson (1983)
(2) Spradley (1979)
(3) Hughes (2002)

One possible criticism of the idea that policy ethnography looks inside the ‘black box’, is that it risks falling into the trap of naive realism and treats field data as straightforward reproductions of the world ‘out there’. Martyn Hammersley (1992) has argued for a third position beyond crude realism and idealism, which he calls ‘subtle realism’ (see also: Pope and Mays 1995; Murphy et al. 1998; Mays and Pope 2000). This position accepts that knowledge claims are uncertain and that researchers inevitably see events through the filter of their own culture and values, but argues that research can say useful things about a real world. However in Hammersley’s view, researchers should be cautious and should limit themselves to the goal of searching for knowledge about which they can be ‘reasonably confident’. Such confidence is based on the credibility and plausibility of knowledge claims. For subtle realists, there is a reality that exists independently of the researcher’s knowledge claims, and such claims can be more or less accurate. Subtle realism is different from the naive version because it holds that research reports *represent* reality rather than *reproducing* it. Reality can be represented from a range of different perspectives, and more than one of the different (but logically compatible) accounts produced may be true. But it is also the case that some accounts can be shown to be false, and research can help to indicate which have most plausibility and credibility. Subtle realism points to the imperfect attempts of researchers to reach practical understandings of

social phenomena, and adopting this approach is the best way the researcher knows of responding to the charge of ‘naïve realism’.

The research question and objectives were described in Chapter 1. The study aims to elucidate a policy implementation process at local level and this seems highly compatible with a policy ethnography approach. Strong and Robinson studied the implementation of the NHS Griffiths reforms mainly by using interviews. Rather than using case studies, they aimed to build up a synoptic picture of the roll-out of the reforms by interviewing a large number of actors spread over many settings. This had the advantage of generalisability, but the disadvantage that data on particular sites was often limited to a partial snapshot of events provided by a single interview. Later policy ethnographies have tended to include a bigger observational component, and use case studies which either stand alone or are supplemented by interviews in a larger sample of settings. This study takes a midway position where a large number of actors are interviewed but within the context of three case studies. It was decided not to include observations as one of the main research methods (a) because of the large scale of the data collection task in the three provinces and (b) because interviews were considered more manageable for a researcher attempting his first policy ethnography study. Thus the design is closer to that of the original Strong and Robinson (1990) version of policy ethnography, which relies mainly on interviews.

3.3 The case study approach

Because not all policy ethnographies use case studies, the case study approach will be discussed in more detail. Case studies are appropriate when ‘how’ or ‘why’ questions are being considered, and when the focus is on a contemporary phenomenon within some real-life context (Yin 1994). This resonated of the aim of this study to explore local actors’ perspectives on the implementation of policy and their actions in real-life contexts.

Yin (1994) discusses how in examining ‘how’ and ‘why’ questions, case studies need to explore sets of related propositions which can describe patterns of social action or events in the area covered by the case, such as an organisation or locality. Case studies aim at an in-depth investigation of the interaction between significant factors affecting some phenomenon. This approach seems to have clear applicability to a topic like the

implementation of UC policies, where factors such as local power networks, the influence of different groups and the nature of organisational cultures all play a part in the story.

However, it should be noted that there is no method that is free of problems, and case studies are no exception. Table 3.2 describes strengths and weakness of case studies method.

Table 3.2: Strengths and weaknesses of case studies

Strengths	weaknesses
<ul style="list-style-type: none"> - allows in-depth interviews, - produces first-hand information, - employs methods that encourage familiarity and close contact with the informants, - allows the employment of a variety of interrelated methods and sources, - permits long-term contacts and personal experiences in the field, - focuses on verifiable life experiences, - produces information that covers the whole unit and not only small aspects of it. 	<ul style="list-style-type: none"> - Results relate to the unit of analysis only and allow no inductive generalisations, - findings entail personal impressions and biases; no assurance of objectivity, validity and reliability, - Research cannot be replicated, - It is difficult to convey in research reports the complexity of the field and to the personal and subjective information that constitutes the basis of case studies, - the interviewer effect may cause distortions; even the presence of the researcher in the field can result in problems of reactivity..

Adapted from: Sarantakos, S 2005

This study, which examines three cases, resembles what Yin (1994) has called a ‘multiple-case design’. This is a common study design which is often used when independent innovations occur at different sites. Thus each site might be subject of individual case study, and the case study as a whole would have use a multi-case design (Yin 1994).

The cases were purposively selected for the study. They were chosen because they had particular features or characteristics which would enable detailed exploration and understanding of the central themes and puzzles which the research aimed to study (Mason 2002; Patton 2002). Although selection did not rest on a formal statistical sampling process, the choice of sites was made to capture one of the main sources of variation in local implementation approaches: the administrative divisions.

The north-east (Esarn) region was chosen as the location for the study partly because it is the area near the author’s university, but also because it is the poorest region of Thailand, and the one where the UC reforms were predicted to make the most difference to the health of previously under-served populations. The researcher wished to select three ‘heartland’ provinces typical of Esarn, but also to try to capture any variation of approach

that existed in the region. For MoPH purposes Esarn is divided into three administrative departments or health regions⁹ (*Khet-* in Thai), whereby PHOs reported to different Regional Offices, which (it was hypothesised) might enforce directions from the MoPH in rather different ways. Thus one central Esarn province was selected from each health region: Mahasarakham in Health Region 5, Kalasin in Health Region 6 and Roi Et in Health Region 7. Each of the three provinces contained a provincial city, as well as small town and rural areas, as indeed can be found in almost all Esarn provinces. More detail on the characteristics and comparative information on the three cases study provinces is provided in chapter four.

3.4 The doctoral project and its companion study

This doctoral study was linked to a wider study carried out by the supervisor of the policy formation and implementation process via which Thailand's universal coverage health care reforms came into existence. The supervisor was in Thailand in 2002-03 and arranged for the student to be accepted for doctoral studies at the beginning of this period, with the aim of putting in place a linked study and studentship. The supervisor's research included interviews with policy makers in Bangkok and additional data collection in the north-east which have informed sections of this thesis (especially Chapter 1), but are not described here. The supervisor accompanied the student to many interviews, which were carried out by the student, but which it is hoped will eventually be used to produce publications for both studies.

3.5 The research process

The research plan for the doctoral study was conceived in 2002, and has been adapted in the light of subsequent events. The research questions arose from the dramatic transformation of the Thai health care system that began in 2001. The research process comprised three broad phases: (1) Formulating the research questions and planning the research design; (2) completing necessary preparations, collecting the data and undertaking preliminary analysis; and (3) supplemental data collection, further analyses and reaching conclusions. This is adapted from Yin's (1994) framework but makes some amendments to the last phase. One complication in the present study is that there were two stages of data collection because the initial interview study was followed up with a focus group

⁹ During the year when the study was started, Thailand was divided into 12 regions under the supervision of Health Regional Offices headed by Inspector Generals.

stage carried out about a year later. This latter stage was intended to corroborate and further elucidate findings from the interviews. Thus it has been included in Phase 3.

3.5.1. First Phase: define and design

This phase was concerned with four activities (1) formulating the research questions and refining the theoretical approach, (2) designing the data collection protocol, (3) selecting case studies and (4) preparing for field-work and piloting the interview guide.

Initially, the research questions considered focused on the extent of organisational change in the district health system after the UC reforms. But, following a review of the literature and discussion with the supervisor, the author became more interested in examining the implementation of the reforms as a complex process worthy of study in its own right (see: Chapter 1).

The data collection strategy and general approach for both the in-depth interview and the focus group discussions, were developed by reviewing the literature and discussing the issues with acquaintances working in the health care system (The books by Yin (1994) and Arthur and Nazroo (2003) were particularly helpful). Although the interview guide was prepared at this stage, the corresponding guide for the focus groups was left undefined, to be determined by the interview findings.

The selection of the case studies was described in section 3.3. Three provinces were selected to provide a multiple-case study design.

The preparations for the study included arranging access, considering ethical issues and appropriate safeguards, and piloting the interview guide.

Most of the interviews for the study involved personnel who worked in the public health care system overseen by the Ministry of Health. It was considered necessary to get permission for the study at a high level in the Ministry, and then later to seek consent from individual respondents at lower levels in the system. Verbal permission for the study had been obtained by the supervisor in a face-to-face meeting with the deputy Minister of Health, some months before the doctoral research began. However, it was decided that formal written permission would be required to show to actors in the system who might

want this information. Thus a letter requesting access was sent in March 2003 to the Permanent Secretary of the MoPH, the highest civil servant in this department. This covered both the doctoral project and the related study being undertaken by the supervisor. The Permanent Secretary responded positively and sent a formal letter giving permission for the research to proceed. Subsequently individual respondents were approached individually to see if they were willing to take part. Although random sampling was not used, respondents were selected purposely to include staff at all levels in the local health systems of the three provinces. The approach used to recruit these respondents is discussed in the next section. With regard to respondents outside the MoPH, such as the municipalities and private hospitals, the author sent letters requesting co-operation and a project information sheet to the relevant Mayor or Doctor Director.

The ethical issues raised by the study were considered and necessary safeguards were put in place (because of its importance, this is discussed in section 3.9).

Finally the interview guide was piloted. This was done with four public health officers who were studying at Mahasarakham University in the part-time program for bachelor degree of Public Health. These were not working in three study provinces and not eligible for the main study. The pilot exercise resulted in a few small changes to the questions to make them more 'user friendly', and one change in question order.

3.5.2. Second phase: prepare, collect and start preliminary analysis

The author's position as a lecturer in Faculty of Public Health at Mahasarakham University (MSU) helped him gain access to policy actors within the three study provinces. The Faculty provides Bachelor and Masters Degree programmes to health professionals throughout the north-east, and also has a good network of research contacts. In April 2003, the author began approaching key personnel in the three provinces to see whether they would take part in the research. A twin-track approach was used that involved (a) approaching key personnel in the MoPH and local government administrative hierarchies of the three provinces, and (b) approaching lower-level actors in the system who were studying at the university and would thus be accessible for interviews there. Informal, verbal requests, often by telephone, were formalised with letters to the Chief Medical Officers (CMO) of the PHOs requesting permission to conduct the study. The author then

approached persons lower down the hierarchy. Some senior staff, such as PHO administrators and the Heads of District Offices, helped to set up interviews with colleagues in other offices. A number of local health administrators who were past or present students were particularly helpful in making approaches to others for the researcher. From then on it was fairly easy to access the key informants in the local health areas. A similar approach was taken to certain non-MoPH personnel, mainly in local government, who were interviewed.

The group under the command of the MoPH comprised the Chief Medical Officers (CMOs) who headed the PHOs, the deputy CMOs in Medical Care, Public Health and Administration in each PHO, the heads of Group or Department in the PHOs, doctor directors of provincial hospitals or their deputy, doctor directors of community hospitals (including large, middle and small hospitals), and heads of District Health Offices (in large, middle and small districts). At a lower level the study also covered heads of health centres (including both those already upgraded to primary care units (PCUs) and traditional health centres), and Health Officers who worked in the PHOs, hospitals, district health offices and health centres. The non-MoPH respondents consisted of the Mayors of Muang (city centre) municipalities, Directors of the Public Health and Environment Divisions, and health officers in municipalities, as well as the Doctor Director of a private hospital in the UC scheme.

The respondents who were current students posed some special ethical problems which are discussed later (see 3.9). The objective was to recruit informants from this source so as to provide a snapshot of views from lower staff in the PHOs, district offices and health centres. This would supplement the accounts of higher-level post holders who were approached because of their place in the hierarchy. A list was made of all students on current courses who held such positions. A selection was then made according to geographical locations and bands of grades. In a few instances where a selected person declined to take part, a reserve was picked from the same group.

Overall, the group of respondents selected must be considered to be a convenience sample. However, purposive considerations were taken into account in getting a roughly even split between the three provinces, and representation of different grades and districts within

each province. As it turned out the numbers included from Kalasin province were slightly lower than intended because of difficulties in recruiting some categories of staff.

Although the response to the study was generally good, a few intended respondents in key positions declined to take part. These included the Doctor Director of one of the three provincial hospitals, a Doctor Director of a community hospital, a Doctor Director of one Private hospital and a Mayor of a Muang municipality.

In total 147 respondents participated in the study. 124 took part in in-depth interviews. The focus groups involved 31 respondents, of whom 23 had not been previously interviewed. Overall 55 respondents were from Mahasarakham, 44 from Kalasin and 55 from Roi Et. The breakdown of respondents at different levels is presented in table 3.3.

Table 3.3: The study respondents

Respondents	Mahasarakham		Kalasin		Roi Et	
	In-depth interviews	Focus groups	In-depth interviews	Focus groups	In-depth interviews	Focus groups
Health officers in MoPH						
- Chief Medical Officers (CMO) of PHO*	1	-	1	-	1	-
- Deputy CMO or Assistant CMO*	3	1(1)**	2	-	3	1(1)**
- Head of PHO groups/departments*	8	1(1)**	5	2(1)**	5	1
- Doctor Director of Provincial Hospitals or representatives	1	1	1	-	1	1
- Doctor Director of Community Hospitals	6	1(1)**	7	-	7	1
- District health Office Heads	6	3(1)**	7	2	7	1
- Head of Health Centres	4	3	4	3(1)**	6	2
- District Health Officers						
- hospitals	3	-	-	-	1	-
- district health offices	4	-	3	-	2	2
- Health Centres/PCU	4	-	4	-	8	1
Out-side the MoPH						
- Senior municipal representativesities***	2	-	1	1	2	1(1)**
- Health officers in municipalities	2	1	-	-	1	1
- Doctor Director Private Hospital	-	-	1	-	-	-
Total each methods	44	11(4)**	36	8(2)**	44	12(2)**
Total each provinces	44+7= 51		36+6= 42		44+10= 54	
Total this study	147					

Note: * In later data extracts all these respondents have been identified as 'senior administrative officer, provincial health office' (SAO-PHO) to hide identities.

** The numbers of focus group participants in brackets indicate those who also took part in in-depth interviews. Thus the total of 147 indicates the number of persons participating in the study.

*** 'Senior municipal representatives' included two mayors and three Directors of Public Health and Environmental Division. These are not distinguished to anonymise respondents.

The interviews with respondents in the three provinces were conducted within six months during April to September 2003. Though there was a small degree of overlap as the research moved from one province to another, the general sequence was to do field interviews in Mahasarakham, then Roi Et and lastly Kalasin. As mentioned above co-operation was generally good, but a few respondents declined to participate because of heavy workloads or personal reasons. Several interviews had to be postponed because participants had to prioritise other duties, and some were rescheduled several times. A more detailed account of the interviews is given in 3.6.1

All but one interview was in the Thai language. The bulk of the interviews were transcribed fully, although questions were entered in shortened form. The exceptions were some routine responses that were summarised. Provisional analysis was undertaken using Thai language transcripts. This required reading the transcripts several times and documenting key ideas and details of the policy stories of the three provinces. Often it was necessary to cross-refer to other interview transcripts for corroborating information. The analysis was done manually, using a paper list of categories and codes, rather than through a qualitative software package. The main reason for this was the problem of working in the Thai language. Problems of translation and exploring meaning in cultural context could not have been easily handled with available English language software applications

A selection was made of passages that might be used verbatim in the thesis and these were translated into English. This translation was verified with a native language speaker, the supervisor.

3.5.3. Third phase: supplemental data-collection, additional analysis and conclusions

The last phase of the research process involved supplemental data collection, further analysis and the drawing of conclusions.

Although they involved additional data collection, the focus group discussions have been included in this phase because they were concerned mainly with checking and updating the picture emerging from the preliminary analysis of the interviews.

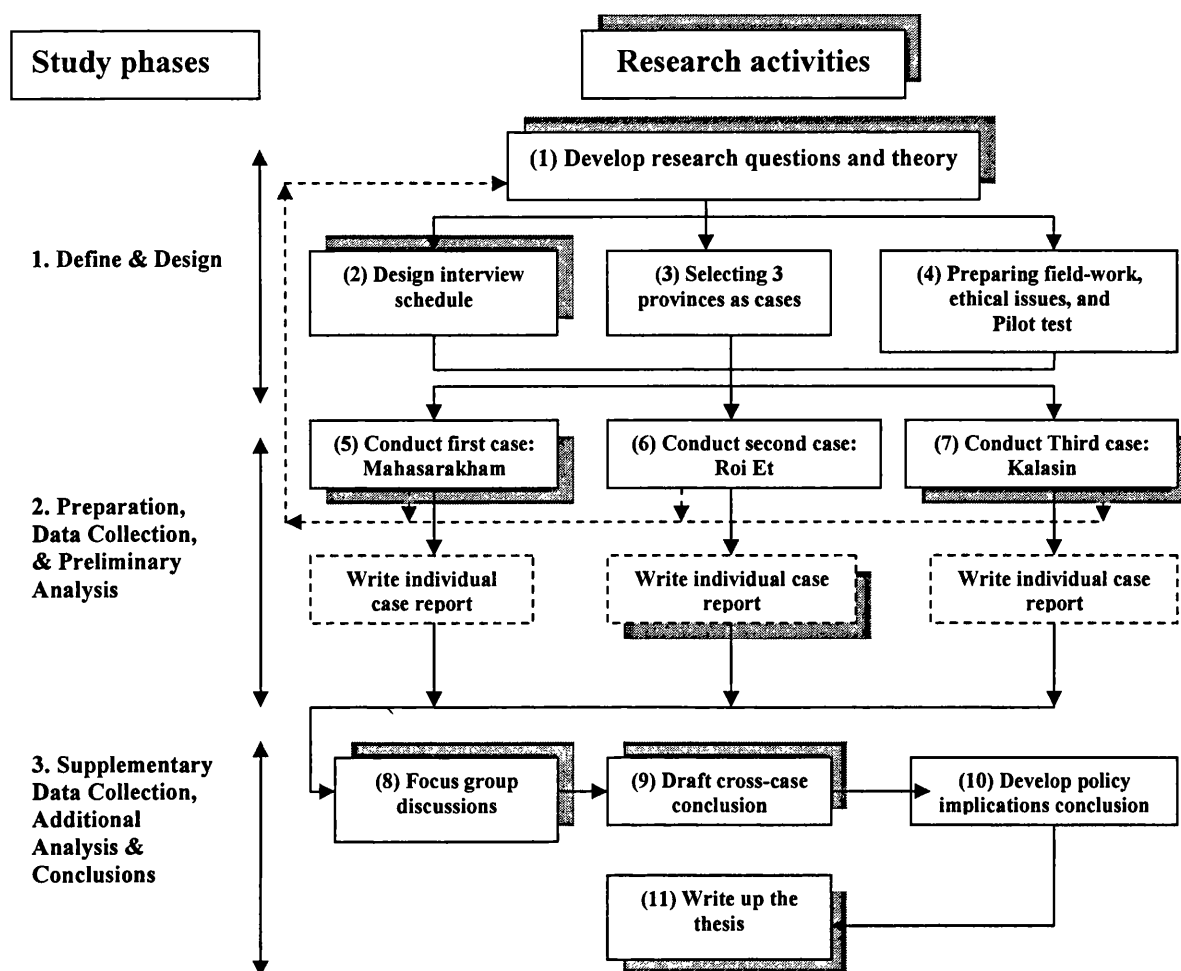
Focus groups are more than a collection of individual interviews, because they generate data from interaction between key actors (Finch and Lewis 2003). Focus groups can have various purposes. Apart from being used as the primary method, they can be applied both as a pre-research and post-research tool in a mixed methods study (Saratakos 2005; Khan et al. 1991). In this study, the focus groups were a post-research method, aimed to further explore and confirm findings gained from the interview phase, and also to update some points that had been unclear a year earlier.

The content of the focus groups had been left deliberately open in the initial research design, so that it could take account of the provisional findings from the first stage of analysis of the interview transcripts. A list of topics to be covered was prepared, resembling an interview guide. This included a number of points from the interviews that it was determined required clarification. A separate focus group meetings was convened in each of the study provinces. As with the interviews, a range of persons at different levels in the system were invited to attend. This included 8 persons who had already been interviewed, but – partly because of changes in some post holders - an additional 23 new participants.

The final phase of analysis involved finalising the details of the policy stories of the three provinces, looking at key similarities and differences and trying to set this within some broader context. A guiding ‘theme’ for events in each of the three provinces was identified, and these are reflected in the titles of chapters 5, 6, and 7. As the author wrote up the accounts of each province he tried to develop cross-case conclusions, and to find supporting or negative evidence across the three provinces. Chapter drafts were discussed with the supervisor and comments were incorporated into the final version of the thesis.

A schematic of the research processes and activities is provided in figure 3.1. To sum up, this is a mixed-methods study which includes data from semi-structure interviews, documentary analysis and focus group discussions. Case studies were conducted in three provinces. Their policy stories and the cross-case conclusions have been put together from these three kinds of data.

Figures 3.1: Summary of the research processes and activities



Adapted from: Yin 1994:49

3.6 The three data collection methods

The three main data collection methods described above will now be discussed in more detail.

3.6.1 Semi-structured interviews

This study included in-depth interviews that used a loosely structured sequence of open-ended questions. Such an interview aims to cover a number of predetermined questions and/or special topics, but do so in a flexible way. The questions are typically asked in a consistent order, following a prepared 'interview guide', but the respondents are given freedom to response and digress. The researcher as interviewer can probe beyond the prepared questions if answers develop in interesting ways (Berg 2001; Bryman 2004).

Some questions that were not included in the guide may be added as the interviewer picks up on things said by respondents. The semi-structured questions of this study were mainly 'how' and 'why' questions concerned with how local actors interacted with the implementation of the UC policy.

As mentioned above all but one interview was conducted in Thai. All 124 interviews were tape recorded (see in table 3.3) with the subjects' permission (see Section 3.5.1). The author confirmed that all discussions held with them would be guaranteed the greatest degree of confidentiality. The advantage of tape-recording is that a verbatim transcription of recorded interviews provides a good basis for analysis. Most interviews lasted between one and two hours, although a few were shorter.

3.6.2 Documentary analysis

Documentary sources can be useful for reconstructing events and as a check on interview accounts. Indeed Yin (1994, p: 81) states that 'for case studies, the most important use of documents is to corroborate and augment evidence from other sources'. Documentary analysis can also provide evidence on why and how particular policies were made and carried out (Buse, Mays and Walt 2005).

In this study, many documents both Thai and English were examined. Most documents were obtained from the government and academic sectors: the PHO reports, the MoPH report, the NSHO documents and other papers from government organisations and research institutes. A number of statistical tables used to illustrate particular points have been adapted from those sources. Details of financial allocations and the split of budgets were also obtained in this way. The PHO reports in particular were an important source of information on the organisational designs and departmental structure of the PHOs in the three provinces. Overall the documents provided important contextual information which allowed a better understanding of data from the interviews and focus groups.

3.6.3 Focus group discussions

Focus group discussion is one of several qualitative methods that researchers can use to generate valid information. It is a form of group interview usually used with around 8 to 12 subjects from the target population; there is an emphasis in the questioning on a particular fairly tightly defined topic; and the accent is upon interaction within the group. Because of

this the data are more than a collection of individual interviews: data are generated by interaction between group participants, so that there is an exchange of ideas and responses and the group is synergistic in the sense that it works together (Finch and Lewis 2003). It has been said that the focus group contains elements of two methods: the group interview and focused interview. Focus groups are generally conducted under the guidance of a facilitator (moderator) who steers the group towards discussion of the desired topics (Khan et al. 1991; Berg 2001; Bryman 2001, 2004). Some experts recommend that a second observer is present to take notes and manage things such as tape recording.

Focus groups are often considered to be an economical method because they offer some of the advantages of in-depth qualitative studies without requiring full scale anthropological investigations (Asbury 1995). However, they also have many of the limitations such as that the samples are small and purposively selected and therefore do not allow generalisation to larger populations. Focus groups are not natural but organised events. However they are useful in situation such as where there are power differences between the participants, when the everyday language and culture of a group is of interest, and when the researcher wants to explore the degree of consensus on a given topic (Morgan and Kreuger 1993).

In this study, focus groups, like the interviews, were concerned with participants' views about how the UC policy had been implemented at local level. The discussions further explored some of the issues thrown up by the interviews, especially certain areas where evidence seemed unclear. It also invited respondents to reflect back on events after another year of the reforms had passed.

As stated above, focus groups were held with a range of respondents in each of the study provinces. A focus group was conducted on 20 January 2005 in Mahasarakham PHO with 11 participants; while a second took place at the Kalasin PHO on 27 January 2005 with 8 participants, and a third at Roi Et PHO on 28 January 2005 with 12 participants. The CMOs hosted the events and gave considerable support. Each discussion took about three hours, and all were recorded with permission. The author acted as moderator and steered the discussion, while a research assistant made simultaneous video and audio recordings of the meetings.

3.7 Data analysis

Qualitative interviews and focus groups typically produce large amounts of textual data in the form of transcripts and field notes, and this large amount of unstructured textual material is not straightforward to analyse (Bryman 2004). Researchers have used a number of procedures to order and analyse such data, Alan Bryman (2001, 2004) describes two general approaches to qualitative data analysis: analytic induction and grounded theory. Miles and Huberman (1994) describe the activities of data reduction, data display and conclusions (drawing/verifying). Sotirios Sarantakos (2005) suggests that the main types of qualitative analysis are iterative analysis, fixed analysis and subjective analysis. Approaches to analysis vary in terms of basic epistemological assumptions about the nature of qualitative enquiry and the status of researchers' accounts. They also differ between different traditions in terms of the main focus and aims of the analytical process (Spencer, Ritchie and O'Connor 2003). It could be said that several writers have distinguished rather different analytical approaches depending on their aims and focus. However, the common elements of these analytic methods are their relationship with interpretive or hermeneutic paradigms, their understanding of the world as being socially constructed through language, and the notion that analysis deals with the presentation of cultural representations (Benini and Farber Quoted from Sarantakos 2005).

In this study, the interpretive perspective was adopted in analysing of data. In this approach human action is seen as a collection of symbols expressing layers of meaning. The researcher set out to examine social action in terms of patterns and meanings expressed in interviews, which could be investigated by analysing interview texts. The interviews and focus group discussions data were transcribed for analysis. The analysis then involved trying to organise and reduce these data to reconstruct the policy stories of the three provinces and to uncover patterns of the key actors' activities, actions and meanings (Berg 2001). The process of data analysis consists of three activities, as Miles and Huberman (1984, 1994) suggest: data reduction, data display and conclusion. Details of this process are described as following;

- **Data reduction.** This is the process of transcribing the interviews and focus group discussions, and then selecting relevant sections on which the analysis can focus. After the transcription is completed, the textual data can be coded (in this case manually). The author wanted to identify all the key issues, concepts and themes by

which the data can be examined and referenced. This starts with the questions derived from the original research aims, but also brings in emergent issues raised by informants themselves or by other kinds of data such as documents (Pope, Ziebland and Mays 2000).

- **Data display.** The next stage of analysis involves an organised assembly of information to permit the formulation of generalisations and conclusion drawing. This happened as preliminary accounts of events and perspectives in each case study province were written up as draft chapter sections. As the second and third cases were also written up and similar issues addressed comparisons and contrasts were explored. It was then necessary to re-visit the earlier drafts and to add missing comparative information, and think about possible explanations for differences of approach.
- **Conclusion-drawing and verification.** This is the process of drawing conclusions from the case analysis used a cross-case analysis to determine commonalities and differences across boundaries (Patton 2002). This is what happened as the initial drafts were revised to take account of differences and similarities in findings and the ideas for the different key themes in each province were refined. Attempts were then made to verify or test these conclusions by checking that sufficient evidence has been produced verified, and in some cases looking for corroborating information in documents or in a few instances by follow-up telephone calls to a small number of key informants to check specific points. (Miles and Huberman 1984, 1994).

The three streams of data analysis are not necessarily sequential; these activities can occur early in the process, may take place simultaneously, and are likely to be revised throughout the course of the study.

As mentioned earlier, the aim of this research was to produce an understanding of the context of the UC policy implementation and the factors that influenced the implementation of the reform policy in local level. The study aimed to build a general account of the reforms and their implementation that fitted each of the individual three provincial cases based on the descriptive approach of the policy ethnography method.

3.8 Quality controls of the study

There are various strategies available to protect against bias and enhance the reliability of findings. Most authorities agree that the approaches taken in qualitative studies are rather different from those used in quantitative studies, so that conventional considerations such as reliability, validity and generalisability cannot be approached in the same way (Mays and Pope 2000). Seale (1999:266) uses the term 'trustworthiness' as an alternative to cover some of the issues usually discussed as validity and reliability. In the author's view, 'trustworthiness' depends mainly on the depth and quality of the data presented, and evidence that steps have been taken to corroborate the main findings on which the analysis is based.

One way to gather corroborating information is through 'triangulation', and indeed that is the main approach used in this study. Triangulation is broadly defined by Denzin (1978:291) as "the combination of methodologies in the study of the same phenomenon". The idea is based on the traditional practice in navigation of taking multiple compass bearings, beyond the minimum two necessary to establish a position. The extra data (additional compass bearings) then increase confidence that the calculated position is correct. Translated into the research domain, the extra sources of data, and cross-checking between them, are considered to minimise the chances of incorrect findings and increase study validity.

Denzin discusses several types of triangulation, including data triangulation (the use of multiple sources to help understand a phenomenon), methods triangulation (the use of multiple methods to study a phenomenon), investigator triangulation (the use of multiple investigators in collecting, analysing and interpreting the data), and theory triangulation (the use of multiple theories and perspectives to help interpret and explain the data) (Denzin 1978:295). In practice, most studies tend to focus on either data or methods triangulation, which is the approach taken in this study. Triangulation is not an absolute guarantee of validity, and some see it more as a way of ensuring comprehensiveness and encouraging a more reflexive analysis of the data than as a pure test of validity (Mays and Pope 2000). However at the practical level it did assist the cross checking of the details of the policy stories of the three provinces that was important in this study.

A second approach to building 'trustworthiness' advocated by some writers is 'respondent validation' or 'member checking' (Bloor 1983; Lincoln and Guba 1985; Murphy et al. 1998). This involves feeding back the study findings to respondents for their comment and possible correction as a final stage of data collection. This may be done by circulating summary findings to a group of respondents or by a final round of interviews. It has been pointed out that accounts offered at a later time may be more than simple corrections of accounts made earlier, and that this exercise may be more complex than at first sight appears to be the case (Bloor 1997). However, it would be likely to minimise the kinds of gross errors that can sometimes occur. In the present study, the focus groups carried out about a year after the main data collection included an element of member checking. Although findings were not fed back to respondents in detailed form, several of the questions discussed were designed to test whether preliminary analysis was on the right lines and to fill in possible gaps or get corroborating information where existing data were thin. This final stage also helps to increase confidence on the findings reported.

3.9 Ethical issues

Almost all research raises significant ethical issues that need to be addressed at the design stage. A number of safeguards were incorporated into the present study.

Although Thailand has a system of formal ethical committees overseeing biomedical research, this does not cover the type of health policy research conducted in this study. In fact in 2003 there was no formal framework with which the present study needed to comply. The School of Health Science at Swansea University has recently created an ethics committee to oversee projects that are outside the remit of NHS or overseas ethics committees, but this did not exist in 2003. Similarly, the institution that facilitated aspects of this study, Mahasarakham University (MSU) did not have such a committee, though it has established one since. However, it was known that the study would pose some ethical issues, such as those raised by the wish to recruit some respondents from the ranks of current MSU students, and it was therefore decided to set up a small informal committee to advise on what safeguards would be required. This comprised the Dean of the Faculty of Pharmacy and Health Sciences, the UK supervisor (at that time in Thailand), and an assistant professor experienced in health research.

The advisory committee suggested that the research needed to pay particular attention to confidentiality and informed consent, and should take special steps to advise respondents who were students that if they decided not to participate this would have no adverse consequences for them in terms of their studies at the University. It was suggested that an information sheet should be prepared for all potential respondents, and that this should include an explicit statement that non-participation would not be penalised, and also consent forms for all participants. Regarding confidentiality, it was suggested that a statement giving assurances on this point should be included in the information sheet, and that arrangements were made to keep data in a secure place to which only the researcher and supervisor would have access. It was also suggested that the researcher should seek explicit permission for tape recording before or at the start of interview sessions, and if necessary would proceed without taping the interview.

In summary, the informed consent of respondents was sought in writing, and this supplemented an initial verbal request to take part in interviews and later a specific request to allow taping before the machine was switched on. Taping was always done openly. More than half the respondents were interviewed in their place of work, so that the researcher was there at their invitation and it was open to them to cancel that invitation without needing to go through any difficult face-to-face contact. The group (less than half) who were current students were in a more difficult situation, because interviews mostly took part after classes at the University. Efforts were made to assure student candidates for inclusion that saying 'no' would have no adverse consequences. This was done verbally in initial meetings and was also mentioned in the Information Sheet. Actually a number of student respondents did decline to take part.

3.10 Limitations of this study

There are many sources of possible quality problems in qualitative research, including researcher bias, selective reporting, lack of rigor and inadequate analysis of data. As explained previously, a number of strategies were used to try to safeguard quality control in this research. The author is confident that a substantial study has been completed, but accepts that it inevitably has some limitations.

On unavoidable limitation is that this study of the UC policy only examines three provinces of the 76 in Thailand. It is clear that the three cases will not capture all the nuances of the policy implementation process as it unfolded throughout the country. No claim is made that the specific findings from the three provinces can be generalised and transferred to other localities. However, in the author's view some of the general propositions about the nature of the implementation process in the three provinces may well be generalisable, albeit with caution. Case studies can be used in policy-oriented research, and are a legitimate part of the evidence that policy makers can look towards for lessons, but cumulative evidence is needed to improve confidence in the findings emerging. The findings of this study need to be set alongside other studies conducted in this period, and its conclusions assessed in that light.

Another limitation of this thesis concerns the way data have been reduced and represented. The data gathering process was complicated because the interview needed to be translated. Translation, however, is not simply finding word for word correlations. Translation includes communicating concepts and ideas between cultures (Simon 1996). Words that seem equivalent can take on different meanings in different cultures (Patton 1990; Bassnet 1994). Translators add a new dimension to research. They must "constantly make decisions about the cultural meanings which language carries, and evaluate the degree to which the two different worlds they inhabit are 'the same'" (Simon 1996: 138). Where, the researcher relies on a third person to provide precise translation of interviews this adds an extra element of difficulty (Temple and Edwards 2002). However in this study, the author and supervisor were able to use personal (though unequal) knowledge of both languages and cultures to discuss difficult passages and to reduce - if not eliminate - these problems. The reason why the problem may not have been entirely eliminated is that researchers as translators still bring a personal cultural perspective to the translation process (Avruch and Black 1993; Overing 1987). The literature suggests that there may be not a single correct translation or interpretation of data (Bassnet 1994), and that translation choices often rest on unacknowledged biases.

Data reduction was complicated by the extra step of translating interview data. All of 124 cases interviews and 3 focus group discussions in this study were conducted in Thai, and this increased the burden of work and the possibility of errors. The phases of translation

and provisional analysis in Thai, followed by translation into English and then final analysis and writing-up in English added an additional level of complexity.

The complications in data display concerned on the extent to which supporting data in the thesis should be presented in the original language. In any study where more than one language is used, the researcher must carefully consider how to display data extracts. Many ideas and concepts are not easily translated using a word-by-word format. Ideally the data would be displayed in the original language together with the translation, in order to preserve the original meaning and make the translation available for scrutiny. Unfortunately, the researcher must also consider issues of accessibility and word count, and the interests of the target readership. This study has taken a pragmatic approach and presented almost all interview extracts in English. Only in a few instances where translation has been highlighted as particularly problematic has explicit reference been made to the original Thai words.

The final limitation in conducting this study was the difficulty in finding comprehensive, systematic data. Some of the MoPH, provincial and district statistics were incomplete, or not up to date. Additionally, some explanations about important policy processes such as financial arrangements and management of resources were only described in outline detail by key informants and needed to be fleshed out from other sources. In a few cases it was not possible to fill in all the gaps. This was made more difficult because the key informants tended to conceal their failures, poor practices, and past mismanagement. For example, the administrators groups who had the major responsibility for policy implementation in the three provinces sometimes gave rather guarded accounts of past events. These gaps were not always filled in by lower officers who might hesitate to criticise the role of the higher level officers.

3.11 Summary of chapter

This qualitative study was designed to explore and understand the implementation of the Thai UC reforms in the three case study provinces. It is a 'policy ethnography', which uses a multiple case study strategy. The study gathered data through the mixed methods of in-depth interviews, documentary analysis and focus groups. It employed naturalistic inquiry to build a picture of the policy stories of the three provinces and the perspectives of participants on the UC reforms.

Chapter 4

The three cases study provinces: characteristics and comparisons

Chapter 4. The three cases study provinces: characteristics and comparisons

4.1 Introduction

This chapter describes the three case study provinces where data on the implementation of the UC reforms were collected. It gives a brief account of the north-eastern Region as well as the individual provinces, and then presents some background data on patterns of health care provision and levels of financing under the UC reforms.

4.2 Thailand's Esarn region

The three provinces selected as case studies are clustered together in the geographical heartland of Thailand's North-eastern, Esarn Region.¹⁰ For the MoPH purposes, Esarn is further sub-divided into three Health Regions (*Khet* - in Thai), covering the 19 provinces (*Jangwat* - in Thai) of the region (*Paak* - in Thai). The three study provinces are at the boundaries where the three Health Regions intersect. Mahasarakham is in Health Region 5, Kalasin 6 and Roi Et 7¹¹.

For long periods the history of Esarn was different from that of the rest of Thailand. At various times it has been part of the Lao, Khmer, and Siamese empires, and its people are descended from Thai, Lao, Mon, Khmer, Indian, Chinese, and Euro-American fore bearers (Wyatt 1982:1). Most Esarn natives acknowledge a strong affinity with the people across the border in the People's Democratic Republic of Laos, and are almost as likely to describe themselves as '*khon Lao*' (Lao people) as '*khon Esarn*' (Esarn people). The present five administrative regions of Thailand, and the name of 'Esarn' for the north-east, go back to the end of the 19th century and the reign of King '*Chulalongkorn*' (Rama V), who was concerned to unite and draw together the nation of Siam in the face of European colonial incursions into South-east Asia.

¹⁰ (อีสาน in Thai; also *Isan*, *Isarn* and *Isaan*)

¹¹ In 2003, the MoPH comprised 12 health regions and then re-organised into 19 health regions in 2004

However, Esarn has continued to suffer from a sense of separation from the rest of the nation, and an unequal share of its resources. There is a history of political dissent in the 1930s, wartime resistance to the Japanese occupation and the collaborator Bangkok government, and communist insurgency from the 1950s to the 70s (Cohen 1991). The region was one of the centres of support for the Thai Rak Thai party, which won 126 of 136 Esarn seats in the 2005 general election. This reflects widespread support for its populist reform programme, of which the 30 baht scheme was the centre piece. A number of former communist insurgents, now active in local politics and civil society groups, were among the organisers of the 'caravan of the poor' which staged counter demonstrations at the time of the anti-Thaksin protests in Bangkok in early 2006, and which among other things were a statement of support for the UC reforms. After the military coup of September 19th 2006 which ousted the Thaksin government, Esarn was seen as one of the main sites of potential opposition (Tunyasiri and Nanuam 2006).

From around the 1970s Government investment in Esarn increased, partly in an attempt to limit support for the communist insurgency. In the Vietnam War era the United States established four air force bases in the north east, and channelled substantial aid to the region. This included infrastructure projects such as the Freedom Highway from Bangkok to Udon Thani, which passes just to the west of the study provinces. However despite further government development projects after the US withdrew from the region, the economic gap between Esarn and the affluent Central Region remained. This contributed to a situation where large numbers of Esarn people migrated to find work in Bangkok, the industrialised Eastern seaboard and the tourist resorts, typically in low paid work in construction, factories and service industries, and also as sex workers. Although some migrated permanently, many Esarn people alternate between periods spent away as waged labour and periods working in the rural subsistence economy. This pattern of episodic or seasonal migration has opened a route for cultural influences from central region, changed patterns of consumption, and also an increase in social problems and the spread of diseases such as HIV/AIDS. It also contributes to the well-documented problem of getting treatment away from the home area that arose with the UC reforms.

Maharakham, Kalasin and Roi Et are agricultural provinces located on the southern Korat plain. This is mostly an area of flat paddy fields, but rises as one moves north into Kalasin and comes closer to the Phu Phan mountains. Much of the land is divided into

smallholdings clustered around rural villages. The farmers depend on cultivation as well as animal husbandry, including water buffalo, cattle, pigs, chickens, ducks and fish. The main crop is glutinous rice, with some production of jasmine rice, cassava root (tapioca), maize, sugar cane, peanuts, cotton, sweet potatoes, jute, and water melons. The soil quality is generally poor, but in recent years attempts have been made to extend the areas given over to higher value crops such as vegetables and soya. Many areas suffer from both drought and flooding, and can cultivate only one crop per year, which limits the income potential of subsistence farmers.

Esarn remains culturally distinct from other parts of Thailand. The three provinces in the study lie within the Lao-influenced area, as opposed to the Khmer-influenced area near the Cambodian border, and most residents speak both Thai and the Lao-Esarn dialect. There is a strong cultural identity based on a distinctive Esarn cuisine, folk music and dance forms, literature and an oral story-telling tradition. As in the rest of Thailand, Esarn people follow the Theravada Buddhist tradition, typically combined with elements of Brahmanism (*phram*), spirit beliefs and magic. Traditionally Lao people, including those in Esarn, have suffered from negative stereotyping and low evaluation from the central Thais (Chiengthong 2003). Thus for many Esarn people feelings of pride in their cultural heritage are mixed with an awareness of social disadvantage and low status.

In 2003, Esarn had a population of 21,659,698 against Thailand's population of 63,079,765, but although about a third of the Thai population lived there, they received only about one tenth of the nation's income (Intarachai 2003). It remains the poorest region of Thailand. Esarn contains fourteen of the fifteen poorest provinces in the nation. Amnat Chareon province had the lowest Gross Provincial Product-GPP per capita, with 17,530 baht in 2005, compared with the nationwide average of 109,696 baht. In 2005, the 10 poorest provinces of Thailand were all provinces in Esarn (NESDB 2005).

There is a problem of income inequality within the region as well as income distribution in relation to the rest of the country (Isara 1998). Economic development and inward investment in factories or larger commercial enterprises is concentrated mainly in the major cities of Khon Kaen, Korat, Udon Thani and Ubon Ratchathani. By contrast, there is far less development in the small cities and rural areas, including the three case study

provinces, and that has led to a wide gap in the standard of living between rural and urban people.

This social disadvantage is reflected in the distribution of health care facilities. Esarn has eight of the ten provinces in Thailand with the fewest physicians per capita (Srisaket had fewest, with one per 13,474 in 2002; the Esarn average was 21,047 and the national average was 3,568). It also has eight of the ten provinces with the fewest hospital beds per unit of population (Srisaket has fewest, with one per 1,972 in 2002; the Esarn average was 2,180 and the national average was 4,650) (NESDB 2005). However, as elsewhere in Thailand, all districts (*amphur*) have a hospital, and all sub-districts (*tambon*) have a health centre.

4.3 Maharakham

Maharakham province was separated from Roi Et in 1865 in the reign of King Prajomkao (Rama IV). The provincial city was upgraded from a '*Baan kudyangyai*' (large village) to become the capital of the new province and given the name 'Maharakham', which means 'the residence for wealth and merit'. (Maharakham Cultural Office 2006)

Maharakham lies to the west of Kalasin and Roi Et, and is the nearest of these provinces to the capital, being about 470 kilometres from Bangkok. With an area of about 5,289 square kilometers, it is one of Thailand's smaller provinces. It is located at the middle point of Esarn region and is sometimes called '*Sadue Esarn*' (the navel of Esarn) (Maharakham Cultural Office, 2006). It is composed of 13 districts with a total population of 936,883 in 228,656 households in 2003. Maharakham is a poor province, ranking 69th of the 76 Thai provinces in terms of average per capita income. Although its position has improved slightly in recent years, income is still lower than the other two provinces in the study. For many years, Maharakham competed with Srisaket (in lower Esarn) for the title of Esarn's poorest province. As will be shown in section 4.6, other characteristics of Maharakham are similar to the other provinces in this study.

The provincial capital, the city of Maharakham, is relatively under-developed compared with larger Esarn cities like Khon Kaen, Udon Thani, Ubon and Korat. By 2003 it had a

single medium-sized department store, and a virtual absence of Western-style facilities. It was a traditional Esarn town with a picturesque but unhygienic fresh food market, a night market for general goods, several central streets of small shops and businesses, and two cinemas. There is no railway connection or airport, and the main transport links are via express bus, or by connections to the airports at Khon Kaen and Roi Et. The road links south that were previously rather poor benefited from a recent major upgrading of the connecting road to the Freedom Highway (Route 2 from Bangkok to Udon Thani) to the west, which by 2004 was mainly dual carriageway. There has been a spurt of development in the past few years mainly as a result of the expansion of Mahasarakham University.

Mahasarakham has long been a regional educational centre. An ancient city located in the Punjab province of Pakistan known as Taxila¹² was a major centre of learning, and this is reflected in Mahasarakham's other nickname of 'the Takkasila of Esarn', or what westerners sometimes term 'the education province' (DaGrossa 2003).. The institutions of higher and further education within the city include: Mahasarakham University (MSU), Mahasarakham Rajaphat University (in 2003 still the Rajaphat Institute), Ratchamongkhon College (an agricultural college), Mahasarakham College of Nursing, the Physical Education College, Mahasarakham Vocational College and Mahasarakham Technical College. Mahasarakham is a 'college town', and to the extent that its prosperity has increased a little in recent years this is largely due to the impact of the growing educational sector (Intarachai 2003). MSU had received major investment from the Ministry of Education and with a student body of over 20,000 in 2003, it was the second largest University in the North East. It has been the centre for a number of research studies on political and social topics including a major British Academy funded-study on civil society in Esarn (McCargo 2006), a study of student culture and sexuality (DaGrossa 2003), and cooperative projects on development and cultural exchange with other countries from Indo-China.¹³ Additionally, there are a number of research centres for the study and development of local wisdom in Esarn, such as the Research Institute for North Eastern Art and Culture, the Silk Innovation Centre, the Research Centre for Palaeontological Study, and the Centre for the Study of Eastern Archaic Manuscripts (MSU 2006).

¹² The city of **Taxila, or Takkasila in Pali**, was an important Buddhist centre of learning from the 5th century BCE to the 2nd century CE. UNESCO has listed 18 locations at Taxila as world heritage sites.

¹³ For example, the Confucius Institute, MSU, has a joint project with Guangxi University of the People's Republic of China, and there is also a project between the Faculty of Public Health MSU and Laos PDR Government to strengthen the health workforce in Laos PDR.

The research and scholarship of the University has had a significant influence on local organisations and people, including civil society organisations, like farmers groups, local government administrators and also local health care bodies, such as the PHO and health administrators. The Local Politics Information Centre at Mahasarakham University has been a major centre for critical analysis of the good governance and civil society movement. Thus some of the University-supported projects, notably the collaborative project with Leeds University, sought to strengthen citizen participation in local communities. Additionally, other government organisations such as the Health System Research Institute (HSRI) and the Training and Development Centre for Primary Health Care in the North-east (in line of the command of the MoPH) have launched cooperative research projects aimed at raising the quality of scholarship and debate about health care services in the province. These projects have also promoted ideas about good governance and civil society, and have paid special attention to the needs of the poorest social groups during the period of economic crisis and recovery from 1997 to 2002.

4.4 Kalasin

Kalasin city was founded in 1833 in the reign of the King Rama I. At times it has been classified as a district or sub-district under different names, and in the past has come under the control of Roi Et, Korat and most recently Mahasarakham. Kalasin province was divided from Mahasarakham in 1947, taking its name from the city of the same name (Thai Heritage Treasury 2006). Kalasin means "black water", which is probably a reference to the dark colour of the Pao river that runs close to the city. The province is composed of 18 districts with a total population of 994,600 in 225,717 households in 2003.

The Lam Pao dam, built across the Pao and Huai Yang rivers, was intended to alleviate floods, provide a site for fish breeding and help agriculture. Many irrigation projects have been introduced in the surrounding areas which have improved the quality of the land. Kalasin is noticeable greener than its neighbors. Production of sugar cane and cassava are particularly strong in this province

The scenic Lam Pao dam and reservoir, the Phu Phan mountains and the research centre and museum for the dinosaur fossils at Phu Kum Khao are a stopping-off point for the many Esarn tours, which are a growing segment of Thailand's tourism industry. The province contains part of the Phu Phan National park, fourteen conserved forests, three parks and three reserves with protected wild animals (Kalasin Provincial Hall, 2003). The city of Kalasin is an unexceptional Esarn town, with similarities to Mahasarakham. Again it has few western-style facilities. By the end of the research period it had two shopping plazas with large department stores to Mahasarakham's one. It is also the location of the largest fresh food and general goods market in the heartland area. The town centre features the usual mix of shop houses and a more modern retail premise found in Esarn towns, and is known in the central North East for its textile shops, including many selling the local silks and cotton fabrics that are produced in Kalasin province. At the time of the research, Kalasin had no University or large higher education institution. Recent statistics on the urban poor in Thailand show that Kalasin city possesses a higher proportion of people under the poverty line than either Roi Et or Mahasarakham cities (Chutimaskul, 2006).

Kalasin city has no railway station or airport. It is connected to Khon Kaen, and thence the south, by a recently-upgraded four-lane highway. As with the neighboring cities, the main means of long-distance transport for ordinary people is express bus.

4.5 Roi Et

The history of Roi Et goes back at least to the reign of King Thaksin in the 17th century when it was a fortified city and a strongpoint of the Thonburi empire and early Ratanakosin empire in the Northeast. (Thai Heritage Treasury 2006) The name Roi Et, signifying '101' in Thai, is believed to be an exaggerated reference to the 11 gates of the walled city or its rule over 11 surrounding colony settlements (Sirindhorn Isan Information Centre 2006) The city of Mahasarakham probably originated as an outpost of this older and more important regional centre. Roi Et has an area of about 8,299 square kilometres. It is composed of 20 districts with a total population of 1,322,389 in 298,146 households in 2003.

In the past, the agricultural land of Roi Et province was at least as poor as that of the adjoining provinces, being subject to flooding, drought and saline soil. Major Government and NGO investment programmes over several decades have improved this situation. Jasmine rice is the best-known product from this area. Roi Et province is also home to a large Thai army base, which provides further support to the local economy. Although not a major tourist destination, the province contains a number of Khmer temples, pagodas and ruins which attract some visitors.

Today Roi Et city is an important commercial and administrative centre. It is an attractive town that justifies its nickname of 'diamond of Esarn'. Roi Et city has a more developed, more affluent appearance than Kalasin or Mahasarakham cities. There are three superior-class hotels. Shopping is better than in the two other provincial cities. There are large branches of the British-owned superstores Tesco-Lotus and Makro.

Roi Et is not an educational centre in the mode of Mahasarakham, but it has a small student population. In 1998, one of the four public universities in Esarn, Ubon Ratchathani University, opened a satellite campus in Roi Et. Recently a new branch of the Rajabhat University was established in the province. However, these institutions were still developing at the time of the study. For this reason, there is no tradition of health research in Roi Et, and the university has not had the same influence on local organisations as Mahasarakham University. While road links are reasonably good, the journey across to the main Freedom Highway south is longer than from Mahasarakham. However Roi Et possesses a small regional airport, which offers daily flights to Bangkok.

4.6 Comparing the provinces

The following sections are intended to provide some comparative information about the provinces. No attempt is made to investigate associations between these factors and differences in the implementation of the UC policies in the 3 provinces. It must be remembered that this is a qualitative study based on three cases, and not a cross-sectional quantitative study. The information provided here is for background purposes and also to allow external comparisons with data from other studies, which might perhaps be illuminated by the detailed case study material in this thesis.

4.6.1 General information

To summarise some of the information for 2003 already presented, Roi Et is the biggest province (with an area of 8299.4 Sq.km² and population of 1,322,389), Kalasin comes next (with an area is 6946.7 Sq.km² and 994,600 people) and Mahasarakham is the smallest of the three cases (with 5228.0 Sq.km² and 944,385 people). Roi Et is divided into 20 districts (*amphur*), 192 sub-districts (*tambon*) and 2,292 villages (*moo baan*); Kalasin contains 18 districts, 134 sub-districts and 1,509 villages; and Mahasarakham is made up of 13 districts, 133 sub-districts and 1,874 villages.

The local government administration in Roi Et consists of one City Municipality '*tesabaan muang*', 16 Municipal Districts '*tesabaan amphur*') and 186 sub-district administrative organisations (SAOs or 'ABT' in Thai). Kalasin was divided into one City Municipality, 23 Municipal Districts, and 129 SAOs. Mahasarakham comprised one City Municipality, 10 Municipal Districts and 132 SAOs.

4.6.2 Economic characteristics

In 2003, the Gross Provincial Product (GPP) of Roi Et was the highest of the three cases at 32,897 millions baht, compared with Kalasin as 25,812 million baht and Mahasarakham at about 23,727 million baht. The population's income per capita per year in Roi Et was the highest at 22,785 baht, with Kalasin at 21,302 baht and Mahasarakham as around 21,030 baht. In terms of the overall ranking of population income across the whole 76 provinces of Thailand, Roi Et was 65th, Kalasin was 69th and Mahasarakham was 70th. Table 4.1 shows comparative information about the three provinces.

Table 4.1: Comparative general information for the three case study provinces

Characteristics	Maha	Kalasin	Roi et	Note Whole kingdom
- Area (Sq.km ²) ^{a, b, c}	5,228.0	6,946.7	8,299.4	514,000
- Distance from Bangkok ^{a, b, c}	470 kms	519 kms	512 kms	
- Districts ^{a, b, c}	13	18	20	
- Sub-districts ^{a, b, c}	133	134	192	
- Villages ^{a, b, c}	1,874	1,509	2,292	
- City (Muang) Municipality ^{a, b, c}	1	1	1	
- District Municipalities ^{a, b, c}	10	23	16	
- SAOs (Sub-district LGO) ^{a, b, c}	132	129	186	
- PAO (Provincial LGO) ^{a, b, c}	1	1	1	
- Population (2003) ^d	944,385	994,600	1,322,389	63,079,765
- Households (2003) ^d	217,994	225,717	298,146	17,853,423
- Move-in rate (per 1000) ^d	42.19	42.67	41.32	59.36
- Move-out rate (per 1000) ^d	38.11	39.29	39.40	53.44
- Population density ^d (persons/Sq.km ²)	180.5	133.0	151.0	127.0
- Gross Provincial Product GPP at Current Market Prices (Million of Baht) ^e	27,799	30,534	39,216	Gross Domestic product (GDP) = 7,104,228 Gross Regional Product (GRP) = 742,534
- GPP Per capita (Baht) ^e	31,524	30,947	28,461	Whole country, GPP average = 64,763 NE Region, GPP average = 21,902
- Population income (in 2002) ^f (Per capita/year)	21,030	21,302	22,785	
- Rank order of population income within Thailand's 76 provinces ^f	70	69	65	76

Sources: a. Mahasarakham Provincial Hall, 2003 "Provincial Annual Report"

b. Kalasin Provincial Hall, 2003 "Provincial Annual Report"

c. Roi Et Provincial Hall, 2003 "Provincial Annual Report"

d. Department of Local Administration, Ministry of Interior, 2003 "Population Report"

e. NESDB, 2006 "Gross Domestic Product and Gross Regional Product"

f. Bank of Thailand (the North-eastern Branch Office), 2005 "Provincial Economic Report"

4.6.3 Epidemiology and health facilities

The health profiles of the three provinces are broadly similar, though recent epidemiological data do show some small differences. Traditionally the main killers in the north-east have been cancer and heart disease followed by diseases associated with the liver. Table 4.2 shows that the rate of deaths from cancer is similar to the national average (with Kalasin a little higher), and deaths from heart disease a little higher than the national average (but with Mahasarakham being lower). Deaths from liver disease are less common than in the past and do not feature in this table.

For many years respiratory illness, digestive disorders and infectious diseases have been the common diseases in Esarn, and this continues to be the case, especially as far as

outpatient treatments are concerned. This is a different pattern than that at national level, where endocrinal, nutritional and metabolic conditions as well as mental disorders feature more prominently. Regarding inpatient statistics, the categories of ‘intestinal infectious disease’ and ‘other infectious and parasite’ are common, just as at national level. Admissions for normal single births feature higher in the list in the case study provinces than nationally, while disorders of the blood do not feature in the top three as they do nationally.

Table 4.2: Main categories of diseases affecting the three provinces

	Maharakham	Kalasin	Roi Et	whole country
Illness with surveillance diseases	Group of diseases/Per 100,000 pop	Group of diseases/Per 100,000 pop	Group of diseases/Per 100,000 pop	Group of diseases/Per 100,000 pop
First	Diarrhoeas 1,413	Diarrhoeas 1,649	Diarrhoeas 1,586	Diarrhoeas 1,745
second	Fever causes 356	Fever causes 306	Fever causes 342	Fever causes 364
third	Pneumonia 220	Food poisoning 278	Food poisoning 216	Food poisoning 254
Cause of deaths	Group of diseases/Per 100,000 pop	Group of diseases/Per 100,000 pop	Group of diseases/Per 100,000 pop	Group of diseases/Per 100,000 pop
First	Heart disease 85	Malignant neoplasm, all form 116	Malignant neoplasm, all form 80	Malignant neoplasm, all forms 78
second	Malignant neoplasm, all forms 73	Infectious and parasites 55	Heart disease 65	Accident and poisoning 57
third	Accident and poisoning 31	Accident and poisoning 52	Infectious and parasites 47	Hypertension and cerebrovascular 35
Out-patients report	Group of diseases/Per 1,000 pop	Group of diseases / Per 1,000 pop	Group of diseases / Per 1,000 pop	Group of diseases/Per 100,000 pop
First	Respiratory tract infections 265	Respiratory tract infections 297	Respiratory tract infections 301	Endocrine, nutrition, metabolism 9487
second	Digestive and intestines 178	Digestive and intestines 230	Digestive and intestines 258	Other infectious and parasites 8974
third	Other infections and parasites 110	Muscle, skeleton and ligaments 138	Other infectious and parasites 164	Mental, behaviour disorder 3295
Inpatients report	Group of disease Per 100,000 pop	Group of disease Per 100,000 pop	Group of disease Per 100,000 pop	Group of diseases/Per 100,000 pop
First	Other intestinal infectious disease 463	Other intestinal infectious disease 379	Other intestinal infectious disease 475	Other intestinal infectious disease 517
second	Other infectious and parasite 296	Single spontaneous delivery 357	Single spontaneous delivery 348	Other infectious and parasite 334
third	Symptom, signs abnormal clinical and laboratory finding 280	Symptom, signs abnormal clinical and laboratory finding 349	Other infectious and parasite 297	Blood, blood forming organs and related 211

Adapted from: 1. Maharakham PHO, 2003
2. Kalasin PHO, 2003
3. Roi Et PHO, 2003

These three provinces have a lower reported incidence of HIV/AIDS than the national average. The accumulated numbers of AIDS patients reported in Thailand from 1984 to 2003 were 244,383 cases nationally, with 2,187 in Mahasarakham, 1,758 in Kalasin and 3,215 in Roi Et. In 2003, the numbers of new cases of AIDS reported were 285 in Mahasarakham, 222 in Kalasin and 306 in Roi Et, against a total in Thailand of 24,579. In 2003, the number of AIDS patients per 100,000 population is 30.2 in Mahasarakham, 22.37 in Kalasin and 23.14 in Roi Et, against the average figure for the whole country of 39.29. In 2003, 6,659 people were recorded as dying from AIDS in the whole country, with 31 in Mahasarakham, 24 in Kalasin and 108 in Roi Et. (Department of Communicable Diseases Control 2006) Although most of these figures are likely to underestimate the real epidemiology of AIDS, they indicate that these provinces are not 'hot spots' of this disease.

One surprising point emerging from official statistics on health status in the three provinces see Table 4.3) is that indicators such as the crude death rate and the infant mortality rate do not appear to have any clear relationship with the income of the province. Mahasarakham, the poorest province, has a crude death rate lower than Roi Et, the richest, and a lower infant mortality rate than the two other provinces. Interestingly all three provinces have lower rates on these two indicators than the national average, with the exception of the high infant mortality rate in Roi Et. Of course, it would be unwise to put too much emphasis on a single year's figures. These data are included here as background information relating to the year of the study.

Table 4.3: Indicators of health status in the three provinces in 2003

Health status (Vital statistic)	Mahasarakham	Kalasin	Roi Et	Whole country
Crude birth rate per 1000	8.74	9.34	8.51	11.79
- Number of live births	8,250	9,273	11,257	742,174
- male	4,220	4,731	5,733	382,612
- female	4,030	4,542	5,524	359,562
Crude death rate per 1000	5.53	5.14	5.73	6.10
- Number of deaths	5,215	5,101	7,585	384,131
- male	2,880	2,885	4,238	221,962
- female	2,335	2,216	3,347	162,169
Infant mortality rate Per 1000 of live births	3.76	6.58	9.86	7.21
- Number of infant deaths	31	61	111	5,349
- male	14	35	49	2,915
- female	17	26	62	2,434
Maternal mortality rate Per 1000 of live births	12.12	0.00	0.00	13.74
- Number of maternal deaths	1	0	0	102

Sources: Bureau of Policy and strategy, Ministry of Public Health, 2004a "*Health Resources Report*"

As mentioned previously, hospitals and health centres in Thailand are generally located (one-to-one) in local government districts and sub-districts. The existing number of districts and sub-districts thus explains a good deal about the distribution of health care facilities in the three provinces. The numbers of doctors and dentists are roughly in line with the relative population sizes of the three provinces. However, the second most populous province, Kalasin, is less well off for pharmacists, nurses and health workers than smaller Mahasarakham. Conversely Kalasin has more favourable ratios of doctors and dentists to population than the other two provinces. Roi Et has three private hospitals compared with one each in the other two provinces, which may be a reflection of its relative wealth.

Table 4.4: Numbers and population ratios of health resources in the three case study provinces: 2002

Health resources	Mahasarakham (number) population ratio	Kalasin (number) population ratio	Roi Et (number) population ratio	Whole country (number) population ratio
Public hospitals ^a	(13) 1:72,645	(14) 1:71,042	(18) 1:73,466	(973) 1:64,830
Public beds ^a	(952) 1:952	(960) 1:1,036	(1,143) 1:1,156	(105,539) 1:597
Private hospitals ^a	(1) 1:944,385	(1) 1:994,600	(3) 1:440,796	(320) 1:197,124
Private beds ^a	(50) 1:18,887	(30) 1:33,153	(235) 1:5,627	(28,914) 1:2,181
Health centres ^c	(175) 1:5396	(156) 1:6375	(230) 1:5749	(9,810) 1:6430
Doctors ^{a, b}	(84) 1:11,207	(108) 1:9,147	(110) 1:12,011	(17,529) 1:3,295
Dentists ^{a, b}	(25) 1:37,657	(31) 1:31,866	(32) 1:41,288	(3,529) 1:8,022
Pharmacist ^{a, b}	(66) 1:14,264	(47) 1:15,680	(67) 1:19,720	(6,168) 1:8,511
Nurses ^{a, b}	(665) 1:1,416	(622) 1:1,588	(877) 1:1,507	85,392 1:739
Health workers ^c	(537) 1:1,744	(430) 1:2,264	(559) 1:2,911	(28,835) 1:1,657

Sources: a. Bureau of Policy and strategy, Ministry of Public Health, 2004 “*Health Resources Report*”

b. The National Economic and Social Development Board, 2006 “*Health Resources*”

c. Wibulpolprasert, S. (ed.), 2005 “*Health Profiles 2001-2004*”

Unfortunately figures for health care facilities were only available for 2002 rather than the year of the study, but are unlikely to have changed greatly.

4.7 Health finance and the 30 baht scheme

Before telling the reform stories of the three provinces, it is necessary to give some additional background on the way the financing mechanism changed in the first two years of the UC reforms and how this affected the Esarn provinces. This is important because it affects one of the main areas for local decision making by health administrators in each province.

As discussed in Chapter 1, one of the most radical aspects of the UC reforms was the introduction of capitation-based funding. One of the original policy objectives was that money would 'follow patients', so that the financing mechanism would be used to engineer a re-distribution of the medical workforce. Hospitals in Esarn would receive funding in line with their populations and be able to pay the salaries of extra health care staff to draw a fairer share of the professional workforce to the north east.

However, in the course of detailed implementation various problems arose in the purchaser mechanism, particularly in the public hospitals which remained under the command of the MoPH. The most difficult problem was the survival of hospitals that were dependent on MoPH funding. It was relatively straightforward for the MoPH (via PHOs) to use the planned contracting system to purchase care from private hospitals and hospitals controlled by others ministries (such as military or university hospitals), which were also supported by other funding streams. However, it was problematic to channel all funding to public hospitals via capitation-based contracts, while simultaneously ending the old system of annual grant allocations. This was mainly because the switch to capitation-based funding would have significantly reduced the total budgets available to many of the larger units to the extent that they ceased to be financially viable.

There were two aspects to this problem. The first concerned the way resources were allocated at national level, and the second concerned the way resources were distributed within provinces. At national level the reforms involved a dramatic shift from annual allocations to provinces based on historic uplift, to funding based on the population served, which threatened to render the existing distribution of health professionals and facilities unviable. For example, Racha Buri province in central region has four large general

hospitals serving a relatively small population of under one million people, and it was evident that a capitation-based budget would not cover existing staff salary costs.

At provincial level, the problem concerned how far the new fund holding bodies on the provider side, the CUPs would distribute monies within the local health care system. The CUPs would be funded on capitation, but the larger hospitals would depend on payments from the CUPs made in respect of referrals. There were worries that the CUPs might hold some patients inappropriately in community hospitals to save on referral payments to provincial and tertiary hospitals, and that this would also lead to underfunding of the big hospitals.

These two problems taken together cast doubt on whether it would be possible to introduce full capitation-based funding immediately. The reality facing policy makers was that the main health resources such as the workforce, the buildings and medical equipment could not be easily moved, and any attempt to use the financing mechanism as a lever of change was going to take time and would have damaging short-term consequences. In particular there was strong professional opposition in the main urban areas. Widespread financial crisis in provincial hospitals and larger units in urban areas would have been highly detrimental to the overall reform agenda, especially given that around 90% of the hospitals were controlled by the MoPH and they these would play a key role in policy implementation. Reduced budgets would leave these hospitals unable to implement the new policies as expected. In a situation where there were insufficient funds for core hospital salary costs, there was the risk that promotion and prevention activities and the upgrading of primary care would be neglected.

The existing mal-distribution of resources across the nation also affected the pace at which extra resources could be transferred into underserved areas. Areas such as the north-eastern region had large populations but historically had only a limited health infrastructure and longstanding staff recruitment problems. Again it was evident that even if more money was forthcoming, there problems of structural adjustment would mean that money would not convert automatically into improved health care delivery.

Senior MoPH administrators had been aware of this problem from the beginning and had established a national 'Contingency Fund' of 5000 million baht at the central level for the

first year of implementation. However, a significant group within the MoPH argued that further additional adjustment mechanisms would be required. This was a highly controversial issue on which no consensus was forthcoming. Ultimately the issue was only resolved by a decision of the Permanent Secretary and the approach taken in the first year of policy implementation represented a compromise. It was agreed that provinces would be allowed decision making power to decide the preferred approach at local level. In essence, the MoPH allowed provinces discretion to introduce two measures that would enable them to pull back the budget to the large hospitals:

1. PHOs could opt to separate out salary costs from the capitation payment. This involved 'top-slicing' the salary cost element for the entire province from the total UC budget allocated to the province based on capitation. Supporters argued that the PHO could then use this central budget to redistribute monies to support the larger hospitals by paying their salary costs. It would also promote a more co-operative attitude in which salary costs across the entire province were disbursed in an equitable manner.
2. PHOs should split the UC budget (with or without salaries taken out) into the three categories of inpatient Care (IP), outpatient care (OP) and promotion and prevention (P&P), and could opt to retain the IP element for disbursement by the PHO rather than the CUP. This was known as the 'exclusive' payment model, as compared with the 'inclusive' model in which IP + OP + P&P was paid to the CUP. Advocates of the exclusive approach argued that it would ensure that referrals would be funded and solve the problem of delay in referrals. Additionally, it secured the position of provincial hospitals which would be more confident about their income stream since it would come from the PHO rather than the CUP.

The central 'war room' decided that the MoPH would still provide a contingency fund at the centre to support hospitals in exceptional difficulties whose problems could not be managed at provincial level (MoPH 2002a).

The first measure conflicted with the 'money follows patients' concept associated with the 'capitation model' and led to much controversy. In those provinces that opted both to

hold the salary budget at the centre and use an exclusive allocation model a reduced proportion of the total capitation payment was disbursed to the CUPs, and the PHO had control over a substantial fund which could guarantee monies for referrals to, and staff salary payments in hospitals that would otherwise have been capitation losers.

Official figures show that a variety of approaches was taken across the nation (Table 4.5). A narrow majority favoured centralised salary budgets and exclusive payments, while a smaller but substantial group opted for devolved salary budgets and inclusive payments, and a significant minority used mixed arrangements. Generally speaking, provinces that held salaries at the centre also opted to do the same with IP budgets, and those that favoured devolved salary budgets also passed IP budgets to the CUPs.

Table 4.5: Model of the staff salary costs funded and model of capitation during October 2001-June 2002

Province	FY 1 (Oct 2001-Sept 2002)		Plans for FY2 (as recorded in June 2002)		FY2 Outcome following New MoPH policy	
Nation level	Salary fund at	Model	Salary fund at	Model	Salary fund at	Model
	PHO = 40	Ex = 38	PHO = 36	Ex = 29	PHO=75	Ex=75
	CUP = 30	In = 31	CUP = 32	In = 40	-	-
	Mixed = 5	Mixed = 6	Mixed = 7	Mixed = 6	-	-
Total	75	75	75	75	75	75

Adapted from: Bureau of Health Insurance, MOPH, 2002

In June 2002 the MoPH asked provinces to report on their intended financial strategy for the following year (i.e. from October 2002). The responses showed a move towards greater support for devolved budgets, with a growing majority favouring use of the inclusive model. (31 provinces in October 2001 rising to 40 provinces in June 2002). This was interpreted in the MoPH as a sign that CUPs (and their associated community hospitals) might be insufficiently willing to support the large hospitals. There was additional uncertainty because it was known that many provinces had moved back and forth between the two models several times during the 2001/02 financial year, and that the situation was more complex and fluid than the above table suggests.

Following much debate in the MoPH, it was decided that in 2002-03 that the Ministry would hold the salary fund centrally and would require PHOs to use an exclusive payment

model. Many commentators attributed this to a crisis of funding in the hospitals which was intensifying at this time. This change had a big impact in the Northeast. Full capitation funding meant an increase in Esarn's UC budget in 2001/02 (see Table 4.6). These figures may overstate the shift in funding between central region and Esarn because they exclude Bangkok and also take no account of the contingency fund, but they show that the new allocation system had the potential to engineer a significant redistribution of revenue. However the changes in 2002/03 worsened the allocation to Esarn more than for any other region, significantly reducing its allocation at a time when all regions were having to cope with an increase in workload because of the 30 baht scheme. Although total health spending rose between 2001-02 and 2002-03 (Table 4.7), the capitation payment set remained the same at 1202 baht per head, and the salaries component of this was now held at the MoPH.

Table 4.6: Allocation of the health budget per capita from the government by region, FY 2000-01 to 2002/03

Region	Number of provinces (2001)	Number Of hosp. beds	No. Doctors (2001)	UC Population (2001)	FY 2000-01 (Baht) ⁽¹⁾	FY 2001-02 (Baht) ^(2,3)	FY 2002-03 (Baht) ⁽⁴⁾
Central	25	23,800	2,404	12,154,023	1,042	1,052	1,076
Esarn	19	23,184	2,040	17,381,915	616	1,052	834
The North	17	15,148	1,576	9,272,061	894	1,052	1,065
The South	14	11,975	1,130	6,225,624	993	1,052	1,064
Nationwide (75 provinces)	75	74,107	7,150	45,033,623	840	1,052	1,009

Adapted from: (1) Rural Doctors' Society Report, 2003

(2) Tiamworakul, S., 2002

Note: 1. FY 2000-01 was the last year before capitation funding was implemented across the country

2. This information excludes the Bangkok Metropolitan Area, which may lead it to understate inequality.

3. The per capita allocation in FY 2001-02 excludes top-ups from the central CF budget.

4. In FY2002/03 the salary budget was separated from the capitation payments and held at the MoPH.

Figure shown includes UC capitation payment plus per capita salaries payment from centre.

Table 4.7: The real allocation of health budget from the government, from FY 2000-1 to 2003-04

	FY 2000-01 (Million)	FY 2001-02 (Million)	FY 2002-03 (Million)	FY 2003-04 (Million)
1. MoPH/NHSO ⁽¹⁾	61,097.20	70,923.19	74,133.89	77,720.79
1.1 MoPH fixed cost	61,097.20	41,500.62	41,995.49	45,147.92
1.2 UC	-	22,138.45	27,138.40	29,727.54
1.3 central fund for UC	-	1,597.43	5,000.00	2,845.33
1.4 central CF fund	-	5,686.69	-	-
2. For other Ministries	5,157.10	1,846.51	4,090.31	6,065.81
Total health budget ⁽²⁾	66,254.30	72,769.70	78,224.20	83,786.60

Source: (1) Bureau of Policy and Strategy, MoPH, 2004 "Health Resources Report"

(2) Ministry of Public Health, 2006 "Budget from FY 1997 to 2005"

Note: FY 2001-02 was the first year of UC scheme spread across the country

Payments from the central salaries budget were channelled via the PHOs to public health staff, but this money was now ring-fenced so as to be under the control of the Ministry. However, in practice the new system allowed the Ministry to reallocate money from the central salaries fund according to the needs of the different regions rather than being distributed on the basis of population. Consequently the money allocated to Esarn fell sharply and that going to Bangkok rose. The result of these changes was to further weaken the re-distributive impact of the reforms, both at the level of individual provinces (where the position of large hospitals was strengthened and the re-channelling of funds to primary care was halted) and at the level of the nation (where Bangkok hospitals were the main beneficiaries). This issue of the change in the financing mechanism in 2002-03 will be discussed further in Chapter 8.

4.8 Implementing reforms at provincial level: '76 flowers bloom'

The provincial case studies are important because they examine an administrative level that was given a significant degree of devolved decision-making power at a key stage of implementation of the UC reforms. One of the respondents interviewed as background for the research was a senior economist who had chaired a key national committee, advising on the reforms and the initial capitation payment. When asked whether the reforms represented top-down or bottom-up policy implementation he said:

"Top down only in the broad outlines of what they wanted. They haven't got a blueprint. The Ministry of Public Health... interestingly, the Permanent Secretary

at the time said that to this group that I chair: the whole thing was implemented so rapidly that this became part of it, in more senses than one. In the end I think there was so much conflict at the top of the Ministry of Public Health that the issue was per force devolved to the provincial level. So it is 76 flowers bloom. Everybody had their own thing, you know, not only about the salaries but also whether because of the referral problem - I am thinking mostly of the reimbursement system because I am economist - but whether there should be a split in payment for IP and OP, or whether it is just straight capitation” (Senior Economist, Anonymous Think Tank, Bangkok) (English language interview).

The ‘76 flowers’ are the provinces of Thailand. The following chapters explore the reform stories of three of them.

4.9 Summary of chapter

This chapter has provided background information on Esarn Region, the three case study provinces and issues concerning the financing mechanism that opened up an area of choice for provinces. It prepares the way for Chapters 5, 6 and 7, which describe the reform stories of Mahasarakham, Kalasin and Roi Et. Those chapters will outline the implementation strategies used, and also examine how much decision space local actors had to shape the UC reforms in particular ways. Each chapter will consider the distinctive aspects of the approach used in the province, the question of which actors or interest groups were able to mobilise influence, and the interaction between the various influence groups. The constraints that limited the scope of local decision making will be considered in Chapter 8.

Chapter 5

Mahasarakham province:

distributed power and civil society engagement

Chapter 5. Mahasarakham province: distributed power and civil society engagement

5.1 Introduction

This is the first of three chapters concerned with the differing approaches to implementation of the UC reforms in the three case study provinces. The chapter will consider Mahasarakham province and the particular influences and conditions there that affected the approach taken. It will describe the role of key actors and the power structure in place (termed here ‘distributed power’), the guiding themes of the reform effort in the province, and changes in organisational arrangements that occurred. The chapter will consider a number of areas where key actors had decision space to adapt the reforms to local conditions, including determining the financing model that would apply, managing the allocation of resources, including the health service workforce, and making decisions about the degree of public participation. It will also briefly consider how the discretionary space open to local actors was affected by the existing positive relationship with the MoPH.

An important policy theme at local level in Mahasarakham, not found to the same degree in the other two case study provinces, was ‘civil society engagement’ – the attempt to involve of voluntary civic and social organisations and institutions. This was bound up with the particular distribution of power that existed in the provincial health office, the commitment of senior officers to decentralisation and community empowerment, the relatively autonomous position of hospital Doctor-Directors in the province, and the attempts by professionals to engage the population at grass roots level.

5.2 Implementing the UC reforms in Mahasarakham

5.2.1 Actors, networks and power

As elsewhere in Thailand, the local implementation of the UC reforms in Mahasarakham Province was crucially shaped by the approach taken by senior officers in the Provincial Health Office (PHO). Although the policy template initially communicated from the

Ministry of Public Health (MoPH) was not fully worked out, a number of requirements needed to be put in place within a defined timescale, including the rolling out of the UC gold card scheme, the development of an health insurance office at provincial level, reform of the financing system to incorporate capitation-based funding, creating of the Contracted Units for Primary Care (CUPs), reform of primary care services to create the Primary Care Units (PCUs), and changed arrangements for referrals within the system. At the centre of much of the key decision-making were a small group of senior officers inside the PHO, comprising the Head, two deputies and an assistant.

There are three senior administrators who act as the assistant team in each sector, such as the hospital sector. I have a senior doctor who acts as the deputy CMO in medical preventive care, he is a former doctor director of a community hospital. In the district health office sector, there are a former DHO head, who had a strong relationship with the group of the DHO heads, to act as the assistant to the CMO. And in the public health sector, there are a senior public health technical expert, who came in to be the deputy CMO in public health. (SAO-PHO, MK 01)

These officers worked in conjunction with the Provincial Committee for Implementing Health Insurance (PCIHI), a body that was set up in provinces across the nation in line with a MoPH regulation. The regulation provided that PCIHIs could be formed either from existing the Provincial Sub-committees for Health Card Administration (PSHCA) – based on an older insurance scheme - or the Area Health Boards (AHBs) that had been formed in some provinces. The AHBs were local committees established as part of the ongoing decentralisation reforms of local government, which were deemed by the MoPH to be capable of the new role.

In Mahasarakham senior officers were not attracted to the idea of creating the PCIHI from the Provincial Sub-committees for Health Card Administration because the membership of the latter was drawn exclusively from the PHO and lacked representation from other bodies in the local health system. An AHB had recently been appointed. However, the senior PHO administrators considered this too new and untried to be trusted to act as PCIHI. The delay in creation of the PCIHI attracted attention at MoPH level, where similar problems in several provinces had emerged as a major hold up. Finally, Mahasarakham PHO negotiated permission to set up a PCIHI anew, rather than basing it

on the existing bodies. As a *quid pro quo*, the AHB has given a new role as the advisory board to the PHO. This re-arrangement of the local power structure was accepted by the national 'war room'. It necessitated a change in the published MoPH regulations (MoPH 2001), so as to allow a PCIHI comprised of the CMO, the doctor director of the provincial hospital, representative of the DDCHs, representative for the doctor director of private hospital (optional), representative of non-MoPH hospitals (optional), representative of the DHO heads, representative of health centres, representative of local government, representative of UC scheme members, the deputy CMO and the head of the Health Insurance division. It was this group that made early important decisions about the allocation of funding between the PHO, hospitals and other parts of the provincial system, and also the approach to be taken with respect to referrals and primary care reforms.

In the early stages of the reforms the structural position of the PHO in the local health care system was ambiguous. On the one hand, the PHO remained in a chain of command which was headed by the MoPH and stretched down to the district health offices and medical care facilities. Thus in 2001-02, the PCIHI acted as the local policy board and the PHO was the main operational arm of the MoPH within the province. The PHO played a key role in negotiating budget arrangements with hospitals, which was one of the main problems in year one. The Deputy CMO in medical preventive care, who acted as the UC project manager, headed the 'provincial war room' which generated documents for the PCIHI meetings and was responsible for putting PCIHI resolutions into effect. Since the PHO still had authority to command the hospitals, the DHOs and the health centres across the province, the CMO and the PHO staff had significant authority to control activities covered by both the UC policy and non-UC policies. Additionally, both the MoPH and the government departments in the centre still requested routine reporting via the PHO using the pre-existing command and control channels.

On the other hand, the long term power of the PHO was in doubt and it was cast in a transitional role as a purchaser which was likely to cease operating when the NHSO's plans for permanent local offices became known. The new capitation-based financing arrangements seemed to threaten the financial stability of the hospitals and led to a loss of confidence regarding the power of the PHO in a period of turbulence. There had been many budget setting meetings, and many arguments about allocations, which the

community hospitals took to be a sign of the PHO's inability to protect them from the consequences of the new policy.

In November 2002, the National Health Security Act B.E. 2545 (A.D. 2002) was passed, and the NHSO was established as the organisation with formal responsibility for oversight of the UC policy implementation. However, as mentioned in Chapter 1, a provision in the bill introduced a transitional arrangement whereby the MoPH retained responsibility for budget allocation for three years. As part of this arrangement, in early 2002 the NHSO gave PHOs the authority to act as its local branches. This approach, which had originally been adopted as a crisis management measure by the War Room, meant that PHOs were buying services from hospitals which they also directly managed, and continued to be a source of tension as implementation proceeded. Most significantly, it ensured that the PHO – rather than some new local purchasing agency – was still the main body at local level in UC implementation, even though it was a body whose role was unclear.

Regarding its role as local purchaser, the PHO had a range of specified powers and duties:

- To function as the Provincial registration centre.
- To evaluate health services delivered by the CUPs and their networks.
- To be responsible for the arrangement of implementing the UC policies in the province.
- To act as a protection agency to ensure people's rights under the UC scheme.
- To support the CUPs and their networks in quality development.
- To support the Provincial Sub-committees, overseeing different aspects of the UC scheme which were appointed from the central and the local levels.
- To monitor and control the implementation process, and act as the representative of the NHSO in co-operation with other health-related bodies such as NGOs, voluntary agencies and community groups.

As mentioned above, the PHO operated in conjunction with the PCIHI. The latter's duties, as set out by the National Committee for Implementing Universal Coverage, included:

- To formulate the provincial UC implementation policies consonant with the policies of the National Committee for Implementing Universal Coverage at the central level.

- To determine local arrangements and decision making mechanisms for implementing the UC policies and agree a PHO action plan.
- To monitor and supervise UC-related activities at provincial level.
- To appoint a working committee to support implementation of UC policies.

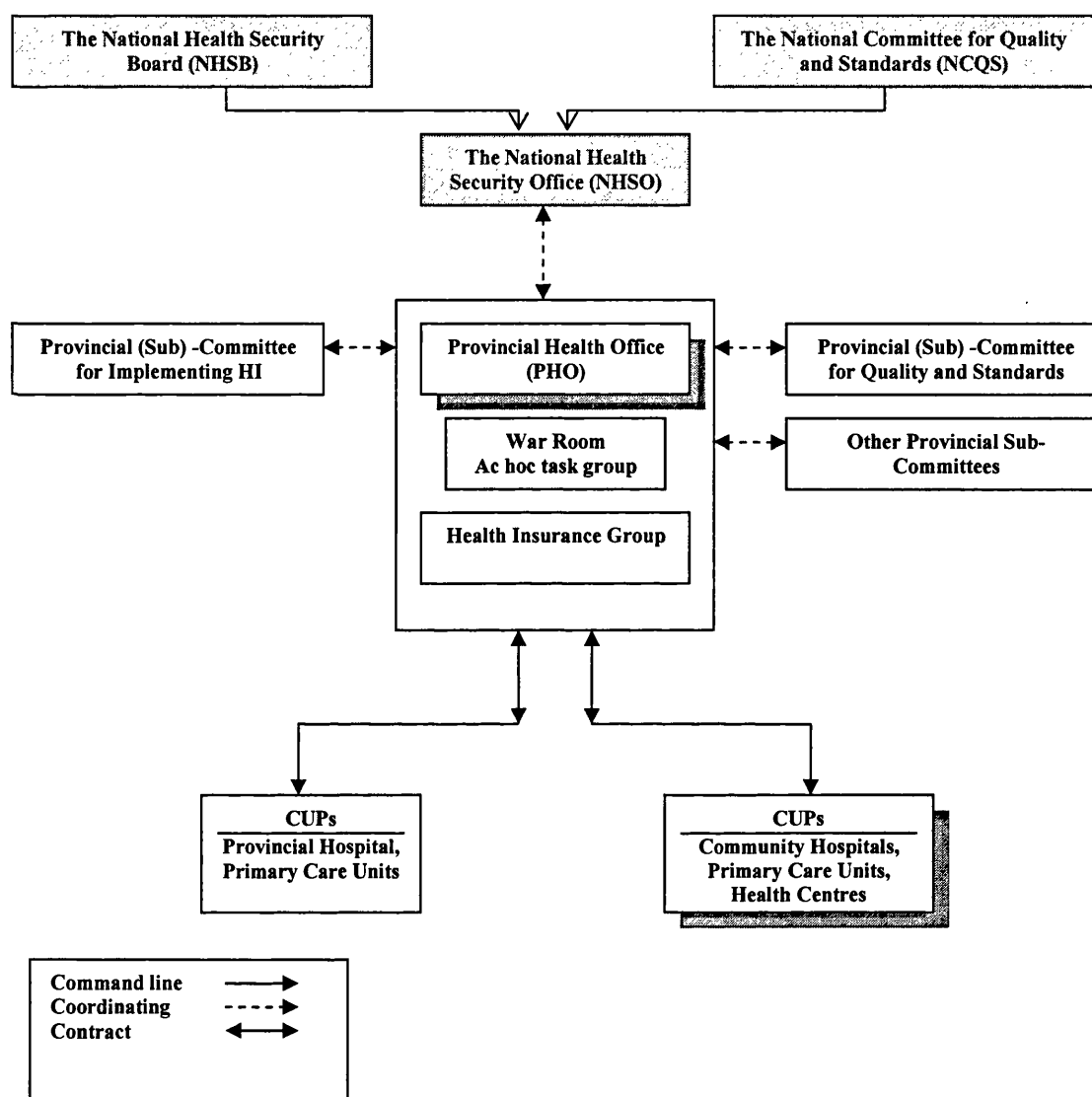
The PCIHI comprised four parties: a purchaser group, provider group, service user group and local experts group. The Chief Medical Officer (CMO) of the PHO chaired the sub-committee and the deputy CMO took the role of secretary. A third officer, the Head of the Health Insurance group acted as assistant secretary. In practice the various working groups developed policies in different areas, which were then referred back to the main committee for final decisions and resolutions. The PCIHI was responsible for allocation of the UC budget, and it was this process that was used to determine the methodology of allocation and the distribution of monies to the contracting units for primary care (CUPs). The CUP boards then allocated monies at local level. (Interview MK 06)

The MoPH in Bangkok had set up an ad hoc working group to monitor and ‘trouble shoot’ emergent problems associated with the reforms known as the ‘war room’, and this was copied on a smaller scale by senior officers in the PHO. The provincial war room was effectively a co-ordinating centre for solving early problems thrown up by the reforms. The CMO appears to have acted alone to decide on an appropriate division of labour and determine the membership. While the PCIHI contained representatives from many organisations, the war room group consisted mainly of PHO staff, headed by the Deputy CMO. The division of labour between the war room and the PCIHI was not entirely clear-cut. However, in broad terms the first took responsibility for day-to-day problem management and the fine tuning of procedures, while the second set the longer term policy direction in the province and made formal decisions.

Another important component of the local service network was the Provincial Sub-Committee for Quality and Standards, which had a remit to monitor standards in provider units, to receive complaints and promote public understanding of the reforms. It consisted of a health professionals group of doctors and allied health professions, and a non-health professionals group made up of representatives of the public, local government and local experts in various fields.

It is this nexus of actors in the PHO and the PCIHI, generally led by, but extending beyond the PHO leadership, that has been termed ‘distributed power’ for the purposes of this chapter. By this is meant that senior officers in the Mahasarakham PHO sought to involve a wide range of actors in decisions, and to drive the reforms forward by gentle steering rather than old style command. Although senior officers talked of a shift in their role from control to supervision, they continued to take a leadership role, though one based on influence and persuasion rather than line management. This can be contrasted with the more top-down leadership style in one of the other study provinces and, taken together with the emphasis on civil society engagement, set a different tone for the administration of the reforms.

Figure 5.1 Organisation and management structure for UC implementation in Maharashtra, 2001-2002



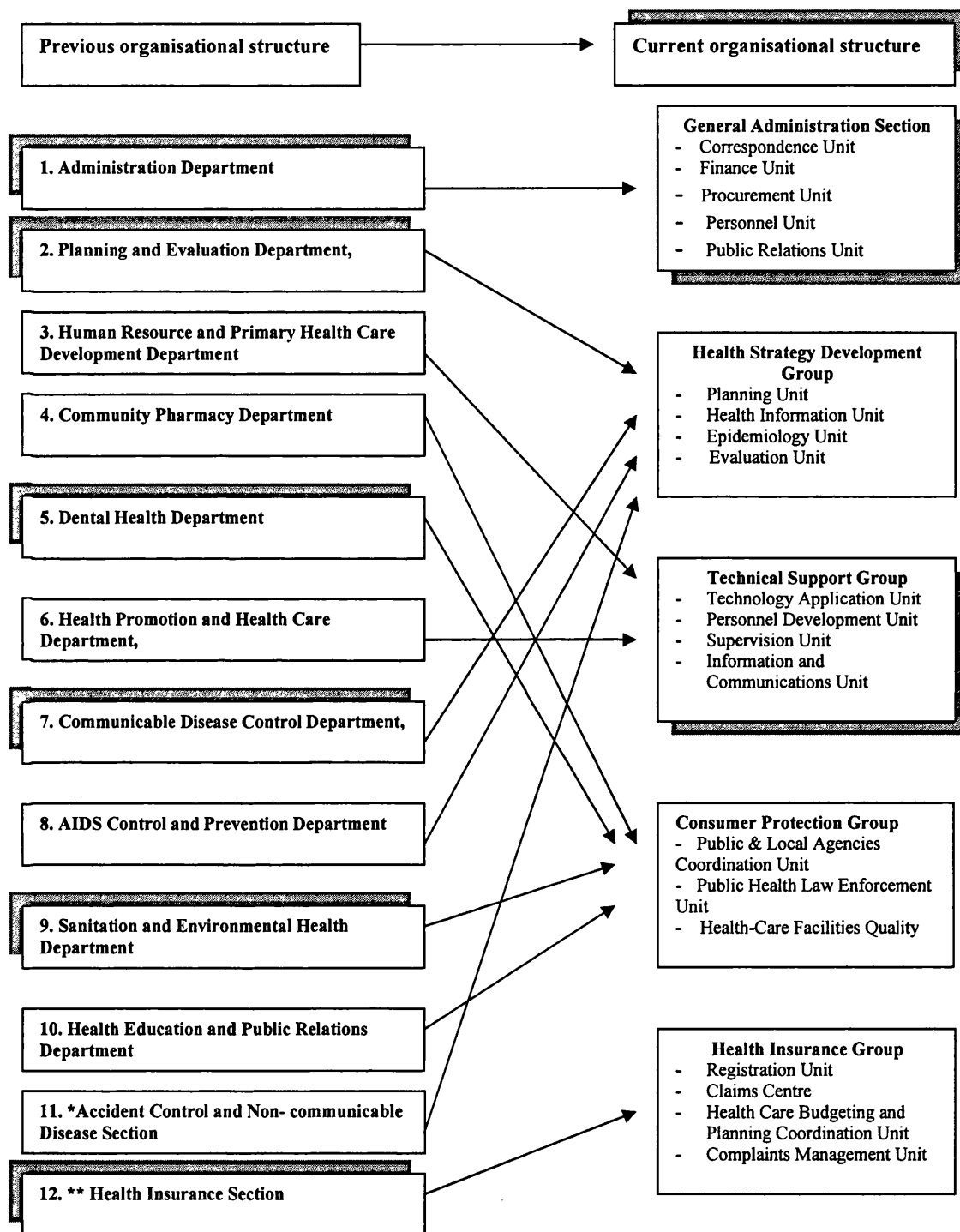
Source: Adapted from a Manual for the National Health Security Implementation
FY 2004 (National Health Security Office 2004)

5.2.2 Recent changes in organisational structure

In the early 1990s, the Mahasarakham PHO was divided into ten organisational divisions listed in Figure 5.2.¹⁴ An Accident control and Non-communicable Disease Section was set up around 1995, as an unofficial department in the PHO. However, as the result of the bureaucratic reforms which followed the 1997 Asian financial crisis and the launch of the 30 baht policies in 2001, there was a period of rationalisation which culminated in a contraction to five groups (listing in the second row of figure 5.2).

¹⁴ When the government rolled out the 30 baht scheme across the country and forced the PHOs to prepare, a Health Insurance Section was established unofficially in the PHO. Thus several respondents reported that the PHO organisational structure comprised 11 or departments (or 12 with the Accident Control and Non-communicable Disease Section).

Figure 5.2: Transforming the new organisational structure in the Maharashtra PHO, 2002 to the present



Adapted from: Ministry of Public Health: A new mandate and structure, 2002

Note: * This department was established unofficially in the PHO in around 1995 and was unrelated to the UC reforms

**The unofficial organisational structure which was established in mid-2001 to prepare for the new policy

Consideration of possible adaptation of the old 10-departments structure began in the province around 1997 as preparation for the decentralisation reforms that were under discussion by the then government (see Chapter 1). The main issues at this time were the possible transfer of some functions to local government, and reappraisal of the duties of departments to take account of the new division of labour. At that time Mahasarakham province was included in a scheme whereby 1 in 4 provinces took part in pilot projects on the transfer of functions to local government. Later, in 1999-2000 the Sarakham PHO participated in an additional Ministry scheme involving 1 in 6 PHOs which were required to implement action research projects on approaches to organisational change linked to the Government's reforms of the state bureaucracy. Consequently the Sarakham PHO had already investigated a range of possible structures and options for allocating tasks to sections, so that they had a good basis for action when reform came. These projects meant that the culture of the organisation was relatively open to change, and that there was not the same entrenched opposition found in some other provinces.

However, the 30 baht scheme was introduced with such rapidity across the entire country that PHO officers had given little consideration to the specific adaptations that would be needed. Thus the prospect of sudden dramatic change still caused a degree of uncertainty and anxiety. The CMO emerged as the key actor to plot a way forward and communicate this to staff.

Regarding the reform of the organisational structure of the PHO, the reduction in staff numbers caused us concern. However, the CMO had held meetings to try to help staff understanding how things would change and started to allocate some staff outside so as to prepare for downsizing and give people freedom to move to the hospitals and health centres. We had a short period of crisis but the administrators stepped in to make staff understand. Then some staff moved out. (SAO-PHO, MK 07)

Though the onset of the reforms was rapid Mahasarakham had already taken more steps than neighbouring provinces to control the size of the staff complement. As part of the 1999 project on bureaucratic reform, projections had been made of likely future staffing needs. At that time the PHO had taken a decision to freeze routine recruitment of new staff and to cover new activities by redeploying existing staff. This led to a gradual fall in staff numbers. The news of the UC reforms created a need for significant additional reductions, but from a base that was lower than in provinces such as Kalasin and Roi Et.



The main impact was to require some secondees and junior staff to move to positions in the service units.

Previously, we had 108 posts in the PHO but there were around 130-140 staff working here. When the 30 baht policy came in, they set the number of staff working in the PHO at not more than 98. So, we had a continuation of the downsizing process, because, instead of the PHO officers being operational staff they had to change to be 'supervisors' (in English). So there were many staff who had to go back to the service sector, in roles that would safeguard their careers, but they were more valuable working here. (SAO-PHO, MK 01)

This was unwelcome to many of the staff involved, but despite a degree of resistance, this transfer was accomplished quite rapidly. A senior administrator associated with the new Health Strategy Development Group, looking back on this period reflected on the personnel problems that this caused.

Personnel management is very difficult. In Mahasarakham PHO we prepared for 5 years on this before the new system came. However, we are still having many problems. In other provinces - such as Khon Kaen, which had more than 300 PHO staff, who had come in from the community hospitals, and Korat, where in one of the biggest cities they had 300 to 400 staff in the PHO - when the reforms came in a lot of people came under pressure to move out. There were a lot of people suffering over this. The 30 baht scheme is a good policy but it came in suddenly and we should have been given time to prepare the workforce - it would have been better. Now we have a lot of problems because of this. (SAO-PHO, MK 06)

In Mahasarakham, the reorganisation of the PHO from the former 10 departments and one section to five groups proceeded in a planned way, co-ordinated by the CMO. Initially the functions and tasks of the old departments were mapped on to the new structure (see Figure 5.1), in accord with top-down guidance, and key personnel from the old departments were allocated to the five new groups accordingly.

The management system in place as the UC reforms were implemented was therefore a simpler, more streamlined one than had previously existed, but arguably it still had not undergone sufficient preparation to proceed smoothly. The staff losses, and need to concentrate staff resources on the internal PHO re-organisation, made it difficult for PHO staff to look outwards and support the service units in the planned transformation of the local health care system.

The MoPH, when it was in discussions with the politicians, did not negotiate enough time for the preparation phase. (...) If the politicians and the senior administrator at the policy level had talked together and agreed things, the problems would not have arisen. For example, in the first year, the minister told the health officers that they would be given allowances if they worked at full capacity a lot of money was thrown at the allowances budget. That caused their working behaviour to change. The new behaviour might be called 'no money, no work'. The officers have learned this and some people have made a down-payment on a new car. When the budget was cut 50%, they did not get the money they expected. That caused them trouble. (SAO-PHO, MK 06)

In Mahasarakham, as in many other NE provinces, a sharp increase in the budget in Year 1 of the reforms led to a policy where monetary rewards, in the form of allowances to reward flexible working, set up certain tensions in local service networks.

5.3 How the financing framework was adapted to local conditions

5.3.1 Adapting to the new financial framework

As explained in Chapter 4 one of the main areas of latitude given to provinces concerned the financing arrangements to be adopted locally, but the way PHOs reacted to this depended on how they conceptualised their own role in the rapidly changing system. Senior officers in Mahasarakham saw the PHO's role as changing from controller agency to monitoring and general support unit. A senior administrator officer (SAO-PHO) described the change as follows:

Previously we acted as an administrative organisation, to support and control the health care service in the local area, both hospitals and health centres. All health activities had been centralised by the PHO office, such as: personnel, policy, strategies and resources. We were the main administrative organisation. (...) The PHO has changed to a new role - from controlling unit to monitoring unit. So we act as coordinator, compromise broker and evaluator under the new policies. (SAO-PHO, MK 01)

The new financial framework did not allow the PHO the power to control the budget as at the past. Initially, however the PHO still has to act both the supervisor and monitor to the local health unit due to rapid roll-out of the new policy. 'Supervision' still implied active engagement with the service units, and a proactive approach to driving the reforms.

Previously we were controlling a budget of 200 million baht per year. Now we have only 3 million baht per year. This budget needs to support both the PHO and all the district health offices in our province. It seems the administrators have lost the power to conduct and control any more because of we have no money. (...) We still have the same responsibilities, but we don't need to do all these things by ourselves. We must go outside to monitor community hospitals or health centres. The money has gone but our responsibilities still remain. We must request money from community hospitals when we need to go to supervise them. (SAO-PHO, MK 08)

The provincial 'war room' was tasked with anticipating problems and proposing solutions, as far as possible using a co-operative approach. As one informant reported:

We tried to make things clear and bring the problems into the open. The PHO is a neutral agency which can oversee negotiations. We tried to solve the problems by providing information and discussing the problems in meetings. We gathered the background information and options for the committee to make a decision. If we can't discuss it in this way the problem will not end. (SAO-PHO, MK 02)

Lower level respondents seemed to accept that committee membership in Mahasarakham had been opened up more than in many other places.

Regarding policy at provincial level, I think that in Mahasarakham, we have participated at all levels. On the provincial committee for budgeting (the war room), we have representatives of the health centres, the DDCHs, the DHO heads and Head of provincial groups. These all participated at the beginning. With regard the workforce allocation process, we pushed the involvement concept at the provincial level, which was different from in the past when there were only the DDCHs and DHO heads. There are much more participation in the committee but I don't know about their actions. However, it is better than previously because we could more easily report problems concerning budgets or the workforce from the lower level.
(ADHOH, MK 35)

This relatively inclusive approach included the war room, the PCIHI, and even the composition of CUP boards, which included lay representatives. Overall, the Mahasarakham PHO took a stance where it accepted that lower-level actors should be involved in the core committees, and where co-operation was preferred to conflict. The decisions about the financial allocation model to be employed in the province also appeared to reflect a wish for a fair distribution to the CUPs, while at the same time safeguarding the position of the hospitals.

5.3.2 Choosing a budget allocation model

As mentioned In Chapter 4, the MoPH gave the PHOs important decision-making powers in two areas in FY 2001-02:

- Firstly, they had discretion to decide whether to hold the staff salary budget at the provincial level or the CUP level;
- Secondly, they could opt to use either an 'inclusive' or 'exclusive' model to channel funds to CUPs.

One national requirement was that the UC budget should be divided into (a) in-patient costs - IP (b) outpatient costs – OP, and (c) the costs of prevention and promotion - P&P. The 'inclusive' model involved passing on the nationally-agreed capitation payments to CUPs without deduction, including the monies for inpatient, outpatient and P&P activities (IP+OP+P&P). In the 'exclusive' model, the IP component of the payment was retained at the provincial level and only the payments for outpatient and promotion and prevention activity were passed to the CUPs (OP+P&P). However, there was also scope to vary the basic models and create a 'mixed' approach.

In 2001/02 all three case study provinces opted to hold salary budgets at the provincial level. However, as we shall see in Chapters 6 and 7, Roi Et and Kalasin took different approaches from Mahasarakham regarding the choice of allocation model for IP. In October 2001 Kalasin opted for an exclusive model, while Roi Et favoured the exclusive approach, but with a different Clearing House arrangement, and Mahasarakham employed a mixed payment method. In June 2002 the MoPH asked provinces to state their plans regarding the model that they intended to use for the year starting October 2002. Mahasarakham opted for the inclusive model, while the two neighbouring provinces both stated that they would use the exclusive model (see Table 5.1). Following policy discussions at the Ministry level it was decided in the event that all provinces should use the Exclusive model from 2002/03 onwards.

Table 5.1: Comparing the budget model decided in three provinces in the FY 1 and their intention in FY 2

Province	FY 1 (From Oct 2001)		Plan for FY 2 (June 2002)	
	Salary fund at	Model	Salary fund at	Model
Maharakham	PHO	Mixed	PHO	In
Kalasin	PHO	Ex	PHO	Ex
Roi Et	PHO	Ex	PHO	Ex

Source: Adapted from a table produced in: Bureau of Health Insurance, MOPH 2002

Note: Salary fund refers to where the salaries budget is held – PHO or CUP.

Model refers to the models of capitation used at the provincial level, for example:

- Ex = Exclusive model in which IP is held by PHO and OP+P&P is paid to CUP

- In = Inclusive model where OP+P&P+IP is paid to CUP

- Mixed = situation where some element is split between PHO and CUP

As Table 5.1 shows, Maharakham opted in financial year 1 to hold the salary budget at the PHO and to use a mixed payment model. This involved splitting the IP budget and holding 60% in the Provincial Clearing House while allocating the remaining 40% to the CUPs, together with the payments for OP and P & P. This effectively meant that the PHO created a budget to provide extra support for hospitals and districts that were under-financed under the capitation model, using the top-sliced element of the salaries and IP budget.

Within the PHO, the war room took the lead in organising a series of discussions and fine-tuning the policies coming from the PCIHI. There were a series of minor technical adjustments, but the key decisions centred on the handling of the salary budget and the IP budget that would support referrals. The senior PHO officer who responsible for leading policy on financing describes how this fitted into the wider policy agenda:

I was responsible for this task directly. We considered that, in respect of the policies, the government told us two things must change, first, financial changes which allocated money to people based on registration, and second, health care delivery which focused on primary health care units in the community or ‘close to the home, close to the heart’. So, we had to set the goal of working together. We have got problems. First, cooperation between the hospitals and health centres; these have long been very different organisations, so how could we make them work together? And second, the capitation budget included staff salary costs, so it would cause problems if we allocated directly to areas, especially in the provincial hospital. In principle, we had analysed the total provincial budget and it was enough to survive. But if we focused on each health unit there would be problems in some areas, for example, regarding the issue of staff salaries in the provincial hospital. Therefore, we have aimed to pool resources within the

province and decide a rule together, and then arrange a series of meetings to make decisions. (SAO-PHO, MK 02)

It has been decided that the salary budget must be held centrally 'for the reason that all the hospitals must collectively support the referral system, as well as technical and staff support.' (Mahasarakham PHO 2003: 23-24). The decision to 'pool' funding did not fully resolve the issue of whether this would be done entirely through the salary budget or would also require central use of IP monies. This was discussed over a series of 'war room' meetings. Senior officers considered a range of options, and worked out simulation models of the results of different funding splits. In the event it was decided to use what was to be called an inclusive model, but one which performed a sleight of hand which effectively changed this to a mixed approach. The PHO Report to the Government Inspector of Health Region 5 recording the choice of the 'inclusive capitation model' also states: 'However, it was agreed that there would be an additional special arrangement in respect of IP, where 60% of monies for referrals would be managed by the PHO Clearing house. In the event that some of this remained unspent it would be reimbursed to the CUPs at the end of the financial year.' (Mahasarakham PHO 2003: 23-24)

The provincial hospital, represented by its doctor director, had been a powerful voice pushing for monies to be managed at the PHO. But other senior officers had put limits on the amount the provincial hospital could receive.

In the first year we deducted salary costs at the province with the additional condition that the provincial hospital would not receive more than 60%. That was our agreement. Then after about 9 months we analysed how this should be developed in the second year. At the beginning we did not have a policy about deducting salary costs. We agreed that we would deduct 50% of salary costs at the province: that means dividing 50% for the CUP and 50% at the province. That is an 'inclusive model'. We have run simulation models to understand our budget, what would happen if we deducted 50% or 100% at the provincial level. We presented data from the simulations to the committee. We found in the case of the provincial hospital that if we directly allocated staff salary costs to CUPs, they would be facing a difficult situation, because there is only one hospital which has had high staff salary costs amounting to more than Bt 100 million per year, whereas the PHO and all the CUPs, excluding the provincial hospital, have a salary budget of Bt 200 million. The budget of CUPs where they have under 50,000 people registered will not increase too much. On the other hand, the community hospitals which have more than 100,000 people will have increased budgets, for example, where previously they received Bt 30-40 million per annum, they will now get Bt 60-70 million. (SAO-PHO, MK 02)

This respondent describes how the war room's preferred plan for year two was to retain the (partially) 'inclusive' model of funding, but to split the salary budget so that 50% was now disbursed to the CUPs. This would have resulted in an increase in devolved budgets to CUPs in line with what officers took to be the spirit of the reforms, but there were also worries about the destabilising effect on the provincial hospital if more money went to the community hospitals. The war room's recommendation of a split salary budget plus inclusive funding went to the PCIHI but, after long debate, the Board took the view that this strategy carried unacceptable risks. The PCIHI decided that the salary budget would continue to be held in its entirety at the PHO and also opted to increase the proportion of IP held at the Clearing House from 60% to 80%, with the rest disbursed to the CUPs. The detailed policy on disbursement of funds for referrals is discussed in a later section.

5.3.3 Safeguarding the service units

The position of the provisional hospital was one of the main concerns behind both the decision to hold salaries at the PHO, and policy on the use of the IP budget. The doctor director of the provincial hospital and some PHO officers perceived that capitation-based funding threatened the survival of larger hospitals with many staff, and that this made it necessary to devise a local mechanism that would mitigate the intended effect of the 'money follows patients' policy.

We must arrange our budget locally to be fair and systemic. For example, what payment model to use. So we had to have a meeting with the key administrators to decide how to allocate funds. For example, the basic capitation payment was 1205 baht. When it has been deducted from the centre, we got only 1052 baht which included provincial salary. But if we decide to apply this strictly across the area it will create problems. Especially in the case of a large hospital such as the provincial hospital, where there would be problems with salary costs. It seemed that all the funding would go for staff salaries and that would mean the hospital could not survive if we made the allocations based on capitation only. Therefore, we decided to deduct staff salary costs at the provincial level before re-allocation. (SAO, MK 05)

Another approach, used early in implementation, was to re-draw the boundaries of the CUP in which the provincial hospital was located, so as to increase its catchment population and boost the capitation-based budget available to support the hospital for the 'local' aspect of its work.

Regarding the provincial hospital, they didn't have enough money because they have 32 doctors and nearly 1000 nurses. The great majority of the budget is spent on staff salary costs. The PHO created a new catchment area so that the provincial hospital gained population, which increased the budget for the provincial hospital. We took 7 out of the 14 health centres in 'G' district, 2 health centres from 'B' district and 2 health centres from 'K' district and added them to the provincial CUP. That was a way to increase the population and the money. (SAO-PHO, MK 03)

There was thus a twin-track approach involving, first, supporting the provincial hospital from centrally held budgets, and second increasing the population size of the administrative unit from which the hospital's nominal capitation-based funding would be derived.

The risk to the survival of the provincial hospital was one of the big issues of Year 1 of the reforms. However, against the claims of an immediate financial crisis, there were questions about whether the provincial hospital was benefiting from funding streams from other programmes and whether it had been frank in declaring this income fully. This meant that some PHO officers expressed a degree of scepticism about the extent of the problem.

The provincial and the regional hospital, they can easily survive. To tell the truth, these hospitals obtain money in many ways, such as the SSS and the civil servant scheme, whereas the community hospitals do not. In contrast, with regard to staff salary costs they (provincial hospital) receive an amount from the UC budget which is 'inside' information. In the provincial hospital report, they show only Bt 30 scheme income, but do not display other income and then complain that they will not survive. (SAO-PHO, MK 06)

Apart from the financial stability of the provincial hospital, the other major problem facing the PHO was a small number of districts and community hospitals serving areas with insufficient populations to make capitation-based funding viable.

There were problems in some community hospitals, for instance, a small hospital which serves a small population then gets a small budget, such as 'K' hospital or 'Y' hospital. 'K' hospital serves a population of about 20,000 and they will receive a budget of about Bt 10 millions. The budget includes all expenses and that disadvantages a small hospital. In the cases of 'Y' and 'K' hospital, they have been obtaining extra money from the provincial contingency fund, which is

a way of supporting small hospitals to ensure that they survive. Other hospitals in the 11 districts have no problems. (SAO-PHO, MK 03)

In the first year of the reforms in Mahasarakham province the centrally-held salaries budget was used to support the provincial hospital and these two small community hospitals. A similar pattern was discernable in terms of district health offices, with the large Muang district (the central city district) as well as two small districts receiving extra monies to top up the share of the capitation payment. Funding problems in the new system in this province thus tended to concern both the largest and the smallest population units, but not the units in between.

5.3.4 Referrals and the Clearing House

Another area of concern as the reforms were rolled out was the distribution of funds through the local health care system as referrals were made. The importance placed on primary care in the Thai reforms was reflected in the use of the CUP (nominally located at the primary care level) as the entity through which funds would be channelled to the rest of the system. In practice most CUPs were attached to community hospitals and in the first instance channelled a large proportion of monies to them, to support both their work and the cost of referring patients on to higher levels of the system. However, this created perverse incentives for community hospitals to delay referrals to provincial or tertiary hospitals so as not to lose income, and also the possibility of payment delays for referred patients.

This was one of the considerations that led the PHO to top-slice the salary budget and keep a contingency fund to support salary costs in large or very small hospitals. However, an additional factor was that holding all the monies at the provincial level would have meant that referrals had no cost at all to community hospitals and might have led to a flood of cases transferred to larger hospitals. There was thus a perceived need to get the balance between under and over-referral right via the mixed payment system, and to ensure that this was happening through monitoring and 'follow-up'.

In this province we used an 'inclusive' model so had a problem which was the small number of cases referred. If we had used 'exclusive' this would have resulted in a lot of referrals. So, we must follow up and monitor, and manage the

system well. We must accept that the monies were provided for the entire province, not for each hospital. (SAO-PHO, MK 02)

As events turned out in Year 1, it was reluctance to refer rather than over-referral that was the bigger problem in Mahasarakham. Thus there were concerns about the possible slowing down of payments and the rules for holding community hospitals responsible for the costs of secondary or tertiary care referrals in instances where they had had little or no contact with patients at the point of entry.

There may have been delays in referral in some districts. The provincial hospital told us that referrals might be slowed, so we understood this. In the beginning we set up regulations. First, whenever the patient is admitted to hospital then the hospital is responsible for payment. For example, if a patient is referred from 'P' hospital to Mahasarakham hospital, 'P' hospital must pay for everything. We set up a mechanism at the beginning in which we gave 'credit' to the doctor (to decide responsibly). Secondly, where a patient from a private clinic needs an operation and the community hospital cannot do this, then he/she will be referred to the provincial hospital and the community hospital must be held responsible for payment. That led to complaints from the community hospital that they were not involved in treating the case. Sometimes people didn't go to the community hospital and they would like go directly to the provincial hospital. We had talked a lot together about a suitable approach between the 'inclusive' and 'exclusive' models, which both have strengths and weaknesses. There is no single best model. (SAO-PHO, MK 02)

Provinces therefore needed to have a robust system for directing payments for secondary and tertiary care to providers. The MoPH had directed that all provinces needed to establish a clearing house for this purpose and that these should be managed by the hospitals. However, there was an immediate problem in most provinces across the nation because hospitals that were already overburdened by the workload pressures imposed by the extension of the UC had insufficient capacity to manage this task. The result was that apart from some large hospitals in Bangkok, this responsibility was passed on to the PHOs. This change was one of the adaptations sanctioned by the MoPH's 'war-room' as it struggled to manage emergent problems in the early months of the reforms.

One of our duties at the beginning was that we had to establish a Provincial clearing house. In the first year of the UC reforms, the hospitals had a duty to run this but they were overburdened with the documentary reports and passed the responsibility back to the PHO for operating the clearing house. Actually, we could do it because we had experience from the previous health insurance schemes. In the first year, we also managed both IP and OP payments and then

we started to try to encourage the hospitals to operate by themselves. (SAO-PHO, MK 05)

The approach taken to the management of referrals involved setting up a clearing house based at the provincial health office. This was an office that received information in the form of reports of referrals of in-patient cases from community hospitals to the provincial hospital and specialist tertiary hospitals, and arranged payment. The administrative work of the office involved validating data received from the community hospitals, ensuring that cases were correctly allocated to DRG categories, with adjusted relative weights (RWs), and then arranging for reimbursement of hospitals for treatment. The details of the payment mechanism were determined largely by the MoPH and were based on DRG-based payments to providers, up to the level of the global budget allocated to the Provincial Office. (DDCH, MK 20)

In Mahasarakham, the clearing house was a centre located within the Health Insurance division of the PHO, tasked with processing documents and managing the processing of IP payments to secondary and tertiary hospitals. It also had responsibility for channelling payments from the NHSO for 'high-cost cases' (using a special budget already top-sliced from the UC budget) to hospitals. As the extract above suggests, in this province the methodology used was modelled on past experience of administering the Social Security Scheme and the Health Card Scheme. This meant that the PHO was able to adapt quickly to the unexpected contingency of taking over the job of administering the clearing house from the hospitals, but also that the administrative process used was that had been created to manage the earlier schemes rather than one designed specifically with the UC reforms in mind.

One feature of the Thai reforms was that they combined UC and a global budget at the macro level with elements of 'managed care' at the micro level, so that inpatient care was reimbursed using a version of the Diagnosis-related Groups (DRG) system¹⁵. There was therefore little scope to vary the basic reimbursement mechanism or the 'relative weights' (RWs)¹⁶ used to set payment levels for different hospitals, since these were set first by the Bureau of Health Insurance and later the NHSO.

¹⁵ The diagnosis-related group (DRG) is a patient classification system for in-patients that has been utilised as part of the health care financing mechanism in many countries. The system employs a minimum data set to classify admissions into different diagnosis-related groups. In Thailand much research was carried out on DRGs and the alternatives, and a version (since revised) was selected as a reimbursement mechanism for hospital care.

¹⁶ Relative weight, as used in the diagnosis related group system, is an important signal to the hospital about how much it will get from the insurer for providing care to the beneficiary.

We deducted the budget at the province level. It amounted to 60% of the total IP budget of our province, for payments for in-patient cases within the province and referrals outside. We have a condition for referral cases which that that they need to have a referral recommendation letter that is approved by the community hospital or provincial hospital. The higher hospitals need to call for payment to the provincial clearing house, such as the Khon Kaen Regional Hospital or the Srinakarindhra University Hospital etcetera, which receive different amounts according to the relative weight in the Diagnosis Related Group model – (RW with DRGs) between them. The one RW for Khon Kaen hospital was Bt 14000 and Bt 16000 in the Srinakarindhra Hospital. Last year's report for this hospital shows that payments based on RW were more than twice the real costs. So this year, we have a new agreement with the Srinakarindhra Hospital to pay real costs but we still apply RW to pay Khon Kaen Hospital. We agreed with our hospitals first to make payments outside-province and after that we will pay within the province applying the RW model. In the case of RW under 0.5 the community hospitals clear the payments themselves. With RW from 0.5 to 2.5 we calculate the average costs of provincial cases then re-allocate the IP budget remaining from payments outside for reimbursement to community hospitals. And with RW higher than 2.5 we call the NHSO directly regarding what we call the high risk costs such as heart disease or renal failure cases et cetera. (SAO-PHO, MK 11)

In FY 2002/03 the proportion of IP monies disbursed via the Clearing House was increased to 80 per cent. This was divided into (a) IP outside the province, which took first priority and (b) IP within the province, which was funded from the remaining resource pool.

This year, the system has changed to the DRG approach for referrals and we have the funding at the provincial level, where 80% (of IP) is funded at the PHO. Thus we don't have any problem with referral cases. However, the new problem is a decrease in our budget, where the previous one is small this becomes too small. (DDCH, MK 23)

In the second year, the rules were changed so that the CUP rather than the PHO paid providers for out-of-province OP attendances, but with a cash limit of 700 baht per case. Although the rules for reimbursement of inpatient work were fixed at the centre and outside the discretion of the PHO, the arrangements for reimbursing RWs using different mechanisms according to these three bands were determined locally. These arrangements were important because they meant that the mixed model applied in Mahasarakham in Year 1, and to a large extent in Year 2, resulted in a complicated division of responsibilities between PHO and CUP. In both Year 1 and Year 2 relative weights were used to determine the threshold at which responsibility would move from the CUP to the PHO. The rule applied was that the CUP IP budget would pay for treatments whose relative weights were below 0.5, while treatments with higher RWs would be paid for from

other sources. The Clearing House first met the cost of out-of-province referrals, and then used the remaining funds as a pool that could be re-allocated to the CUPs to pay for the treatments with RWs of 0.5 to 2.5. High cost treatments with RWs over 2.5 were funded directly by the NHSO, on a first-come first served basis up to a global budget top-sliced from UC funding at national level.¹⁷

There were a small number of additional innovations in Year 2 such as the creation of a top-sliced provincial 'investment fund', and an additional ring-fenced fund to support district office utility costs.

The financial allocations are sent direct to CUPs, and CUPs will distribute monies to Health Centres. To sum up, we allocated for P&P around 16%, OP around 50% and IP around 28%. That was based on central allocations and we suggested a model to use in our CUPs. However, before making the allocations we deducted 10 per cent for a Provincial investment fund, which we have agreed together because the North Eastern region remains underdeveloped and the 30 baht project aims to improve quality of health service units. So we will use this for investment to increase the capacity of health care units. We have divided the fund into 2.5% for equipment for shared use, and 7.5% for allocating to hospitals based on their own development plans. (SAO-PHO, MK 05)

In assessing the significance of local decision making and its impact on the financing mechanism, it is also important to note that the overall budget allocation for inpatient work (IP) was determined by the PCIHI/PHO. The PCIHI had power to fix the financial allocation between the three categories of OP, IP and P&P, which determined the spending envelop for secondary and tertiary care. In Mahasarakham in the first year of the new system the division was roughly 16 percent for P&P, 50 percent for OP and 30 percent for IP. Following negotiations it was agreed to reimburse the provincial hospital for inpatient care bi-annually and the community hospitals on the basis of quarterly billing (Interview MK20).

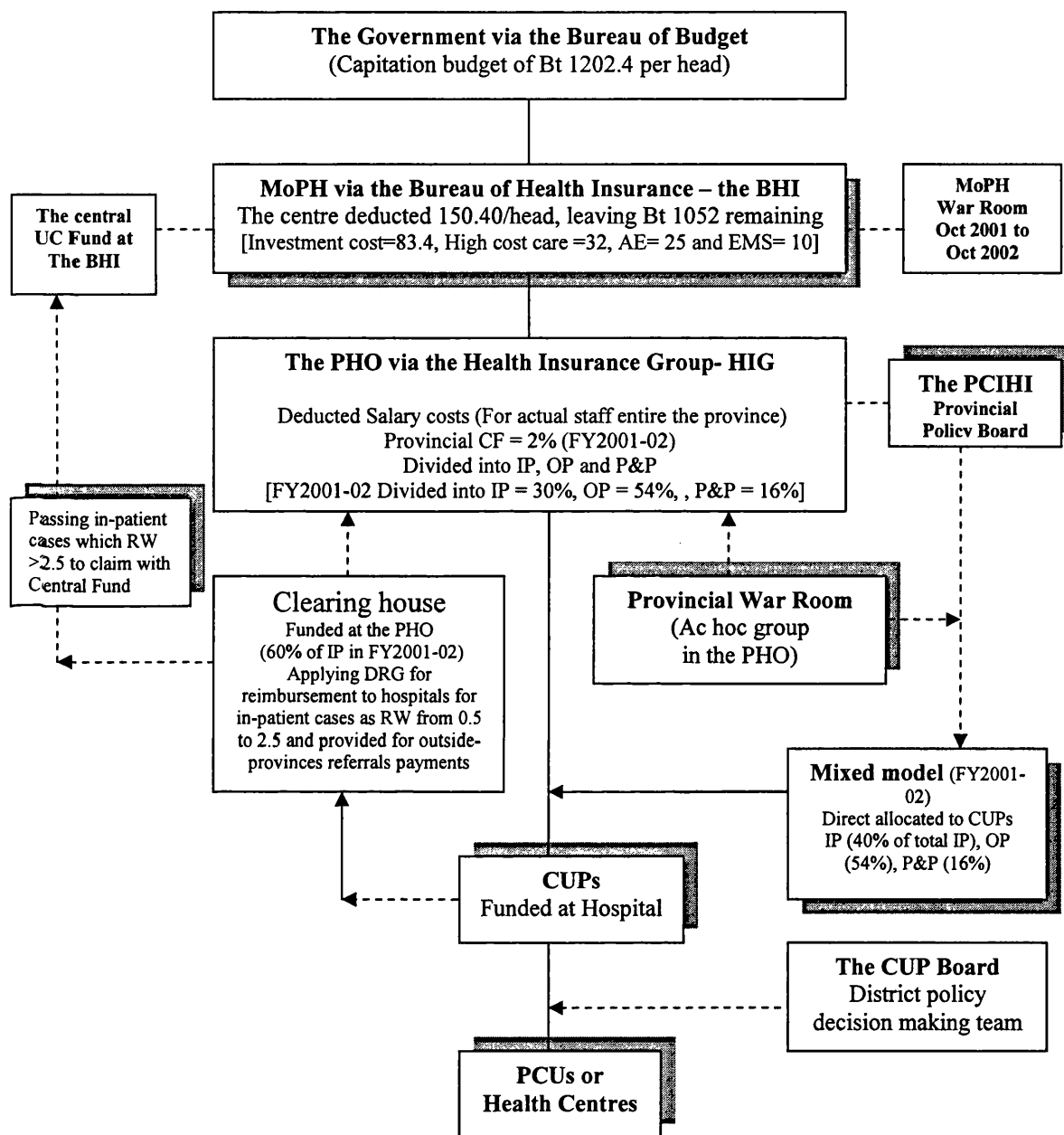
¹⁷ In FY 2001/02 High Cost Care (HCC) was funded from the MoPH Bureau of Health Insurance and in FY 2002/03 responsibility was transferred to the NHSO. Payments for HCC usually related to catastrophic disease cases with RWs over 2.5, and were subject to published maxima for length of stay and prices. In cases where costs exceeded the maxima in the HCC list, either the hospital or the PHO clearing house must pay.

5.3.5 Summary of financial changes in Mahasarakham in FY 2001-02, 2002-03 and 2003-04

In Year 1 there was an iterative process between the MoPH and the PCIHI/PHO in which many of the key decisions about financing were devolved to the province. The PCIHI/PHO employed a 'mixed' approach, which, although described in many official documents and discourses with outside bodies as 'inclusive', involved allocating 60% of the IP budget to the PHO clearing House. Reimbursement to the hospitals was based on DRGs within a global budget – RW 0.5 to 2.5., and 40% of the IP budget was directly allocated to the CUP. Regarding in-patient cases which have RWs above 2.5, the PHO clearing house passed these to central clearing at the Ministry for approval and reimbursement of the hospitals.

In 2003-04, the budget split in Mahasarakham was IP = 30%, OP = 54%, and P&P = 16%. The main funding flows and relationships between organisational divisions are represented in the following diagram.

Figure 5.3: Financing arrangements and relationships between organisational divisions in Maharakham in Year 1 (FY 2001-02)



Adapted from: the Maharakham Report, 2001-02 (Maharakham PHO 2002)

In financial Year 2, following direction from the MoPH, the salary budget was held at the MoPH level and the PCIHI/PHO applied an 'exclusive capitation model'. In Year 2 the PCIHI/PHO agreed to establish as a risk management fund held at the provincial level, based on 2% of total budget. The PCIHI/PHO also created a top-sliced budget to cover the health centres' operational costs, such as the water and electricity bills, which resulted in a separate allocation of Bt 5450 per unit per month. In 2002-03 the PCIHI/PHO again used

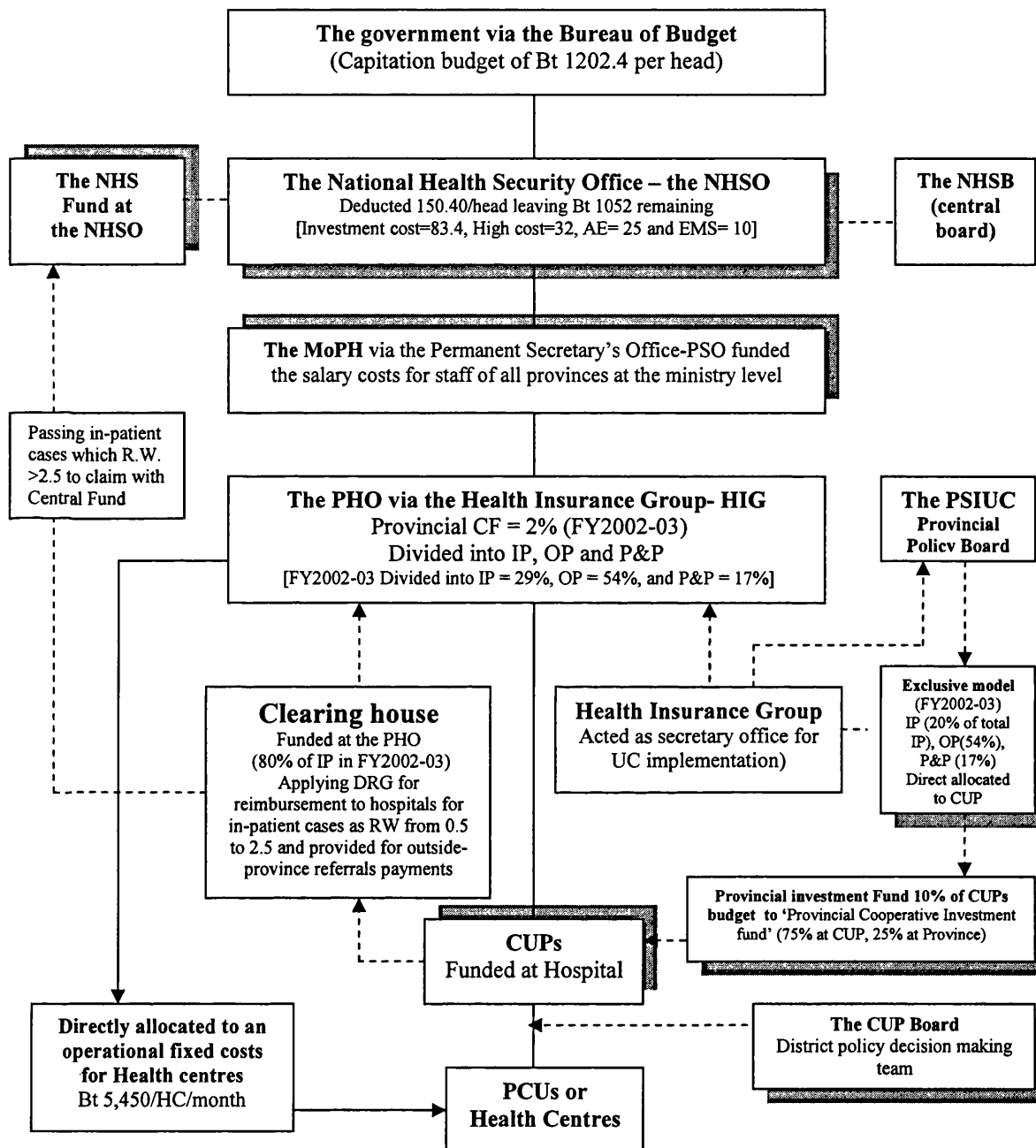
a special arrangement to allocate the IP funds, but this time increased the proportion disbursed through the Clearing House to 80%. In this year the split between budget divisions was OP = 54%, IP = 29% and P&P = 17%. Additionally the PCIHI/PHO agreed to channel 10% of the budget for allocation to CUPs into a 'Provincial Cooperative Investment fund'. This fund was divided into two parts with around 75% going to support CUP investments and 25% allocated for shared investments managed by the PHO (see: Mahasarakham PHO, 2004: 15-16)¹⁸. Figure 5.4 shows the resource flows and relationships between organisational divisions in 2002-03.

When the last interviews were completed in 2003/04 financial year, the basic arrangements had been rolled on, with only minor adjustments.

In Mahasarakham, we have received a capitation payment of 1052 and we have then deducted all provincial staff salaries, and then deducted 2.5% into a risk management fund to act as a safety net for some crisis hospitals. And for health centres we allocated for public utility costs and general expenditure an amount of baht 18 per head per year. All together health centres got around 5450 baht per month in 2003 and we have done the same this year. (SAO-PHO, MK 05)

¹⁸ Report to Inspector Health Region 5

Figure 5.4: Financing arrangements and relationships between organisational divisions in Maharakham in Year 2 (FY 2002-03)

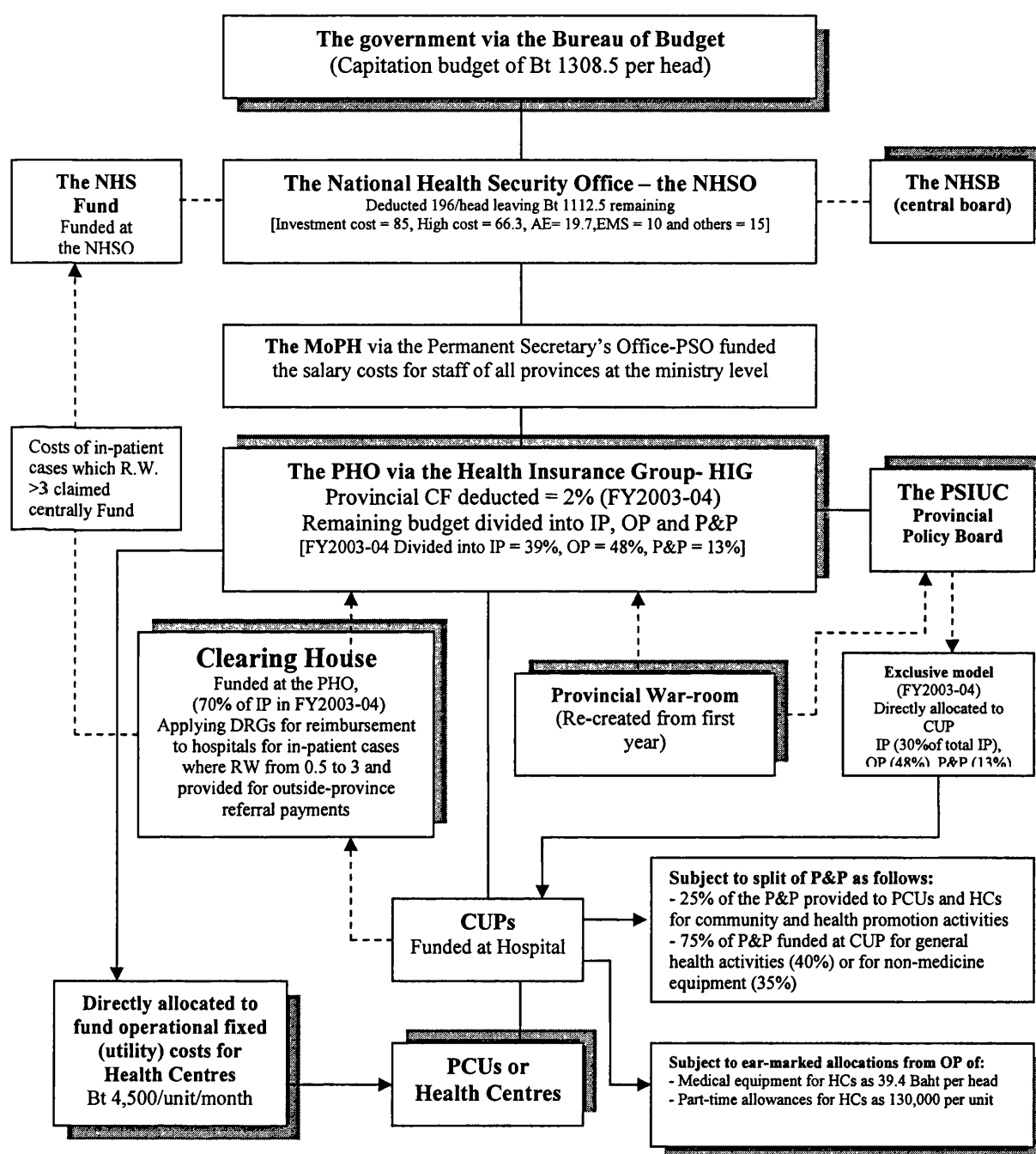


Adapted from: the Maharakham Report, 2002-03 (Maharakham PHO 2003)

In Financial Year 3 (FY 2003-04), as in all Thai provinces, Mahasarakham followed the policy direction from the Ministry that staff salary costs were to be funded at the Ministry and that an 'exclusive model' should be used at the provincial level. In this year the PCIHI/PHO again established a risk management fund held at the province, based on 2% of the total budget. The budget for health centre utility costs remained but was cut from 5,450 baht per unit in Year 2 to 4,500 baht per unit. The percentage of IP monies going to the Clearing House increased a little to 70%. In FY 2003-04 the split between budget divisions was IP = 39%, OP = 48% and P&P = 13%. However there were stricter restrictions on how monies allocated to the CUP should be spend. Thus there were earmarked pots from the OP budget for medical equipment costs in the health centres and part-time allowances for health centre staff. There was also a pre-determined division of the P & P budget between hospitals and health centres, and a direction about how the hospital allocation should be divided between non-medical equipment and other costs.

Figure 5.5 shows the resource flows and relationships between organisational divisions in 2003-04.

Figure 5.5: Financing arrangements and relationships between organisational divisions in Mahasarakham in Year 3 (FY 2003-04)



Adapted from: the Mahasarakham Report, 2003-04 (Mahasarakham PHO 2004)

5.4 The view of actors in the local health care system

5.4.1 The view from the community hospitals

Staff in community hospitals differed sharply in the responses to the reforms and local financing arrangements. This was partly a reflection of when they were interviewed, since the allocation to these hospitals worsened significantly in the second year of the study. But it also reflected the fact that the new system created winners and losers. One school of thought among doctor directors interviewed was that there was no problem with referral delays or reimbursement rates, even in the first year, because the CUP and/or the PHO met the bulk of these costs directly.

In Mahasarakham, we did not have a problem with the referral payments. The CUPs took responsibility for payments themselves, because cases that were referred were screened by us first. Except in emergency cases, for reasons of patient safety, they can go for treatment at another hospital directly. Money for inpatient work was deducted at the provincial level and they applied a DRG model to make the distribution. (...) I couldn't 'delay' [English] the cases that must be referred to a higher level because if I did the patient could sue me. I do not risk doing this. We are not private hospital. I have been referring patients, and if we were to go bankrupt the government should come and help and take responsibility. In cases where we refer patients, the payment is deducted from the provincial fund, so we have no reason to delay referrals. (DDCH, MK 20)

They arranged the IP system where there was 'the centre' at the PHO. If we didn't refer (the patient) then (our) the hospital would pay a lot. So, referral is better because we have already established a clearing house at the province level. (DDCH, MK 19)

Another respondent suggested that the problem had been exaggerated because patients aware of the new Bt 30 project had wrongly believed that this entitled them to choose which hospital they would be referred to.

Regarding the problem with delayed referrals, I think personally it was a problem which people did not understand. Because, if they need to go to hospital for treatment, they expect to be able to choose where they go. For example, we could operate on an appendicitis case here but the patient does not want to stay with us so they need to go to a larger hospital. I think there is a growing problem of personal conflict. In a case where it is medically indicated we must refer. (DDCH, MK 22)

Two community hospitals had benefited directly from use of PHO contingency funds, which had been used to counterbalance the effects of their low populations on their capitation-based budget allocations.

However, others were less happy about the new methodology. Respondents complained that the capitation payment paid to the hospital had been reduced excessively by provincial top-slicing, that the DRG-based treatment payments were excessive and higher than those applied by the SSS or CSMB scheme, and that large hospitals were been reimbursed at a rate higher than would have been warranted if the calculation was based simply on numbers of patients treated.

In my own view, the provincial hospital charged us too much and much more than the price rate under other schemes. There was no discount or anything. If they did not deduct the salary costs I might have other choices for referring cases, based on better quality of service or cheaper process. I have no choice now but to refer to Mahasarakham hospital only, because the budget has already been deducted by the province. I couldn't refer the patient outside the 'chain' [in English]. But irrespective of whether the main network provides good or bad quality, I cannot choose. If I had a choice, I am going to choose the best hospital for my patient. Now the community hospital is dying. (DDCH, MK 20)

One source of grievance was the perception that the provincial hospital was able to benefit from payments under the SSS and the CSMB scheme that had not been taken into account in the overall settlement. Some doctor directors felt that this was not merely an issue of omission but that some large hospitals were concealing the size of this income stream.

I think the government should not apply 'capitation' to all of the system. I think we must take account of existing assets. With regard to the salary budget held at the province I must pay an amount of Bt 8 million to support the provincial hospital. I don't mind but in solving the problem we are missing the point. I think in the case of the provincial hospital where there is a lot of staff, we should use other funds to support them to survive and then they should open up all their accounts. The provincial hospital might lose. But when they open all their accounts, if we know how much they lose, then it is possible to support them through the contingency fund. Now they don't open all their accounts. (DDCH, MK 21)

Several respondents made the point that the early worries about survival of the provincial hospitals had effectively disappeared by FY 2003-04, when policy change to hold the salaries budget centrally by the MoPH had strengthened their position further.

Regarding the criticism about 2001-02 where the registration system was not complete and it seemed that the provincial hospital might not survive. At the moment, the provincial hospital receives its budget from the SSS, the Civil Service scheme and the UC scheme. So, they did not depend on the Bt 30 scheme much more than the other schemes. In 2001-02 we had talked about channelling the salary costs direct to each hospital so that they (the provincial hospital) might not survive. Now the salary costs are funded at the MoPH level they can easily survive. (DDCH, MK 22)

There were also concerns about the ability of community hospitals to use their budgets to purchase supplies so as to get best value. Although lip-service had been paid to decentralisation at national level, respondents argued that the local picture was very different.

In Mahasarakham, it is clear that decentralisation is still not in place because when we need to buy medicines costing more than Bt 100,000, we must request permission from the CMO. They allow the hospital autonomy to make purchases of Bt 100,000 or less. It is not a flexible system: many times they returned documents to us for correction before allowing us to proceed. These problems make us uncomfortable and seem inflexible to the community hospitals. (DDCH, MK 21)

This arrangement was in line with the PHO's overall approach to resource allocation, whereby community hospitals had autonomy below defined spending ceilings and a share of split budgets, but the PHO retained a measure of control over the big picture.

As the reforms moved into their second and third years a new problem emerged because the uplift in capitation payments did not match growing staff costs. Staff costs inflation squeezed non-staff budgets so that monies available for infrastructure, medical goods, and perhaps most of all health promotion and prevention activities was reduced.

Regarding the capitation model, in my view it should include the staff salary costs because they have increased every year. In the long term that reduces the development budget. Additionally, they are applying a new criterion to calculate the budget allocation based on the characteristics of each area. That results in a decrease in our budget so that we did not get the full figure expected. (DDCH, MK 20)

Others too did not receive the expected amounts:

Last year, we obtained a budget of about Bt 680 per head, but then they allocated only 80% of that figure and this year this was decreased to 60% of the expected figure. I am not sure whether we will get the remaining part or not? (DDCH, MK 23)

This failure by the MoPH to pay the full amounts due to the PHO for disbursement in the local health system affected all three study provinces. Because of resource pressures at the centre, monies were paid at several points in the year¹⁹ rather than as a single allocation, and payments were both delayed and less than the promised amounts.

The system of geographical-based weightings, also introduced in Year 2, was intended to adjust allocations in light of the differing health care needs and state of health care facilities in different districts, but was also criticised as 'unfair' in some quarters. It typically meant that districts with limited health care infrastructure, which had been disadvantaged in the past but, were 'capitation winners' in Year 1, saw some of these gains clawed back as the redistributive effects of the reforms were watered down.

The cumulative effect of holding staff budgets at the centre, top-slicing IP budgets introducing new mechanisms to adjust capitation payments, and underpayments, was to claw money back from rural north-eastern provinces to the infrastructure-rich central region, and within province to pull resources away from smaller hospitals towards larger ones. The situation changed from one in Year 1 where it was the large provincial hospitals whose viability was threatened by capitation-based funding, to one in Years 2 and 3 where the smaller community hospitals came under pressure. One doctor director stated bluntly that 'the central management in the PHO did not support the hospitals too much' (DDCH, MK 21). Another talked about a real question of survival.

Now I would say that the most difficult problem is the community hospitals. (...) Mahasarakham hospital is responsible for a population of 170,000 and also receives a budget from the SSS and civil service scheme, as well as the monies for referrals from the community hospital. When I refer patients they charge me every last baht, and they receive everything. So why can't they survive? On the contrary, they are going to be rich. Over the last two years, they've said there is going to be no provincial hospital, it is going to collapse, but they are very rich hospital. The community hospital looks like 'the middle child'. The parents take care of the smallest child - the health centres - where they receive everything, and

¹⁹ Initially payments were made monthly but this was later changed to two-monthly and then three-monthly intervals.

the biggest child - the provincial hospital – which has received too much. I have a question. If a person from my district has been in an accident in Bangkok, who must pay? Of course, I need to pay. Furthermore, I obtain a budget but not the full figure. In cases where I have referred to Mahasarakham hospital then they have referred on to a higher hospital, then I must pay again. How will I survive? The community hospital is going to be bankrupt. (DDCH, MK 20)

Overall the plan to use capitation-based funding to correct the historic imbalance in resources and workforce distribution had little effect on a province like Mahasarakham. Respondents were sceptical about the prospect that the reforms would create new incentives to achieve greater mobility.

I think that if the MoPH forced doctors to re-locate to rural areas that would make them resign. The MoPH should be clear about this policy. I used to say that the doctor distribution problem was caused by the wrong policies a long time ago. Consequently, the way to solve this problem is how we distribute the new graduate group so that they do go to over-supplied areas and we shouldn't use increased salaries in the places that have enough doctors already. (DDCH, MK 20)

Absolutely, we did not solve the human resource distribution problem. In the first year, the policies aimed to redistribute the staff all over the country applying the financial system brought in by the reform. Each of the health units were developing their capacities based on the population in the area. In the second year, the policies changed, there is the concept of survival of the health units. We need to accept the facts; there has been wrong direction of hospital development for a long time, at least 10 years, which included the number of hospitals and the staff problems in some areas. The redistribution policy was launched in the first year of implementation. This line of thought did not take account of the need to ensure the survival of hospitals which concerned the centre. In contrast, in the second year, they came back to secure the position of all the staff which led to the end of the redistribution reform. (DDCH, MK 22)

By Year 3 there was increasing awareness of the intractability of the workforce problem, the difficulty of bringing about planned primary care reforms and the gap between promised and actual funding.

Previously, I wasn't concerned about the resource distribution problem. After the Bt 30 policies came in I started to analyse this problem. For example, 'Rachaburi' (central region); they have population of about 500,000, 4 general hospitals, over 10 community hospitals and hundreds of doctors in the province. In 'Ayuthaya' (central region), they have population less than 300,000 while they have 200 health centres. Regarding Mahasarakham, it has a population of more than a million with a general hospital, 10 community hospitals, 175 health centres and 75 doctors. I just know that in the whole nation we have around 20,000 doctors,

when compared with a doctor/population ratio for the whole country of around 1 in 3000. But in Mahasarakham it is around 1 in 20,000. In my district, we have a population of around 100,000 and we have 3 doctors or around 1 in 30,000. Previously, we never made comparisons but after I analysed this it made me understand why we work so hard. In terms of the numbers of nurses in our district there is the same problem. We have only 50% of the numbers which we should have, and that caused them to work hard. After the new policies came along we supposed that things would improve and we were very glad about the new policies. In the first year, we assigned nurses to go to work in all the PCUs for health service improvement. In the second year, the budget was decreased around 40% from the first year but we did not know about this in advance; they (the MoPH) did not inform us about anything. It was not until the 8th month of the fiscal year that we were told it was decreased, that left us facing problems with work and the budget arrangements. (DDCH, MK 20)

There was also a perception in community hospitals by Year 3 that the PHO's power to make local adjustments was diminishing. After a period when disagreement among national policy makers had given devolved power to the provinces, a more top-down approach to policy development seemed to be re-emerging. The following respondent comments on how the approach to managing the staff salary budget was now dictated from the MoPH.

Now, we don't have a system where the province has the power to make complete decisions. Things were changing every week. In the first year the MoPH directly allocated the budget to the province using a capitation model. In contrast, in the second year this was changed; they deducted all the staff salary costs at the central level. This is different when compared with the first year, when each province received a capitation payment of Bt 1052 that included the staff salary cost. That means the staff salary costs were deducted in the province. When it came to the second year, they deducted at the centre in the MoPH and as you know, the budget that we received was not the full figure. (DDCH, MK 22)

Many doctor directors was expressing disillusionment with the reforms by Year 3 as their budgets were trimmed back and the distribution of resources seemed to be swinging back in favour of the provincial hospital rather than the community hospitals, and central region rather than the north east.

5.4.2 The perspective of the DHOs and health centres

One factor that worsened relationships between the DHOs and health centres and the hospitals was the way that doctor directors of community hospitals gained control over CUP boards, and then made the key decisions about use of the budget. This arose because

most of the medical workforce at district level was in these hospitals, and the health centres were dependent on them to send out professional staff, thus leaving the doctor directors as key actors in the local system. However, as the later case studies will show, the extent of this problem in Mahasarakham was more limited than in many other places. The involvement of a wide range of actors in the PCIHI and the decision to create a separate budget at the PHO to support the fixed expenses of health centres appears to have helped the health centres keep a fair share of the budget in this province.

With regard to the budget, previously the DHO received money from the PHO directly and we were implementing the health projects in the local areas with health centres staff. At present, the budgeting system is the UC budget, which means that the DDCH is responsible for the financial management, and I undertake the personnel management, monitoring, supervising and evaluation of health activity programmes. The health centre's budget comes from the CUP based on the CUP Board's resolution. Regarding the allowances for the health workers, we prepared documents in the DHO then submitted them to the (community) hospital to make payments. Budgets for other items, such as the water and electricity bills, are funded by the PHO. This has dramatically changed the budgeting system. (DHO Head, MK 31)

For front-line health centre staff, the changing structure introduced considerable confusion about lines of accountability and who was responsible for what. Many perceived that they now had two bosses who stood in an unclear relationship to each other.

In the first year, there was a lot of uncertainty about the new system, such as who our boss is. At the moment the line of command is unclear. Previously, '*Nai Amphur*' and the DHO head were the direct bosses. Now, is the DDCH becoming the boss? We are not sure because we have to submit documents for payment to the DDCH but we need to present to the DHO head as well. Now, the health officers at the lower level are very confused and uncertain. (HO-PCU, MK 38)

Now, I don't know who the boss is, which I find confusing. For example, if I buy a computer for the health centre, I don't know who would have the authority to give permission between the DDCH and DHO head. Who makes the final decision on this? (HO-PCU, MK 36)

Although conflict was not as great as observed in the other cases, some DHO staff complained that the dominant role of the DDCHs in the CUPs meant that hospitals worked to their own agendas and gave the health centres insufficient support.

[the] community hospital created projects and then we have to follow them but we didn't have any participation on the planning processes. We would like to be involved with them in project development but we can't do that. . (...) previously, the health centres were involved in financial arrangements with the DHO. Now,

the budget is allocated directly to the CUP and they don't participate. I think the old system is better, because the DHO has a better understanding of the health centres' problems due to the fact that we have worked with each other for a long time. (ADHOH head, MK 33)

Many times, when we implemented health activity projects in the local area, the budget has delayed our plans. We have decided to work with our scheduled plan but the budget did not arrive on time. When the budget did come in sometimes the people did not have time to cooperate with us, because it was in harvest season. Because of this there were only a few people collaborating in our project. (HCO, MK 42)

In Maharashtra the other problems mentioned by many informants concerned the 'incentive' payments made to front-line staff to work extra hours in the community. There were suggestions that some staff were dishonestly over-claiming for hours they had not worked. Some senior staff also believed that the 'overtime allowance' was undermining the public service ethic of staff.

[the] OT (in English) was a double-edged sword. We never had OT for a long time; however, we were able to make faster progress after it came in. But that left us facing a new situation, where we must have extra monies to 'push up' the work rate. It led to a new 'working culture'. In my view, I prefer the old system which encouraged the health centres to work according to an ethic of responsibility. In case of insufficiency in some creative project - there isn't enough money - they cut the money for work in the local area. This means we don't have money for implementation. (HCO, MK 36)

Before the policy came in the health workers never received an extra allowance and we didn't have any problems at all. After the new incentive measure came along, if they did not get it or they got less than they expected, they would complain. I tried to explain in a meeting that they should understand that they would be receiving less than previously because the money had decreased. However, they argued that before the new policies came in there was no money, but after the reform came along the money came too, so they should have the right to get it. That caused conflicts between the hospital and the health workers. (DHO Head, MK 28)

At the beginning of the reforms, many DHO heads anticipated their role would be decreased due to transfer of budgetary power to the CUPs, and there was initially a period of inactivity, but as things settled the burden of work quickly increased. The DHO heads still had authority to control the health centre staff and carried out their old health promotion activities. However, in addition they now found they had a new role as the district monitoring unit.

Initially, some critics said that working in the localities was the province of the health centres and that the DHOs didn't do much of anything. It was true at the beginning that we didn't have much work because we didn't understand about monitoring and evaluating tasks. We then studied our role and went to consult with the deputy CMO in the PHO, who clarified that we had a role in monitoring and evaluating health activities. Now we have a lot of work and must always go outside to supervise, so we don't have time to relax. (DHO Head, MK 29)

When we talked about the 30 baht policy, I think that we've got increasing work, because (there were) a lot activities and high expectations, but we have limited time and insufficient staff. The number of staff is the same but we have to do many activities within limited time (...) they were changing both the working method and our roles. That is, we must move forward to work in the community while we are still responsible for routine work in the office. (DHO Head, MK 26)

5.5 Civil society engagement

5.5.1 The emphasis on 'civil society'

Although prominent in the national policy discourse, civil society involvement was only emphasised as a core aspect of the health care reforms in one of the three case study provinces: Mahasarakham. This section provides an account of the civil society movement and its impact on health sector reform in the province.

There are many definitions of civil society (see: Gosewinkel, 2005), but most scholars agree that the term refers to social institutions and activities that are not part of the state or the commercial sector, and are above the level of individuals. The British Council (n.d.) defines civil society as "the part of a society which is neither state nor private sector, a large and diverse sector which in general is understood to range from the individual at one end to large non-governmental organisations, national and international at the other. In it, we find associations and organisations such as trade unions, trusts, charities, community groups, churches and faith groups, mutuals and cooperatives, academic institutions and political parties and groups representing specific interest groups or working with single issues." Usage of the term in Thailand does not always distinguish between civil society and state or private organisations as sharply as this definition suggests. As will be seen below, some civil society organisations may appear to be sponsored by state bodies and market-related organisations like farmers groups may also enter the picture. In rural

Thailand the main groups involved are national NGOs and grass-roots organisations of various kinds.

The term 'civil society', translated in Thai as '*prachasangkhom*' or '*prachakhom*', has become prominent in Thai political discourse in the last ten years. Some political scientists (e.g. Phatharathananunth 2002, Thabchumpon 2002; McCargo 2002) have distinguished between '*prachasangkhom*', which has the connotation of a self-organised autonomous realm, and the state-sponsored '*prachakhom*' organisations, which every Thai province was ordered by the central government to establish at the provincial, district and sub-district levels. The latter are said to have been 'captured' or even created by state agencies, and are locked into top-down government projects and programmes. According to the critics they constitute a fake civil society, aimed at neutralising potentially dissident community organisations and NGOs. Both terms come up frequently in the context of local policy initiatives.

5.5.2 Civil society at provincial level

Maharakham is the one of a few Esarn provinces that had introduced pilot projects based on the public participation concept. Both public and private agencies have launched projects with an explicit 'civil society' component in Maharakham, such as: the Population Development Association, PLAN (Thailand), the Social Investment Fund, the Local Development Institute, and the University and other academic institutions. (see Table 5.2)

Table 5.2: Chronology of ‘civil society’ projects in Mahasarakham prior to the UC reforms

Year	Events
1992-1997	<ul style="list-style-type: none"> - The Population Development Association’s ‘Meechai Project’ launched a project providing water supply storage tanks with community participation. (<i>Prachasangkhom</i>) - PLAN (Thailand) ²⁰launched a project to provide a community school library (<i>Prachasangkhom</i>). - The Social Investment Fund (SIF) launched a community economic development project based on local activity groups. (<i>Prachakhom</i>) - Thai Farmers Foundation launched a livestock project which provided a cow to selected low-income families. (<i>Prachakhom</i>) - The Local Development Institute (LDI) launched a project on civil society and local political structures in Wapee Phatum District. (<i>Prachasangkhom</i>)
1997-1999	<ul style="list-style-type: none"> - Workshop ‘strengthening civil society in Esarn’ held at MSU - Collaborative Research project on ‘Strengthening civil society in Esarn’ launched by Local Politics Information Centre, MSU and Department of Politics, University of Leeds, UK -MSU initiatives to improve people’s participation in local politics; shift burden of responsibility for training and awareness building to local institutions such as MSU, stimulate contracts between the Local Politics Information Centre and the people, and make it into a source of information and advice for the community. (<i>all Prachasangkhom</i>)
1998-1999	Action research project on ‘Research on social organisations and community developments: a case study of the community of Tambon Nakha, Amphur Wapee Prathum conducted by MSU scholars group with funding from the Health System Research Institute, MoPH. (<i>Prachasangkhom</i>)
1998-1999	A project on civil society development at the sub-district level was launched in Donwan sub-district, Muang District. It was conducted by Centre for Training and Development of Primary Health Care in the North-East, directed by the MoPH and the Mahasarakham Provincial Health Office. It aimed to enhance the capacity of village leaders and community groups to support local health promotion and prevention strategies. (<i>Prachakhom</i>)
February-December 2002	A project on Participatory Action Research to Advance Governance Options and Networks: a case study of the development committee for Nongo village, Borabue District was conducted by the MSU scholars group with funding from the King Prachatipok Institute, Bangkok and United Nations Development Program. (<i>Prachasangkhom</i>)

A rough categorisation of these initiatives suggests that they include both ‘*pra-cha-khom*’ projects, funded mainly by central and provincial agencies, and a number of ‘*pra-cha-sang-khom*’ projects funded by NGOs and the University/academic grant-giving bodies. Mahasarakham University had been a major centre for critical analysis of the civil society movement, and in particular academics there had promoted the notion of state capture of ‘*pra-cha-khom*’. Thus some of the University-supported projects, notably the collaborative project with Leeds University, had consciously sought to move more towards the ‘*pra-cha-sang-khom*’ model, with greater emphasis on autonomy of local

²⁰ PLAN is an international non-governmental organisation that works in 62 countries around the world. For further details, see: <http://www.plan-international.org/>

communities. For this reason civil society projects here probably had less of a top-down character than in many other provinces. Since the other study provinces of Roi Et and Kalasin did not possess a major public university, the influence of MSU in Mahasarakham is a significant point of difference in the study comparison.

5.5.3 Civil society and the UC reforms

Some of the past projects had involved the health sector and it seems likely that the policy environment of Mahasarakham province had a significant impact on thinking within the PHO. There were close links with the University in that many of the senior officers participated as invited speakers on university courses, there are a number of joint projects²¹, and many staff were present or past students on public health degree courses.

Some of the earlier 'civil society' projects were recalled by senior officers when they discussed the background to current developments.

Prior the 30 baht policies, at the provincial level, we had talked to civil society in health from 1999 onwards. That was when we introduced people to participation in health activities, especially, communicable disease prevention projects such as haemorrhagic fever protection etcetera. There were many activities in civil society not only the health sector but also other sectors. (ADHOH, MK35)

However, they indicated that these policies would now be given fresh impetus by the UC reforms, particularly through the new funding arrangements that channelled money to the CUPs and thereby strengthened primary care, and the separate budget for prevention and promotion (P&P). Public participation was mentioned by senior officers as an important element in the development of effective local prevention and promotion programmes.

By the time of this study, public participation featured as an explicit objective in many of the PHO's current planning documents. One of seven objectives of Mahasarakham PHO described in the 2002 PHO Annual Report is: '(6) To enhance civil society (*Prachakhom*) at the sub-district level to improve efficiency of health promotion activities by at least 80%' (Mahasarakham PHO 2002). The role of local stakeholders is highlighted in the first

²¹ For example, one collaborative project on 'The future shape of public health' was being conducted as this study proceeded

of five aims in the mission statement contained in the 2003 PHO Annual Report: '(1) To enhance support, and develop cooperation with stakeholders and the health care network so as to provide health education and information for achieving health promotion...' (Mahasarakham PHO 2003).

Civil society involvement was a theme discussed at length in interviews with senior administrators. They presented the PHO's involvement in this area as a longstanding concern over many years, which could now be developed further.

I began in 1997 and continued to implement the approach in 2000 – so we have about 5 or 6 year's experience of developing civil society involvement. So in doing this we have been pushing at the community level first and then the family level follows. In order to do that, the process must start with the health officer who must understand what is required. The public organisations must co-operate (in civil society development) with key persons from the villages to stimulate and strengthen activities at the family level, as well as in the community. Hence empowerment in the local health system should be achievable by the community. That's the main point. That is to encourage them to participate in the management of all areas, especially decision-making making has an impact on them, including the hospital and health centre and the community too. They get involved, they understand and they learn. We give them training so that they acquire greater knowledge of an appropriate kind. So when they must do this it will be satisfactory. If they do it often it will change behaviour and this will continue. (SAO-PHO, MK 01)

The principle is to empower them - at the same level - because the health system is a system which needs everyone to take care of themselves - make the best of themselves, follow their potential, as humans should. That is the main goal. But how can we empower every person? We need a process. The family is the main thing. They can achieve the goal of good health by taking care of themselves. Only the people have potential to take care of themselves, health professionals cannot do it. In our strategy we do not use health professionals to do everything. Health professionals co-operate with people and promote empowerment in the community. We use civil society. That is our main activity – it is civil society. We are going to build up strong families and link them together. We help them to think, help them to do, and help them with suggestions. We help weak families to be strong through the civil society process (SAO-PHO, MK 01)

Another interview, which links 'public participation' to 'good health' illustrates a degree of ambiguity that came up in a few interviews as to whether civil society is really about taking responsibility for prevention and a shift to healthier patterns of behaviour, or if it should involve a push to widen ownership of the local health system, so that community representatives are involved in consequential policy decisions.,

Currently, public participation is different from previously. At first, people thought good health that was duty of the MoPH. Nowadays, we are working to make them understand that they are responsible and must take ownership and must do things by themselves - not the health officer. (SAO-PHO, MK07)

Another official mentions the province's track record of earlier projects and existing networks, but hints that the culture of the PHO needs to change further.

In Mahasarakham, we are well known for work on civil society and working to strengthen communities. We had worked a lot with certain groups of people, but we haven't put our own house in order. I would say that we have done it a lot outside. In my opinion, a key success of civil society was, firstly leadership and secondly, to share benefits between people within their group, I mean that was going well in some places if they were sharing the benefits together. In the case of '*Baan Khong Kud Whai*', by working together they have built up a strong civil society.²² (SAO-PHO, MK09)

Later in the interview, this informant expanded on his reference to 'leadership'. It became apparent that his version of civil society engagement was one in which effective leadership combined with monitoring and evaluation by the PHO were prerequisites for success.

I think the leader in an organization is the most important thing. Often a doctor is the leader, someone who will dedicate themselves a lot. But some people take part because it is a road to career advancement. I insist that the leader is very important. (...) This year in the PHO we have reorganized, but we can see that some people have not changed their views, that they still work under the old idea which assumes that the PHO needs to have service clinics. That tells us they have not changed their ideas and also that they would like to carry on with their old roles. But in reality, the PHO has changed its function to a role of monitoring and evaluation. They should work on technical support tasks not health service delivery tasks. I think that there was an organizational change but I did not see a lot of change in health officers. (SAO-PHO, MK07)

As interviews were completed with other staff in the chain of command, informants sometimes mentioned limitations in the policies and cast doubt on their real impact at grass roots level. The theme of leadership comes up again in an interview with another senior officer with a professional qualification. However, this time the respondent identifies the CMO as the leader and hints at the kind of top-down model of civil society involvement described by the academic critics. This interview also highlights the perceived problem

²² 'Khong Kud Whai' village is well-known as a local conservation area which generates income through tourism. Some of this has been channelled into a community fund, which supports the village committee that led the local civil society movement

that many community stakeholder groups were less interested in health promotion projects than in projects that would develop local infrastructure, such as road building or water supply improvements.

We have done a lot: we have a leader, the CMO in the PHO, who is quite interested in this area. He tried to build up people participation, for example, he encouraged them to take part in community planning processes: think, identify their problems, and develop own community plan. Nevertheless, regarding the health services sector, I did not see very much. I felt that we have done well as regards the community process, and do a lot, I would say that we are well known at the National level. Many organizations have started public participation activities in the villages, such as NGOs and the University. In the health service sector, increasingly we are bringing in people to the provincial committee, which is a regulation from the centre. For example, (there are) in the case of the Provincial Area Health Board and the other Provincial committees. However, the role of people... they seem to play at councillor level, not a very significant role. Because, we are still facing the same problem as the other provinces: a few people concentrate on health services, whereas, I see that they more pay more attention to the provision of public infrastructure. That is a source of conflict (SAO-PHO, MK12)

One problem for the senior officers was that while there was a strong generalized pressure from the centre to develop public participation policies, this did not fully recognize the problems of local implementation. As one moved nearer the front-line, many informants started to question the reality of public participation projects more openly. This was so among both medical directors and administrators in district offices.

Nowadays, there are many projects, which are the main role of public health officers, working together with Village Health Volunteers. In fact, we still need to stimulate the public to participate much more. For example, we faced problem with villagers, in the haemorrhagic fever control project, when we went to their homes to eliminate mosquitoes. They did not cooperate and sometimes they could not be found at home. Regarding the community environment it seems that they are not aware of improvement. (DDCH, MK 20)

In (this) district, prior to the implementation of the 30 baht policies, we had operated the Hospital Promotion Project - HPP. This project focused on improving public awareness and problem solving in the local service. The 30 baht project changed two things: first, health service delivery standards and, second, hospital accreditation. The MoPH forced us to set up a hospital accreditation scheme, which is based on improving services and internal standards. It seems that in the health sector people have participated little, because it is seen as an academic topic. Instead they just come to use the hospital service. In the last 2

years, people have participated only in the sense that they access hospital services. (DDCH, MK 22)

I have encouraged PCUs to think about various public cooperation projects in local communities. There were many interesting projects, however, we have been hard pressed to find funds because we have got a restricted budget that make it difficult to work. (DDCH, MK 23)

Heads of district offices had both positive and negative messages. Many reported progress in recruiting village health volunteers, who were a tangible manifestation of local involvement, and the ability of DHO staff to engage with them.

A concrete project is the health promotion with exercise activity project that has been the most interesting one from our people. Because we trained the group of Village Health volunteers and built up local society through the health centre officers. Then they have taken the programme into the community and after that we have followed up to monitor it. Not long after starting the exercise activities they had spread to all the villages. As we have seen in the community, this project got a large of people participating and that created an opportunity to give them additional health education. (DHO Head, MK 28)

Previously, we implemented a primary health care project that was called Public Collaboration in Health. Village health volunteers had an important role in cooperating with public health officers. With these community health activities the health officers did not work alone. We needed village volunteers such as village health volunteers, and members of the ABT (Sub-district Administration Organisations) to come to work as well. (DHO Head, MK 27)

But respondents also mentioned the sometimes disappointing limits of participation, the distance between appointed bodies and the communities they served, and the lack of real impact of existing and past projects.

At the beginning of the (decentralisation) reform policy, the policies focused on administration by committee, based on the new model of the Provincial Area Health Board. They were clear that the committee would represent different sections (of the population). They met many times and that gave confidence to the front-line actors that the Provincial Health Board model would be formally established by government. At the district level, we have responded to this direction and tried to build up public participation. After the 30 baht policies were announced, the Provincial Area Health Board stagnated: at the Provincial level it doesn't 'run' (uses English word) at all and they don't even talk about this story any more. The Provincial Area Health Board that was established are now playing at being councillors. (ADHOH, MK 35)

We have focused on village health volunteers only. I think that is not good enough: we should have given the people greater public participation. They come and use health services only. It seems they do not participate much. I feel that they have no power; they have just gone along with our health activity projects. (HCO, MK 37)

We still don't have any obvious activities. I go out to do home visiting but it is a project that we 'feed' to them. For example, the civil society project, we organised the meeting so that people could come to discuss their problems and teach them to make projects to solve local problems. But I am not confident about how much of a success it's been, because so far there's been no follow-up. (HCO, MK 39)

At the moment, there is no clear model. Generally, joint working between health workers and nurses more than anything else, and mainly they work more in the health centre than outside. (HCO, MK 44)

There was a feeling in many quarters that civil society involvement effectively meant little more than participation in health activity projects, which were usually concerned with health promotion (e.g. aerobic exercise class projects) rather than dissemination of information about local policies or participation in policy making.

One route towards greater community involvement might have been closer co-operation between the PHO and local government, of the kind that had been envisaged in the decentralisation reforms. However, although some steps had been taken to begin to develop structures, these had been hampered by the slow pace of implementation. The recently established Area Health Board had not been seen by PHO officers as well enough developed to become the PCIHI, and had relatively little influence during the study period because planned legislation giving power to the AHBs was delayed.

Joint working between the PHO and local government on more detailed policies, such as health promotion, was still at an early stage. In an interview, a senior municipal representative expressed positive aspirations but could give no examples of co-operative projects or activities.

I think in the roles and functions of local government, we participated only a little in this policy because it was a national policy. However, I would like to participate in formulating local policy such as health promotion or health disease prevention more than at present. There should be cooperation between the health organisations in the province and local government, for example, by sharing the

budget and working together on how to prevent rather than cure, how to ensure that people do not get ill. There were a few areas of shared interest and fewer areas of cooperation, although we have requested this many times but with no result. (Senoir municipal representative, MK 15)

Even though both parties had been involved in an earlier pilot project on decentralisation, this had not translated into concrete initiatives under the UC scheme.

There has been little work, and if we view this against the overall progress of the nation it was little, although Mahasarakham was a pilot province in the decentralisation scheme and we have talked together a lot. We always cooperate with the health sector both in the meetings and operationally. We have not any conflicts with the PHO and the hospitals but the MoPH does not allow us to take action. I think the local government is ready but they do not give the opportunity to us. (Senoir municipal representative, MK 15)

The one area of involvement reported by the senoir municipal representative was that the municipality had been requested to assist in publicising the rules of the UC scheme and the need for local residents to register in order to gain eligibility for treatment in local health care facilities.

With regard to the Mahasarakham municipality, we were rarely involved in the management. They just assigned us to announce to the people that they should go to register and have us check their names - that was at the beginning. After that was finished all the activities were controlled by the hospital. (Senoir municipal representative, MK 15)

5.6 Relations with the Ministry and the Health Region

One additional feature of Mahasarakham province that differed from Roi Et and Kalasin was the good channels of communication and good relationships that existed with most of the key departments within the MoPH. Mahasarakham had been a pilot province for a number of past initiatives, including projects on civil society engagement and decentralisation. In the first year of the reforms, Mahasarakham province won an award for best implementation of the Bt 30 Project in Esarn Region. This track record had resulted in very good relations between senior PHO officers and senior officials in the MoPH, and meant that the Ministry took a sympathetic approach to provincial initiatives and granted this province even more autonomy than some of its neighbours. This was reflected in the relaxation of the standard requirements for the formation of provincial

PCIHIs, so that the rules were rewritten to allow Mahasarakham to bypass the AHB and establish a committee from scratch. Despite the possibility that the reforms would eventually result in the purchasing function being removed from the existing health administration bodies, relations between the PHO and local government remained underdeveloped. There was an absence of joint projects and little existing co-operation on which to build. Local government had no significant voice when it came to influencing the direction of reform implementation. The single representative on the PCIHI was too isolated to wield effective influence.

5.7 Summary of chapter

This chapter has considered a number of areas in which the approach taken in Mahasarakham province differed from the other two study provinces, including the specifics of how the reforms were introduced, the choice of financing mechanisms, the emphasis on civil society involvement and the province's good relations with the MoPH. These were all areas in which local actors could exercise substantial influence over the detail of policy implementation, but of course not all actors had equal influence. In Mahasarakham the CMO was probably the most powerful single actor but he had been content to support a set of arrangements in which a wider group of actors, including the three most senior PHO deputies, the director of the provincial hospital, and to the lesser extent the representatives of the community hospitals and DHOs, shared decision making power. The 'war room' dominated by PHO staff was the main operational body for day-to-day problem resolution, but on occasions its recommendations were over-ruled by the PCIHI, as with the question of the handling of the salaries budget in Year 2. The CMO had also been influential in promoting a significant degree of support for civil society participation in Mahasarakham province. There was a history of past projects and a range of current initiatives in Mahasarakham that was more extensive than anything in the other two study provinces. These were a mixture of government-sponsored '*prachakhom*' projects and a small number of grassroots '*prachasangkhom*' initiatives. However, in most cases the positive view of progress from the higher echelons of the local health system co-existed with a more sceptical and mixed assessment of these programmes at grass roots level.

Chapter 6

Kalasin: fragmented power and struggles between professional interest groups

Chapter 6. Kalasin: fragmented power and struggles between professional interest groups

6.1 Introduction

This is the second chapter concerned with the different approaches to implementation of the UC reforms in the three case study provinces. The chapter will consider Kalasin province and the influences and conditions that affected the approach taken there. It will describe the network of key actors and the more fragmented distribution of power that emerged, as well as the ongoing tensions and conflicts that occurred between professional interest groups. These conflicts led to a significant change in the budget allocation process in the third year of implementation, which are a key aspect of the reform 'story' in this province. As in Chapter 5, this chapter will consider several areas where key actors had decision space to adapt the reforms to local conditions, including determining the financing model that would apply, managing the allocation of funding and human resources (i.e. the health service workforce), and correcting emergent problems.

The main themes found in this case study were fragmentation of power and professional struggle. This was bound up with the relatively weak lead given by senior PHO officers (which was the result of a combination of factors, including personalities, impending retirements and staff mobility), the less-dominant position of senior staff at the provincial hospital, the greater influence of middle-ranking policy actors in the PHO and the community hospitals, and the trenchant rearguard action fought by a group of experienced DHO Heads to retain some influence over the course of the reforms. This led to an important change in financing arrangements in Year 3, after the DHO Heads had gained support from the Health Region Inspector and the CMO to correct problems associated with the under-funding of PCUs/health centres.

6.2 Implementing the UC reforms in Kalasin

6.2.1 Actors, networks and power

In Kalasin senior PHO staff faced the same early problem described in Chapter 5 of creating a working set of operational structures based on the incomplete reform template coming from the centre. However, in Kalasin a variety of factors came together to throw the burden of decision-making on the CMO, the deputy CMO (Medical Services) and a small number of relatively junior actors in the PHO. This was largely because other senior staff were not in a position to act energetically to support the reforms. The Deputy CMO (Public Health) was due to retire in late 2001, while the Deputy CMO (Administration) was due to retire in 2003 and appears to have been perceived as someone whose career was winding down. This opened the way for more junior staff, notably the new Head of the Health Insurance Division, to play a more influential role. Within a few months, the Deputy CMO (Public Health) had retired and was replaced by an 'acting Deputy', in the shape of a relatively junior officer who had been Head of Health Promotion in the old organisational structure. As will be seen this relative lack of depth in the senior management of the PHO led to a situation where outsiders were given influential roles in the various committees and working groups that were set up to take the reforms forward.

In Mahasarakham one of the most powerful external actors in the early period of implementation was the head of the provincial hospital, but for various reasons the pattern was different in Kalasin. Here the doctor director of the Provincial Hospital (DDPH) lacked the same degree of influence with the MoPH and the Health Region, and took a less proactive role in local health circles. There were internal problems in the hospital both in terms of managing a reduced budget and handling conflict about the reforms within the medical staff group, which distracted the DDPH from working effectively in outside forums. Later as implementation went ahead there were more management problems concerned with the large volume of patient complaints and adverse coverage in national newspapers.²³ With the relative lack of power in the provincial hospital, the senior doctor directors from community hospitals emerged as the most influential medical professionals in Kalasin province. Two who were to have important roles on key decision making

²³ Within two years the DDPH had moved to a similar post in another province.

bodies were respectively a nationally-prominent member of Rural Doctors Society, and the senior (i.e. longest serving) doctor director of a community hospital in the province.

As in Mahasarakham, the first task was to create the basic structures dictated by the MoPH - the Health Insurance Office (HIO), the five key operational groups of the PHO, a provincial war room, a PCIHI, and a Provincial Committee for Quality and Standards (PCQS). Shortly after these had been established, a provincial IPD fund (i.e. a centrally held budget for inpatient department work) and the CUPs were put in place. The relative lack of 'seniority' at the top of the PHO was again apparent in the leadership of the five operational groups. The two groups most closely involved in implementing the reforms, the Health Insurance Group and the Health Strategy Development Group were headed by staff recently promoted from middle-ranking positions. The Head of Health Insurance Group was a woman who had previously worked as a planning officer, but who now emerged as a key actor in shaping local reform implementation.

Another important difference between Mahasarakham and Kalasin concerned the respective roles of the war room and the PCIHI. Kalasin, like Mahasarakham had opted to set up a PCIHI from scratch. All three case study provinces were in the third wave entering the UC Scheme on October 2001, at a time when the regulations regarding the establishment of PCIHIs were under review. In Kalasin an AHB had not yet been established and senior officers found the options of basing a PCIHI on the Health Card Administration Committee unattractive. The Health Card Committee was a small group within the PHO which did not include the key external actors with whom the CMO was seeking to engage. However, whereas in Mahasarakham the most influential PHO outsiders were recruited to the PCIHI and the PHO insiders dominated the war room, in Kalasin key outsiders were admitted to both bodies. It was the war room that did the initial background work required to support decisions, and which prepared the ground for resolutions passed by the PCIHI.

Regarding the budget arrangement, we set up a committee called the Provincial Committee for Implementing Health Insurance - PCIHI - which acted as the top committee at the provincial level. However, at the beginning we had a small committee called 'the war-room', where we prepared and analysed various things in a meeting very week on Wednesdays. Then the resolutions would go to the PCIHI meetings for decision. (SAO-PHO, KS 04)

In Kalasin the war room included the CMO, the deputy CMO (Medical Services), the Heads of the 5 Groups, a representative of the provincial hospital, two representatives from community hospitals, two DHO Heads representatives, and one representative of the health centres. The Head of the Health Insurance Group acted as secretary to the war room committee. One senior member suggested that the members were selected on the basis of their expected contribution rather than their seniority.

We selected people who were forward-thinking and were not afraid to speak out. The war-room meetings looked like an informal meeting which analysed problems before they went to the PSIHI meeting. Because at the beginning there were so many problems that we usually worked until 1 a.m. or 2 a.m. everyday. (SAO-PHO, KS 04)

In the first year all the members of the war room also held posts on the PCIHI, where they were joined by some additional external actors, comprising representatives of the municipality and the sub-district administrative organisation (ABT - *pronounced in Thai as Aor-bor-tor*), a representative of the private hospital and four representatives of the general public. This substantial over-lap between the war room and the higher level committee meant that war room recommendations were generally accepted without significant change, and that in reality it was the informal committee that shaped major policy decisions. The problem was not so much over-coming opposition from interest groups not already represented in the war room, but of dealing with the lack of knowledge of the local government and public representatives on the PCIHI.

I would say it was not difficult work but about preparing papers for the PCIHI meeting for decisions. It required us to assemble a lot of data and documents that tired us out. They were outsiders who didn't have a good understanding of how we work, and it was hard work to try to make them understand. (SAO-PHO, KS 04)

In Kalasin there was nothing resembling the situation in Mahasarakham where a key recommendation about the preferred resource allocation mechanism in Year 2 was overturned by the PCIHI.

The war room liaised regularly with the Health Insurance Group. This was singled out in some senior officers' accounts as one of the key entities driving the reforms, though it was secondary to the war room in determining local policies.

When the new policies came in, we organised and assigned a team to take direct responsibility for the policies. The CMO had set up a new department to oversee policy implementation before the present reorganisation of the PHO. We selected high quality staff because the new policies came along quickly and there were a lot of things to do. At the beginning we were usually working until one or two a.m. (SAO-PHO, KS 04)

One SAO-PHO characterised the work of the section as: 'To support the Bt 30 policies in particular'.

Any activities that began or ended with '30 baht' were sent here. We acted as the secretarial office for the Bt 30 policy activities. Actually, the Bt 30 scheme affected all departments but at the beginning things were not clear: the CMO gave us the role of analysing things and organising cooperation with other departments before changes were implemented. However, these things must be passed to us first. (SAO-PHO, KS 04)

The precise division of labour between the Health Insurance Group and the war room was not fixed, and there were times when the latter drove particular initiatives. However, the general pattern was that the war room set the framework for action, in the form of recommendations to the PCIHI, and the Health Insurance Group supplied background information and looked at systems for operationalising what had been agreed. Generally the activities of the Health Insurance Group were concerned with the details of policy implementation and fine tuning the procedures and technologies that would be used.

We have been busy setting up an electronics and IT system, because with UC working the IT application in particular is one of the main tools in our office, so we needed to understand about health claims and payments via an electronic system called the 'E-claims' system, which we must use to 'deal' (in English) with the NSHO. One duty of the Health Insurance Group was managing claims from the hospitals, where we handled requests and payments based on the electronic system, which meant that when the hospital requested payment from the NSHO via the electronic system then the NHSO would send it back to us again (SAO-PHO focus group KS)

At the beginning, the main work was about registering people and setting the regulations. With regard to registering people, the population of the province was around 900,000 and we needed to register around 700,000-800,000. So we were busy both with the registration process and giving gold cards to people. The government gave us around 3-4 months for preparing both: checking the household census data and setting up a register for giving out the gold cards. (SAO-PHO, KS 04)

In Year 2, after the war room was dissolved in line with national guidance, more onus fell on the Health Insurance Group to liaise with the PCIHI. However, informants suggested that this arrangement left something of a vacuum in terms of policy preparation for the PCIHI. To try to address this problem a new committee, the Planning and Evaluation Committee, was established in Year 3²⁴.

While the CMO in Kalasin exercised a leadership role, this left a place for delegation and allowing lower-level actors some voice in determining the way the reforms were implemented. This was linked to the view that, if the reforms were to succeed, outside actors would need to be given a central role in determining local policies, and a conviction that in particular the doctor directors of the community hospitals would be important actors in engineering change. Partly because of the lead that the CMO had set and partly because of the limited capacity of senior PHO officers, the Doctor Directors of the Community Hospitals became powerful players in the reform process. This was reflected in their representation on key committees, and also their strategic position vis-à-vis the flow of monies.

A lot of power was decentralised to the doctor directors of hospitals. The previous power of the CMO has dispersed to the doctor directors of community hospitals, while the PHO function was to supervise the provincial budget and cooperate as a member of various committees. Previously, the PHO had the role of managing the entire health care resources of the province. In the past they had been the most powerful organisation. Now, this is changing so that increasingly outsiders have come in to participate on the various committees. (SAO-PHO, KS 03)

Most doctor directors took the role of chair of their local CUP, the body through which most money was dispersed to service units. The change to capitation-based budgets under the UC reforms and the rise in the power of the doctor directors weakened the power of the PHO and changed its relationship with the hospitals.

It seems that 'the power follows the money' and when the budget changed hands and went to the hospitals and the power passed into the hands of the hospitals too. This might be the Thai organisational culture where the power follows the money. (SAO- PHO, KS 05)

The PHO was no longer a supervising organisation at a higher point in the command and control hierarchy than the DHOs, hospitals and health centres, but a body concerned with

²⁴ Re-establishing a committee from the old structure of the PHO

monitoring and evaluating units that it did not control. This change was greater in Kalasin than the other case studies because PHO officers fought a less effective rearguard action to maintain authority.

At the beginning the effect was to change the PHO organisational structure. The terms of the PHO functions changed. The period of 'implementation' has gone and now we have only 'monitoring' and 'evaluation', which are the PHO's functions in the transformation period. There were many aspects of the ministry policies then that we pushed to the CUP for implementation but things did not lead to concrete results. This problem came from the CUP: they couldn't respond well because they weren't familiar with the new style of working. They were still used to working under the command of the PHO, in line with the previous work system where the PHO acted as the main body that passed down the central policies for local implementation and then instructed the district to take action. This was obviously affected by the reforms. (SAO-PHO, KS 07)

This had knock-on consequences for morale within the organisation.

Someone who had been the head of department (in the PHO) might be affected by this, because they wouldn't be head of department any longer. That made them 'suffer' [in English]. And this affected work morale. (SAO-PHO, KS 07)

The reforms affected the morale of PHO staff. It is true to say that there is a good deal of uncertainty about whether the PHO will still remain, or who will come to control the PHO, which it is not clear. (SAO-PHO, KS 07)

These difficulties within the PHO, and the combination of low morale and loss of staff in senior positions helps to account for other problems that will be considered below, such as lack of direction in the DHOs, an imbalance of funding between the community hospitals and health centres, and inadequate support for community-based health activities.

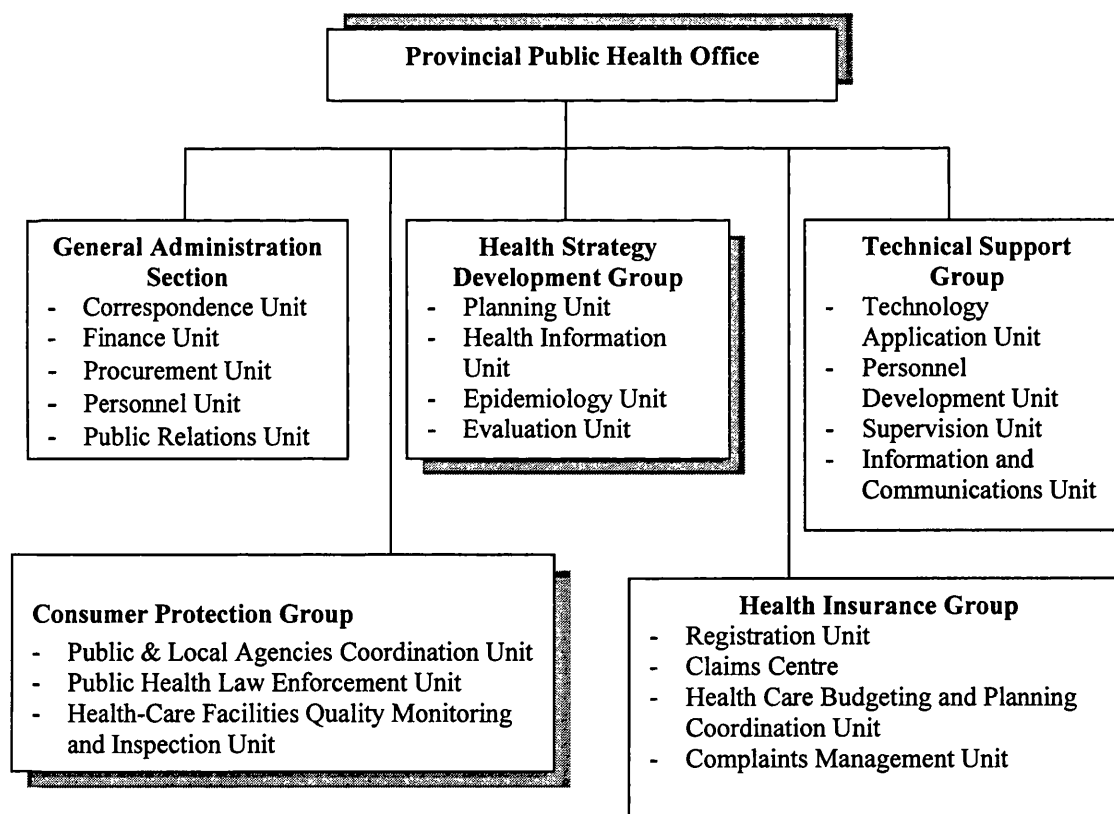
6.2.2 Recent changes in organisational structure

In the early 1990s the organisational structure of Kalasin PHO included ten organisational divisions, similar to the 10 departments in Mahasarakham.²⁵ As in the latter, an Accident Control and Non-communicable Disease Section was set up around 1995, as an unofficial

²⁵ As in Mahasarakham these were: (1) the Administration Department, (2) Planning Department, (3) Human Resource and Primary Health Care Development Department, (4) Community Pharmacy Department, (5) Dental Health Department, (6) Health Promotion and Health Care Department, (7) Communicable Disease Control Department, (8) AIDS Control and Prevention Department, (9) Sanitation and Environmental Health Department, and (10) Health Education and Public Relations Department.

department or section in the PHO.²⁶ After 1997 the trend towards bureaucratic reforms, decentralisation and the possible transfer of functions to local government, led to some changes in the tasks undertaken by departments. During this period certain health functions, such as operational aspects of communicable disease control, were transferred to the municipalities, the sub-district administrative organisation (ABT), and the provincial administrative organisation (ABJ- *pronounced in Thai as aor-bor-jor*). With the launch of the UC reforms in 2001, there was a period of rationalisation which culminated in a reduction to five groups in PHOs across the nation (see figure 6.1). Thus the change in organisational structure in Kalasin is similar to that described for Mahasarakham in the previous chapter.

Figure 6.1: The new organisation and management structure of the Kalasin provincial health office, 2002- the present



Adapted from: Ministry of Public Health: A New Mandate and Structure (MoPH 2002b)

²⁶ In mid-2001 as the government rolled out the 30 baht scheme across the country and pressed PHOs to prepare, a Health Insurance section was established unofficially in the PHO. Thus several respondents reported that the PHO organisational structure of the PHO comprised 11 or 12 departments

The main difference in the implementation of the new structures in these two provinces concerned the extent of preparation for change, and the lead from the top about how it should be phased. Where Mahasarakham's strategy had elements of 'think and then do', Kalasin's approach never moved beyond 'do and then think'. While the Mahasarakham PHO had been selected to complete a pilot project on approaches to organisational change and perceived itself as a research-led organisation, Kalasin took the more reactive approach of a bureaucratic organisation which first responded to commands and 'thought' only reactively when gaps in the reform template became apparent. In the absence of extensive preparation Kalasin had to make rapid plans about how to downsize to five groups from a high staff base. The CMO's approach was not to undertake any extensive planning exercise but to delegate the task of forming the five new groups to the PHO staff.

We let the heads of the 12 departments talk together about reducing from 12 to 5, and in the monthly meetings the CMO had informed us many times about the reforms and was sure it would happen. He had a good 'technique' (in English) which involved getting them to complete a form to apply to the group they wanted to join. Things settled down automatically. I don't quite know how this happened. In my case I got the post here that I wanted: nobody else choose it because they thought it would be hard work. (SAO-PHO, KS 04)

The reorganisation depended on staff preferences and some negotiation rather than any overall plan. This led to various teething problems and ongoing adjustments.

In Kalasin, after the reform policies were announced, the CMO allowed staff to join the new departments as they preferred. That caused chaos at the time because when they moved from the old department and faced problems in the new department, they couldn't come back. And furthermore the CMO found many of the problems hard to solve, so that problems accumulated. (SAO-PHO, KS 06)

Kalasin has started from a higher base in terms of size than the other two case study provinces, and had over 150 PHO staff at the beginning of 2001. This number was progressively lowered in a series of cuts and staff reallocations.

The PHO organisational structure has changed from 11 departments to 5 groups. Previously, we had about 150 to 170 staff in the PHO but then we had to reduce this to 88 persons. That affected our work morale, and those who had to be moved out did so with reluctance. (SAO-PHO, KS 07)

This downsizing seems to have had more impact than in the neighbouring provinces both because of higher baseline workforce and also because it coincided with the loss of experienced staff. As expected, the Deputy CMO (Public Health) retired a few months into 2001 and soon afterwards the deputy CMO (Medical Services) left to take up a CMO post in another province. This deputy post was frozen with no replacement recruited, and this further weakened the capacity of the senior administration tier of the PHO. There was also a loss of competent staff because some officers who had been seconded from lower level posts within the province now had to return to the hospitals and health centres.

Maharakham had prepared for the reforms by organising workshops and training, and placing experienced staff in key posts, but this does not seem to have happened to the same extent in Kalasin. Nor was there a local policy drive towards innovative projects such as civil society involvement or decentralisation, or co-operative projects with NGOs or a local university. One of the biggest problems seems to have been a lack of local capacity to take advantage of the decision space that suddenly opened up when the Ministry of Public Health decided to allow provinces to determine the details of local implementation.

Several senior respondents highlighted this problem of adjusting to a new system in which organisations needed to 'think for themselves', rather than following orders in a command and control system

I don't like to attach blame to the Ministry for the lack of preparation. On the contrary, I thought that they gave us the power to think out what to do by ourselves. They gave us only 'key words' (in English). We couldn't wait for the guidelines about step one, two and three - we didn't have enough time. For people who like to 'create' [in English] it was good. But, if one was waiting for a command, one wouldn't have liked it done like this. (SAO-PHO, KS 04)

The PHO had become familiar with programs and projects which involved top-down [in English] command from the centre, including the details of budget allocation. (...) When the new budgeting system came in, our staff had not prepared adequately to support to district sector. It seemed that there was a lack of knowledge, and this looked like 'do and learn together'. Furthermore, the implementation processes was unclear and we almost started to learn the principles of economics again because previously we weren't familiar with profit and loss, so we needed to take the first steps. There was a few staff who could understand but also some who carried on working in the old style. (...) There were many affects because the PHO was transforming its organisation, which meant that we didn't adequately supervise the districts and that made them rely on themselves for about 6 or 7 months in year one. In the first year that led to a failure to deploy the policies as expected, especially the budgeting arrangement,

where the regional and provincial approach was to use a top-down model. So there was a similar pattern across the entire region which was not responsive to the problems in each local area, as had been anticipated. (SAO-PHO, KS 05)

The 'regional' and provincial approach' mentioned in this quote refers to the allocation of certain non-UC monies from the centre.

The work of the five new groups was not necessarily very different from the work of the previous departments, though the pressure of work increased following the reforms and many previous 'specialists' had to take on responsibility for a wider range of tasks.

It has changed in that previously we were each responsible for a particular task but now we must take responsibility for a variety of tasks. However, sometimes these seem to be fragmented activities which don't integrate together. This may be because the previous system of work should have changed but actually did not change. There were many top down projects from the central government departments, at the Ministry level, where direct commands were issued to the PHO. Actually work at the ministry level is still not well integrated and this then affects the provincial level so that only the language changes. (SAO-PHO, KS 05)

We needed to start learning anew with this work, which is quite a difficult job because there were 20-30 tasks coming in each day and we needed to have coordination with both the lower and higher organisations. Sometimes the commands from the centre came in quickly with a request for an urgent answer, For example, they might need our staff to go to a meeting or training course that required of us to select suitable staff and prepare all the documents to support expenses. (SAO-PHO, KS 06)

6.3 How the financing framework was adapted to local conditions

6.3.1. Adapting to the new financial framework

In general the Kalasin PHO was less creative than its neighbours in adapting to the new financial framework so as to retain some control over the flow of money. Mahasarakham, which opted for inclusive funding model, used the provincial Clearing House to establish effective control over the bulk of the IP monies and limit CUP influence on how money was spent, but Kalasin, although opting for 'exclusive' funding, gave more power to the CUPs/community hospitals to use their devolved budgets as they wished. This comparatively 'passive' approach to managing the roll-out of the new funding

arrangements and disbursing money to the CUPs is captured in the following extract from an interview with a senior administrator.

Now, we have no right to touch the UC budget. Actually, the budget comes to the PHO but within 15 days we must allocate it to the CUP. So, the budget management isn't part of the PHO's duties. Anything concerning buying anything or employing any person comes under the responsibility of the CUP. (SAO-PHO, KS 07)

This contrasts with the relatively interventionist stance taken by the Mahasarakham PHO in relation to health plans and the purchase of medicines.

6.3.2 Choosing a budget allocation model

Kalasin choose an 'exclusive' budget model for allocating resources to public facilities, which involved holding the budget for in-patient services – the 'IP budget' - at the PHO. It also opted to hold a staff salary budget at the PHO. As elsewhere the decision about using inclusive or exclusive funding was a difficult one, and was bound up with discussion of the funds that would be available to allocate to different types of service units, in different geographical areas, under the two models

The most difficult problem was the budget allocation policies whereby the MoPH gave us only a range of methods. We had to discuss this in the PCIHI to make decisions about the budget allocation. For example, with the first CUP before making the allocation we needed to decide how much to deduct for the health centres' fix costs expenses, such as water and electricity bills or the staff allowances etcetera. After that we would go on to the second CUP and so on. Later the central policies required us to use the exclusive method: that was 30% for the IP payment used with the DRG model. The other 70% went partly for the OP and the P&P payments, which were difficult to divide. We had to allocate the P&P payments directly to the health centres and the community hospitals. In this province with regard to the 70% part, we divided 50% for the OP payment and 20% for the P&P payment. At the beginning the Ministry gave us authority to choose between exclusive and inclusive budget models. We chose the exclusive model from the beginning and this year the Ministry issued an order to use exclusive only. (SAO-PHO, KS 04)

Respondents reported that the issue was discussed in a series of meetings and there was much lobbying of directors of community hospitals by the CMO and the Head of the Health Insurance Group, who put forward arguments on the lines of 'we must all survive', and used the Thai cultural rhetoric of '*pee and nong*' (the obligation of older family

members to support younger ones) to try to encourage stronger organisations in the province to recognise the needs of weaker ones.

Given the power of the doctor directors it may seem strange that Kalasin choose an exclusive model from the beginning, rather than an inclusive or mixed model, because the former had the potential to weaken the position of the CUP and community hospital. At face value Kalasin opted for central control, when compared with Mahasarakham's more decentralised funding approach. One possible explanation for this difference is the lower degree of concern in Kalasin with issues of civil society involvement and the need to support the drive to decentralisation, which in Mahasarakham may have led to a need to pay lip service to devolved budgets. However, another explanation is that the doctor directors of community hospitals in Kalasin knew they had a strong voice in the central decision making committees, including the war room, and had few concerns that budgets held by the PHO would be used to draw money away from their hospitals. As we shall see in a later section, the division of monies between the IP, OP and P&P budgets was done in such a way as to favour the CUP and the hospitals. These last two factors may have led some the DDCHs to conclude that the difference between an inclusive and exclusive model would not be very great. In fact the community hospitals were granted considerable flexibility to use OP and P&P monies as they wished. Actually none of the DDCHs interviewed in the study expressed criticism of the exclusive model and some gave surprisingly positive assessments. They presented it as a necessary safeguard for the provincial hospital, which was a key part of the local health system, on which their own hospitals depended.

In Kalasin we applied an 'exclusive model' from the first year to now. Really, I preferred the 'inclusive model' but I couldn't push this point because in my district we have largest population in this province. However, when we used the 'exclusive model', I was pleased and had no problem.' (DDCH, KS 12)

There was enough sympathy from this group that the Head of the Health Insurance Group was also able to gain agreement from the hospital directors to create an additional contingency fund of 5% of the budget to support hospitals in trouble. There appears to been a degree of pragmatism in the decision in that 'exclusive' funding was seen to be the safest option given the uncertain impact on the local health care system if budgets were fully devolved. Thus, the following DDCH respondent points out that the inclusive model

would have been more in keeping with the spirit of reforms, but accepts that this would have carried risks.

We applied the 'exclusive model' in this province, which involved holding part of the budget at the provincial level then applying data-based reporting using the DRG mechanism to re-allocate money, while deducting a part to fund referrals outside the province. We deducted the salary cost at the province. Based on the principle of the policy we should really have used an 'inclusive model' with the salary costs funded at the CUP as well. Because the implications of the policy were not clear we funded the staff salary costs at the province. (DDCH, KS 14)

One point worth noting, in terms of the comparison with Mahasarakham, is that Kalasin had one private provider operating within the UC scheme, and thus applied a split policy where the exclusive model applied to the state sector and an inclusive model applied to this provider (Focus Group KS).

6.3.3 Safeguarding the service units

In Kalasin the choice of the exclusive model and a central salary budget was once again dictated by a perceived need to safeguard the health service units. The central 'IPD fund' was seen as a mechanism to secure the viability of the provincial hospital and small community hospitals. The quotations below highlight the financial problem in the provincial hospital and smaller district hospitals. As elsewhere, the problem for the provincial hospital was that capitation funding reduced its budget.

The clear effect was on the budget: the hospital income was decreased. Previously, the hospital was received the budget from the ministry: including through the Low Income Medical Welfare Scheme and the Health Card Scheme. When the new policies came in, our monies only came from the Bt 30 project, which resulted in a reduction in our total income. (Senoir Doctor PH, KS 09)

Regarding the provincial hospital, if they received only the capitation budget they would not survive. However, we have supporting measures such as the IPD fund which we set up at the PHO for referral payments, when the community hospitals refer patients to the provincial hospital. And they must pay via this fund or in case of the patient jumping over the referrals system they will request fee for service or claim with the hospital where they have registered. The provincial hospital could survive in this way. (DHO Head, KS 20)

If we funded the salary costs at the CUP, the provincial hospital wouldn't have survived because they had responsibility for care at all levels such as: primary care, secondary care and tertiary care. (SAO-PHO, KS 06)

The other vulnerable players were again community hospitals in small districts, whose allocation would then be based on a small population. In some cases the administrative location of the hospital did not coincide with its natural catchment area, and there was some possibility of receiving transfer payments from adjoining CUPs, but there was still often slippage in these payments. Consequently hospitals in this position faced a situation where funding was insufficient to cover operating costs:

The budget, when we looked at the numbers, was a small increase, but we had big expenses, about twice the previous expenses. With the old budget that we got under the previous system, we never worried about financial management but we survived. Nowadays, we economise and strictly control expenditure. We can't get careless because it may take our account into the red. Additionally, the previous budget was allocated on time, based on the size of the hospital. For example, we are a 30 bedded hospital so we would receive a similar budget to others of that size. Now, with the UC budget based on population, this results in different budgets even where we are a similar size. For example, we serve 20,000 people in our district, while Somdej serve 50,000. We have similar numbers of patients visiting the hospital. However, we receive a quite different budget. Furthermore, in a small district, such as Rongkham hospital which serves about 10,000 people, how will they survive? (DDCH, KS 17)

Compared with Mahasarakham, concern focused more on the provincial hospital because this was a larger unit with more staff and beds than its counterpart.²⁷ The Kalasin provincial hospital had relative high fixed costs, including staff salary budget and operational expenses. These high costs in combination with a limited district catchment area caused a major problem, because capitation-based funding would only give the provincial hospital a similar budget to some community hospitals in large districts.

The provincial hospital served similar numbers of people as some districts but they received the budget at the same rate. For example, Kalasin hospital served a population of around 100,000 while Yang Talad hospital served about 80,000, which resulted in a similar budget. However, the fixed costs of Kalasin hospital were higher than the others. One way to deal with this was to re-allocate staff to outside facilities and decrease their primary care role. But they had to set up a PCU, which limited their ability to re-deploy staff outside. (DDCH, KS 18)

This funding took no account of the significant greater tertiary care capacity in Kalasin hospital, and the greater complexity of case mix as compared with community hospitals.

²⁷ Kalasin hospital had around 330 professional staff (36 doctors, 7 dentists, 11 pharmacists and 276 nurses) and 505 Beds, while Mahasarakham hospital had about 235 (39 doctors, 8 dentists, 22 pharmacists and 166 nurses) and 480 Beds.

The fact that Kalasin was a tertiary care centre made this hospital an important component of the local health care system and a destination for a large proportion of referrals coming from community hospitals. This was mentioned by one of the key DDCHs from the war room, who were willing to support the 'exclusive' model on the basis that it would protect a hospital to which he referred many of his patients.

I agreed that it is still necessary for us to apply an 'exclusive model' - that means keeping funding at the provincial level to support large hospitals, such as Kalasin hospital, because they are the only unit that provides specialist care in the province. If they do not survive my hospital might be closed. (DDCH, KS 13)

There were only two community hospitals in very small districts who were serious capitation losers, and thus this aspect of the problem was less serious than elsewhere.

6.3.4 Referrals and the Clearing House

In Kalasin, the key policy actors in the war room initially planned to implement the 'exclusive' model through a 'provincial IPD fund' (i.e. in-patient department fund), rather than a provincial clearing house. This was one of a few important issues where outsiders – in this case, all the directors of community hospitals – were invited to join the regular group for a special discussion. The term 'IPD fund' was a reference to the fact that the source of funding was the IP component of the capitation payment. However, as the reforms evolved and staff became aware of developments elsewhere, the language changed so that the term 'clearing house' was also used. In practice, the Kalasin system was administered by the Health Insurance Group and comprised similar activities to those undertaken by the Mahasarakham clearing house.

The rationale for the IPD fund was to remove the incentive for lower level units to delay referrals and retain patients, because it enabled referrals to be reimbursed direct from the PHO, so that no transfer payment from the referring unit to the receiving hospital was involved. Community hospitals made no payments for referrals but were allocated a proportion of the IP fund direct for their own inpatient work. This meant that 80% of the IP budget went into the provincial IPD fund for referrals, both inside and outside province, and 20% went direct to the community hospitals.

Out-of-province referrals emerged as a particular problem in Kalasin province, partly because public concern about the quality of care in Kalasin hospital led many patients to demand treatment in other tertiary centres. Complaints from patients and relatives about poor treatment in the provincial hospital were reported at regular intervals in national newspapers, which encouraged this trend. Another factor was that senior PHO staff were concerned about the prices charged for these referrals, which were seen as inflated.

I think referral payments were a problem. Regarding outside-of-province referrals they charged us very expensive prices and we needed to pay them as they requested. As we've seen, the provincial hospital director has made many complaints such as in the case of referrals to Khon Kaen (regional) hospital or Srinakharinthara (University) hospital, where they charged us at full prices. While, with regard to within-province referral payments we have tried to limit the charges. Sometimes they have agreed with each other that they will not pay. (SAO-PHO, KS 03)

Kalasin referred to the same regional hospitals as Mahasarakham and suffered in the same way from the high relative weights (RWs)²⁸ attached by the two main Khon Kaen hospitals to the basic DRG prices.

I think we must consider each hospital. In some cases where the hospital is popular with the people they demand to register there. For example, with Khon Kaen hospital I thought they could carry on albeit with difficulty, by which I mean that they must claim in full and try to get as much as they can. (...) I would criticize the university hospital, which at the beginning said 'no' to joining this scheme. Now, they don't say anything, because with regard to the DRG system they got 1RW costed at 16,000 baht so that our Provincial IPD fund is beginning to get concerned, because if we pay 1RW at 16,000 baht many time we will not survive. Furthermore, the regional hospitals, such as Khon Kaen hospital, get 1RW costed at 14,000 baht. That tires us out because a lot of money is taken out. In this situation I am absolutely sure that Kalasin hospital was affected because this amount was pulled out, impacting on the referral system and perhaps forcing them to delay referrals. I thought the financial situation of Kalasin hospital was not good: they could survive but they are overburdened. At present, they can carry on because they are using money they have saved. When they use up all their money, they will increasingly pass on the costs to the community hospitals. (SAO-PHO, KS 01)

The regional hospital and the university hospital taken together accounted for about 75% of Kalasin's out-of-province referral payments in 2002-03. The high expenditure on distant referrals continued to be a problem through the reform implementation period, and

²⁸ RW- Relative weight, as used in the diagnosis related group system, is an important signal to the hospital about how much it will get from the insurer for providing care to the beneficiary.

led to a policy decision in Year 3 to top-slice money to create an out-of-province referral fund, before the subsequent channelling of remaining monies into the IP, OP and P & P budgets.

A number of difficulties emerged in the first year of the reforms in the development of the DRG payments system. The diagnosis-related groups (DRGs) in the Thai system are applied in a slightly different way to the original model, developed by a national advisory group, so that the DRGs categories are used in combination with agreed clinical treatment standards to determine costs. This provides a way of linking the costs of standard treatment plans to disease groups. However, DRGs did not include sufficient detail to capture the costs of different hospitals, and the data sets on which costings were based were often inaccurate. The relative weights (RWs) were fixed at the centre and in the view of many professionals did not properly capture the relative costs of treatments across different specialities in the hospitals concerned

Basically, a RW should be based on the same rate for both the same disease and the same care in every hospital. But in fact it didn't attract the same rate because there were different management costs in each hospital, and the DRGs didn't contain enough detail to identify different hospitals. (...). So, the DRGs perhaps could not include these differences and leave a gap which it easily 'abused' (English). We have to develop the DRG system to be much more accurate and reliable. Regarding fixing the '1RW' rate in the university hospital at 16,000 baht, the regional hospital as 14,000 baht, the provincial hospital as 12,000 baht and the community hospital as 10,000 baht, I would say these are very different rates, which came from the centre. If we considered them in more detail we would see a lot of inconsistencies. (DDCH, KS 13)

As with Mahasarakham, one important area where local actors had decision making power was in fixing the breakdown between IP, OP and P&P. In year 1, while P&P was set at about the same rate as the neighbouring province, a rather higher percentage of funds went to OP and lower percentage to IP. The split in Kalasin was 25% IP; 60% OP and P&P; 15%, meaning that about 5% more of budgets went to OP than in Sarakham. Though there is no direct evidence on this point, this may reflect the powerful position of DDCHs in the war room and PCIHI, and their ability to ensure that a good proportion of UC funds went to the CUPs, which they controlled. In years 2 and 3, as the approach of the DDCH in channelling the bulk of funds to the community hospitals was challenged, the balance between IP and OP returned to similar division to that in Sarakham.

As well as holding an IPD fund at the PHO, the war room decided to create a contingency budget to support activities not covered by the expanded UC budget – the budget for clinical care. The background to this was that the main administrative and general support budgets for organisations like the PHO and the DHOs had been drastically reduced to channel money into the 30 baht project. However, war room staff were able to get agreement from the CUPs and hospitals to top-slice a small proportion of the capitation-based budgets for a fund to support general activities.

Previously, the budget was combined together and we could switch between headings. Now, we can't do this because it is clearly divided between the UC and non-UC budgets. However, in practice we can change some things, because in the transitional period many things aren't a hundred per cent certain and that's the reason why our organisation can carry on. So, we asked the CUPs and hospitals to allow money to stay at the province for use as what we called a 'buffer' (English) or various other terms. With regard to the non-UC sector, the budget was much decreased but activity didn't decrease correspondingly. That was a necessity especially at the provincial administrative level where we must follow many top-down policies so that when the budget comes to the province we must re-allocate it again. (SAO-PHO, KS 01)

Sometimes these monies went to support MoPH schemes, such as the 14 areas for special 'focus', which were pushed hard from the centre but without adequate budgets attached. In Year 3 the province maintained the contingency fund but also set up an additional 'Health Development Fund' to deal with this problem.

6.3.5 Summary of financial changes in Kalasin in FY 2001-02, 2002-03 and 2003-04

In summary, during Year 1, Kalasin selected an 'exclusive model', so that it held an IPD fund and a fund for staff salary costs at the provincial level. The PCIHI/PHO also gained agreement to hold a contingency fund (CF Fund) of 5% of the UC budget to support under-funded hospitals, which in the event assisted the provincial hospital and the smallest community hospital, but remained partially unspent. The remaining UC budget was divided so that 25% went to the IP budget, 60% to the OP budget and 15% to the P&P budget. Regarding the IP budget, 80% went to the 'IPD fund' at the province, managed by the Health Insurance Group to provide for in-province and out-of-province referral payments; while 20% went to the CUPs for community hospital inpatient work. The OPD and P&P budgets were directly allocated to the CUPs, with the condition that the CUPs

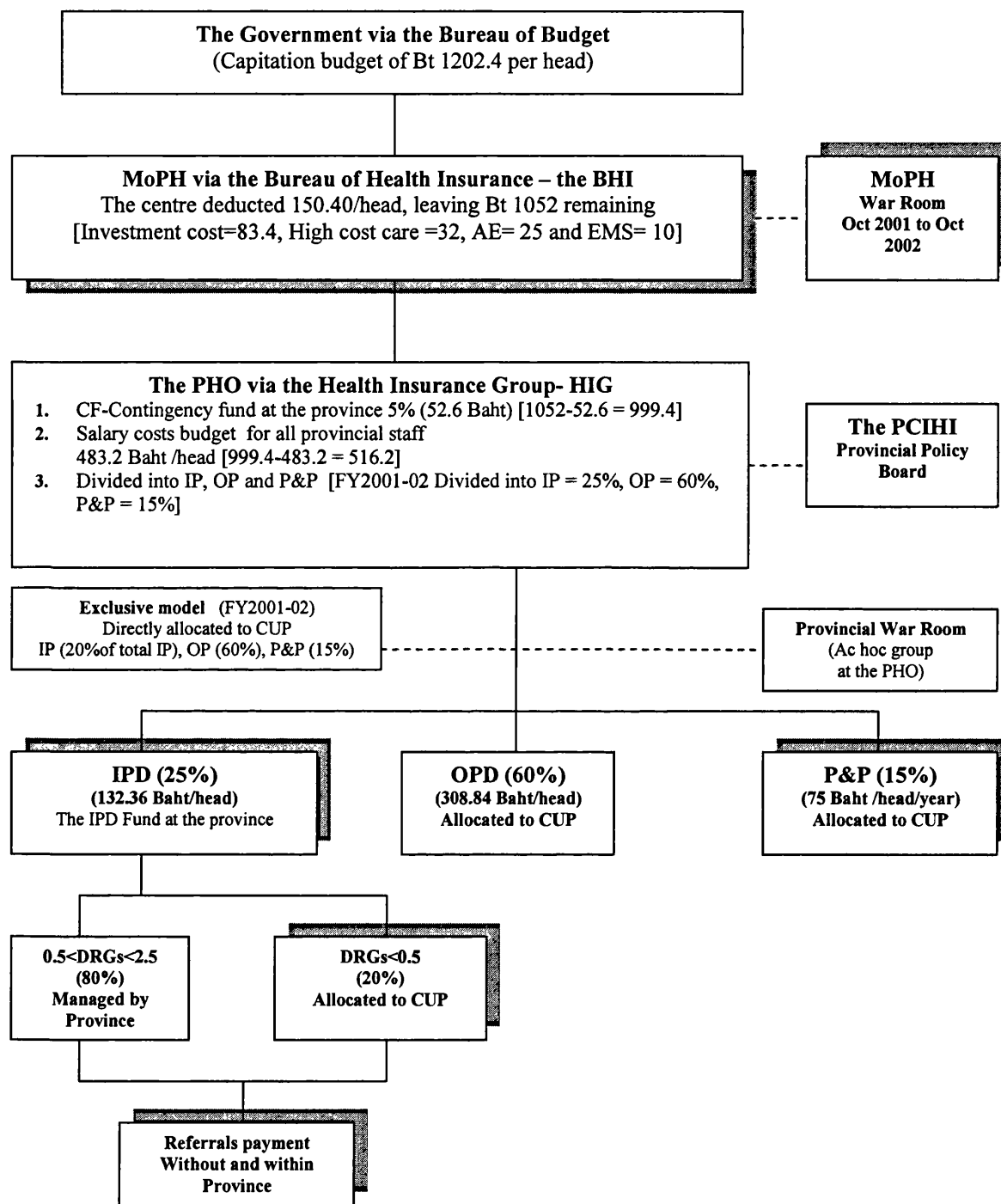
must support PCUs and health centres in their own district in health promotion and health prevention activities.

Overall it can be seen that Kalasin's 'exclusive' model had only limited differences from Mahasarakham's 'mixed' model, in that both split the IP budget between the province and the CUPs. However, Kalasin released only 20% for community hospital inpatient work with no element for referrals, compared to Mahasarakham's 40% which included an element for onward referrals.²⁹ Both had a contingency fund to support the hospitals, and both allocated a similar percentage of the total budget to the CUP for P&P.

The main funding flows and relationships are represented in the following figure.

²⁹ Referrals with a relative weight of less than 0.5, which was the band allocated directly to CUPs, all involve work carried out in the community hospitals.

Figure 6.2: Financing arrangements and relationships between organisational divisions in Kalasin in Year 1 (FY 2001-02)



Adapted from: Kalasin PHO report 2001-02 (Kalasin PHO 2002)

In Financial Year 2 a national policy was established that salary costs would be held and funded at the Ministry level and that all provinces should utilise the ‘exclusive model’.

However the PCIHI/PHO retained some scope to make local adjustments. They agreed to reduce the 'CF fund' from 5% to 1.25% of the total provincial budget. But they re-allocated this money by creating an earmarked budget to support the utility costs of the health centres and a budget for vaccination and medical equipment. In 2002-03 the split between budget divisions was OP = 5%, IP = 28% and P&P = 17%. The IP budget was again split between the 'IPD fund' and the CUPs in the same way as in Year 1.

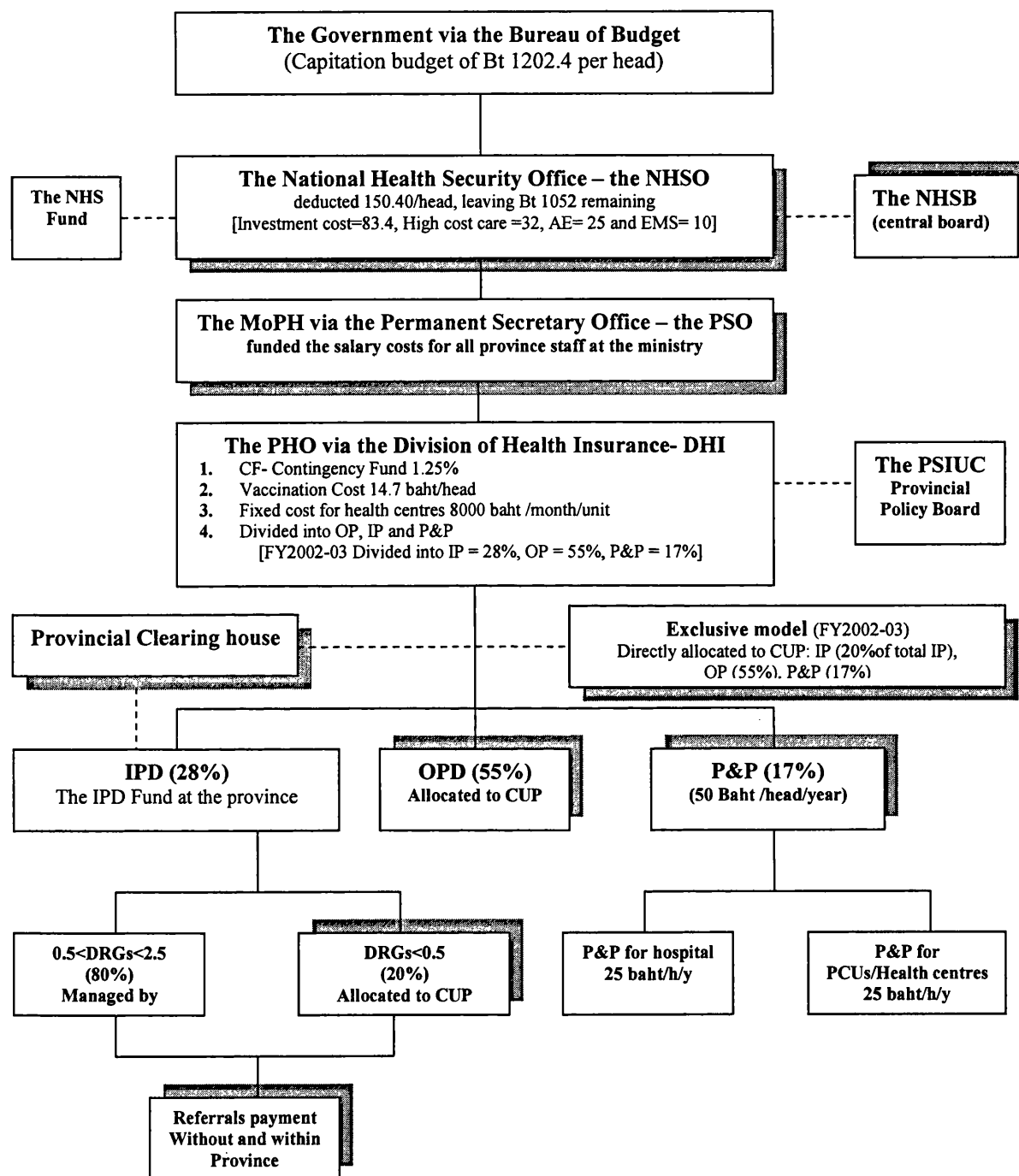
One of the main differences in Year 2 was that the community hospitals lost a major part of their funding because of the changed policy to hold salary budgets at the Ministry and the reallocation of this money to large population centres, mainly in central region. This had the result that the capitation payment to the CUP dropped from about 700 to 400 baht.

In the first year of implementing the reforms – 2002 – I was in favour of the resource allocation system. But in 2003 it collapsed. The money was very small. After the reforms we had employed many new temporary staff and paid for a lot of overtime. Now we did not have enough to pay overtime or pay for the new staff. The budget allocation reflects a conflict between the NHSO and the MoPH. (DDCH, KS 13)

Again the approaches taken by Kalasin and Sarakham were similar, this time in part because they needed to comply with the same central government policies. There were minor differences such as Kalasin's more generous level of utilities payments to the health centres, and the fact that its Vaccinations and Medical Equipment Fund was the nearest equivalent of Mahasarakham's 'Provincial Cooperative Investment Fund' (which is an indication of different priorities in the two provinces). Perhaps the most interesting difference was the treatment of the P&P monies, which Sarakham, as before, allocated direct to the CUP. The issue of P&P funds caused a good deal of debate in Kalasin – as will be seen later in the chapter – and a decision was taken to split the budget equally between the community hospitals and the health centres. However as a pragmatic measure this money was channelled through the CUPs and most did not actually reach the health centres.

Figure 6.3 below shows the resource flows and relationships between organisational divisions in 2002-03.

Figure 6.3: Financing arrangements and relationships between organisational divisions in Kalasin in Year 2 (FY 2002-03)



Adapted from: Kalasin PHO report 2002-03 (Kalasin PHO 2003)

Note: That was a criterion for financial arrangement based on resolution of the PCIHI

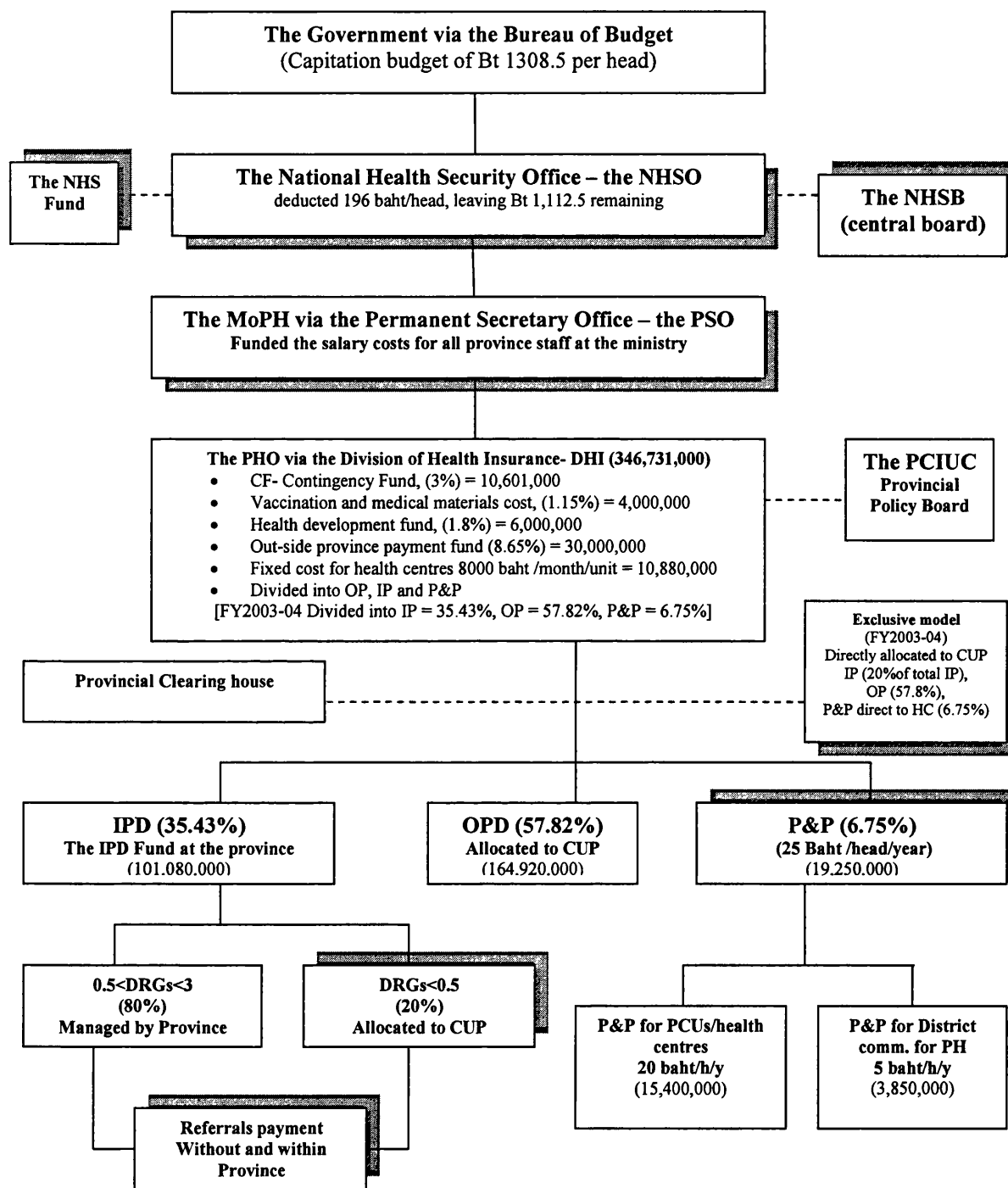
In Year 3 financing in Kalasin followed the Ministry policy, with little change in the formal allocation machinery. There were limited changes in detail. An additional earmarked budget, the 'Health Development Fund' was created, which was linked to the top-

down requirement to start provincial development projects. Also the portion of the IPD budget used for out-of-province referrals was moved across to a separate fund, so that inflation in this expenditure heading did not threaten the position of provincial hospitals. Again one of the most significant developments involved the flow of funding to health centres. In the light of problems of getting their share of the P & P budget channelled to the health centres through the CUPs, it was determined to pay them directly, though with a portion going to the supporting district health offices. . In this year the split between budget divisions was IP = 35%, OP 58% and P&P = 7%.

In terms of the comparison with Mahasarakham, differences did not widen greatly, with the main financing mechanisms still unchanged. Fixed costs (utility) payments stayed at the same level in Kalasin, while these were reduced in Mahasarakham. The changes in Kalasin regarding the new 'Health Development Fund' and the bypassing of the CUP for P & P payments were not copied in Mahasarakham.

Figure 6.4 shows the resource flows and relationships between organisational divisions in FY 2003-04.

Figure 6.4: Financing arrangements and relationships between organisational divisions in Kalasin in Year 3 (FY 2003-04)



Adapted from: Kalasin PHO report 2003-04 (Kalasin PHO 2004)

6.4 The view of actors in the local health care system

6.4.1 The view from the community hospitals

Under the new funding system in Year 1 OP and P&P monies went to the CUPs, which had considerable devolved authority to decide how to share out the money. The general pattern was that each CUP covered a district and was associated with that district hospital, though a few districts with no hospital were brought into a neighbouring CUP. With the exception of the 'Muang' (city) CUP, which was headed by the provincial hospital director, all the CUPs were chaired and dominated by DDCHs. This generally meant that funding for the community hospitals was secure, and indeed much higher than before 2001. One problem that arose concerned the imperfect match between the administrative units on which capitation payments were based and natural catchment areas. Some hospitals had large patient flows – mainly outpatient flows - coming in from adjoining districts. The PCIHI had made some provision for this by making arrangements for the adjacent CUP to make a compensatory payment for outpatient work to the CUP overseeing the hospital. The problem was that DDCHs reported many cases where payments were not made.

We used to claim these expenses from 'K' CUP, but they caused difficulties for us. For example, we claimed about Bt 100, 000 supported by completely detailed documents but they only actually paid Bt 40,000 and slowly at that. They mentioned that they had deducted the Bt 30 per visit fee because we were in the same province, and also some parts of the medicines costs where they claimed these were too expensive, although we have already made a joint decision on this and charged based on the lists and prices we had agreed. (DDCH, KS 17)

There was a problem concerning the catchment area. For example, people in 'N' and 'P' sub-district (under 'K' district) usually came to access health care in 'H' hospital (this hospital) because the transport links are much more convenient. When the UC reforms came in their capitation budgets had been allocated to 'K' CUP, but the people still came to us. This created a problem where 'K' CUP received the monies, but the health care provider was 'H' CUP. (...) Now we are solving this problem by not allowing them to access our service, because it puts a heavy burden on us. (DDCH, KS 17)

In this situation all the capitation-losing hospital could do was appeal to the PCIHI to intervene, which did not always solve the problem.

We have just collected these data and by the end of this year we will produce summaries and present them to the PCIHI (...) Now I can only influence things a little bit because I can only work at the service level; I am not an administrator at the higher level. These problems depended on many factors, including the PSIHI at the provincial level. (DDCH, KS 17)

Reimbursement for community hospital inpatient work, including work involving patients from across district boundaries, came from the central IP fund, the doctor director respondents in Kalasin reported no problems with this flow of monies. If there was an issue with referrals, it was that some hospitals retained patients who should have been referred to larger centres in order to keep the IP payments. Doctor Directors themselves generally denied that this was a problem, though a few respondents in the PHO, and most tellingly, the health centres, reported that this had happened.

I don't like this policy because they have held back patients. There are many people in my area, who will go directly to see a doctor in a private clinic in the city centre, then a doctor will refer them direct to the hospital, for which they must pay themselves. That was the main problem in 'K' (district) where they (the hospital) didn't like to refer patients. As we know, there is the same problem in many areas when I talk with my friends. (Head HC, KS 29)

The biggest funding issue was not any impediment to the flow of monies to the CUP and thereafter the community hospitals, but the flow of monies from the CUP to the health centres. This was bound up partly with self interest and the desire of some doctor directors to use the bulk of funds to develop hospital services, and partly with the failure of the hospitals to establish effective patterns of joint working with health centres because of reluctance to get involved in health promotion work. The CUP had a remit to develop the full range of services in the district including community services as well as hospital services. The policies called for the formation of primary care units (based on the old health centres) that would have doctors and nurses, as well as public health staff. Because doctor directors were not confident about the capabilities of health centre staff, this meant moving hospital professionals out into the community. However, motivating them to do this proved difficult, and there appears to have been a gradual reduction of activity as time went by.

The next problem was the attitude of the health officers where they weren't happy and didn't like health promotion in the community. They thought that this work was useless and not satisfying. They must both think and do by themselves, where it quite difficult work when compared with hospital work, where they can follow a routine. If they go to work outside hospital they find it tiring. Additionally, they

must work with the health centres and the DHO staff which is unfamiliar and where they feel isolated, because the system has been split for a long time. When we decided to roll out treatment activities to the health centres that put a big burden on them and they didn't like it. The nurses who came to the health centre also did not like working on health promotion and community activities. They felt that they didn't like health promotion work in the community and they had a negative attitude to working co-operatively (DDCH, KS 15)

This issue will be discussed from the other side when the perspectives of the DHO and health centres are considered below.

There was also a degree of conflict between the heads of CUPs and the DHOs, which had previously been the line managers of the health centres and still had some residual power. This arose partly because of the two lines of command that now existed from both the CUP and the DHO to the health centres, with the CUP controlling money and trying to develop a community outreach capability, and the DHO having power to direct what tasks health centre staff carried out.

There was the one who took care of the budget and another who took care of the staff. I think the idea was wrong because there were contradictory principles. Whenever they (health officers) required monies we had to approve it, but then it passed outside our control. This meant we couldn't control the direction of work. I must do this through cooperation via meetings with the DHO head. Sometimes I encountered a problem that I needed to solve quickly but I couldn't do that. (DDCH, KS 15)

This will also be explored in more detail below when the changes occurring in year 3 are described.

The other general factor that featured prominently in doctor directors' interviews was the increasing administrative burden associated with the UC reforms. This was not just about the increasing volumes of patients presenting to access low cost care, but also the re-organisation of local services, the extra administration associated with the financial reimbursement mechanism, and the increasing paper work involved based on a quality assurance scheme at the clinical level.

The work was increasing, for example, the contract specifies that we must provide a certain quality of care. The quality was divided into two aspects; firstly, quality as defined in a document called 'PSO' (the Public Sector Standardisation Organisation) and quality of health care based on 'H.A.' (Hospital Accreditation).

Currently we are implementing both these systems. Actually, they do improve our work but they cause us increased 'workload' (in English). They generate both paper work and service work. For example, previously a doctor needed to write down about 4 lines taking about 15 seconds per case in an OPD medical examination, but in the new system reporting has increased a lot. So the 'workload' (English) has increased, regarding the time taken to provide the service. Additionally, more patients came to visit the hospital because of government publicity. Work increased, the staff remained the same and the budget decreased. (DDCH, KS 17)

A number of respondents named colleagues who had resigned from the public service and talked about the comparative attractiveness of private practice.

6.4.2. The perspective of the DHOs and health centres

The rapid implementation of the reforms and the failure to work out all matters of detail meant that the role of the district office and the working of the local health care system remained unclear. This applied particularly to the lines of authority and the focus of work. The reforms seemed to transform the function of the DHO from hierarchical manager to arms-length supervisor and monitor, but as time passed the DHO was frequently called upon to carry on with some of its previous responsibilities.

Regarding the structure and functions (of the DHO) this was changed in line with guidance which set out our responsibilities for monitoring and evaluation. In fact, we are still doing similar work as previously. Perhaps we are doing more because we must operate as the main coordinating body in the district. At the beginning we thought we would have the same functions as the PHO but in fact we need to work at everything. (DHO Head, KS 24)

We are still acting as both an operational body and supporter for local work, as with the previous functions. Actually, we clearly understand that we are the evaluator and supervisor but we can't do this because of our existing responsibilities. The DDCH: he claimed that health centres were under the control of the DHO head and he couldn't command them. I thought this was 'overlapping' (in English) each other's function. If we assigned the DHO head to be evaluator, we could move the health centres out, I didn't worry about losing the power at all. Perhaps the health centres would move under the hospital or local government, depending on policy, but we will act as evaluator and a reporting base on their performances. (DHO Head, KS 19)

We were not responsible for acting as the leader in the district for health activities, but the CUP board was. The DHO should act as the district supervisor. When the health policies were introduced we had to analyse how to do the monitoring and what the evaluation criteria should be. However, we had a problem when implementation happened for real. For example, with the

haemorrhagic fever control and the healthy exercise projects, if we hadn't gone to work on these projects they would have failed. (DHO Head, KS 19)

One part of the reforms, intended to increase the power of primary care, had been the creation of the CUP. In practice, because CUPs were headed by hospital directors, this meant that the hospital became to the lead body directing work in the local health care system. However, the DHO also continued to exist, though with a reduced and ambiguous role. This led to the problem of a command system with 'two heads' also cited in the other case studies. In essence there was a 'boss' who controlled the money, the Chair of the CUP (a hospital director), and a 'boss' who had line management responsibility for health centre staff, the DHO Head.

There was a problem about integrated work in the district, for example the DHO Head and the DDCH. There are two organisations in the district. They (the government) would like them to work together but this didn't happen. Because, the first thing is that there are two bosses. People did not know who the real boss was. When the DDCH needed the health workers to come to work, they must be allowed to do so by the head of the DHO. That caused a dispute between them. And, there was a problem with the budget arrangements. In the first year of implementation, the budget was directly allocated to the hospital, but it was changed in the second year so that the P&P budget was directly allocated to the health centres. So the hospital wasn't responsible for this budget and the health centres were puzzled to get such big money and didn't know what to do with it. After this we (the PHO) focused on cooperative working but the hospital weren't interested, they have just worked by themselves. (SAO-PHO, KS 07)

The transfer of authority to the CUP (and community hospitals) also led to problems of communication and also the co-ordination of hospital and community work, especially curative and preventative activities.

At the start of the reforms all official documents were sent directly to the CUP, which had the result that we didn't get any information and didn't know anything, but the PHO required us to report on the results of the work. Then we had new discussions with the PHO, and then they sent things directly to us as well. For example, in the 'food safety project', at the beginning the PHO had direct contact with the hospital and the CUP, but there were nothing about implementation and we were waiting to start work on this project until nearly the end of fiscal year. Then last month the PHO asked the DHO to come in and take responsibility for this project, including other activities needed to back up the action. The hospital, they didn't focus on health promotion or proactive measures. (DHO Head, KS 24)

The change led to a perception on the part of most DHOs that the CUPs were overly preoccupied with developing treatment activities at the expense of health promotion and

prevention. The 'close to the home, close to the heart' component of the reforms had called for an expansion of primary care, linked to the formation of PCUs, and this involved a transfer of resources from hospitals to the community. This implied that CUPs would not simply use existing health centre resources within a different management structure, but would oversee new patterns of working where doctors and other hospital staff moved out into the community to assist the existing health care officers. The problem in the eyes of many DHO and health centre staff was that there was no enthusiasm for this change of focus.

Of course, it was changed because, in the structure of the CUP, the DDCH is the chair. He or she focuses on treatment activities, and doesn't play up community activities or health promotion as expected. The largest part of the budget is paid for treatment activities in the hospital and does not provide for health activities in the community. (DHO Head, KS 23)

But it seems that a curtain has come down between the health centre and the hospital staff, and they have been separated for a long time. There was a situation where the staff came to work together, they did not get into conflict, but they feel that they still have two bosses. (DHO Head, KS 20)

Part of this problem was about relationships and the cultures of the two groups of workers. Several DHO and health centre informants suggested that hospital staff saw themselves as 'professionals' now forced to work with the 'non-professional' health officers. They did not always conceal their feeling that they were different from the health centre staff. For many respondents in the health centres, this amounted to being treated like 'second class citizens'.

In my opinion, the hospital staff seem to be biased against the health centre staff; they always treat them as second class citizens, including the nurses who go to work in the health centres, and I don't know why they do it. I tried to explain that in the hospital staff that they have better facilities and more comprehensive equipment than the health centres, and receive about 10 times more. Such as a free house and a car available when they have to go to work outside, whereas the health centres staff don't have this. They must take care of themselves and stay in the community. They have problems in work with either the lack of good facilities, support or poor quality of work life, especially when compared with the hospital staff. (...). So they treat them as second class citizens. (DHO Head, KS 24)

Apart from status differences, different working conditions and career prospects applied to hospital and community work. Hospital work brought better fringe benefits, including housing and car, and better allowances. This arose largely from the hospital staff's

continuing civil servant status, and the employment of community staff on new 'government officer' grades, in line with changes introduced as part of the wider reforms of the state bureaucracy after 1997.

For example, two newly graduated nurses came to work in 'N' (this district): one worked in the health centre and the other worked in the hospital. This made them compare the facilities. The one who worked in the hospital got everything and worked mainly in the municipal area with extra monies for supporting work in rural areas. The one who worked in the health centre didn't receive this even though she worked in a village. They got together and compared these things and told me about it. (...) One person came to see me in tears, saying she needed to work in the hospital. Working in health centre didn't lead to success in a nursing career, while a nurse working in hospital receives more rewards and has an easier time because they only have to follow doctor's orders. (DHO Head, KS 22)

In turn health officers had negative feelings about hospital staff, especially when their suggestions for changes in practice were ignored. The following extract describes a situation where a hospital team had come to carry out a clinic in the health centre:

We gave 'feedback' [English] but they didn't change things and answered back in sarcastic terms that made us afraid to give feedback again because we are at a lower level. Sometime we were busy and didn't help them to move medicine bottles, which made them get angry and blame us. When they came to the health centre we had to entertain them with food when they finished, and after they went back we had to tidy up and clean everything. I wanted to tell them that we are the same team, so don't treat us as subordinates. They work in hospital and they act as the boss, even though we have graduated with the same degree. If we were dissatisfied with something and we went to talk with the boss, they will be keeping an eye on us. We felt pressurised. (...) Ordinarily, the relationship between the health centres and CUP is not close. They came to see us every two months. (HO-PCU, KS 35)

In the view of several respondents, the problem was the medical control of the CUP and the difference in perspective between acute medicine and public health.

They tried to get across the problem that I described, but the doctors obstructed any change, they did not change much. They listened but made no concrete changes. If the chair [of the CUP] wasn't the doctor it would be better. (DHO Head, KS 24)

These difficulties in working together co-operatively led to a series of problems in community services, which pulled the DHOs back into the area of operational work. This was partly because the PHO and Ministry, when confronted with difficulties expected the DHO to take some responsibility. They still required reports from the DHOs, rather than

the CUPs and encouraged them to get involved in P&P projects that were under threat of going wrong.

When the Bt 30 policy came in they re-assigned the DHO to be the supervision body to support the people, so that they could access health care service based on the core-benefit package in the new policy. However, when we had a problem, for example, in a case where haemorrhagic fever had spread in our area, the higher administrators intervened to put pressure on the Head DHO. Meanwhile, the UC budget was allocated direct to the hospital and the DHO received a lower budget figure of around 10% of the UC budget to district for all supervision work. (...) As I have said, 'our responsibilities have changed little'. Everything still remains with us, the regional health inspector and his team still require reports from us. We do not avoid our responsibilities but they should go to the CUP. (DHO Head, KS 19)

It was also the case when things went wrong that it was the DHO rather than the CUP that higher-level bodies blamed. In the following extract, a DHO Head recounts how failures of the part of the doctor director went unnoticed, and how control is separated from responsibility.

We don't work only on the evaluation task; we must help the hospital work too, because if communicable diseases spread in the district, such the PHO don't blame the CUP, they blame only the DHO. For example, in the case of hemorrhagic fever control in 'S' district (another district), there were many hemorrhagic fever cases in that area even though the CUP there has obtained a large budget. But the DDCH did not allocate money to the health centres to support these activities and that led to a situation where the disease spread widely. In a PHO meeting, they blamed the head DHO, and the head DHO explained that he had already done everything and could control the cases in the DHO area, but he did not know about control in the hospital area. So why did they separate the two areas? With regard to this case, it made us feel uncomfortable that we cannot touch them [i.e. the doctors]. We must accept that doctors have a lot of prestige; we must go to talk with them (DHO Head, KS 24)

The problem between CUP and DHO remained an issue in the early years of the reforms, especially in Muang CUP, where the provincial hospital led the CUP and should have co-ordinated primary care. A DHO Head on the CUP recalled how meetings ranged over tertiary and secondary care but rarely discussed primary care issues.

To tell the truth about 'the city' CUP it is very different with other districts that I have worked in. In another district we could easily ring each other. Regarding the provincial hospital in the last 3 months we have just had one meeting because they are a very large organisation and responsible for 3 levels of care. At the primary care level they are responsible for the health centres, and at the secondary and the tertiary care levels for the entire province. When we met in the CUP

board there were many issues discussed concerning both secondary and tertiary care, but we should have been talking about primary care. They are a large organisation and don't have a champion for primary care activities. Actually the social medical department should have taken on this role but they didn't. For example, in the case of communicable disease control, if we have early detection it would be easily controlled, but they did not do this. I don't know why. At the moment they are trying to solve this problem. I think that the CUP conference topic should be the problem of primary care and the Bt30 scheme, but they have picked the opposite topic. (DHO Head, KS 19)

6.4.3 The role of the private sector

The single private hospital in Kalasin province opted to join the 30 baht scheme in the first year of roll-out to the North East. At the same time Mahasarakham's private hospital also applied for entry but was rejected because it had no dentistry. However early dealings with the PHO were not smooth. Unlike in some other provinces, Kalasin residents were allowed to select between the provincial hospital and the private hospital, which meant that the population group covered was not confined to a separate locality. Health promotion and prevention work had to be covered by both hospitals taking patients from the 'Muang' (city centre) district. However activities were not co-ordinated, so that there was overlap in their work.

I don't know about elsewhere, but here with my hospital we have a different system from the main policy. I have a problem about people who came to register with us, for example, in a family which has 10 persons but only 3 persons come to us and others are registered with the provincial hospital. Regarding treatment care, we didn't have a problem but there were problems with health promotion activities where we had to go to do family visits or give vaccinations. It was complex and difficult work. For example, take the community activities based on the dengue fever control project where we (the private hospital team) went to kill mosquito larva in the family home. Later the provincial hospital team went to do this again, which was redundant work because it was the same area where we share responsibility. Of course, this may have been more convenient for people who could chose which hospital to register with, but it caused the management system double work and double costs. That was the problem. If I had a question about our capacity, we could do this. But in my view, as the manager, I would say it is like a stupid but diligent man. We could do this but why do we want to do the same thing twice? (DPH, KS 10)

A senior PHO source explained that this problem had arisen because it proved unviable to allocate different catchment areas to the two hospitals. Initially the PHO had created separate municipal areas but many people had expressed unwillingness to be registered

with the private hospital. Local MPs had become involved in the issue and the PCIHI had been forced to move to a policy of choice between the two local providers.

Initially, 'the city' district was separated into 5 areas and we expected to assign a hospital to be responsible for each area. However the people would not agree to this. They said that they had the right to choose the hospital and caused us problems in making the arrangements at the beginning. Because some people in some areas who had to register with the private hospital did not accept this and asked to register with the provincial hospital. They pressured the politicians who came to force us to change this. Finally we gave the people a free choice of hospital, either the provincial hospital or the private hospital. (SAO, PHO, KS 04)

Many senior PHO administrators supported the PCIHI decision, not so much on choice grounds, but because of their lack of confidence in the capacity of the private hospital to offer a full range of services.

However, we didn't get a satisfactory performance from the private hospital, based on both direct and indirect evaluation. For example, we asked the people, such as diabetes sufferers, for their views. They said they got medicines in small quantities and had frequent appointments.³⁰ Patients at the provincial hospital are given more medicine. (SAO, PHO, KS 04)

At the beginning, I thought that we might have a lot the people going for care in the private hospitals. In fact, the situation was the opposite: the people didn't go to the private hospitals. This made them launch a campaign to attract people to come to register with them. Then, the PHO decided to divide the catchment areas so that it was clear that people should register with the public or the private hospital. However, some groups of the people in the private hospital area objected to this because they wanted to get health care in the public hospital. There were a lot of people who didn't want to register with the private hospital. (SAO-PHO, KS 08)

Regarding the community activities I wasn't satisfied with the performance of both the private hospital and the provincial hospital. There are a lot of problems and - if I could make a suggestion - the DHO should be working better. (SAO-PHO, KS 05)

The director of the private hospital argued with this outcome was not efficient and went against the aims of the UC policy.

If it was based on the manager's view, the separate areas would be used economically to maximise the use of resources. If we were taking account of public satisfaction we wouldn't achieve this. Freedom for a person to register was good but it was not efficient or good for quality management. A freedom should

³⁰ Each attracting the 30 baht co-payment.

have limits for the public benefit because this freedom may waste too many national resources. (DPH, KS 10)

If we examine public satisfaction, it passed but only at about 60%. However, there were many complaints about the health care system because the government gave the people high expectations. They announced that '30 baht Treats All Diseases' but in fact that was not true because it doesn't treat all diseases. Due to the people's expectations, it 'failed' (in English) but with regard to access to services it is going on. (...) When we talk in terms of the business management concept it 'failed' (in English). From talking with others in public hospitals, I know they are in deficit, including the University hospital too. This policy is going as long as the 'Thai Rak Thai' government stay. I am 100% sure because it comes with the politics; also it is going to go with the politics. (DPH, KS 10)

From the private hospital's point of view the PHO was not allowing free competition with the public sector. The doctor director argued that public hospitals were allowed to participate in the scheme without meeting the same accreditation requirements that applied to private hospitals. Also the PHO was not a fair arbiter because it was biased in favour of the public sector. It was the purchaser but also controlled the public providers, evaluated provision, and let the contracts.

When the competition started the politics came in. Competition is a good thing but it was not clear that there was competition: if somebody has more power than another person it would not fair. It is 'idealism' (in English). (...) In the last two years I have fought a lot. Now the fighting seems to have ceased but this is not really true. There are differences between the provincial hospital, the community hospitals and the private hospital. Actually, I have only got around 400-500 baht (per head) because they played a game with me that caused me delays in getting involved. For example, I was supposed to join in October but they fobbed me off in January and again in March last year, which made me lose money each month. This is not transparent management. I don't know if these were on table or under-the-table policies. We was also faced with the same problem in nearly all provinces on the part of private hospitals. (DPH, KS 10)

Regarding the money which I should receive, it came to the PHO but did not come to me and I don't know why. The PHO officers are human beings who may be biased. If they keep my money for around 4 to 5 months then where has my profit gone? The bureaucrats have used the 'tactics' (In English) of blaming me and delaying my monies. If these were directly transferred via a bank there would be no problem. If we talked about the 'internal control' (In English) idea it would be wrong. The implementer, controller and auditor should be different persons but this is the same person, and that conflicts with 'the internal control' concept. (DPH, KS 10)

By year 3, the private sector was in a difficult situation because participation in the UC scheme had not turned out to be as profitable as expected and there had been many withdrawals. Private hospitals perceived that they were not receiving support from central policy makers and were having difficulties with the financing system applied at provincial level.

Commonly, around 10,000 people could be registered with me. In my hospital we have got only 2,000 to 3,000. How can I survive? They annoy me in lots of ways. I insisted that we were being defamed but we remained patient, and they don't do it any more. (...) We tried to adapt themselves because we knew that this would be the new 'monopoly' (in English). We are willing to take some losses for the sake of the future. Now we cut ourselves to the bone and run on existing resources. (DPH, KS 10)

6.5 Professional struggle and the change of approach

6.5.1 How middle-level policy actors gained influence

A number of factors in Kalasin came together to increase the influence of middle-level actors and open the way for a struggle between interest groups more visible than anything in the other two provinces. This came about partly because of the loose control imposed by the CMO, and his preference to act as arbiter between parties rather than leader. The large number of retirements of senior officers, the promotion of replacements from fairly junior positions, and the fact that the most experienced senior administrators were in posts not concerned with the UC reforms, meant that there was not the same direction from the top of the PHO as elsewhere. Additionally the inspector general in Health Region 6 was more hands-on and interventionist than in Mahasarakham and Roi Et. He monitored events and exerted influence at key points,

Kalasin was different from the other case studies because a larger number of middle-ranking actors were given places in the key 'war room' committee. The senior PHO officers had accepted the notion that the CUPs would drive the reforms to a greater extent than their counterparts in Kalasin and Roi Et, and accepted that the DDCHs would be key actors in the UC scheme. This meant that the DDCHs were given two places in the war room and were seen as middle-level managers dictating the micro-level arrangements at the district level. Having got a place in the war room and PCIHI, the two DDCH

representatives were then able to ensure that doctor directors had a powerful role in terms of budget control and lines of command.

DHO Heads were also represented by two representatives, but initially were less powerful than the DDCH group. They had little control over budgets and diminished authority over staff. However, their co-operation was needed to keep work on track because of the DDCHs' unwillingness to engage fully with P&P work. The other way they managed to augment their power was by gaining the support of the Health Region inspector. Different factions within the war room thus looked towards different allies and had different strategies for exercising influence.

6.5.2 Struggle between professional interest groups

As mentioned earlier, in Year 1 there were allegations that many of the Kalasin CUPs were failing to pass sufficient money on to the health centres and channelling it instead towards the community hospitals. The hospitals were well resourced but in the view of many low-level actors were not very effective in carrying out their responsibilities for health promotion and prevention. Under the influence of certain DDCHs, resources went to fund curative work rather than P & P, so that many of the existing projects of the health centres/PCUs were curtailed. Some money also went to capital investment in the community hospitals. However, improvements in services were limited by staff recruitment problems. Joint working between hospitals and health centres was not well developed, partly because of the different cultures and work orientation of hospital and health centres staff.

The DHOs which had traditionally overseen health centres were also strapped for cash and struggled to help keep community projects going.

[the] entire district budget was transferred to the CUP, then was allocated to health centres. The previous budgeting system of the health centres was based on the line of command, whereby the health centre submitted proposals to the DHO and then the head of the district government office had to approve it. Now the budget is channelled to the hospital and the health centres must ask for payment from the hospitals. The effect was that the DHO couldn't check these plans and projects and whether they would benefit the public or not. (...) Previously, the DHO received the budget directly. When the financial reform came in, money

was divided into the UC budget and the non-UC budget, and the DHO only received a small proportion of the non-UC budget. (DHO Head, KS 20).

This situation, and particularly the starving of the health centres of funding, led to continuing complaints from health centre staff and lobbying from the DHO representatives on the PCIHI for change. This included both representations to senior PHO staff and to personnel in the Health Region and the Ministry. One of the most significant factors at this time appears to have been the increasingly active stance of the Health Region and its Inspector. This post holder was an ambitious and energetic official, who within two years was to be promoted to a Deputy Permanent Secretary position in the Ministry. He determined to take a more directive approach to the implementation of the reforms in Health Region 6, and paid special attention to a number of emerging problem areas. In the words of one PHO informant: 'Year 2 was the Year of Inspection'.

One of these areas was the underfunding of the health centres, and the Inspector gave a strong steer to the CMO, the PCIHI and the CUPs that change was necessary. However the extent of the Health Region's ability to command in these circumstances was unclear, and initially, rather than imposing a change directly, the Inspector pressed the PCIHI to agree a mutually acceptable arrangement with the CUPs. Near the end of Year 1, the DHO Heads get together to try to exert influence to change things, especially via the Health Regional Inspector. They also complained to the CMO in the war room. There were heated arguments. One informant looking back at this period recalls:

Last year, before we started to do the work, we spent 7-8 months talking about the budget arrangements. I think that in other districts they faced the same problem, with regard to payment channels and how to manage the allocation of the budget. Nevertheless, this year they (PCIHI) made the determination that the (P&P) budget wouldn't pass to the CUP and would be directly allocated to the health centres. But we wasted time discussing how much to allocate, whereas the (provincial) policies were clear that it must be transferred. We wasted time asking the DDCHs whether we should do this or not. I was a one of the PCIHI members and we spent far too much time discussing the budget arrangement, before finally deciding to allocate directly, but the DDCH group wouldn't agree to this, and then the PHO came back to ask whether we would do it or not. We discussed the policy for about 2-3 hours and a DHO Head and one DDCH almost hit each other. We wanted to make a direct allocation but the DDCH didn't like that, and then we got into an argument about how much of the budget could be allocated in this way. The PHO received the P&P budget as Bt 50 per head, and then we gave Bt 25 to the health centres and must give Bt 25 to the hospitals. So we had to share the money with them again. These things happen. (DHO Head, KS 20)

The initial result of the pressure was a change in financing arrangements in year 2 whereby, in terms of the formal allocation, the P&P fund was divided equally into allocations for the community hospitals and the health centres.

Unfortunately this was not a complete solution to the problem. Because the discussions had continued until close to the budget allocation deadline, it was decided that there was insufficient time to allocate monies directly to the service units. Thus the money still passed through the CUPs, and this had the consequence that some doctor director chairs still did not pass the full funds due on to the health centres.

[t]he budget had been tricky because it was directly allocated to the hospital. The problem was that some hospitals did not allocate the budget to the health centres and some hospitals allocated a little, whereas the hospital could manage things according to their likes and dislikes. (DHO Head, KS 20)

Last year the budget was allocated directly to the CUP, so that the CUP was manager. There were problem in some CUPs so that they didn't transfer money to the health centres. This caused complaints about money not being received or received late. (DHO Head (1), Focus group KS)

In other areas where PCUs were in operation the monies were passed to the lead health centre, and were not shared with the other centres on a fair basis.

Last year, for PCUs which comprised 2 or 3 health centres, the budget was allocated to the main health centre then they needed to share this budget. That resulted in some health centres which didn't receive a budget directly feeling unhappy, because if the budget remained with the main health centre they might retain the full sum. (DHO Head, KS 20)

This led to further expressions of disquiet, and further lobbying by the DHO Heads Group of the Health Region and the Ministry. It seems to have been widely accepted that there was indeed a problem and that the answer would be to let money bypass the CUP and go direct to the service units. After negotiations between the CMO, the DHO Heads Group and the Directors of the Community Hospitals it was agreed that this should go ahead. The same 25 baht per head notionally allocated to the health centres in the previous year was paid directly to them, with a proportion separated off to go to support the DHOs. A separate stream of P & P monies also went to the hospitals. The change was welcomed by all the DHO and health centre staff interviewees. In the words of one DHO Head: '...the

DHOs group fought hard and we won when the budget was directly allocated to the health centres'. (DHO Head, KS 20).

However there were indications that this change further weakened the hospitals' commitment to work co-operatively with the health centres.

Possibly, the budget caused conflict. Because at the moment the budget is directly allocated to the health centres, so the DDCH assumed that the promotion activities are the responsibility of the DHO. It is not seen as the hospital's task. (SAO-PHO, KS 05)

This contributed to a loss of momentum in the move from health centres to PCUs, which had anyway been constrained by staff shortages. Now however, as well as limited outreach from the hospitals there was a tendency for health centres with their own budgets to think they could go their own ways.

I am not sure whether the health officers understand the difference between the PCU and the health centres, because the health centres still work in the same way and the hospital doesn't give much support. At the beginning the doctor team came to the health centre one day a week on Tuesdays. Now they don't visit on time and it changed to once a month and sometimes there was only a nurse coming, or the doctor would come but not the pharmacist. (HO-DHO, KS 30)

The (P&P) budget was allocated directly to health centres which made the importance of PCUs decrease but we still call them PCUs.' (SAO-PHO, KS 05)

Another consequence was that the future of the CUP and its role in the local health care system became less certain. A small number of doctor directors in particular were disillusioned with the turn of events.

Really, the CUPs have been abandoned now. There was an official letter from the permanent secretary of the MoPH that they made the decision to change things so that the CUP board came back to the DCCPH (The District Cooperative Committee for Public Health), the previous district committee before the Bt 30 reforms. Following this they have already selected members of the DCCPH and are waiting for an official announcement. So they returned to the previous committee and don't have the CUP board any more. Really, the CUP board and the DCCPH have the same function; it is the same whatever we call it. However, the (P&P) monies weren't directly allocated via the CUP board or the hospital, only the budget for medicine costs, which we need to share, was directly allocated through the hospital. However, the P&P or health promotion budget was directly allocated to the locality (i.e. the health centre). This was managed by the MoPH for solving the conflict between the DDCHs and the DHO heads in the first year, when the CUP did not transfer monies to the health centres. Now, they have

changed that so the budget is directly allocated to the health centres, which decreased the role of the CUP. (DDCH, KS 12)

As mentioned in this quotation the other major change that occurred in Year 3 was a change in the overseeing administrative structures. The CUPs were supplemented by a 'district committee for cooperation in public health', which was a body from the previous administrative structure. This returned more power to the DHO. There was equal representation with DDCHs as before, but either a doctor director or a DHO head was now eligible to head the committee, unlike the CUP where only the former could take the lead role. This shift coincided with a change of Permanent Secretary in the MoPH in Year 2 and a shift to more conservative policies. However, these were to continue for only a year, before a further change in Permanent Secretary led to the return of CUP influence.

6.6 Relations with the Ministry and the Health Region

The last chapter showed how the close contacts of Mahasarakham's senior PHO officers with the Ministry helped them to keep their organisation in a position of influence, and to gain approval for local policy changes. Despite the fact that Kalasin also had a very experienced CMO he seems to have been unable to mobilise channels of influence to the Ministry in the same way.

Other senior PHO officers reported that in the early stages of the reforms, contacts with the MoPH were relatively unhelpful in resolving problems and areas of uncertainty.

The other departments (in the PHO) came to ask us what should we do about this topic and we didn't know either. After this we rang the Ministry and they told us they didn't know either. This was an example where the policies came in very quickly. Therefore, we needed to think by ourselves how to implement. The Ministry often gave us orders about the policies, sometimes right and sometimes in the wrong direction. However, after the government announced the policies, this forced us to come up with solutions by ourselves because we didn't have time to wait for the detail from them. For example, they announced that Bt 30 scheme must be implemented across the entire provinces on 1 October (2002), which they have just told us about in a short command letter, then we needed to think ourselves what to do and how to prepare for implementation. (SAO-PHO, KS 04)

The external body that was most influential in Kalasin was the Health Inspector's Office of Region 6. The office was mainly preoccupied in year 1 with developing audit and evaluation tools, but became very active in Year 2, prompting one informant (as mentioned

above) to call this 'the year of inspection'. However, formal authority for the oversight of the reforms was still centralised at the Ministry. Although the health inspector was concerned to support change and push it in positive directions, he had to be careful not to be seen to go beyond his audit and evaluation remit. This meant that his attempts to steer actors in particular directions had to be done informally and through indirect influence. A SAO-PHO described the inspector's influence in the following way:

The regional health inspector's office has fixed appointments for supervision visits twice a year. They came to help by seeing what our problems were and giving support when we requested it. However, in the final instance we must report directly to the MoPH because we are under the direct command of the Ministry. The regional health inspector might support us both through direct supervision in the local area and indirect influence. (SAO-PHO, KS 01)

Informal influence proceeded alongside a conventional audit role that did not meet with the approval of some local actors. One senior PHO source complained that their efforts to move forward proactively were frustrated by the inspector's office, which 'stays in the same mode and voices old concepts that just bore us'. It was only later that the Inspector did indeed start to press local actors to address some of the most pressing implementation problems, and played his part in the change in the budget allocation process.

6.7 Summary of chapter

This chapter has described some of the events and circumstances in Kalasin province that makes its reform story different from the other two case study provinces. Two features that were highlighted are the influence of middle-ranking actors, including professionals, and the fragmentation of power. Both may be partially attributed to the absence of a strong lead from senior officers in the PHO.

One important concern of the thesis overall is the role of front-line actors in implementing, and sometimes re-shaping national policy templates at local level, and this chapter shows that it is not always those at the top of the organisational hierarchy who exercise decisive influence. In this province, the key actors included PHO officers outside the senior officer group, the doctor directors of the community hospitals and the DHO heads – all actors towards the middle of the provincial 'command and control' hierarchy,

Middle-ranking actors exercised influence in the context of professional struggles between interest groups. This chapter shows how conflict centred mainly on resource allocation and the determination of the respective roles and scope of hospital and primary care. These struggles were reflected in disputes over budgets in years 1 and 2 as the health centres found themselves starved of funds, and latter in a significant policy shift as new arrangements were made for the P&P budget allocation in Year 3. Another important example of policy change following the mobilisation of local opinion, was the PCIHI's decision to allow people freedom to register with their chosen hospital in 'Muang' municipality area. The problems surrounding this episode may reflect the relative lack of experience of the Kalasin PHO in engaging with community groups, as compared with, for example, Mahasarakham. Throughout the period studied, one of the major lines of conflict at provincial level was that between the DDCHs and DHO heads, which concerned funding and delivery of new primary care policies. However, it is important to recognise that this was not just a local Kalasin issue, but ran parallel with a similar clash of views at the highest levels of the Ministry, where a conservative group favouring the prioritisation of curative medicine opposed a radical group, who wished to divert resources to health promotion and prevention.

Chapter 7
Roi Et: using active purchasing
to steer the local system

Chapter 7. Roi Et: using active purchasing to steer the local system

7.1 Introduction

This is the third chapter concerned with the differing approaches to implementation of the UC reforms in the three case study provinces. The chapter will consider Roi Et province and the influences and conditions that affected the approach taken there. It will describe the key actors there and the way the CMO was able to maintain significant control over the local system by casting the PHO in a purchaser role and developing a system for evaluating health service bodies against key performance indicators. As in Chapters 5 and 6, this chapter discusses several areas where local actors had discretionary space, including determining the kind of purchaser/evaluator role that the PHO adopted, deciding on the financing model and the way contingency funding was utilised, and correcting emergent problems. The chapter also considers how the CMO and other local actors used channels of communication to the MoPH and the Health Region.

The main themes found in the case study of Roi Et were the development of an active purchaser role by the PHO and its 'steering' of the local health care system. More than the other two case studies, this province exemplified hierarchical control from the top, though under the guise of the PHO as evaluator rather than line manager. The situation in Roi Et is related to the strong position and formidable political skills of the CMO, his accommodation with another powerful local actor in the shape of the doctor director of the provincial hospital, and his ability to manage a powerful group of community hospitals directors.

7.2 Implementing the UC reforms in Roi Et

7.2.1 Actors, networks and power

A central element of the Roi Et study concerns how a powerful CMO was able to retain control for the PHO, compared with the position in neighbouring provinces, mainly through his skills in reaching understandings with other powerful groups in the province such as the DDCHs and the DHO heads. Within, the PHO itself, the CMO was able to consolidate control partly because of the unusual circumstance that his wife operated as

deputy CMO, but also because his success in safeguarding the position of the PHO earned the support of other senior officers.

The Roi Et CMO had been in post for about two years, following a three-year period in a similar post in Khon Kaen province. Although this amounted to a move back to his hometown, this was a reverse in career terms because the Khon Kaen post was seen as one of the most attractive CMO positions in Esarn region and an upwardly mobile civil servant would expect to move on from such a post to a senior departmental position in the MoPH. Nevertheless the CMO seems to have been determined to make the most of this posting. He was a member of one of Roi Et most prominent business families and continued to pursue business interests alongside his public duties. The position of the CMO and his wife as members of a wealthy and well-connected provincial elite seems to have enhanced their organisational power and social influence with other professionals in the province. At the time of the study he operated a large garden restaurant near the city ring-road, which functioned as a convenient site for the many informal meetings with PHO colleagues, doctor directors and DHO heads. In April 2006 the CMO stood as a candidate for the upper chamber of the Thai Parliament. He was elected as one of three senators for Roi Et province, and at that stage left the health service.

Following his move from Khon Kaen, the CMO had raised some eyebrows when he appointed his wife as Deputy CMO in Public Health ahead of a number of internal candidates. She had moved into administration after an earlier career in nursing. She proved to be a very effective networker and seems to have worked hard to get other senior PHO officers to support her husband.

The other two key players in the PHO were the deputy CMO (Medical Care) and the assistant CMO (administration). Shortly after the reforms came in, the deputy was moved to another province. The replacement official appointed in 2002 had previously been a community hospital doctor director. Partly because of this background he was asked to take on additional duties as care-taker director of a community hospital. This hospital faced a difficult financial position, which had led to the resignation of the previous DDCH. This meant that an officer who was relatively new in post was also quite heavily burdened with two positions, and left him in no position to challenge the CMO's authority or take the lead on implementation issues. The Assistant CMO (administration) had previously

been a senior DHO head. He had headed DHOs in several districts in the province, and retained good relationships with the current DHO heads. However, this post was traditionally one which focused on routine activities such as buildings and vehicle maintenance and had little to do with policy development.

As in the other two case studies, another key actor operating in a supporting role was the Head of the Health Insurance Group. The post holder in Roi Et had headed the Environmental Health Department in the old structure, and had good contacts in the DHOs. However he retired in late 2003, and was replaced by the assistant head. This lack of experienced officers in high positions tended to strengthen the authority of the CMO.

As in the other two case studies, a war room was created in Roi Et in line with central guidance. The CMO was the chair and dominant figure. The situation was different from Mahasarakham where the corresponding committee was chaired by the deputy CMO, and Kalasin, where the CMO chair had ceded power to the DDCHs on the committee. However, on paper the general composition of the war room committee was similar to elsewhere.

The war room comprised the CMO acting as head, the head of five groups in the PHO, representatives of the hospitals, both the provincial hospital and the community hospitals, representatives of the DHO heads, a representative of the health centres, and the Health Insurance Group provides secretarial support. (SAO-PHO, RE 07)

Despite the presence of outsiders, influence remained mainly with the PHO officers. The CMO was supported by the deputy CMO operating in the role of secretary. The latter was assisted by the assistant head of the Health Insurance Group, who came to have a key role as a troubleshooter and problem solver. Interestingly this man had been head of the Health Insurance section in the old PHO structure, but had stepped aside to let a more senior department leader take on the new Headship role (when 10 departments reduced to 5 groups). However, this meant that a new Head with relatively little experience of health insurance issues found himself responsible for this key function.

Previously I was head of the 'E' Department (in the old structure) and the CMO appointed me to be a member of the war room committee. Initially, I thought that 'my department' was not related to health insurance. In the meeting we discussed the budget and numbers a lot, which gave me a headache because it concerned medical techniques and treatment activities which were not my interest.

Sometime I felt bored, and wondered why there were so many meetings and arguments. Later I started to understand that these things were all related, because 'my activities' depended on money from the UC budget so we needed to form a plan to request money as well. Additionally, in the new organisational structure of the PHO, I had to apply for the post of the Head of the 'new' Group. And the previous Head had been one of my staff in 'K' district health office, so we understood each other and I assigned him to be responsible for technical issues. We didn't have any conflicts and could work alongside each other. (SAO-PHO, RE 05)

The assistant became a key actor in the day-to-day working of the war room, albeit operating under the wing of the CMO. This is a further example of how the pattern whereby higher level actors had greater influence on the shape of local implementation, was sometimes broken when lower-level actors in key positions gained an unexpected degree of influence. When the Head of the Health Insurance Group retired in late 2003, the assistant replaced him.

The war room operated alongside the PCIHI, which functioned from the start of the reforms as the provincial health board, based on MoPH guidance. As in the other case studies, the option of using the Area Health Board as the basis for the PCIHI was rejected, in this instance because the latter was not fully operational due to wrangles about representativeness and the appropriate mix of members from different organisations.

Instead it was decided that the PHO would set up the committee by merging some of the membership of the Health Card Committee, some AHB members and some newcomers. It was agreed that membership should be split between purchaser and provider organisation representatives, and also public representatives. The CMO acted as the chair on behalf of the purchaser interests and selected additional purchaser members, including the deputy CMO Medical Care, the Head and Assistant Head of the Health Insurance Group, and a representative of the DHOs. Representatives on the provider side were drawn from the provincial hospital, the community hospitals, a private hospital and the health centres. Public representatives comprised the Mayor of the provincial administrative organisation (*Aor-Bor-Jor*), a representative of the Mayors of the municipalities (the *Thesaban*), a representative of Mayors of the sub-district administrative organisations (*Aor-Bor-Tor*), a representative of the village health volunteers and a lay public representative. Additionally the committee included two local experts selected by the public.

At the end of Year 1 the war room was stood down in line with guidance from the MoPH (and the ending of the central war room). The Health Insurance Group continued with the routine administration of the 30 baht project, and also assumed responsibility for trouble shooting and local policy adjustments. However, some respondents reported that this led to poor liaison between senior officers and front line staff.

At the beginning we established the 'war room' based on government guidance. At the moment the war room has gone, and that caused problems in communication, so that we thought we might re-establish the war room. The previous war room committee comprised representatives of the hospitals and the DHO heads from around 3 to 4 districts, and when they allocated resources most were transferred to the districts represented in the committee. Now, that we will use the committee for planning and evaluation (CPE) to replace the war room, that cause of conflict has decreased because we all understand the issue. That was the nature of the committee approach because each member of the committee represented their own different interests. For example, in the case of allocating newly-graduated staff these were allocated to the home districts of the committee. (SAO-PHO, RE 05)

In Year 3 a successor committee to the war room, named the Committee for Planning and Evaluation was created. This comprised the CMO, two deputy CMOs, the assistant CMO, and five heads of PHO divisions. As mentioned in the quotation above, there had been a perception that some of the 'outside' members of the original war room had used their position to benefit their own organisations or localities, and this was now used as a justification by the CMO to restrict membership to PHO officers. This had the result of strengthening his ability to steer developments in the province.

Overall then the picture in Roi Et is one of a relatively powerful and resourceful CMO who was able to impose his authority on the PHO officer group. However, in this province there was also a powerful, doctor director in the provincial hospital (DDPH), and an influential group of DDCHs with a strong local organisation.

The doctor director of the provincial hospital differed from the typical middle-level health administrators occupying this position, because he had moved from a senior post in one of the central departments of the Ministry - the division for hospital support - in early 2002. He had been a casualty in the shakeout of senior administrators that occurred after the new Permanent Secretary came to power in October 2001, and his move to a post in a small

Esarn province represented a considerable loss of status. He had been seen as a prominent senior doctor in the progressive camp within the MoPH, who had clashed with the more conservative policies being introduced by the Permanent Secretary of MoPH, and still had good contacts with some in the MoPH and the NHSO. In the research period, he was successful in gaining funding for a number of development projects directly from the centre, largely bypassing the PHO.

The doctor directors of community hospitals in Roi Et province had organised effectively into a strong professional network. This centred on the provincial Society for Doctor Directors of Community Hospitals, which was stronger in Roi Et than in the other two provinces and which virtually all the DDCHs had joined. The society functioned as a local pressure group which co-ordinated negotiations between DDCHs and the PHO and helped DDCHs to share information on their experience of UC implementation. This society had close links with the Rural Doctors Society at national level.

The Roi ET DHO heads also had a strong professional network, but were less effective in translating this into influence on the PCIHI. The 'city' DHO head was the chair of the Esarn regional branch of the Society for Public Health of Thailand. He made efforts to use the informal authority of the society to gain influence in local health circles but did not succeed in gaining a place on the PCIHI. Generally the Public Health Society was less powerful than the Rural Doctors Society, and lacked the organisation and contacts of the former. The 'city' DHO head took the early-retirement in late 2003.

7.2.2 Recent changes in organisational structure

The UC reforms were introduced in 2001 at the same time as previous bureaucratic reforms, aimed at down-sizing public organisations came into effect. The PHO was required to become a smaller, more streamlined organisation just as the UC policy forced it to transform from being a local health administration unit to a supervisory unit. As was true elsewhere, Roi Et PHO staff found themselves pressed to move in two directions simultaneously as both the administrative structure and the functions of the PHO were changed.

[the] change had been forced by the situation. Due to the organisational restructuring, the 10 departments shrank to 5 groups. They must change both their concept and method of working. For example, in the Dental Health Department previously they had provided care to serve schools in the municipality area, then they had to change and transferred all activities to the provincial hospital. Dentists in here weren't responsible for dental care. They moved to work in technical support activities so that they would be accepted. (SAO-PHO, RE 03)

The CMO was a key actor leading change in the office. Many heads of department in the old structure had to accept positions as subordinates in the new organisation due to the shrinkage from ten departments to five new groups. The CMO decided that the changeover would be accomplished by a formal process of application for the new posts, so that even senior staff had to reapply for posts.

There were many old heads of departments that went back to being staff, so that they felt hurt. However, the CMO is very able and has good mediation skills for getting people affected by the reforms to accept what had happened. (SAO-PHO, RE 04)

...regarding the new organisational structure they didn't 'fix' [English] people to be the new heads; they were selected competitively according to seniority and experience. So, the new heads of groups had to apply as well and were appointed based on seniority. (SAO-PHO, RE 03)

However, a number of senior staff resigned due to the uncertainty introduced by the ongoing changes, times of changing, and concern about the fairness of the selection system.

This led to a loss of experience and capacity in the early days of the reforms, which combined with the overall downsizing exercise, increased pressure of work on the remaining staff. Roi Et had reacted at quite an early stage to the reforms, not waiting for legislation to work its way through the system, but there was a period of about two years before the new arrangements began to settle down.

When the reforms were coming in, we considered whether to wait for the government's orders, but the trend from the government told us we were going to have organisational change. We saw drafts from the Ministry, which changed many times, so we were absolutely sure this was coming. So, in the first stage we started preparing our staff by arranging a seminar course, which got our staff thinking, before the Ministry order came out about the [bureaucratic] reforms. In the second stage, the Ministry issued an official command to us about changing and transferring duties to other organisations. For example, regarding AIDS and Venereal Disease activities we must transfer responsibility to the provincial

hospital because we didn't have area responsibility, so that we had to transfer this. That made us start to understand that the reforms were real because we didn't have either money or responsibility due to the new financial mechanism which was based on the capitation model. The third stage came after we had talked and accepted that the reforms were certainly coming. The CMO held a meeting and gave us freedom to fill in applications to apply to whatever group we wanted to join. Later we reorganised the PHO structure in line with these choices, and then about 1 to 2 months later the CMO held another meeting and gave staff an opportunity to move again. (...) We spent a lot of time on the reorganisation – about 2 years – before it settled down. Yet, there were certainly some people who were hurt by the reforms. (SAO-PHO, RE 03)

As discussed earlier, the planning and co-ordinating functions on the purchaser side was very underdeveloped in many provinces and the main co-ordination role at district level lay with the CUP on the provider side. However, in Roi Et the CMO was clear that the co-ordinating or 'central management' function rested with the PHO, assisted by the PCIHL. From the perspective of senior administrators of PHO was the central manager that would smooth out the problems caused by capitation-based funding, and the viability of smaller districts and units.

We still have to the 'central manager' at the province level because in our country at each level - villages, sub-districts, districts - there were differences in capacity and different numbers of population, so that budgets based on numbers of people would lead to problems. That is because in a large district which has a lot people, say 100,000, they might receive a large budget, maybe around 60 million baht, which they didn't get in the past. Regarding a small district covering a population of about 20,000, they might get 12 million baht. So there might be a big difference between the two. So that certainly the last one could not have survived, because in terms of the hospitals, they have the same fixed costs. That is a reason why we have a 'middle man' in the form of a committee to manage the balancing here. Consequently, we had an office at the province to oversee this matter. And perhaps the district administrators might not understand because they didn't have experience of this. (SAO-PHO, RE 01)

During the period from the start of implementation to the creation of the NHSO in 2002 there was considerable ambiguity about what the new supervisory role of PHO entailed. From the MoPH perspective the idea of 'supervision' was not clearly linked to the purchasing role, and in the view of many local actors was more about acting as the local arm of the Ministry to keep reform implementation on track. However from 2002, the NHSO (although still not functioning as the primary purchaser) designated the PHOs as its branch offices. This opened up a discretionary space in which different PHOs could decide to develop their role in different ways. Some like Kalasin and Mahasarakham interpreted

the supervision role in traditional MoPH terms, but others like Roi Et started to put more emphasis on the purchaser role.

The senior Roi Et officers did this by emphasising the 'evaluation' aspect of supervision, which also linked to purchasing. They developed a system of performance appraisal and grading – much more elaborate than anything in the other two case study provinces - that they imposed on the lower-level units, and which gave them a new way to steer the local health care system, which did not depend on control of money.

We changed the PHO organisational structure in line with the reforms of the bureaucracy. After that we started to act in an evaluation role much more and we developed local supervision to include evaluation. We brought together supervision and evaluation. When we had finished evaluating the local units, we would make suggestions. (...) The supervision style has changed to evaluation. We set new criteria based on the new policies about 'KPIs' (in English – key performance indicators), then decided what to do and how we should follow this up. We divided the supervision schedule into 3 phases. Phase one is checking on the planning process – whether it is based on policy and is going in the right direction, and benefits people. The second phase concerns planning processes and whether they are working to follow their plan or not. And, the last phase concerns 'outcomes' (in English) what they have achieved. We have reported on all phases and presented this to district health administrators. Additionally, we gave them a grading or score, which is an overall grading based on 'KPIs', which allows them to make comparisons with others. Scoring is helping us to develop together in the province. (SAO-PHO, RE 01)

Interestingly the new system involved reporting back to lower level organisations on performance scores, just as much as reporting upwards to supervising bodies, such as the Health Region, on aggregate performance of the province. The new arrangements thus emerged as a powerful tool via which the PHO could force units to compare their performance with others and press for improvements where scores were low. This came at a time when the PHO was losing its previous control of resources and the management of the district offices and service units, and appears to represent an attempt to create an alternative source of power based on the evaluator role.

From the point of view of senior administrators, the supervision role was linked to the PHO's new role of purchaser, as the local office of the NHSO. From their perspective the PHO would need to set standards and ensure that the central funder was getting value for money. The PHO was able to maintain this stance with bodies in the local health care

system despite the fact that its own budget had been cut dramatically. Although it could not retain monies, the PHO could exercise some control over the new UC budget channelled from the MoPH to the CUP by delaying or speeding up payments. It could also use the threat of redirecting payments based on performance against KPIs.

The top PHO administrators admitted in interviews that the change to this style of supervision led to a degree of conflict with staff in the service units.

When the new policy came in that caused the management of the PHO to change. Previously, the PHO commanded the health care service units but it now became a 'purchaser or standard setter' [English]. That brought in a much clearer relationship between them, like a purchaser/ provider split. This affected the PHO because their service activities have been pushed to providers. Many staff in the service sector has moved out to the service units, which decreased PHO staff numbers. (...) Regarding the new roles as the purchaser and standard setter, that forced staff to learn new functions and also increased workload. (SAO-PHO, RE 02)

The ministry ordered us to use the seven issues of the strategic plan in evaluation and supervision. That meant we had to learn about this but one problem was that the health officers weren't very familiar with the 'new evaluation' (in English). The new indicators that we had developed led to problems when we used 'ranking' (in English) and linked this with a reward system, because the results reduced work morale. Instead of the evaluation system encouraging the staff, it actually discouraged them. For example, in some districts where they did not work well their scores were high, that was an error of the system. (SAO-PHO, RE 02)

Regarding supervision, we gave scores and summarised the overall results across the province and then gave feedback to them. At the beginning we had a bit of a problem with them because we were unclear about the criteria. Later on we made changes and told them about this which lessened the problem. (SAO-PHO, RE 06)

The CMO appears to have set out to counter these problems by using his strong networking and communications skills. There was a proliferation of meetings, sometimes located at the CMO's family restaurant, at which problems were discussed and thrashed out.

We used the top administrators' meeting for provincial problem solving, and sometimes we allowed others staff to come to meetings to solve problems together. (SAO-PHO, RE 03)

We learnt things from training and meetings. The CMO was an important 'key man' [English] and presented data and problems to discuss, so that we discussed and learnt from each other in the meetings. (SAO-PHO, RE 07)

Meetings were used to disseminate information about the new evaluation system, and discuss changes such as the decision to apply a system of 'PSO'³¹ standards.

We used meetings as the main method, and we had a good opportunity to put ourselves forward for the public service organisational contest award, which was promoted by the central government. We started the 'PSO' (English) and in this scheme they could check our work against that of others. I tried to add in 'innovations' and didn't tell our staff. We had to introduce 'provincial standard data sets' which would help us to think things out together. (...) Of course, some people can understand and some people did not understand. (SAO-PHO, RE 01)

These 'innovations' were what set Roi Et apart from the other study provinces and allowed its PHO to maintain a relatively active stance to overseeing the reforms.

Respondents in lower-level organisations who were interviewed reported a degree of confusion about the new approach to evaluation. Some claimed that it was peripheral to the real problems of resource allocation and shortage of money about which the PHO did little to help. There was a feeling that evaluation related to an additional level of analysis that was not the service units' problem.

The PHO didn't help us move forward because the money was gone and they acted only as a supervisor. The supervision style was changing. They didn't have many suggestions. They went to collect results and give a score. (DHO Head, RE 20)

With regard to the supervision, the PHO came to follow up their problems, they weren't our problems. For example, in the case of the Minister visiting, they only came to prepare for the tasks that concerned them, such as that the Minister had to give out the gold cards to people. We had to work all night preparing when the Minister came, and the PHO staff only assembled in the morning. After the Minister finished they were gone as well. They were only there to take the credit. (HCO, RE 40)

In late 2002, when the NHSO began to operate in a partial purchasing role, there was a corresponding reorganisation in the MoPH, The Bureau of Health Insurance in the Ministry transferred part of its functions (and staff) to the NHSO, but retained part of its

³¹ Standardisation for Public Service Organisations or so-called PSO was a quality management scheme adopted by the government based on the ISO (International Standards for Organisations).

work in the Division of Health Insurance. This came after a period of uncertainty when it had at first seemed that the Health Insurance Group would work under the NHSO, but then seemed more likely to remain under control of the MoPH. PHO staff had to adjust to these successive changes, and try to develop new working relationships and learn the new rules.

Working in the Health Insurance Group we work rather hard because we have to be familiar with all the data and manage both the claims system and budget allocation. Regarding cooperation with the centre, at the beginning we contracted with the Bureau of Health Insurance in the MoPH. Then last year based on the National Health Security Act they were divided into two organisations: one being the NHSO which was an independent organisation and one that remained in the MoPH being called the Division of Health Insurance. At the provincial level, in the beginning we supposed that the Health Insurance Group would move to be under the NHSO according to the new bill at around 2004 or 2005. However, the Ministry gave new orders that we were to remain under the command of the Ministry, because the PHO was under the command of the Permanent Secretary as well. But the NHSB appointed the PHOs to act as the branch offices of the NHSO in the local areas, based on the authority of the new bill. Yet, this is an abstract approach because we are still reporting to the Ministry. This confused roles and things did not settle down. (SAO, PHO, RE 05)

Now, the CMO acted as director of the branch office of the NSHO in the province, as appointed by the NHSO in addition to his CMO role. Many orders have been sent down from the Ministry and the NSHO, so that we have to respond to both. However, we certainly have to obey the Permanent Secretary because we get our salary from the Ministry. (...) As we have seen there are a lot of problems because the guidelines have changed day to day and new regulations were announced week to week and these have always been changing. (SAO-PHO, RE 06)

The NHS Act required the PHO to act as the branch office of the NHSO in the province. That meant that the CMO had dual duties both as the director of the NHSO branch office and the chief of the PHO, which was the main organisation on the provider side under the MoPH. This placed the PHO in a complicated situation in relation to the purchaser provider split, but opened the way for a dominant CMO to exercise considerable influence over both the purchasing function and providers in the local area. Across the nation different PHOs reacted in different ways to this opportunity: in some places the CMOs were able to control the main service and professional networks in the province and gain near-absolute power over UC implementation, but in other places where power was more fragmented the CMOs had to struggle for control with other interest groups. As discussed above, the CMO in Roi Et had previously occupied a senior administrative position in the MoPH and had strong leadership skills and good contacts, which enabled him to take a

dominant role in managing the local health care system, largely using the justification of exercising the purchaser function. At the same time however a good deal of the talk about commanding activities in the province centred on traditional public health activities such as setting a lead on disease prevention strategies and co-ordinating activity in times of crisis, such as disease outbreaks. Thus the approach taken in Roi Et was based on a PHO claim to elements of both the new and old roles.

The CMO in Roi Et was in a position where there were no real rivals to his power in the senior levels of the PHO, where his wife occupied a strong supporting role as Deputy CMO and where others in the hierarchy were willing to give support. The organisational culture that emerged was one in which traditional hierarchical authority remained important, but where seniors continued to have an obligation to assist juniors in accord with the Thai cultural mores of '*quam-bpen- pee- bpen- nong*' (the idea that older siblings help younger ones)

Regarding that topic the non-UC budget, it's been given already but not used adequately. Due to the system we come from, we act like seniors towards juniors. If the money is finished then ask in the community hospital via the doctor director in the CUP. The CMO might help make the connection. We have a good organisational culture and a mutual support system. Many people come into contact which they admire and which brings us an advantage. The assistant CMO is also a person close to the CMO. Personal relationships and sibling relationships still help a lot in solving work problems. And the senior administrators group in the province works as a good team together, which helps in work of different kinds. (SAO-PHO, RE 06)h

The image of family relations transposed on to an administrative organisation conveys an idealised image of social relations in the local health care system. However, in more general terms this may be seen as an attempt to stress the importance of close relationships and co-operation between organisations in changing times, when new resource allocation arrangements and the purchaser provider split might have led some organisations to act in a self-interested way.

7.3 How the financing framework was adapted to local conditions

7.3.1. Adapting to the new financial framework

Roi Et represents another, though different example of a an active stance to the new resource allocation arrangements. In line with the role of active purchaser, with a strong emphasis on evaluation and monitoring of performance in the service units, the Roi Et CMO tried to maximise his control over the flows of funding. As will be described below, Roi Et used the exclusive model, held a salary budget at provincial level and created additional contingency funds, so that the basic capitation payment channelled to the CUPs was already minus significant deductions. Roi Et utilised provincial contingency funds to top slice money from the better off and adjust allocations for service units in trouble.

Regarding the new budgetary system, we could not use the money. However, we could adjust the allocations. For example, in 'M2' (district) we certainly knew they were in trouble because they served a small population and that led to a funding crisis. We decided to top slice around 5% of the provincial budget to set up a 'Contingency fund'. When the hospitals faced money problems, they had to submit a proposal to the PCIHI, and later on we would discuss in the committee whether to allocate funds to support them, which took the form of a 'LOC' or Letter of Credit (English) to enhance their budget. We applied this method to solve problems last year. But this year, we are perhaps applying a new support mechanism, which will allow them to get funds but impose conditions, to stop them just making requests and not trying to solve their problems. Or alternatively they could pay back the money by instalments out of next year's budget, which is a way to safeguard the central fund for the future. (SAO-PHO, RE 01)

7.3.2 Choosing a budget allocation model

In early discussions about the budget model to be adopted, senior PHO administrators, including the CMO, favoured using the 'inclusive model'. This is confirmed in a summary of the supervision report of Bureau of Health Insurance on January 2002. Respondents interviewed informally (and off tape) suggested that this was in line with the stance taken by the Society for Doctor Directors of Community Hospitals in discussions with the PHO. It also reflected senior administrators' view that the logic of the reforms involved channelling monies to the CUPs and that 'fairness' required that most of the capitation payment be passed on. However, at this time the doctor director of the provincial hospital, whose voice carried weight because of his former MoPH position, made a strong argument

for use of the 'exclusive' model on the basis that the hospital might otherwise not be financially viable. In subsequent discussions some of the Community hospital doctor directors changed their previous position to support the provincial hospital, on the basis that its viability was important for their own tertiary referrals. Soon the CMO also changed his view to support this approach. It was agreed that the salaries budget would also be held centrally. As in Kalasin, the main reason for favouring an 'exclusive model' was to ensure that the provincial hospital could carry on and guarantee that staff salaries across the province could be paid.

Respondents reported that once the choice had been made there was little opposition and few problems. Although a small number of doctor directors interviewed were still unhappy with the system, a majority appeared to support it,

In Roi Et we use an 'exclusive model' and 'the salary costs' are held at the province, so that we have had no problem. If we applied an 'inclusive model' they would have a problem because the provincial hospital was the largest hospital. Their salary costs are a burden because they have a lot of staff. (DDCH, RE 18)

One senior doctor director offered an interesting variant on this view when he said that he supported the exclusive model, but had realised in retrospect that the top-slicing of the salaries budget had not benefited the province. This was because in the following year, the separate salary budgets were consolidated into a single central budget held at the Ministry, which then allowed a re-allocation of monies away from the North-eastern region.

Here, we used an 'exclusive model' from the beginning and we have had no problems, so I would agree with this. But, with regard to the salary costs being held at the Ministry, I disagree. We should fund more at the regional level so as to support workforce reallocation. Deducting salary costs at the Ministry did not force a redistribution of staff, while the money held at provincial level was so small. (DDCH, RE 14)

In this respondent's view the system would have been fairer if the salaries budgets had been held at Health Region level rather than national level.

One senior PHO respondent mentioned that the capitation model had made direction and co-ordination of P&P activities more difficult, but this was not a consequence of exclusive funding as such:

In Rio Et, we used an 'exclusive model' and deducted the salary costs at the province, then allocated a part based on the capitation model. Generally, there seems to be no problem but this has affected promotion and prevention activities. Previously, we had a central fund at the province so that in the case of communicable disease control, such as hemorrhagic fever, which by the nature of the disease spreads to other areas, prevention and control were commanded from the provincial centre. But when the budget was isolated in each CUP, we may have a problem in linking everything together. (SAO-PHO, RE 04)

7.3.3 Safeguarding the service units

As mentioned above the choice of resource allocation mechanism was made mainly to safeguard the provincial hospital. However, a number of other steps were undertaken to support service units likely to lose budget under capitation. In particular the CMO established a 'Fund for Service Unit Investment'. This was created by top-slicing about 10% of the provincial budget after deductions had been made for salary costs. In the first year, this fund was divided into two parts: 5% went into a contingency budget (known as the CF budget), and 5% went to a 'reserve' for outside referrals under the control of the Health Insurance Group. The CF was intended to be used to top-up the budgets of capitation-losing hospitals in the province. Such hospitals were able to make requests for assistance to the PCIHI, who were then able to make payments according to their assessment of the problem. In Year 1 and Year 2 this was paid as a non-returnable grant to a small number of problem hospitals, but in Year 3 the majority of hospitals within the province tried to claim on the fund. This led the PHO to review the mechanism and a new policy was introduced whereby payments to hospitals were regarded as repayable advances against the next year's allocation.

In Years 1 and 2, the CF help was concentrated on just four small hospitals which were receiving insufficient capitation funding to be viable.

We were covering a small population of about 30,000 and this year the budget decreased. At the moment we have received around 63% of what we got last year. However, we can maintain ourselves and continue work. If we faced money problems, the central fund at the province would help us. There are 4 hospitals which the fund has to support- 'S', 'P', 'M1' and 'M2'. (...) Last year we obtained from the 'CF' 3 million baht and this year they told us we would receive 2 million. (DDCH, RE 19)

Actually, this year I received 12 Million. In the past I got about 5 million per year. Regarding the size of the population we could have 10 million but an expert

- Dr. Ammar - has studied this and suggested that in places which were covering a population under 30,000, there would be difficulties so that they should have a central fund at the province to support these. Roi Et established this fund and that led to me getting a top up of 2 million; so in total I received 12 million. (DDCH, RE 18)

Despite their relatively small size all these hospitals incurred significant fixed costs and salaries costs, which could not have been met without the additional CF. They faced the additional problem that government regulations required hospitals in some remote rural districts to pay a salary top-up for health professionals. This was not included in the top-sliced salary budget controlled by the PHO and had to be paid directly from the hospital budgets in Year 1.

I am worried about the budget because in my district I have to ask for the special monies that we called 'CF monies'. If we didn't get this we wouldn't survive. Another budget was the support budget for remote areas, which we didn't get in the first year but we got in the second year, so that we had to pay from the UC budget in the first year. Regarding this budget, we have to pay a top-up to the salaries of the health professionals – the doctors, dentists and pharmacists - who work in the rural areas, as in our district. (DDCH, Focus group in RE)

In year two, the CF was decreased from 5% to 3% of the UC budget (minus salaries). This was the year when the total budget for the province was reduced because the Ministry held the salary budget at the centre and reallocated part of this to support hospitals in other regions. This general reduction in the budget affected all hospitals, both large and small, across the province.

Regarding the capitation rate, at the moment it wasn't sufficient for implementing the policy. In 2003, I felt we had a problem with insufficient money and as we've seen this was 'cut' across the entire (health) region. We had to argue about the budget, many community hospitals requested money from the 'CF'. The Roi Et hospital had lost out, but we've seen that the community hospitals have lost much more and everyone lost so that we didn't know what to do. The older brother has to save the younger brother, so that we had to put our reserve money to use. (SAO-Provincial hospital, Focus group in RE)

I was worried in the first year because according to our expenses and income we could lose in many ways. We discussed this a lot and I don't know if our staff got as stressed as me. But in year one I felt very pressured. I had to fight at the provincial level for additional budget. We weren't clear about the mechanism which made me feel stressed about whether they would support us or not. Sometimes, the provincial committee came to visit us but we felt neglected because of the PHO's approach to us. They didn't seem to pay much attention to

us. We continued the work in year two and the pressure decreased somewhat. Later on in year three the pressure was gone (laugh) although they took the same interest in us. Perhaps, we could change ourselves with much adaptation. This year is the third year and we aim to stop using the CF, but I don't know whether we could survive or not without it. (DDCH, Focus group in RE)

The pressure on budgets resulted in a proliferation of claims on the CF budget and increased conflict between the provincial and the community hospitals about the costs of referrals. Senior PHO administrators acted in a mediator role and set up a number of meetings to try to resolve problems. They reviewed the existing CF mechanisms and prepared new arrangements for Year 3 which increased the proportion of UC funds (after salary) going to the CF to 8%.

I worried about the relationship between the large hospital and small hospitals, such as the provincial hospital and community hospitals. If they did not understand each other they would grab money and that would cause a lack of co-operation between them. The large hospital complained that they were loaded with large numbers of referrals, while they got a low budget and claimed that payments did not cover their costs, or they argued for a different RW rate, etcetera, etcetera. That meant when the new financing arrangement came in they all worried about bankruptcy, so that they tried to keep as much money as possible. We were facing this problem on a couple of occasions when the PHO came in to solve a problem. And we agreed that if we went bankrupt we would both be affected and if we became rich we would be rich together, so that we should support each other across the entire province. So, in the mid-month meeting we changed so that we only had UC implementation on the agenda, and where we all tried to solve the problems together. (SAO-PHO, RE 01)

7.3.4 Referrals and the Clearing House

As in the other provinces, Roi Et made arrangements in Year 1 to create a central fund for referral payments to the provincial and other tertiary care hospitals. This was overseen by a section in the Health Insurance Group and it was only in Year 2 that this became known as the 'Clearing House'. Part of the money for referrals was directed through the referral reserve which made up about half of the Fund for Service Unit Investment. This referrals reserve was funded by separating off part of the UC budget, and was fixed at around 5% in each of the first three years of the scheme. The other monies used for referrals came from the main IP budget, also controlled by the Clearing House. The arrangement in Roi Et differed from those in neighbouring provinces, where the clearing houses allocated IP funds for referrals, but had no additional referral reserve. One problem with IP monies was

that the main UC budget arrived in four instalments through the year and the IP funds could fall low just before each new quarterly payment was due. In Roi Et the reserve was allocated in full at the beginning of the financial year and was used to guarantee referrals in at times when the IP budget was low. As elsewhere, the Roi Et Clearing House administered the claims system, and reimbursed hospitals based on the DRG model.

A senior PHO administrator stated that the 'exclusive model' and the associated central fund had prevented significant problems with delayed referrals.

If we used the 'inclusive model' it would certainly lead to this problem. We learnt from the pilot provinces that in provinces where they used the 'exclusive model' they did not have this problem, but in the provinces where they used the 'inclusive model' they faced a problem with delays, because if they referred from the district hospital to the provincial hospital they would have to pay all costs. So they tried to keep as much as they could. The experts had already predicted this, which they called 'financially-led services'. But, if we used the 'exclusive model' as in this province, we would have a 'central fund' at the province so that they could routinely refer because the claim payment was managed through the provincial fund. (SAO-PHO, RE 02)

DDCHs, such as the following respondent, also suggested that the problem of delays had been avoided in Roi Et. This doctor argues that professional ethics and the risk of public complaints anyway meant that most doctors would refer appropriately rather than retaining patients to maximise income for community hospitals.

We had no problem in this province because we are people-oriented and we think patients are like relatives. So why would we retain them? If we did this we would risk both that they complained about us and that we wasted money. We can make referrals if it is better because we already have a fund at the province. Additionally, the Medical Council is very strict on this now. (DDCH, RE 17)

The main problem between the community hospitals and the provincial hospital was rate at which referrals were charged. This rested on a complicated calculation based on the relative weights (RWs) payable to different hospitals in relation to particular DRGs, and frequently led to arguments in PCIHI meetings, as reported by the DHO head responding below.

Regarding the budget arrangement they argued every month about aspects of the referral system, claim payments and the provincial hospital's payment rates

etcetera. Those were usually the issues for argument between the provincial and the community hospitals. (DHO Head, RE 20)

A source in the provincial hospital confirmed that staff there had been unhappy about the calculation of RWs, and especially what he regarded as the inadequate differential between cases that could be treated in the community hospitals and referred patients requiring more specialised treatments.

Generally, the provincial hospital has often lost because we are the highest secondary care unit, and when they cleared money based on DRGs we usually got low scores. In this province we applied the 'exclusive model'. One problem was that we used RWs in DRGs to allocate money back to the hospitals, but in Roi Et '1RW' was set at the same rate for both the provincial hospital and the community hospitals³². Whereas we have different capital costs so that the community hospitals send a lot of referrals to the provincial hospital and don't take responsibility. Regarding other provincial hospitals, such as Korat and Khon Kaen, they are regional hospitals so that they got the benefit because they could receive much more than us, almost twice the amount, especially in a centre of excellence they could take much more³³. I would like to see a study of the basis of the RW rate by unbiased outsiders to set a new rate which would be acceptable to everybody. (Senior doctor PH, RE 09)

The provincial hospital was the main centre for referrals inside the province, and frequently complained that referral payments did not cover its expenses.

For their part, the community hospitals argued that the provincial hospital received income from a number of funding streams, including routine cases and primary care. This overlap between the hospitals 'district role' and its role as a referral centre often came up as an area of controversy in the PCIHI and other forums.

There is a difficult problem of management regarding Roi Et hospital because they are a general hospital which looks after Muang district, but with regard to the budgeting problem, the PCIHI assigned two districts – Chaing Khwan and Thoongkaoluang - to come in as well. However, they still have a lot of expenses so that they usually complained that they had lost, while the community hospitals complained that Roi Et hospital had charged quite a high rate. (...). There were often arguments between Roi Et hospital and the community hospitals in the war room meetings. (SAO-PHO, RE 04)

³² 1RW in the provincial hospital and the community hospital = 10,000 baht

³³ 1RW in the regional hospital = 14,000 baht and the university hospital = 16,000 baht

Some respondents suggested that the provincial hospital should have responsibility only for referrals and tertiary care, and should be funded only for this activity.

I could never see why the provincial hospital couldn't survive. For example, now, Roi Et hospital has a reserve of more than 100 million. Actually, if we need to develop the health care system, the provincial hospital should only be the tertiary care centre of the province. They should have responsibility for special care and referrals. (DDCH, RE 19)

The clearing house and referral payment system in Roi Et was different from both Maharakham and Kalasin. These two provinces released some part of IP budget to the CUP and then applied the DRG system to re-allocate monies depending on claims between hospitals in the province. In contrast, Roi Et's PHO established a referrals reserve used to smooth out fluctuations in the IP budget. Any remaining IP monies were then returned to the CUPs at the end of fiscal year, but usually there was no unspent balance.

7.3.5 Summary of financial changes in Roi Et in FY 2001-02, 2002-03 and 2003-04

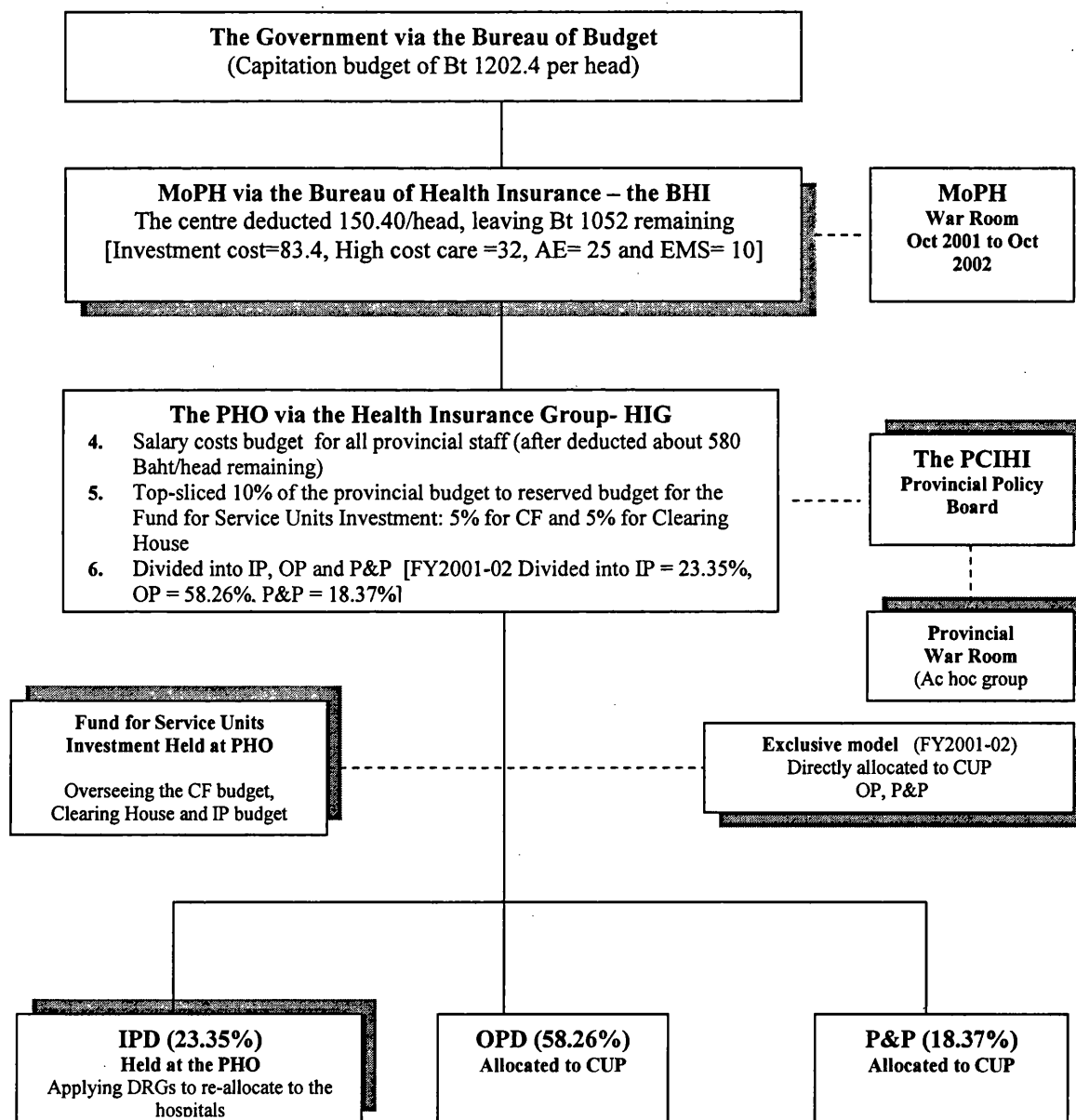
In summary, during Year 1, Roi Et applied an 'exclusive model' and also held the staff salary costs at the province. A 'Fund for Health Service Units Investment' was set up which top-sliced about 8% of the UC budget to be managed by the Health Insurance Group. This was split roughly between the 'CF budget' (which supported smaller hospitals) and the referrals reserve. The remaining 90% of the UC budget was divided into the three categories of: IP, OP and P&P. In Year 1, this was split between IP at 23.35%, OP at 58.26% and P&P at 18.37%. The OP and P&P budgets were directly allocated to the CUPs, with the condition the CUPs must support PCUs and health centres in their own district.

On the whole, the financial arrangements in Roi Et's 'exclusive' model differed only a little from Maharakham's 'mixed' model and Kalasin's 'exclusive' model. The main difference concerned use of the IP monies. Roi Et PHO held the IP budget centrally and used the DRG model to pay for referrals on behalf of the CUPs based on actual inpatient treated. In contrast both Maharakham and Kalasin released some part of IP to the CUPs, to spend on low-cost inpatient cases in their own hospitals. An additional point of difference between Roi Et and the other two provinces was the allocation of monies for fixed costs to health centres. In Maharakham and Kalasin these were excluded from the

provincial UC budget and directly allocated to the health centres. However, in Roi Et there was no separate fund for these expenses, and the corresponding monies were included in the P&P budget and directly allocated to the CUPs. This meant that it was within the discretion of the DDCHs who acted as the chair of the CUP board whether to allocate monies to cover fixed costs and at what level.

The main funding flows and relationships for Year 1 are shown in the following figure 7.1.

Figure 7.1: Financing arrangements and relationships between organisational divisions in Roi Et in Year 1 (FY 2001-02)



Adapted from: Roi Et PHO Report 2001-02 (Roi Et PHO 2002)

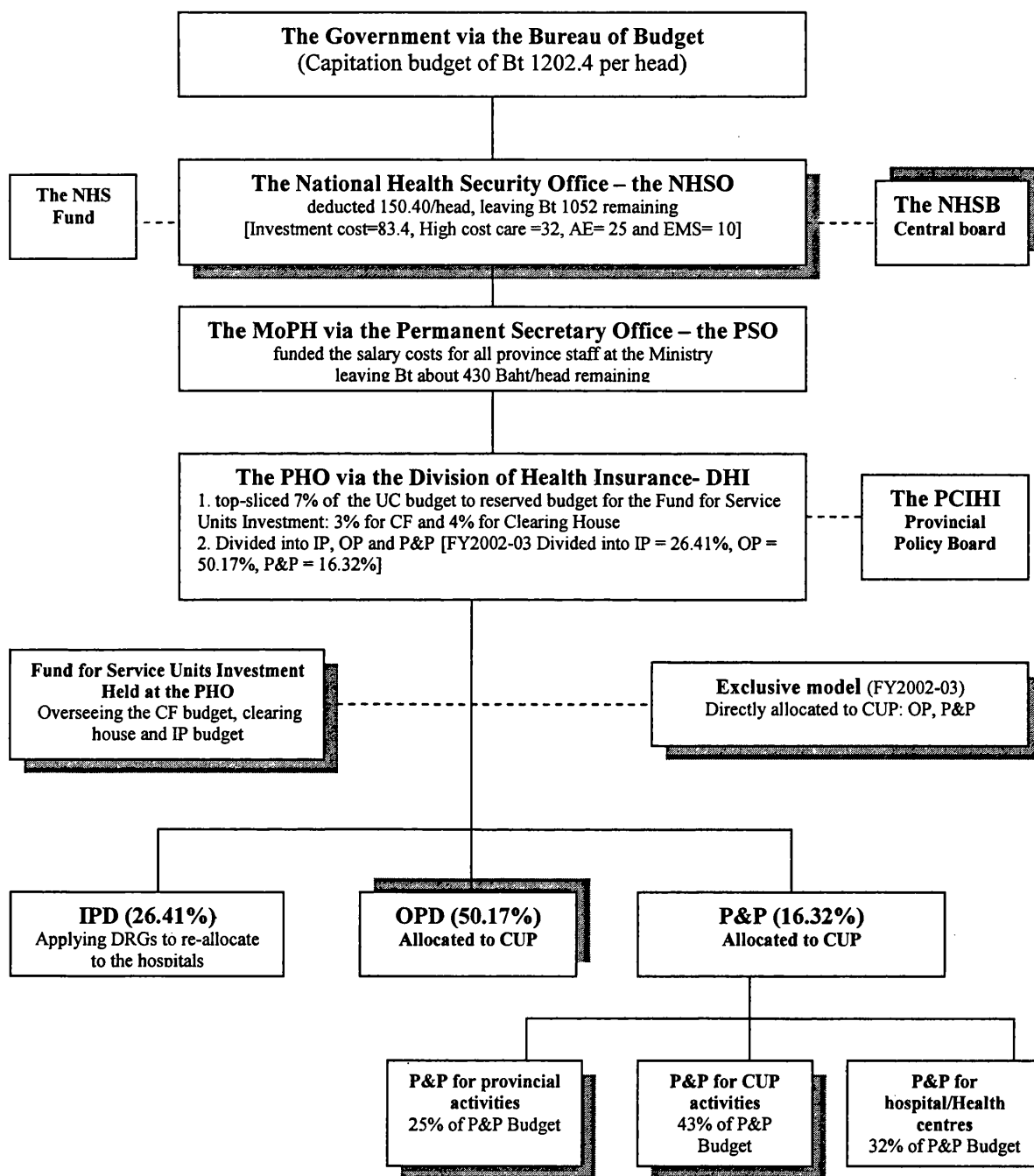
In Year 2 the Ministry required all Esarn provinces to draw salaries from a central national budget, and also to apply an 'exclusive' funding model at provincial level.

Roi Et continued with the Fund for Service Units Investment, which was reduced slightly to 7% of the UC budget. This was now split between 3% for the CF budget and 4% for the referrals reserve. In Year 2, the split in the remaining UC budget was 50.17% for OP, 26.41% for IP, and 16.32% for P&P. The IP budget was again under the control of the clearing house at the PHO, while the OP and P&P budgets were directly allocated to the CUPs. However, the P&P budget was now divided into three categories: 25% for provincial activities, 43% for CUP activities and 32% for hospital and health centres activities.

As in Year 1, there was still conflict between the hospitals and the health centres about the P&P budget. It was, because many health centres didn't receive the expected budget. This is discussed later in the chapter.

Figure 7.2 shows the resource flow and relationships between organisational divisions in FY 2002-03.

Figure 7.2: Financing arrangements and relationships between organisational divisions in Roi Et in Year 2 (FY 2002-03)



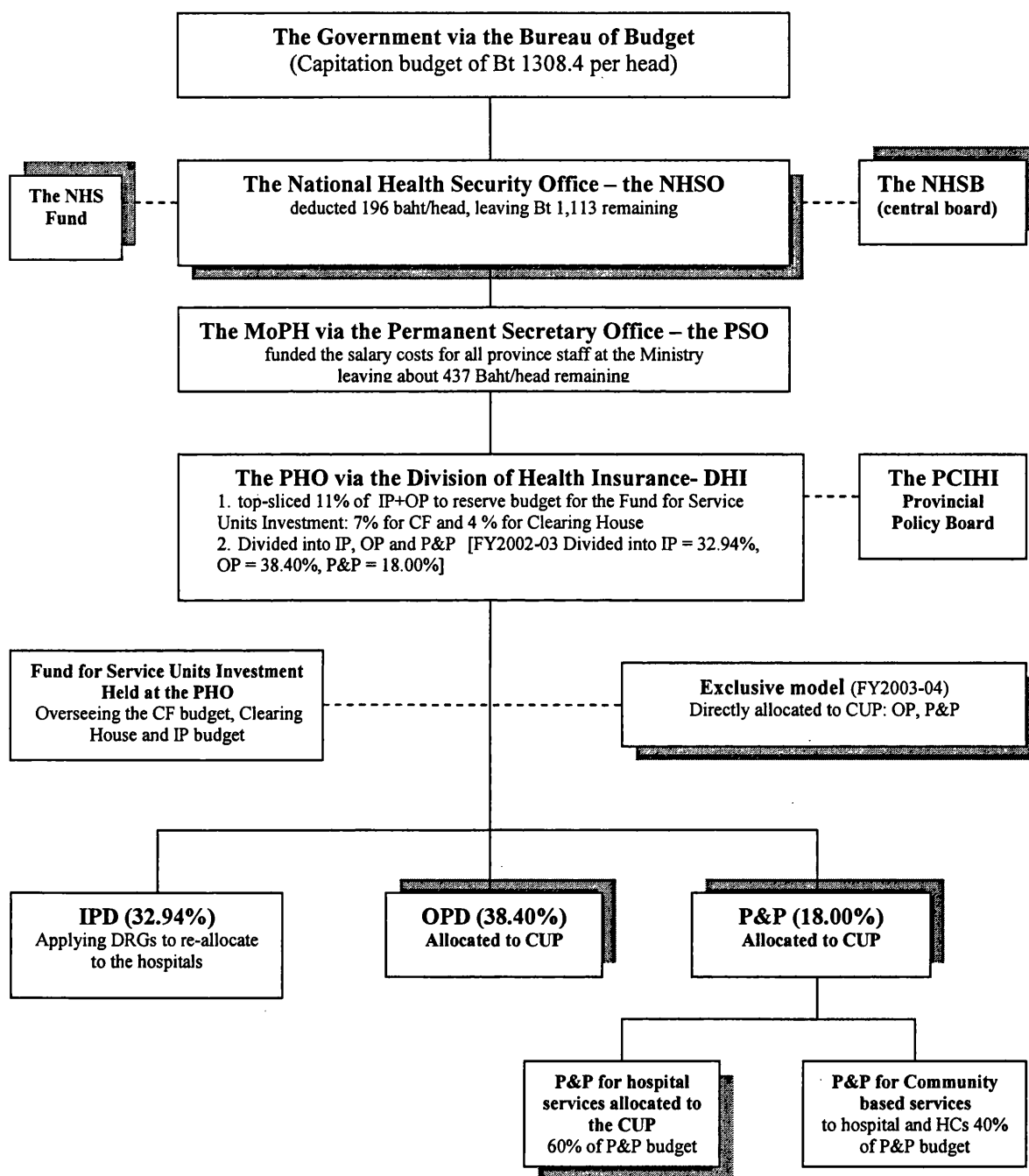
Adapted from: Roi Et PHO Report 2002-03 (Roi Et PHO 2003)

In Year 3 salary costs were again held at, and disbursed from the Ministry. In this year, the Fund for Service Units Investment was increased so that it now accounted for 11% of the UC budget, with 7% going to the CF budget and 4% to the referrals reserve. In Year 3 the remaining UC budget was split between 38.40% for OP, 32.94% for OP, and 18% for P&P. As before, the IP budget remained under the control of the clearing house, and the OP and P&P budgets were directly allocated to the CUPs. However, the P&P budget was now divided into two categories: 60% for hospital activities and 40% for health centres activities.

There was still no separate fund for health centres' fixed costs. However, the PCIHI/PHO had now ring-fenced 40% of the P&P budget to go to health centres so as to solve a problem of under-funding of health centre. Again this will be discussed later in the chapter.

The main funding flows and relationships are show in the following figure 7.3.

Figure 7.3: Financing arrangements and relationships between organisational divisions in Roi Et in Year 3 (FY 2003-04)



Adapted from: Roi Et PHO Report 2003-04 (Roi Et PHO 2004)

7.4 The views of actors in the local health care system

7.4.1 The view from the community hospitals

For most community hospitals the arrival of capitation-based funding, channelled through the CUP, resulted in a significant increase in funding. In year 1 the doctor directors had more money than at any time before. As discussed earlier, the exceptions were smaller hospitals, based in low population districts, whose funding streams were small, but who - in the worst four cases - were assisted by the CF scheme.

The general picture, however, was of significantly increased funding and the possibility of taking on more staff and developing new facilities or projects. The problem was that new staff were not easy to recruit. This was not so much related to the availability of funds to the hospital, but to the Government rules that set public sector salaries at a low level, which was unlikely to attract doctors to move to remote Esarn provinces.

For example, my district covers a population of 80,000 and the guideline that was decided was one doctor per 10,000 population, so that we should have at least 8 doctors but we have only 4. We were able to keep working but with regard to proactive work it didn't go well. We needed to increase the staff but where could we go to get them? Actually, we had budgets to employ them but doctors didn't come because nobody would come for a salary of around 8,000 baht per month, plus extra payments of say 20,000 to 30,000 baht. With regard to work in the private sector they could all get sums of nearly 100,000 baht. Additionally, working for the public sector under the new title of 'government officer' didn't bring the same benefits as the civil service. As we have seen, this year the rate of doctor resignations is significantly higher. At this point the centre needs to come and see what is happening. (DDCH, RE 15)

We have a problem with shortages of staff such as nurses. We have only 27 or 28. This doesn't meet the requirement in the guidance, which we've missed from the beginning. When we raised this at a higher level they told us that the budget was already allocated to us, so that we had to recruit additional new staff by ourselves. However, we don't know what we should do because nobody wants to come. For example, in case of a doctor, here, I were working alone from 1995 to 2000, then in 2001 we just had one other who came in. At the moment we have 4 doctors. Now, the government rate is around 8,000 baht per month, while the private hospital pays about 100,000. The result of that is that nobody comes: even though we had money we couldn't find new staff. (DDCH, RE 19)

Regarding health professionals in other disciplines such as nursing, we were allocated limited numbers. We tried to work with each other. If we had to increase the number of posts we would have to consider that carefully, because we don't employ people for only 2 or 3 days. We have to consider whether this is economic or not. (...) With regard to the problem of the staff shortages, we are trying to solve this, even though it is difficult to recruit new staff. For example, in the case where 'Suwanaphumi' hospital advertised to recruit new nurses, they did this for 3 to 4 months, but didn't have any applicants, and in the case of Roi Et hospital they assigned newly-graduated nurses to jobs as temporary employees to fill about 40 to 50 posts. After not very long about half of them left for better jobs, which were much more firm. They quit because here the salary rate was lower and their position wasn't as stable as being in the civil service. Because after the year of economic crisis in 1997, the civil service was the most secure job, which is the strength of being a civil servant, even though there is the downside that the salary is not high. (DDCH, RE 15)

Many of the staff working in community hospitals in Esarn are professionals who come from the north-eastern provinces. As one DDCH respondent (RE 16) told us: 'the majority of staff in the hospital are native to the district'. One recruitment strategy employed by some community hospitals was to target Esarn people who had moved to find work elsewhere and encourage them to return to their home areas. The problem was that this involved an element of forward planning and took time to achieve, and within a year community hospitals found their budgets cut following the change of policy on salaries at the MoPH. At the same time, the old system of temporary secondments, which had often meant that staff moved from smaller to larger community hospitals was changed. Under a new work force planning system, the permanent staff complements of service units with a large de facto staff (i.e. units with a history of boosting their permanent staff by accepting many secondees) were allowed to increase the number of permanent employees in line with their actual staff needs. This meant that many smaller units, which had been managing with less than their official staff complements, suddenly found that their official numbers were cut in line with their actual staff on site.

Previously some of our staff moved to work temporarily in other places in line with the regulations of the bureaucratic system, and we supposed that they would come back based when we heard about the new financial mechanism announced by the Government at the start of the reforms. But, now both the positions and the staff have gone, due to the new rules via which posts move in line with budgets. The overall affect was that what at first we thought were positive measures have turned out to be negative measures. (DDCH, RE 15)

By Year 2, when salaries were held centrally, and not paid within the capitation funding, smaller community hospitals found that they no longer had money to recruit extra staff or even to reclaim seconded who had gone elsewhere on a temporary basis.

As stated above, failure to fill posts was a serious issue both in terms of the direct impact on workload, but also in respect of inability to meet Ministry guidelines and move towards the new ways of working required by the reforms. The 30 baht scheme was launched rapidly without good preparation at the local level. In Year 1, when hospitals and other local service units found themselves cash rich, yet were unable to recruit new staff, there were sometimes problems in using the money. One doctor director reported.

When the money went through to the health centres, say about 100,000 baht, some places didn't know what to do with it, but other places could manage it because they may have studied a lot such as for masters degrees. However, this depended on the DHO heads, who had various approaches, both conservative and progressive. With regard to the community hospitals as well, in some places when the money showered down, there was a problem of using it efficiently. Regarding the PHO when the budget was taken away, they had to reduce their roles which is a point I disagree about: because we should be using the PHO's experience to oversee things. However, at first the community hospitals clamoured because doctors had big voices in the health system. At the moment, I think the way budgets are used is not efficient. (DDCH, RE 14)

In some CUPs there was also uncertainty about how the new policies on 'close to the home' care and P&P should be apportioned between hospitals and PCUs/health centres, and the appropriate balance between curative care and other services.

The following doctor director puts forward a version of care in the community close to official policy, but draws attention to some of the problems of getting doctors out into the community and also of securing a population that will guarantee the hospital's survival. From his perspective community outreach is partly about establishing a relationship that will prevent people on the edge of the community hospital's catchment area from registering with adjacent providers, when the next phase of the reforms makes this possible.

The basic concept of the 'PCU' is not that of an 'extended OPD', but the doctor team has to go to the community. For example, [that was] regarding 'N' (sub-district) we visit there every Wednesday, so that a doctor goes to see people there because this area is far from the hospital. It meant that we moved the OPD to them. If a doctor didn't go, a nurse would have to take care of them but doctors

and nurses are accepted differently by the people. Under the guidelines of the PCU, nurses have to examine but they still don't have the same respect as the doctor. Additionally, the next step in this policy will be that the people will have freedom to register with a hospital. If we didn't go to block this, they would move to register with the provincial hospital because they are not far from the provincial hospital. We need to go out and establish a relationship with them. Due to the new financing mechanism, we would not survive, so we have to round them up. (DDCH, RE 17)

A contrasting view offered by another informant represents a trend affecting a number of hospitals, especially in Years 2 and 3, whereby the PCU was sited in the hospital and came to resemble an outpatient clinic. In this case, even though the PHO pushed hard for the service to be clearly separated from 'routine' hospital services, there was no actual split except at the level of data reporting.

Firstly, I would like to discuss the concept of the PCU, because I may have a different view from the others. We upgraded or improved the health centres to be PCUs, in line with the wishes of local people that they would like to have a doctor and nurse go to see them, but that was not the principle of the PCU. In fact a doctor was only advisory, and didn't go out to examine people like in the 'extended OPD' of the past. However, in the public perception when they saw a doctor that meant the doctor had to diagnose them. That was a misunderstanding of the PCU concept. When we have a problem with staff shortages then the guideline says we should create the PCU inside the hospital, separate from the routine units. Here, we didn't separate from the beginning because we considered that if we divided the unit we would need increased resources including staff, office space, materials and costs especially, and this might lead to double standards of service. Because people came to visit the PCU even though it was a PCU inside the hospital they might not see a doctor because that day a doctor wasn't working at the PCU. So, we didn't create a separate PCU away from the hospital. We split out only the data-base system. The supervisors from the PHO have visited us and tried to push us to divide into separate units, I needed to find something to make reference to and found that the central war room agreed in October 2001 that units should not provide care according to a double standard, and confirmed this with them. At the beginning, many hospital staff would have liked to split, but I didn't allow this because in the long term it wouldn't 'work'. [English] (DDCH, RE 15)

The justification used by this doctor director is that, given the possibility that doctors might be too busy to cope with hospital and PCU work, creating a separate PCU service might result in patient care that is inferior to care in regular hospital clinics, and that this would run counter to MoPH regulations about avoiding double standards. However it seems clear that his approach is quite contrary to the idea of the PCU as a community-based service unit.

Other DDCHs took the idea of community outreach more seriously and tried to find ways for staff to visit patients in their homes. The following doctor director respondent was enthusiastic about the benefits that home visiting could bring, but still wished to leave the hospital as the core unit in the local health care network. He suggested that visits to hospital for those requiring treatment were more appropriate than setting up clinics in community-based health centres.

With regard to this policy (PCU), I would like to highlight family visiting in which we have to identify a clear target because we are short of staff. Firstly, we plan to visit chronic disease cases but at the moment we are in the process of improving this. Perhaps in the coming 2 to 3 months we will go out every day and that would be the main element of community care services. Regarding people who come to see us in the hospital it is harder to get a good understanding of the case, but with cases outside hospital, if we have seen their home, we have a clearer understanding. For example, in a case of diabetes mellitus where we think that they may not be taking medicines following instruction we then visit their house and find a lot of medicines remaining unused. In some cases where they needed insulin by injection we wondered why they didn't get better even though we increased the 'dose', and when we went to their home we found they had problem both with the injection method and storing the medicines properly etcetera. We should focus on community care in this way, and this is much more useful than creating a PCU in the health centre. In my opinion, at the moment, transport from the sub-district to the district to access the hospital is easy. (DDCH, RE 15)

In this same respondent's view there should be a division of labour where the hospital was responsible for curative treatment, backed up by some home visiting, and the health centre should concentrate on P&P activities.

I think that we shouldn't push the health centre's role towards treatment care. On the other hand I would say that the health centre could act in health promotion and disease prevention much more. With regard to treatment care they should be responsible only for emergency care and basic care before referral to hospital. If we improved the health centres so they are small hospitals it would be the wrong direction to take because we have problems with shortages of staff and we haven't put aside a budget for this. Additionally, at present, most of the staff of the health centre are health officers and there are only a small number of nurses. If we were concerned with treatment care we would need to give them additional training because they have studied in a different field. We have to reflect on why we upgraded the health centres - for what and for whom? And the PCU is for whom? (DDCH, RE 15)

As in Kalasin, an important part of the Roi Et story concerns the failure of some doctor directors, acting in their role of CUP chairs, to pass money on to the health centres. As

another informant (DDCH, RE 14) acknowledges: 'When the budget came to the CUP everyone would try to get money, and with regard to meetings they would argue about their proportion, based on population and how much they should have had, whereas they should have been discussing real problems such as how we should control dengue hemorrhagic fever in the district etcetera'. Although holding back of monies was rarely mentioned in interviews with doctor directors, it came up frequently in interviews with DHO heads and health centre staff. This will be discussed in the next section.

7.4.2 The perspectives of the DHOs and health centres

In the view of some DHO heads the issue of resource allocation within the local health care system was the biggest problem in the implementation of the UC reforms. Part of the problem was that community hospitals needed to safeguard their own staff by ensuring that they had funds to pay the extra allowances introduced under the reforms to reward performance, and this led to the prioritisation of their needs over that of health centre staff.

The problem of the budgeting arrangement in the 30 baht policy was equity of distribution. Especially, starting at the CUP to primary care level, the health officers in the front-line didn't have sufficient money. The hospital was afraid that it would lose and not have enough money to pay extra allowances to hospital staff, so that the front-line staff in the health centres were seen as a burden and didn't get equity in this. As we've seen, the staff at the lower level didn't get fairness, and they usually made comparisons between the health centre and hospital staff. The hospital has been providing all facilities to staff, while in the health centres the staff have to look after themselves and pay for some things themselves. (DHO Head, RE 22)

The P&P budget, in particular, was a source of conflict between the hospital and health centres in many places. In Roi Et as elsewhere the budget had to be split to cover some P&P costs at the CUP, as well as P&P work in both the community hospitals and the health centres. Given that there was no separate fund for utilities expenses in this province, proper disbursement of the P&P budget was crucial to the health centres. Even where health centres had some reserves carried over from previous years, these only gave a temporary respite from current under-funding. Some health centres that had mistakenly assumed that funds would be distributed downwards, used their reserve money quickly in the mistaken expectation that they would soon be paid back.

The big problem was the budget. Such as when last year our projects weren't successful according to our targets, because we had no money so that we couldn't work as we planned. The CUP was received the budget but they didn't pass it to the PCUs and the health centres as we had agreed together. (...) They (the government) gave us money but the CUP took all of our part and gave only a small part back to us. At the beginning we expected we would get money, so that we had paid in advance using our reserve money. Later when our reserve money ran out, they told us that the budget had gone too. (Head HC, RE 36)

There was conflict between the health centres and the hospital about budget management. The health centres are still wondering about the transparency of the hospital in this. Because the hospital used a lot of the money but sometimes this was transferred late and in small amounts. When the health centres requested money from the hospital they didn't want to pay. (HCO, RE 34)

Under the low cost health card scheme that had existed before 2001 (the 500 baht per family card) health centres were able to establish a local fund from contributions paid which they could manage themselves. However, the switchover to the 30 baht project meant that, apart from the small receipts from co-payments, health centres were dependent on allocations from the CUP which were smaller than expected and subject to delays

The problem (...) was delays in the budget allocation. Early in the year, we had agreed we would receive this amount but in fact it was late by around 4 to 5 months. As is common in health promotion, we had already planned to work every month but the budget didn't come so that we couldn't work as intended. Previously in the other health insurance schemes, such as the health card, we could pay from the fund to support this work. (Head HC 2, Focus group in RE)

Just as occurred in Kalasin, the starving of the health centres of funding continued into Year 2. It was only in Year 3 that the position improved somewhat, partly as a result of pressure from the MoPH for PHOs to allocate directly to health centres

The main problem was the distribution of resources, both money and staff. In particular, the budget was not managed well when it came to the hospital: in some places they didn't re-allocate money to the health centres. Some hospitals said this belongs to me so you must make a formal request to me, something like that. They should transfer money to them but they did not. In some places we talked and discussed this a lot in meetings, but it wasn't successful. I did this many times and I think I am a mature person, so that I allow bygones to be bygones. It wasn't in accordance with Ministry guidance: when the budget came into the province it didn't go out. This year the Permanent Secretary urged the province to allocate directly to the health centres, because last year this was a big problem, especially in the case of the health promotion and prevention budget. (DHO Head, RE 20)

However, in Roi Et there was no equivalent to the mobilisation of DHO heads that occurred in Kalasin, and the improvement in the funding of health centres in Year 3 was more limited. The CMO tried to mediate between the two sides, but was unwilling to interfere too much in the freedoms of the main provider organisation, the CUP, in line with the vision of developing purchaser provider relations that the PHO was pushing. The approach in Roi Et was to do just enough to keep things under control at the health centre level, encouraging players to move in the direction set by the MoPH, while concentrating most PHO attention on developing the new evaluation and oversight role linked to the purchaser function. Thus from the perspective of the lower participants there was sometimes a gap between what they believed the PHO had said would happen and the behaviour of CUPs at local level.

The problem was the budgeting arrangement. For example, we went to hear about the policy from the province but, when we came back to the district, the policy and action didn't match - even though the province told us they would allocate the P&P budget to the health centres via the CUP. Actually the CUP didn't pass it through to the health centre. Now, it is the last month of the fiscal year. (...) that has affected the public because the budget didn't come as we had planned. (DHO Head, RE 26)

The view from the bottom-up did not necessarily distinguish clearly between the new purchaser role and the old supervision one, but what was clear was that the relative positions of the PHO and the community hospitals had changed. This was largely due to the change in the way money flowed through the system.

In my opinion, I think the CMOs in many places didn't like to touch the hospitals because they still had to ask for money from them as well. If they didn't make these requests, they would not survive, so that they didn't touch them. The CMO, when he arranged a meeting with the DHOs, promised that he would act, but when he talked with the hospitals he didn't use the same words, because we didn't meet at the same time. We raised the problem many times, particularly about the budget, when we made presentations to them but nothing changed. (DHO Head, RE 20)

The reduction in health centre budgets also affected the DHOs. Since these were not provider organisations, they were not in line for direct capitation payments and needed to recoup a share of the payments going to the CUP. However, many CUPs passed on very little to DHOs.

The money holder was the CUP - they told us don't worry about money and continue work. However, then we requested money, they didn't give it to us, which

meant that we couldn't continue with the work because we were in debt to others. The government allocated the budget but the money holder was mad. If the money was directly allocated to the health centre it wouldn't have been a problem but the Ministry didn't allocate through the DHO and told us to go to ask the CUP. I think this is the difficulty: we are the administrator but don't have money. The Bureau of Budget³⁴ should understand who are the real workers, so that they should have changed the financing mechanism by allocating directly to the DHO. I think at the moment the budgeting arrangement wasn't fair to the DHO or the PHO. (DHO Head, RE 23)

In some areas even the relatively under-funded health centres had more money for routine expenses than did DHOs. There was no separate PHO fund for utilities and fuel costs that could help DHOs. Yet they were expected to carry on with some of their past activities.

We drew a comparison in the health centres, they had lot of money but we didn't, it was gone. Before the reforms we got allowances of around 5,000 baht per year but after the reforms we had a problem. We had no money for things such as office costs and car fuel. We were in debt but the health centre staff still came to use facilities in the DHO, as at the past. (HO-DHO, RE 27)

We have to adapt from the previous situation where we had our own budget which was easy to work with. Now we have to plan carefully but we must still go to work outside on disease surveillance, such as with SARS and hemorrhagic fever, etcetera. This was necessary activity and we had to go out into the community, for which we needed to pay the costs of car fuel, but we didn't have the money. At the moment I am requesting support from the hospital. With regard to a small district they get tiny money, so I am not sure they can help us. (DHO Head, RE 25)

As in the above case, some DHOs resorted to asking for money wherever it might be available – CUP, hospital or health centre – in respect of particular projects or crisis situations. Getting money often depended on good relations with these organisations, and might involve bending the rules. In the Thai language this is sometimes termed '*zig-zagging*'.

Regarding the UC budget, the service unit could use the money, but we couldn't. So the CUP had to allocate money to the health centre. When we wanted to use this, we had to '*zigzag*' (in English) to get a share. Sometimes this led to problems between the DHO and the health centres. The senior administrators said when the budget came in to the CUP that we had to support each other. However, in fact when the budget came in the CUP, they didn't give money to the health centres, or at least not much. (DHO Head, RE 20)

³⁴ The Bureau of Budget (BOB) is a central government agency which monitors and evaluates public sector expenditure.

I think the DHO and the health centres had problems with each other because the budget didn't pass through the DHO. At the moment the DHO must request money from the health centres - every month at 1,000 baht per month. We have to fill in the paper work pretty much as we like to take out the money for the DHO, and I am afraid that I may get a problem the next day when the officer of the OAG (the Officer of the Auditor General of Thailand) comes in. Last year we gave them about 1200 baht per month. This year it has reduced to 1000 baht. Early in the year we tried to negotiate them down to 500 baht per month and that the DHO should provide clear accounts regarding the payments. But they didn't accept this. (HCO, RE 39)

Zig-zagging in its widest sense in Thai suggests 'gaming' the system or bending rules by creative interpretation. As in this case, it sometimes has the connotation of bringing about something by hidden and indirect means that could not be done openly and directly. In theory, money from the UC budget allocated to the CUPs to purchase care should have been kept separate from the non-UC budget allocated to support the administrative units. The CUP thus had no legitimate means of transferring UC funds to pay for the routine expenses of the district health offices. However, it was possible to get around this by transferring money first to the health centres (a UC body), which could then pass on a portion to the DHOs. Thus the money got to the intended destination via a zig-zag route.

Transfers of money at that level were less visible but still technically irregular. Zig-zagging helped keep the system functioning, but led to misgivings and feelings of vulnerability. In a context where there was already a lack of transparency and hints about possible misallocation of funds for development projects, the absence of proper paper work caused concerns. In one rare case where the DHO obtained a large allocation for office expenses, health centre staff were critical of their former boss' probity.

The DHO head in my district has a problem with 'commissions' that frustrates me. He wasn't 'fair' (in English) to us. For example, the PHO gave us a budget for office expenses of about 70,000 baht but he only paid himself for car fuel and car maintenance. With regard to materials for the DHO they pestered us because they had no money. (Head HC, RE 35)

Getting money usually involved opening a dialogue with the doctor director chairing the CUP, and trying to get some recompense for activity that both agreed needed to be done. However, even where there was an acknowledgement that the DHO deserved money, its allocation was likely to be much less than before the reforms.

Of course, there are problems in work because the budget is small. I needed to make savings everywhere and asked the health centres to support our expenses. Previously, we had a budget of more than 300,000 per year because this was the largest district. In the first year we got below 100,000 and this year we received about 50,000 to 60,000. We still face a lot of debts because we work the same as in the past. We have been talking in the CUP with the Doctor Director of the hospital about our duties. We still look after many things because there is a lack of clarity about our new functions, but they were afraid of the change. Regarding all problems they said we have responsibility. (DHO Head, RE 20)

The cut in DHOs' funding and the scaling down of their old role coincided with a reduction in their staff numbers. Many staff moved out to the health centres or hospitals due to the increase in workload there, and the incentive payments on offer. They also perceived that career opportunities in the DHOs were sharply reduced.

The staff in the DHO were limited (by the government) to not more than 7, while the PHO, which is non-UC as well, still have more than 100 even though we are carrying out the same functions. They had a substantial budget and facilities. The hard worker was the DHO because we had to follow up and work in the community. Then we had to report on performance to the PHO, and after they passed on this result they got a grade³⁵ 8 and 9, while the DHO didn't even get given a grade 8. (DHO Head, RE 23)

Here, (the DHO) the number of staff was decreased because they moved to the health centres and the hospitals due to the fact that they could get allowances there. That increased the burden of work because the staff was reduced from 6 to 4. Nobody wants to work in the DHO because it is hard work. Previously, everyone wanted to work in the DHO but when the UC reforms came in nobody wanted to come. (DHO Head, RE 26)

The DHO staff were non-UC staff and short of money. Many people moved out to the health centres or the hospitals because of the allowances and promotion prospects. For example, at the moment the position of the professional nurse in the health centre is still unclear, so that they move back to the hospital where they receive better allowances and can get promotion to grade 8. The government should be clear about this aspect, because they announced the policy as 'promotion-led cure', but the majority of staff are in the hospitals which are the curative units. (DHO Head 2, Focus group RE)

As the above quotes suggest, this movement of staff may have reduced the capacity of the local system to undertake P&P projects. It also contributed to a widespread sense that the DHOs were organisations in decline, which did not easily fit into the new structure of local services and had an uncertain future.

³⁵ These are grades from the standard Thai civil service hierarchy.

One source of frustration for several respondents was that the PHO still held the DHO responsible when things went wrong in the district health care system. When haemorrhagic fever spread through many districts of the province, a group of DHO heads were summoned by the PHO to account for the problems that had arisen. This was seen as unfair and unreasonable by some respondents.

I told the PHO that haemorrhagic fever was spreading in the province and asked why they were pressing the DHO heads. They should talk to the DDCHs about what to do and speak in same way as they did with the DHO heads. (DHO Head, RE 20)

The uncertainty about the DHO's role also affected the chain of command. The DHOs were still expected to oversee and manage aspects of the local system, but found that because funding now flowed through the CUP, the directors of community hospitals acting as CUP chairs were also exerting control over the content of health centre work.

When the budget was held at the CUP, the DDCH said that the health centres came under hospital control because the money was channelled through them. They could arrange this as they wanted. The PHO told us that we should still take care of things if we had a problem, such as communicable disease, we would have responsibility. Then we informed to the PHO that since we didn't have money we couldn't act as the past. However, the CMO said you have to look after things whatever may have happened. (DHO Head, RE 20)

This problem of the two lines of command from both the hospitals and the DHOs down to the health centres and PCUs was a common one across Esarn and will be considered in more detail in the next chapter.

7.4.3. The role of the municipal sector

The UC policies built on the earlier decentralisation reforms by requiring closer co-operation between the MoPH services and local government. The National Health Security Act B.E. 2545 (AD 2002) provides for the establishment of Area Health Boards with health and local government representatives. However, because the municipalities were short of resources and their roles focused mainly on environmental health and sanitation activities, little was done to implement this policy. In Roi Et, the role of local government in health care was not extensive at the time of the study, though there were some developments that did not occur elsewhere. In an interview conducted with a senior

municipal representative, he explained that the impact of the 30 baht project on his organisation had been limited because of the traditional separation of functions between the health system under the MoPH and local government health departments.

[Regarding the UC reforms] We didn't have many changes because the municipality's role in the public health sector was mainly that we looked after sanitation activities, such as: cleaning, flood prevention, sewage and drains, the fresh markets, restaurants and beauty shops. (...) We are accountable for disease prevention and sanitation, based on our duties, while the public health organisations look after treatment activity. Now, we have different functions. (Senior municipal representative, RE 11)

The main change that occurred affected two centres for public health services set up by the municipality to serve people in the local area when the UC scheme came in, these centres entered a co-operative agreement with the CUP associated with the provincial hospital, and became the sites for its urban PCUs.

In the municipality, we have 'centres for public health services', in which they do similar work as 'the health centre' under the MoPH. Previously, we had a co-operative project with Roi Et hospital and Roi Et PHO in which the professional teams from both organisations took turns to visit the two centres for public health services that we have. When the 30 baht policy came along, the nature of co-operation changed because they divided the municipal area into three sections for 3 hospitals which had joined this scheme. (Senior municipal representative, RE 11)

The provincial hospital used our service centre to provide treatment care for people. People were very interested because a specialist doctor came to examine them. (...) Our roles are still the same but our treatment role has decreased so that we do only basic care, because the provincial hospital came in to look after all that. We moved to work on health promotion activities and increasingly go out into the community. (Senior municipal representative, RE 12)

However, the main funding for these centres still came from the municipality. It was unable to get reimbursement for the fixed costs of the centres because it could not get access to the UC budget allocated to the CUP (linked to the provincial hospital). Municipality public health staff continued to share the work of health promotion using their existing budgets.

Before the 30 baht scheme came in, we worked in isolation from the hospital. When the new policy came along we didn't get any of the UC budget because it was directly allocated to the hospital based on population registration. Regarding the 16 communities in the municipal area, these were separated between Roi Et

hospital and [the private] hospital so that there were 12 that went to Roi Et hospital and 4 to [the private] hospital. Roi Et hospital used our offices in the two centres for public health services to establish a PCU and assigned hospital staff to work there so that the roles of our staff decreased. With regard to health promotion activities we worked with hospital staff but we didn't receive a budget from hospital, we used the municipality budget for everything. (HCO-CHPS, RE 44)

The main obstacle preventing the municipality from contracting directly with the CUP or the NHSO, was that they were aware that they would be unable to meet the criteria set out in MoPH guidance under the UC regulations. This was because they had insufficient qualified professional staff. The existing local government public health officers were however permitted to carry on their previous health promotion activities, working alongside public health officers in the PCUs, and sometimes supported in the community by the health professional team from the hospital.

We have two centres for public health services which have full time staff working there. Regarding the PCU standard based on the UC guidance, the regulations state that we must have a doctor and nurse working full-time at least 50 hours per week, so that we wouldn't meet those criteria because in the past we were only concerned with basic treatment. So we participated mainly in health promotion activities, which the provincial hospital did not do, and they used our offices in the centres for public health services to set up the PCU outside the hospital. They arranged a schedule for a doctor to come to see people there. Additionally we operated in the areas where they didn't, such as exterminating rats and mosquitoes and also providing health education for the public. (DPHED, RE 12)

The existing budget split led to a feeling of unfairness on the part of municipality staff. They perceived that the UC budget had been intended to pay for both curative and P&P activity, and that they were being unjustly excluded from their share of the P&P budget.

The municipality did have problems with the budget arrangement because we survived for a long time before the reforms came in. However, the UC budget was allocated to support all health care, both treatment care and health promotion work, but with regard to managing the UC arrangements we didn't have much participation. We felt dissatisfied because we had insufficient involvement and our role was too small. Actually, I would like to see, if they clearly separated the budget from the top, how much we would get. (DPHED, RE 12)

This was only partly an issue about money, since the municipal Health Department was able to survive given its modest activities, but was also about the limits this put on its ability to play a bigger role in the overall UC scheme. Given the possibility, foreshadowed in the public debate, that local government would eventually have a larger role in

purchasing, especially for prevention and promotion activity, some senior staff were keen to establish that they had a part to play.

7.5 The active purchaser role and top-down steering

As seen earlier in the chapter, the distinctive characteristic of the PHO in Roi Et was its attempt to construct a new role as purchaser. The fact that the NHSO entered into contracts with the CUPs, through the PHO (as its local office), and with the contracts signed by the CMO and the CUP chairs, opened the way the PHO to see its role in this way, even though the neighbouring PHOs did not. Nevertheless, parts of the old role remained and there was still an expectation from lower level units that the PHO would remain responsible for the oversight of public health care services across the entire province. This meant that the PHO could also engage in a considerable amount of top-down steering alongside the new approach.

The purchaser role gave it a new source of power at a time when it had lost control over funding. The PHO was able to develop the evaluation and monitoring aspects of the old supervision role to develop the notion of the purchaser as the overseer of provider units, which had to be accredited before contracts could be signed and money channelled on.

Regarding the health contracting units who will contract with us, basically, they should have developing themselves in line with UC guidance, and we must go to accredit them before signing a contract. However, in the remote areas the problem was that the health units were still missing the required standard, while the PHO had responsibility for providing health care to the people as well. The result was that we had to return to the issue of developing health care for people in remote areas. Rather than going to certify the health service units we had to go to develop the providers to gain the UC standard in remote areas such as 'M', 'P', 'P' and so on. (SAO-PHO, RE 02)

This is close to the active purchasing role in a traditional purchaser/provider split system such as the British NHS, but was not an approach that most provinces took in the early years of the Thai reforms. Indeed the Roi Et senior PHO officers were themselves aware that their 'style' was different.

We thought things out ourselves and learnt from each other in the top administrator group. After the CMO went back to receive the policies from the Ministry he brought these to the PHO meeting for discussion, such as how to

apply the new financial management arrangements and which model we should select for payment. That was the 'Roi Et style' (in English) due to the fact that we couldn't copy from others because there were different – all the other provinces. (SAO-PHO, RE 03)

As seen earlier in the chapter, the logic of the purchaser/provider split model required that there had to be strong organisations on both the purchaser and provider sides. This meant that although being the purchaser reinforced the PHO's position, it also had to allow space for the CUPs to develop as autonomous provider organisations. This may account for why the PHO did not step in more strongly to do something about the non-allocation of CUP monies to health centres. The CUPs had to be allowed under the new financing mechanism to take responsibility for many things themselves. Yet, this introduced a complication because many of the CUPs lacked the capacity to do this immediately.

When the new policy came in, the budget was transferred to the districts, under their authority. Actually, in the transitional period this is possibly leading to problems because they had been 'fed' (in English) by the PHO for a long time and now they must do by themselves and take responsibility for their own area with their own money, based on the 30 baht budget that includes everything. (SAO-PHO, RE 01)

In the transitional period the PHO had to support the CUPs because they were accustomed to working in an old system where the PHO had made all the important decisions and directed work across the district. Although the PHO was seeking to operate as a purchaser, it sometimes slipped back into a more traditional role to help compensate for the weaknesses of some providers. This was also used to justify the holding of some budgets centrally to support province-wide activities and to provide a safety net when things went wrong.

Of course, in the transitional period they (district staff) didn't work very skilfully so that the PHO had to go to help them. But, we didn't have a budget for this, so things did not change much. After that, we came to an agreement that the PHO's role is to act as an evaluator and supervisor by using performance indicators to do this. That improved district staff's understanding of their roles and functions. However, I think we should have a part of the budget held at the province for emergency problem solving. We must bring in the capitation model as part of local implementation, but we should also have a 'central fund' held at the province to support province-wide activities, such as health promotion campaigns across the entire province and so on. As regards health promotion activity, this should not be fragmented activities. Perhaps, there are problems in the province

and the PHO should have the authority and budget to support the districts. (SAO-PHO, RE 01)

Active purchasing was thus accompanied by a good deal of top-down steering.

Overall then, the system remained a hybrid one, in which the PHO would sometimes emphasise its role as purchaser and sometimes its duty to support the local service units. There were other remnants of the old system, such as that the PHO remained the body responsible for deciding promotions and the award of salary increments for all staff in the province. This mixture of old and new roles was also apparent in the attitude of the Ministry, which simultaneously regarded the PHO as the local branch of the NHSO (the purchaser), and as the body that would be held responsible if implementation went poorly or there were major health problems in the province.

7.6 Relations with the Ministry and the Health Region

The role of Roi Et's overseeing Health Region – Khet 7 – was less directive than that of Khet 6 in Kalasin or even Khet 5 in Mahasarakham. Respondents said much less about it in interviews than in the other provinces. Health Region 7 seems to have focused mainly on technical support and routine supervision.

The Regional Health Inspector has a local office in Ubon Rachathani. This is an advisory office opened at our request. The main services are technical support such as academic materials. We have a relationship with the regional health inspector office in preparing the performance report. Actually when we have problems we have to contact to the Ministry directly. (SAO-PHO, RE 06)

This light remark appears to accurately reflect the tendency of senior staff in Roi Et to communicate directly with the Ministry. This may reflect the standing of both the CMO and the Director of the Provincial Hospital as well connected people, who had previous held very senior positions, and had good relationships with senior Ministry officials.

7.6 Summary of chapter

This chapter has examined the distinctive features of the implementation of the UC reforms in Roi Et province. The areas where the policy choices of local actors were most

evident were selection of the financial allocation mechanism, the development of a PHO role as active purchaser and - linked to this - an attempt to create a strong evaluation function for the PHO, which gave it a new source of power to steer the local health system.

Overall top-down steering was more evident in Roi Et than in the two neighbouring provinces. Its CMO skilfully emphasised the purchaser/provider split aspect of the reforms in a way that Mahasarakham and Kalasin did not, and built up strong local networks with key actors. Middle-level actors did not accumulate the same influence in the main decision forums that they did in Kalasin. However, the community hospitals nevertheless gained control over a good share of resources, with only minimal interference from the PHO, largely on the basis that the purchasing organisation should not interfere too much in the sphere of the provider CUPs.

Although there was a problem of poor micro allocation from the CUPs to the health centres, it was handled in a different way than elsewhere. The Roi Et CMO concentrated most administrative effort on the development of the new PHO evaluation and standard setting role, and tried to manage the problem of the health centres by discussion and mediation rather than direct intervention. Pressure from the MoPH affecting all Esarn provinces had some impact, but the CMO did nothing to force the CUPs to move further. Rather he emphasised the need for them to learn to work effectively as the main provider organisation in the new system. This meant that the problem of underfunding health centres was kept within manageable proportions, but not resolved in the way that occurred in Kalasin. Even beyond Year 3, Roi Et still had problems of CUPs starving health centres of funds.

In Roi Et the most influential policy actors in the local health care system were generally those in high positions – the CMO and a handful of supporting senior PHO officers (including his wife), the Director of the Provincial Hospital, and one or two influential Directors of Community Hospitals. Those middle-level actors, who had a voice, such as the Assistant Head of the Health Insurance Group, were operating very much under the CMO's control. Most doctor directors and the DHO Heads were relatively weak compared with in Kalasin. Grass roots involvement in Roi Et was also very limited. There was no attempt to engage civil society, even in the limited way attempted in Mahasarakham. Channels of communication upwards were generally directly with

contacts in the MoPH. Health Region 7 covering Roi Et, and its Inspector General, played a less interventionist role than did Health Regions 5 and 6 covering the neighbouring provinces.

Chapter 8
General findings: common pressures
and problems in Esarn

Chapter 8. General findings: common pressures and problems in Esarn

8.1 Introduction

The three preceding chapters present data on the different policy stories of the three case study provinces, highlighting their divergent approaches to policy implementation. The present chapter fills some gaps by describing common features of reform implementation across Esarn region. Inevitably there is a degree of overlap because in the course of telling the three stories, it has already been necessary to touch on some background factors that remain the same for all provinces. This chapter therefore contains some sections that present new data on common aspects so far not examined in detail, but also sections which draw together findings already discussed to highlight shared trends across the three provinces.

8.2 The problem of the financing mechanism

It has already been suggested that the implementation of the UC reforms was affected by both a macro allocation problem and a micro allocation problem. The macro allocation problem related to the pre-existing problem that the reforms had been designed to address: the mal-allocation of health care resources across the nation. Capitation funding was designed to help rectify this problem, but the attempt to change patterns of resource allocation in such a short time span created difficulties for capitation-losing regions that eventually had consequences for capitation-gaining Esarn. An early phase where Esarn gained money was followed by a later phase where this was clawed back to the centre, and this had highly visible consequences in all three study provinces.

The second, micro-level resource allocation problem related to the distribution of resources within the local health care system. It involved the increased funds going to the CUPs and the decreased funds available to the PHO and DHO, but also the issues relating to the payment of hospitals for inpatient care and the distribution of money from the CUP down to the PCUs and health centres. Again this was a general problem that set up

tensions in the implementation process across Esarn, though with some differences in local detail touched on in previous chapters. Because it has been discussed already, this aspect is covered more briefly here.

8.2.1 Unequal financing at the national level

Most Thai policy analysts agree that a significant degree of reallocation of funding occurred in Year 1 of the reforms. Southern region gained money and Esarn too received a slightly higher level of funding than in the past, which was reflected in a corresponding squeeze on funding in Bangkok and central region, as well as some other large urban centres. However, this general picture hides considerable variation across different Esarn provinces. Actually the experience in the three case study provinces suggests that the gain may have been very limited. In Roi Et, the wealthiest of the case study provinces and the one set to benefit least from the change, PHO administrators claimed that the new level of funding was only roughly equivalent to the old one.

The budget was a big problem because according to my analysis of the budget for the entire province before the new policy came in, we received about 700 to 800 million baht per year. That was the budget from the lower income scheme of about 200 million baht and the Health Card Scheme of about 400 to 500 million baht, and excluding the staff salary costs. When the 30 baht scheme came in Roi Et had a population of about 1,300,000 and the population covered by this scheme was say 1,100,000, and multiplied by the capitation budget at about 1000 baht per head, in total we would get around 1,100 to 1,200 million. Regarding the staff salary costs for the entire province, in year one this was 397 million, say about 400 million baht, and then taking 1,100 to 1,200 minus 400 the budget would remain at 700-800 million baht. That meant that under the new policy we got a similar budget amount as last year. It wasn't very different with the old system. (SAO-PHO, Focus group in RE)

The budget holder was changed from the administrative unit to the health service unit but the total amount allocated to the province didn't change. The first year was the best year for us regarding the UC budget, because we deducted the staff salary costs at the province level, say 400 million, so that in Roi Et we still had about 700 million baht, and we were 'happy' (in English). In FY 2003 they deducted the salary costs at the Ministry, which had the result that our budget in this province lost nearly 200 million baht. Additionally, in FY 2004 the salary costs were held at the Ministry again so that suddenly our budget had gone down by 200 million baht again. This is a big problem in the province, we are worried and have difficulties with this. (SAO-PHO, Focus group in RE)

Because of the compartmentalisation of funding and the different types of funding streams applying before and after 2001, it is difficult to obtain definitive official figures on this point. However, rough calculations suggest that Kalasin and Mahasarakham initially received small budget increases, while Roi Et received about the same as in the past. Of course, as we shall see in the next section, there was a big change in the ways the money was distributed between bodies within the province.

What is clear is that all three provinces then experienced a significant squeeze in budgets in 2002/03 as the salaries budget was held at the Ministry and a corresponding cut was made in the amounts of UC funding going to the provinces. This common change had similar impact in all three provinces, although where Roi Et appears to have received a lower budget in Year 2 than before the reforms, the other two may have been merely returned to close to the baseline position.

The change received a good deal of publicity at national level and was apparent to respondents on the ground from personal experience. They were fully aware that after a period when Esarn had made limited gains, or at least held its own in terms of survival of units, the position of the north-eastern provinces weakened significantly in Year 2.

In the first and the second year of implementation, if we got the budget that they promised, we could easily survive but some provinces in the central region had insufficient money, especially for the staff salary which they could not to pay. Nevertheless, the MoPH could not bring this problem into the open. They could not call for additional budget because they had less population and more staff than the north-eastern region. Their budgets were not enough to cover both staff salaries and medicine costs. Therefore, the north-eastern budget had to be cut to support this. In fact, the north-east had also been disadvantaged for a long time, because, a long time ago, it had a larger population and less staff than the others. (SAO-PHO, MK 06)

If we considered the size of the budget, we received much larger increases than previously. However, in 2002 we received about Bt 600 million, while in 2003 we got about Bt 400 million, which was a loss of Bt 200 million. But we understood that they took a proportion from the north east to the central region, where they faced a cash crisis. Previously we were never concerned about the budget allocation but when we came to analyse this after the reform came along, which gave us a better understanding. However, at the health centre level, where they never directly received a budget before, when this policy came in an increased amount of money went to the health centres. (SAO-PHO, KS 02)

The financial allocation problem, which was a hot issue in the newspapers, came about because the budget allocation was unfair. (In FY 2002-03) Some provinces got 1400 or 1500, while some provinces received around 1100 or 1200 due to the problem of workforce distribution, as in the past. Then the salary costs were funded at the Ministry, so that first they top-sliced the salary costs for the entire country and, after that, they allocated a part to the province based on capitation with an adjustment for population-age structures. That was a measure to support each other because some provinces did not have enough budget even to pay salaries. (SAO-PHO, RE 05)

Generally the notion of a change of policy necessary to 'support each' other seems to have been accepted by respondents in the PHOs, though there was a sense that the division of resources between particular provinces had been unfair. However, doctor directors of community hospitals which experienced a sharp fall in budgets in 2002/03 were more critical about the budget cuts in the North East.

8.2.2 Unequal financing at the local level

The change in financial allocation within the district health care system affected (a) the position of the overseeing administrative bodies, the PHO and the DHO and (b) the funding of the service units and the share of the budget that they received.

The PHO has lost its previous control of the provincial budget and found its own funding curtailed sharply. Funds were now separated into the UC budget, which was channelled through the PHO but could not be retained for PHO projects, and the non-UC budget, which supported administrative activity. The three PHOs in the study differed in the extent to which they were able to use their responsibility to disburse the UC budget to retain authority in the local system, and were able to channel some funds towards provincial contingency funds and other re-distributive mechanisms aimed to safeguard weaker health system organisations. However all struggled to cover expenses from the reduced non-UC budgets that they received. All needed to augment this budget by requesting funds for particular activities and projects from the CUPs, which were now the main UC budget holders.

Regarding the financing system, it is based on 'direct capita' or what we call the 'UC budget'. We cannot use the UC budget: it must be directly allocated to health care service units. (SAO-PHO, MK 01)

Previously, we were the budget controller but then we had no money, which had a big effect because we had never prepared for this situation before. Previously the PHO had had a management budget of several hundred million per year: now we have only 3 to 4 million and that was affected us. If we used this for the PHO it would be sufficient but we must share it with the DHOs in the entire the province too. This has had an effect. (SAO-PHO, KS 05)

Regarding that topic, the non-UC budget - it's been given already but was not sufficient. Due to the system we come from, we act like seniors towards juniors. If the money is finished then ask in the community hospital via the doctor director in the CUP. The CMO might help make the connection. We have a good organisational culture and a mutual support system. Many people come into contact which they admire and which brings us an advantage. The assistant CMO is also a person close to the CMO. Personal relationships and sibling relationships still help a lot in solving work problems. And the senior administrators group in the province works as a good team together, which helps in work of different kinds. (SAO-PHO, RE 06)

The provincial hospitals in all three provinces faced similar problems because of their high salary costs compared with the community hospitals. Each received funding through a combination of capitation payments based on population of the CUP in which they participated, and also DRG-based payments in respect of inpatient work referred to them from other CUPs. However the income from these sources was insufficient to meet salary costs in all three of the case study provincial hospitals. In each case they depended on the salary budget coming from the PHO, which was skewed to give the provincial hospitals more than they would have received had salaries been paid with the capitation payment.

The clear affect was on the budget: the hospital income was decreased. Previously, the hospital received the budget from the ministry: including through the Low Income Medical Welfare Scheme and the Health Card Scheme. When the new policies came in, our monies only came from the 30 baht project, which resulted in a reduction in our total income. (Senior doctor PH, KS 09)

For instance, Mahasarakham hospital, before the 30 baht scheme came, had savings from income of about 100 million baht. After the first year of implementation they had a deficit of 15 million baht. Under the current model of allocating budgets, they may go so far but they (the government) need to pay the same amount, or more than at present. But, this year (the second year) they received around 60% of the first year. The reason for this was that the MoPH deducted money to help some hospitals in other regions. They may have known that there was a lot of money in the north-eastern region, and therefore they allocated some to another area. Nowadays, we are just playing to survive. (SAO-PHO, MK 05)

The provincial hospital couldn't have survived because they were covering a small population, when compared with their expenses which were high. And to claim referral payments we use DRGs, so that they need to return complete case reports.

We were trying to solve this problem. If the provincial hospital had to pay the staff salary costs by themselves they could not carry on because they have a lot staff. (SAO-PHO, RE 04)

As the dominant players within the CUPs, whose boards their directors typically chaired, the community hospitals across all 3 provinces were well funded in 2001/02. However, they then experienced a sharp fall in their allocations in Year 2. This problem was accentuated because the budget that had been announced was often not paid in full. This gap between the funding expected and actually received left many hospitals with deficits in Year 2. It meant that they struggled to pay routine expenses such as the extra allowance payments for staff in the community hospitals and health centres.

With regard to the budget, we have been able to obtain increased funding and we have increased power to use that in a positive way. In contrast, the money that came was less than the full figure the centre promised. In the management system, there were increases in the efficiency of the system with high technology such as an e-inspection model of supervision that is better and more rigorous than the previous system. (DDCH, MK 23)

Especially, regarding the funding arrangement, the government did not allocate full figures following their promises to us. If the monies came to us in full we would have no serious problem. During this year - over the last 10 months - Kalasin has obtained around 63% of the expected figure. The government planned to give 1202 baht (per head) after top-slicing at the centre, which would leave 1052 baht. In fact we received 633 baht, which included the staff salary costs. (This amount) when we deducted the staff salary costs that left 328 baht which included all expenses, both the medicine costs and the P&P budget. This was linked to other problems and affected other activities in the chain. (DDCH, KS 14)

With regard to the budgets, in 2001/02 we got the full figure that the government had promised us. We received this and used the budget with considerable flexibility. After that in 2002/03 at the start of the year we anticipated that we would receive not less than the previous year, so that we went ahead with programs and projects. Later, in the middle of the year, we started to become aware that we might not receive the budgets we had expected, because we made estimates from the last 2 or 3 budget allocation periods when the Ministry transferred money to the PHO. It was about 50 to 60% of the amount given last year. It has gone down around 40% which is a large amount, so this affected our plans and projects, which had been decided. (DDCH, RE 15)

In all three provinces, though less so in Mahasarakham, there were problems in the distribution of the budget from the CUPs down to the PCUs and health centres. In many places, there was conflict between the hospitals and the PCUs or health centres because the P&P budget was not allocated to them or delays occurred in payment. This severely

limited the ability of some cash-starved health centres to engage in preventative and promotive projects.

The problem of the budgeting arrangement in the 30 baht policy was equity of distribution. Especially, starting at the CUP to primary care level, the health officers in the front-line didn't have sufficient money. The hospital were afraid that they would lose and not have enough money to pay extra allowances to hospital staff, so that the front-line staff in the health centres were seen as a burden and didn't get equity in this. As we've seen, the staff at the lower levels didn't get fairness, and they usually made comparisons between the health centre and hospital staff. The hospital has been providing all facilities to staff while in the health centres the staff have to look after themselves and pay for some things themselves. (DHO Head, RE 22)

Last year the hospital and us could coordinate our budgeting. Recently it seems that the hospital has delayed releasing money and held on to it at the hospital. When we asked to use money, it was difficult. For example, I faced a problem with the 'Pink Card Project' which is about mosquito larva control, where they (the PHO) gave the authority to the CUP to allocate the budget which supported the awarding of a prize of 1000 baht per sub-district for households without mosquito larva. I didn't see this money and the CUP was doing nothing. (...) The main power is still the hospital and, in Kalasin, we funded the P&P budget at around 17 baht (per head) at the hospital, and when we need to use it the DDCH won't allow this. (HCO, KS 30)

Many times, when we implemented health activity projects in the local area, the budget has delayed our plans. We have decided to work with our scheduled plan but the budget did not arrive on time. When the budget did come in sometimes the people did not have time to cooperate with us, because it was in harvest season. Because of this there only few people to collaborate in our project. (HCO, MK 42)

Almost all DHOs received a much reduced budget, perhaps amounting to 10% of the previous allocation, and often insufficient to cover basic office expenses. Across all three provinces many DHOs had to ask for additional financial help from the CUP or the health centres. Nevertheless they were still required to exercise oversight over many P&P projects, and were sometimes able to negotiate some extra funding to support this work. The DHOs found themselves in an anomalous position after the reforms due to the confused chain of command to the health centres, which now found themselves dependant for funding and approval of many projects on the CUP, but still under the line of command of the DHO. This is discussed in a later section.

8.3 The Problem of the health workforce

One of the main problems for the health services in Esarn is the unfavourable ratio of health care facilities and professional staff to population.

Table 8.1: Distribution of the main health resources (reported in population ratio) by region, in 2003

	Bangkok	Central	The North	The south	Esarn	Nationwide
Bed ⁽¹⁾	1:206	1:391	1:496	1:496	1:759	1:462
Health centres ⁽¹⁾	-	1:4,629	1:4,662	1:4,433	1:5,540	1:4,895
Doctors	1:974	1:3,577	1:4,754	1:4,632	1:7,542	1:3,577
Dentists	1:6,836	1:17,799	1:17,699	1:19,767	1:26,675	1:17,416
Pharmacists	1:3,793	1:8,894	1:13,437	1:8,845	1:13,437	1:8,963
Nurses	1:282	1:494	1:582	1:527	1:888	1:562
Health centre office	-	1:1,552	1:1,713	1:1,511	1:2,097	1:1,762

Sources: Report on Health Resources 2004, Bureau of Policy and Strategy, MoPH, 2004

Note: ⁽¹⁾ Data for 2002

The UC reform policy aimed to encourage a reallocation of the health workforce from other regions to Esarn, in line with the plan that ‘money follows patients’. However, the MoPH’s backtracking from the original policies in 2002/03, particularly holding the salary budget at the Ministry level, ended the dream of an easy solution to the under-strength workforce in the north east. These problems were highly visible to respondents in all three case study provinces and were mentioned often in the interviews.

8.3.1 The mal-distribution of the workforce

Although there was an obvious problem of insufficient professional staff which almost all recognised, respondents pointed out that the reforms had worsened the situation in some ways. The extra burden of work imposed when 30 baht treatment became available put extra pressure on already busy staff, who also needed to develop more community projects. The guidelines about numbers of professional staff per 10,000 population were unrealistic, and staff in large centres resisted the idea of moving to rural areas.

At the moment given how the budgets are arranged, the allocation of staff will not change. Additionally, in FY 2002-03 the salary costs were held at the Ministry level so that there weren't any staff moving, some hospitals had many staff and that still continues and these aren't re-distributed to others. That is contrary to the 30 baht policy intention, which was announced as at the beginning and this affects Esarn region where they had the problem of a big population but a small workforce with a heavy workload. For example, I talked with doctors in our hospital - they all said that we work hard with out-patient attendances averaging 300 per day, covered by 4 doctors, who also have to look after both emergency cases and about 40 in-patient cases per day. When you compare this with other provinces and the same size of hospital, they have about 6 to 7 doctors. (DDCH, RE 15)

There were many things that have been affected by this policy. For example, we have limited staff and when the policy was introduced quickly the increasing numbers of patients made our quality of service fall. There were insufficient numbers of the main health professional staff such as doctors, dentists and nurses (...) especially nurses, who have to work hard because the major part of work was nursing care. We had big shortages. (DDCH, KS 16)

The problem was workforce distribution, which the policy aims to address by re-allocating the health professionals, such as doctors and pharmacists, to go to work in the rural areas. At the moment they are still bunched in the urban areas. That was a one of the failures of this policy, which they couldn't solve. The Bt 30 scheme means that we must have the health team to go to work in the community at least in a proportion as a team to the population of around 1 to 10,000. Now it wasn't anywhere near this, so the government must solve this problem. (...) The most difficult problem is the distribution of the health workforce. For example, in the case of doctors, most of the newly-graduated doctors come from the big city or urban area then work in a rural area for about 2-3 years. Then they try to move back to work in an urban area or large city. I think that we should select local students to study in the medical schools so that after they graduate they will go back to work in their communities. (SAO-PHO, MK 07)

8.3.2 Differences in workload and the problem of morale

The problem of workforce mal-allocation was accentuated by a sense of unfairness about how the burden of work, and the rewards on offer, were shared out between different parts of the local health care system. In all three provinces there was a big difference between the situation of hospital staff and health centre staff. In terms of the monetary incentives, workload and facilities, the hospital staff enjoyed big advantages over health centre staff. From respondents' accounts, this translated into dissatisfaction and problems of morale in the disadvantaged group.

For example, two newly graduated nurses came to work in 'N' (this district): one worked in the health centre and the other worked in the hospital. This made them

compare the facilities. The one who worked in the hospital got everything and worked mainly in the municipal area with extra monies for supporting work in rural areas. The one who worked in the health centre didn't receive this, even though she worked in a village. They got together and compared these things and told me about it. (...) One person came to see me in tears, saying she needed to work in the hospital. Working in the health centre didn't lead to success in a nursing career, while nurses working in hospital receive more rewards and have an easier time because they only have to follow doctors' orders. (DHO Head, KS 22)

I think the problem was how to get staff to go to work in the community. In our district, we launched the PCUs in many places but we had insufficient staff. At the beginning, the DDCH used money to 'push' them to do the work; those who went out to work could get allowances and so the allowance rates were increased. After this the DDCH decreased the allowance rates for those staff who wanted to go to work in PCUs. Previously they could receive an allowance for 5 days per week. Now, it became 4 days per week and decreased from 500 baht per day to 250 baht per day. (DN-PCU, MK 39)

Regarding the health workforce; after they graduate, the majority of newly-qualified health officers want to work in the hospitals because the hospitals have sufficient budget to pay allowances, and better facilities. For example, when hospital staff go to work outside in the community, they have both a car and driver to run the service. This is different from the health officers in the health centres, even though they may have graduated in the same subject from the same college. So they would like to work in the hospitals much more. (DHO Head 1, Focus group RE)

On a smaller scale this was also true of the relative positions of hospital and health centre staff in large (capitation-rich) and small (capitation-poor) districts. Staff in the urban areas were said to have relatively easy work and less pressure than the staff in rural areas.

8.3.3 The new public sector employment scheme

Thailand introduced a series of bureaucratic reforms in the 1990s which led to the downsizing of the civil service and public officer status replacing civil servant status for some post holders. This affected many health workers, and led to recruitment difficulties and more feelings of unfairness. This had the dual impact that the posts that still carried civil service status were harder to obtain, and that the posts that had officer status were hard to fill. Limits on the number of new entrants meant that well-qualified graduates often had to wait for the dwindling number of more attractive posts. The officer posts did not enjoy the same favourable health, pension and other benefits available to civil servants.

At the lower levels, limits were also set on the numbers of public service officers, which led to a practice of appointing staff as 'temporary employees'.

A MoPH student scholarship scheme covered both higher professions such as doctors, dentists and pharmacists, and para-professionals such as nurses and public health officers. This meant that about 3,000 new graduates become ready to enter the employment market at about the same time each year, and are allocated to posts through a formal process in the MoPH. Health professionals are required to work for 3 years in the public sector, while the para-professionals are required to work for the MoPH for twice the number of years spent in higher education. Before the public sector reforms, all new graduates were appointed to civil service posts, but after the reforms they had to be split between civil service and officer posts. While the higher professions had first priority for civil servant jobs, in most years some doctors would only be offered officer status. Yet the unattractiveness of the new grade meant that some graduates at all levels found these posts unacceptable. Many would leave after their term of duty, or resign and pay the required fine so that they could go to work in the private sector.

At the moment the MoPH has a problem with newly graduated officers because there are insufficient 'civil service' positions available. So they have appointed the '4 year group' into the civil service positions but the '2 year group' are appointed as 'temporary employees'. And they take on new graduates every year so that they deal with this problem year to year, because they can't negotiate with the government about the quantity of civil servants due to government policy on controlling staff in the public sector. They didn't allow an increase in the numbers of new civil service positions. We couldn't even use retirement positions. Regarding the higher administrative positions we have had to merge around 4 or 5 of the lower positions to make up one senior position. That led to the loss of many lower positions. (SAO-PHO, focus group RE)

The best way of achieving workforce redistribution was to have a good system. We can't force staff in the central region to move to Esarn but we need to good motivation system such as topping up salaries or extra allowances for staff in rural areas. I agreed with the previous measure that the new health professional graduates must start work in the public sector and we must change the health workforce in the 'public government' scheme back to the civil service scheme to keep them working in the public sector. (DDCH, MK 24)

Regarding the new scheme of public sector employment which is not the 'civil service', that influenced our staff greatly. For example, this year one doctor (in the new scheme) has resigned. Actually, nobody wants to have a private boss: we would like to have the King as the boss in the civil service scheme. However, they must leave due to the fact that the system has changed. (DDCH, KS 17)

The consequences for the health reforms in Esarn were problems of staff recruitment and retention, and further loss of capacity in the system. Although the MoPH allocation process might have seemed to be a way to transfer the workforce to Esarn, there was a longstanding agreement that new graduates would not be sent to remote areas against their wishes, and that a different approach based on incentive payments would be used. However, where Esarn hospitals only had low paid, non-civil service posts on offer, the remote area allowance was not a sufficient incentive to counter the basic unattractiveness of the job.

8.4 The impact of changes in the management system and organisational structure

In all three provinces, capitation-based funding led to problematic changes in relationships between organisations. Because UC funding channelled money into the system in a different way it led to a change in the balance of power, based on who held and allocated budgets and who did not. Previously, the PHO was the most powerful unit in the local health system with authority to determine the patterns of allocation of health resources within the province. However, when the CUPs became the main budget holder under the new financing mechanism of the UC policy, they became much more influential players in the local health care system, particularly at district level.

8.4.1 New relationship of health service units at the provincial level

Previous chapters have explored the decision space that PHOs had to adjust to the new conditions in different ways. The three provinces studies represent a spectrum from active to passive responses to change, with the Roi Et PHO in particular retaining considerable power by developing a purchaser role. However, the point that also needs to be made in this chapter is that all three PHOs confronted a common set of changes, which in many ways had similar impacts. Thus all needed to downsize to reduce their 10 old divisions to 5 groups, and all had to adjust to losing their former status as the 'commander' of the local system, and the problem of developing a new role (where in terms of supervision, evaluation or purchasing). All also had to get to grips with the new financing arrangement which separated off the UC and non-UC budget. After the reforms the PHO had direct

control over a non-UC budget of under 10 million baht per year, compared with the past when they controlled a total budget of several hundreds of million baht per year.

Previously, we were controlling the whole provincial budget. I feel that this did not sufficiently emphasise the performance-based model. We received the monies and paid them out according to a trimester budgeting system. After the 30 baht scheme came in, there were many changes which affected our department. In addition, the new system forced us to decentralise power to community hospitals, under the system that we call CUPs. So, we (the PHO) don't have very much money, which causes difficulties. We need to request money from the CUPs or the UC sector. The PHO senior administrators have changed their roles. Even the CMO has changed his role to coordinator or monitor. (SAO-PHO, MK 08)

With regard the policy level, they wanted the PHO to change from a controller to a supervisor but didn't provide any detail about how the change should occur. And, the PHOs were familiar with the old style of work as controller. Then they had to work without money. So we didn't know what to do. I accept that I had no idea. (SAO-PHO, KS 05)

We take responsibility for the non-UC budget and all programs and projects of the PHO in the entire province. All of the non-UC budget which comes from central sources - both departments and divisions - is known as the 'health system development budget' or 'cluster 300'. This budget in some provinces may be under the control of the General Administration Section but in this province the CMO gave it to the Health Strategy Development Group to look after. We have to check both how much money we have and how to manage on it. In this year, we received a budget of only 4 million baht. In addition we have to share this budget with the DHOs too. That is very small money when compared with the past, so that it doesn't cover our expenses. We have to ask for help from part of the UC budget with CUPs to support our expenses. (SAO-PHO, RE 07)

Even allowing for the striking differences in the ways the three PHOs adjusted to the new situation, they shared a common problem of adjustment. They were all smaller, less wealthy bodies that had experienced a period of contraction and retrenchment, and faced an uncertain future.

8.4.2 Confusion in the line of the command at the district level

The rise of the CUPs as the main fund holders caused a problem in the line of command to the PCUs and health centres. Again this was a common issue in all three provinces, though one that was handled in different ways. Before the reforms the DHOs had acted as administrative bodies in the line of command from the PHO which oversaw the health centres. After the reforms, DHO Heads still retained formal authority over health centres in

accordance with the provincial government administrative system. In the new situation the CUP Board Chair, who also usually a hospital director, allocated money and needed to approve work in the newly developed PCUs and ensure their co-ordination with the community hospital. This led to a dual chain of command and some confusion and conflict. Lower-level staff in health centres and PCUs had to liaise upwards with two organisations, which might issue contradictory orders. There was sometimes a clash of authority between the 'task boss' and the 'money boss'.

When the budget comes to the CUPs at the bottom, the health workers also have two bosses. The 'money boss' is the doctor director of the community hospital and the 'task boss' is the head of the district health office. In the principles of management, they say that the totality of resources comprises man, money and material. At the moment, the one controls money and another controls health activities. In the district, when the policies are implemented there are many confusions. (SAO-PHO, MK 06)

After the 30 baht scheme came in, we felt that we had two bosses: both the CMO/DHO head and the DDCH. To tell the truth, if we had a meeting in the CUP we would go along with the chair of CUP board. But, the DHO head said that he was our boss, which led to conflict and each not talking to the other. (Head HC, KS 26)

Regarding the workforce, it wasn't clear whether they were under the command of the CUP or the DHO. In the first year, we were confused about this because there was a lack of clarity about both the line of command and the management system. So this looked like a unit that held the budget and also had the authority. That was unclear and confusing in year one. And, the Ministry wasn't clear about this either. In the second year, the DHO group tried to push on this and asked the Ministry for greater transparency about the budget and the allocation to the health centres, especially regarding the health promotion and prevention budget, because in the last year we got only a tiny part. Later the Ministry ordered the PHO to make a separate allocation to the health centres of about 37 baht per head from the P&P budget. (DHO Head, RE 22)

8.4.3 The control of the CUP by the hospital

Across all three provinces, there was a pattern whereby CUPs were associated with, and effectively controlled by, a community hospital. The policy to introduce capitation-based funding led to the creation of CUPs based on registered population. For practical reasons these were aligned with the existing local government administrative districts on the principle of 'one CUP in one district'. There were exceptions to this pattern in some urban ('Muang') districts where there were UC-accredited private hospitals and more than one CUP. Also, the provincial hospital would typically head one 'Muang' CUP. However the

general pattern (in line with the UC implementation guidance) was that the doctor director of a community hospital (or provincial hospital) acted as the head of CUP board. Most doctor directors combined their CUP chair duties with their hospital duties, and did not draw a clear line between the two areas of their work. This meant that developments which were major priorities for the hospital usually became major priorities for the CUP, and that other projects or developments tended to receive less attention. This usually translated into problems in getting finance for health centre projects.

Someone has said that if the health centre staff saw the CMO walking through they would disregard him but if that was the DDCH they would be super courteous. (...) It seems that whoever had the money would have the power. We've seen something like this in my district. This was a policy of the CUP that they told us about: we must deliver the performance and then we'd get the money. That was okay, I wouldn't have argued about that, but I think that I didn't see any difference between the PCUs and health centres. However, the CUP policy focused on the PCUs whereby they got a lot of support while the health centres didn't have any. They said that the health centres weren't the focal point and didn't support them as we expected. (DHO head, RE 35)

When this became the CUP, it seemed that all health care services were transferred to come under the hospital. Although the parties had to work together in line with the committee model, all of the decision-making was under the control of the doctor director. (SAO-PHO, KS 03)

Some districts have conflicts because the DHO head tried to protect the rights of health workers in their budgets and the DDCH did not arrange the budget fairly. The bulk of the budget was allocated to support the hospital staff, whereas the health workers were given an insufficient budget and neglected. After that, the PHO came to a clear understanding that the budget did not belong to the DDCH. These budgets were allocating for the staff of the entire district and all of them were part of the same district team. The PHO recommended that they should all be given help. (DHO Head, MK 28)

As we have seen in preceding chapters, this problem was dealt with in different ways in the three provinces. Nevertheless, similar issues regarding the micro-allocation of resources occurred in all three case studies. This raises questions about the role of the CUP in the Thai purchaser/provider split, and whether a provider-side organisation of this kind was able to co-ordinate health services in the district area effectively. The CUP is innovative because it represents a unique approach for mediating between the purchaser and the service units in the local health care system, but the evidence gathered here suggests that it did not work well.

8.5 The controversy over primary care-led (PCL) policy

8.5.1 Arguments over the PCL policy

One of the strands of the UC reforms not so far discussed in detail was the idea that care should be 'close to the home, close to the heart'. This policy slogan – '*glai baan, glai jai*' – was widely used to promote the idea of a PCL system and the proposed upgrading of health centres to PCUs. Some critics contended that this was really just the repackaging of an old idea, and represented the continuation of 'primary health care' as in the past. Others thought that the creation of PCUs might bring genuine change. Many aspects of the policy discourse remained unclear. From one perspective the hospital might provide community care at arms length in the form of an 'extended OPD'. Another view was that health care units in the community could be developed, and then would function as 'gate keepers' for entry to hospitals. Implementation was affected by disagreement about the best approach, and also by workforce and staff recruitment problems.

I would to say that this was the old strategy we called 'primary health care' (in English) where we go to provide health care in the community (in English) or at the primary level (in English). Previously, there wasn't any real focus on this policy but when the new reform policy was launched it focused on '*glai baan, glai jai*' and real 'primary health care' (in English). The health officers have to go into the community to do surveys with the 'family folder' (in English) to understand the public. (...) We advised our health officers that we should categorise people in three groups: the ill, at-risk and well. Previously health care focused on illness and risk but according to the '*glai baan, glai jai*' policy, we must go into the community to work with all groups. So, this policy wasn't only talked about and announced but also specified in the core-benefit package of UC scheme, which forced to staff to go into the community. That was the real '*glai baan, glai jai*' policy. (SAO-PHO, RE 02)

It was not so different from the old concept. Previously, we had implemented 'the decade for health centre development project' which aimed to improve the health centre to be the PCU as well. In addition, this government tried to develop the previous idea to become the primary care led policy. There was a good policy but not good preparation for implementation, especially regarding people's expectations when we told them things like the doctor will stand by in the PCU. We did not fully implement this which left us facing a problem. (DDCH, MK 21)

I am not sure whether the health officers understand the difference between the PCU and the health centres, because the health centres still work in the same way and the hospital doesn't give much support. At the beginning the doctor team came to the health centre one day a week on Tuesdays. Now they don't visit on time and

it changed to once a month and sometimes there was only a nurse coming, or the doctor would come but not the pharmacist. (HCO, KS 30)

8.5.2 The burden of implementing the PCL policy

However, the real problem in implementing the PCL policy was the shortage of staff in the health centres. This was partly about an absolute shortage of qualified professionals in Esarn, but also about relationships between different sections of the workforce. Getting new community projects and other necessary work underway usually depended on the mobile team from the hospital going out to assist community-based staff. That led to a new problem in the relationship between hospital staff and health centres or PCU staff. These difficulties raised question marks about the sustainability of the policy in the long run.

I think at present implementation it is not good, because the health professionals who came from the hospital went into the community on the basis of incentive payments for the work, whereas the health workers in the community still worked whether they had money or no money. Then, the allowance was decreased and the doctors didn't want to go to the PCUs. Often they would go to the PCU once a week and this became twice per week. At present the nurse must work to replace the doctor in some places. The doctors who go to the PCU are only responsible for treatment activities. They don't understand the roles of the health professional team based on this concept. They did not help or support the health officers as expected. On the other hand the health officers must take care of them and let them use the facilities. (DHO Head, MK 30)

With regard to the health workforce plan of the MoPH, it was specified that health staff in the PCU, based on the criteria in the standard manual, must comprise a doctor and nurse. In fact, the average staff number in health centres was below five, which did not follow the criteria. Then they (the MoPH) brought together three health centres to become one PCU, which would cover a population of around 10,000. However, in the government administrative structure they have a health centre in one sub-district, whereas the decentralisation bill, which was based on the Thai constitution, specified that health centres must move under the command of the local government organisation (LGO), and the LGO must support the health centres both in terms of staff and other resources. However, the MoPH created a new organisational structure based on the health care unit network to serve people in the local area. This included the proposals to merge three health centres into one PCU. That meant that one PCU had around 9 staff. They each had to do their own work, but are brought together for some tasks (SAO-PHO, KS 02)

The health centre staff and hospital staff still work separately and hardly speak to each other. There were disputes in some PCUs where the health centre staff accused a nurse of claiming the allowance payment without visiting people in the community. There are still problems in some areas and worsening relationships. (HO-PCU, RE 39)

8.6 The perspectives of local actors on the purchaser/provider split

Although the policy design of the UC reforms called for the creation of a purchaser/provider split, this was an aspect of the reforms that few respondents spoke about at length in the interviews. Generally speaking they fell into the two camps of those who did not think anything had really changed and those who did not understand the planned changes. This can be partly attributed to delays in implementation associated with the 3 year transitional period of phasing in the provisions of the NHS Act. However, it also seemed to indicate that many informants regarded the idea of purchasing state-funded health care as an alien concept, which did not mesh with Thai culture, or simply found the idea difficult to grasp.

It did not change, in my view. There was no split between the provider and the purchaser; they are the same person who is both provider and purchaser. In 2003 (the second year of implementation), the government said that it must create a clear split. However, it was more than 6 months ago and I did not see any change. It is still unclear. (DHO Head, KS 22)

I think it will take a long time until people understand. With regard to purchasing I may deny some people entry to the UC scheme, For instance, if local government is to be the purchaser and we act as the provider, perhaps we may not accept everyone for registration. For example, some villages or sub-districts come with high risk factors because they do not take care of themselves adequately, and we may set the insurance fee at a different rate in each area based on their risk. I am not sure if the government and the people understand this point. If the government policy forces the hospitals to become public organisations, we must manage the hospital as the company which is responsible for running itself. We should have the right to determine the insurance rate and therefore we could not accept payment at the same rate as the capitation rate which the government has announced. Moreover, I must manage the increasing burden of both the staff salary costs and other expenses in the hospital, so I must receive money based on the real risk factors. I have a question about the preparation and readiness of purchasers. If they give me 3 years to prepare I would be ready, but in ten years what about the people? For example, the people in the municipality area where there are many risk factors such as drugs, AIDS, accident. If I do not accept them for registration, they should not complain to me and the government should not force me to take them either, because if we transform to be a public organisation we must survive by themselves. Surely the government would not push us to work with an insufficient budget that would make us bankrupt and ensure absolutely that we would not survive. (DDCH, MK 20)

In the purchaser/provider concept there is good chance to support each other. However, in the Thai health care service system, given the people's behaviour in accessing health care, provider and patient have been helping each other. In

particular, Thai culture and the relationship between the doctor and patient resembles parenthood and does not look like a purchaser and provider relationship. In future, we need to separate them - I think it should be done - but this is not the right time. Also, we have talked about the purchaser and provider split but we were not clear about who will act as the purchaser. (DDCH, RE 22)

Only in Roi Et, as seen in Chapter 7, did the PHO emphasize its purchaser role. However, even in that province the degree to which messages about the purchaser/provider system permeated down to lower level actors in the local health care system was limited and variable. Even there many had only a limited understanding of the policy.

8.7 The change of direction in top-level policy

Actors across the three provinces were well aware of the change of direction in high level policy that occurred in the second year of the reforms. The holding of the salaries budget at the centre, the cutting back of capitation payments to Esarn and a degree of slippage in implementing the provisions of the National Health Security Act all had highly visible effects in the provinces. There was also a perception that influence had passed to a more conservative group in the Ministry. The change of Permanent Secretary of the MoPH in October 2001 significantly changed the implementation on the UC policy. The conflict between the reformist Deputy Minister and the new Permanent Secretary, led to the transfer of the Deputy Minister to another ministry. As described earlier in the thesis, this resulted in a confusing transitional period when both the MoPH and the NHSO tried to exercise influence at provincial level. The PHOs had been appointed as branch offices of the NHSO, but were also the local supervisor organisation of the MoPH with an oversight relationship to the providers. PHOs therefore had dual functions on both the purchaser and provider sides. Local actors in all three provinces perceived that the direction of implementation had changed and that this threw up new problems.

I think that initially, they were sincere and clearly under the control of the Deputy Health Minister, Surapong. That was clear direction. Nowadays, things are becoming confused: for example, they have deducted staff salary costs at the central level. That new system needs to make it clear that they must not increase staff numbers in areas where they already have a large staff. I agree with the MoPH about the need to solve these problems, but it must be under conditions that do not move new staff into problem areas where there are limited staff salary budgets. The capitation model is the way to re-distribute health resources: in places where there are too many staff they cannot survive. The MoPH approach does not ensure a long term solution. It only solves the immediate problem. After 3 years of

implementing the policies, the budget from the NHSO will be allocated direct to health units. It won't be channelled through the MoPH, and so what does it do next. That is my question to the MoPH, I don't know what they are thinking now. It should have prepared the whole system. The system design was clear, and there was a clear direction. If the MoPH does not instruct them (the Hospitals in Central region) to change it will have problems. The MoPH does not have a clear long term view, it is an uncertain situation and the budget is uncertain too. How to develop quality of human resources is one question. The minister, she does not understand. I suppose that when the transition period is over we will still be in a state of confusion if we don't do it the right way. When the time comes, who will be responsible for paying staff salary costs? There is no answer, or perhaps they will have one, but I do not know. Regarding the decreasing budget, we asked the Health Region inspector when he came, but we did not get an answer. (SAO-PHO, MK 02)

This policy is very a good policy but there are problems with its implementation. Firstly, the budget in the first year, the hospitals expected that they would receive a sufficient figure where they would feel 'happy' (in English) to pay for extra allowances and other activities. Then, in the second year the ministry cut their capitation budget and that blocked many activities and affected their programs and projects. These made them work at less than full capacity. I have seen in some CUPs that they have good plans and have dealt with their problems well, but when the budget was decreased that forced them to make changes and cut off many good projects, because they need to adapt their work to match the actual budget. They were unclear about the budget arrangement and they (the centre) never warned them in advance about this situation. (SAO-PHO, KS 07)

Regarding the top level of the NHSO and the MoPH, I think that in the new system we couldn't work as we like it because we are actors and the NHSO is the payer. The NHSO launched a lot of guidance to support the public such as freedom for people to register with the hospital they chose. I think the NHSO was a forward-thinking organisation but the MoPH was a conservative one. The civil servants would have been pushed to work with the new dimension and if some people didn't change they would be forced to leave. I have been working with the NSHO staff in the PCU on the Dream Project, and I understand the way they think, which led to me getting an award from them. And the directions of the NHSO and the MoPH were different. (DDCH, Focus group in RE)

8.8. The limits on the power of local actors to shape change

This chapter sets a context for the chapters on the individual reform stories by describing some of the common forces that affected all three provinces. Where Chapters 5, 6 and 7 emphasised the areas of local discretion that provinces had to respond to the national reform template in different ways, this chapter list some of the constraints that affected all of them. It is not easy to combine an account of these shared pressures with the details of

the policy narratives in the three provinces. However a kind of balance between constraints and limited freedom of action emerged in all three case studies.

In most of the areas touched upon the three provinces could not escape problems, but they did have scope to manage them in different ways. The macro resource allocation problem was one that no province was able to influence to any real extent, and which led to a policy change in the Ministry (in the form of the central salaries budget) that affected all three in similar ways. The micro-resource allocation problem surfaced in similar ways across all three provinces, but was managed differently in different places. Mahasarakham had managed to prevent the problem appearing in such acute form by putting much emphasis on the development of community projects. Kalasin experienced open conflict between CUP board chairs and health centres but resolved the problem when DHO Heads and PHO staff gained support from the Health Region Inspector to change the rules. The Roi Et PHO limited the problem through mediation and kept the issue in the background, even though it was present for the whole of the research period.

The problems of workforce distribution, changes in the terms of public sector employment, and the differing benefits available to different sections of the workforce derived mainly from central rules that had a similar impact across all three provinces. Only in the area of staff morale did there seem to be any real difference. Mahasarakham's interest in civil society engagement and community projects seemed to have given community-based staff in that province more recognition, and avoided the depth of bad feelings and divisions apparent in the other two provinces.

The lower-level actors who influenced local implementation of the UC policies were mainly people within the formal health care system, rather than actors within civil society or private companies. Even in Mahasarakham, where a number of community projects had been started up, these developments had very little impact in shaping UC policy. The involvement of international NGOs in the three provinces was limited mainly to a number of projects targeted at specific diseases, such as HIV/AIDS, and again had no effect on the way UC policy was rolled out at local level. NGOs had a more significant role at national level, where they were influential in areas such as expanding the UC scheme's core benefits package to include haemodialysis and ART, but this is outside the scope of the present study. Multi-national private enterprises, such as drug companies, played a

significant role at national level in areas like ART policy (Tantivess, 2006), but had little or no role at the provincial level discussed in this thesis.

Similarly the changes in the administrative structure and functions of the different bodies had a generally uniform effect across the three provinces. As explained earlier, the PHO in Roi Et adjusted to give itself a powerful post-reform role, while the PHO in Mahasarakham had less power but retained a degree of influence in a co-operative network of local bodies. The problem of the local hierarchy and the organisation with 'two heads' were represented an area of weakness in the reform design and was never properly resolved in any of the case study areas.

All three provinces had difficulties in adjusting to the purchaser/provider split system. Although Roi Et moved further than the others in embracing this concept at PHO level, local actors in the provincial health care system still lacked a good understanding. The change of direction in Year 2, and the move into a confusing transitional phase had an effect in all the case studies. Although they tried to manage the problem in rather different ways, there was a shared sense of uncertainty about the future.

8.9. Summary of chapter

This chapter has examined common pressures or policy developments that affected all three study provinces. It has discussed factors that constrained the decision making freedom of local policy actors, and which must be set alongside the areas of discretion to shape local policy in different ways described in Chapters 5, 6 and 7.

Chapter 9

Discussion and conclusions

Chapter 9. Discussion and conclusions

9.1 Introduction

This study set out to investigate the interaction between top-down and bottom-up influences on the implementation of UC policy in the local health system of the three NE Thai provinces. The research examined the role of different actors, contexts and processes in policy implementation at local level. This chapter brings together the overall findings about the policy implementation process. It also considers lessons from the Thai reforms for other countries, and directions for future research.

9.2 Implementing UC policy: perspectives from three provinces

9.2.1 The Policy stories

This thesis aims to shed light on the nature of implementation process by a qualitative study of events and perspectives at local level. It analyses the policy stories of three provinces to examine common patterns and differences. The analysis pays attention to the extent of local discretionary power, the networks of local actors, the interactions between higher and lower levels, changes in the organisation of local services, perspectives on the reforms, problems encountered, and the balance between local discretion and central constraint. Some of the key elements of the policy stories will now be summarised.

As explained in Chapter 1, the MoPH had given all Thai PHOs significant areas of local discretion in the first year of the reforms, mainly relating to the choice of financing arrangements. However one important finding of this study is that it was not just the narrow choice of funding model that distinguished the provinces, but the wider issue of how PHOs constructed their role as a key policy implementation agency within the new framework. The reforms created an ambiguous space within which different PHOs could construct themselves as decision making agencies of rather different kinds, and which then led them to approach their (official) areas of devolved discretion in different ways. This initial positioning of the PHOs affected most of the other elements of the policy stories and is reflected in the titles of Chapters 5, 6 and 7.

9.2.2 Mahasarakham: distributed power and civil society engagement

The stance of Mahasarakham province was characterised as involving 'distributed power'. The PHO remained the key organisation driving the reforms, but reached out to involve other bodies at different levels of the local health care system and involve them in the decision making process. Rather than directing events through the chain of command, the PHO sought to do so by influence and persuasion. It exercised a form of gentle steering, which gave the appearance of wide participation, but where in practice most key decisions accorded with the plans of the PHO. This was reflected in the fact that though the PCIHI contained representatives from many bodies, the highly influential war room committee was composed mainly of PHO insiders. One aspect of the inclusive approach of the PHO was its emphasis on the importance of civil society, which was linked to its involvement in a range of community projects over many years.

The distinctive features of the policy story in Mahasarakham include the relatively well-developed project management capabilities of the PHO, the attempt to link a wide range of actors into the local policy making network, the public commitment to civil society engagement, and the good communication links between the PHO and the MoPH

There was a history of past projects and initiatives in Mahasarakham that was more extensive than anything in the other two study provinces. Many involved close co-operation with the MoPH and helped strengthen relationships and standing with the centre, as was illustrated by an award for best implementation strategy in Esarn in the first year of the reforms. The CMO and senior PHO officers were already experienced in managing change across a range of agencies, and their capacity to manage change appeared stronger than that in the two neighbouring provinces.

A range of other actors were involved in local policy making, but did not divide into rival camps or themselves draw power away from the PHO to the extent that happened elsewhere. Although other local actors, such as the provincial hospital head, the DDCHs or the DHO heads felt that they had exercised influence over the detail of certain policies, the PHO retained broad control over the direction of change. The CMO was probably the most powerful single local policy actor, but he was willing to give other agencies a share of influence and seats on important committees. Although the 'war room' dominated by PHO staff generally set the lead, there were examples when its recommendations were

over-ruled by the PCIHI, such as the handling of the salaries budget in Year 2. The choice of the so-called 'inclusive' funding model in Year 1, which in reality was a mixed approach, reflects Mahasarakham's more general commitment to inclusiveness in the local health system, which here again was not quite what it seemed on the surface. The mixed approach struck a balance between the interests of the provincial hospital and the CUPs dominated by the DDCHs, and the PHO also took steps to safeguard the position of the health centres. Even the DHOs which seemed to be the big losers in the initial reorganisation of services, recovered some influence as their roles were clarified in Years 2 and 3.

Senior PHO officers gave considerable support initiatives to develop civil society participation in Mahasarakham province, but there are question marks about how far these impacted on the implementation of UC policies in the province. These were a mixture of government-sponsored '*prachakhom*' projects and a small number of grassroots '*prachasangkhom*' initiatives. However, in most cases the positive view of progress from the higher level actors co-existed with a more sceptical assessment from front-line actors. All of the current initiatives were aimed at community-based health promotion rather than citizen involvement in local policy making.

The excellent relationship between senior PHO administrators and high-level MoPH contacts seems to be one factor that made the CMO's subtle steering approach viable. Other local actors who might have formed rival power groups, such as the provincial hospital and the DDCHs had poorer links with the centre, and relied on the PHO to solve problems by bringing influence to bear. The case of the PCIHI and the change in MoPH regulations necessary to let the PHO bypass the AHB (which linked to local government) is an example.

9.2.2 Kalasin: fragmented power and struggles between professional interest groups

In Kalasin the story is about the PHO's failure to be proactive and construct a viable new role in the early period of the reforms. The absence of a clear lead from the PHO resulted in a fragmented distribution of power, and greater influence for middle-ranking professional groups, such as the DDCHs and later the DHO heads. Factors such as early retirements and loss of experienced staff in the PHO, and the personalities of senior officers help to explain this. The passive stance of the PHO led to the ongoing tensions

between the professional interest groups, and finally necessitated top-down action when there were changes in the mechanism for funding health centres in Years 2 and 3.

The main elements of the policy story in Kalasin are the wide range of actors in both PCIHI and war room, an unusual pattern in local medical networks with weak provincial hospital leadership and strong DDCHs, a skilful rearguard action by DHO heads, and the interventionist stance of the Health Region Inspector.

The involvement of a wide range of actors in the two key committees, coupled with the relative lack of seniority of the Head of the Health Insurance Group and the passive stance of the PHO leadership, resulted in a leakage of power away from the PHO. When added to the lack of a strong doctor director in the provincial hospital, this opened the way for middle-ranking actors – the DDCHs – to become more powerful than in the other two provinces. In Kalasin the leading figures in this group had a prominent national profile. The DDCHs' influence was augmented because other policy actors in Kalasin accepted that the CUP was a key entity in the new organisational structure.

In Kalasin, conflict between interest groups centred mainly on resource allocation and the question of the roles of the hospitals and health centres in primary care. The fight back by the DHO heads illustrates how another group of middle-level policy actors regained some influence mainly by getting the support of an external ally – the Health Region Inspector. His intervention seems to have been crucial in persuading the PHO to take action and curb the power of the CUPs to control the funding of health centres.

Kalasin had no major civil society projects, but it did throw up an interesting case where local people were able to mobilise influence to change an aspect of the UC reforms. This concerned the PCIHI's decision to allow people freedom to register with their chosen hospital in 'Muang' municipality area, after opposition to the initial plan of separate catchment areas for the provincial and private hospitals. It is significant that this happened through people exerting pressure on local politicians rather than through any consultation process set up by the PHO. The public furore surrounding this incident reflects the poor capacity of the PHO to manage community involvement and its lack of experience in this area compared with Mahasarakham.

9.2.3 Roi Et: using active purchasing to steer the local health system

The CMO in Roi Et emphasised the purchaser/provider split aspect of the reforms in a way that Mahasarakham and Kalasin did not, and used this to redefine relationships with key actors at local level. The PHO developed a new evaluation and monitoring role, linked to the notion of purchaser as the overseer of provider organisations which had to be accredited before contracts could be entered and money passed on.

The main elements of the policy story in Roi Et concern the working out of the new 'monitoring' role, the reshaping of relationships with lower level organisations, and the creation of an evaluation and monitoring system quite different from that operating in the neighbouring provinces.

Compared with the other provinces, Roi Et had a close-knit circle of senior administrators at the top who did make great efforts to share power with lower level organisations. 'Monitoring' sometimes resembled the older PHO 'supervision' role, and there was more directive, top-down steering in Roi Et than in the two neighbouring provinces. Nevertheless conflicts among the local actors were handled through discussion and negotiation in meetings rather than direct command. An understanding was reached with the doctor director of the PHO, whereby hospital interests were safeguarded, even though the DDPH remained at arms length from the senior PHO administrator group. Middle level actors did not build up the same influence in the main committees that they did in Kalasin, even though the DDCHs were well organised through a strong provincial society. Nevertheless, the community hospitals were given control of a good share of resources, with only minimal interference from the PHO, largely on the basis that the purchasing organisation should not interfere too much in the sphere of the CUPs. The choice of the inclusive model in Year 1, may have been as much about the Roi Et PHO's to conform with the logic of the purchaser/provider model which gave it a new source of power, as with any real move away from central control.

The new PHO evaluation and standard setting role was supported by the development of a system of performance appraisal and grading. Health units at the different levels were evaluated against their plans and then given scores, which were then mentioned in reports to the MoPH, and which enabled higher level administrators to draw comparisons between

units. The PHO's control over this process gave it a new source of leverage over the lower level health organisations.

The Roi Et PHO's approach to conflict between other organisations was to stop short of directing CUPs to change behaviour and rather to use influence to try to achieve compromise. This approach kept problems in channelling funds to health centres within manageable proportions, but did not solve the problem by a change in funding methodology such as occurred in Kalasin.

Senior Roi Et administrators did not emphasise civil society involvement and there were no projects of the kind implemented in Mahasarakham. Relations with MoPH generally involved communication through formal, routine channels and was not especially warm, perhaps reflecting the same absence of friends at the top which may have led to the CMO's posting to a relative backwater after holding the prestigious Khon Kaen CMO post. By contrast, the Head of the provincial hospital was able to use his good MoPH contacts to get funding for a number of projects directly from the centre.

9.3 Answering the research questions

In chapter 1, eight questions were listed about the UC policy implementation process. Based on a synthesis of elements from the above policy stories, some provisional answers will now be put forward.

1. Who were the main actors involved in the processes of UC policy implementation in the local health system?

As expected, the main policy actors at local level were staff in the various tiers of the Ministry of Public Health system in the province – actors working in the PHO, the provincial hospital and, to a lesser extent, the community hospitals, the district health offices and the health centres. The most important committees were the PCIHIs and the 'war room' committees, as well as the CUP boards and PHO quality committees. Local government generally had a very limited role in implementing the UC reforms in the north east, and in none of the case study provinces did Area health Boards have an important role. Directors of private hospitals lacked influence, with the only Director interviewed stating that he had been largely excluded from decision making processes. The possibility

for lower level actors to influence events was very limited, with the only significant civil society projects (in Mahasarakham) having more to do with health promotion than public involvement in policy making. Such influence that was exercised was through other means such as local politicians (see the Kalasin case).

2. What were the channels of communication between lower level and higher level actors?

The Thai system resembles some other command-and-control health systems where a central Ministry transmits guidance and instructions to actors in the lower tiers. During the research period certain guidance permitted latitude for local discretion such as that concerning selection of funding models, while there were also directives that permitted no local variation, such as the order to use the 'exclusive' model in Year 2. While there was a system of formal reporting from the lower tiers to the MoPH, and also the possibility of contact with the national 'war room' to solve problems in the first years of the reforms, there seemed to be no mechanisms for more general feedback to policy makers regarding the implementation process. One finding of the study was that provinces varied in their ability to supplement formal communications with informal contact with higher level actors to help solve problems. Mahasarakham, in particular, had good channels of communication with MoPH contacts. The Health Regions varied in the way they engaged with the UC reforms, and the extent to which local actors used them to try to influence developments, with Region 6 covering Kalasin being the most interventionist.

3. What changes occurred in the organisation of local health services as the UC reforms were implemented?

The main changes reported by respondents centred on the changed role of the public organisations, and tensions between the old and new administrative structures. The financing mechanism transformed the relative positions of the PHO and the hospitals, because the CUP gave more power to DDCHs. The tension between old and new structures extended from wrangles within the MoPH and NHSO at the top, all the way down to conflict between DDCHs, DHO heads and health centre staff at the bottom. At face value, the changed framework seemed to leave the PHOs in a less dominant role, but as illustrated in the case studies, the way PHOs constructed a new role differed markedly. In Mahasarakham and Roi Et, the PHOs both managed to define their roles in ways which

left them with considerable influence, one through gentle steering and one through a more top-down active purchaser role. The purchaser/provider split remained mainly a plan not yet properly implemented during the period of the study. Its likely impact and what it might mean for a greater local government role remained unclear.

4. How much scope did local actors have to influence the content of the reforms or the approach to implementation taken?

For most of the time only local actors at a relatively high level in the provinces (such as the CMO, senior PHO administrators and doctor directors of provincial hospitals) had any real prospect of offering feedback and influencing the way UC policy was implemented. The PHO officers in particular was the group given devolved powers to select local financing approaches by the MoPH, and tended to have the best channels of communication to the MoPH.

However, the study also found examples where actors at the middle-level in the provincial public health hierarchy gained a surprising degree of influence. This occurred because the absence of a strong PHO lead created this opportunity (as in the Kalasin case), but it also reflected the ability of middle-level actors to take advantage of their strategic position in the new organisational framework (e.g. the Kalasin DDCHs) or to gain support from powerful allies (e.g. the Kalasin DHO heads and the Health Region Inspector).

Many middle and lower-level staff characterised the reforms as overly 'top-down' and complained about a lack of responsiveness from the MoPH. Many respondents from lower staff grades did not have a good understanding of the reforms, and had no clear channels for feeding back their views. Although most expressed strong support for UC health care, the involvement of low-level public health officers in actively shaping policy was virtually non-existent, and several respondents flatly stated that nothing had happened at local level to change policy.

The case study evidence shows that the way the reforms were applied in bodies such as the PHOs and the CUPs were shaped by actors at PHO level and sometimes the middle-level. However, but this does not mean that changes they made determined the final shape of the reforms. Usually there was a cycle where local adaptations were made, but were then subject to review by higher-level actors, sometimes on the basis of emergent problems, and

where the higher-level actors then brought in further policy changes. This happened at both provincial level with the PCIHIs/PHOs, and at national level with the MoPH/NHSO. This cycle of policy roll-out, local adaptation, and higher level policy revision, seems to apply to many health reforms worldwide. While questions can be asked about the ultimate impact of the kind of local influences described here, these influences did affect the way reforms were implemented in the early years, and whatever the subsequent policy adjustments from the centre, will have crucially shaped the public experience of the reforms and probably their longer-term path.

This research presents the voices of local actors in Esarn, the poorest and probably the least heard region of Thailand. One missing component of the study, in terms of implementation influences, is the voices of the professional interest groups in the MoPH and central region. This includes leading members of the medical profession in the large teaching hospitals and super-tertiary centres in central region, who were probably among the most important influences in forcing the turn towards more conservative policies in the MoPH in 2002. The struggle between pro-reformist elements and conservatives in the MoPH/NHSO is a crucial part of the implementation story that needs to be told elsewhere. Events in central region probably influenced the overall direction of UC policy in Thailand more than events in Esarn. Bits of that story, and commentary on what was happening at the centre, came through in the accounts of respondents in this study, but this is no substitute for a proper study of those actor networks.

5. Given the importance of the financing mechanism in the UC reforms, how was that mechanism adapted to local conditions?

As expected, the choice of funding mechanism was an important area of local discretion (probably second only to the overall approach adopted by the PHO in terms of its new role). At the time when the case study provinces were selected it was not known whether these provinces had taken the same or different approaches, but actually they all took a different route. In October 2001 Kalasin opted for an exclusive model, while Roi Et also favoured the exclusive model, but with a different Clearing House arrangement, and Mahasarakham employed a 'mixed' approach. Though the subsequent change of MoPH policy towards a more directive approach, then pushed all three in a similar direction, differences remained in areas such as the operation of the clearing houses, the kinds of provincial contingency funds held, how PHO activities were funded, and how monies were

channelled to health centres. The differences are explained in detail in the respective policy stories.

6. What were the perspectives of local actors on the UC reforms, their feasibility and the implementation approaches adopted nationally and locally?

Many respondents, especially at lower levels, had a poor understanding of the purchaser/provider split about to be implemented in the Thai system, which highlighted the huge shift in culture that would be required if the new system was to work as intended. Nevertheless, there was widespread support for UC reform from staff at all levels. At the same time there was concern that limited funding might undermine the new system. There was an increasing feeling that Esarn was not getting its fair share of resources, and that the early re-distributive objective of the reforms had been undermined due to pressure from professionals in central region. Towards the end of fieldwork several respondents suggested that the financial viability of community hospitals was especially precarious. They pointed out that the problems of workforce distribution and recruitment in Esarn region remained largely unsolved. Ambiguous policy on spreading funding and manpower more equally, lack of resources and the lack of responsiveness of the MoPH to the views of local actors were the main problems as seen by the respondents.

7. What were the problems encountered in implementing UC policies and how far did they differ in the three provinces?

In terms of the core financing reforms, there was a macro-level problem concerning the distribution of finance and the workforce across the nation, and a micro problem concerning how resources were distributed by CUPs to hospitals and health centres.

The capitation funding system had been designed to address the problem of unequal funding and staffing by having money follow patients, but was quickly undermined by opposition from large hospitals and professionals in urban centres (central region). The respondents in the present study were able to witness the effects of changing policies, which first gave them more money and then clawed it back, but could do little to influence this.

The micro allocation problem at CUP level was a concern in all three PHOs in the study, but surfaced in more acute form in some places than others (it was especially problematic in Kalasin). All three provinces managed to avoid the risk (highlighted by many commentators early in the reforms) that tertiary hospitals would be starved of funds through non-referrals from the CUPs. But all experienced the problem of CUPs not passing sufficient funds to health centres. The three PHOs each used different strategies to deal with this problem: negotiation and gentle steering plus the mixed funding approach in Mahasarakham, mediation plus use of contingency funds and a tough inspection regime in Roi Et, and an initial hands off approach followed by intervention and top-slicing of health centre funds in Kalasin.

The above problems contributed to a failure to fully implement the planned move towards primary care-led services. The aim of upgrading health centres to PCUs by adding doctors and nurses remained largely unrealised. Many community hospitals created PCUs on site but these usually resembled conventional outpatient clinics rather than 'close to the home' care. Because the initial 'standard' specified for PCUs proved unattainable, 3 levels of development were identified, and most PCUs remained stuck at the low or middle levels.

8. What are the areas of autonomy and the constraints affecting local actors?

The areas of autonomy open to local actors were those described under 4 and 5 above, but these were hemmed in by various constraints discussed in Chapter 8. Many of the constraints were concerned with macro resource allocation issues, and the inability of actors in Esarn to exert influence when policies changed. They were unable to do much at local level to mitigate the effect of clawing salaries back to the MOPH and subsequently reduced budgets, or to address the workforce distribution and recruitment problems. At the same time staff at all levels experienced an increase in workload linked to the administrative burden of introducing the reforms and the increased patient attendances that resulted from low cost care.

9.4 Conclusions and future research

This study was conceived as a 'policy ethnography', an approach that uses qualitative methodology to investigate the perspectives of actors within the health care system. The research supports the idea that macro-level social structures, such as health care reforms,

emerge from micro-level interactions but also constrain those interactions. The shape of the UC reforms during the 2001-04 period were determined as much by the implementation process as by the 'blueprint' devised at the policy formation stage, which in the Thai case was substantially revised as events unfolded. There was a cycle of policy prescriptions, local adaptations and higher level policy revisions that affected several aspects of the reforms and particularly the financing mechanism, and in which lower level actors clearly had a major impact. Of course, the influence of local actors is not equal and is often confined to those in strategic positions of authority, but sometimes middle-ranking actors may be able to harness their special position or links to powerful allies to influence the local implementation of reforms.

However, although local actors played their part in 'field testing' and adapting the reform plan, this was something that the MoPH did not acknowledge. It made no efforts to gain the benefits that better channels for feedback from the lower levels might have brought. The implementation 'model' favoured by the MoPH was flexible to the extent that no complete reform 'blueprint' existed, but it lacked an effective mechanism for engaging with lower level actors, and was dominated by certain over-riding resource concerns which meant that local voices at the lower level were ignored. There is a case for a more explicit role for bottom-up feedback and this is a possible lesson for Thai policy makers to learn. One radical suggestion is that high-level policy actors should act as network managers or facilitators, who improve the conditions under which actors interact, so that policies can be refined and their goals realised (Kickert, Klijn and Koppenjan 1997). Arguably the government should help facilitate discourse and discussion so that lessons are learned and implementation processes are improved. Enhancing research capacity and linkages to networks of actors at the service level might be one element of this.

This study suggests a number of directions for future research. The study was conducted in Esarn because it was thought useful to assess the impact of the reforms in the poorest area of Thailand. However, it is important to compare these findings with accounts of other regions which also encountered problems in policy implementation. As mentioned earlier, interest groups in central region appear to have been very influential in bringing about a change in MoPH policies, and comparable data on events there would be especially valuable.

This study focused on implementation from the point of view of administrative and provider organisations in the local health care system, but has little to say about the consumers of health care. Studies are needed that look at the views of the general public as well as patients and relatives about the UC reforms. Historically people in Esarn have been heavily disadvantaged by the mal-distribution of health funding and the professional workforce and stand to benefit considerably from the UC reforms, but there are questions about whether their impact has been as great as was predicted. There are indications that sections of the public have doubts about the quality of '30 baht' health care, and especially the drugs and level of service provided under the scheme.

Finally there is a need for research that examines policy implementation over a longer period, and takes account of developments such as the increasing involvement of the NHSO and local government. This leads to various questions. What agency will act as local purchaser? What kind of purchaser/provider contracting will develop? How will relationships in the local health system evolve? And what will be the respective roles of the MoPH and the NHSO in the local health system? The tendency of some Thai commentators to see the UC reforms as a big bang reform introduced in little over a year has diverted attention from the continuing implementation effort needed to keep the reforms on track. In many ways the initial swift roll-out of coverage was the easy part, and the longer-term development of the purchaser/provider split and the financing mechanism that will be more challenging. There is a need for further implementation studies to examine the next phases of reform.

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APPENDICES

Appendix 1: Interview Guide (Prepared February 2003)

a. How have the reforms affected your organisation?

การปฏิรูปสุขภาพภายใต้นโยบาย 30 บาทรักษาทุกโรค หรือการสร้างหลักประกันสุขภาพถ้วนหน้า มีผลกระทบที่ทำให้เกิดการเปลี่ยนแปลงต่อหน่วยงานของท่านอย่างไร (เจาะประเด็น บทบาท และภารกิจ โครงสร้างการทำงาน ทรัพยากรที่เปลี่ยนแปลงไป (เจาะประเด็นการปรับเปลี่ยนวิธีการทำงานของผู้ให้สัมภาษณ์ และการจัดการที่เกิดขึ้น)

b. How have they changed relationships with other organisations, including new organisations?

ผลกระทบจากการเปลี่ยนแปลงดังกล่าว ทำให้สัมพันธภาพ ภายในและภายนอกหน่วยงานมีการเปลี่ยนแปลงอย่างไรบ้าง จงอธิบายและกรณียกตัวอย่างประกอบ

c. Have the reform policies changed/been adapted at all since the Government first announced the Bt30 scheme? That is to say, is the content of the reforms evolving as implementation occurs?

ได้มีการเปลี่ยนแปลงหรือปรับเปลี่ยนบางประการเกิดขึ้น เกี่ยวกับนโยบาย 30 บาทรักษาทุกโรคหรือไม่ นับแต่รัฐบาลได้ประกาศนโยบายนี้ หรือกล่าวอีกนัยหนึ่ง มีพัฒนาการด้านนโยบายในการดำเนินงาน 30 บาทรักษาทุกโรคเกิดขึ้นหรือไม่ อย่างไร (ถามถึงการเปลี่ยนแปลงทางนโยบายที่พัฒนามาในระยะเวลาที่ผ่านมา)

d. How have those changes in policy affected your organisation?

การเปลี่ยนแปลงหรือการพัฒนาด้านนโยบายดังกล่าว นั้น มีผลกระทบต่อหน่วยงานของท่านอย่างไร

e. What aspects of the reforms have been most difficult to implement?

ในฐานะที่ท่านเป็นผู้ปฏิบัติงานได้การเปลี่ยนแปลงของระบบสุขภาพปัจจุบัน ท่านคิดว่าประเด็นสำคัญที่ยากที่สุดและในการดำเนินโครงการ 30 บาทรักษาทุกโรค ประเด็นใดยากที่สุด เพราะเหตุใด

f. In your province, what has been done to further the policy aim of greater public participation in the reform process and the health service?

ในจังหวัดของท่าน ได้มีการดำเนินกิจกรรมที่ป็นลักษณะการสร้างการมีส่วนร่วมจากภาคประชาชนหรือภาคีอื่นในการปฏิรูปสุขภาพ หรือการจัดบริการสุขภาพหรือไม่ อย่างไร โปรดยกตัวอย่างประกอบ

g. What in your view are the main problems of the reforms at national level?

ท่านคิดว่าการดำเนินโครงการ 30 บาทรักษาทุกโรค ประเด็นใดที่เป็นปัญหาในระดับชาติหรือในภาพรวม

h. What are the main problems affecting your organisation?

ท่านคิดว่าประเด็นปัญหาใดในโครงการ 30 บาทที่เป็นผลกระทบสำคัญต่อหน่วยงานของท่าน

i. Have people in the organisation adapted local policy in any way to deal with those problems?

บุคลากรในหน่วยงานของท่านได้มีการปรับตัวอย่างไร เกี่ยวกับผลกระทบที่เกิดขึ้นต่อหน่วยงานในการดำเนินโครงการ 30 บาทรักษาทุกโรค

j. What kind of communication occurs between your organisation and higher level health organisations about implementation?

รูปแบบการติดต่อสื่อสารหรือการประสานงาน ภายในหน่วยงานของท่าน และระหว่างหน่วยงานของท่านกับหน่วยงานอื่นในระดับที่สูงกว่า ในการดำเนินโครงการ 30 บาท

Probes about –

Monitoring and supervision การกำกับติดตาม และการนิเทศงาน

Requirement for written reports on implementation ระบบระเบียบรายงาน เกี่ยวกับการดำเนินงาน

Use of models of good practice ได้มีการไปศึกษากรณีตัวอย่างหรือองค์กรที่ประสบความสำเร็จ

k. Have lower level organisations been able to feed back information on implementation problems that led to changes in policy?

หน่วยงานในระดับพื้นที่หรือหน่วยปฏิบัติที่สามารถที่จะสะท้อนข้อมูลปัญหาในการดำเนินงานในโครงการนี้ ไปสู่องค์กรที่สูงขึ้นจนนำไปสู่การเปลี่ยนแปลงในระดับจังหวัด หรือประเทศหรือไม่

Specific areas of reforms

l. The reforms have a number of components. I wonder if you can tell me a bit about how some of these are being implemented in the Province.

การปฏิรูประบบสุขภาพได้มีการเปลี่ยนแปลงหลายอย่าง กรุณาบอกได้หรือไม่ว่าการเปลี่ยนแปลงในเรื่องอะไรบ้าง อย่างไร

m. The changes in funding so that money follows patients and the plan to move to a purchaser/provider split

มีการเปลี่ยนแปลงเกี่ยวกับการงบประมาณไปสู่ระบบใหม่ที่แยกระหว่าง ผู้จัดบริการ และผู้ซื้อบริการ

n. Administrative devolution or decentralisation – balance of power between centre and lower level organisations.

ได้มีการกระจายอำนาจในการทำงานระหว่างหน่วยงานส่วนกลางและส่วนปฏิบัติอย่างไร

o. New district organisation with integrated local services including the district office, hospital and PCUs

องค์กรที่มีการจัดรูปแบบใหม่ในพื้นที่ ได้มีการประสานงานและร่วมมือการทำงานกันอย่างไร ทั้ง สำนักงานสาธารณสุขอำเภอ โรงพยาบาลชุมชน และ PCUs probes in Primary Care Led

p. Areas of criticism and views

1. The universal coverage reforms have many critics and there are many reported problems. I will list some of these and ask for your opinion on the accuracy of these reports and the size of the problem. Please mention any steps to correct problems that are being taken in your province

มีการวิพากษ์วิจารณ์ปัญหาเกี่ยวกับการดำเนินโครงการ 30 บาท หลายประการ ซึ่งต่อไปนี้จะได้ลำดับให้ฟัง และท่านมีความคิดเห็นต่อประเด็นเหล่านี้หรือไม่ และเกิดปัญหาเช่นนี้ในพื้นที่ท่านหรือไม่

2. It is said that the Bt30 reforms are reinforcing health inequalities by providing an inferior service for poorer people (a ‘poor man’s health service’ as Ammar Siamwalla termed it). The allegation is that Bt 30 patients get cheaper medicines, wait longer, and experience greater barriers of access for some high-cost treatments.

มีการวิจารณ์ว่า โครงการ 30 บาทนำไปสู่การจัดบริการสุขภาพที่ด้อยคุณภาพ โดยเฉพาะมีคนกล่าวว่า “บริการสำหรับคนจน” และมีการกล่าวว่าเป็นโครงการที่จ่ายยาที่ด้อยคุณภาพ และมีการรอนานในระบบบริการ ทำให้เข้าถึงบริการที่ดีกว่าได้ยากขึ้น

3. It is said that there are still very large gaps in coverage for the population, particularly for people working away from their home province (whose housing registration is different from their actual place of residence).

มีการวิจารณ์ว่าทำให้เกิดช่องว่างในการครอบคลุมประชากร โดยเฉพาะอย่างยิ่งประชากรที่อยู่อาศัยไม่ตรงตามการขึ้นทะเบียนราษฎร

4. It is said that the shortage of funding means that some of the more ambitious aims of the reforms like better health promotion and preventative medicine are being put on the back burner because all the money is needed for acute treatments.

มีการวิจารณ์ว่าโครงการนี้มีเป้าหมายที่จะสร้างสุขภาพ แต่การจัดงบประมาณกลับไปมุ่งเน้นการรักษา มากกว่า

5. It is said that the present capitation system results in under-funding of provincial hospitals and over-funding of district hospitals. The argument is that specialist hospitals with more complex case mixes are only being re-paid at the same rate as district hospitals who treat more straightforward conditions. There are also allegations that some district hospitals have been slow to refer to specialist hospitals because they do not wish to pass on the money.

มีการวิจารณ์กันว่า การจัดงบประมาณรายหัวประชากร ส่งผลให้โรงพยาบาลจังหวัดหรือโรงพยาบาลศูนย์มีค่าใช้จ่ายไม่เพียงพอต่อการจัดบริการ ในขณะที่โรงพยาบาลอำเภอมีงบประมาณมากกว่า โรงพยาบาลจังหวัดหรือเฉพาะทางซึ่งมีความสลับซับซ้อนในการให้บริการก็ได้รับเงินเท่ากับโรงพยาบาลอำเภอ ทำให้ส่งผลกระทบในระบบส่งต่อผู้ป่วยเนื่องจากโรงพยาบาลอำเภอไม่อยากจ่ายเงินให้กับโรงพยาบาลที่ได้ส่งต่อไป

6. It is said that there has been a failure to explain the nature of the reforms to the public so that many have unrealistic expectations or basic misconceptions.

มีการวิจารณ์ว่าโครงการ 30 บาทจะประสบความสำเร็จล้มเหลว เนื่องจากไม่อยู่บนพื้นฐานความคาดหวังที่ความเป็นจริง

7. Some critics say that the reforms will lead to waiting lists and new forms of gate keeping. They say that the old system involved rationing by price but that the new system will involve rationing by waiting or medical prioritisation?

มีบางคนวิจารณ์ว่าระบบเดิมอยู่บนพื้นฐานราคาและการจ่ายเงิน แต่ระบบใหม่อุ้บนฐานการเรียงลำดับปัญหา

8. From your position in your organisation do you hear of any other criticisms that I have not mentioned?

จากประสบการณ์ของท่าน ท่านได้รับฟังปัญหาในการดำเนินงานนอกเหนือจากนี้ที่ยังไม่ได้กล่าวถึงหรือไม่

9. The 30 baht project has been in operation for about 2 years. Commentators are still very divided about its success or failure. Do you think the 30 baht scheme will still be in existence in 2 more years?

โครงการ 30 บาทรักษาทุกโรคได้ดำเนินงานมา 2 ปีแล้ว นักวิจารณ์บางท่านได้พยายามสรุปความสำเร็จและล้มเหลวในการดำเนินงาน ท่านคิดว่าโครงการนี้จะดำเนินต่อไปอีกมากกว่า 2 ปีหรือไม่

10. The final question is about whether I have missed out anything. If I am interested in studying the implementation of health reforms are there any other areas that I need to ask about?

คำถามสุดท้าย คุณมีข้อเสนอแนะหรือข้อคิดเห็นประการใดในการดำเนินโครงการ 30 บาทรักษาทุกโรคในพื้นที่ของท่านมีประเด็นใดหรือปัญหาอย่างไรที่นอกเหนือจากที่กล่าวมาแล้วหรือไม่

Appendix 2: Focus Group Guide (Prepared December 2004)

Guide for the focus group discussions (คู่มือการดำเนินการ ประชุมสนทนากลุ่มย่อย)

1. Make Introductions and inform participants of objectives (การแนะนำตัวและแจ้งวัตถุประสงค์)
 - 1.1 Explain research topic and objectives - (เป็นโครงการวิจัยเรื่อง “การปฏิรูประบบสุขภาพในประเทศไทย: การดำเนินนโยบายกรณีศึกษาสามจังหวัด” ซึ่งเป็นส่วนหนึ่งของงานวิจัยเพื่อประกอบการศึกษาระดับปริญญาเอก และเป็นการทำงานวิจัยภายใต้การควบคุมของ ศาสตราจารย์ดอกเตอร์เดวิด ฮิวส์ จากมหาวิทยาลัยแห่งเวลส์ สวอนซี ประเทศสหราชอาณาจักร)
 - 1.2 Methodology of the study based on policy ethnography and multiple case studies - (ระเบียบวิธีการศึกษาวิจัยเป็นงานวิจัยเชิงคุณภาพที่ใช้เทคนิคการรวบรวมข้อมูลหลายประการในทางการศึกษาวิจัยเชิงคุณภาพ ประกอบกันโดยวิธีระเบียบวิธีวิจัยที่เรียกว่า Policy Ethnography method - โดยใช้กรณีศึกษาในสามจังหวัดในการเปรียบเทียบ)
 - 1.3 Focus group discussions objectives - (วัตถุประสงค์ในการประชุมกลุ่มย่อยวันนี้เป็นการศึกษาลึกซึ่งลงไปประเด็นต่างๆ ที่ค้นพบจากการเก็บรวบรวมข้อมูลในขั้นต้นในปีที่ผ่านมาที่ใช้กระบวนการสัมภาษณ์เชิงลึก)
2. Get participants to introduce themselves - (ขอความกรุณาให้ผู้เข้าร่วมประชุมแนะนำตัว)
 - 2.1 Positions and work place (แนะนำตัวโดยให้ผู้ร่วมประชุมแนะนำตนเองเกี่ยวกับตำแหน่งและสถานที่ปฏิบัติงาน)
3. Request permission for video and tape recording (ขออนุญาตอัดเทปและบันทึกเสียงและภาพ)
4. Ask the questions, listen and observe ตั้งประเด็น ตามลำดับ (พยายามใช้คำถามเกี่ยวกับ เกิดอะไรขึ้น เกิดอย่างไร และทำไมถึงเกิดอย่างนั้น)
 - 4.1 Financial arrangement themes, ประเด็นเกี่ยวกับการจัดการงบประมาณตามนโยบายสร้างหลักประกันสุขภาพถ้วนหน้า หรือ นโยบาย 30 บาทรักษาทุกโรค (ความพอเพียง, ความชัดเจนในระบบการจัดการ, การมีส่วนร่วม)
 - 4.2 Workforce issues, ประเด็นการจัดการด้านทรัพยากรบุคคล (ความพอเพียง, การเปลี่ยนแปลงด้านปริมาณและคุณภาพ, การเสริมสร้างขวัญกำลังใจ, การพัฒนาความรู้ความสามารถ)
 - 4.3 Organisational and power structure, ประเด็นเกี่ยวกับสายการบังคับบัญชาและการจัดโครงสร้างการทำงานในระบบที่เกิดขึ้นใหม่ (ความชัดเจนในระบบการทำงาน, โครงสร้างการประสานงาน, การเอื้อหรืออุปสรรคในการทำงาน)
 - 4.4 The primary care led policy, ประเด็นเกี่ยวกับการจัดการระบบบริการในระดับปฐมภูมิ (แนวคิดการสร้างนำซ่อม, ความพอเพียงของทรัพยากร, การทำงานร่วมกันระหว่างหน่วยงาน)
 - 4.5 Policy implementation in the province and action taken, ประเด็นเกี่ยวกับการก่อเกิดนโยบาย การสื่อสารนโยบายการมีส่วนร่วมในการกำหนดและดำเนินการตามนโยบาย รวมทั้งกรอบแนวคิดรอยต่อของนโยบาย 30 บาท รักษาทุกโรค (การสร้างความร่วมมือร่วมกันในนโยบาย, วิธีการสื่อสารจากส่วนกลางกับพื้นที่, ความชัดเจนในทิศทางการดำเนินงาน, ประโยชน์ต่อประชาชน)
 - 4.6 Decentralisation and working with local government, ประเด็นการกระจายอำนาจและการทำงานร่วมกับองค์กรปกครองส่วนท้องถิ่น (ความพร้อมและการมีส่วนร่วมของ องค์กรปกครองส่วนท้องถิ่น, การทำงานร่วมกัน อุปสรรคและความสำเร็จ)
 - 4.7 Other issues, ประเด็นอื่นๆ ที่เกี่ยวข้องและน่าสนใจ
5. Conclusion of meeting สรุปผลการประชุม
6. Thank you ขอบขอบคุณผู้เข้าร่วมวิจัย

Appendix 3: Information Sheet (English Translation)

Research on Health Sector Reform in Thailand: policy implementation in three provinces

This is a qualitative study based on interviews with health care staff at various levels in the local health system in three North-eastern provinces (Mahasarakham, Kalasin and Roi Et).

The study will examine:

- (a) The significance of the Thai health reforms in the wider international context;
- (b) The extent to which the three provinces have faced common problems in implementing the reforms and arrived at similar solutions;
- (c) The dynamics of the implementation process and the extent to which health reforms are reshaped in light of emergent problems and the input of front-line staff.

The research will draw out lessons relevant to policy and feed these back to the Thai policy community.

Interviews will be completed with a sample of staff from the provincial health offices, district health offices, provincial and community hospitals, health centres and PCUs, and Muang municipalities. This will be a convenience sample but the staff included will be selected to cover the full range of organisations in the three provinces. Some will be recruited from the large group of health care professional currently undertaking degree studies at Mahasarakham University, while others will be selected via approaches to the relevant organisations.

The supervisor, Professor David Hughes has discussed the study with the Ministry of Public Health and the Director of Health System Research Institute, Dr Wiput Poolcharoen, and will liaise with the regional co-ordinator for studies of the UC reforms at Khon Kaen University, Dr Wongsak Loahasiriwong. He will seek the agreement of the regional co-ordinator before the results are presented in Thailand.

The data for the study will consist mainly of interviews, involving open ended questions, which will be tape recorded where possible. These will be seen only by supervisor and staff helping with transcription. When the study is written up, the interview data will be presented in anonymous form so that no real names are mentioned. The contents of individual interviews will remain confidential to the researcher and will not be passed on to other people working in the health care system. Respondents should be disadvantaged by participating in the research. Their main commitment will be to agree to help with one interview lasting between 60 and 90 minutes, and carried out at a time and place convenient to them.

Appendix 4: Consent Form – Interviews (English Translation)

Research on Health Sector Reform in Thailand: policy implementation in three provinces

Are you willing to be considered for inclusion in the research?

Name: _____

(....) No, I prefer not to take part. (tick if applicable)

(....) Yes, I am willing to be considered but understand that I can still pull out later. (tick if applicable)

If you ticked 'yes', please complete the following:

Position: _____

Work address: _____

Telephone: _____

E-mail address (optional) _____

- Note:**
1. Students who decide not to take part will not be disadvantaged in any way.
 2. Those who say 'yes' may be asked to take part in an interview lasting about 60-90 minutes, at a time and place convenient to them.

Appendix 5: List of informants

In this study 147 informants were formally participated-124 persons by interviewing based on the semi-structured questionnaire as interview guide and 23 persons by focus group discussions. See tables A1, and A2 for lists of respondents.

Table A1: List of interviewees

No.	Position/Job title	ID	Interview date
	Maharakham		
1.	Senior Administrator Officer Provincial Health Office	SAO-PHO MK 01	25/06/03
2.	Senior Administrator Officer Provincial Health Office	SAO-PHO MK 02	10/06/03
3.	Senior Administrator Officer Provincial Health Office	SAO-PHO MK 03	10/06/03
4.	Senior Administrator Officer Provincial Health Office	SAO-PHO MK 04	11/06/03
5.	Senior Administrator Officer Provincial Health Office	SAO-PHO MK 05	13/06/03
6.	Senior Administrator Officer Provincial Health Office	SAO-PHO MK 06	12/06/03
7.	Senior Administrator Officer Provincial Health Office	SAO-PHO MK 07	12/06/03
8.	Senior Administrator Officer Provincial Health Office	SAO-PHO MK 08	13/06/03
9.	Senior Administrator Officer Provincial Health Office	SAO-PHO MK 09	16/06/03
10.	Senior Administrator Officer Provincial Health Office	SAO-PHO MK 10	20/06/03
11.	Senior Administrator Officer Provincial Health Office	SAO-PHO MK 11	18/06/03
12.	Senior Administrator Officer Provincial Health Office	SAO-PHO MK 12	17/06/03
13.	Senior Doctor in Provincial Hospital	Senior doctor PH MK 13	25/06/03
14.	Senior Nurse in Provincial Hospital	Senior nurse PH MK 14	27/06/03
15.	Senior Municipal Representative	SMR MK 15	25/06/03
16.	Senior Municipal Representative	SMR MK 16	26/06/03
17.	Senior Officer of Health Service Department in city municipality	SOHSD MK 17	26/06/03
18.	Head of PCU in Muang municipality	HPCUM MK 18	10/04/03
19.	Doctor Director Community Hospital (D 1)	DDCH MK 19	04/07/03
20.	Doctor Director Community Hospital (D 2)	DDCH MK 20	03/07/03
21.	Doctor Director Community Hospital (D 3)	DDCH MK 21	07/07/03
22.	Doctor Director Community Hospital (D 4)	DDCH MK 22	01/07/03
23.	Doctor Director Community Hospital (D 5)	DDCH MK 23	04/07/03
24.	Doctor Director Community Hospital (D 6)	DDCH MK 24	02/07/03
25.	Head of Health Promotion Department in Community Hospital (D 2)	HHPD MK 25	03/07/03
26.	District Health Office Head (the city)	DHO Head MK 26	16/06/03
27.	District Health Office Head (D 2)	DHO Head MK 27	19/06/03
28.	District Health Office Head (D 4)	DHO Head MK 28	23/06/03
29.	District Health Office Head (D 7)	DHO Head MK 29	17/06/03
30.	District Health Office Head (D 6)	DHO Head MK 30	24/06/03
31.	District Health Office Head (D 5)	DHO Head MK 31	18/06/03
32.	Assistant DHO Head (D 7)	ADHOH MK 32	21/04/03
33.	Assistant DHO Head (D 5)	ADHOH MK 33	09/04/03
34.	Health Officer DHO (D 7)	HODHO MK 34	08/04/03
35.	Health Officer DHO (D 6)	HODHO MK 35	04/04/03
36.	Health Centre Officer (D 8)	HCO MK 36	10/04/03
37.	Health Centre Officer (D 2)	HCO MK 37	28/04/03
38.	Health Centre Officer (D 5)	HCO MK 38	08/04/03
39.	Dental Nurse in PCU (D 2)	DN-PCU MK 39	30/04/03
40.	Health Officer in PCU (D 6)	HO-PCU MK 40	29/04/03
41.	Health Officer in PCU (D 8)	HO-PCU MK 41	25/04/03
42.	Head of Health Centre (D5)	Head HC MK 42	09/04/03
43.	Health Centre Officer (D5)	HCO MK 43	22/04/03
44.	Dental Nurse Community hospital (D 2)	DN CM MK 44	29/04/03

Table A1: List of interviewees (continued)

No.	Position/Job title	ID	Interview date
	Kalasin		
45.	Senior Administrator Officer Provincial Health Office	SAO-PHO KS 01	11/08/03
46.	Senior Administrator Officer Provincial Health Office	SAO-PHO KS 02	11/08/03
47.	Senior Administrator Officer Provincial Health Office	SAO-PHO KS 03	12/08/03
48.	Senior Administrator Officer Provincial Health Office	SAO-PHO KS 04	13/08/03
49.	Senior Administrator Officer Provincial Health Office	SAO-PHO KS 05	14/08/03
50.	Senior Administrator Officer Provincial Health Office	SAO-PHO KS 06	15/08/03
51.	Senior Administrator Officer Provincial Health Office	SAO-PHO KS 07	13/08/03
52.	Senior Administrator Officer Provincial Health Office	SAO-PHO KS 08	12/08/03
53.	Senior Doctor in Provincial Hospital	Senior doctor PH KS 09	15/08/03
54.	Doctor-Director Private Hospital	DPH KS10	19/08/03
55.	Senior Municipal Representative	SMR KS 11	20/08/03
56.	Doctor Director Community Hospital (D 1)	DDCH KS 12	29/08/03
57.	Doctor Director Community Hospital (D 2)	DDCH KS 13	27/08/03
58.	Doctor Director Community Hospital (D 3)	DDCH KS 14	26/08/03
59.	Doctor Director Community Hospital (D 4)	DDCH KS 15	29/08/03
60.	Doctor Director Community Hospital (D 5)	DDCH KS 16	26/08/03
61.	Doctor Director Community Hospital (D 6)	DDCH KS 17	27/08/03
62.	Doctor Director Community Hospital (D 7)	DDCH KS 18	28/08/03
63.	District Health Office Head (City)	DHO Head KS 19	28/08/03
64.	District Health Office Head (D 1)	DHO Head KS 20	19/08/03
65.	District Health Office Head (D 3)	DHO Head KS 21	22/08/03
66.	District Health Office Head (D 5)	DHO Head KS 22	20/08/03
67.	District Health Office Head (D 4)	DHO Head KS 23	21/08/03
68.	District Health Office Head (D 8)	DHO Head KS 24	18/08/03
69.	District Health Office Head (D 7)	DHO Head KS 25	28/08/03
70.	Head of Health Centre (City)	Head HC KS 26	03/04/03
71.	Head of Health Centre (D 9)	Head HC KS 27	06/05/03
72.	Head of Health Centre (D 10)	Head HC KS 28	19/05/03
73.	Head of Health Centre (D 9)	Head HC KS 29	13/05/03
74.	Health Officer in DHO (D 9)	HO-DHO KS 30	08/04/03
75.	Health Centre Officer (D 1)	HCO KS 31	09/05/03
76.	Health Officer DHO (D 9)	HO-DHO KS 32	06/05/03
77.	Health Centre Officer (D 1)	HCO KS 33	07/05/03
78.	Health Officer DHO (D 11)	HO-DHO KS 34	12/05/03
79.	Health Officer in PCU (City)	HO-PCU KS 35	04/04/03
80.	Health Officer in PCU (City)	HC-PCU KS 36	14/04/03

Table A1: List of interviewees (continued)

No.	Position/Job title	ID	Interview date
	Roi Et		
81.	Senior Administrator Officer Provincial Health Office	SAO-PHO RE 01	16/07/03
82.	Senior Administrator Officer Provincial Health Office	SAO-PHO RE 02	17/07/03
83.	Senior Administrator Officer Provincial Health Office	SAO-PHO RE 03	17/07/03
84.	Senior Administrator Officer Provincial Health Office	SAO-PHO RE 04	21/07/03
85.	Senior Administrator Officer Provincial Health Office	SAO-PHO RE 05	22/07/03
86.	Senior Administrator Officer Provincial Health Office	SAO-PHO RE 06	21/07/03
87.	Senior Administrator Officer Provincial Health Office	SAO-PHO RE 07	23/07/03
88.	Senior Administrator Officer Provincial Health Office	SAO-PHO RE 08	24/07/03
89.	Senior Administrator Officer Provincial Health Office	SAO-PHO RE 08	21/07/03
90.	Senior Doctor in Provincial Hospital	Senior doctor PH RE 09	25/07/03
91.	Senior Nurse in Provincial Hospital	Senior nurse PH RE 10	07/07/03
92.	Senior Municipal Representative	SMR RE 11	28/07/03
93.	Senior Municipal Representative	SMR RE 12	28/07/03
94.	Doctor Director Community Hospital (D1)	DDCH RE 13	30/07/03
95.	Doctor Director Community Hospital (D 2)	DDCH RE 14	29/07/03
96.	Doctor Director Community Hospital (D 3)	DDCH RE 15	25/07/03
96.	Doctor Director Community Hospital (D 4)	DDCH RE 16	30/07/03
97.	Doctor Director Community Hospital (D 5)	DDCH RE 17	29/07/03
98.	Doctor Director Community Hospital (D 6)	DDCH RE 18	25/07/03
99.	Doctor Director Community Hospital (D 7)	DDCH RE 19	23/07/03
100.	District Health Office Head (City)	DHO Head RE 20	01/07/03
101.	District Health Office Head (D 2)	DHO Head RE 21	05/08/03
102.	District Health Office Head (D 8)	DHO Head RE 22	01/07/03
103.	District Health Office Head (D 3)	DHO Head RE 23	04/08/03
104.	District Health Office Head (D 9)	DHO Head RE 24	07/08/03
105.	District Health Office Head (D 6)	DHO Head RE 25	04/08/03
106.	District Health Office Head (D 7)	DHO Head RE 26	04/08/03
107.	Health Officer DHO (D 3)	HO-DHO RE 27	07/08/03
108.	Health Officer DHO (D 3)	HO-DHO RE 28	11/04/03
109.	Nurse in PCU (D 3)	NPCU RE 29	05/08/03
110.	Health Centre Officer (D 4i)	HCO RE 30	04/08/03
111.	Dental Nurse PCU (D 8)	DN PCU RE 31	05/08/03
112.	Health Centre Officer (City)	HCO RE 32	11/04/03
113.	Health Centre Officer (D 9)	HCO RE 33	10/06/03
114.	Health Centre Officer (D 1)	HCO RE 34	11/06/03
115.	Head of Health Centre (D 9)	Head HC RE 35	12/06/03
116.	Head of Health Centre (D 9)	Head HC RE 36	13/06/03
117.	Head of Health Centre (D 10)	Head HC RE 37	10/06/03
118.	Head of Health Centre (D 2)	Head HC RE 38	26/05/03
119.	Health Centre Officer (D 11)	HCO RE 39	27/06/03
120.	Health Centre Officer (D 2)	HCO RE 40	28/05/03
121.	Head of Health Centre (D 5)	Head HC RE 41	30/05/03
122.	Head of Health Centre (City)	Head HC RE 42	11/04/03
123.	Health Centre Officer (City)	HCO RE 43	03/04/03
124.	Health Centre Officer in Centre for Public Health Service	HCO-CPHS RE 44	28/07/03

Table A2: List of participants in focus group discussions

No.	Name	Job title/office
	Mahasarakham workshop	(Held on 20 January 2005)
1.	Ms A*	Senior administrator officer PHO
2.	Ms B*	Senior administrator officer PHO
3.	Ms C	Senior administrator officer in provincial hospital
4.	Dr. D*	DDCH (D4)
5.	Ms E	Senior municipal representative
6.	Ms F	Senior municipal representative
7.	Mr G*	DHO Head (D2)
8.	Ms H	DHO Head (D 9)
9.	Mr I	DHO Head (D 5)
10.	Ms J	Health centre officer (City)
11.	Ms K	Health centre officer (D 7)
12.	Ms L	Health centre officer (D 10)
	Kalasin Workshop	(Held on 27 January 2005)
1.	Ms A*	Senior administrator officer PHO
2.	Ms B	Senior administrator officer PHO
3.	Mr C	DHO Head (D 2)
4.	Mr D	DHO Head (D 12)
5.	Ms E	Senior municipal representative
6.	Mr F	Health centre officer (D 3)
7.	Mr G	Health centre officer (D 2)
8.	Ms H*	Health centre officer (D 3)
	Roi Et Workshop	(Held on 28 January 2005)
1.	Mr A*	Senior administrator officer PHO
2.	Mr B	Senior administrator officer PHO
3.	Ms C	Senior administrator officer in provincial hospital
4.	Dr. D	DDCH (D 12)
5.	Ms E*	Senior municipal representative
6.	Mr F	DHO Head (D 13)
7.	Mr G	DHO Head (D 3)
8.	Mr H	DHO Head (D 6)
9.	Mr I	Health centre officer (City)
10.	Ms J	Health centre officer (D 4)
11.	Ms K	Health centre officer (D 14)

Note: * These participants also took part in in-depth interviews. Initials are based on pseudonyms.