CHAPTER I

INTRODUCTION & RATIONALE OF THE STUDY

1.1 Background Information

It has been 20 years since the Thai Health System started undergoing reforms (WHO-SEAR, 2003). An important event was the passing of the health act in 2001 with the introduction of the Universal Coverage (UC) scheme (popularly also called "30-Baht Scheme") for 70% of the population who were not covered under the Social Security Scheme (SSS), a social health insurance for employees and the Civil Servant Medical Benefit Scheme (CSMBS), a contribution free sickness fund for civil servants (Pongpisut Jongudomsuk, 2005).

The main features of the UC are 1) tax-based financing apart from the rather symbolic contribution of 30 Baht for disease episode and 2) purchasing of services from the Ministry of Public Health (MOPH) by an autonomous office, the National Health Security Office (NHSO), on the basis of a lump-sum amount per capita in the catchment population - capitation (Siriwan Pitayarangsarit, 2004). While the reform was to a major extend finance-driven, the government and the NHSO are aware of the need to provide attractive and cost-effective services with a focus on family medicine as primary care.

Both concepts, the purchaser-provider split and capitation as well as the move away from hospital oriented health care provision to family medicine as primary care, demand a major change of attitude and expectations among providers and consumers. At the same time the performance of primary care (PC) needs to be improved.

These changes cannot be centrally ordered or enforced. They demand careful and intensive efforts in introducing new technical skills and ways of thinking. This can only be achieved through a management process, which involves all actors concerned. In addition a supportive management system has to be in place.

Thailand has a tradition of centralized management and strictly regulated organization of services. While modern concepts and innovations are largely embraced, not enough attention may be given to an appropriate management of their implementation.

With the introduction of the UC, the health care financing system had to be reformed, shifting resources through a contracting process to primary care and including private providers (Pongpisut Jongudomsuk, 2005). One process of contracting is through a contracting unit for primary care (CUP). A CUP is a network of PC facilities most of them health centers (HC) which is managed a board. The board is headed by a director who in general is the Director of the District Hospital or Community Hospital (DH/CH) in a district. All prevention and health promotion services are also delivered by this network, while the District Health Office (DHO), is responsible for the classical, community-oriented public health services.

The CUP is contracted by NHSO to be the main provider of primary health care to its registered population. In general a CUP-network comprises a district or community hospital with all health centers in the district. In urban areas a provincial or tertiary care hospital may be the management center for a network with several urban health centers. The CUP receives a budget per capita to provide comprehensive primary care services to its registered population. Primary care units (PCUs) in general are upgraded HCs, but also established in hospitals. PCUs are designed to deliver primary health care as well as promotion and preventive health services. Patients can access health care services in the nearest HC or the hospital of their respective CUP (Towse et. al., 2004). The PCU should have a gate keeping function with regard to secondary and tertiary care with one of the objectives being cost containment.

The CUP as the main provider for primary care is an important innovation in the Thai health care system (Chatri Banchuin, 2003). To develop the health care services to fulfill the principles of primary care unit, there must be a supporting system such as specification of the target population in order to make continuous plan, skilled team, efficient management, appropriate size of facility, and financial management that supports both curative and promotion health services (Supatra Sriwanichakorn & Surasak Athikmanont, 2004).

The MoPH has developed health care service administrative guidelines for a CUP network. However, the implementation of guiding ideas has not been followed up systematically. Different provinces manage the CUPs differently and even among districts in the same province major variations can be observed.

1.2 Rationale of the Study

A reformed and appropriate management is of crucial importance to support changes in health care financing, services, and attitude to services. An important managerial innovation of the UC-scheme is the contracting unit of primary care (CUP) at district level that is contracted by the NHSO to provide primary care to its catchment population. Relatively little research has been done on the management performance of CUPs.

Knowing CUP management performance and the main factors influencing it will help decision makers to plan systematically successful implementation of the UC-scheme. It would be important to see 1) if the management is appropriate and supportive for family medicine and primary care, 2) if existing rules and regulations for CUP structure and procedures are supportive for effective and motivating management, and 3) what the reasons are for strengths and weaknesses of CUP management.

It needs to be clarified that the study does not try to measure the expected outcome of appropriate management, which could be the quality of primary care services, although this outcome is also influenced by factors that are not under the control of the CUP-management and therefore not a specific indicator. Apart from this, the limitation of time and funds does not allow to do a study that correlates management performance to service quality.

1.3 Research Question

The research question was "do CUPs have an appropriate management system in support of family medicine and rationale use of health services?"

1.4 Objectives

General Objective

To determine if the management of CUPs is appropriate to support family medicine and rational use of health services.

Specific Objectives

1) To identify strengths and weaknesses of the management system in CUPs
2) To identify the main factors influencing the management performance in CUPs
3) To determine if the current structures and management procedures are supportive for effective CUP management
4) To propose evidence-based steps to improve the management performance in CUPs

1.5 Study Variables

For the purpose of this study, variables related to actors, administrative framework conditions and management performance were studied. The variables were grouped as independent and dependent.

Independent variables were divided into actors and administrative framework conditions that influence CUP management. Variables related to actors consisted of 1) socio-demographic data of CUP team members, 2) management training, and 3) previous management related work experience.

Variables related to administrative framework conditions included 1) availability of management advice, 2) autonomy in decision-making, and 3) support by PHO/DHO/TAO and community. Detailed variables are shown in Figure 1.

Dependent variables that measured the appropriateness of CUP management included 1) the chosen structure of CUP-management, 2) functions and procedures of management such as a) planning, b) delegation of tasks and responsibilities, c) human resource management, d) finance management, and e) monitoring and evaluation.

1.6 Operational Definitions

1) *Socio-demographic data* of CUP management team members included age, gender, basic professional qualification, current position in the CUP and tasks performed in the CUP management.

2) *Management training* in this study means any training that the respondents had done that focused on management aspects e.g. planning, monitoring and evaluation, human resource management/personnel management. The training could be short courses, in-house training, workshops or seminars.

3) *Previous management related work experience* means any previous position(s) held by the respondent that involved managerial tasks such as leadership, planning, supervision, and personnel management.

4) *Availability of management advice* means sources of management advice, such as a written guideline on CUP management.

5) *Autonomy in decision-making* means what degree of authority the CUP has on human resources management and financial management.

6) *Support by PHO/DHO/TAO/Community* means the degree of technical, financial, encouragement, or moral support that the CUP management gets from these key actors.

7) *Appropriate CUP management* means the chosen CUP structure and administrative functions and procedures that strengthen holistic district primary care services and respond to the increasing autonomy of local authorities and awareness of communities.

8) *The CUP structure* means the chosen arrangement and composition of the CUP management team or board including, number of members and their responsibilities, and participatory management style of leadership.

9) *The planning process* means presence of CUP plans and the degree of participation in developing these plans.

10) *Delegation of tasks and responsibilities* is whether there is clear allocation of duties and responsibilities shown by availability job descriptions and degree of decentralization to the PCUs/HCs.

1.7 Expected Outcome and Benefits

This study identified the strengths and weaknesses for performance of management in a CUP, the main factors influencing this management performance, determined if the current structures and procedures are supportive for affective CUP management, and finally proposed steps to improve the management performance in CUPs.

The findings from this study can be used to direct more attention to systematic capacity building for CUP management as well as plan necessary interventions for improving management performance of CUPs.

CONCEPTUAL FRAMEWORK

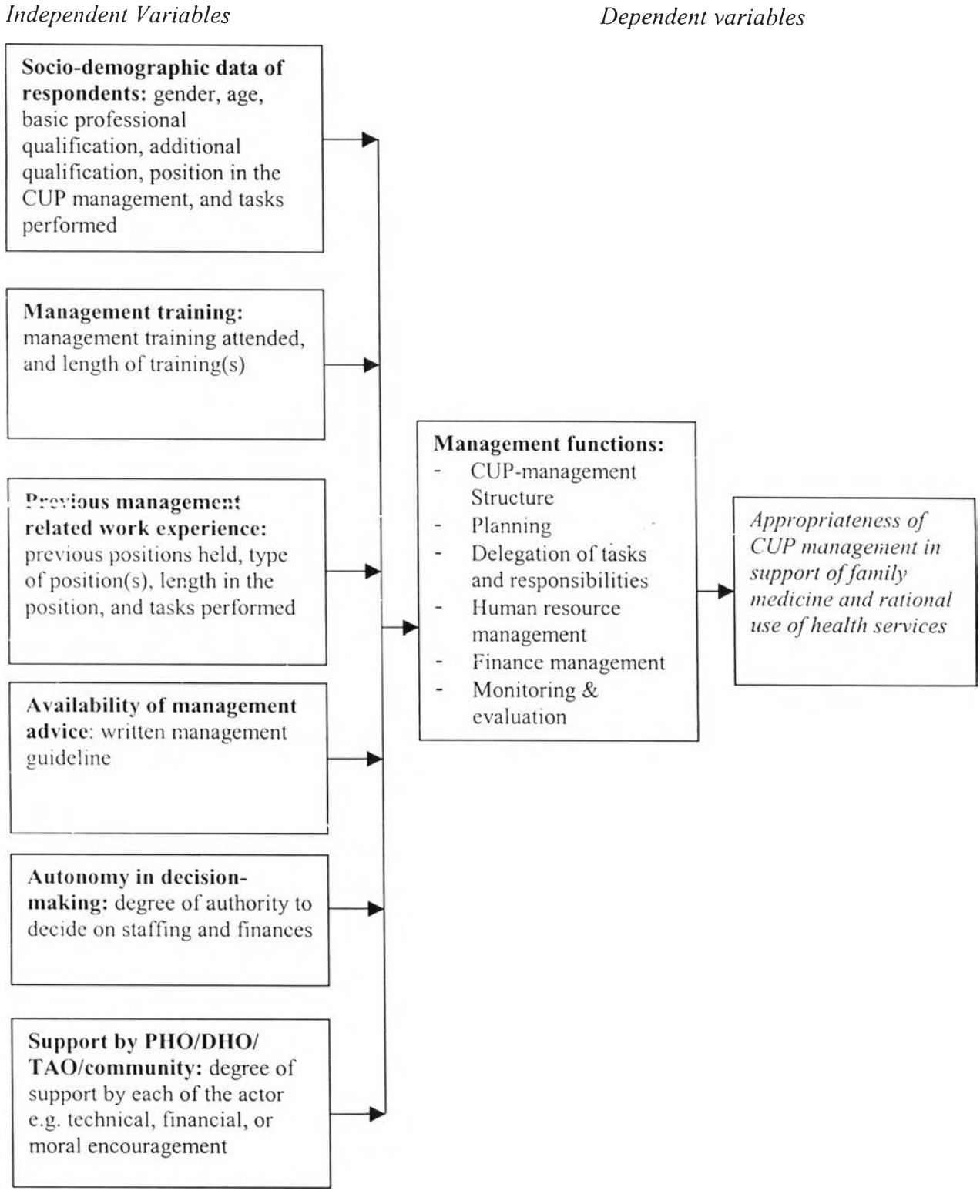

Figure 1: Conceptual Framework