DECENTRALIZATION AND HEALTH SYSTEMS
A Review on the Experience of Thailand

Somsak Chunharas[1]
Choochai Supawongse[2]
Supakorn Buasai[3]
Udom Thumakosit[4]

Decentralization is often claimed as a means to improve the working of health systems. Some countries (e.g. Botswana, Mexico, New Zealand, Sri Lanka) had implemented explicitly the decentralization policy primarily through specific legislation and reorganization of public health structures.[5] In Thailand, decentralization has become a subject of public debate only since recently. So far the debate centered on the devolution of government's administrative authority in general and infrequently touched upon the national health system.

A dominant theory on national development describes the three primary functions of the state: (1) resource allocation; (2) prosperity distribution; and, (3) systems stabilization. In effect, health systems represent a channel through which the state may realize all three of those functions. Generally, the allocative function is mediated by the inter- and intra-sectoral management of health resources which include personnel, money, and materials. The state can spread the prosperity of the economic growth through equitable provision of quality health services that meet the public needs. Finally, the population often faces the various forms of epidemics which threaten economic and social stability. Public-health measures represent state intervention to maintain national stability. The degree to which the state decision is made centrally generally determines the direction, effectiveness, efficiency and responsiveness of its functioning. The political apparatus then acts as the primary mechanism which conditions the extent of social welfare.[6] Hence it could hinder or enhance the extent to which the government accomplishes the functions through the health systems.

Thailand's achievements in public health are commonly argued as the consequences of centralized policy-making, particularly that by the Ministry of Public Health (MOPH). Decentralization of the health systems was seldom taken as explicit policy. In case any decentralization process did occur at all, it likely emerged as implicit component of another primary policy rather than was formulated as primary itself. Then a relevant

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[1] Health Systems Research Institute (HSRI), Thailand

[2] Department of Health , Ministry of Public Health, Thailand

[3] HSRI, Thailnd

[4] National Institute of Developmental Administration (NIDA), Thailand

[5] Mills, A., Vaughan J.P., Smith, D.L., and Tabibzadeh, I. *Health System Decentralization: Concepts, issues and country experience.* World Health Organization, Geneva, 1990.

[6] Pipatsentham, Krirk-kiat. Financing of economic distribution, Thammasart University Publisher, Bangkok, 1992

question becomes whether the development of Thailand's health systems included any significant manifestation of decentralization. If so, how did they take place in relations to the distribution of welfare (essential services), social stabilization (disease control), and resource allocation?

Purpose of this study

This study provides a review on significant changes of Thailand's politico-administrative structures and health systems over the past few decades. Primarily, it aims at describing the "streams of changes" within the national health systems and that of explicit decentralization. Wherever possible, the review will include elaboration of the possibilities of association between the two streams. Emphasis will be placed on three facets of the national health system: health services; personnel; and, public budgeting. However, given the time constraint, this scrutiny tends to be impressionistic rather than exhaustive assessment. The study could provide basic information about the past development on which further research or comparison between countries could evolve.

Definition

Prior to this study, the Health Systems Research Institute organized a focus-group meeting to discuss the scope of study on decentralization and health systems. The 30 participants included academics of various disciplines, distinguished community leaders, and public health officials. The definition of "decentralization" was exhaustively addressed and eventually the group agreed on a broad definition. Here "decentralization" refers to ***the transfer of authority over public enterprises from the central government to peripheral units***. The "periphery' can be spatial (e.g. local governments, provincial offices of the central government) or functional (e.g. specialized autonomous units). As for health systems, the focus group argued that "deconcentration" is yet the most probable form of the short-term development whereas one would look forward to "devolution" as a long-term development.[7]

[7] For definitions of the various forms of decentralization, please look in Mills et. all.

Decentralization Stream

Decentralization made up a basic course of changes along the national development. Generally, the decentralization stream involved the politico-administrative structure of the public administration in general. The Ministry of Public Health (MOPH) constituted a subsystem of the national public administration. Meanwhile, it made a major part of the national health system which represented the other exemplar of this study. The two streams converged from time to time and could generated effects on each other. This section will describe the evolution of the decentralization. Emphasis will be placed on political and administrative changes along the stream.

Early development

The Kingdom of Thailand has a long history as an agricultural country. The Thai national bureaucracy was established solidly by the reform of 1892 during the reign of King Rama V. First, the feudal system was replaced by a centralized absolute monarchy. The initial centralization was to strengthen the country's capacity to defend against the European imperialism. King Rama V also initiated the modernization of the Thai society through improving infrastructures, education, and social reforms.

In 1932, during the reign of King Rama VII, a group of young elites successfully launched a coup d'etats. They accomplished to establish a constitutional monarchy in place of absolutism. The political reform recruited new breed of educated elites to the public administration. Further, for years since the Second World War, Thailand had acquired foreign assistance in implementing several modernization programs affecting the Thai administrative system. Among those, a team of foreign consultancy came to review the Thai budgetary system, followed by another from the International Bank for Reconstruction and Development. Those missions led to the First National Development Plan (1961-1966) and that the former Economic Council was reorganized as a central planning organization.[8]

Meanwhile a super-Ministry of National Development was formed, whereby existing departments concerned with development were consolidated. In addition, at least two national-level boards were established to complement the national development capacity, namely, the Board of Investment and the Board of Tax Supervision. Furthermore, foreign advisors came to Thailand to assist departments in project formulation and implementation.

The Thai administrative structure of today evolved from the initial design of the administrative structure which had emerged following a series of

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[8] Technical paper -- NIDA, 1970.

fundamental reforms during the reign of King Rama V (Figure 1). A major feature of that "revolution" was the consolidation of power into the hands of the King in Bangkok. Later this ultimate power had devolved primarily to military and civilian officials of the central administration. Second, ministries were set up in Bangkok to administer both military and civilian matters. The first ministries evolved from the original *jatusadom* ("four ministries") system consisting of four administrative elements responsible for urban, palace, finance and rural matters. Third, to attain unity of control, the Ministry of Interior (MOI) seized the ultimate administrative authority over all local public organizations. Finally, multiple forms of local administration, with initial emphasis on specific tasks, e.g., cleanliness programs, sanitation programs, etc., were established, yet had played only modest roles in local development[9].

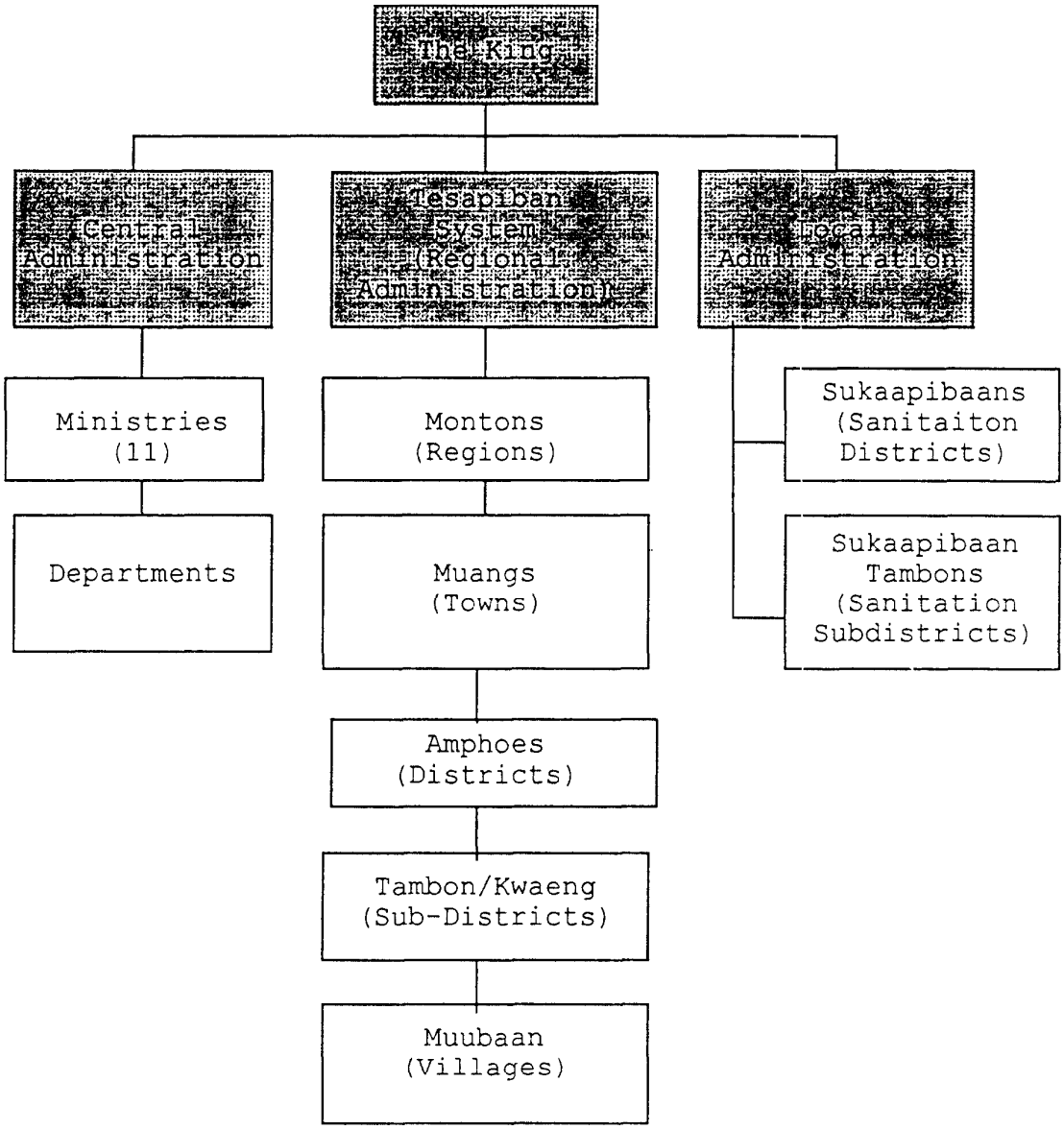
Present Administrative Structure.

Under the present administrative structure (Figure 2), a central government (cabinet) initiated national policies and oversaw their implementation through three branches of line administration; central administrations; regional administrations; and local administrations. Ministries represented the mechanism whereby the work of the central government was carried out. The Central Administration was characterized by a centralization of power in the interest of each ministry. The Regional Administration comprised of 76 *changwats* (provinces), each changwat divided into *amphoes* (districts), *tambons* (subdistricts), and *muubaans* (villages), respectively. Each ministry approved representatives to administer ministerial activities at the province. Among those, the MOI delegate directed the provincial administration board and acted as the supreme commander of all ministerial representatives. Each province also had the Local Administration comprising of five types of authorities: *tesabaan* (municipality); *sukaapibaan* (sanitation districts); provincial administrative organizations; and *tumbon* (subdistrict) councils. Two special local forms of local administration are found in Pattaya and Bangkok. Of the three branches, the **central administration** was considered the ultimate authority that directs the other two regarding policy formulation, implementation and resource allocation.

[9] The Royal Decree, R.E. 116)

Figure 1

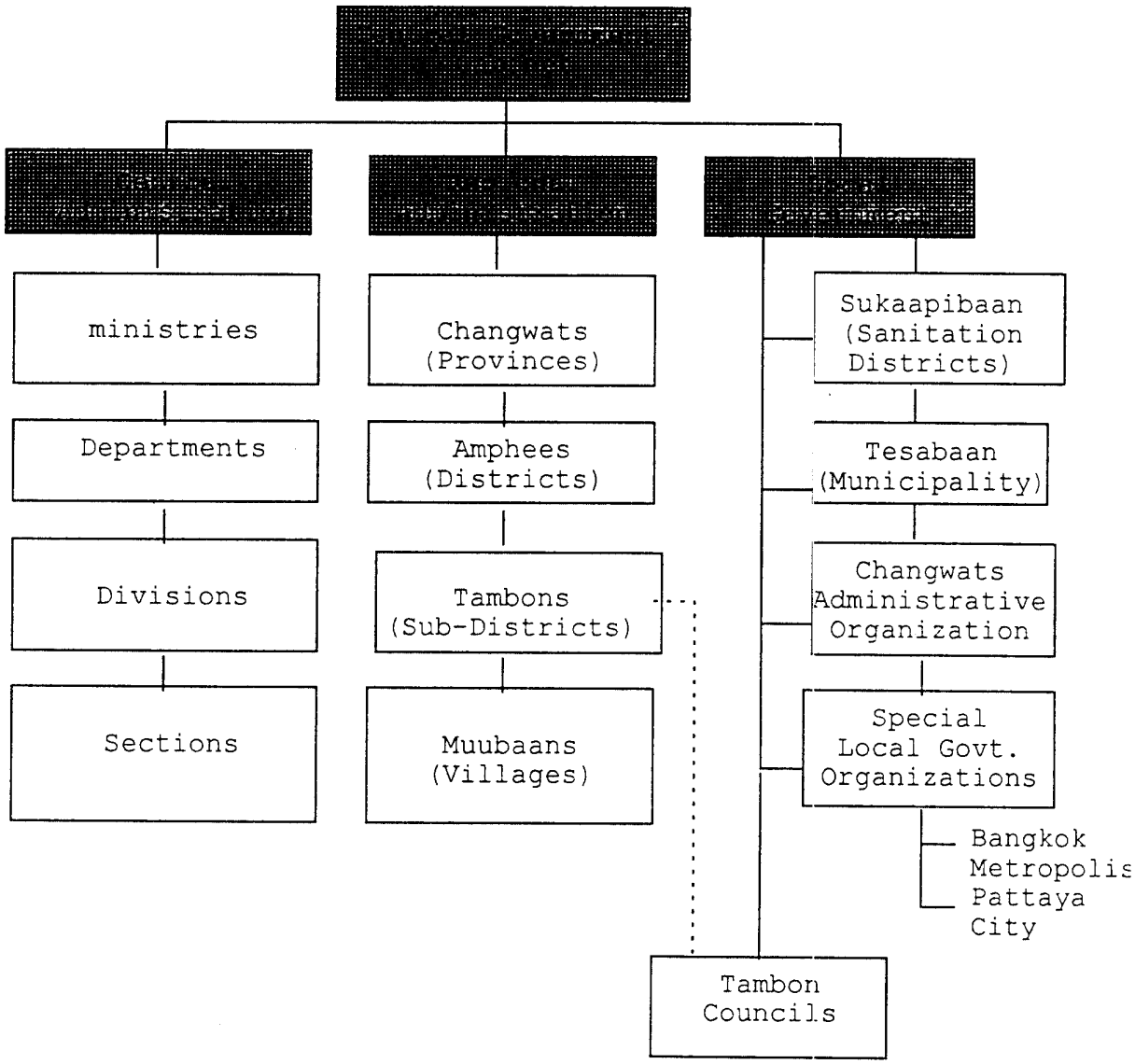
The Thai Administrative Structure After the Fundamental Reforms of King Rama V (1894)



Source : Suganya, 1990 : 92

Figure 2

The Present Thai Administrative Structure



Sources : Suganya, 1990 : 94

Regional Administration

Regional administration was characterized by a deconcentration of administrative authority from the central ministry to its local representatives. Provincial governors assumed supreme command over all local bodies and were appointed from among senior officials of the Ministry of the Interior. These officials were subject to periodic transfer. They were authorized to direct both representatives of other ministries and local administrations.

Government units made up the hierachical structure of *changwats* (provinces), *amphoes* (districts), *tambons* (sub-districts) and *muubaans* (villages), in accordance with the Provincial Administration Act of 1932. Thus, regional administrations involved essentially with organizations at these four levels. The regional administration could be argued as the extension of the central ministries to local communities.

Local governments

Five kinds of local government included: (1) *changwat* (provincial) administrative organization (PAO); (2) *tesebaan* (municipality); (3) *sukaapibaan* (sanitation district); (4) tambon (subdistrict) council; and, (5) subdistrict administrative organization. Besides two special forms of local government existed, namely, Bangkok Metropolis Administration and Pattaya City.

The Provincial Administrative Organization performed some functions in the provincial rural areas, while the municipality served the constituency in urban areas. The sanitation district took care of semi-urban areas. Finally, the subdistrict administrative organization represented a strengthened form of sub-district councils which were usually authorized for only limited functions in small communities.

Of the five forms, the municipality has the greatest dispersion of power. Even so, they were also under the control of provincial governors. Municipal councils were authorized to collect local taxes and duties, and issue permits. Income from these local sources, combined with that derived from the provision of central public services, was used to finance the operations of the municipalities (Pipatseritham,1979 p.114).

Figure 3 Forms of Decentralization in Thailand

Decentralization of Power			
Forms	Deconcentration of power		Devolution of power
Level of Government	Regional Government - Changwats - Amphoes		Local Government - Tesabaans - Changwat Administrative Orgs. - Sukaapibaans - Tambon Councils
Responsibilities depending on type of power wielded	Decision making powers	- Central govt. decides policies for changwats - Changwats oversees the amphoes	- Greater independence because some administrators are elected - Some degree of autonomy to initiate projects
	Financial powers	- Authorization from the center is necessary because budget allocations are from central funds	- Financial powers are restricted because of financial dependence on central/regional govt.
	Personnel mgt. power	- The Ministry of Interior and Cabinet appoint high-level administrators in the regions	- There is a central agency for personnel management (Central Civil Service Commission) (see p.18: Human Resource for Health)

Sources : adapted from Suganya, 1990 : 102

Policy and Planning

The Thai government had attempted to make central policies and planning more flexible and responsive to local needs. Although regional development was mentioned since the Second National Development Plan (1967-1971), the Fourth Plan (1977-1981) made a debut that explicitly included decentralization strategies. The Plan specified various policies: decentralized industries and spread of employment opportunities; decentralization of basic economic services to increase rural production; and, decentralization of social services to reach the maximum number of people.

Under the first two National Development Plans, development policies focused primarily upon economic and social development at the national level in order to lay the foundation for future growth of the economy. Therefore, public sector investment aimed mainly for the construction and renewal of infrastructure facilities such as highways, electricity, irrigation systems, schools, hospitals, etc. This policy resulted that economic growth during the 1960s was quite remarkable. The growth achievement was also attributed to rapid increase in private-sector investments and favorable international economic conditions. During this period, gross domestic product, at constant price, grew at an average rate of about 8.1 percent annually and per capita income almost doubled (NESDB, 1977)

The 1960s economic growth occurred in parallel with increasing rural-urban dissimilitude in economic welfare and income disparity among different occupations. The inequity problem became especially pronounced among the rural population and hence recognized in the Third National Plan (1973-1976).

In response to rural poverty and the alarming income disparity, provincial development planning was introduced in 1977 as key mechanism for subnational development planning. Regional policy objectives mainly directed towards "reduction of poverty, improved quality of life, and better delivery of social services", as follows:

1. Decentralization of industries in order to expand employment opportunities and establishment of regional centers and special programs for depressed areas in all regions.
2. Decentralization of basic economic services (public utilities, transportation, communications, and electric services) in order to support production in rural areas and improve the quality of life.
3. Pricing policy revisions on public utility services to promote better income distribution and offer fairer deal to rural producers.
4. Decentralization of social services (education, public health, social welfare and nutrition) in order to reach rural areas and reduce disparities between urban and rural areas (NESDB, 1977).

Also the Fourth National Plan (1977-1981) remarked that this decentralization scheme would further enhance the capability of local self-governing bodies to become responsive and viable agents for integrated development in the rural areas. It included the Provincial Development Plan as an essential part.

To facilitate systematic approach to decentralized planning at the provincial level, the Thai government promulgated a Provincial Development Planning Regulation in July 1977. Since then the Regulation had required that every province (except Bangkok Metropolitan Administration) formulate periodically a five-year development plan, which included analysis of existing overall socio-economic conditions and local problems. The plan should address "felt needs" of the people, presented specific project and program proposals, and estimated financial input requirements. The Regulation mandated the Provincial Development Committee (PDC) as primary local planning board.

The PDC was chaired by the Provincial Governor, and comprised 15-20 members of departmental representatives and those from local self-governing bodies. PDC had responsibility to coordinate and integrate both the top-down inputs and the bottom-up basic felt needs of the villages, communes and districts. Furthermore, each year the PDC has to prepare an Annual Operation Program (AOP), in close cooperation with the regional office of the NESDB, for submission to the National Rural Development Committees (NRDC) for reviewing, approving and budgeting prior to implementation.

Health Systems Changes

The evolution of the Thailand's health service system showed that it started adopting the western medicine about a century ago. Since then traditional medicine had progressively become less accepted. The Ministry of Public Health (MOPH) was established about 50 years ago when modern medical professionals and hospitals existed but a few. Then health centres represented common health facilities and they were usually staffed with auxiliary personnel. The private sector also formed a minute part of the service delivery system. Over time this government-dominated system had expanded gradually with the proliferation of rural health centres which lately had covered the entire population. Besides larger facilities in each province included generally a provincial hospital and a network of community hospitals. Since 1981 the number of community hospitals had rapidly increased and recently covered all districts.

The Bangkok-based MOPH had represented the sole policy-making body which determined the type of programmes and services to deliver at any level. The MoPH comprised departments each of which was responsible for discipline-oriented programmes. The departments played the role of both programme planning and implementation. Previously, departmental programmes were delivered through the MOPH's vertical structure and dispensed at local facilities of the corresponding department. The Departments of Medical Service (DMS) and of Health (DH) were the two primary ones responsible for curative and preventive programmes, respectively. In late 1970s the MoPH was restructured to enhanced the unity of implementation. The restructuring made the Office of the Permanent Secretary (OPS) a line authority that directed all service faclities. Also it made DMS and DH supporting departments providing technical supports to health personnel of integrated skills. Those technical departments played minimal role of services delivery . This structural change was often referred to as a main cornerstone in the Thai health service delivery system for it had created more coordinated and integrated administration of curative care and preventive programmes. It also led to unified relationship between the central headquarters and peripheral units. At present, all forms of peripheral facilities (i.e. health centres, community hospitals, and provincial and regional hospitals) usually implemented programmes of all central departments through a single line of OPS authority. The provincial representative of the OPS, called the "provincial health office" (PHO), was responsible for the integrated delivery of programmes and services.

The MOPH departments generally determined a part of the health budget allocated to the province through line-itemized budgeting. This part usually designated for departmental programmes. The OPS appropriated another portion (including a big chunck that financed curative services) allocated to the province on a lumpsum basis. The PHO assumed authority to make subsequent allocation of the lumpsum budget to its sub-

units. However the decision on personnel management was still centralized (see the section on health manpower development).

More recently the Thai health sevice System saw a rapid increase of private hospitals, new accounting for almost 25% of the total health facilities in the Country. There is also the Social Security System, whose annual expreditureˆin health is around 2% of the total health expenditure, estoblished in 1990. As these constituted the more recent charge in the Thai health sevices seystem, a detailed analysis on the achievament in health and the health system charge here will focus more on the government-deminated role portrayed mostly by the MOPH.

Here the review health financing of the public sector and health will focus on three basic components of the health systems, namely, changs in, human resource for health, and, health services achievement reflecting the results of the structural financing and HRH changes during the last 2-3 decades. These components represented the fundamental functioning of the health systems and could be in close association with the decentralization process.

I. Government Budgets

This section describes mainly the changing pattern of the state's allocative function. The way the public resources are allocated could reflect the extent of decentralization. Further, not only how much resources are allocated to the periphery but also the extent to which the decision on directing them is made locally corresponds with the degree of decentralization. The description centers upon: (1) sources of government revenues; and, (2) how budgeted resources were a located to the geographical periphery particularly to provincial health systems.

In the province, two major categories of the political apparatus existed: (1) local administrations; and, (2) local representatives of the central government. The former included five forms of local authorities: the municipality, sanitary district, subdistrict council, provincial administrative agency, and, subdistrict administrative agency. The latter comprised representatives of the central government at the three levels: province, district, and subdistrict. Existing legislation allows some forms of the local authorities ("local governments") to be relatively self-directing regarding the formulation and implementation of local policies. In reality, they acquired only limited autonomy owing to the dependency on centrally-apportioned resources -- financial and human. On the other hand, the local representatives of central ministries yet retained immense power with respect to resource deployment.

Municipalities and other local administrations

Over the past 20 years, the revenue structure of the central government has remained almost unchanged. Generally, taxation contributed to over

85 percent of the total revenue. Non-tax revenues constituted 5-10 percent annually. Besides, since 1975 Thailand has received international financial supports decreasingly for a few percent of the total revenue.

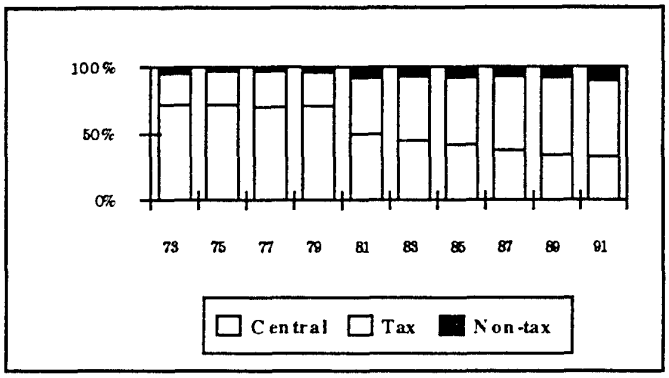


Figure 4: Revenues of Local Administrations by Sources (1973-1991)

By contrast, the revenue components of local administrations had exhibited a distinct trend. Basically, to a sizable extent, the financing of local governments depended upon the budgets apportioned by the central government. In 1975 the centrally-approved portion amounted to 70 percent of the total revenue. The appropriation was generally line-itemized so the local administration possessed only marginal liberty to decide on what to spend operationally. However, the share of local tax revenues had been increasing steadily due to the gradual change of the government policies to allow more autonomy to the local government. Then proportion was almost reversed. In 1991 central budgets accounted for 30 percent and local taxes made up about 60 percent of the total revenue. Non-tax revenues showed a deliberately growing proportion (3 percent in 1975 and 10 percent in 1991). Figure 4 presents the trends of the share of financial sources earned by local administrations.

Despite the fact that the changing revenue structure suggested decreasing dependency of the local government, only limited fiscal autonomy can be expected given its modest amount. Annually less than 10 percent of the central budget was allocated to local governments.[10] Furthermore, although the law mandates that 10 percent of sale taxes go to local governments, the Bangkok Metropolitan Administration received the greatest share of 60 percent.[11] Local governments in other 75 provinces altogether obtained just the remaining 40 percent of the apportioned sale taxes. The taxes basically constituted the most significant portion of the local tax revenues.[12]

Finally, the administrative authority at the local government had largely been under the influence of the representative of the Ministry of Interior

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[10] Information Service Center, Bank of Thailand

[11] This 60:40 ratio was recently changed from the 70:30 prior to 1991.

[12] Triratana, Nuannoi. Decentralization from the Budgetary Process Angle, in How to Decentralize for Democracy? Piriyarangsan, Sungsidh and Phongpaichit, Pasuk, editors. Centre for Political Economy Study, Chulalongkorn University, Bangkok 1994, pp. 179-186.

(MOI). Generally, MOI bureaucrats usually directed the administration of the local governments. Apparently, the existing law gave favor to the appointed administration rather than the elected. For instance, the law instructs that only the sanitary district which earned more than 200,000 dollars annually was allowed to have elected chairperson. But the ledger seldom showed the revenue meeting this threshold. Why was that? Not only the chairperson of the local board but also all district tax-collectors were officers of the central ministries. Technically, those officials maintained the authority to manipulate the ledger position under weak auditing system.[13]

MOPH provincial network

Local administrations represented ancillary rather than primary deliverer of health services. Their health-related role included primarily physical sanitation, marketplace hygiene, and procurement of clean water within the constituency. In the typical province, the municipality operated only a few health centers in town whereas the MOPH dispensed the largest share of health services through its extensive network -- the provincial hospital, 5-15 community hospitals, and scores of subdistrict health centers. In larger provinces, the Ministries of Defense and University Affair also provided medical services.

In 1982[14] the national health expenditure was estimated regarding the main sectors: MOPH (20.5%), other ministries (8.8%), public benefit schemes (4.7.0%), foreign aid (1.2%), and private households (64.8%).[15] While the percentage of the household share fluctuated between 65-75 percent, the public money had steadily accumulated at the MOPH by the end of the Sixth National Plan (1987- 1991) then later showed modestly deconcentrating trend (Figure 5).[16]

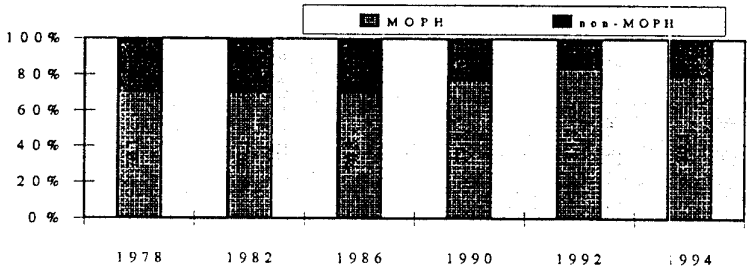

Figure 5 : Proportions of the Public Budgets Allocated to the MOPH and non-MOPH Agencies(1983-1995)

[13] Charoenmuang, Thanet. Report of the Seminar on the Sanitary District Administration: Problems and Solutions. Charoenmuang (editor), Faculty of Sociology, Chiengmai University, May 15, 1993.

[14] This marked the beginning of the Fouth National Plan (1982-1986)

[15] National Economic and Social Development Board, Bangkok, Thailand (unpublished data), 1993. The figures was estimated by B. Smuttrak, College of Public Health, Chulalongkorn University

[16] Estimated from the data of the National Economic and Social Development Board and the Department of Cencomptroller

In 1982, inclusive of the government budgets, about 70 percent of the national health expenditure was outlaid through the MOPH. In 1992, this proportion went up to 84 percent. Possibly, this resulted from that the MOPH budget had increased faster than the overall budget since the second half of the past decade (Figure 7). The MOPH made substantial investment in the construction and operation of small community hospitals which had emerged in almost every district by 1990.

Then the MOPH share gradually descended to 85 percent in 1995. It corresponded with the period of the national economic boom. Between 1988 and 1995, the government budgets increased markedly for the non-MOPH expansion of health facilities, yet the MOPH budget kept outgrowing the government budget. Plausibly this reflected the increasing demands for health services. Besides, starting in 1992, the AIDS prevention program became inter-ministerial, hence substantial budgets further poured into non-MOPH authorities.[17]

The government provided relatively more financial support to non-MOPH agencies around the turning to 1980s. Non-government groups possibly represented one of major recipients. Particularly in 1976, community organizations started receiving the special "summer grant", which altogether accounted for 6 percent of the total government budget. For the first time, the Rural Employment Generating in the Summer Project allowed the community to make its own decision on what the grant would be spent.. Later this generously decentralized authority had shortly been pulled back to the provincial government agencies. [18] Possibly, sizable local outlay went to health-related projects including the procurement of safe water.

The summer grant was terminated when the military came into power in late 1976. The project was revived in 1981 but with more stringent regulation. However, the government approved the earmarked budget for the rural development as stated in the Fifth National Plan (1982-1986). Accordingly a number of rural communities were designated as the area under poverty. Then the central government apportioned extra budgets to those areas. The MOPH also provided added resources to the designated communities. During this Plan's period the MOPH's area-specified budget usually amounted to 4-5 percent of the total budget.[19] Since the Sixth National Plan the MOPH had gradually integrated the area-based grant into the normal budget of departmental programs.

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[17] The AIDS prevention represented a significant decentralization. However, in 1994 the MOPH was approved as the primary administration of the budgets which amounted to over 40 million dollars.

[18] The often-raised argument for the withdrawal contended that the spending by the community was "wasteful", "uneducated", and sometimes "corrupt." However, the positive argument suggested that this decentralized budgeting strengthened the local politics and the community. (Theeravakin, Likhit. Evolution of the Thai Politics. Fourth edition. Thammasart University Press, 1994, p. 249.

[19] Estimated from the figures of the Bureau of Health Policy and Planning, Ministry of Public Health.

Table 1: National health expenditures (1978-1992; in percent)						
	1978	1982	1986	1988	1990	1992
Public sources						
MOPH	19.9	20.5	15.3	13.5	15.0	16.8
Other ministries	8.5	8.8	6.5	5.6	4.4	3.3
Others	2.4	4.7	5.1	4.9	4.8	3.9
Private sources	68.3	64.8	72.3	75.7	75.8	75.8
Foreign aids	0.98	1.18	0.83	0.41	0.08	0.24
% of GDP	3.4	4.5	5.5	5.8	5.7	5.9

The recent deconcentration of the public expenditure away from the MOPH corresponded with the booming of the national economy since early 1990s. The shift could reflect the growing demand for medical services in various sectors. During the period the public budget for hospital construction expanded markedly. Besides, since 1992 the AIDS prevention had become inter-ministerial. This program was bountifully financed, hence shifting the share from the MOPH despite its increasing budget.

Over the past 20 years, the MOPH budget increased from 72 (in 1975) to 1,780 million US dollars (in 1995) or approximately by 7.8 times in real value (Figure 6). In 1995, approximately 250 million dollars (14 percent) was allocated for facility construction and 1,000 million dollars (56 percent) for financing the operation of hospitals and health centers.[20] The remaining 30 percent of the MOPH budget included the administration and program-specific items. The latter was partially allotted to the provinces but usually they were tied to prescribed activities.

Although the spending of the budget had to adhere with the regulation issued by the Ministries of Prime Minister Office and Finance. The MOPH

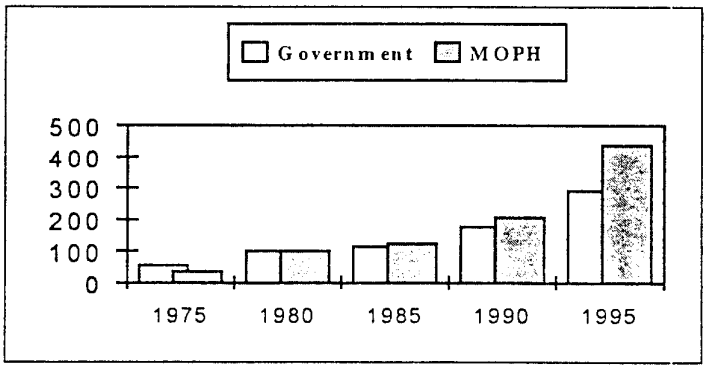

Figure 6: Real-Value Indexes of the Government and MOPH Budgets (1975-1995: 1980=100)

[20] Estimated from the figures of the Department of General Comptroller, Ministry of Finance (unpublished document), 1995.

periodically made successful attempts to relax the regulation, particularly in 1982, 1991, and 1993-95.[21]

Progressively, the MOPH apportioned greater budgets to finance the operations of peripheral facilities (Figure 7). Community hospitals had been most significantly supported since the 1980s. In 1990s, the MOPH further strengthened the subdistrict level for providing primary services in the rural. Besides the indigent medical program had represented politically popular services since its inception in 1975.

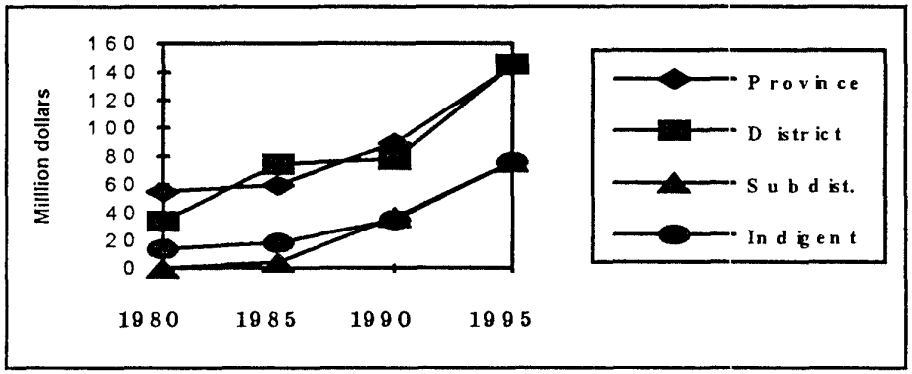

Figure 7: Trends in the Allocation to Facilities at Provinces, Districts, and Subdistricts, and Indigent Program (1980-1995; 1980 value)[22]

Since MOPH facilities were mostly located outside of the Bangkok Metropolitan, grossly the above trends suggested greater public allocation to the periphery. However, the local MOPH officers possessed modest authority on the outlay. The program appropriation was entirely itemized in Bangkok, whereas the facility-related portion was loosely prescribed. So the latter represented the more locally-managed part of the budget. Generally, the hospital budget appeared to primarily finance curative services, and, therefore, the medical profession who worked at the local hospital had some influence on its disbursement.

Obviously, the peripheral facility could attain greatest financial autonomy on the revenue it collected and managed locally rather than on the centrally-allocated budget. This non-budgetary revenue included mainly the remuneration from drugs, medical treatments, operations, and hospitalizing services. The facility collected those payments either directly from service recipients or from third-party payers. This locally-circulating system were more dominant under the MOPH than other ministries.

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[21] MOPH circula authorizing provincial governors, provincial chief medical officers, and hospital directors.

[22] These budgets included that suporting opreational expenditures only. In 1980, the district and subdistrict shared a single bundle. though larger part went to the district.

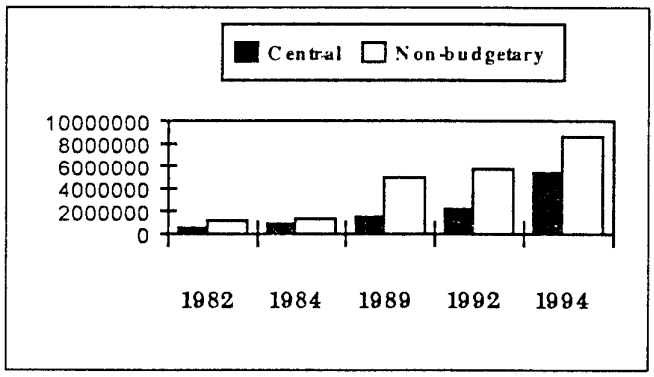

Figure 8 : Centrally-allotted Budget and Non-budgetary Revenue of A Steadily-growing Community Hospital (1980-1993; real term, 1980=100)

The fact that the hospital was revenue-generating facility made possible the non-budgetary system. The respectability of the medical profession also enabled the detaching from the central regulation. Notably, this financial autonomy was initiated by the assertion of distinguished medical doctors who worked devotedly in the rural, namely Dr. Sem Prinkpuangkeaw and Dr. Kamthorn Suwanakij.[23] Both were highly praised by the community, hence their hospitals received significant donation. They refused to submit the money to the Ministry of Finance but spent it on local development. More rural physicians followed suit here and there. Subsequently it became obvious that local donation brought about significant improvements more responsive to the community's needs. Eventually, in early 1970s, the Ministry of Finance approved and issued the regulation for the non-budgetary system.

II. Human Resource for Health

The mechanism of health manpower development in Thailand had been fragmented with inadequate coordination with respect to production, staffing and deployment. The MOPH was responsible for manpower planning despite a small share of manpower production. Only the production of nurses and auxiliary health personnel was mplemented by the MOPH for its own use. Production of professional categories of health personnel namely doctors, dentists, pharmacists technicians and nurses was under the authroity of the Ministry of University Affair. Further, while the MOPH formed the primary service delivery network, the authority in determining the staffing belonged to the Central Civil Service Commission (CCSC). The CCSC also determined the salary scale and benefits for civil servants. The CCSC also organized the examination to recruit personnel for all ministries. The MoPH was allowed to launch the recruitment only in a few exceptional circumstances. As for promoting and firing the central

[23] Told by Dr. Vichai Chokewiwat, a senior medical officer, the Ministry if Public Health, in June 1995.

ministry and the provincial authority retain different levels of authority according to the rank of the personnel involved. However the rules, procedures and criteria were set mostly by the central authority. The rigid bureaucracy sometimes created severe pressure so the MOPH requested for the cabinet's approval make proposals to alleviate the situation. Examples included the proposal to introduce compulsory services period for medical doctors, dentist and pharmacist, the introduction of additional payment to doctors to attract them to work in the rural areas, etc. The authority of CCSC extusled loas to the look government in the respect to pesonnel management.

Over the past two decades, Thailand had implemented strong policies to increase the number and improve the distribution of human resources for health (HRH.). The number of health professionals had steadily increased. Despite the absolute increase, their maldistribution across the country was aggravated concurring with the economic disparity. Progressively, the geographical shortage represented a primary threat to the national health system. Basically, it abashed the equitable access to health services. This section will describe the trends of the HRH development with respect to supplies and distribution. Major policies and changed environments will be addressed. Also points will be elaborated for any event associated with decentralization.

Over the years, the increase in numbers of health professionals in all major categories was remarkable. The number of physicians doubled between 1979 and 1993 from 6,620 to 13,630. Similarly the numbers of nurses, dentists and pharmacists increased by 2.8, 2.7 and 1.9 times, respectively. Their ratios against the population are shown in Table 2.

Table 2: Population-professional Ratios for Four Categories of HRH (1980-1993)

	1980	*1983*	*1987*	*1990*	*1993*
Physicians	6,499	6,259	5,595	4,500	4,207
Nurses	2,704	2,099	1,743	1,444	1,229
Pharmacists	16,934	16,541	14,799	13,517	12,150
Dentists	44,854	39,662	36,515	24,656	20,589

Although the HRH production appeared to outpace the population growth, the shortage was generally perceived and the demand for greater recruiting capacity often voiced particularly for high-skilled categories. Despite the difficulty in determining the optimal numbers, the MOPH estimated that the country needs 20,000 more nurses (about 50 percent of

existing) in 1995.[24] Similar estimation for physicians was presented elsewhere but inconclusively debated on the contentious assumptions.[25] Nonetheless, it was generally agreed that Thailand yet needs sizably more professionals of all four categories.

Meanwhile the problem of HRH maldistribution was accepted with wider agreement. Grossly, large gaps among regions were obvious, especially between Bangkok and the rest of the country. The MOPH recently declared the "brain drain" of physicians to Bangkok and affluent towns as a major HRH problem. Table 3 shows the regional density of physicians during the past decade.

Table 3 : Physician Density (population per physician) by Regions (1979 - 1993)

	1979	1983	1989	1993
Bangkok	1,210	1,400	1,060	910
North	13,110	10,880	5,330	6,240
North-east	25,720	19,680	11,760	10,850
Central	11,650	7,180	5,920	5,220
South	15,640	10,060	6,310	5,740
Whole kingdom	6,960	6,260	4,360	4,210

In response to the geographical disparity, since 1939 the MOPH had recruited progressively a goodly number of paramedics to serve at health centers (subdistrict level). Between 1975 and 1981, the training extended to more diverse categories of personnel. Currently, they had become the primary resources who generated health care at the community level.

In 1992, approximately 81 percent of physicians worked in the public sector. This sector had accommodated a lion share of health personnel despite a recent trend that skilled professionals were increasingly moving into the private sector. However, the public sector represented the fundamental structure through which the state might "allocate" HRHs. Of the government-hired physicians, 56 percent worked for the MOPH. The rest worked mostly in university hospitals with a larger preporation of physicians to health facilities. Its budget is also not included in the repular health expenditure estimation. MOPH owned about 68 percent of hospitals and 64 percent of hospitals beds, mostly located in up-country. This made

[24] Institute for Health Manpower Development (IHMD). Report to the Minister of Public Health, Ministry of Public Health, 1995.

[25] MOPH estimated the shortage of physicians nation-wide at 3,000 in 1995. (Bureau of Health Policy and Planning. Internal document, 1995)

the ministry the largest service provider for the populace outside of Bangkok. Generally, private hospitals and non-MOPH public hospitals were found in Bangkok and some densely populated areas. Since 10 percent of the population lived in Bangkok and 78 percent dwelled in the rural, the MOPH, therefore, represented the fastidious channel through which physicians could be distributed to cover the national population. This ramification should also be true of the other highly-skilled categories of HRH.

Figure 9 describes the shares of physicians by major sector. As argued, the MOPH's share could make indicative of the extent to which physicians was channeled out of Bangkok. Another major sector - the Ministry of University Affair - also operated three of its eight teaching hospitals in the regional cities. It was noted that the number of municipality physicians remained proportionally minuscule throughout the two decades. Finally, since 1988 physician transfer into the private sector had become striking. This group represented the clustering of physicians within Bangkok and affluent urban towns.

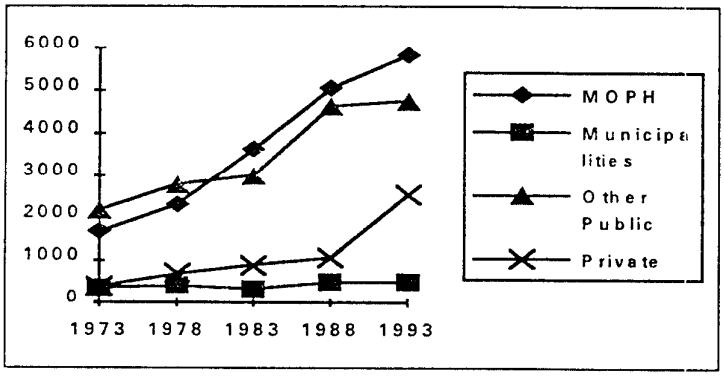

Figure 9: Number of Physicians by Sector (1973-1993)

Evidence suggested that Thailand had undergone imbalance economic growth resulting in skewed development. Growth centers emerging particularly in Bangkok and a few regional towns attracted all -- including health professionals, hence depleting them from the vast but less affluent population. The economic magnetism had become turbulently forceful since 1988 when the GDP started growing by two digits. To ensure adequate supplies and to counter the manpower drift, the Thai Government had implemented stringent policies as follows:

1. ***Increased production*** of HRH of various categories. The Ministry of University Affair had continually increased the training capacity of physicians, dentists, pharmacists and nurses. Meanwhile the MOPH recruited most nurses who worked at provincial and rural facilities. Table 4 shows the elevated production of health professionals over the decade. Although the capacity increases appeared modest, at times the production leaped significantly. For instance, in early 1980 the

opening of new training centers stepped up the number of medical graduates by 14 percent. In 1984-85, the medical curricula were shortened by one year resulted in almost doubled recruitment and subsequent reduction of training lead-time. The striking increase in pharmacist graduates occurred twice during 1980s, and that of dentists in late 1980s. Significant increases in nurse production were initiated by the MOPH in late 1970s, mid 1980s and early 1990s. Those punctual boosts resulted that the number of physicians almost doubled and that of nurses, dentists and pharmacists increased by 98, 123 and 58 percent between 1983 and 1993, respectively. They illustrated the commitment of the government and its policy execution. Nevertheless, the government had yet retained the production authority within the public sector.

Table 4: Numbers of Health Graduates Per Annum and Decade Increase by Category (1983-93)

	1983	1993	Total increase
Physicians	569	841	7,742
Nurses	2,236	4,950	37,946
Dentists	172	330	2,650
Pharmacists	252	600	4,433

2. ***Compulsory services*** for graduates of the major categories. Health graduates were required to work at designated facilities of the public sector for a period of three to four years. The largest served agency was the MOPH which generally assigned them to provincial and community hospitals. The MOPH also filled some health center positions with nurse graduates. These included primarily nurses graduating from the MOPH nursing schools located in the regional centers. Since 1971 when the policy commenced, the increase of physicians working in the province had stepped up much faster than in any public authorities. In 1982 the MOPH became the largest employer of public physicians. The MOPH recruited nurse gradates to compulsory service even earlier. The compulsory work of dentists and pharmacists began later in late 1980s and had yet produced less obvious effects.

3. ***Procurement of professional positions*** and improved working facilities at community hospitals. In 1975 the government then introduced the policy to increase the capacity of the rural health system, especially at the district level. Since then 10-60 bed hospitals had proliferated at the district level. Gradually, the

staffing had extended from a solo doctor and a squad of nurses to a full health team (3-5 doctors, dozens of nurses, 1 pharmacist and 1-2 dentist per hospital depending on the size of district hospitals). Besides the proportion of larger facilities (30-90 bed hospitals) had steadily increased. The MOPH continuously improved the equipment and the working environment at the community hospital so it could attract the professionals even after they completed the compulsory period.

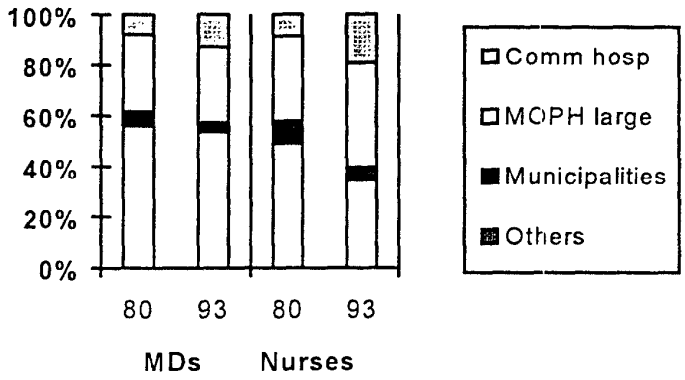

Figure 10: Proportions of physicians and nurses working at community hospitals, MOPH large facilities, municipality health centers, and other facilities (1980-93)

Figure 10 shows the distribution of physicians and nurses across to MOPH and local administrations. During the past decade, the MOPH managed to recruit physicians and more impressively nurses to community hospitals. However, the proportion of physicians working at larger facilities remained stable while greater proportion of nurses went to both provincial and district-level facilities. For both categories, municipality facilities attained only marginal proportions and without improvement over the years.

III. Health Services

Facility coverage

The Ministry of Public Health (MOPH) represented the largest provider of health services in all regions excluding Bangkok. By 1995, the MOPH operated 87 general hospitals (33,532 total beds), 702 community hospitals (19,499 total beds) and 8,700 health centers. Altogether they served 64 million outpatients and 4.3 million inpatients annually. Services comprised both preventive and curative care. The lower level was oriented towards more basic services.

The expansion of the MOPH service network appeared accelerated particularly during the implementation period of the Fifth National Plan (1982-1986). In 1982, about 55 percent of districts, each was served by one community hospital (10-90 beds). The coverage went up to 85 percent in 1991. The number of health centers had been proliferating from 5,891 to 7,460 during the Fifth Plan's period. The Seventh Plan (1992-1996) could mark a second surge of the network growth both physical and in number. Presently health centers covered almost all subdistricts.

By 1977, the MOPH had already settled one general hospital in each of the provinces. Thereafter, the proliferation ceased. Instead, the expansion took place as improved equipment and increasing bed number which grew deceleratedly about five percent per year during the period of the Fourth National Plan (1977-1981) and appeared stable during the Sixth Plan. The share of patient services among the three types of facilities is shown in Table 5.

Table 5: Shares of Patient Services among MOPH Facilities (1977-1994; thousands)

	1979	1994	Change (times)	% Share 1977	% Share 1994
Out-patients					
Provincial hospitals	6,456	13,333	2.1	34.7	20.8
Community hospitals	5,078	23,607	4.6	27.3	36.9
Health centers	7,064	27,092	3.8	38.0	42.3
				100	*100*
In-patients					
Provincial hospitals	1,455	2,184	1.5	77.0	50.6
Community hospitals	434	2,134	4.9	23.0	49.4
				100	*100*

Private hospitals represented a major provider of hospitals beds in urban areas, particularly where the economic growth was relatively significant. Their proliferation apparently started in 1984 and grew fastest between 1988 and 1992. The period corresponded with the two-digit booming of the national economy. In 1995, Thailand had 335 private hospitals altogether amounting to 21,300 beds. More than half were located in Bangkok and the rest found generally in affluent towns.

Since the Fourth National Plan, the MOPH had determined to spread its facilities to cover the entire population. The extension of its hierachical infrastructures was stated as a major policy and laid out explicitly. However, the MOPH attempt was secluded somewhat. It had achieved insignificant success in the collaboration with other government authorities in distributing the facilities to cover inaccessible populations.

EPI coverage

By the mid-point of this decade, communicable diseases were no longer considered the top health problem in Thailand. (AIDS was the only exception.) The coverage of the expanded program on immunization (EPI) achieved appreciable levels; namely, 90.99 percent for DPT, 91.54 for OPV, 83.62 for measles vaccination, and 98.99 percent for neonatal BCG. The national plan had conceived the EPI since 1977. At present, the unreached population consisted of the urban poor, hill tribers, immigrants and those living in some remote areas.

Sanitation, environmental hygiene and supply of potable water

In 1976, the inaccessibility to potable water was yet a major public health problem of the rural. Then only 16.74 percent of households outside of Bangkok had access to clean water. All national plans since then incorporated the supplying of drinkable water, resulting in organized efforts to raise the accessibility coverage. Particularly, the endeavor was underscored in the Fifth and Sixth National Plans. Consequently, in 1994, the coverage went up to 88.55 percent.

The MOPH had consistently made efforts to promote the use of sanitary latrines for three decades. Until 1981, the coverage was slowly increased reaching 42.28 percent of households (excluding Bangkok). The Fifth and subsequent national plans stressed this policy even more. As a result, in 1994, 94.23 percent of households had access to the sanitary latrine.

To attain the accomplishment, the MOPH had adopted and reformulated several strategies in promoting the sanitary program. Initially, centrally-appointed officers made the servicing role -- building sanitary facilities for the people. Little progress was conceived. Then the MOPH realized the need for community's participation. The new strategy led to gradual transfer of the problem-solving responsibility to the community. Sanitary volunteers were trained. Those volunteers became primary builders of household latrines and water receptacles. Subsidy was provided bringing down the prices of construction materials. In the village, the sanitation fund was initiated to give out loans. Meanwhile the Department of Health Service gradually changed their role to providing technical support to the provincial health office rather than recruiting squads of specialized implementers. Supporting center was founded in each of the twelve zones. Nevertheless, partly the achievement resulted from that the MOPH determined to involve local representatives of the Ministry of Interior (MOI) who generally had strong authority over the community.

Nutritional supplements

Despite the fact that Thailand had been agriculturally bountiful, yet many children suffered from protein-calorie malnutrition and deficiency of micro-nutrients. By 1977, nutrition-related maladies had been prevalent

including goiter, anemia, night blindness, beriberi, angiostomatitis, and bladder stones. The Fourth National Plan (1977-1981) recognized these preventable diseases, therefore for the first time, launched the nutritional supplement program.

During the period of the Fifth National Plan, the primary health care approach was first adopted as primary strategy. The active involvement of community health volunteers allowed for local modification of the national plan to comply with the local lifestyle. When village volunteers weighed the children, then they internalized the extent of the problem. This involvement urged them to actively solve the problem. Then supplementary food was prepared according to local resource and preference which, in turn, enhanced compliance of the family. Meanwhile MOPH officers retreated from providing ministry-formulated supplements to giving technical advice and monitoring the outcome. The nutritional supplement program thereby represented a significant model of community-level decentralization. Table 6 presents the impressive changes in the nutritional profile achieved during the Fifth Plan period.

Table 6: Percent of PCM Children during the Fifth Plan Period (1982-86) and Most Recently

	1982	1986	1994
First degree	35.66	23.82	11.9
Second degree	13.00	3.85	0.75
Third degree	2.13	0.17	0.003

Family planning

Thailand first declared the family planning (FP) as a national program when its population was 35.6 million in 1970. Since then the rate of population growth substantially had declined from 31.5 per thousand in 1970 to 13.0 per thousand in 1994. Since early 1980s, private agencies had played an active role in campaigning for public adoption of the family planning value.

Plausible factors contributing to the above improvements included:

1. The government made the FP widely accepted as a "national goal". So the MOPH obtained ample collaboration from the other three "primary ministries" (i.e. Ministries of Interior, Education, and Agriculture and Cooperatives). Particularly, the inter-ministerial approach was emphasized during the Fifth Plan 's period.

2. The program was implemented through the MOPH extensive network including more than 600,000 volunteers in the community.
3. Professional authority to perform simple procedures (e.g. instillation of intra-uterine devices, progesterone injection, distributing contraceptive pills) was delegated to less-skilled personnel; namely, public-health nurses, hospital nurses, and community health volunteers. Meanwhile the MOPH offered adequate supplies and adequately provided the training for those personnel.
4. The private sector had strongly supported the program. Private hospitals, clinics, and pharmacies made up alternative deliveries of the services.
5. The family planning message had been disseminated through various channels including person and non-person media. Community leaders were made understand and hence enhanced the convey of the message. Eventually, the few-children attitude replaced the previous norm which favored large family size.

Consumer protection

The Food and Drug Administration (FDA) of the MOPH represented the primary regulator of health-related commodities including food, drugs, medical devices, and cosmetics. Experiencing overwhelming workloads, recently the FDA delegated the regulatory authority to the province. However, provincial personnel comprised only a few officers. It was argued that the current structure at the province remained insufficient for effective consumer protection.

Health Services outputs could be seen as on indication of how much the health system has been able to achived under its structure and resources management. The Thai health system, predominanthy represented by the government sector has gradendly undergone changes both in teme of its power structure between the central and the peripheral units as well as the increasing share of the non-governmental, non-MoPH, sector. Despit the system depending heaily on the government for the last 50 years with a seuningly centralized bcereace cracy, certain degree of deconcentralion of power could also be obseved. The next section will offer some critecal view about some of the change observed

Discussion and Conclusion

This study has presented the progress of the two streams of changes : decentralization in public administration; and, health systems. This section will summarize critical events that show possible association between the two streams.

1. The initial centralization of Thailand's public administration basically dated back to a century when the absolute monarchy attempted to improve the national unity against European imperialism. It grew along with the early modernization endeavor and eventually generated huge bureaucratic structures composing of central ministries.

2. During the first four decades of the Thai democracy, the government adopted the policy that placed strong emphasis on economic growth and national security. In effects, the policy led to increased centralization. The government extended its control authority through strong regional administration. The MOI had acquired the supreme command over all local organizations including those representing other central ministries.

3. Starting in the Fourth National Plan, the increasing disparity was recognized and explicit strategies provided to disperse the development to provinces. Decentralization was stated as a key strategy. Then regional and provincial planning became a requirement for the regional (provincial) administration. However, this "bottom-up" process was undertaken through the slightest modified structure of the existing centralized administration. The key players still included provincial governors (who represented the MOI) and other centrally-appointed officials. The local administration played only insignificant roles.

4. The MOPH underwent a significant structural change in 1975. The altered structure allowed greater unity of control. Importantly, it abandoned the facility-based hierachical administration. Then new breeds of health facilities (community hospitals and health centers) proliferated. All local facilities became under the directing of the provincial chief medical officer who reported to the office of the permanent secretary.

5. The MOPH represented the primary channel through which resources and services were allocated to the less affluent but majority population. MOPH had determined to implement full coverage of basic service. Over time, it managed to increasing provide basic services at community-level facilities. This strategy had boosted the coverage of many preventive-

promotive services and plausibly contributed to the improved health status nationally.

6. Although the official command line appeared somewhat centralized, the *de facto* administration of the provincial chief medical officer could be much less authoritative that provincial counterparts of other ministries. Mainly, because hospitals were operated by professionals who tended not to follow the authority completely. Further, all health facilities maintained their own financial resources making them less dependent on the central ministry. The fact that they interacted with the community made them more inclined to respond to local incidents, albeit not fully responsive. Therefore, community-level facilities could represent the most explicit form of health system decentralization. Key features included: (1) the facility was professional-driven; (2) relatively autonomous resource-management and partly self-financed; and, (3) close interaction with the community.

7. Another manifestation of decentralized health service was the empowerment of middle- and low-skilled personnel including nurses and paramedics. Besides some programs adopted the primary health care implementation that encouraged community workers to take parts in health surveillance and the provision of basic care. This strategy significantly improved the technical efficiency and acceptance of the services resulting in rapid increases in their coverage. Finally, certain public-private collaborations could be considered another form. Examples included campaigns on family planning, AIDS prevention, and anti-tobacco.

8. Devolution had been a less dominant manifestation considering both the public administration in general and the health systems. The health-related role of the local administration had yet restricted to urban hygiene and sanitation. Specifically, the Public Health Act of 1992 required the local administration to implement community-based health activities only a few conducted the programs effectively. Although the present legal basis authorized the provincial administrative organization, municipality and subdistrict administrative organization to implement local policies, their functioning was yet inadequately encouraged. Fundamental hindrance included: (1) overshadowed authoritatively by the MOI; (2) financially dependent on central funding; and (3) unstrengthened absorptive capacity of the local staff.

Over the past three decades, one can perceive a trend of increasing decentralization of Thailand's health systems. But the past manifestations seldom took place explicitly or were stated as a distinct policy. Rather they

occurred inherently along the stream of changes. Specifically, greater decentralization emerged at two aspects: organizational and operational. The former included the development of relatively autonomous health facilities of the MOPH. The encouraged participation of the community made up primarily the latter. Recently, a variation of the latter occurred as the cooperation between the MOPH and private organizations. This decentralized model contributed not only to the operation but sometimes the formulation of high-level policies.

One can argue convincingly that the past accomplishments in better health status resulted significantly from the centralized planning, in particular of the MOPH. The centralized model at the policy level could lead to the implementation of impactful policies as in Thailand case (given sensible prescription was made!). Also the Thailand case showed that decentralized functioning at the organizational and operational levels could inherently take place and sometimes enhance the implementation of rightly prescribed policies. At the time when public-health interventions have swept out much of diseases from the mass population and the diseases remain only among gap populations, customization of the policy to local environments became more critical. Further, unprecedented public health problems (e.g. accidents, substance abuses, indecent sex practices, mental health) emerge alarmingly and some are linked to unhealthy behavior. Behavior-related problems need interventions specific to subgroups and locality. Finally, inter-sectoral cooperation becomes essential to launch successful implementation. Then would decentralization be a strategy to improve public health interventions of the present time?
