CHAPTER II

LITERATURE REVIEW

2.1 Health Sector Reform

All countries are in various stages of health sector reforms (World Health Organization – South East Asia Region [WHO-SEAR], 1997). The reasons for this reform are the ongoing socioeconomic changes taking place globally, poverty and underdevelopment, cost-containment, privatization efforts, epidemiological, and demographic transitions. The underlying objectives for reforms are to deal with issues related to equity, efficiency, and quality of health systems. The reform processes involve a clear definition of priorities, the strengthening of policies, and the reshaping of the organization and management of health systems. This may involve changes in the organization and management of the health system, health care financing, health care delivery, civil service structure, and administration, such as decentralization, de-concentration and devolution.

In the last two decades, health sector decentralization policies have been implemented on a broad scale throughout the developing world, usually as part of a broader process of political, economic and technical reform. New efforts of democratization and modernization of the state have fuelled this process (WHO-

SEAR, 2002). Policy makers have long been concerned with improving the performance of their health systems (Collins, Green & Hunter, 1999) with reforms targeting all system functions - financing, provision, stewardship and resource generation (Maynard & Bloor, 1995).

Decentralization is pursued for a variety of reasons: technical, political, and financial (Brinkerhoff & Leighton, 2002). On the technical side, it is frequently recommended as a means to improve administrative and service delivery effectiveness. Politically, decentralization usually seeks to increase local participation and autonomy, redistribute power, and reduce ethnic and/or regional tensions. On the financial side, decentralization is invoked as a means of increasing cost efficiency, giving local units greater control over resources and revenues, and sharpening accountability.

Many governments have realized the need to strengthen peripheral and local authorities and have adopted decentralization as one the major means of implementing reforms for better efficiency, quality, and equity (WHO-SEAR, 2002). Decentralization has provided means for community participation and local self-reliance, and ensured the accountability of government official to the population (World Bank, 2001). It is also a way of transferring some responsibilities for development from the center to the periphery.

Some benefits of decentralization policies include 1) decision-making closer to the communities served, which promotes community participation, greater potential for multi-sectoral and multi-agency collaboration at the lower service delivery levels,

2) improved allocation efficiency by allowing the mix of services and expenditure to be shaped by local needs, epidemiology as well as provider skills and performance, 3) enhances ability to tap new forms of finance generation, 4) improved technical efficiency through greater cost consciousness at the local level, service delivery innovation through experimentation and adaptation to local conditions, 5) improved quality, transparency, accountability and legitimacy owing to user oversight and participation in decision-making, and 6) greater equity through distribution of resources among traditionally marginalized regions and groups (WHO-SEAR, 2002).

Financing mechanisms have become a driving force of reform. Governments throughout the world are increasingly realizing the value of developing health systems that provide health care while financially protecting the people in the fairest way possible (WHO-SEAR, 2003). In fact, health care financing reform is the path towards improved health system performance.

In order to ensure fair financing while providing appropriate incentives to health care providers, countries need to reform and harmonize the three interrelated sub-functions of financing, namely: 1) collecting of revenue, 2) pooling of financial resources, and 3) purchasing of interventions (WHO-SEAR, 2004). Of these sub functions, pooling is of particular significance for fair financing. The two most common mechanisms of financing that incorporate pooling are social health insurance and government tax funding. While these two mechanisms share some common characteristics, they also have some important contrasts. In tax-based systems, people contribute to the health funds only indirectly via taxes, whereas in social health insurance schemes, people, as members, contribute directly and are aware of the

amount they contribute specifically for health care. Thus, social health insurance scheme is an explicit contribution. Despite these contrasts, it is generally agreed today that these two systems complement each other in achieving the goal of Universal Coverage.

2.2 Thailand's Health System

Health systems in Thailand show the classical 3 level-structure: Health centers for sub-districts with 3000-8000 inhabitants, District/Community Hospitals in districts with 40,000-150,000 inhabitants, and referral specialized provincial and central levels. (Towse, et. al., 2004) Before 1990, financing of health services was mainly based on user-charges. Civil servants had security through CBMBS. Experiment for social health insurance such as Health Care Project (HCP) was introduced in the 1980s and SSS in 1990 to protect workers for all private firms with more than one employee.

The most important step in reform was the introduction of the 30-Baht UC in 2001 to achieve universal coverage with access to health care. Prior to the introduction of the 30-Baht UC, only 69% of the population was insured: 37% by the medical welfare scheme (MWS) for the poor, senior citizens, children under 12 and the disabled, 11% by the CSMBS for civil servants and their families, 9% by the SSS for private sector employees, and 12% by the Voluntary Health Card Scheme (VHCS) for the general population especially in rural areas. Thirty-one per cent of the population was excluded (Chutma Suraratdecha, Sonmying Saithanu, & Viroj Tangcharoensathien, 2004).

Thailand took a big bang approach to introduce universal access to subsidized health care (Towse, et. al., 2004). In 2001, after years of debate and slow progress it extended coverage to 18.5 million people who were previously uninsured, out of a population of 62 million. This move was combined with a radical shift in funding away from major urban hospitals in order to build up primary care. The UCS for health care is the leading policy and main influence on health care organization at district level in Thailand. UCS can protect citizens from financial consequences of health care and ensure all citizens have access to health care. Underlying the concept of UCS is the ethical principle that access to health care is a right of citizens that should not depend on individual income or wealth.

2.3 Strengthening Primary Care

For the hospital-dominated Thai healthcare system, the emphasis on primary care in the universal scheme represents a bold departure. Initial problems included a shortage of doctors to staff primary care units, necessitating use of hospital doctors in rotation, and little attention being paid to preventive and health promotion services. High-level policy makers have so far not been prepared to put the necessary staff management mechanisms in place to support redeployment. Little attention has been paid to the role of provinces in purchasing and monitoring quality of care and to the importance of giving people choice of contractor. Very limited private sector participation is allowed, even in urban areas where a large private sector exists (Towse, et. al., 2004); APHEN, 2001).

On the other hand, Thailand has had successful experience in expanding the primary care infrastructure, health centers and district hospitals, covering the

population nationwide (Pongisut Jongudomsuk, 2005). Access to basic health services, especially prevention and health promotion (P&P) services for rural people, has been improved substantially from the contributions of health centers and district hospitals. However, lack of resources and competency of health personnel at the health center level is still a major weakness in Thailand, and hence people do not accept quality of curative services provided by health center personnel.

2.4 Significance of Management

Besides assuring access to health care for all, improvement of primary care services through tax-based financing mechanism is the main target of the UC policy (Towse, et. al., 2004). Improvement of management is essential of the strengthening district primary health care. Planning, setting priorities and objectives are important but operational management is equally crucial e.g. allocation of duties, delegation & supervision of staff, monitoring and control, supplies & logistics, maintenance of facilities & equipment as well as financial management (Tarimo & Fowkes, 1989).

Improving service delivery depends on having some key resources such as manpower, materials, time, money, and management skills (WHO, 2005). It also depends to a large degree on the ways those resources and services are managed. The lack of managerial capacity at all levels of the health system is increasingly cited as binding constraint to scaling up services and achieving set goals. Some basic management weaknesses include: limited skills in basic accounting, managing drug stocks and stores, basic personnel management, and delegation of responsibilities and authority, just to name a few. Weak management support systems may compound the problem as well as the working environment (rules, procedures, reporting lines, which

frame their freedom for maneuver). Hence, it is essential to do something about improving management.

In such cases, some management skills are essential and further education of staff may therefore be required, as well as ensuring that manpower and skills are matched with the tasks to be carried out and distributed approximately throughout the district health system (Tarimo & Fowkes, 1989).

Despite the differences in operating environments among countries, the requirements to achieve enhanced managerial capacity are the same. Examples include 1) building managerial competencies or skills, 2) creating functioning management support system, and finally 3) creating a supportive enabling environment (incentive system, rules and procedures) - (WHO, 2005).

2.5 The Management Cycle

Health sector activities cannot be evaluated without considering the organizational and managerial context. Management is organized around four condensed management functions: planning, organizing, directing, and controlling (Robbins & Mukerji, 1997). These functions are goal-directed, interrelated and interdependent. "Management" helps organizations to define their purpose and the means to achieve the purpose. The management cycle allows the manager to plan, implement, monitor, evaluate, and re-plan. This cycle should be repeated on a large and small scale throughout the organization life and therefore the management cycle's functions must be routinely performed.

Planning: This function consists of defining an organization's goals, establishing an overall strategy for achieving these goals, and developing a comprehensive hierarchy of plans to integrate and coordinate activities (Robbins & Mukerji, 1997). Planning process decides what must be done, when and by whom it must be done. Plan can be long term, medium-term or short-term. Planning is the key management cycle function because everything else in the cycle flows from it. It encompasses time frames ranging from a year or more down to a daily "to-do" list. Planning gives directions, reduces the impact of change, minimized waste and redundancy, and sets the standards to facilitate control. Planning establishes coordinated effort and it gives direction to managers and non-managers alike. When all concerned know where the organization is going and what they must contribute to reach the objective, they begin to coordinate their activities, cooperate to reach the objectives, and work in teams. A lack of planning can prevent an organization from moving efficiently towards its objectives (Robbins & Mukerji, 1997).

Organizing: This function involves determining what tasks are to be done, who is to do them, how the tasks are to be grouped, who reports to whom, and where decisions are to be made. Organizing involves designing an organization's structure (Robbins & Mukerji, 1997). In any organization, resources must be allocated to meet the needs of the planned objectives including, personnel, equipment, location, trainings as well as time.

Directing: This function includes motivating subordinates, leading others, selecting most effective communication channels, and resolving conflicts (Robbins &

Mukerji, 1997). Every organization has people who must be directed and coordinated in order to maximize the output.

***Controlling*:** This function involves monitoring activities to ensure they are being accomplished as planned and correcting any significant deviations. After the goals are set, the plans formulated, structural arrangement delineated, and the people hired, trained and motivated; there is still a possibility that something may go wrong. To ensure that things are going as they should, management must monitor the organizations' performance (Robbins & Mukerji, 1997).

2.6 Management of District Health Systems

Management performance of the district team influences how the health facilities (district/community hospitals and health centers) perform in terms of health service delivery (WHO, 1988). The district is the most appropriate level for coordinating top-down planning, organizing community involvement as well as coordinating public and private health care. The scope of the management responsibilities at the district level will depend, to a considerable extent, on the way political and executive authority is distributed, degree of decentralization that has taken place, and the availability of qualified manpower.

The main pillars of a district health system include: 1) organization, planning and management, which refers to the organizational structure and managerial process for primary health care such as program and manpower planning, implementation, monitoring and evaluation, and coordination; 2) financing and resource allocation which emphasizes active role in resource allocation decisions, identifying sources of

funding and use of financial information for better decision making; 3) inter-sectoral action entails promotion and coordination of different sectors (WHO, 1988).

2.7 Research related to Management of District Health Systems

Diaz-Monsalve (2003), did a study to investigate the knowledge and job performance of 218 District Health Managers (DHM) from nine Latin American countries. The study was based on 12 performance indicators, two self-administered questionnaires, formal and informal, interviews in the work place, and direct observation of the DHM.

The study found that the DHM investigated were particularly weak in system management (community involvement, Inter-sectoral cooperation), monitoring activities and the systematic organization of meetings. They were rarely involved in the identification of primary health problems or of high-risk groups and failed to use health service indicators sufficiently in relation to the district health system. They were stronger in relation to the organization of technical meetings and development of implementation of local health plans.

Factors associated with good management performance were favorable organization structure (including written job description, support from authorities, decision power), and a good knowledge of local situation.